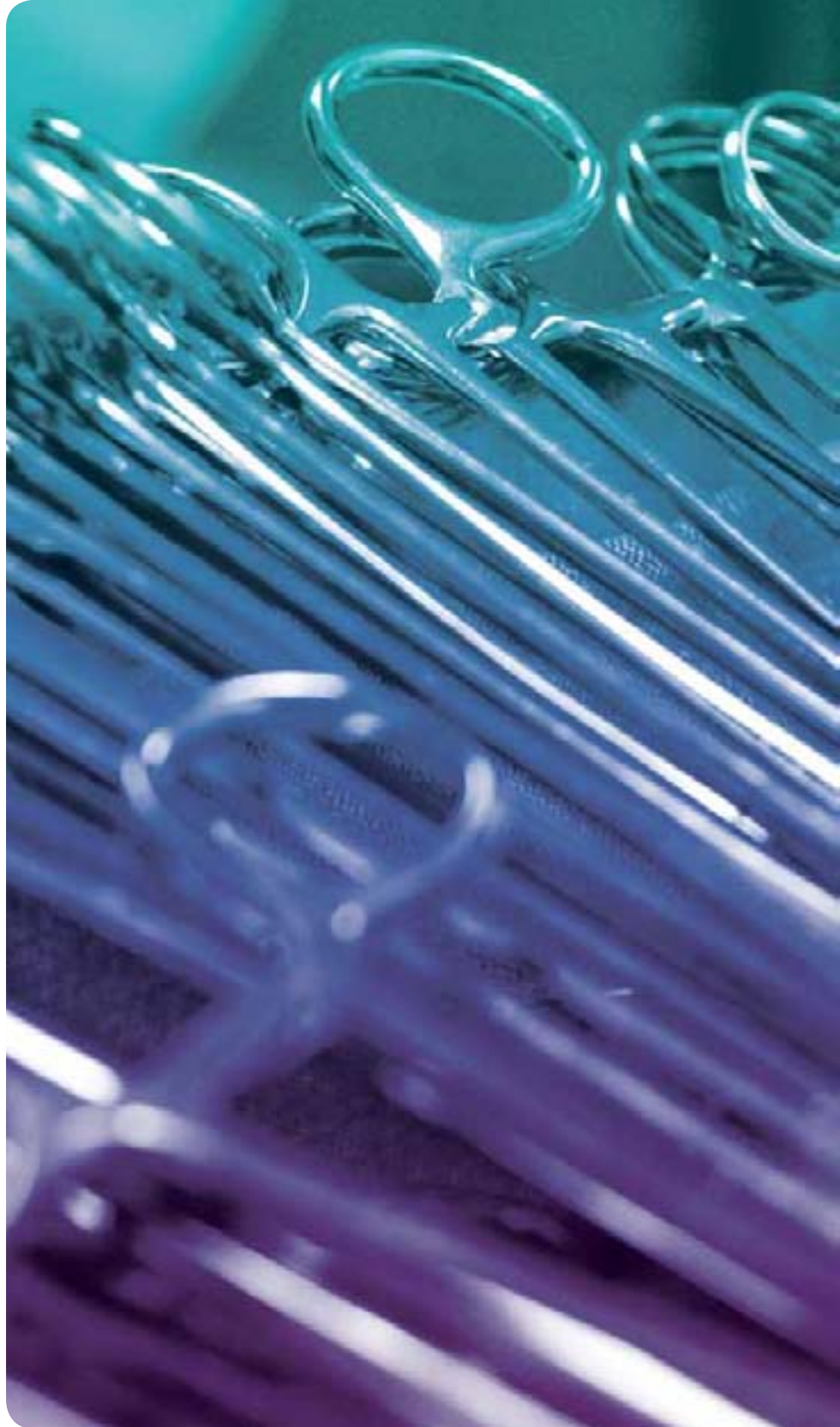


Never Events

FRAMEWORK 2009/10

Process and action for Primary Care Trusts 2009/10



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

*High Quality Care For All*¹ proposed that a policy on Never Events should be introduced in the NHS in England from April 2009.

