Never Event Framework Consultation

Easy Read summary

NHS England

Skills for people

Easy read summary made by the Easy Info team at Skills for People employing people with a learning disability.

The **Never Event Framework** is a way to learn from things that go wrong in healthcare.

Some people think the Never Event Framework helps the NHS keep people safe in healthcare.

Some people think there are better ways to learn from things that go wrong in healthcare.

We want to know what you think about the Never Event Framework.

Why should we change the Never Event Framework?

The Care Quality Commission and the Healthcare Safety Investigation Branch asked us to change the Never Event Framework.

The Care Quality Commission checks all health services.

You can read their report on the different health services on their website: www.cqc.org.uk

The Healthcare Safety Investigation Branch looks into things that have gone wrong so that we can learn how to keep people safer.

They also look at how we deal with things that have gone wrong and say what other things we can do to keep people safe.

‘Never Event' means something that should not happen.

Mistakes do happen in healthcare even when staff are doing their best.

We try to stop staff from making mistakes by putting up blocks or controls to help them.

Some controls are strong.

For example, keeping medicine in a locked cupboard.

Some controls are weak.

For example, putting up a sign on the cupboard.

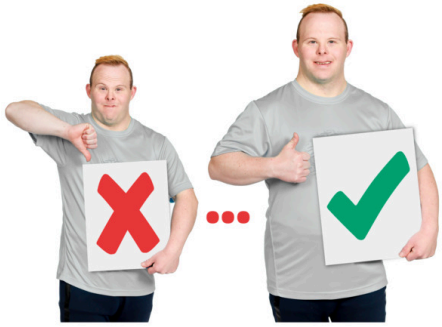
If the control is weak, it is easier for staff to make mistakes. The Care Quality Commission and the Healthcare Safety Investigation Branch told us it is not correct to say that something will ‘never’ happen if the control is weak.

Impact on staff

Our staff sometimes feel it is their fault when a Never Event happens. This can make them feel sad, even when it was not their fault.

We want staff to be treated fairly if things go wrong or if they speak up about something they think is wrong.

We want our staff to carry on learning from things that happen.



We want our staff to carry on making changes that keep people safer.

Making the Never Event Framework work well

It is hard to know if the Never Event Framework helps the NHS keep people safe in healthcare.

In some areas it has worked well. The number of times that things have gone wrong has gone down.

In some areas there has been no change. The number of times that things have gone wrong has stayed the same.

We learn from things that go wrong in lots of ways.

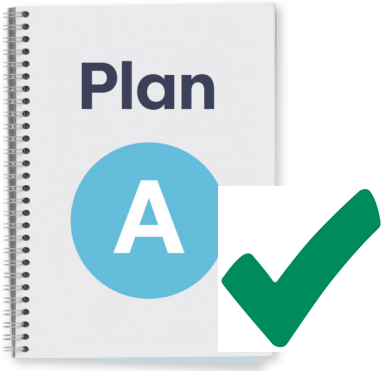
The Never Event Framework is one way we learn.

If we stop the Never Event Framework we will still learn from things that go wrong in other ways.

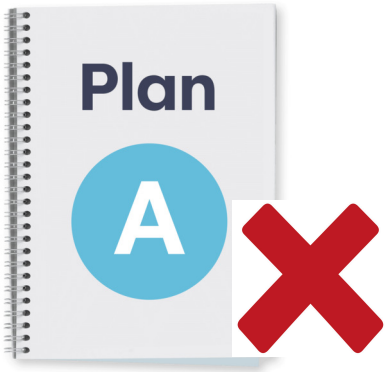
We want to find the best way to learn from times when things have gone badly wrong.

We want you to tell us what you think we should do with the Never Event Framework.

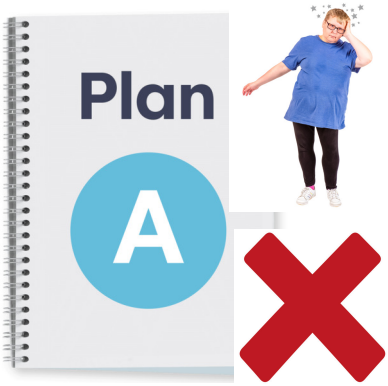
Please tick one box to tell us what you think we should do.



Option 1. Keep the Never Event Framework. Don't change anything. ☐



Option 2. Get rid of the Never Event Framework. We have other ways to learn from things that go wrong. ☐



Option 3. Take away the events with weak controls from the Never Event Framework. If a control is weak it is easier for staff to make mistakes. ☐

Option 4: Do something different. Make a new list of events with weak and strong controls which we can learn from. Do not call them 'Never Events' because mistakes do happen in healthcare even when staff are doing their best. ☐

Please don't forget to tell us what you said we should do.

There are 2 ways to do this:

You can send us an email and tell us which box you ticked. Please write Never Events Framework in the title of your email and send it to: patientsafety.enquiries@nhs.net

If you ticked a box on a paper copy you can send it to us at:
National Patient Safety Team
Level 6 Wellington House
133-155 Waterloo Road
London
SE1 8UG

Thank you.