

Never Events Policy Review 2016/17

6. Does the NHS need a nationally agreed list of incidents that are considered wholly preventable if existing guidance is followed and implemented?

If the purpose of Never Events Policy and Framework is to "improve safety culture" then the policy must be challenged.

Never events are rare and should not be assumed to be the right metric to gauge safety status with an organisation for the following reasons:

- 1) poor practices will only occasionally result in a Never Event
- 2) lack of Never Events is not an assurance of a healthy safety culture and practice within that organisation.
- 3) more common, non-Never Event related, harm can arise from: poor communication, planning and teamwork
- 4) pragmatically the focus of quality and safety improvement should be common outcomes and complications.
- 5) The label Never Event is also contradicted by what we know about the trajectory of these events (Burnett, Russ, Sevdalis (2014) Surgical 'Never Events' Learning from 23 cases in London Hospitals. <http://bit.ly/2eTr0PI>).

7. Is the description of how managers, commissioners, regulators and inspectors should respond to Never Events as written in the current Never Events Policy and Framework generally appropriate? See section 6 'Roles and responsibilities', page 9.

The introduction to this questionnaire points out the contradiction (5th paragraph) that people are being harmed by events not listed as "never events". We believe the Serious Incident Framework should address this anomaly. The National Quality Forum in the United States that coined the term "never events" has subsequently revised this term to "serious reportable events" and this work provides an opportunity to review this UK policy.

Page 10 of the Revised Never Events Policy and Framework points to the planned relaunch of the Incident Decision Tree (IDT). We would welcome this. The IDT was valuable work and probably underused.

8. Do NHS provider leadership teams (including your own if you work for a provider of NHS care, such as a trust or in primary care) respond appropriately to Never Events in a way that is proportionate and balanced with a focus on learning?

Not applicable/don't know

9. Do you feel commissioners respond in a proportionate and balanced way when a Never Event is reported?

Don't know <Don't know>

10. Do you feel the Care Quality Commission and NHS Improvement (formerly the NHS Trust Development Authority and Monitor) respond in a proportionate and balanced way to the occurrence of

Never Events?

Don't know

11. Thinking of the overarching Serious Incident Framework and the range of incidents that require investigation, do you think the Never Events Policy and Framework adds value and helps organisations to focus investigation and action planning where it is most needed?

The Never Events Policy and Framework is questionable. It may even undermine the validity of the Serious Incident Framework.

12. Which of the following do you consider would best support improvements to * patient safety?

The Serious Incident Framework would still apply if the Never Event sub-category was removed. The events described are serious and as such are addressed by the SIF.

If as a result of this consultation we retain the Never Events Policy and Framework, you may feel that changes should be made to the list of incidents that make up the current Never Events list.

Not applicable.

13. Should any incidents on the current Never Events list be **removed** for not meeting the criteria that define a Never Event?

Not applicable

14. Are you aware of any new national guidance (later than the 2014 consultation on the Never Events list

2015/16) or other factors that provide a strong enough systematic barrier to a type of error for that error to be considered for addition to the Never Events list?

No

If yes, please use the box below to suggest new Never Events and explain your reasons why.

** As compiled by NHS England patient safety experts and health professionals and referenced in the Never Event list. These include: physical barriers (eg special equipment that makes it impossible to deliver medications via the wrong route); time and place barriers (eg withdrawal of concentrated medications from settings to prevent accidental selection) or systems of double or triple checking only where supported by visual or computerised warnings, standardised procedures, or memory/communication aids. As all human action is vulnerable to human error, particularly where there is a risk of staff becoming overloaded, processes that rely on one staff member checking the actions of another or referring to written policies are not strong barriers.

<Not applicable>