Whittington Health NHS

ITEM: 11/059
Doc: 04

Meeting:	Trust Board
Date:	27 April 2011

Title: **Patient Safety: Reducing the risk of Never Events**

Executive Summary:

A policy on Never Events was introduced in the NHS in England in April 2009 after Lord Darzi proposed this in his 2008 report "*High Quality Care for All*"

Never Events are very serious or devastating Patient Safety events that are considered largely preventable.

The National Patient Safety Agency (NPSA) definition of a Never Event is "*A serious largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers*."

Commissioners are expected to use the Never Events policy in their discussions about patient safety with their providers, as described in *The Operating Framework for the NHS in England*, ensuring that Never Events are reported to the NPSA and published annually according the number and type. The NPSA must in turn pass on relevant information to the CQC.

In addition, from April 2010, PCTs have been expected to recover the costs of healthcare where a procedure or treatment has resulted in one of the Never Events.

The NPSA published a framework for implementation of the Never Events policy, and initially eight Never Events were chosen, to test the initiative, focusing mainly on safety issues in acute care.

For 2011/12 the list was revised, and the number of Never Events was increased from eight to twenty-five.

In response to this major increase in the number and range of never events, and in response also to the incorporation of Haringey and Islington Community Services into the newly-formed Whittington Health on 1 April 2011, the Trust is drawing up an Action Plan to mitigate against the risk of each Never Event. This Action Plan will be taken to the Patient Safety Committee (PSC) on 26 May, after which the PSC will submit to the Executive Committee a proposed new entry on the Trust's Risk register around the risk of a Never Event occurring.

The purpose of this paper is to highlight to the Trust Board the national policy around Never Events, their recent major expansion in number and range, and the work that is being done within the Trust to develop an Action Plan to mitigate against the risk of a Never Event, and the time scale in which this work is taking place.

	So far, since their introduction in April 2009, this Trust has not had a Never Event.

Action:	For information/discussion

Report from:	Richard Jennings, Deputy Medical Director (Chair of Patient Safety Committee)

Sponsor:	Yi Mien Koh, Chief Executive

Compliance with statute, directions, policy, guidance Lead: All directors	**Reference:** Department of Health (2011) *The Never Events List 2011/2012: Policy Framework for Use in the NHS* National Patient Safety Agency (April 2010) *National framework for reporting and learning from serious incidents*

Compliance with Care Quality Commission Standards Lead: Director of Nursing & Clinical Development	**Reference:** Care Quality Commission (December 2009) *Essential Standards of Quality and Safety*.

PatientSafety: Reducing the risk of Never Events

Background

A policy on Never Events was introduced in the NHS in England in April 2009 after Lord Darzi proposed this in his 2008 report "*High Quality Care for All*"

Never Events are very serious Patient Safety events that are considered largely preventable because

- There is guidance that explains what the relevant care should be
- There is guidance that explains how the risks & harm, and so the Never Event, can be prevented
- There has been adequate notice and support to put systems in place to prevent the Never Event from happening

The National Patient Safety Agency (NPSA) definition of a Never Event is "*A serious largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers*."

In its 2009/10 annual report on Never Events, the NPSA says "*Never Events are one of the indicators that can be used to demonstrate how safe an organisation is and its patient safety culture. Continued occurrence of Never Events can be considered an indicator of an organisation that has not put the right systems and processes in place to prevent them from happening*."

The NPSA published a framework for implementation of the Never Events policy, and initially, in April 2009, eight Never Events were chosen, to test the initiative, focusing mainly on safety issues in acute care.

The criteria used to define a Never Event were:

- The Never Event may or does result in severe harm/death to patients and/or the public;

- There has been evidence of occurrence in the past;

- National guidance and/or national safety recommendations exist on how to prevent the event along with support for implementation;

- Occurrence of the event can be easily defined, identified and measured on an ongoing basis

Since April 2010, Primary Care Trusts (PCTs) have been monitoring Never Events within commissioned services and reporting publically on them.

