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# **RCGP Revalidation Toolkit:** **Significant Event Analysis:** **a guide for GP appraisers** **and appraisees**

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## Definitions

The National Patient Safety Agency (NPSA) defines significant event analysis as:

*A process in which individual episodes (when there has been a significant occurrence either beneficial or deleterious) are analysed in a systematic and detailed way to ascertain what can be learnt about the overall quality of care, and to indicate any changes that might lead to future improvements.<sup>1</sup>*

The terms significant event analysis and significant event audit are used interchangeably in a general practice context and mean the same thing. It is a technique to reflect on, and learn from, individual cases to improve quality of care overall.

## Terminology: serious incident, significant event, and case review

There is some discrepancy in the use of the term significant events when comparing documentation produced by the GMC and the RCGP.

**The GMC** refers to serious incidents as events where there was or could have been a detrimental outcome involving patient safety. A doctor may go several years without experiencing these but if they are involved in one they must include it in their appraisal portfolio. Examples might include a drug reaction resulting in death or serious injury, a delayed admission for a life threatening disease such as meningococcal septicaemia or myocardial infarction, a perioperative death, or maternal death.

**The RCGP revalidation** guidance requires that GPs submit two significant event analyses (or case reviews) annually. The definition in this context is broader than that used by the GMC when referring to serious incidents. Significant events suitable for analysis are events where the practitioner can identify an opportunity for making improvements, either because the outcome was substandard or because there was a potential for an adverse outcome ('near miss'), but these incidents involve a lower level of safety concern than a 'serious incident'. Examples might include: a delayed cancer diagnosis; a prescription error; a delayed action on an investigation; or a breach of confidentiality. Alternatively, a GP may decide to analyse an event that went 'well' because of luck or good organisation (such as the way the whole practice reacted to a patient who collapsed in the surgery and needed resuscitation) in order to consolidate learning from the event.

Significant events are included each year in the doctor's appraisal portfolio. Both types of events are available to the responsible officer for review when the time comes to make a recommendation for revalidation.

**Case review:** this format can be used to analyse the learning points from a significant event when the doctor does not have access to a work based or even an external forum in which to discuss the event with colleagues. It is a structured document identifying opportunities for reflection and improvement. Case reviews are not confined to administrative issues/problems (e.g. the

<sup>1</sup> NHS National Patient Safety Agency. *Significant Event Audit: guidance for primary care teams* (2008), [www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501](http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61501).

use of the telephone for triage, the availability of appointments and the systems used in the practice to communicate abnormal results). A review of a series of cases (e.g. a case note review) can also be submitted in accordance with GMC guidance as evidence of quality improvement, as an alternative to clinical audit, where clinical audit is not an appropriate option. Clinical cases that present particular challenges (diagnostic, management, ethical, multidisciplinary, communication, safeguarding and so on) – when appropriately structured with reflection – can illustrate well the doctor’s ability to reflect and learn from his/her work with a view to introducing or consolidating improvements.

	<b>How many do I need to have?</b>	<b>When would an appraiser worry?</b>	<b>Examples</b>
<b>Serious incident:</b> usually involves a patient safety element (adverse outcome)  (GMC definition)	You may have none for many years	If you have several in one year	A drug reaction resulting in death serious injury, a delayed admission for a life threatening disease such as meningococcal septicaemia or myocardial infarction, a perioperative death, or maternal death
<b>Significant event:</b> Can be an outcome or near miss, less significant safety element  (RCGP definition)	Need to present two analyses per year	If you cannot submit two analyses in a year. Would merit discussion of your understanding of SEA and also whether there might be an insight issue or reflection issue	A delayed cancer diagnosis, a prescription error, or delayed action on an investigation, breach of confidentiality

## Revalidation requirements

*The RCGP Guide to Revalidation for General Practitioners* recommends that each year a GP should undertake quality improvement activities that **include**:

- SEA / Case Review:
  - at least two per annum
  - any serious incidents must be included (which may bring the total up to more than two)
- clinical audit and other activities such as case discussion, review of referrals and review of record keeping; small quality improvement activities that are not full-cycle audits may also be included in this section.

Even though significant event analysis is by definition a quality improvement activity, GPs will demonstrate a range of quality improvement activity in several areas of their portfolio.