*The NHS in England: The operating framework for 2009/10*² states that Primary Care Trusts (PCTs) will monitor the occurrence of Never Events within the services they commission, and publicly report them on an annual basis.

This *Never Events Framework 2009/10* sets out guidance for PCT commissioners on implementing the Never Events policy. This guidance has been developed following wide stakeholder input.

Implementation of the Never Events policy is designed to provide further impetus to increase patient safety through greater transparency and accountability when serious patient safety incidents occur. It will also inform new ways in which local commissioning can act as a lever for safer care.

Implementation of the Never Events policy will be phased, with the first phase running from April 2009 to March 2010. During the first phase the policy builds on existing local and national processes for reporting of serious incidents.

The National Patient Safety Agency (NPSA) will work closely with the NHS throughout the year to review implementation of the Never Events policy. What we learn in the first phase will help develop the policy for future years.

The *Never Events Framework* includes a description of a core list of Never Events for use during 2009/10, a suggested implementation plan for PCTs and signposts the existing guidance available to prevent Never Events.

The core list of Never Events:

- 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
- Escape from within the secure perimeter of medium or high secure mental health services by patients who are transferred prisoners
- In-hospital maternal death from post-partum haemorrhage after elective caesarean section
- Intravenous administration of mis-selected concentrated potassium chloride

¹ *High Quality Care For All – NHS Next Stage Review Final Report*, Department of Health, June 2008

² *The NHS in England: The operating framework for 2009/10*, Department of Health, December 2008

Purpose and audience

This document has been produced by the NPSA and includes guidance to PCTs as commissioners on implementation of the Never Events policy during 2009/10, described in *The NHS in England: The operating framework for 2009/10*.³

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, providers and Strategic Health Authorities (SHAs) are available at www.npsa.nhs.uk/nrls/neverevents

Introduction

*High Quality Care For All*⁴ 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 has co-produced a core list of Never Events for adoption during 2009/10 (page 5). The Never Events on the list are, by definition, rare. The Never Events policy is just one part of wider safety improvement efforts in the NHS, many of which have a focus on more common incidents.

Implementation of the Never Events policy will be phased. In the first phase (April 2009 to March 2010), policy implementation will be based on current commissioning arrangements and relationships, and the processes that underpin them. Lessons and learning from the first phase will allow us to develop the policy for future years.

The first phase of implementing the Never Events policy has a number of linked objectives:

- to introduce the Never Events concept within the NHS in England;
- to focus on a defined core list of Never Events and to learn from the experience for future years;
- to raise PCT and provider awareness of patient safety, and reporting and response processes for serious incidents;
- to promote greater openness and transparency; and
- to explore ways in which payment systems may be linked to the occurrence of Never Events.

³ *The NHS in England: The operating framework for 2009/10*, Department of Health, December 2008

⁴ *High Quality Care For All – NHS Next Stage Review Final Report*, Department of Health, June 2008

In addition, there is evidence that the defined Never Events are currently under-reported. Therefore, a supplementary objective of the first phase of implementation will be to encourage more comprehensive reporting.

Why implement a policy on Never Events?

Implementation of the Never Events policy forms part of the wider agenda for improving and assuring patient safety across the NHS.

The policy is designed to drive improvements in patient safety in several ways. The incidence of Never Events can be an indicator of how effective an organisation is at implementing safer practices, and whether organisations have the right systems in place to prevent recurrence of such incidents.

Implementation of the Never Events policy will:

- serve to strengthen transparency and accountability when serious patient safety incidents occur; in particular, assuring the community that action has been taken in relation to prevention of these events;
- provide additional impetus to reducing serious, preventable and costly incidents;
- act as an example of how local commissioning can act as a lever for safer care, through reinforcing the importance of commissioner responsibilities in relation to patient safety reporting and learning, serious incident protocols, investigation methods and implementation of risk-reducing interventions.

