Provisional publication of Never Events reported as occurring between 1 April 2024 and 30 April 2024

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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 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 28 February 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.

Never Events framework consultation 2024

In February 2024, NHS England launched a consultation seeking views on whether the existing Never Events Framework remains an effective mechanism to support patient safety improvement.

Never Events are defined as patient safety events that are 'wholly preventable' because of the existence of strong systemic protective barriers at a national level. However, reports from the CQC and HSIB highlighted for several types of Never Events the barriers are not strong enough and called for the framework to be reviewed.

The consultation closed on the 5 May 2024 and we are reviewing the responses to establish next steps.

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, The National Patient Safety Committee established in 2021, (this committee replaced the National Patient Safety Alerting Committee) bringing key national healthcare organisations together to address complex patient safety issues, including oversight of the National Patient Safety Alerts process. These Alerts require

healthcare providers to introduce new systems for planning and coordinating the required actions, including executive oversight.

In September 2015, the first set of National Safety Standards for Invasive Procedures (NatSSIPs) were published by NHS England 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 Centre for Perioperative Care published revised National Safety Standards for Invasive Procedures (NatSSIPs 2) in January 2023.

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 2021 National Patient Safety Alert – Eliminating the risk of inadvertent connection to medical air via a flowmeter

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 and LFPSE, 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 01 April 2024 and 30 April 2024, and which on the 27 May 2024 were designated by their reporters as Never Events.

Data on Never Events for 2023/24 and previous years can be found on the NHS England website. Once sufficient time has elapsed after the end of the 2024/25 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 27 May 2024, 20 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April 2024 and 30 April 2024. Of these 20 incidents:

- 20 Serious Incidents appeared to meet the definition of a Never Event in the Never Events list 2018 (published 28 February 2018) and had an incident date between 1 April 2024 and 30 April 2024; this number is subject to change as local investigations are completed

More detail is provided in the tables on the following pages.

Table 1: Never Events 01 April 2024 and 30 April 2024 by month of incident*

Month in which Never Event occurred	Number
April	20
Total	**20**

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

Table 2: Never Events 01 April 2024 and 30 April 2024 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**7**
Injection to wrong organ/structure	1
Procedure not required	1
Wrong side/site procedure	2
Wrong site block	2
Wrong skin lesion removed/ biopsy	1
Retained foreign object post procedure	7
Surgical needle/ part of surgical needle	1
Surgical swab	1
Vaginal swab/pack	5
Overdose of insulin due to abbreviations or incorrect device	**3**
Wrong syringe	3
Wrong implant/prosthesis	**2**
Knee	1
Lens	1
Misplaced naso- or oro-gastric tubes	**1**
X-ray misinterpretation; no indication 'four criteria' used	1
Total	20

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

Table 3: Never Events 1 April 2024 and 30 April 2024 by healthcare provider*

Organisation Name	Total
Basildon And Thurrock University Hospitals NHS Foundation Trust	1
Blackpool Teaching Hospitals NHS Foundation Trust	1
Chesterfield Royal Hospital NHS Foundation Trust	1
Circle Health Group, Beardwood Hospital, Blackburn reported by Lancashire and South Cumbria ICB	1
Countess Of Chester Hospital NHS Foundation Trust	1
County Durham And Darlington NHS Foundation Trust	1
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	1
East Lancashire Hospitals NHS Trust	1
Epsom And St Helier University Hospitals NHS Trust	1
Frimley Health NHS Foundation Trust	1
Homerton Healthcare NHS Foundation Trust	1
Lancashire Teaching Hospitals NHS Foundation Trust	1
Leeds Teaching Hospitals NHS Trust	2
Nottingham University Hospitals NHS Trust	1

SpaMedica Newark reported by NHS Nottingham and Nottinghamshire ICB	1
Tameside and Glossop Integrated Care NHS Foundation Trust	1
Warrington and Halton Teaching Hospitals NHS Foundation Trust	2
York And Scarborough Teaching Hospitals NHS Foundation Trust	1
Total	**20**

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

Table 4: Never Events reported as occurring after 1 April 2024 but actually occurring prior to this

. None reported.

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