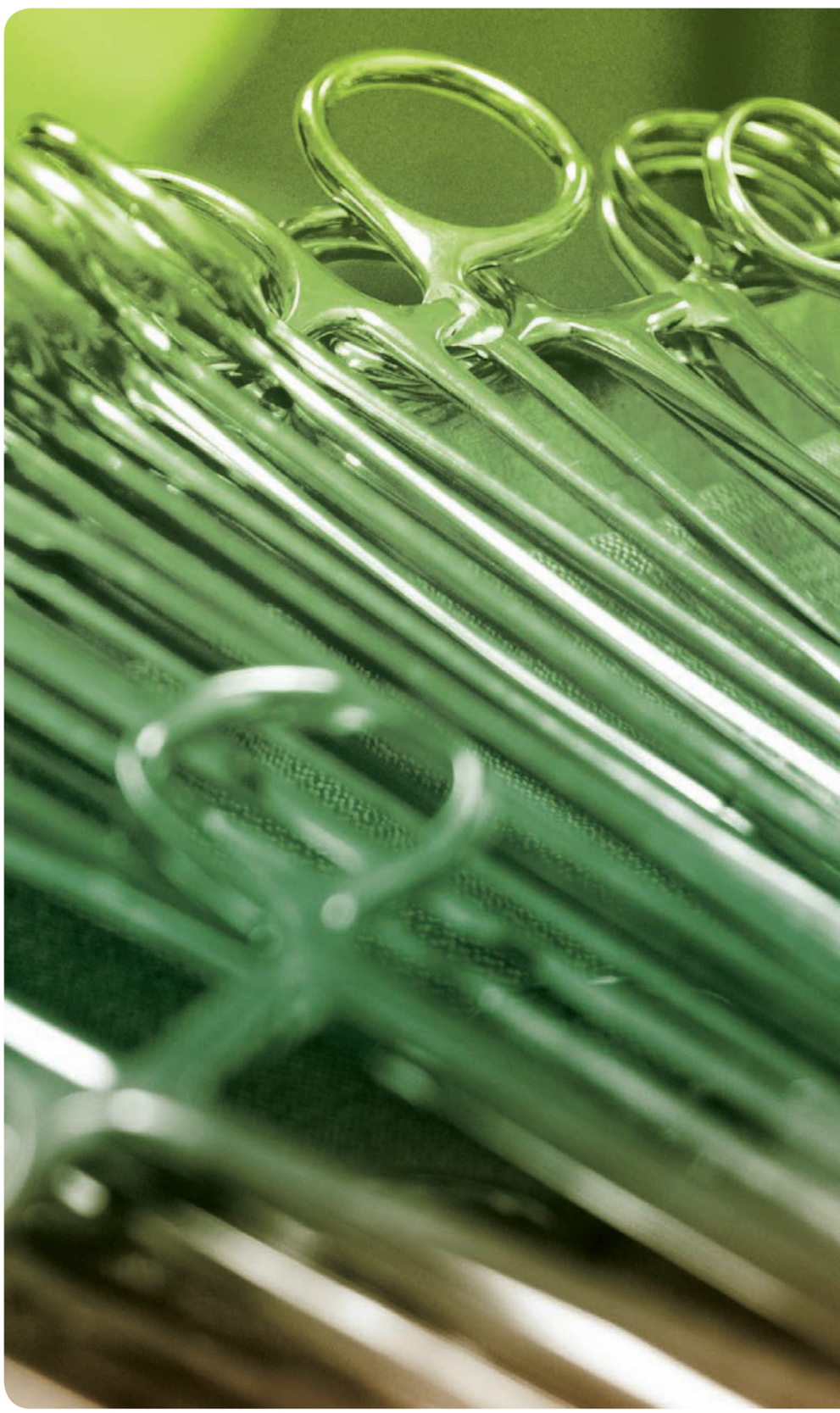
NHS
National Patient Safety Agency
National Reporting and Learning Service

Never Events

FRAMEWORK: UPDATE FOR 2010/11

Policies and action for Primary Care Trusts

NeverEvents



Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

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Executive summary

A policy on Never Events was introduced in the NHS in England from April 2009, following its proposal in *High Quality Care for All*.[1] The policy is designed to promote transparency and accountability when serious patient safety incidents occur. Commissioners should use the Never Events policy to inform discussions about patient safety with their providers.

