NHS Improvement

Provisional publication of Never Events reported as occurring between 1 April and 31 July 2018

Published 30 August 2018

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

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.

Please note that because the definitions and designated list of Never Events were revised from February 2018, direct comparison of the number of Never Events since that date with earlier periods is not appropriate.

The revised 2018 Never Events policy and framework requires commissioners and providers to agree and report Never Events via the Strategic Executive Information System (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

To help prevent Never Events a set of new national safety standards for invasive procedures (NatSSIPs) was published in September 2015, and all relevant NHS organisations in England have now been instructed to develop and implement their own local standards based on the national principles of the NatSSIPs.

These new standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice: for example, through a series of standardised safety checks and education and training. The standards also support NHS providers to work with staff to develop and maintain their own, more detailed, local standards and encourage organisations to share best practice.

To help prevent nasogastric Never Events, an Alert *Nasogastric tube misplacement: continuing risk of death and severe harm* and resource set were published by NHS Improvement in July 2016. These provide materials to help trust boards, or their equivalents, assess whether previous alerts and guidance about nasogastric tubes have been implemented and embedded in their organisations.

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 National Reporting and Learning System (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 April and 31 July 2018 and which on 8 August 2018 were designated by their reporters as Never Events.

Data on Never Events for 2017/18 and previous years can be found on the NHS Improvement website.

Once sufficient time has elapsed after the end of the 2018/19 reporting year for local incident investigation and national analysis of data, NHS Improvement 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 8 August 2018, 167 Serious Incidents on the StEIS system were designated by their reporters as Never Events and had a reported incident date between 1 April and 31 July 2018. Of these 167 incidents:

- 150 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 1 April and 31 July 2018; this number is subject to change as local investigations are completed
- 16 Serious Incidents did not appear to meet the definition of a Never Event.
- One was a duplicate entry.

More detail is provided in the tables below.

Table 1: Never Events 1 April to 31 July 2018 by month of incident*

Month in which Never Event occurred	Number
April 2018	35
May 2018	47
June 2018	48
July 2018	20
Total	**150**

Note: A further 16 Serious Incidents did not appear to meet the definition of a Never Event and one was a duplicate entry.

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

Table 2: Never Events 1 April to 31 July 2018 by type of incident with additional detail*

Type and brief description of Never Event	Number
Wrong site surgery	**63**
Biopsy of wrong breast	1
Botox injection instead of nerve block	1
Grommet inserted to wrong ear	1
Incision to wrong part of ear	1
Incision to wrong side of knee	1
Injection to both eyes rather than just one	1
Injection to wrong toe	1
Lumbar puncture performed on wrong patient	1
Tonsils removed in error during an adenoidectomy/grommet insertion when plan was to conserve them	2
Wrong ear lesion removed	1
Wrong eye injection	2
Wrong finger incision	2

Wrong hip procedure	1
Wrong laparascopic port site re-explored	1
Wrong patient - central line inserted that was intended for another patient	1
Wrong patient - had a colonoscopy intended for another patient	1
Wrong patient - had laser eye surgery intended for another patient	1
Wrong side angiogram	2
Wrong side angioplasty	2
Wrong side hernia incision	1
Wrong side of toe nail removed	1
Wrong side ureteric stent	1
Wrong side ureteric stent removed	1
Wrong side ureteroscopy	2
Wrong site block	7
Wrong skin lesion biopsy	1
Wrong skin lesion removed	3
Wrong squint surgery esotropia rather than exotropia	1
Wrong toe incision	1
Wrong toe removed	1
Wrong tooth/teeth removed	19
Retained foreign object post procedure	**32**
Acetabular sizing trial	1
Guide wire - central line	2
Guide wire - chest drain	1
Guide wire - PICC line	1
K wire	1
Metallic object	1

