

Annex 2 – NHS Serious Incident Framework

NHS England provides [guidance on the identification and management of Serious Incidents](#) in three parts⁴⁴.

Part One: Definitions and Thresholds

Part Two: Underpinning Principles

Part Three: The Serious Incident Management Process

This guidance provides examples of incidents which should be reported but states that *“there is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of [incidents](#)⁴⁵. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list.”*

Examples of serious incidents relevant to homecare services included in Part One of the guidance are

- Duty of Candour incidents
- Safeguarding incidents which were the subject of Serious Case Review (SCR) or Safeguarding Adult Review (SAR)
- Never Events as further defined within the guidance
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation’s ability to continue to deliver an acceptable quality of healthcare services

NHS organisation are responsible for STEIS reporting of incidents in independent organisations providing NHS funded services which they commission. Every effort should be taken to avoid duplication and participate in joint investigations where multiple organisations are involved.

Other sections of the NHS Serious Incident Framework Guidance relevant to homecare services are:

- Appendix 2 provides a useful checklist for notification of interested bodies.
- Appendix 5 provides guidance on assigning primary investigator accountability using the RASCI model