Criteria for deciding the list of Never Events

The NPSA worked with key stakeholders to agree the core list of Never Events for the first phase. The following criteria were used to create the list:

- The Never Event may or does result in severe harm or death to patients and/or the public.
- There is evidence that the Never Event has occurred in the past, that it is a known source of risk (data sources: NPSA Reporting and Learning System, and other Serious and Untoward Incident reporting systems).
- There is existing national guidance and/or national safety recommendations on how the Never Event can be prevented, along with support for implementation.
- The Never Event is preventable if the national guidance and/or national safety recommendations are implemented.
- Occurrence of the Never Event can be easily identified, defined and measured on an ongoing basis.

The core list of Never Events

Note: The list of Never Events developed for the first phase of implementation has a focus on acute care. In future phases of implementation the NPSA will work with stakeholders to extend the core list to include incidents from a wider range of care settings.

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 after 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 is to be excluded for the first phase.

2. Retained instrument post-operation

Description: One or more instruments 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 guide wires, screws, swabs or other similar material.

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.

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.

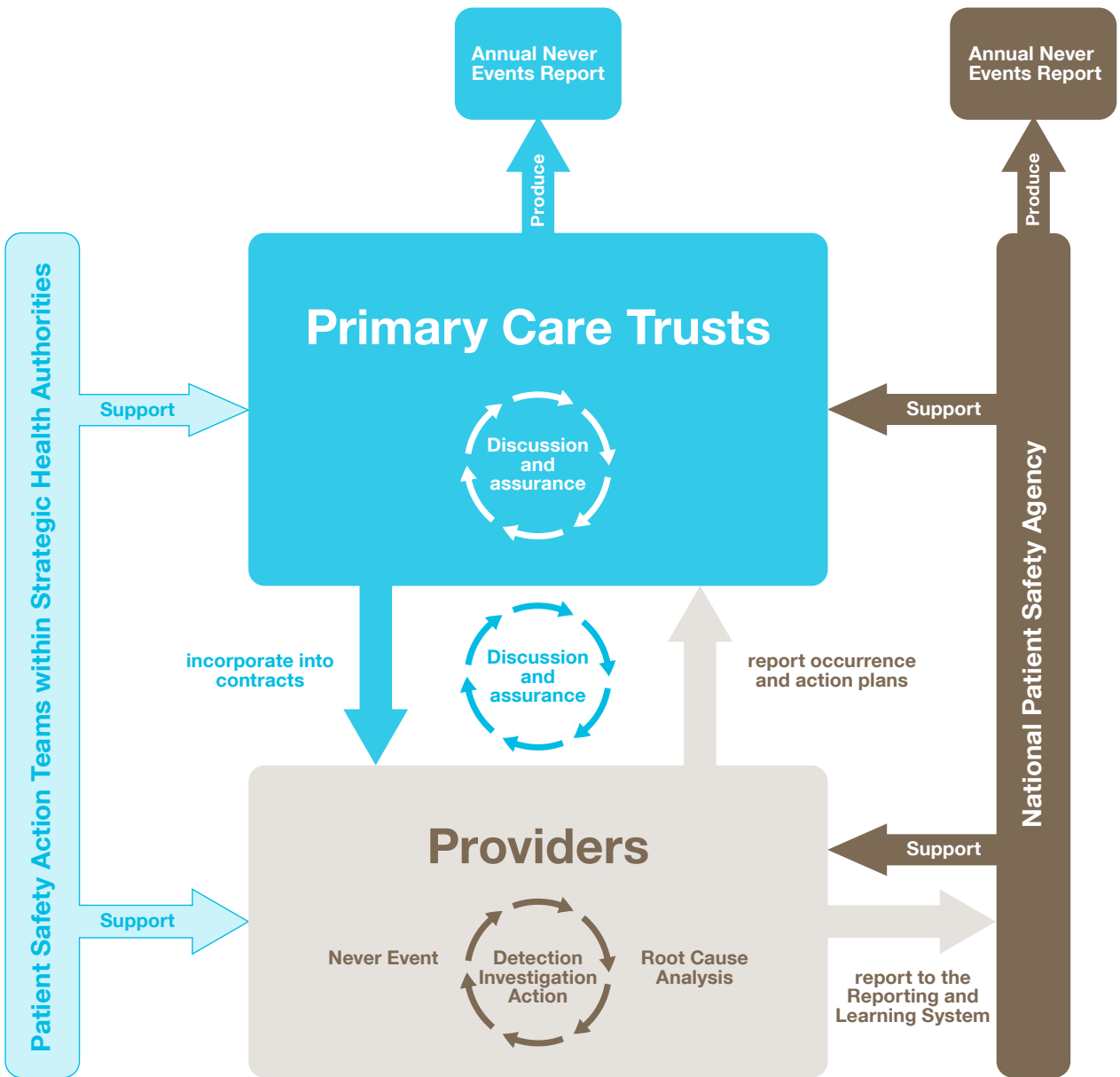
Never Events process

The reporting and management processes that underpin implementation of the Never Events policy build on existing processes and mechanisms wherever possible. The Never Events policy brings together these processes to enhance the resulting benefits.

- Commissioners within PCTs need to draw up the full list of Never Events that will be used locally and meet with their providers to ensure a shared understanding of roles and responsibilities in relation to implementation of the Never Events policy. The core list of Never Events should be adopted in its entirety, but PCTs can add other events to this list if they meet the selection criteria (see page 9).
- Provider reporting of Never Events to their PCTs should form part of existing requirements for reporting of Serious Untoward Incidents. It is important that commissioners and providers have processes in place for this reporting to happen and make checks to ensure that they are working properly.
- Having met with their PCTs, providers need to ensure that they have implemented all applicable national standards and guidance to prevent the occurrence of Never Events. An overview of the guidance can be found in Appendix A or at **www.npsa.nhs.uk/nrls/neverevents**
- When Never Events occur, providers will use existing mechanisms to report the incident (locally to the PCT that a serious incident has occurred, and nationally to the NPSA). Providers should carry out a root cause analysis of why the event occurred and discuss learning and preventative action with the PCT.
