CQC guidance on Significant Event Analysis (SEA)

The CQC issued the following guidance.

Practices should be able to demonstrate a team based learning environment. Significant event analysis can be used to show quality improvement in the safety domain of the CQC GP inspection.

Agreed principles for SEA requirements for GP practice inspections
The NPSA's definition of a significant event analysis (SEA) is as follows:
"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."

Significant events can be very wide-ranging and can reflect good as well as poor practice.

• Significant event audit is an important part of revalidation. A GP's revalidation portfolio will be expected to contain two SEAs per year, this equates to 10 SEAs per five year revalidation cycle.
• In line with revalidation there should be a minimum of two SEAs per practice with a focus on quality improvement. If a practice has done no SEAs, it is likely that there is a cause for concern and should be investigated further.
• SEAs should act as a learning process for the whole practice, individual SEAs can be shared between members of staff including GPs. The focus of the SEA is that learning is disseminated within the practice.
• A practice that we would rate as 'Good' ensures that the learning involves the whole team and becomes embedded in everyday practice. 'Good' is linked to the impact and learning resulting from the SEA.

What is a significant event analysis?
Significant events can be very wide-ranging and can reflect **good** as well as **poor** practice. Examples could include new cancer diagnoses, coping with a staffing crisis, complaints or compliments received by the practice, breaches of confidentiality, a sudden unexpected death or hospitalisation, an unsent referral letter or a prescribing error.
SEAs are a qualitative process describing: What happened and why? How could things have been different? What can we learn from what happened? What needs to change?

Aims of SEA:
• To identify events in individual cases that have been critical (beneficial or detrimental to the outcome) and to improve the quality of patient care from the lessons learnt.
• To instigate a culture of openness, not individual blame or self-criticism, and reflective learning.
• To enable team building and support following stressful episodes.
• To enable identification of good practice, as well as suboptimal.
• To be a useful tool for team and individual continuing professional development, identifying group and individual learning needs.
• To share SEA between teams within the NHS where adverse events occur at the 'overlap' or in shared domains of clinical responsibility, e.g. out-of-hours (OOH), discharge problems.

What are the processes involved in a SEA?

On an inspection, an inspector will be looking at the seven steps involved in an SEA:

1. All staff should be aware of and be able to prioritise a significant event.
2. Information gathering – There should be evidence of information gathering; this will include factual information on the event from personal testimonies, written records and other healthcare documentation. For more complex events, more in-depth analysis will be required.
3. Facilitated team-based meeting should have occurred to discuss, investigate and analyse events.
4. There should be evidence of the team meeting regularly for the purpose of SEAs Analysis of the Significant Event including - What happened and why? How could things have been different? What can we learn from what happened? Is change required and if so what needs to change?
5. Agree, implement and monitor change. There are no fixed end-points; outcomes should be revisited and the implementation and success of any agreed changes monitored at pre-set intervals.
6. Written records, all the processes of the SEAs should be written up to form a report. The SEA report is a written record of how effectively the significant event was analysed.
7. Report, share, review. The SEA should be shared with all members involved in the significant event.