NHS England

Provisional publication of Never Events reported as occurring between 20 May and 30 June 2015

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**03880**
Document Purpose	Resources
Document Name	Provisional publication of Never Events reported as occurring between 20 May and 30 June 2015
Author	NHS England Patient Safety Domain
Publication Date	31 July 2015
Target Audience	Published on NHS England website for public access
Additional Circulation List	
Description	This report provides a provisional summary of Never Events reported as occuring between 20 May and 30 June 2015
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	Patient Safety Domain NHS England Skipton House 80 London Road London SE1 6LH

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Provisional publication of Never Events reported as occurring between 20 May and 30 June 2015

Version number: 1

First published: 30 July 2015

Prepared by: Patient Safety Domain, NHS England

Classification: Official

Contents

Provisional monthly publication of Never Events reported as occurring between 20 May and 30 June 2015

This report provides a provisional summary of Never Events that have been reported as occurring between 20 May and 30 June 2015.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations had been implemented by healthcare providers. For more detail on Never Events, see: www.england.nhs.uk/ourwork/patientsafety/never-events/

Please note that because the definitions and designated list of Never Events was revised from April 2015, direct comparison of numbers with earlier periods would be misleading.

The revision of the Never Events Policy and Framework 2015 requires commissioners and providers to agree and report Never Events via StEIS. Where a Serious Incident is logged as a Never Event but does not appear to fit any definition of a Never Event on the Never Events List 2015/16, commissioners are asked to discuss with the provider organisation and either add extra detail to the StEIS system to confirm it is a Never Event or to remove its Never Event designation from the StEIS system.

IMPORTANT NOTES on the provisional nature of these data

To support learning from Never Events, NHS England is committed to early publication. However, because reports of apparent Never Events are made as soon as possible before local investigation is complete all data are subject to change.

This provisional report is drawn from the StEIS system, and includes all Serious Incidents where the date of the incident was between 20 May and 30 June 2015 and where on 10 July 2015 they were designated by their reporters as Never Events.

This report is part of a series of reports based on provisional data that are made available throughout the year. Provisional data on Never Events for earlier periods of 2015/16 can be found at: http://www.england.nhs.uk/ourwork/patientsafety/never-events/ne-data/

Future reports will be provided on a calendar month basis; the spilt in reporting mid-May 2015 between this current provisional data report and the previous provisional data report has occurred becomes of changes to the STEIS database.

After the 2015/16 period has ended and sufficient time has elapsed for local incident investigation and national analysis of data to take place, a final whole-year report of Never Events reported as occurring in 2015/16 will be produced and will replace these provisional reports.

Summary

At the time data for this report were extracted on 10 July 2015, 39 Serious Incidents on the STEIS system were designated by their reporters as Never Events with a reported incident date between 20 May and 30 June 2015. Of these 39 incidents:

- There were 38 Serious Incidents that appeared to meet the definitions of a Never Event in the Never Events List 2015/16 and the actual date of incident fell between 20 May and 30 June 2015. This number is subject to change as local investigation takes place.
- One of the reported Serious Incidents occurred before 20 May 2015.

More detail is provided in the tables below.

TABLE ONE: Never Events 20 May to 30 June 2015 by month

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Month in which Never Event occurred	**Number**
20-31 May	13
June	25
Total	**38**
Note as described above, one of the reported Serious Incidents occurred before 20 May 2015	

TABLE TWO: Never Events 20 May to 30 June 2015 by type of incident

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type of Never Event	**Number**
Wrong site surgery	18
Retained foreign object post procedure	7
Wrong implant/ prosthesis	6
Misplaced naso or oro gastric tubes	4
Wrong route administration of medication	3
Total	**38**
Note: As described above, one of the reported Serious Incidents occurred before 20 May 2015	

TABLE THREE: Never Events 20 May to 30 June 2015 by type of incident with additional detail