Implementation of the Never Events policy is phased: the first phase was from April 2009 to March 2010. Primary Care Trusts (PCTs) have been monitoring Never Events within commissioned services and are expected to have reported publicly on these after April 2010, as outlined in *The NHS in England: The operating framework for 2009/10.*[2] The National Patient Safety Agency (NPSA), working with the NHS, published a core list of eight Never Events for 2009/10. Guidance was published in the *Never Events Framework 2009/10*.[3]

Following preliminary feedback from the NHS, initial data from the Reporting and Learning System of the NPSA, and recommendations in *The operating framework for the NHS in England 2010/11*,[4] this update of the Never Events framework outlines new aspects for 2010/11 with regard to:

- strengthening discussion and reporting of Never Events;
- refinements to the core list of Never Events; and
- seeking recovery of cost if a Never Event occurs.

Discussion and reporting processes based on contracting arrangements described in the *Never Events Framework 2009/10* continue to apply and should be strengthened as needed. For 2010/11, processes should reflect the NPSA's *National framework for reporting and learning from serious incidents*,[4,5] and Care Quality Commission (CQC) registration requirements with regard to the mandatory notification of events (including Never Events).[6]

The operating framework for the NHS in England 2010/11[4] reaffirms that PCTs should:

- use the national set of eight Never Events as part of their contract agreements with providers;
- ensure that patient safety incidents which are Never Events are reported to the NPSA; and
- publish the numbers and types of events on an annual basis.

1 Department of Health. *High Quality Care for All – NHS next stage review final report.* June 2008. Available at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825**

2 *The NHS in England: The operating framework for 2009/10.* December 2008. Available at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091445**

3 National Patient Safety Agency. *Never Events Framework 2009/10.* February 2009. Available at: **www.nrls.npsa.nhs.uk/neverevents**

4 *The operating framework for the NHS in England 2010/11.* December 2009. Available at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107**

5 National Patient Safety Agency. *National framework for reporting and learning from serious incidents.* April 2010. In publication.

6 Care Quality Commission. *Essential Standards of Quality and Safety.* December 2009. Available at: **www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_FINAL_081209.pdf**

In addition, from April 2010, where procedure/treatment results in one of the core Never Events, PCTs will be expected to recover the costs of the healthcare (except for 'escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners', to which this cost recovery element does not apply).

Purpose and audience

This document is an update of the *Never Events Framework 2009/10*,[7] published in February 2009. It has been produced to update guidance to PCTs, as commissioners, on implementation of the Never Events policy during 2010/11, building on *The operating framework for the NHS in England 2010/11.*[8]

The key audiences for this document are:

- PCT boards and commissioning functions; and
- care trust boards and commissioning functions (where applicable).

Additional resources for commissioners are available at: **www.nrls.npsa.nhs.uk/neverevents**

Introduction

High Quality Care for All proposed that a policy on Never Events should be introduced into the NHS in England from April 2009.

Never Events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Working with key stakeholders, the NPSA co-produced a core list of eight Never Events for adoption from 2009/10 and guidance on their use. The Never Events policy is part of wider safety improvement efforts in the NHS. Further information on the rationale can be found in the *Never Events Framework 2009/10.*[7]

Implementation of the Never Events policy is phased. In the initial phase (April 2009 to March 2010), policy implementation was based on existing commissioning arrangements, relationships and processes. The *Never Events Framework 2009/10* illustrated how these are expected to work, and advised on PCT, provider, Patient Safety Action Team and NPSA roles and responsibilities.

