Never events: on their 10th anniversary, do we need a new name?

This spring sees the tenth anniversary of the introduction of never events to the NHS. The idea of reporting and analysing serious, untoward events was developed by the USA's National Quality Forum in 2002, which termed them 'serious reportable events' and defined them as:

> **'serious, largely preventable and harmful clinical events designed to help the healthcare field assess, measure, and report performance in providing safe care' (National Quality Forum, 2019).**

The term 'never events' was used by the Centers for Medicare & Medicaid Services (2006), which adapted the National Quality Forum's serious reportable events and attached financial penalties to their occurrence.

The 2008 publication of Lord Darzi's *High Quality Care for All* report announced the introduction of never events into the NHS (Department of Health, 2008), and the first Never Events Framework was published a year later, which listed the eight original never events and gave them a definition of:

> **'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented' (NHS Improvement, 2014).**

Changing definitions

The last 10 years has seen changes in the number of events which are defined as never events, with a peak of 25 in 2012 decreasing to the current number of 15. The definition has also changed over the years, with the current one being: 'patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong, systemic barriers are available at a national level and have been implemented by healthcare providers', with provisos that the incident should have the capacity to cause serious harm or death, should have happened before and should be easily identifiable as a never event (NHS Improvement, 2018a).

The change in wording over time is significant, as the original concept was of something that was 'largely preventable', whereas now such an event is considered to be 'wholly preventable'. The assumption is therefore that the published barriers, such as the Patient Safety Alerts published by NHS Improvement itself, are both strong and systemic, and that the fallibility that leads to the incident must therefore be that of those charged with providing care to the patients. In this way, the 'blame culture' that pervaded the NHS in previous years was escalated, something that was not helped when, in 2012, the Department of Health's Never Events Policy Framework baldly stated that 'the aim of this policy is to reduce the incidents of never events to zero. They are intolerable and inexcusable.'

By 2016, it was becoming apparent that the number of reported never events was not decreasing; indeed, it was increasing. NHS publications were careful to point out that because the number and definition of never events were changing and reporting may well have been increasing, it was not possible to compare data between years. However, the reported numbers of the three 'surgical never events' that constitute >80% of all reported never events (wrong site surgery, retained foreign object, and wrong implant or prosthesis) were by no means on the decrease (NHS Improvement, 2016).

Criticism of the never event system abounded, with articles such as the author's 2011 editorial highlighting concerns about the use of the name never event and the blame it inevitably implied (Harrop-Griffiths, 2011). A landmark paper by Moppett and Moppett (2016), and its accompanying editorial (Pandit, 2016), drew some striking conclusions:

- The incidence of a surgical never event was about 1:17 000 operations
- The incidence of serious patient harm was about 1:250 000 operations
- The occurrence of never events follows a Poisson distribution, implying that they are both rare and random
- There was no meaningful association between the occurrence of never events and other safety indicators in individual trusts.

Pandit (2016) concluded that:

> **'it is clear that never events are misnamed. They are really events that will always occur, and do so randomly – but from which learning for individuals and teams should emanate.'**

By 2016, the dichotomy between the intention of never events – to allow examination of errors in health-care systems and thereby to derive learning that can prevent future occurrences – and the reality – the punishment of health-care professionals for involvement in system errors – was becoming increasingly apparent. With harm to patients deriving from the never events themselves being rare and an increasing number of those professionally involved in the never events suffering illness as a result of the investigation and ensuing disciplinary processes, there was concern that the number of 'secondary victims' was greatly exceeding the number of 'primary victims'.

2016 saw a consultation and review of the Never Events Policy Framework, the results of which were published in 2017 (NHS Improvement, 2017). The views of those individuals and organizations that responded to the consultation led to positive changes: financial penalties are no longer to be levied from hospitals in which never events happen, the disproportionate focus on never events compared to other

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serious incidents is to be addressed by combining the two types of event into a single framework, and there are to be additional efforts to share learning from the analysis of never events. Sadly, the consultation did not ask respondents their views of the name 'never events'.

Jeremy Hunt commissioned a thematic review of never events from the Care Quality Commission in the second half of 2017, the results of which were published in December 2018. Although the initial focus of the review was to be never events, it was eventually entitled *Opening the Door to Change: NHS Safety Culture and the Need for Transformation* (Care Quality Commission, 2018). It is an intelligent and readable report that makes a number of valid recommendations that, if implemented, will help develop the NHS's safety culture and thereby benefit patients. It says much that was said about safety culture in Don Berwick's 2013 report that followed the events in Mid-Staffordshire (National Advisory Group on the Safety of Patients in England, 2013).

The report makes recommendations about teamwork training, education and human factors that appear in the National Safety Standards for Invasive Procedures in 2015 (NHS England, 2015). When it comes to never events, however, it makes this recommendation: 'NHS Improvement should work with professional regulators and Royal Colleges to review the Never Events framework' (Care Quality Commission, 2018). The conclusion of a review of never events is that there should be a review of never events: the can has been kicked further down the road.

The Healthcare Safety Investigation Branch

The creation of the Healthcare Safety Investigation Branch in 2017 is starting to bear fruit: two of its recent reports have covered incidents that are never events: wrong prosthesis and wrong site nerve block (Healthcare Safety Investigation Branch, 2018a,b). The recommendations of these reports cast doubt on whether the barriers upon which the definition of never events depends are indeed strong enough to prevent a never event. Meanwhile, NHS Improvement's (2018b) Never Event Framework excluded wrong level spinal surgery from its list of never events pending the 'development of robust national barriers to prevent this incident'. The continuing occurrence of these safety incidents has made clear that the barriers are not sufficiently strong or protective within the context that they are being used.

Where do we go now?

The never events industry now faces an almost Catch 22-like existential crisis:

- If a never event keeps happening, it must mean that the barrier to its occurrence is not sufficiently strong or protective to prevent it
- This means that never events that happen should not be defined as never events
- Therefore, the only never events that can exist are those that have never happened
- Which in turn means that, by definition, they cannot be never events.

Now is the time to get rid of the name 'never events' as a clear and unequivocal signal from the NHS's leadership that they seek to leave behind the culture in the NHS by which people rather than systems were automatically blamed for errors. It would also indicate a very real commitment to guarantee the resources to provide health-care workers with the education and training that will in time support the culture change demanded by Berwick, the National Safety Standards for Invasive Procedures and now the Care Quality Commission's *Opening the Door to Change*.

Let's close the door to never events. **BJHM**

KEY POINTS

- 2019 sees the 10th anniversary of never events in the English NHS.
- The number of surgical never events reported is not decreasing.
- There is evidence that never events will keep happening and that these are not an indicator of patient safety in trusts.
- Never events are associated with adverse health outcomes for the health-care professionals involved in them.
- The author suggests that now is the time to change the name of and approach to these safety incidents.

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