Specimen retrieval bag	1
Surgical swab	7
Throat pack	1
Tonsil swab	1
Vaginal swab	15
Wrong implant/prosthesis	**19**
Hip	7
Knee	4
Lens	3
Wrong intra uterine device	2
Wrong neuro stimulator	1
Wrong spinal cord stimulator	1
Wrong stent	1
Unintentional connection of a patient requiring oxygen to an air flowmeter	**18**
Patient connected to air flowmeter rather than oxygen flowmeter	18
Misplaced naso- or orogastric tubes	**7**
Nasogastric tube in the respiratory tract and feed administered	7
Administration of medication by the wrong route	**4**
Bladder irrigation given intravenously	1
Oral medication given intravenously	3
Overdose of insulin due to abbreviations or incorrect device	**5**
Wrong syringe	4
Insulin withdrawn from a pen device	1
Overdose of methotrexate for non-cancer treatment	**1**
Overdose of methotrexate for non-cancer treatment	1
Collapsible shower or curtain rails	**1**

Collapsible shower or curtain rails	1
Total	**150**

Note: A further 16 Serious Incidents did not appear to meet the definition of a Never Event and one was a duplicate entry.

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

Table 3: Never Events 1 April to 31 July 2018 by healthcare provider*

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
Abbeyfield Medical Centre, reported by NHS North East Essex CCG	1									1
Airedale NHS Foundation Trust	1									1
Barking Havering and Redbridge University Hospitals NHS Trust			1							1
Barnsley Hospital NHS Foundation Trust							1			1
Barts Health NHS Trust	2	1		1						4
Basildon and Thurrock University Hospitals NHS Foundation Trust		1	1			1	1			4
Bedford Hospital NHS Trust	1	1								2
Birmingham Community Healthcare NHS Foundation Trust	2									2

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
Birmingham Women's and Children's Hospital NHS Foundation Trust	1				1					2
Blackpool Teaching Hospitals NHS Foundation Trust	1									1
Bolton NHS Foundation Trust	1									1
Bradford Hospitals NHS Foundation Trust		2					1			3
Brighton and Sussex University Hospitals NHS trust		1								1
Buckinghamshire Healthcare NHS Trust	1									1
Cambridge University Hospitals NHS Foundation Trust					1					1
Cambridgeshire Community Services NHS Trust	1									1
Chesterfield Royal Hospital NHS Foundation Trust		1								1
City Healthcare Dental Services, reported by NHS Hull CCG	2									2

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
City Hospitals Sunderland NHS Foundation Trust	1									1
Community Dental Services, reported by NHS Luton CCG	1									1
County Durham and Darlington NHS Foundation Trust	1			1						2
Dartford and Gravesham NHS Trust			1							1
Dental Services, reported by NHS South West regional team	1									1
Derby Teaching Hospitals NHS Foundation Trust			3							3
Derbyshire Community Health Services NHS Foundation Trust		1								1
East and North Hertfordshire NHS Trust	1				1					2
East Cheshire NHS Trust				1						1
East Kent Hospitals University NHS Foundation Trust		1								1
East Lancashire Hospitals NHS Trust			1							1

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
East Suffolk and North Essex NHS Foundation Trust	1			1						2
Frimley Health NHS Foundation Trust	1									1
Gentle Dental Care, reported by NHS Croydon CCG	1									1
Gloucestershire Hospitals NHS Foundation Trust	1									1
Great Western Hospitals NHS Foundation Trust	1									1
Guy's and St Thomas' NHS Foundation Trust	1									1
Heart of England NHS Foundation Trust		1								1
Hillingdon Hospital NHS Foundation Trust	1									1
Homerton Hospital NHS Foundation Trust		1		1						2
Imperial College Healthcare NHS Trust		1								1
King's College Hospital NHS Foundation Trust	2		1			1				4

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
Kingston Hospital NHS Foundation Trust						1				1
Lancashire Teaching Hospitals NHS Foundation Trust		1			1					2
Leeds Teaching Hospitals NHS Trust			2							2
Leicestershire Partnership NHS Trust									1	1
London North West University Healthcare NHS Trust	2	1		1						4
Maidstone and Tunbridge Wells NHS Trust		1								1
Manchester University NHS Foundation Trust					1					1
Mid Essex Hospital Services NHS Trust	2									2
Mid Yorkshire Hospitals NHS Trust	1									1
Milton Keynes University Hospital NHS Foundation Trust	1					1				2
Moorfields Eye Hospital NHS Foundation Trust	1									1

