Expanding the list of “never events”

Equality Impact Assessment

The Policy Proposals

Ensuring the safety of everyone who comes into contact with health services is one of the most important challenges facing health care, with up to 10% of patients experiencing some kind of patient safety incident. “Never events” are the most serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Defining “never events” nationally provides further impetus to increase patient safety through greater transparency and accountability when serious incidents occur and provides a lever through which commissioning can promote safer care. The Government wishes to maintain and increase the focus on safety in the NHS, especially through encouraging the reporting of patient safety incidents and ensuring that lessons are learned and implemented. However, it is also clear that serious failure is not acceptable, especially where there are clear guidelines and procedures in place to support organisations in preventing serious incidents.

Therefore the Government has committed to expand the current list of incidents that are considered to be “never events” and to continue to allow cost recovery by commissioners when these “never events” occur. This will act as a further incentive for NHS organisations to ensure “never events” never happen.

Overall, the policy aims to reduce the incidence of likelihood of these serious adverse incidents occurring in NHS funded care. Errors are by definition unintentional and make no distinction between those of different ages, genders, religions, ethnicity, ability or sexual orientation. The reduction in error should therefore benefit all groups. However, as discussed below there is some evidence that certain groups may be more at risk from error simply due to their increased reliance on health care services or their vulnerable status. For these groups we would argue that if there is any differential impact of this policy, it will be to benefit these vulnerable groups proportionally more than the rest of the population. We also discuss how some of the specific “never events” are applicable only to certain groups. Again, any efforts to reduce the incidence of these particular errors should benefit those groups to whom the error is applicable.

How the policy is likely to affect the promotion of equality and the elimination of discrimination

Age
Errors in health care only directly affect those people receiving health care, and the largest demographic using health services are older people. There is therefore some evidence that older people are more at risk from certain ‘adverse events’ (Thornlow, 2009). It should be noted though that this does not specifically apply to “never events”. The “never events” policy is aimed at reducing errors in health care and as such should reduce the potentially unequal impact of patient safety errors on older people. However, it is specific only for a small subset of these errors (i.e. “never events”) about which there is no available evidence demonstrating a greater impact on particular age groups. One of the reasons for this may be that the sample sizes are too small to draw statistically significant conclusions as “never events” are, by definition, very rare. Therefore, we can only make the assessment based on general assumptions.

It has been argued by some that expanding the “never event” list, and maintaining the ability for commissioners to implement cost recovery, could discourage providers from reporting “never events” and learning from them – hence potentially increasing the risk of serious errors. This in turn could therefore affect older people proportionally more than the rest of the population. However, we feel cost recovery is unlikely to be punitive enough to discourage reporting and there is no evidence that it has been, given it has been available to commissioners since April 2010. In any case, a number of other policies are in place to mitigate against this risk, including the fact that all providers must report serious incidents, including “never events”, to the CQC as part of their registration requirements – failure to do so will result in regulatory action. There are also protections in place for staff members to ‘whistle blow’ where they feel full disclosure was not occurring.

On this basis, it is felt to be unlikely that there will be any significant negative impact on older people. In addition, any theoretical negative impact will be countered by the potential positive impact from the overall policy aim, which is to reduce very serious errors.

Disability
As with older people, errors in health care are limited to those receiving health care, and those with disabilities use health services more than some other demographic groups. This means there is a theoretical potential for those with disabilities to be at increased risk from patient safety errors. The NPSA reported in 2004 that people with learning disabilities are at greater risk from some types of patient safety incident (NPSA, 2004). This policy is aimed at reducing errors in health care and as such should if anything reduce the unequal impact of patient safety errors on those with disabilities.

On this basis, it is felt to be unlikely that there will be any significant negative impact on those with disabilities.

Ethnicity
There is conflicting evidence on the link between safety and ethnicity. Some research suggests that as a whole, the likelihood of experiencing a patient safety incident does not consistently vary with racial background (Shimada et al 2008). Other research does argue there is a link, but suggests it is due to factors that operate in the US health system as opposed to the UK NHS (for example issues with access to health care and disparities in the quality of health care

provider accessible to different ethnic groups) (Coffey et al 2005). Even in studies that suggest a negative safety impact due to ethnic minority, only some types of safety events appear to impact disproportionately on ethnic minorities. Other safety incidents disproportionately affect Caucasian patients, further suggesting the causes for differential impacts are multi-factorial and specific to the type of event, rather than being consistent for minority groups.