- Throughout the year, PCT boards should receive regular reports on the incidence of Never Events and the actions providers are taking to prevent their occurrence. At the end of the year, it is expected that PCTs will publicly report on Never Events and their incidence as part of their annual reporting on quality and safety.
- Patient Safety Action Teams (PSATs) within each SHA will support PCTs with commissioning safer services and support providers in carrying out local root cause analysis of incidents that have occurred.

The NPSA will:

- support implementation by providing a 'one stop shop' on its website for all information, tools and guidance related to Never Events and root cause analysis;
- initiate action to promote learning across the NHS following the occurrence of Never Events, where required;
- evaluate implementation of the Never Events policy and produce an annual report on implementation across the NHS in England, including the lessons that have been learned.



The figure above illustrates the central role of PCT commissioners in linking the processes that underpin the Never Events policy.

PCT action plan

To help your PCT implement the Never Events policy, the following action plan can be used as an implementation checklist.

Preparation actions: February – March 2009	<input checked="" type="checkbox"/>
Identify a member of staff who will be responsible for leading on implementing the Never Events Framework within your PCT.	<input type="checkbox"/>
Finalise the list of Never Events that your PCT will be using during 2009/10. The core list of Never Events should be used in its entirety; however there is scope for PCTs to identify additional, locally defined Never Events using the guidance in Note 1, opposite.	<input type="checkbox"/>
Gain organisation-wide sign up to the list of Never Events and commitment to public reporting of these within annual reporting arrangements.	<input type="checkbox"/>
Ensure contracts with providers cover the list of Never Events that your PCT will be using and discuss requirements with them. Use the Provider action plan (Appendix B) to assist you with these discussions.	<input type="checkbox"/>
Implementation actions: April 2009 – March 2010	<input checked="" type="checkbox"/>
Monitor any Never Events that have occurred and discuss them with providers during the regular reviews of serious incidents (see Note 2, opposite).	<input type="checkbox"/>
Monitor and regularly discuss provider implementation of action plans developed from root cause analysis investigations.	<input type="checkbox"/>
Ensure that the frequency and types of incident being reported are reviewed regularly by your PCT board together with the actions providers are implementing to prevent further occurrence.	<input type="checkbox"/>
Publicly report on Never Events as part of annual quality reporting arrangements, identifying: <ul style="list-style-type: none"> • the frequency and type of Never Events that have occurred in commissioned providers; and • a summary of the types of actions that these providers have implemented following a root cause analysis or significant event audit. 	<input type="checkbox"/>

