NHS

Provisional publication of Never Events reported as occurring between 1 and 30 April 2021

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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.

We are currently working to systematically review the barriers for each type of Never Event to identify if they are truly strong and systemic, starting with those that occur most frequently. As a result, we are making changes to the Never Events list during 2021/22 which means direct comparison of the number of Never Events with earlier periods is not appropriate. The definitions and designated list of Never Events were also revised from February 2018. You can find about more about these changes on the Revised Never Events policy and framework webpage.

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 fitting/using physical barriers to risks). As mentioned above, we are in the process of conducting this review, and details of any resulting changes to the Never Events list can be found on the Revised Never Events policy and framework webpage.

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; 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 and 30 April 2021, and which on 12 May 2021 were designated by their reporters as Never Events.

Data on Never Events for 2020/21 and previous years can be found on the NHS England website.

Once sufficient time has elapsed after the end of the 2021/22 reporting year for local incident investigation and national analysis of data, 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 12 May 2021, 31 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 01 and 30 April 2021. Of these 31 incidents:

- 30 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 01 and 30 April 2021; this number is subject to change as local investigations are completed
- 1 Serious Incidents did not appear to meet the definition of a Never Event and had an incident date between 01 and 30 April 2021.

More detail is provided in the tables below:

Table 1: Never Events 01 and 30 April 2021 by month of incident*

Month in which Never Event occurred	Number
April	30
Total	**30**

Note: As described above, a further 1 Serious Incident did not appear to meet the definition of a Never Event and the relevant organisation has been asked to review accordingly.

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

Table 2: Never Events 01 and 30 April 2021 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**17**
Biopsy of mediastinal mass rather than pleura	1
Biopsy of wrong lobe of lung	1
Injection to wrong eye	1
Injection to wrong finger joint	2
Injection to wrong fingers	1
Nerve root block intended for another patient	1
Not specified	1
Resection of wrong eye muscle during squint surgery	1
Wrong side angioplasty	1
Wrong side burr holes	1
Wrong site block	5
Release of elbow nerve rather than muscle	1
Retained foreign object post procedure	**6**
Guide wire - central line	1
Guide wire - chest drain	1
Scalpel blade	1
Small piece of metal from knee instrumentation not identified at the time of the procedure	1
Vaginal swab	2
Wrong implant/prosthesis	**2**
Knee	1
Mandibular plate	1
Misplaced naso or oro gastric tubes and feed administered	**2**
Placement checks not described or not clearly described	2
Overdose of insulin due to abbreviations or incorrect device	**1**
Insulin withdrawn from an insulin pen	1
Falls from poorly restricted windows	**1**
Window restrictor failed	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	**1**
Patient connected to air instead of oxygen	1
Total	**30**

Note: As described above, a further 1 Serious Incident did not appear to meet the definition of a Never Event and the relevant organisation has been asked to review accordingly.

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

Table 3: Never Events 01 April 2021 and 30 April 2021 by healthcare provider*

	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
County Durham and Darlington NHS Foundation Trust							1	1
Dorset County Hospital NHS Foundation Trust				1				1
East and North Hertfordshire NHS Trust							1	1
East Suffolk and North Essex NHS Foundation Trust							1	1
Humber NHS Foundation Trust			1					1
Kettering General Hospital NHS Foundation Trust							1	1
Lancashire Teaching Hospitals NHS Foundation Trust							1	1
London North West Healthcare NHS Trust				1				1

	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Manchester University NHS Foundation Trust	1						1	2
Mid Essex Hospital Services NHS Trust							1	1
North Bristol NHS Trust							1	1
Northampton General Hospital NHS Trust						1		1
Oxford University Hospitals NHS Foundation Trust				1				1
Portsmouth Hospitals NHS Trust		1						1
Robert Jones Agnes Hunt Orthopaedic Hospital NHS Foundation Trust							2	2
Royal Free London NHS Foundation Trust				1				1
Royal Orthopaedic Hospital NHS Foundation Trust				1				1

	Falls from poorly restricted windows	Misplaced naso or oro gastric tubes and feed administered	Overdose of insulin due to abbreviations or incorrect device	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Wrong site surgery	Total
Sandwell and West Birmingham Hospitals NHS Trust					1		1	2
Spire Montefiore Hospital reported by NHS Brighton and Hove CCG						1		1
University College London Hospitals NHS Foundation Trust		1						1
University Hospitals Bristol NHS Foundation Trust							1	1
University Hospitals of Derby and Burton NHS Foundation Trust							2	2
University Hospitals of Leicester NHS Trust							1	1
Western Sussex Hospitals NHS Foundation Trust							1	1
Worcestershire Acute Hospitals NHS Foundation Trust				1			1	2
Total	**1**	**2**	**1**	**6**	**1**	**2**	**17**	**30**

Note: As described above, a further 1 Serious Incident 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 01 April 2021 but actually occurring prior to this

. None reported.

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

Contact us:

NHS Improvement

NHS England

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

This publication can be made available in a number of other formats on request.