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**Serious Incidents (SI) vs Significant Events (SEA) or Incident:**

**How to report**

**Introduction and Background**

NHS England has a responsibility for assurance, oversight and surveillance of the responses to SI’s in services that it directly commissions. As commissioner of Primary Care, it has a responsibility to ensure that there is a robust system in place for reporting, investigating and learning from SI’s that occur or are identified in its Primary Care contracted services.

The purpose of the incident reporting and learning process is:

* To demonstrate assurance of good governance and safety for the most serious of incidents;
* To facilitate the wide sharing of learning arising from incidents, locally, regionally, and nationally where appropriate;
* To help prevent reoccurrence where the incident occurred and reduce the chance of a similar incident happening elsewhere;
* To support health service improvement by providing information, guidance and recommendations to support health care managers in directing resources where they are most needed to improve quality and safety.

The investigation process should focus on the learning that is to be gained from the incident.

**Serious Incidents**

Serious Incidents, as set out in the Serious Incident Framework (March 2015) ([here](https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf)) are ‘events in healthcare where the potential is so great, or the consequences to patients, families and carers, staff or organisations are so significant’.

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. However, the definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using the description below:

Serious Incidents include:

* + Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past;
  + Unexpected or avoidable injury to one or more people that has resulted in serious harm;
* Never Events – these are serious incidents that require investigation as they are wholly preventable because strong systemic protective barriers are available. Not all Never Events necessarily result in serious harm or death, as defined in the Never Events Policy and Framework. The defined list of Never Events (2018) ([here](https://improvement.nhs.uk/resources/never-events-policy-and-framework/)), with those relevant to primary care highlighted albeit unlikely is:
  + Wrong site surgery (wrong patient or wrong site) ie incorrect dental extraction or ingestion of a foreign body
* 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, Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

**Significant Events**

Significant Events involve a lower level of safety concern than a ‘serious incident’. They 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’).

The recording of Significant Events is a valuable means of sharing learning and capturing themes and trends within Primary Care. A Significant Event Audit (SEA) is a technique to reflect on and learn from individual cases to improve quality of care overall. SEA’s should form part of individual and practice based learning and quality improvement. Whether clinical, administrative or organisational, the SEA process should enable a practice to answer the following questions:

• What happened and why?

• How could things have been different?

• What can we learn from what happened?

• What needs to change?

• What was the impact on those involved (patient, carer, family, GP, practice)?

**Process for informing NHS England SW South of an incident**

Once an incident is identified within the Primary Care practice, whether via a practice SEA meeting or otherwise, a completed Primary Care incident notification form **(Attached)** is to be sent via email to:

[england.devcorn-incidents@nhs.net](mailto:england.devcorn-incidents@nhs.net)

On receipt, the information will be reviewed by the Medical and Nursing Directorate and triaged according to the SEA process and either redirected to a more appropriate team for actioning (incidents relating to safeguarding, pharmacy or screening and immunisations), redirected as a SI if deemed to meet the threshold or logged for theming and shared learning. This learning (anonymised) will be shared with Primary Care on a quarterly basis via newsletters and appropriate fora, e.g. the Primary Care Quality Hub.

**Duty of Candour**

Duty of Candour is a legislative requirement ([here](http://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour)). Healthcare organisations registered with CQC in England are now subject to a statutory duty of candour, introduced in April 2015. In England, the professional duty of candour is supported by a duty on all organisations delivering healthcare to be open and transparent with the people using their services. This duty is monitored by the Care Quality Commission. As professionals following the GMC/NMC guidance, you will be helping your organisation to meet any statutory duty of candour in force where you practise.

Attached – SEA Form