Revalidation:

FAQs for Doctors in Postgraduate Training

Involved with Serious Incidents

What is a Serious Incident (SI)?

Patient safety incidents are defined by the **National Reporting and Learning System** as 'any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare'. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe.

The Serious Incident Framework - A serious incident an **incident** that occurs in **NHS-funded services and care** which results in:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
  - Unexpected or avoidable death8 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 past9 (see Appendix 1);
  - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:—
  - the death of the service user; or serious harm;
  - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring10; or
  - where abuse occurred during the provision of NHS-funded care.
    This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information).
- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information;11
- 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, including (but not limited to) the following:

What is the difference between a Serious Incident, a Critical Event, a Significant Event and a Serious Untoward Incident?

In the past a range of terms – Serious Incident, Critical Event, Significant Event, Serious Untoward Incident – have been used to describe occurrences in health care where harm or the risk of harm to patients has occurred. These terms were used interchangeably by some – however due to individual preferences, certain terms were preferentially used in different settings e.g.: clinical governance meetings, root cause analysis documents and the reflective logs of individual doctors.

In 2010, the National Patient Safety Agency (NPSA) developed a national framework for the notification, management and learning from serious incidents in the NHS – National framework for reporting and

learning from serious incidents requiring investigation. It also unified much of the terminology surrounding such incidents around the term Serious Incident.

Why does the Deanery need to be informed?

As part of the revalidation process, the GMC requires all LEPs (Trusts/GP Practices) to notify the Deanery when a doctor in postgraduate training, on an approved training programme, is involved in an SI. The communication channel is between the Medical Director for the Trust (or practice you are placed with) and the Postgraduate Medical Dean.

What does it mean to me as a trainee if I am implicated in a Serious Incident (SI)?

As part of the requirements for revalidation, it is expected that all doctors will record and reflect anonymously on serious incidents in their portfolios, with a particular focus on what they have learnt as a result of the event(s). This reflection must not contain any details that would allow someone to be identified. Investigations or complaints should be referenced with a note on your Form R to indicate where the reflection can be accessed in your portfolio. As a trainee you will also need to complete a Form R annually. This will require you to answer questions about any complaints or SIs over the last year. You will only need to record information on your Form R if any formal investigations arising from a SI have not been completed and resolved, or if completed investigations have not been reflected upon in your portfolio.

If you have been involved in a SI your placement provider will be asked to provide a brief summary of the SI Investigation. If this has been resolved satisfactorily with no on-going concerns about your fitness to practise and you have reflected upon this appropriately, it will not affect your revalidation recommendation. If there are unresolved concerns, your placement provider will be asked to give a brief summary and the anticipated date of the outcome of any investigation. Should this happen at the time that you are due to be revalidated then your RO will request a deferment in order to give time for the investigation to conclude.

How can I ensure that I benefit from the experience of being involved in an Serious Incident (SI)?

SIs can be powerful learning experiences that can provide opportunity for reflection and learning across a broad range of areas from the specifics of clinical event to aspects of communication, team-working, record keeping and professionalism.

It is therefore important to take time to consider any learning needs that might have been identified through an SI and to discuss with your educational supervisor and other colleagues about how to begin to approach addressing these.

It is important to incorporate any learning needs into your personal development plan and to approach in a structured, realistic way alongside your other learning objectives. Usually SIs involve more than one person and sometimes whole teams are implicated. Therefore there may well be the opportunity to work together on planning and addressing learning needs.

How might being involved in an SI affect my future career?

Despite best efforts SIs do happen. One of the reasons to identify them and act upon them is to try to ensure they do not happen again, but unfortunately working in the complexity of health care sometimes unforeseen events and consequences arise.

Being involved in an SI can therefore give you the opportunity to demonstrate your professionalism and ability to reflect and adapt. This will be useful for your training record and can provide you with easy worked up answer to that sometime difficult interview question: “Tell us about a time when things did not go well for you. How did it make you feel? What did you do?”

I am a trainee on a team where a Serious Incident has happened but I was not directly involved with the patient at the time. What should I do?

If the SI has been reported then the incident should be taken as a learning opportunity even if you were not directly involved. If, however, you have sufficient knowledge the incident meets the criteria for reporting (outlined in the definition above) but has not been reported you have a duty to raise this concern in line with GMC guidance *Raising and acting on concerns about patient safety*. In the first instance, as a trainee, you should raise the issue with your clinical or educational supervisor who will advise you further.

Where it has been necessary for you to contribute to a SI investigation it would be appropriate to record this in your portfolio and Form R even if the subsequent process confirmed that you were not directly involved.