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## Criteria for an acceptable SEA submission at appraisal

- Each of the submitted events must demonstrate, through the analysis, areas for improvement, reflection and the implementation of change.
- Wherever possible the doctor should only submit analyses of significant events in which they have **been directly involved**.
- Wherever possible, the event should be discussed in a **team meeting** (usually a significant event analysis meeting) with an appropriate selection of other primary care team members present.
- If the doctor has responsibility for systems at the level of the practice then they should also consider choosing SEAs that involve them personally in **implementing the change**. They should then show that they have actually made the proposed change and attempt to demonstrate that it has had an effect. For doctors with a managerial responsibility this may mean, for example, development of new protocol or standard operating procedures, or instituting training for staff. For doctors without managerial responsibility, this may simply mean an undertaking to proceed personally in a different manner, with evidence of impact only possible where a repeat incident has occurred (which cannot be guaranteed in any given revalidation cycle).
- Where GPs are unable to bring their personal SEAs to a multidisciplinary team meeting (for example because they work as a locum and are not included, or because as a salaried GP they have been unable to influence practice agendas) then they should seek to demonstrate that they have sought opportunities to discuss their personal events with colleagues in other settings. The commonest alternative being **self directed learning groups, also known as peer groups, young practitioner groups or CPD groups**. The challenge in this setting is to ensure that discussions impact positively on patient care. Where improvements concern only the individual doctor this is more straightforward. Where they may require systems changes the doctor may need to take some of the outcomes of their discussions back to the clinical setting for consideration by the clinician responsible for that service.
- Doctors are also responsible for **alerting services about adverse events** if there is no formal forum to systematically conduct a significant event analysis. If there is a patient safety concern or event (also known as a serious incident) within the doctor's clinical practice, that event must be included as one of the ten significant event analyses and included in the revalidation portfolio.

## What should a significant event analysis look like?

An account of a significant event analysis should be anonymised and should comprise:

- the title of the event
- the date of the event
- the date the event was discussed and the roles of those present
- a description of the event involving the GP
- what went well?

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- what could have been done differently?
  - reflections on the event in terms of:
    - knowledge, skills and performance
    - safety and quality
    - communication, partnership and teamwork
    - maintaining trust
  - what changes have been agreed:
    - for the doctor personally
    - for the team
  - changes carried out and their effect.

The Clarity & RCGP Appraisal Toolkit for GPs contains standard fields to be populated.

## Patient Safety Incidents and Enhanced SEA

Involvement in a patient safety incident challenges the quality of an individual or team performance and may be similar to receiving negative feedback with the potential to trigger emotional responses (including fear of blame or feelings of guilt), which can impede a clinician's preparedness to highlight significant events and engage adequately with the SEA process. SEA literature also indicates that the application of a structured analytical framework is generally lacking in this SEA process – meaning it is often approached superficially and without the high standard of critical reflection and analysis required to identify the range of human and system interactions contributing to these incidents. Consequently, safety incidents may not be analysed constructively and therefore not result in a meaningful or tangible improvement plan missing opportunities to improve patient safety.

An alternative and enhanced method of SEA prompts reflection on the individual reaction to a patient safety incident and takes a human factors systems-based approach to understanding how and why events happen by considering the people, activity and environmental factors that interact to contribute to any adverse event – thereby reducing the psychological barriers to openly acknowledging safety incidents and resulting in a more detailed analysis.

- *People factors* (e.g. a newly trained health visitor practising in an immunisation clinic under clinical supervision, while being frequently distracted by parents and colleagues).
- *Activity factors* (e.g. performing repetitive but different vaccination tasks in a very busy and recently combined immunisation clinic, with similarly labelled vaccinations within immediate reach).
- *Environment factors* (e.g. a poorly designed workspace layout and immunisation system, and a well-intentioned practice decision to combine clinics to improve efficiency).

The reporting format for this method prompts the recording of a more in-depth analysis, targets learning and helps to formulate a more detailed improvement plan. The assisting toolkits can also aid analysis of SEAs by the individual where team discussion may not be possible.

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The enhanced SEA toolkit, which includes report proforma and supporting resources, is available from: [www.nes.scot.nhs.uk/shine/](http://www.nes.scot.nhs.uk/shine/).

## When should an appraiser be concerned?

Significant event analysis is a technique to reflect on, and learn from, individual cases to improve quality of care overall. In the first cycle of revalidation, the GMC expects responsible officers to be satisfied that GPs have brought to their appraisals two significant event analyses (to each annual appraisal).

