Royal College of Anaesthetists

NHS Improvement consultation on Never Events Policy and Framework

Response from the Royal College of Anaesthetists
(submitted via NHS Improvement online portal)

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

Although there may be value in such a list, the RCoA would like to make the following suggestions on behalf of its 17,000 Fellows and Members:

- The name "Never Event" should be abandoned as a clear and public indicator that the stress is no longer on blame but on root cause analysis, systems change and learning from adverse events. This is in line with the Secretary of State for Health's recent call for "*a learning culture not a blame culture*"[1].
- We propose that the term "**Preventable Event**" replaces the term "Never Event" not only as clear indicator of this change in emphasis but also to signal an understanding that although these events should be preventable, there may be occasions on which they do occur and that these incidents should be investigated in order to understand why they were not prevented.
- The assumption that an occurrence is "wholly preventable" simply because there is published guidance that should act as a barrier ignores the possibility that there may be flaws in the guidance or human factor issues that make adherence to the guidance problematic under some clinical circumstances.
- Recent research indicates that the occurrence of Never Events in an organisation does not correlate with accepted indicators of care quality[2]. It should therefore be made clear that the occurrence of these rare events does not necessarily imply the existence of overall organisational deficiencies but may point to specific processes within an organisation's care pathways that could be improved.
- A formal, external review of the Never Events programme should be conducted in order to determine its efficacy, its effect on patient safety, and its impact on those involved in the commissioning and provision of healthcare, and those directly involved in Never Events from both the patient and healthcare professional perspectives.

2. 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.

[1] https://www.gov.uk/government/speeches/from-a-blame-culture-to-a-learning-culture

[2] Moppett IK and Moppett SH. Surgical caseload and the risk of Never Events in England. *Anaesthesia* 2016; **71**: 17-30

It describes how managers should respond but there is at present a significant gap between how managers **should** respond and how many managers **do** respond. In our members' experience, early allocation of blame, punitive investigations and disciplinary action are all too common, leading to a high incidence of "second victims": healthcare professionals whose work and health is significantly affected by their involvement in a Never Event. This is reaching a level at which it is becoming apparent that the number of "second victims" of Never Events is likely to exceed the number of "First Victims", i.e. patients who suffer significant harm from the occurrence of a Never Event. This situation derives from early attitudes taken by NHS leaders towards Never Events but its persistence is fuelled by the continued use of the name "Never Events" and even the approach taken in the 2015 Revised Never Events Policy and Framework, in which care that leads to a Never Events is described as "substandard" (page 17) – there is no evidence to support this assumption for all Never Events, and such terms are unhelpful.

Some members commented that there should be greater clarity and more flexibility in the Never Events Policy and Framework with regard to the timescales relating to the reporting and investigation of Never Events. In particular, the use of the term "two working days" seems to imply that the NHS does not provide a 24/7 service.

3. 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?

Our members were clear that NHS provider leadership teams frequently lose focus on the important issues related to Never Events: identifying and disseminating the learning that comes from thoughtful root cause analysis, and working to build a safety culture that minimises patient harm. Rather, they identified that managers first tried to exclude the incident in question from the Never Events definition if possible, then rushed investigations to fit into rigid timescales, and concentrated on the financial and reputational penalties that result from the occurrence of Never Events as being the most important issues. This was a particular concern, as patient safety problems are usually the result of systems failures[3], and the people responsible for leading Serious Incident investigations are usually the same people who are responsible for the systems that led to failure – a conflict of interest that often leads to individual blame rather than an acceptance of organisational responsibility and a willingness to address systems failures.

A significant deficiency in the Never Events Policy and Framework is that there is no obligation upon organisations to share the learning that derives from the investigation and analysis of Never Events. We think that there should be a statutory, national framework for reporting and dissemination of learning so that the lessons deriving from Never Events do not remain solely in the organisation and that others can benefit from the analysis of adverse patient incidents.

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

Paragraph 8.3 on page 16 of the Never Events Policy and Framework suggests that commissioners should consider the following remedial actions: "*a detailed review and analysis of the circumstances leading to the failure to recognise and/or report the incident… consideration of disciplinary action against* ***individuals***…". This seems further to emphasise the focus on individual

[3] A promise to learn – a commitment to act (The Berwick Report). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

blame and ignores the role of corporate or organisational deficiencies in the reporting of Never Events.

5. 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?

Cost recovery and punitive financial sanctions should be removed from the Never Events programme. There is no evidence that financial sanctions improve standard of healthcare, and linking significant costs to Never Events – but not to other Serious Incidents – distorts managers' views of the importance of Never Events, often at the expense of the appropriate investigation and management of other Serious Incidents.

6. 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?

Top-slicing 14 Serious Incidents and labelling them Never Events simply because there is easily identifiable (but not necessarily fully effective) guidance that should prevent them creates a significant and artificial divide between the management of Never Events and other Serious Incidents. This divide places undue focus on some incidents at the expense of other avoidable adverse patient events. Any programme that seems to imply that the investigation of a failure to fit collapsible curtain rails is worthy of greater attention and resources than the investigation of the death of a mother in childbirth is in need of urgent review.

The Royal College of Anaesthetists' Lay Committee expressed the view that a publicly visible and openly reported system of investigating and remediating significant, preventable healthcare events is of value in giving the public confidence that there is appropriate scrutiny of such events and, more importantly, that the NHS is being candid with patients and the public about the root causes of adverse healthcare events, while taking appropriate action to minimise the chances of recurrence.

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

The RCoA supports the following option:

"Continue to have a renamed and relaunched Never Events Policy and Framework, remove the financial sanctions, and work with commissioners, regulators and organisational leaders to improve the response to Never Events with an increased focus on learning and improvement."

We would suggest the following changes:

- Changing the name to "Preventable Events", placing the focus on trying to identify why an event that should have been preventable occurred in spite of available guidance, and seeking to identify whether there are deficiencies in the guidance or its implementation under clinical conditions, and thereby developing learning focused on human factors and teamwork.
- Removing all financial sanctions linked to Never Events and their successors.
- Making reporting and investigation timescales realistic and placing the stress more on getting the investigation right than doing it quickly.
- Making the sharing of learning from Never Events within and between organisations mandatory through a national process.

- Rewarding organisations delivering NHS care for examining adverse incidents in a way that supports staff and treats them fairly. Staff involved in incident investigations should be surveyed anonymously from outside the organisation, and organisations that get positive responses from staff involved in investigations should be publicly lauded and rewarded. In this way, a positive and supportive safety culture may develop from investigations that are currently all too often inquisitions that act against the interests of patient safety.

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

The incidents on the current Never Event list fulfil the set criteria. However, a review of the programme should address whether some of the incidents in the current list occur so rarely that there is little value in their continued appearance in the list.

9. 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?

Wrong site blocks for chronic pain procedures can now be included because of the publication and dissemination of the following document by the Faculty of Pain Medicine: Safety Checklist for Interventional Pain Procedures under Local Anaesthesia or Sedation (https://www.rcoa.ac.uk/system/files/FPM-checklist-LAorSedation.pdf).