Version 2, JUNE 2017

How to deliver outstanding significant event audit

Clinical Audit SUPPORT CENTRE

Significant Event Audit (SEA) is a well established process and technique predominantly used in general practice to review, learn from and minimise the recurrence of significant events and untoward incidents.

Although many practices have conducted SEA since it became a contractual part of the Quality and Outcomes Framework over ten years ago, recent Care Quality Commission (CQC) inspections and reports have identified that many practices are failing to get the best out of SEA. Indeed, across the CQC scorecard, practices rate least well in response to the "are they safe" question/domain.

This short report summarises the wider research that the Clinical Audit Support Centre (CASC) have carried out in 2016-17. This study links together CASC's research and our wider understanding and experience of significant event audit. The purpose of this report is to share best practice and key findings with the primary care community so that SEA and patient safety can be improved, where required. In addition to this document, CASC are also producing a number of further resources and training materials that will help practices ensure that their SEA is not just 'fit-for-purpose' but outstanding.

KEY MESSAGES:

- **CQC have high expectations in terms of how practices carry out SEA and maintain the safety of their patients**
- **All practices need to get the basics right in SEA in order to meet CQC expectations (see page 2)**
- **We have identified five characteristics that set outstanding practices apart from the rest when it comes to SEA**
- **Use the CASC online barometer to assess how well you deliver SEA and access accredited CASC training to enhance current practice.**

INTRODUCTION

The Clinical Audit Support Centre Ltd (CASC) were established in 2006 and their co-directors and business owners, Tracy Ruthven and Stephen Ashmore, previously undertook quality improvement work with general practice via their positions at Leicestershire Primary Care Audit Group from 1997 to 2006.

CASC offer a wider range of training and support in clinical audit, patient safety/significant event audit and various quality improvement techniques. CASC's aim is to help healthcare providers review and improve their care and services for the benefit of patients. With this in mind in 2016 and following the delivery of several regional significant event audit workshops for NHS England, CASC decided to review Care Quality Commission (CQC) reports for practices awarded an 'outstanding' rating.

This report focuses on the main findings from practices rated 'outstanding' by the CQC in relation to the way they register, manage, review and learn from patient safety incidents and significant events.

HOW WE COMPILED THIS REPORT

In Autumn 2016, the CASC team searched the CQC website for practices who had been awarded an "outstanding" rating. A total of 50 reports were selected and these were picked randomly (3 from 2014, 15 from 2015 and 32 from 2016). The CASC team then researched each report for any feedback or comments relating to significant event audit. An Excel spreadsheet was created and this allowed CASC team members to conduct a rigorous content analysis.

This report features the outputs of that analysis. The main aim of this piece of work is to provide all practices who do not have time to review and research CQC reports with useful information.

The rationale for conducting significant event audit is to improve care by sharing learning. The aim of this document is to help practices improve delivery of their significant event audit and in turn strengthen patient safety by sharing learning from the practices that the CQC have identified as leaders in this field.

This document was compiled in May 2017 and given the slight delay in production, we selected a further 10 'outstanding' reports published in 2017. Content analysis of these reports produced themes consistent with those sourced from 2014, 2015 and 2016. Therefore, 60 CQC reports were assessed in total.

GETTING THE BASICS RIGHT

Our reviews of the outstanding CQC reports identified that it is imperative that practices have strong foundations and processes in place to enable significant event audit to flourish and work effectively.

Indeed, we identified a number of stock CQC phrases that highlighted their expectations when reviewing SEA and patient safety when inspecting practices. These included:

'There was an open and transparent approach to safety and an effective system for reporting and recording significant events'.

'The practice had a system in place for reporting, recording and monitoring significant events'.

In addition, we noted a number of themes that highlight what the CQC clearly view as good practice in relation to the management of significant events:

- **All staff understanding their role in the significant event audit process**
- **Significant events are investigated regularly**
- **There is a lead person designated to oversee the significant events process**
- **Thorough and detailed records of previous significant events are maintained and archived.**

CQC QUOTES: SEA BASICS

'Staff were aware of the significant event reporting process. All staff felt able to raise any concern however small' **St Thomas Medical Group, Exeter**

'The practice reviewed significant events on a monthly basis and earlier if required' **Claythorpe and Ancaster Medical Practice, Grantham**

'The Business Manager was the designated lead in this area [significant event audit]' **Tong Medical Practice, Bradford**

'There were records of the significant events that had occurred in the last 10 years' **East Leake Medical Practice, Loughborough**

5 CHARACTERISTICS OF OUTSTANDING SEA

The Clinical Audit Support Centre reviewed the outstanding CQC reports in detail and in addition to the aforementioned 'SEA Basics" that CQC inspectors undoubtedly expect to be in place, we were able to identify five further key themes. These themes are not ranked in order of importance and in each case we have supplied at least one CQC quote to provide context.