An appraiser should be concerned if:

- a GP presents no SEAs at an annual appraisal. This might be an indication that the doctor has no insight into his or her practice. Equally, if a doctor only submits SEAs that focus on positive events, that might suggest a lack of insight into his or her practice. It is good practice to report significant events throughout the revalidation period
- if for example there were ten significant events analysed in year one and none in subsequent years.

Appraisers may encourage GPs to think about issues where although they may not at first believe that they were directly involved, on reflection, they were (for example a complaint about how long people are waiting to be seen in the surgery). As explained above, a GP may even decide to look at things that went very 'well' because of luck or good organisation (such as the way the whole practice reacted to a patient who collapsed in the surgery and needed resuscitation).

A significant event may have taken place in the period immediately before an appraisal, leaving insufficient time to meet, reflect, change and demonstrate that change. In this case, the event can be carried through to the next appraisal and discussed more fully then.

Appraisers and responsible officers are asked to not only look at the exact criteria outlined above but also to look at whether or not the doctor has taken an open, honest and reflective approach to any event that has been submitted and apply judgement accordingly.

A patient who complains may seek legal or regulatory redress. If the issue is of a serious nature GPs should be encouraged to discuss the matter with their medical defence body. Although it is important to be open and honest and to say sorry when it is appropriate, all responses to complaints and minutes of significant event meetings are documents that are disclosable for the purpose of a court case.

## Specific advice for doctors who do not have responsibility for services and have limited or no organisational influence (for example freelance locums and some employed GPs)

The doctors:

- need to inform themselves of local processes for reporting adverse events and also for being informed of adverse events that relate to clinical episodes they have been involved with. This is

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relevant whatever the status of the GP (partner, salaried, locum, out of hours (OOH)) and might be addressed in their terms of engagement/employment

- should endeavour to request access to clinical meetings where SEAs are discussed
- should endeavour to access records in order to participate in SEA discussions
- may struggle to follow up cases where they are working only for short-term placements. Their terms of engagement can help reinforce their openness to receiving feedback and to accessibility for discussing adverse outcomes
- are encouraged to follow up cases that have been challenging, for example emergency admissions, cancer referrals, complex cases, or cases where there may have been significant divergence of opinion between doctor and patient or between doctors. A log will assist this process
- should attempt to access a suitable group of colleagues (such as a self-directed learning group,<sup>2</sup> also known as young practitioner group, peer group or CPD groups) to discuss anonymised cases and significant events (this may serve as a substitute for when the doctor cannot access a multidisciplinary team)
- should proactively discuss adverse events with other doctors in the organisation and ask for advice as to how they and the whole organisation might act to prevent it happening again.

Organisations are responsible for ensuring:

- they have systems in place for facilitating the report of events by doctors
- they inform the doctors of any significant events
- they are inclusive of all their clinicians at meetings
- they provide access to medical records when required for SEAs to all clinicians
- all clinicians can place their personal SEAs on agendas for discussion.

## References and sources of further help

- National Patient Safety Agency (NHS). *Significant Event Audit: guidance for primary care teams*. A full guide to an effective significant event audit and a quick guide to conducting a significant event audit. London: NPSA, 2008.
- *The RCGP Guide to the Revalidation of General Practitioners*. Available from [www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx](http://www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx).
- RCGP Quality Improvement Toolkit. Available from: [www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx](http://www.rcgp.org.uk/revalidation-and-cpd/new-revalidation-guidance-for-gps.aspx).
- RCGP Quality Improvement e-learning module, <http://elearning.rcgp.org.uk/revalidation>.

<sup>2</sup> Wright P. Self directed learning groups for GPs: a support framework for revalidation. *BMJ Careers*, 8 May 2013, <http://careers.bmj.com/careers/advice/view-article.html?id=20012222>.

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- NHS Education for Scotland. Scottish GP Appraisal Toolkit. Domain 2: safety and quality / significant event analysis, [www.scottishappraisal.scot.nhs.uk/toolkits/scottish-gp-appraisal-toolkit/domain-2/significant-event-analysis.aspx](http://www.scottishappraisal.scot.nhs.uk/toolkits/scottish-gp-appraisal-toolkit/domain-2/significant-event-analysis.aspx).



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