Note 1: To take into account local circumstances and priorities, PCTs can identify additional incident types to include in the list of Never Events as part of the implementation process. It is important that your proposed additional events meet the following national criteria:

- The Never Event may or does result in severe harm or death to patients and/or the public.
- There is evidence that the Never Event has occurred in the past, that it is a known source of risk (data sources: NPSA Reporting and Learning System and other Serious and Untoward Incident reporting systems).
- There is existing national guidance and/or national safety recommendations on how the Never Event can be prevented, along with support for implementation.
- The Never Event is preventable if national guidance and/or national safety recommendations are implemented.
- Occurrence of the Never Event can be easily defined, identified and measured on an ongoing basis.

PCTs should use discussions about Never Events with all of their providers to get a common understanding of the list of Never Events that will be used, reinforce expectations and clarify the arrangements in place to meet these.

Note 2: Two requirements are central to the success of implementing Never Events:

- Providers should continue to report patient safety incidents to the NPSA's Reporting and Learning System.
- Providers should meet regularly with their commissioning PCT(s) to report and discuss serious incidents that have occurred and the learning from them.

These requirements are already included in standard provider contracts.

Risk management

As with all new initiatives, robust risk management should be in place. This is particularly true for implementation of the Never Events policy as organisations are likely to be implementing a number of different patient safety initiatives simultaneously.

Specific national guidance and/or safety recommendations are available to prevent each of the Never Events on the core list. Both providers and commissioners should assure themselves that they are aware of the guidance and that it has been implemented. An overview of the main guidance is given below, and more detail and further links to support providers and commissioners can be found at www.npsa.nhs.uk/nrls/neverevents

1. Wrong site surgery

The Chief Medical Officer for England identified that errors involving operations on the wrong side or part of the body are ‘particularly worrying for the public, especially when they seem to be repeated.’⁵ Operating on the wrong site can have devastating consequences for patients. Implementation of the following guidance can help providers prevent wrong site surgery:

- *Safer Practice Notice – Standardising wristbands improves patient safety, 2007*

NPSA guidance on the use of wristbands for patient identification.

 www.npsa.nhs.uk/nrls/alerts-and-directives/notices/wristbands/

- *Patient safety alert – WHO Surgical Safety Checklist, 2009*

The NPSA, in collaboration with a multi-professional expert reference group, has adapted the World Health Organization’s (WHO) Surgical Safety Checklist for use in England and Wales. This alert includes advice to the NHS on implementing the checklist, and incorporates previous best practice identified by the NPSA and the Royal College of Surgeons on making surgery safer in its *Patient safety alert – Correct site surgery* from 2005.

 www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/safer-surgery-alert/

2. Retained instrument post-operation

Unintentionally retained instruments are a potential cause of complications and repeat surgery. Most providers will have developed their own local policies based on available advice, including the following in the UK:

- *Standards and Recommendations for Safe Perioperative Practice, 2007.*

This document from the Association for Perioperative Practice (AfPP) contains recommendations on counting and checking instruments after surgery.

 www.afpp.org.uk/news/safe-practice-highlighted-in-new-afpp-publication

- *Swab, Instrument and Needle Counts: Managing the Risk, 2005*

This document summarises the relevant chapter from the AfPP advice mentioned above.