1. SHARED LEARNING:

There is absolutely no doubt that the CQC expect practices to share key information and learning from their significant event audit work as widely as possible. This should come as no surprise given that the fundamental ethos of SEA is to understand why an untoward incident/event has occurred and alert others to ensure they are less likely to experience the same fate. Many practice fall into the trap of only sharing their significant events internally, but this is an example of silo working. The message from the CQC is clear: share your SEA work as far and as widely as you can.

'Findings from investigations were shared with the wider healthcare community' **Schoolhouse Surgery, Stockport**

'We saw that in appropriate cases significant events were fed back to other providers, such as the local hospital and recorded on the NRLS' **Whitstable Medical Practice**

2. GET PATIENTS INVOLVED:

Don Berwick highlighted the importance of involving patients in patient safety work via his extensive 2013 report on the NHS entitled 'A promise to learn - a commitment to act: improving the safety of patients in England'. The very best practices involve patients and their Patient Participation Groups (PPGs) in patient safety work. This is complex, but in many instances patients who have experienced the event have vital information to aid learning.

'When there were unintended or unexpected safety incidents, patients received appropriate support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again' **Windmill Green Medical Practice, Bradford**

3. OVER REPORTING:

It is clear from reading the CQC reports that as an inspectorate the CQC expect practices to encourage all staff to report as many significant events as possible. The CQC advocate that all practice staff report incidents and that complaints should also be regarded as significant events.

'Staff told us they had a low threshold on incident reporting and preferred to discuss all incidents where they felt changes could be made to improve the outcomes for patients' **Olive Family Practice Limited, Bolton**

4. RISK RATING:

We found a number of examples that indicated that the CQC like practices not just to record incidents, but to also rate them in terms of their wider significance. A number of outstanding practices were commended by the CQC for taking a similar approach as per the example below.

'There were 40 recorded incidents, which were colour coded red (potential for significant harm), amber (caused no harm but a point of learning) and purple (to be shared with an external party such as a hospital)' **Marden Medical Practice, Shrewsbury**

5. IMPLEMENTATION OF CHANGE:

Practices must remember that they are not conducting SEA to go through the motions but to reduce the likelihood of future recurrence. The CQC want to see clear examples of changes implemented as part of the SEA process.

'We saw examples where processes had been changed following incidents being reported' **Salford Health Matters, Eccles**

CQC INSPECTOR's ADVICE

It is always useful to gain a full appreciation of what the CQC are looking for when they visit practices and review SEA functions. We were lucky enough to speak to an experienced CQC inspector off-the-record who wished to remain anonymous. He identified three key deliverables in relation to SEA that practices need to get right (but often don't) and these are listed below in the form of direct quotes:

1. STAFF NEED TO KNOW HOW TO REPORT EVENTS

'Staff need to know what sort of event they should be passing upwards. That can be achieved by a documented training syllabus and proof that staff have been trained to that standard, a clear definition in the practice policy document and by showing examples of incidents that staff have reported'.

2. MULTI-DISCIPLINARY APPROACH TO SEA

'Conduct a proper investigation into what happened and why. Ensure the investigation is documented and fully shared amongst everyone. Non-clinicians need to be at least aware of the general issue when there is a clinical incident as in any practice the reception staff are the GPs "backstop" and its surprising just how many times something slips by a GP or nurse and is caught just in time by the receptionist before it hits the fan.'

3. SECOND CYCLE REVIEW

'The most common failing is to treat the SEA as a single incident, investigated, changes made and then just filed in a drawer. Checking that the changes/learning have been understood at the end of the investigation is not the end of the matter but revisiting the issue in 6 or 12 months time to ensure that staff and clinicians especially are actually now doing what they should'.

USE OUR SEA BAROMETER

To assist practices better understand how they are currently delivering SEA and patient safety we have created our easy-to-use significant event audit barometer. This is based on best practice in SEA and patient safety and involves a member of the practice team working through 40 short statements and answering 'yes or no'.

The barometer takes no more than 10 minutes to conduct and once completed respondents are provided with an immediate score out of 100 with supporting comments. As more and more practices use the barometer we are gaining an appreciation of strengths and weaknesses in the current delivery of SEA and we are sharing this information with practices and Clinical Commissioning Groups.

The barometer is freely available via the Practice Index website: www.practiceindex.co.uk

ACCREDITED TRAINING IN SEA

This short information leaflet is just one of a number of resources that the Clinical Audit Support Centre have created to help practices improve their significant event audit and patient safety work.

In addition, we have a strong track record in providing accredited training in significant event audit and root cause analysis. Both techniques are seen as current best practice in terms of learning from significant events and maintaining the safety of patients.

Training can be delivered in-house or as part of a wider multi-practice, CCG or protected learning time event. We can provide intensive hour-long updates, half-day training or one-day workshops. We are also happy to discuss your training needs to deliver bespoke workshops..

Clinical Audit Support Centre Ltd work with practices across the UK. We provide advice on SEA/patient safety, clinical audit, quality improvement, PPGs, reducing DNAs, etc. Visit www.clinicalauditsupport.com