Response to the Never Events Policy and Framework Review 2016-17

About the Faculties

This is a joint response submitted on behalf of the Faculty of Dental Surgery and the Faculty of General Dental Practice (UK) at the Royal College of Surgeons of England ("the Faculties").

The Faculty of Dental Surgery is a professional body committed to enabling dental surgeons to achieve and maintain excellence in practice and patient care. It represents over 5,500 specialist dentists, many of whom work in primary, secondary and community care, and in public health settings.

The Faculty of General Dental Practice (UK) improves the standard of primary care dentistry delivered to patients through standard setting, postgraduate training and assessment, publications, policy development and research, and provides a national voice for around 5,000 members and fellows.

Does the NHS need a nationally agreed list of incidents that are considered wholly preventable if existing guidance is followed and implemented?

Yes

The Faculties agree that the NHS does need a nationally agreed list of Never Events. Anecdotally, some of our Board members have encountered situations where Never Events are defined and recorded differently by different clinical groups, even within a single trust. A clear definition of incidents which should be recorded as a Never Event is therefore essential, and an agreed list of Never Event incidents represents an important component of this.

Is the description of how managers, commissioners, regulators and inspectors should respond to Never Events as written in the current Never Events Policy and Framework generally appropriate? See section 6 'Roles and responsibilities', page 9.

Yes

In the view of the Faculties, it is absolutely vital that learning and improvement are positioned as central themes within the Never Events Policy and Framework. The focus of Never Event procedures should not be on punishing those staff involved, which would ultimately be counter-productive and in all likelihood inhibit reporting, but rather on facilitating positive system change and improving patient safety. The policy and framework must therefore facilitate a shift from a "blame culture" to a "learning culture" around Never Event incidents. The statement on page 9 describes capturing and implementing relevant learning from an incident as "the most crucial aspect of this policy and framework", and it is on this basis that we have responded "Yes" to this question.

Thinking of the overarching Serious Incident Framework and the range of incidents that require investigation, do you think the Never Events Policy and Framework adds value and helps organisations to focus investigation and action planning where it is most needed?

Usually

In response to this question, we would echo points made in the submission from the Royal College of Surgeons. We agree with the comments put forward in that response that while Never Events are a subset of serious incidents, there is value in having a dedicated policy and framework which deals with wholly preventable incidents where systematic barriers should have been in place. However, as the Royal College of Surgeons submission emphasises, it remains crucial that the focus of the framework is on encouraging organisations to respond to Never Events in a way which facilitates reporting and learning, rather than punishing individuals.

Which of the following do you consider would best support improvements to patient safety?

- Continue to have a Never Events Policy and Framework with a broadly similar approach to the current version.
- Continue to have a Never Events Policy and Framework with a broadly similar approach to the current version but remove the financial sanctions in the NHS Contract.
- ***Continue to have a Never Events Policy and Framework, remove the financial sanctions, and work with commissioners, regulators and organisational leaders to improve the response to Never Events with an increased focus on learning and improvement.***
- None of the above options if implemented would support the Never Events Policy and Framework in achieving its purpose of improving patient safety.

Should any incidents on the current Never Events list be removed for not meeting the criteria that define a Never Event?

No incidents should be removed

Are you aware of any new national guidance (later than the 2014 consultation on the Never Events list 2015/16) or other factors that provide a strong enough systematic barrier to a type of error for that error to be considered for addition to the Never Events list?

In Appendix 1 of the Never Events Policy and Framework, which sets out the Never Events List 2015/16, Section 1 on Wrong Site Surgery defines a Never Event as "A surgical intervention performed on the wrong patient or wrong site (for example wrong knee, wrong eye, wrong limb, wrong tooth or wrong organ)".

On balance, the Faculties believe that it would be helpful to clarify this definition with respect to tooth extraction, to ensure that it encompasses the wrongful removal of a deciduous (i.e. non-permanent) tooth where the consequences of this meet the "serious harm" threshold. This will particularly be the case where a successor tooth is developmentally absent and the wrongful removal of a deciduous tooth commits the patient to long-term corrective treatment.

The systematic barriers to the removal of deciduous teeth will be the same as those for permanent teeth, but there can be uncertainty amongst practitioners as to whether the removal of a deciduous tooth should constitute a Never Event, so we feel clarification in this area would be helpful. In order to achieve this, we propose the addition of a new bullet point in the Wrong Site Surgery section of Appendix 1 which reads:

"Includes removal of wrong deciduous tooth where successor is absent and the patient is committed to long-term restorative treatment as a direct consequence"