 www.afpp.org.uk/filegrab/swabcountposter.pdf?ref=57

⁵ *On the state of public health: Annual report of the Chief Medical Officer 2007*, Department of Health, 2008

- *Patient safety alert – WHO Surgical Safety Checklist, 2009*
Implementation of the NPSA's Patient safety alert (see Never Event 1) will also help ensure that instruments are not left in the patient after surgery.


 www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/safer-surgery-alert/

3. Wrong route administration of chemotherapy

Cancer drugs such as vincristine continue to be given occasionally via the wrong route worldwide, sometimes resulting in paralysis or death of a patient. In 2000, *An organisation with a memory*⁶ highlighted incidents where wrong administration of a drug led to the death of a patient. The following guidance for providers on administering intrathecal chemotherapy is available:


- *HSC 2008/001: Updated national guidance on the safe administration of intrathecal chemotherapy.*

This guidance reinforces the message that intrathecal chemotherapy remains an important patient safety issue, and should be read in conjunction with the NPSA's Rapid Response Report (see below).

 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Healthservicecirculars/DH_086870

- *Rapid Response Report NPSA/2008/RRR004 – Using vinca alkaloid minibags (adult/adolescent units)*

This NPSA alert focuses on safer administration of a particular cancer drug to prevent wrong route administration.

 www.npsa.nhs.uk/nrls/alerts-and-directives/rapidrrr/using-vinca-alkaloid-minibags/

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

There is a risk that nasogastric or orogastric feeding tubes may be inserted in a lung or bronchus instead of the stomach, resulting in potentially serious harm and/or death. Providers should familiarise themselves with the following guidance to help prevent this happening:

- *Patient safety alert – Reducing harm caused by misplaced nasogastric feeding tubes, 2005*

This NPSA alert contains guidance on how to confirm correct placement of tubes.

 www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/nasogastric-feeding-tubes/

- *Patient safety alert – Reducing the harm caused by misplaced naso and orogastric feeding tubes in babies under the care of neonatal units, 2005*

This NPSA alert includes guidance specifically for nasogastric and orogastric feeding tube placement in babies.

 www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/feedingtubes/


⁶ *An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer, 2000, Department of Health, June 2008*

5. Inpatient suicide using non-collapsible rails

Inpatients in mental health units are at high risk of suicide, and hanging or strangulation is the most common method of suicide in this group. In 2000, *An organisation with a memory*⁷ highlighted the issue of collapsible rails. The following advice is available for providers to reduce this risk:

- *NHSE SN (2002) 01: Cubicle rail suspension system with load release support systems*

This NHS Estates Safety Notice states that any cubicle track, curtain track, shower track and wardrobe rail with load release support systems must be maintained in accordance with manufacturer's instructions and subjected to an annual safety load test.

 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Estatesalerts/DH_4122863

- *NHSE (2004) 10: Bed cubicle rails, shower curtain rails and curtain rails in psychiatric in-patients settings.*

This NHS Estates alert requires all NHS organisations to identify and remove all non-collapsible rails and replace them with collapsible rails, and to identify other potential ligature points, for example windows, coat hooks, door closures, suspended ceiling tracks, and remove or neutralise these risks.

 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Estatesalerts/DH_4119476

- *Clinical Guideline 16 – Self-harm: the short term physical and psychological management and secondary prevention of self-harm in primary and secondary care, 2004*

This evidence-based guidance from the National Institute for Health and Clinical Excellence (NICE) covers the general management of those who have already self-harmed.

 www.nice.org.uk/Guidance/CG16

- *DH (2007)08: Cubicle curtain track rails (anti-ligature)*

This alert from the Estates and Facilities Division of the Department of Health encourages correct installation of rails to ensure that they collapse as intended.