On this basis, it is very difficult to make an overall assessment for this policy area on ethnicity and equality. However, applying similar arguments to those discussed earlier, this policy is aimed at reducing errors in health care. If errors disproportionately affect one or more ethnic groups, then it follows that this policy are should reduce those inequalities. In the absence of evidence showing that errors in general disproportionately affecting certain ethnic minorities, there is nothing to suggest that a policy of this type will disproportionately assist one ethnic group over another.

It should also be noted that the research referred to above looked at indicators of patient safety that for the most part do not map directly to any of the proposed “never events”, further reducing their relevance to the current proposals. The only event examined of direct comparability to the proposed “never events” (foreign body left during procedure, Shimada et al 2008) showed no significant greater risk for any ethnicity studied over white comparators.

Overall, it should be noted that the numbers of “never events” are so small that there will not be any significant impact on any particular demographic or minority group.

Gender (including transgender), Religion or belief, Sexual Orientation
There is no evidence to suggest any unequal impact of errors, positive or negative, on different genders

Socio-economic disadvantage
The evidence on the impact of socio-economic grouping on the rate of errors in health care is similar in many ways to that on ethnicity. Research suggests, for some types of error, people on lower incomes are at greater risk. However, the converse is also true in that for some types of error, those with lower incomes are at less risk (Coffey et al 2005). This research is based on the experience in the USA where socio-economic background has a greater impact on access to healthcare due to the specifics of the US healthcare system, therefore it is debatable whether such research is applicable to the UK. At the same time the research states that it is not possible to make definitive statements about the impact of socio-economic background on error rate in general, only for particular types of error, which do not map directly to any of the proposed never events.

No negative impact is considered likely.

How the policy will meet the needs of different communities and groups

Age
In general as discussed above, any attempt to reduce errors in healthcare is likely to benefit older people.

Where a particular group is affected by a particular type of error, then efforts to reduce the incidence of that error could be said to be meeting the needs of that group.

In terms of specific impacts on age groups, inclusion of the following events may have a differential impact;

- Wrong route administration of chemotherapy – The risk of cancer generally increased with age (although this is not true for all cancers) and inclusion of this event could be argued therefore to have a differential impact on older people. This “never event” is very rare though (there were no reports of this last year) and so it is difficult to argue that reduction in likelihood of this event will have a differential impact or meet the needs of any particular age group.

- Maternal death due to post partum haemorrhage after elective caesarean section is a proposed “never event” that is only relevant to women of child-bearing age, so will only meet the needs of this group.

- Death or serious disability associated with entrapment in bedrails whilst being cared for in a healthcare facility is more likely to occur to older patients (and those with reduced mobility) as patients with bedrails are on average, older and had poorer mobility according to NPSA research (NPSA, 2007). In addition, patients involved in deaths through bedrail entrapment tended to be very confused, restless, elderly, and frail (NPSA, 2005). For this reason inclusion of this “never event” could be argued to meet the needs of the elderly. However, the occurrence of this event is very rare (we estimate 3 instances per year) and so any significant effect is unlikely.

- ‘Severe scalding of patients’ will likely only apply to those who are being bathed by immersion in water and who are unable to remove themselves from very hot water or clearly indicate if the temperature is too high. This could include the very old with reduced mental capacity. Efforts to further reduce incidence of this event would benefit this group

Disability
In general as discussed above, any attempt to reduce errors in healthcare is likely to benefit those with disabilities due to their increased use of health care compared with the general population. The only specific “never event” that would appear to potentially impact on those with physical disabilities to any greater extent than the others is ‘Death or serious disability associated with entrapment in bedrails whilst being cared for in a healthcare facility’. This is because patients with bedrails have on average poorer mobility according to NPSA research (NPSA, 2007) which could be argued to equate to disability. Therefore, reduction in the incidence of this event could help meet the needs of those with disabilities. However, as discussed above the occurrence of this event is very rare (we estimate 3 instances per year) so any impact is not likely to be significant.

There are also certain “never events” which apply to those in mental health settings, which could include those with learning disabilities or mental health issues that could be considered disabling. These events are ‘Suicide using non-collapsible rails’, ‘Escape of a transferred prisoner’, ‘Falls from unrestricted windows’, and ‘Severe scalding of patients’. In all these cases inclusion on the “never events” list should help decrease the impact of these events and therefore benefit those who would otherwise have been affected.

Ethnicity
There is no evidence that any of the proposed “never events” will specifically meet the needs of any particular ethnic group, as there is no evidence of any proposed “never event” having a disproportionate impact on a particular ethnic group.

