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Submitted to Never event framework consultation
Submitted on 2024-04-25 09:55:41

Consultation on the Never Events framework

Are you responding as an individual or on behalf of your organisation?

Organisation

Consultation on the Never Events framework

What is your name?

What is your name?:
[redacted]

What is the name of your organisation?

What is the name of your organisation?:
The Royal College of Ophthalmologists

Email address:

Email address :
[redacted]

Job title:

Job title:
[redacted]

Consultation on the Never Events framework

Which is your preferred option for the Never Events framework?

Option 4 - Revise the definition of and process for Never Events to create a new system that does not require all relevant incidents to be 'wholly preventable'.

Please provide any additional comments :

The Never Events Framework has been a great tool to monitor and help avoid incidents of harm happening to patients under the care of the NHS. For ophthalmology, this focus has been on the surgical never events. Whilst the never events framework has provided focus in this area, and we have seen an associated reduction in harm, these events still occur and will continue to occur as we are unable to introduce strong systemic barriers. Due to this, the College would be keen to explore Option 4: Revise the definition of and process for Never Events to create a new system that does not require all relevant incidents to be 'wholly preventable'.

Ideas for New system

Harm in ophthalmology is occurring primarily from issues associated with capacity and demand within our outpatient settings. Our members most significant concerns are in this area, and we would welcome additional focus from NHS England in addressing these concerns. To continue aligning with the overall purpose of reducing harm, we would encourage NHS England to work with the College to define terms for events where delay to treatment and diagnosis have caused harm.

'Rebranding' of Never Events

Whilst receiving additional welcome focus from provider governance teams, the terminology associated with never events has had significant impact on surgical teams. There is commonly an associated experience of blame for individuals involved in surgeries rather than an acknowledgement that the majority of issues are systemic in nature. Human factors play a significant role in the occurrence of never events and the College believes that any future terminology should avoid using the term 'never' and strongly emphasise the systemic nature of incidents.

What category describes your role best?

Patient safety specialist

Other::

What is your organisation type?

Professional body (e.g. royal college)

Other::