Commissioners are expected to use the Never Events policy in their discussions about patient safety with their providers, as described in *The Operating Framework for the NHS in England*, ensuring that Never Events are reported to the NPSA and published annually according the number and type. Investigations after Never Events should follow the *National framework for reporting and learning from serious incidents*. NHS Trusts must report Never Events to the NPSA, who must in turn pass on relevant information to the CQC. The CQC may use information on Never

Events to inform its regulatory processes in conjunction with other indicators and, following a Never Event, may take any enforcement action it deems appropriate.

In addition, from April 2010, PCTs have been expected to recover the costs of healthcare where a procedure or treatment has resulted in one of the Never Events.

The government proposed, in its White Paper of 2010, to expand the list of Never Events, and after consultation on a draft expanded list (published October 2011) the list was revised, and the number of Never Events was increased from eight to twenty-five.

The choice of Never Events has been recognised to be deliberately focussed on Acute care at the current time but the stated longer-term ambition is "*to embed the concept of "never events" more fully in all sectors of NHS provision*".

The Never Events list for 2011/12

1. Wrong site surgery (existing)
2. Wrong implant/prosthesis (new)
3. Retained foreign object post-operation (existing)
4. Wrongly prepared high-risk injectable medication (new)
5. Maladministration of potassium-containing solutions (modified)
6. Wrong route administration of chemotherapy (existing)
7. Wrong route administration of oral/enteral treatment (new)
8. Intravenous administration of epidural medication (new)
9. Maladministration of Insulin (new)
10. Overdose of midazolam during conscious sedation (new)
11. Opioid overdose of an opioid-naïve patient (new)
12. Inappropriate administration of daily oral methotrexate (new)
13. Suicide using non-collapsible rails (existing)
14. Escape of a transferred prisoner (existing)
15. Falls from unrestricted windows (new)
16. Entrapment in bedrails (new)
17. Transfusion of ABO-incompatible blood components (new)
18. Transplantation of ABO or HLA-incompatible Organs (new)
19. Misplaced naso- or oro-gastric tubes (modified)
20. Wrong gas administered (new)
21. Failure to monitor and respond to oxygen saturation (new)
22. Air embolism (new)
23. Misidentification of patients (new)
24. Severe scalding of patients (new)
25. Maternal death due to post partum haemorrhage after elective Caesarean section (modified)

Never Events Nationally

The NPSA Never Events Annual Report for 2009/10 summarises the Never Events reported to the National Reporting and Learning System (NRLS) (this was before the number of Never Events was expanded from eight to twenty-five). A total of 111 Never Events were reported to the NRLS at the NPSA. In summary:

The Never Events were spread throughout England, occurred throughout the year and occurred across different trusts.

Just over half were related to wrong site surgery (57).

The second highest reported Never Event was related to misplaced naso or orogastric tubes (41).

There were no reports of Never Events related to wrong route administration of chemotherapy, in-hospital maternal death from post-partum haemorrhage after elective caesarean section and inpatient suicide using non-collapsible rails.

The remaining three Never Events had fewer than 10 events reported over the year

Never Events at the Whittington

Since April 2009, when a policy on Never Events was first introduced in the NHS in England, the Whittington Hospital NHS Trust (now Whittington Health) has not had any Never Events.

Whittington Never Events Action Plan

An Action Plan is being drawn up by the Risk Management Team (Richard Jennings, Chair of Patient Safety Committee, Deborah Clatworthy, Assistant Director of Nursing & Risk Management, & David Williams Head of Quality Improvement Haringey and Islington Provider Services Alliance) to mitigate, for each Never Event, against the risk of its occurrence. This Action Plan will be taken to the Patient Safety Committee (PSC) on 26 May, after which the PSC will submit to the Executive Committee a proposed new entry on the Trust's Risk register around the risk of a Never Event occurring.

One Never Event, relating to organ transplantation, is not applicable to this Trust, which does not undertake organ transplants. Key leads have been identified in the relevant areas to contribute to the Action Plan.

Monitoring our performance

Never Events are included in the Trust Performance Dashboard Report under Clinical Quality.

Never Events are monitored through the Risk Management Department through the Datix Incident Reporting System. They may also be identified through the departmental and trust-wide Death Audits and Global Trigger Tool Audits.

References

Department of Health (2008). *High quality care for all – NHS next stage review final report*
Available at:
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