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED	
Type *and brief description* of Never Event	**Number**
Wrong site surgery	**18**
Wrong site block	8
Wrong tooth/ teeth removed	3
Wrong skin lesion removed	1
Wrong finger incision	1
Wrong eye injection	1
Wrong site angioplasty	1
Wrong side ureterorenoscopy	1
Fallopian tube removed instead of appendix – patient pregnant and anatomy distorted	1
Injection to wrong joints	1
Retained foreign object post procedure	**7**
Surgical swab	2
Guide wire – CVC line	2
Guide wire – re perfusion catheter	1
Microsurgical clamp	1
Peg guide for internal fixation screws	1
Wrong implant/ prosthesis	**6**
Lens	4
Knee prosthesis	1
Hip prosthesis	1
Misplaced naso or oro gastric tubes	**4**
NG tube in respiratory tract and not detected prior to feed, flush or medication administration	4
Wrong route administration of medication	**3**
Epidural medication given intravenously	3
Total	**38**
Note: As described above, one of the reported Serious Incidents occurred before 20 May 2015	

TABLE FOUR: Never Events 20 May to 30 June 2015 by healthcare provider

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED						
Provider organisation where Never Event (NE) occurred	Retained foreign object post procedure	Wrong implant/ prosthesis	Wrong site surgery	Misplaced naso or oro gastric tubes	Wrong route administration of medication	Sub-total SI reported as NE that can be matched to NE list type 1-14
Alder Hey Children's NHS Foundation Trust			1			1
Ashford and St. Peters Hospitals NHS Foundation Trust		1				1
Barts Health NHS Trust	1			2		3
Bedford Hospital NHS Trust			1			1
Birmingham Children's Hospital NHS Foundation Trust			1			1
Bolton NHS Foundation Trust				1		1
Brighton and Sussex University Hospitals NHS Foundation Trust			1			1
Central Manchester University Hospitals NHS Foundation Trust		1				1
Chesterfield Royal Hospital NHS Foundation Trust		1				1
Colchester Hospitals University NHS Foundation Trust	1					1
Community patient of CONCORDIA HEALTH – Essex County Hospital			1			1

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED						
Provider organisation where Never Event (NE) occurred	**Retained foreign object post procedure**	**Wrong implant/ prosthesis**	**Wrong site surgery**	**Misplaced naso or oro gastric tubes**	**Wrong route administration of medication**	**Sub-total SI reported as NE that can be matched to NE list type 1-14**
Doncaster and Bassetlaw Hospitals NHS Foundation Trust			1			1
Dorset County Hospitals NHS Foundation Trust			1			1
East and North Hertfordshire NHS Trust			1			1
East Kent Hospitals University NHS Foundation Trust			2			2
Guy's & St Thomas' NHS Foundation Trust	1		1	1		3
Hampshire Hospitals NHS Foundation Trust			1			1
Homerton Hospitals NHS Foundation Trust					1	1
Ipswich Hospital NHS Trust					1	1
Kings College Hospitals NHS Foundation Trust		1				1
Newcastle Upon Tyne Hospitals NHS Foundation Trust			1			1
Norfolk and Norwich University Hospitals NHS Foundation Trust			1			1
Northern Lincolnshire and Goole NHS Foundation Trust		1	1			2

PROVISIONAL DATA: SUBJECT TO CHANGE AS LOCAL INVESTIGATION COMPLETED						
Provider organisation where Never Event (NE) occurred	**Retained foreign object post procedure**	**Wrong implant/ prosthesis**	**Wrong site surgery**	**Misplaced naso or oro gastric tubes**	**Wrong route administration of medication**	**Sub-total SI reported as NE that can be matched to NE list type 1-14**
Papworth Hospitals NHS Foundation Trust	1					1
Pennine Acute Hospitals NHS Trust		1				1
Sandwell and West Birmingham Hospitals NHS Trust	1		1			2
Spire Washington Hospital – Spire Healthcare			1			1
University College London NHS Foundation Trust	1				1	2
University Hospitals Birmingham NHS Foundation Trust	1					1
University Hospitals of Morecambe Bay NHS Foundation Trust			1			1
	7	**6**	**18**	**4**	**3**	**38**