**Significant Event and Incident Policy (England)**

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| **Version:** | **Review date:** | **Edited by:** | **Approved by:** | **Comments:** |
| v1 | 09/08/2019 | Sultan Mohamed | Munira Mohamed |  |
| v2 | 16/06/2022 | Sultan Mohamed | Munira Mohamed |  |
| v1.4 | 01/10/2024 | Sultan Mohamed | Nine Taylor | Incident reporting policy changed to current one |
|  | December 2025 |  |  | Next review |
|  |  |  |  |  |

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# Introduction

* 1. **Policy statement**

This policy will outline the procedure for reporting significant events (SEs), patient safety incidents (PSIs) and non-clinical incidents at Sheerwater Health Centre. By promoting a learning culture, staff are encouraged to report SEs, PSIs and other types of incidents that will foster learning and help to prevent the recurrence of similar incidents in the future.

It is the responsibility of all staff to ensure that they recognise, respond to and take the necessary actions regarding all incidents. Staff must operate in an open and transparent manner, acknowledging that mistakes happen and take the subsequent necessary actions to report all incidents, thereby further reducing the risk of recurrence and ensuring that a high level of patient care is consistently delivered.

Furthermore, staff are required to share best practice as SEs, PSIs and incidents can arise through positive actions.

* 1. **Status**

The organisation will aim to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents). Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment. Furthermore, this document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

1. **Significant events**
	1. **Overview**

The [General Medical Council](https://www.gmc-uk.org/registration-and-licensing/managing-your-registration/revalidation/guidance-on-supporting-information-for-revalidation/significant-events#:~:text=A%20significant%20event%20is%20any,event%20should%20have%20been%20prevented.) (GMC) defines a significant event as any unintended or unexpected event which could or did lead to the harm of one or more patients. This includes incidents when the event should have been prevented.

* 1. **Significant event analysis**

[CQC GP Mythbuster 3: Significant event analysis (SEA)](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-3-significant-event-analysis-sea) explains that the SEA uses case analysis to encourage the team involved in a case or incident to have a supportive discussion. The aim is to use this as a process to allow reflection and learning from the incident and to improve care. Significant events can reflect good as well as poor practice.

At this organisation, all staff will be involved in the SEA process.

* 1. **Aims of SEA**

[CQC GP Mythbuster 3: Significant event analysis (SEA)](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-3-significant-event-analysis-sea) details the aims of the SEA as well as CQC expectations.

* 1. **Examples of significant events**

[CQC GP Mythbuster 3: Significant event analysis (SEA)](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-3-significant-event-analysis-sea) gives examples of SEs. In addition, the following are also considered to be examples of SEs. Note, this list is not exhaustive:

* Important messages not relayed
* Suspected meningitis
* Wrong/incorrect treatment
* Drug interaction
* Delayed diagnosis
* Loss of care data
* Health and safety concerns or breach
* Evidence of good practice/customer service
* Unexpected positive clinical outcome
* Any celebrated best practice/innovation
	1. **Benefits of significant event analysis**

By undertaking the SEA, this organisation will be able to:

* Reflect on the incident
* Undertake root cause analysis
* Discuss and implement preventative measures
* Enhance learning
* Demonstrate a culture of openness and transparency
* Improve patient care and experience
* Identify best practice

The diagram below illustrates the SEA process.

1. **Analysis of an event or incident**

## Root cause analysis

Root cause analysis (RCA) is a collective term that describes a wide range of approaches, tools and techniques used to uncover the causes of problems.

* 1. **How to use RCA**

RCA can be conducted for an SI, SE or PSI to understand why the incident occurred in the first place and to identify areas for improvements that may prevent reoccurrences.

Repeatedly asking the question 'why?' (use five as a rule of thumb) can quickly identify the source of an issue or problem, allowing the focus of resources in the right areas.

An example of a root cause analysis using ﬁve whys would be:

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| **The Five Whys** |
| 1 | There was a delay in the patient receiving oxygen when suffering with a medical emergency | Why? |
| 2 | The oxygen was not readily available | Why? |
| 3 | The oxygen bottle was empty and had not been replaced | Why? |
| 4 | The patient was being tended to by a locum member of staff who did not know where the emergency equipment was located and no emergency equipment checks had taken place | Why? |
| 5 | The regular member of staff was absent through sickness and replacement staff had not been tasked to undertake the emergency checks | Why? |

## Audit and learning from an event or incident

Following any incident or event, part of the management response will be to instigate an investigation that includes an audit. The [Royal College of General Practitioners](https://elearning.rcgp.org.uk/mod/book/view.php?id=12537&chapterid=428) has produced significant event audit guidance which this organisation will use to audit incidents and events.

1. **Raising and reporting significant events**
	1. **Raising a SE**

All staff are permitted to raise and complete a SE. However, to enable learning and prevent similar repeat occurrences, it is requested that staff advise the Practice Manager of their intention to complete a SE.

The [MDU](https://www.themdu.com/guidance-and-advice/guides/significant-event-analysis) advises that staff and patient identifiable information should be anonymised. Therefore, when completing a SE staff at this organisation should refer to the individuals involved as Patient A, Doctor A, Nurse A, etc.

* 1. **What to report**

Section 3.4 provides examples of the types of events that should be reported. [CQC GP Mythbuster 21: Statutory notifications to CQC](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-21-statutory-notifications-cqc) explains that there are certain types of event and incidents that this organisation is legally obliged to notify the CQC about.