This update to the *Never Events Framework 2009/10* outlines how processes should continue to be based on existing arrangements, and also addresses some changes for the second phase. Evaluation of the Never Events policy is underway and the NPSA will publish an annual report on the first year of Never Events in the NHS in early 2010/11, including the numbers and learning from national data received by the NPSA.

7 National Patient Safety Agency. *Never Events Framework 2009/10.* February 2009. Available at: **www.nrls.npsa.nhs.uk/neverevents**

8 *The operating framework for the NHS in England 2010/11.* December 2009. Available at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107**

Never Events process in 2010/11

Strengthening discussion and reporting of Never Events

As a result of implementing the Never Events policy during 2009/10, PCTs will have mechanisms in place for discussing and recording the number of Never Events that occur in providers. From April 2010, PCTs should ensure that planning with providers includes new aspects in the process that are detailed below. PCTs should refer to and build upon the *Never Events Framework 2009/10.*[9] Further details and links to support providers and commissioners can be found at **www.nrls.npsa.nhs.uk/neverevents**

Continued

Processes described in the *Never Events Framework 2009/10* continue to apply in relation to reporting and learning if a Never Event occurs. Methods of measurement and reporting of Never Events should continue to be refined locally.

Regular board assurance around monitoring and learning continues to be important and should be strengthened as needed for 2010/11; for example where PCTs consider that discussion and reporting mechanisms could be improved.

New

From 1 April 2010 the quality of reporting and learning from investigations after Never Events should reflect the *National framework for reporting and learning from serious incidents*,[10] which has been developed to clarify roles and responsibilities, provide information on reporting and regulatory requirements and timescales, and guidance on standards for investigation of serious incidents.

From 1 April 2010, commissioners and providers also need to take account of the Care Quality Commission (CQC) registration requirement around statutory notification of incident reports (including Never Events) that indicate or may indicate risks to compliance with other registration requirements. For NHS trusts the requirement means that they must report Never Events to the NPSA and the NPSA will report relevant information to the CQC; therefore avoiding unnecessary duplication. NHS trusts must submit the reports within the relevant timescale to meet the notification requirements.[11]

9 National Patient Safety Agency. *Never Events Framework 2009/10.* February 2009. Available at: **www.nrls.npsa.nhs.uk/neverevents**

10 National Patient Safety Agency. *National framework for reporting and learning from serious incidents.* April 2010. In publication

11 Care Quality Commission. *Essential Standards of Quality and Safety.* December 2009. Available at: **www.cqc.org.uk/_db/_documents/Essential_standards_of_quality_and_safety_FINAL_081209.pdf**

Refinements to the core list of Never Events

Following initial feedback from the NHS and data received to date, the NPSA will be keeping the same eight Never Events in the core list for 2010/11, with some changes in scope to two of them:

1. Wrong site surgery Never Event – the definition will now apply from the start of any operation, rather than needing to be detected after the operation to fulfill the definition.
2. Retained instrument post-operation Never Event – the definition will now also apply to retained surgical swabs and throat packs (see also page 7).

As before, both providers and commissioners should assure themselves that they are aware of guidance to prevent Never Events on the core list and that it has been implemented. Criteria for selecting additional Never Events if commissioners wish to do this remain the same as in the first phase.[12]

Seeking recovery of cost if a Never Event occurs

As specified in *The operating framework for the NHS in England 2010/11,*[13] from April 2010, PCTs will be expected to seek recovery of the cost of the procedure/treatment where one of the following seven Never Events occurs:

- Wrong site surgery
- Retained instrument post-operation
- Wrong route administration of chemotherapy
- Misplaced naso or orogastric tube not detected prior to use
- Inpatient suicide using non-collapsible rails
- In-hospital maternal death from post-partum haemorrhage after elective caesarean section
- Intravenous administration of mis-selected concentrated potassium chloride

'Escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners', which otherwise remains on the core list of Never Events, will not be subject to recovery of cost.

