Study highlights difficulty in estimating serious preventable events in primary care

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In hospitals, such events, known as 'Never Events', include operations where something went wrong (e.g. wrong limb amputated) or inadvertent administration of drug overdoses, already require mandatory reporting in hospitals. However, Never Event lists are currently not used in GP settings. A team of NIHR-funded researchers from The University of

Manchester and NHS Education for Scotland wanted to see if there was any merit in developing and implementing a similar system specifically for general practice.

A survey including the list of ten potential Never Events devised by NHS Education for Scotland, was sent to a sample of GP surgeries in Manchester and across Scotland, with 556 GPs in 412 practices responding.

The study, published in the Journal of Patient Safety, aimed to:

- assess the annual frequencies of the proposed ten Never Events as estimated by UK GPs
- explore the extent to which the approach is acceptable to GPs
- examine the relationship between GP's opinions and estimates and the characteristics of the GPs and their practices.

Dr Jill Stocks, one of the study authors said: "We found a very different set of circumstances in GP surgeries compared to hospitals, as critical events build up incrementally over time, can arise from many settings and consequences are complex and difficult to measure systematically."

"We suggest that the Never Events that occur more often might be useful to monitor safety in general practices and the Never Events that rarely occur could be useful for surveillance in a similar way as in hospitals."

More information: Susan J. Stocks et al. Never Events in UK General Practice, *Journal of Patient Safety* (2017). DOI: 10.1097/PTS.0000000000000380

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