* 1. **Reporting to the Learn from Patient Safety Events service**

The CQC expects this organisation to have in place a robust system for responding to and recording events and incidents. Furthermore, [CQC GP Mythbuster 24: Recording patient safety events with the Learn from Patient Safety Events (LFPSE) service](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-24-recording-patient-safety-events-learn-patient-safety-events) encourages the use of the LFPSE service to record events when:

* A patient was harmed or could have been harmed
* There has been a poor outcome, but it is not yet clear whether an incident contributed or not
* Risks to patient safety in the future have been identified
* Safe and effective care has been delivered that could be learned from to improve patient safety

This organisation will record significant events and patient safety incidents using the  [(LFPSE)](https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/) service (registration required).

When recording events using the LFPSE service, staff are to adhere to the [NHS England policy guidance](https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/#definitions-harm-grading) that explains which event type is appropriate for different circumstances and how to select the most appropriate options for the levels of harm categorisation.

* 1. **Contractual requirements**

The Network Contract Directed Enhance Service (the Network Contract DES) [contract specification 2024/25](https://www.england.nhs.uk/wp-content/uploads/2024/03/PRN01035-ii-pcn-des-contract-specification-2024-25-pcn-requirements-and-entitlements-April-2024-version-2.pdf), at Section B6.2.e., explains that if a PCN employs a physician’s associate, the physician’s associate must partake in significant event reviews.

* 1. **Reporting template**

A reporting template for incidents and events can be found at Annex A should the organisation wish to utilise other methods of recording and sharing significant events and incidents. However, the LFPSE service is the CQC’s preferred method of reporting and recording events and incidents.

1. **Other types of incidents**
	1. **Patient safety incident**

[NHS England](https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/#definitions-harm-grading) explains that a PSI is when something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm.

* 1. **Serious incidents**

[NHS England](https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf) defines serious incidents as events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

* 1. **Near miss**

A near miss may be referred to as a prevented incident and is when an incident resulted in no harm due to a timely intervention.

* 1. **Never events**

[NHS England](https://www.england.nhs.uk/patient-safety/patient-safety-insight/revised-never-events-policy-and-framework/) explains that never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

* 1. **Reporting process for other types of incidents**

This organisation will use the LFPSE service to report all types of incidents. **Note,** the [Patient Safety Incident Response Framework](https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/#who) (PSIRF) will replace the Serious Incident Framework. However, while it can be used, the PSIRF is not yet mandatory for primary care. organisations.

Serious incidents or suspected serious incidents must be declared as soon as this organisation becomes aware of the incident. Initially these will be discussed between partners and managers although consideration must be made soonest as to the likely requirement to escalate to the local Integrated Care Board (ICB).

1. **Demonstrable evidence**
	1. **CQC expectations**

A SEA can be used to demonstrate quality improvement activity. Detailed guidance relating to what the CQC will look for during an assessment is detailed within [CQC GP Mythbuster 3: Significant event analysis](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbusters/gp-mythbuster-3-significant-event-analysis-sea).

1. **Administration**
	1. **Organisation lead**

At this organisation, there is a nominated significant event and incident lead. This additional responsibility is detailed within the individual’s job description/terms of reference. All staff are to be aware of who the lead is.

* 1. **Team meetings**

At this organisation, team meetings to discuss SEs and incidents are held regularly and all staff are invited to attend. Agendas and minutes of meetings are retained as evidence and can be shared to enhance learning. The MDU [provides guidance](https://www.themdu.com/guidance-and-advice/guides/significant-event-analysis) on SEA meetings.

* 1. **Sharing of information**

[Medical Protection](https://www.medicalprotection.org/uk/articles/significant-event-audits) recommends that incident and event reports are worded with the anticipation that they will be shared with the patient and any person or agency that may learn from the event or incident such as community pharmacists, ICBs and PCN colleagues, the Medicines and Healthcare products Regulatory Agency and other organisations as required.

**Annex A – Reporting template**

|  |  |
| --- | --- |
| **Reference**  |  |
| **Date of incident** |  |
| **Date of incident meeting** |  |
| **Title of incident** |  |
| **Staff present at meeting** |  |
| **Incident raised by**  |  |

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| **What happened?**  |
| *Describe in detail what happened. It is pertinent to include where the incident happened, those involved (Patient X, Dr Y and Nurse Z), how it happened and the consequences of the event.* |

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| **Why did it happen?**  |
| *What were the root causes that led to the event happening (both positive and negative)?* |

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| **What could have been done differently?**  |
| *Consider what, if anything, could have been done differently that would have led to a more positive outcome or experience.*  |

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| **What has been learned?**  |
| *Describe in detail the lessons learned. Include information about whole-team and individual learning post-event, including reflection.* |

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| **What are the requirements for change?**  |
| *Describe in detail the agreed requirements for change and how the change will be implemented and subsequently monitored. Where applicable, hyperlink updated policies or protocols to reflect and evidence change.* |

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| **What is the overall outcome?**  |
| *State the outcome of the incident which can include no further action required, training identified, a requirement to audit, best practice identified, etc.* |

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| **Outstanding actions?**  |
| *State any outstanding actions, who is to complete the action/s and the agreed date for completion.*  |

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| --- | --- |
| **Signature of incident lead** | [Signed electronically] |
| **Name** | [Insert name] |
| **Date** | [Insert date] |
| **Signature of Practice Manager** | [Signed electronically] |
| **Name** | [Insert name] |
| **Date** | [Insert date] |