

Publication: [Never events in general practice: a focus group study exploring the views of English and Scottish general practitioners of 'never events'](#)

Publication details (Vancouver format)

Morris RL, Cheraghi-Sohi S, Bowie P, Esmail A, de Wet C, Campbell SM. Never events in general practice: a focus group study exploring the views of English and Scottish general practitioners of 'never events'. *BMJ Open*. 9,7 (2019)

What are the most important findings/conclusions in this paper? Why are they important?

In hospitals 'Never Events' are rare but serious preventable incidents, such as operations where something went wrong (e.g. wrong limb amputated). This study builds on previous work looking at how often Never Events happen in general practice. This study showed that GPs we spoke to think the Never Events concept is one way to make primary care safer for patients but must be linked with other existing safety initiatives in general practice. It explained initiatives designed to prevent Never Events could be developed to make it easier to prevent Never Events from happening, or to reduce how often they happen. It also showed that it can be difficult to use something that was developed for hospitals in another healthcare setting, like primary care.

What did you do?

We talked to 25 general practitioners in groups from Scotland and Greater Manchester. We used an existing list of ten Never Events in general practice and asked the GPs to think about the following questions:

1. What would they have to do to prevent the Never Events happening in their practice?
2. Who would have to be involved?
3. What computer systems might be used?
4. What are they already doing that might prevent the Never Events from happening?

Why did you conduct this research?

A 'Never Event' is a concept that has been used in hospitals to identify events which are serious and preventable. In general practice, previous work has identified a list of potential Never Events (for example, a cancer referral not being sent). In this paper we looked at whether using the Never Events approach would be useful in general practice and whether initiatives developed for hospital settings would be useful in general practice.

What was known before your paper was published?

General practice uses a lot of approaches that were developed for other areas of healthcare, such as hospitals. But the type of work done in general practice is different to these other settings, so the approaches might not work in the same way. For example, in general practice a lot of the work involves diagnosis, monitoring, and treatment over time, as well as providing support for people to live with long-term conditions.

A list of ten Never Events that can happen in general practice had been created and a survey of GPs showed that some of the never events were very rare and others happened quite often.

What is next? What is the potential impact of the work in this paper? What will change as a result of this paper (or the study it describes)?

We looked in depth at the strengths and limitations of using an approach created to support patient safety in hospitals and moving that into general practice. GPs we spoke to recognised the idea of preventing Never Events as having potential in general practice, but some didn't like the name 'Never Events' and some weren't sure how to combine this approach with others that had a similar aim already being used in general practice.

Also, we can avoid some of the Never Events on the list by using simple solutions (such as IT systems) but other Never Events solutions involve more people and so are harder to use in everyday practice.

Does this paper link in to a particular study / project? If so, please summarise the study and explain how this paper has improved understanding, or will move the study forward.

This is part of the Never Events project and links with another paper:

Stocks SJ, Alam R, Bowie P, Campbell S, de Wet C, Esmail A, Cheraghi-Sohi S. [Never Events in UK general practice: a survey of the views of General Practitioners on their frequency and acceptability as a safety improvement approach](#). J Patient Saf 2017;00: 00-00

There was also a [Plain English summary](#) to accompany this paper.