 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Estatesalerts/DH_076400

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

Escape from secure mental health services is a high profile safety issue for other patients, staff and the public. Mental health providers should have local policies in place to define the security arrangements as per the following document:

- *Standards for Medium Secure Units, 2007*

This document from the Royal College of Psychiatrists maps the security arrangements that should be in place for medium secure units.

 www.rcpsych.ac.uk/pdf/Final%20Standards%20for%20Medium%20Secure%20Units%20PDF.pdf

⁷ *An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer, 2000, Department of Health, June 2008*

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

Worldwide, obstetric haemorrhage remains a problem in terms of both morbidity and mortality. Providers should be aware of applicable guidelines before and after caesarean section to prevent women from dying from haemorrhage, particularly after an elective procedure:

- *The role of emergency and elective interventional radiology in postpartum haemorrhage, Good Practice No. 6, 2007*
This guidance was produced jointly by the Royal College of Obstetricians and Gynaecologists, the Royal College of Radiologists and the British Society of Interventional Radiology. It urges all obstetric units to consider early or prophylactic interventional radiology as an important tool in the prevention and management of post-partum haemorrhage.

 www.rcog.org.uk/resources/Public/pdf/goodpractice6a.pdf

- *Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer – 2003-2005, 2007*
The Seventh Report on Confidential Enquiries into Maternal Deaths in the UK includes a number of recommendations on prevention and treatment of haemorrhage, including the use of imaging the placental site before delivery, and the use of early warning scoring systems after delivery.

 www.cemach.org.uk/getattachment/927cf18a-735a-47a0-9200-cdea103781c7/Saving-Mothers--Lives-2003-2005_full.aspx

- *Patient safety alert – WHO Surgical Safety Checklist, 2009*
The surgical team involved in a caesarean section should use the NPSA's Patient safety alert based on the WHO Surgical Safety Checklist (see Never Event 1) to ensure best practice around the procedure.

 www.npsa.nhs.uk/nrls/alerts-and-directives/alerts/safer-surgery-alert/

8. Intravenous administration of mis-selected concentrated potassium chloride

Mis-selection of concentrated potassium chloride for intravenous administration for a flush or instead of the correct medication can have fatal effects. Providers should be aware of the following national advice to reduce the risk of this happening:

- *Patient safety alert – Potassium chloride concentrate solutions, 2002 (updated 2003)*
This NPSA alert recommends withdrawal of concentrated solutions from clinical areas other than defined critical care environments, and the use of prepared-in-pharmacy or bought solutions in standard diluted forms.

 www.npsa.nhs.uk/patientsafety/alerts-and-directives/alerts/potassium-chloride-concentrate/

Appendix B: Provider action plan

Preparation actions: February – March 2009	<input checked="" type="checkbox"/>
Meet with commissioners to discuss requirements and processes for implementing the Never Events policy.	<input type="checkbox"/>
Ensure that national standards and guidance to reduce risks of Never Event occurrence are implemented and that processes are in place to identify and learn from near misses (see Appendix A or www.npsa.nhs.uk/nrls/neverevents).	<input type="checkbox"/>
Inform senior management and board (if relevant) about the list of Never Events and reporting requirements and processes that will take place if a Never Event occurs.	<input type="checkbox"/>
Implementation actions: April 2009 – March 2010	<input checked="" type="checkbox"/>
If a Never Event occurs:	
a. Report the incident through your risk management system.	<input type="checkbox"/>
b. Communicate with the patient or service user, family or their carer as soon as possible about the incident in line with the <i>Being open</i> policy: www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/beingopen/	<input type="checkbox"/>
c. Report to the relevant PCT that a Never Event has occurred, using the agreed route.	<input type="checkbox"/>
d. Report the incident to the NPSA's Reporting and Learning System	<input type="checkbox"/>
e. Undertake a comprehensive root cause analysis or significant event audit of the incident to understand what went wrong, how and why.	<input type="checkbox"/>
f. In parallel, managers are encouraged to use the NPSA's Incident Decision Tree to inform their decision on what initial action to take with the staff involved in the incident. This ensures a consistent and fair approach. www.npsa.nhs.uk/idt	<input type="checkbox"/>
g. Implement changes that have been identified and agreed following the root cause analysis or significant event audit.	<input type="checkbox"/>
h. Discuss the learning and corrective/preventative actions following the occurrence of the Never Event with the PCT.	<input type="checkbox"/>

Visit the www.npsa.nhs.uk/nrls/neverevents for further information on:

- root cause analysis;
- significant event audit;
- *Being open* policy; and
- Incident Decision Tree.

