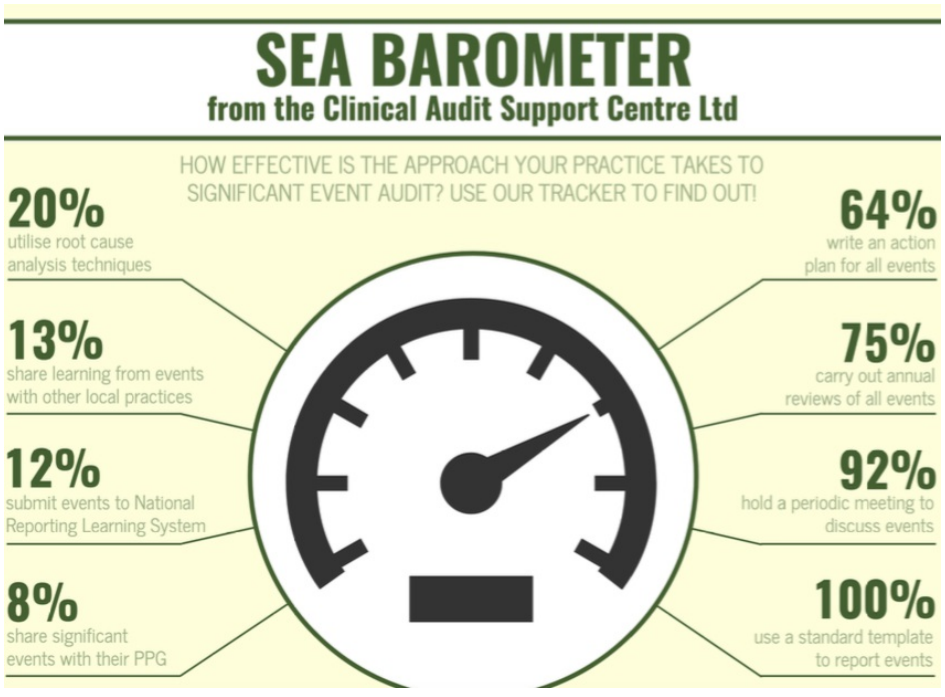
Case study #7

Work with Practice Index
Significant Event Audit Barometer

The Directors of the Clinical Audit Support Centre have a long-standing track record of working in collaboration with practices and primary care teams. Over the years we have developed accredited training in significant event audit (SEA), a simple process for improving patient safety by learning from incidents.



Practices have been expected to use SEA since the introduction of the GP contract in 2004. However, recent Care Quality Commission reports have identified that many practices fall short of what is expected in terms of maintaining patient safety. Indeed, many CQC reports have uncovered poor delivery of SEA. To help practices gauge and evaluate their current approach to SEA, we collaborated with Practice Index to create our the SEA barometer. By completing a series of forty questions practices can immediately find out how well they perform in their delivery of SEA.

The barometer has proved very popular and an unexpected benefit of creating the online tool has been that we are increasingly able to benchmark results in terms of identifying the relative strengths and weaknesses of those practices carrying out SEA. This is helping practices to make targeted changes to help them improve the safety of their patients.

In addition, we have supplemented this work by creating a four-page guide that outlines CQC expectations in terms of SEA delivery. The guide provides a step-by-step account of how to ensure your SEA is outstanding.


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.

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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.