Provisional publication of Never Events reported as occurring between 1 April and 30 June 2020

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Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. The Never Events policy and framework – revised January 2018 suggests that Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes. Never Events are different from other serious incidents as the overriding principle of having the Never Events list is that even a single Never Event acts as a red flag that an organisation's systems for implementing existing safety advice/alerts may not be robust.

The concept of Never Events is not about apportioning blame to organisations when these incidents occur but rather to learn from what happened. This is why, following consultation, in the revised Never Events policy and framework – published January 2018 we removed the option for commissioners to impose financial sanctions when Never Events were reported. The foreword to the framework states: "……allowing commissioners to impose financial sanctions following Never Events reinforced the perception of a 'blame culture'. Our removal of financial sanctions should not be interpreted as a weakening of effort to prevent Never Events. It is about emphasising the importance of learning from their occurrence, not blaming." Identifying and addressing the reasons behind this can potentially improve safety in ways that extend far beyond the department where the Never Event occurred, or the type of procedure involved.

Please note that because the definitions and designated list of Never Events were revised from February 2018, direct comparison of the number of Never Events with earlier periods is not appropriate.

The provisional data in this report relates to April - June 2020 when the NHS was at a key stage of responding to the COVID-19 pandemic. During this time there were major shifts in service provision away from planned and elective surgery towards medical and intensive care. Reporting to the Strategic Executive Information System (StEIS) and National Reporting and Learning System (NRLS) has been maintained but the number of Never Events reported April - June 2020 is lower than for previous periods. This may reflect these changes in service provision as historically most reported Never Events typically related to surgical and invasive procedures. This example highlights how it is inappropriate to compare Never Events data from different periods.

The revised 2018 Never Events Policy and Framework 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 on the Never Events list 2018 (published 31 January 2018) commissioners are asked to discuss this with the provider organisation and either add extra detail to StEIS to confirm it is a Never Event or remove its Never Event designation from the StEIS system.

Supporting healthcare providers to prevent Never Events

The Care Quality Commission has undertaken a thematic review in collaboration with NHS Improvement to get a better understanding of what can be done to prevent the occurrence of Never Events, with the resulting report 'Opening the door to change' published in December 2018.

The report includes a recommendation that "NHS Improvement should review the Never Events framework and work with professional regulators and royal colleges to take account of the difference in the strength of different kinds of barrier to errors (such as distinguishing between those that should be prevented by human interactions and behaviours such as using checklists, counts and sign-in processes; and those that could be designed out entirely such as through the removal of equipment or introducing physical barriers to risks).

The report also suggested that organisations did not always have strong systems for implementing alerts. Key problems included organisations circulating alerts to raise awareness rather than taking the required actions to address an issue; responsibility taken at a junior level for recording an organisation's completion of the actions required by an alert; and instead of central coordination across an organisation, individual teams being asked to implement the required actions locally, leading to duplication and the most effective systemic actions left incomplete.

To help address these issues, a new National Patient Safety Alerting Committee (NaPSAC) has been established, whose role includes the development and governance of the new National Patient Safety Alerts. These alerts require healthcare providers to introduce new systems for planning and coordinating the required actions, including executive oversight.

In September 2015, a set of National Safety Standards for Invasive Procedures (NatSSIPs) were published to help prevent Never Events, with all relevant NHS organisations in England instructed to develop and implement their own local standards based on the national principles. The standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice.

The national patient safety team and our partners also continue to work to further prevent individual types of Never Events. Examples include our 2016 Alert *Nasogastric tube misplacement: continuing risk of death and severe harm* and resource set; the May 2020 aide-memoire produced by professional bodies for nutrition, anaesthetics and intensive care to help prevent nasogastric tube Never Events, including special considerations for COVID-19 patients; and the 2019 Estates and Facilities Alert A*nti-ligature' type curtain rail systems: Risks from incorrect installation or modification* (note: this alert is not accessible publicly but can be accessed via log in to the Central Alerting System).

As set out in the NHS Patient Safety Strategy, patient safety research and innovation also has an important role to play. We are continuing to work with partners including the Patient Safety Translational Research Centres, Academic Health Science Networks and other researchers, in conjunction with the National Institute for Health Research and the Department of Health and Social Care, to develop new technical solutions to Never Events.