Information on the method of measurement and the consequences per breach is provided in NHS Standard Contracts for 2010/11 (Never Events are termed Nationally Specified Events).[14]

Where a Never Event is related to a commissioned procedure/operation, the consequence of this breach would be the recovery of the cost of the procedure/operation and for there to be no charge to the commissioner for any corrective procedure/operation. Where there is in-hospital death, the consequence of the breach would be recovery of the cost of care to date (within the financial year) for the ongoing patient episode based on the provider's average daily rate costs.[14]

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12 National Patient Safety Agency. *Never Events Framework 2009/10.* February 2009. Available at: **www.nrls.npsa.nhs.uk/neverevents**

13 *The operating framework for the NHS in England 2010/11.* December 2009. Available at: **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107**

14 Department of Health *New NHS Contracts.* January 2010. **www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Systemmanagement/DH_085048**

In addition to recovery of the cost of the procedure/treatment, PCTs will seek from the provider a remedial action plan to ensure that future breaches are avoided. The management of this plan will be through the monthly contract review process, and any breach may result in contract withholding in accordance with contract performance mechanisms set out in the NHS Standard Contracts.

Further detail on costing mechanisms for individual Never Events should be determined locally. PCTs must encourage transparency and learning, and decide how this is best supported. It would be relevant for PCTs to take into account the openness, quality and content of reporting and learning, in applying local discretion about recovery of cost. Reporting and local action planning could also be linked to Commissioning for Quality and Innovation mechanisms according to local priorities. Discussions about processes and measurement with regards to recovery of cost mechanisms should take place at the start of 2010/11.

The core list of Never Events

Note: The list of Never Events continues to have a focus on acute care. The NPSA is continuing to work with stakeholders to extend the core list to include incidents from a wider range of care settings. Changes to the core list for 2010/11 are marked in **bold text.**

1. Wrong site surgery

Description: A surgical intervention performed on the wrong site (for example wrong knee, wrong eye, wrong patient, wrong limb, or wrong organ); the incident is detected **at any time after the start of the operation** and the patient requires further surgery, on the correct site, and/or may have complications following the wrong surgery.

Main care setting: Organisations that provide major, minor and/or day case surgery. Dentistry continues to be excluded.

2. Retained instrument post-operation

Description: One or more instruments **or swabs, or a throat pack**, are unintentionally retained following an operative procedure, and an operation or other invasive procedure is needed to remove this, and/or there are complications to the patient arising from its continued presence. This Never Event does not include interventional radiology or cardiology procedures, and the definition of instrument does not include guidewires, screws, or other similar material. **It does not include retained swabs after non-operative vaginal delivery.**

Main care setting: Organisations that provide major, minor and/or day case surgery.

3. Wrong route administration of chemotherapy

Description: Intravenous or other chemotherapy (for example, vincristine) that is correctly prescribed but administered via the wrong route (usually into the intrathecal space).

Main care setting: Acute care.

4. Misplaced naso or orogastric tube not detected prior to use

Description: Naso or orogastric tube placed in the respiratory tract rather than the gastrointestinal tract and not detected prior to commencing feeding or other use.

Main care setting: All care settings.

5. Inpatient suicide using non-collapsible rails

Description: Suicide using curtain or shower rails by an inpatient in an acute mental health setting.

Main care setting: Mental health.

6. Escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners

Description: A patient who is a transferred prisoner escaping from medium or high secure mental health services where they have been placed for treatment on a Home Office restriction order.

Main care setting: Mental health.

7. In-hospital maternal death from post-partum haemorrhage after elective caesarean section

Description: In-hospital death of a mother as a result of a haemorrhage following elective caesarean section, excluding cases where imaging has identified placenta accreta.

Main care setting: Acute care maternity services.

8. Intravenous administration of mis-selected concentrated potassium chloride

Description: Intravenous administration of mis-selected concentrated potassium chloride.

Main care setting: All care settings.

For advice, guidance, an action plan and frequently asked questions, see the *Never Events Framework 2009/10*, which can be downloaded from: **www.nrls.npsa.nhs.uk/neverevents**

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