Kingston GP Chambers	Significant Event Policy & procedure		Reviewed	October 2020
			Revised	Yes
	Adopted	26/08/14	Next review	October 2021

SIGNIFICANT/CRITICAL EVENT PROTOCOL

INTRODUCTION

KGPC aims to:

- Foster an open and fair culture committed to learning
- Ensure that lessons are learned as part of KGPC's commitment to maintaining high quality services and supporting staff
- Ensure that incidents are reported to external organisations in line with mandatory requirements
- Formalise roles and responsibilities to ensure that significant events are managed effectively and appropriately
- Ensure the provision of feedback to all staff

Definition of a significant event

There is no single definition of a Significant Event. KGPC sets a low threshold for recording an incident as a "significant event" in order to maximise opportunities for learning. These include both events which are adverse and those which are commendable.

In broad terms, any incident which has caused (or has the potential to cause) harm to patients, staff or the future viability of the service, should be recorded as a significant event. In addition, any incident which does not meet the criteria above but where there is potential for organisation-wide learning and improvement should also be recorded; this may include incidents where there has been a positive outcome.

Serious incidents

Some significant events will also be defined as Serious Incidents. NHS England guidance advises against being too prescriptive about the type of events which constitute a "serious incident", as doing so could risk overlooking incidents which may not strictly meet the criteria but are nonetheless worthy of reporting.

Therefore, each significant event should be judged on its own merits to determine if it meets the broad definition provided by NHSE of "events in health care 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. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff."

NHSE defines a "serious harm" as:

- Permanent harm to one or more persons receiving NHS-funded care
- Chronic pain (continuous, long-term pain for more than 12 weeks after the time that healing would have been thought to have occurred in pain after trauma or surgery)
- Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. lasted or is likely to last for a continuous period of at least 28 days)

Some serious incidents carry a mandatory reporting requirement; these are listed in NHSE's Serious Incident Framework page 13.

KGPC will consider the details of each significant event against NHSE's broad definition of "serious incidents" to determine whether the event meets the "serious incident" threshold. This decision will usually be made by the Compliance & Governance Manager, and will be recorded, along with the rationale for the decision, on the significant event recording form.

Objectives of significant/critical event reporting

- To record adverse incidents effecting, or with the potential to effect patients or staff.
- To record "near misses" so that steps may be taken to prevent a recurrence.
- To learn from the event as a team, discuss, and put change or procedures in place to improve.
- To commend and acknowledge good practice.
- To provide a permanent record of events and evidence of remedial steps taken.
- To satisfy the requirements of nationally required incident reporting standards.
- To operate and discuss incidents in an open environment and within the safety of a "blame-free culture".
- To comply with mandatory requirements to report incidents to external bodies.

Recording of the event
It is the responsibility of all staff (including doctors, clinical and administrative staff, both temporary and permanent) to report significant events. A Significant Event Record form is held in Significant Event Form.doc

Every person with a significant part in, or witnessing an incident should each complete a Significant Event Report Form independently and without conferring as soon as possible after the incident. This will ensure that each account of the proceedings is, as far as possible, as accurate as it can be and without the influence of a third party. Each statement will form part of the incident record. Event record forms are disclosable if legal proceedings follow and should not be stored or recorded in the patient's record.

Notes on completing report forms:

Each person involved in, or witness to, the event will complete a Report Form to record:

Date / time	The time of the incident may be a critical part of the record (e.g. in the case of a communication failure).
Brief description	This is the witness or staff statement of the events from their own perspective. This may disagree or conflict with other accounts of the event. No attempt should be made to influence a change to the statement although a written note of any points clarified may be made.

Completed forms should be passed to the KGPC Compliance and Governance Manager(C&G Manager), or an appropriate representative in their absence, to collate for an initial check. This check will ensure that the forms are properly completed and any queries arising from each account of the incident can be raised in good time. The C&G Manager can also assess at this point whether any urgent or remedial action or external reporting is required without delay (e.g. for health and safety issues) and initiate this.

The investigation
An appropriate individual should be appointed to lead on the investigation of the event. The name of this person should be recorded on the significant event recording form. In the

process of investigating the incident, the investigator should keep records of all actions taken, including notes of interviews with staff and patients and notes of inspections of equipment.

On conclusion of the information gathering stage of the investigation, the investigator will either produce conclusions and outcomes, or, where appropriate, bring the incident to a Review Meeting. A meeting will usually be convened where there is need for wider discussion and input to understand the root cause of the incident, identify key risks and establish appropriate actions.

Where a Significant Event has been defined as a Serious Incident, all recording and reporting must be done within the timescales prescribed in the Framework.

Monitoring and sharing outcomes, actions and learning points
Each Significant Event will be entered onto the SEA tracker, which records details of the event and those responsible for investigation, deadline dates for any resulting actions, and details of when and how outcomes and learning have been shared with staff.

All actions identified as a result of the investigation will be assigned a responsible member of staff and a deadline date; these will be recorded on the significant event recording form and tracker. The C&G Manager will be responsible for monitoring progress against deadlines.

Learning points and details of any new or amended processes resulting from the event will be shared with staff immediately where appropriate and will also be discussed as a standing item in team meetings; a link to minutes of team meetings where these have been discussed will be saved on the tracker.

Details of the need for additional training or disciplinary action relating to an individual member of staff

Details of all significant events will be shared with the Board via the monthly Board meeting; where applicable (e.g. where the impact of an event is so serious as to threaten the viability of a service), Board members will be notified immediately.

Record keeping
As soon as a significant event arises, a new electronic folder, solely for filing documents relating to that event, will be created in the Significant Event folder on the H:drive (H:\CORPORATE\Significant Events); all records and documents relating to the event should be saved into the corresponding folder. Note that significant event forms should not be saved to patients' clinical record.

External reporting

All Significant Events, relating to patient/staff safety (including minor issues) should be reported to the National Reporting and Learning Service (NRLS) using the link on their website.

All Serious Incidents must be handled in line with NHSE's Serious Incident Framework, including reporting the incident to the Commissioner of the service and any other relevant bodies (e.g. CQC).

The C&G Manager will be responsible for reporting to external agencies, (unless an alternative manager is delegated this task in their absence).

Monitoring compliance with this policy

The Compliance and Governance Manager will maintain regular overview of actions relating to significant events as part of the preparation of the monthly Board Report.

An annual review of all significant events will be undertaken by the Compliance and Governance Manager at the end of each reporting year (March 31st) to ensure that all identified actions have been completed (or are on track to be completed).