Investigating and learning from Never Events

NHS providers are encouraged to learn from mistakes and any organisation that reports a Never Event is expected to conduct its own investigation so it can learn and take action on the underlying causes.

The fact that more and more NHS staff take the time to report incidents is good evidence that this learning is happening locally. We continue to encourage NHS staff to report Never Events and Serious Incidents to StEIS and all patient safety incidents to the NRLS, to help us identify any risks so that necessary action can be taken.

Important notes on the provisional nature of this data

To support learning from Never Events we are committed to publishing this data as early as possible. However, because reports of apparent Never Events are submitted by healthcare providers as soon as possible, often before local investigation is complete, all data is provisional and subject to change.

Because of the complex combination of incidents identified as Never Events when first reported, Serious Incidents designated as Never Events at a later date, and incidents initially reported as Never Events that on investigation are found not to meet the criteria, our monthly provisional Never Event reports provide cumulative totals for the current financial year. This is to ensure the information provided is as consistent and as accurate as possible.

This provisional report is drawn from the StEIS system and includes all Serious Incidents with a reported incident date between 1 April 2020 and 30 June 2020, and which on 11 July 2020 were designated by their reporters as Never Events.

Data on Never Events for 2019/20 and previous years can be found on the NHS Improvement website.

Once sufficient time has elapsed for local incident investigation and national analysis of data after the end of the 2020/21 reporting year, we will produce a final whole-year report of Never Events, which will replace this provisional data.

Summary

When data for this report was extracted on 11 July 2020, 69 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2020 and 30 June 2020. Of these 69 incidents:

- 60 Serious Incidents appeared to meet the definition of a Never Event in the Never Events list 2018 (published 31 January 2018) and had an incident date between 1 April 2020 and 30 June 2020; this number is subject to change as local investigations are completed
- 9 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 1 April 2020 and 30 June 2020.

More detail is provided in the tables below:

Table 1: Never Events 1 April 2020 and 30 June 2020 by month of incident*

Month in which Never Event occurred	Total
Apr	20
May	17
Jun	23
Total	**60**

Note: As described above, a further 9 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review accordingly.

*Numbers are subject to change as local investigations are completed.

Table 2: Never Events 1 April 2020 and 30 June 2020 by type of incident with additional detail*

Type and brief description of Never Event	Total
Wrong site surgery	**21**
Botox injections to the forehead rather than eye injection	1
Laser treatment to wrong eye	1
Tumour marker inserted into wrong breast lesion	1
Wrong side angioplasty	1
Wrong side chest drain	1
Wrong side femoral puncture	1
Wrong side ureteric stent	1
Wrong site block	6
Wrong skin lesion biopsied	1
Wrong skin lesion removed	6
Wrong tooth/teeth removed	1
Retained foreign object post procedure	**18**
Guide wire - ascitic drain	1
Guide wire - central line	2
Guide wire - chest drain	1
Guide wire - vascath	1
Surgical needle	1
Surgical swab	5
Vaginal swab	7
Misplaced naso or oro gastric tubes (naso gastric tube in respiratory tract and feed, medication or fluids administered)	**7**
Placement checks not described	3
X-ray misinterpretation; no indication 'four criteria' used	3
X-ray showed respiratory tract placement; unclear why feed commenced despite this	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	**5**
Patient connected to air flowmeter rather than oxygen flowmeter	5
Administration of medication by the wrong route	**4**
Oral medication given intravenously	3
Oral medication given subcutaneously	1
Wrong implant/prosthesis	**2**
Cardiac stent	1
Hip	1
Mis-selection of a strong potassium solution	**1**
Potassium administered instead of insulin	1
Mis-selection of high strength midazolam during conscious sedation	**1**
Wrong strength midazolam administered	1

Chest or neck entrapment in bedrails	**1**
Patient trapped between mattress and bedrail	1
Total	**60**

Note: As described above, a further 9 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisations have been asked to review accordingly.

*Numbers are subject to change as local investigations are completed.