Appendix C: Frequently asked questions

As PCTs begin implementing the Never Events policy, this list of frequently asked questions will be updated regularly and posted at: www.npsa.nhs.uk/nrls/neverevents

Q How were the Never Events selected for the core list?

A. The Never Events were chosen if they met the following criteria:

- The Never Event may or does result in severe harm or death to patients and/or the public.
- There is evidence that the Never Event has occurred in the past, that it is a known source of risk (data sources: NPSA Reporting and Learning System, and other Serious and Untoward Incident reporting systems).
- There is existing national guidance and/or national safety recommendations on how the Never Event can be prevented, along with support for implementation.
- The Never Event is preventable if national guidance and/or national safety recommendations are implemented.
- Occurrence of the Never Event can be easily defined, identified and measured on an ongoing basis.

We used NPSA and other sources of data, expert opinion and national guidance to form a shortlist which was discussed with clinical experts and further refined based on feedback from the service. The list of events developed through this method has a focus on acute care. We anticipate that, in future, the number and range of Never Events on the core list will cover a wider range of care settings.

Q. What is the number of Never Events reported to the NPSA's Reporting and Learning System each year?

A. The number of Never Events reported to the Reporting and Learning System is small but there is evidence of under-reporting. A key aim of the first phase of Never Events implementation is to encourage accurate reporting to PCTs and the Reporting and Learning System. This will allow us to create a baseline for the future.

Q. Why have uncommon events been selected? Wouldn't it be better to include more common events with lower severity?

A. Never Events are a subset of patient safety incidents that meet certain criteria for a specific purpose. They have been chosen to represent a breadth of outcomes that are potentially or actually severe. Implementation of the Never Events policy is just one part of wider safety improvement efforts, many of which have a focus on more common incidents. In subsequent years, more common events may be considered, to lever change.

Q. How will Never Events be reported?

A. PCTs will report local incidence of Never Events as part of routine quality and safety reporting and will publicly report annually on their incidence. In addition, the NPSA will publish national results on the number of Never Events reported to the Reporting and Learning System.

Q. Does the process cover independent sector provided, NHS-funded care?

A. Yes.

Q. Should processes that make up Never Events implementation take place for all Serious Untoward Incidents?

A. Yes. The only additional requirement in the first phase of Never Events is for PCT boards to publicly report Never Event incidence. However, PCTs will need to ensure that processes for the reporting, investigation and communication of Serious Untoward Incidents are working correctly to allow this to happen. The NPSA is working on developing definitions and advice about Serious Untoward Incident reporting and investigation, and Never Events will fit clearly into this.

Q. Why does this framework not include reporting of incidence of Never Events in provider quality accounts?

A. The NPSA is discussing inclusion of reporting of Never Events as part of provider quality accounts with the relevant parties. We will keep you updated as discussions progress.

Q. Why is the NHS Never Events list different from the United States list(s)?

A. There are differences between the USA and UK in the policy for Never Events, and the criteria for selection of Never Events reflects these differences. However, we did draw on lessons from the US experience when developing the UK's list.

Q. How will patients, service users or carers know if a Never Event has happened to them or their relatives?

A. As with any patient safety incident, it is expected that providers will provide explanation and an apology for Never Events that occur. The NPSA's *Being open* guidance explains the principles behind this approach.

www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/beingopen/

Q. How can I get further support and guidance?

A. Visit the Never Events section on the NPSA's website for further information, guidance and tools: **www.npsa.nhs.uk/nrls/neverevents**

Your regional PSATs can help to support good practice and root cause analysis training. Contact your SHA for local PSAT details.

Q. Did you involve patients in the development of the Never Events policy?

A. We sought and received feedback from patient organisations and national patient safety champions during policy development.



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