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
My dentist Leigh, reported by Greater Manchester Direct Commissioning	1									1
Newcastle Upon Tyne Hospitals NHS Foundation Trust	1					1	1			3
Norfolk and Norwich University Hospitals NHS Foundation Trust		1		2						3
North Cumbria University Hospitals NHS Trust		1								1
North Middlesex University Hospital NHS Trust				1						1
Oxford University Hospitals NHS Foundation Trust	2	2								4
Parkside private hospital, reported by NHS Wandsworth CCG				1						1
Pennine Acute Hospitals NHS Trust			1							1
Pinehill private hospital, reported by NHS East and North Hertfordshire CCG				1						1

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
Poole Hospital NHS Foundation Trust	1									1
Portsmouth Hospitals NHS Trust	1									1
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	1									1
Rotherham NHS Foundation Trust	2									2
Royal Berkshire NHS Foundation Trust		1								1
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust				1						1
Royal Cornwall Hospitals NHS Trust		1								1
Royal Devon and Exeter NHS Foundation Trust	1									1
Royal Free London NHS Foundation Trust	3	1	2							6
Royal Liverpool and Broadgreen University Hospitals NHS Trust				1						1

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
Royal Surrey County Hospital NHS Foundation Trust		1								1
Royal Wolverhampton NHS Trust	2	2								4
Sheffield Children's NHS Foundation Trust	1									1
Sheffield Teaching Hospitals NHS Foundation Trust		1								1
Shrewsbury and Telford Hospitals NHS Trust	1	1								2
South Tees Hospitals NHS Foundation Trust		1								1
South Warwickshire NHS Foundation Trust	1									1
Southport and Ormskirk Hospital NHS Trust		1								1
Spire Regency Hospital, reported by NHS Eastern Cheshire CCG	1									1
St George's Healthcare NHS Trust					1					1

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
St Helens and Knowsley Teaching Hospitals NHS Trust		1								1
Surrey and Sussex Healthcare NHS Trust				1						1
Tameside and Glossop Integrated Care NHS Foundation Trust		1								1
Taunton and Somerset NHS Foundation Trust				1						1
United Lincolnshire Hospitals NHS Trust	1				1					2
University College London Hospitals NHS Foundation Trust		1								1
University Hospital Southampton NHS Foundation Trust	1									1
University Hospitals Birmingham NHS Foundation Trust	1									1
University Hospitals of Leicester NHS Trust	2		1							3
University Hospitals of Morecambe Bay NHS Foundation Trust	1			1						2
University Hospitals Plymouth NHS Trust	2			1						3

	Wrong site surgery	Retained foreign object post procedure	Unintentional connection of a patient requiring oxygen to an air flowmeter	Wrong implant/prosthesis	Misplaced naso- or orogastric tubes	Overdose of insulin due to abbreviations or incorrect device	Administration of medication by the wrong route	Overdose of methotrexate for non-cancer treatment	Collapsible shower or curtain rails	Total
Walton Centre NHS Foundation Trust				1						1
West Hertfordshire Hospitals NHS Trust				1						1
Western Sussex Hospitals NHS Foundation Trust	1		1							2
Wye Valley NHS Trust			2							2
York Teaching Hospital NHS Foundation Trust			1					1		2
Total	**63**	**32**	**18**	**19**	**7**	**5**	**4**	**1**	**1**	**150**

Note: A further 16 Serious Incidents did not appear to meet the definition of a Never Event and one was a duplicate entry.

*Numbers are subject to change as local investigations are completed

Table 4: Never Events occurring before 1 April 2018 not previously reported

None reported.

Contact us:

NHS Improvement
Wellington House
133-155 Waterloo Road
London
SE1 8UG

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

@NHSImprovement

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

 Publication code: TD 21/18