Table 3: Never Events 1 April 2020 and 30 June 2020 by healthcare provider*

	Administration of medication by the wrong route	Chest or neck entrapment in bedrails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during concious sedation	Misplaced naso or oro gastric tubes	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
Barts Health NHS Trust						2				**2**
Bedfordshire Hospitals NHS Foundation Trust					1	1				**2**
Buckinghamshire Healthcare NHS Trust									1	**1**
Calderdale and Huddersfield NHS Foundation Trust						1			1	**2**
Chelsea and Westminster Hospital NHS Foundation Trust							1			**1**
Croydon Health Services NHS Trust						1				**1**
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust			1							**1**

	Administration of medication by the wrong route	Chest or neck entrapment in bedrails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during concious sedation	Misplaced naso or oro gastric tubes	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
East Kent Hospitals University NHS Foundation Trust					1					**1**
East Suffolk and North Essex NHS Foundation Trust									1	**1**
Epsom and St Helier University Hospitals NHS Trust							1			**1**
Gloucestershire Hospitals NHS Foundation Trust									2	**2**
Heatherwood and Wexham Park Hospitals NHS Foundation Trust							1			**1**
Homerton University Hospital NHS Foundation Trust				1						**1**
James Paget University Hospitals NHS Foundation Trust						1				**1**

	Administration of medication by the wrong route	Chest or neck entrapment in bedrails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during concious sedation	Misplaced naso or oro gastric tubes	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
King's College Hospital NHS Foundation Trust									1	**1**
Liverpool Women's Hospital NHS Foundation Trust						1				**1**
Lyons Court Care Home, Careline Lifestyle reported by NHS Durham Dales, Easington and Sedgefield CCG	1									**1**
Medway NHS Foundation Trust								1		**1**
Mid Cheshire Hospitals NHS Foundation Trust									1	**1**
Mid Yorkshire Hospitals NHS Trust						1			1	**2**
Newcastle Upon Tyne Hospitals NHS Foundation Trust					1					**1**
Norfolk and Norwich University Hospitals NHS Foundation Trust							1			**1**

	Administration of medication by the wrong route	Chest or neck entrapment in bedrails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during concious sedation	Misplaced naso or oro gastric tubes	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
North Cumbria Integrated Care NHS Foundation Trust						1				**1**
Northumbria Healthcare NHS Foundation Trust						1				**1**
Pennine Acute Hospitals NHS Trust					1					**1**
Portsmouth Hospitals NHS Trust									1	**1**
Queen Victoria Hospital NHS Foundation Trust									1	**1**
Royal Berkshire NHS Foundation Trust					1					**1**
Royal Cornwall Hospitals NHS Trust						1			2	**3**
Sheffield Teaching Hospitals NHS Foundation Trust									1	**1**
South Tees Hospitals NHS Foundation Trust	1					2				**3**

	Administration of medication by the wrong route	Chest or neck entrapment in bedrails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during concious sedation	Misplaced naso or oro gastric tubes	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
St George's University Hospitals NHS Foundation Trust									1	**1**
St Helens and Knowsley Teaching Hospitals NHS Trust	1								1	**2**
Surrey and Sussex Healthcare NHS Trust					1					**1**
The Rotherham NHS Foundation Trust						1				**1**
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust									2	**2**
The Shrewsbury and Telford Hospital NHS Trust		1								**1**
University Hospitals Birmingham NHS Foundation Trust						2				**2**
University Hospitals of Leicester NHS Trust					1			1		**2**

	Administration of medication by the wrong route	Chest or neck entrapment in bedrails	Mis selection of a strong potassium solution	Mis selection of high strength midazolam during concious sedation	Misplaced naso or oro gastric tubes	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant / prosthesis	Wrong site surgery	Total
University Hospitals of Morecambe Bay NHS Foundation Trust						1				**1**
University Hospitals Plymouth NHS Trust									2	**2**
Warrington and Halton Teaching Hospitals NHS Foundation Trust									1	**1**
West Hertfordshire Hospitals NHS Trust						1				**1**
Wrightington, Wigan and Leigh NHS Foundation Trust	1									**1**
Wye Valley NHS Trust									1	**1**
York Teaching Hospital NHS Foundation Trust							1			**1**
Total	**4**	**1**	**1**	**1**	**7**	**18**	**5**	**2**	**21**	**60**

Note: As described above, a further 9 Serious Incidents did not appear to meet the definition of a Never Event and the relevant organisation has been asked to review.
*Numbers are subject to change as local investigations are completed.

Table 4: Never Events reported as occurring after 1 April 2020 but actually occurring prior to this*

. None reported.

* Numbers are subject to change as local investigations are completed.

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