Gender (including transgender)
Only one of the proposed “never events” will have a theoretical impact on one specific gender - Maternal death due to post partum haemorrhage after elective caesarean section. The effect (if any) is likely to be positive.

Religion or belief, Sexual orientation
There is no evidence to suggest any unequal impact for any of the specific “never events” proposed, positive or negative, on different religious or belief groups. We have sought to mitigate the risk of those who refuse blood transfusions for reasons of belief from being restricted from undergoing elective caesarean section by excluding these people from the scope of the ‘Maternal death due to post partum haemorrhage after elective caesarean section’ event.

Socio-economic disadvantage
There is no evidence to suggest any unequal impact for any of the specific “never events” proposed, positive or negative, on different religious or belief groups. Where evidence for variation in the number of patient safety incidents according to socio economic group exists, the data relates to types of safety incident that are not included in this policy proposal.

Consultation Evidence

The Department ran a 6-week engagement process from 8 October until 19 November 2010, asking for comments on and suggestions for an expanded list of “never events”. The comments received during this exercise were used to edit the proposed list, clarifying some definitions, addressing the concerns of respondents and reflecting their comments by adding or removing proposed events as appropriate.

The proposed, expanded list was issued on the DH website and emailed directly to a range of NHS bodies, individuals and external interested partners and organisations asking for their comments. This was accompanied by a letter from the NHS Medical Director. The proposed list was sent in particular to

- NHS Confederation networks
- SHA Contracting leads and Clinical Governance Leads and QIPP Safe Care leads
- NHS Nursing leads (via the CNO’s bulletin)
- NHS Chief Executives (via CE’s bulletin, The Week)
- NHS Medical Directors
- Monitor and the CQC
- NHS Blood and Transplant

- Professional organisations including the Royal Colleges and the BMA
- Patient groups including Action against Medical Accidents, Cure the NHS and The Patients Association
- Other third sector organisations including the British Heart Foundation, Cancer Research UK, Diabetes UK, Macmillan Cancer Care, Age Concern, MIND and SANE

All those bodies were encouraged to bring the proposals to the attention of anyone they considered may have an interest and therefore responses were received from other sectors, including the legal profession and commercial bodies.

People were able to submit comments directly via email, in writing to the Department or via a ‘commentable’ version of the policy proposals available on the internet. Comments were received through all 3 media.

144 direct emails were received from individuals, NHS organisations and external organisations. 67 people contributed via the ‘commentable’ internet version of the proposals, all of which are still available to view publically. Four of these respondents used both email and the commentable web document. 3 hard copy responses were also received. Most respondents commented on a number of the proposed events and, in some cases, all of the events, as well as providing answers to our wider questions on the framework and the general policy. In total, 795 separate comments were made relating to specific proposed events or the contractual framework.

Overall, responses indicated support for the “never event” policy. 28 responses contained support for the idea of a “never event” framework and in general the proposals put forward. A further 24 responses provided constructive criticism with the aim of improving the policy in general. 14 responses were unsupportive of any “never event” policy or the concept of “never events”.

76 responses commented on the principle of cost recovery and the contractual framework. Responses tended to understandably conflate the questions on whether cost recovery was appropriate and if there were alternative suggestions for the contractual framework. In all 13 responses demonstrated relatively clear support for a contractual framework in which commissioners recover costs from providers when “never events” occur. 28 responses offered constructive criticism of this concept, suggesting amendments or alternatives. 34 responses were clear in their lack of support for cost recovery or contractual penalties in relation to “never events”.

Considering the individual proposed never events there were a total of 358 comments on individual events that were supportive (162) or constructively critical (196, i.e. they were suggesting improvements in the definition). 256 comments were unsupportive of particular “never events” or called for radical changes to definitions. Note that a single respondent was likely to comment on a number of events.

The greatest number of comments was received for the ‘overdose with opioid’ event (61 comments) with the next most commented on being ‘wrongly prepared high-risk injectable medication’ (47). ‘Escape of a transferred prisoner’ received only 7 comments. The average number of comments received was 28 per event

The most supported event (highest proportion of comments being supportive as opposed to constructively critical or unsupportive) was for ‘entrapment in bed rails’ (60% of 20 comments) followed by a “never event” on transfusion of incompatible blood products (52% of 27 comments) and ‘falls from unrestricted windows’ (51% of 37 comments). ‘Falls from unrestricted windows’ received the single highest number of supportive comments (19)

The least supported event (highest proportion of unsupportive comments as opposed to supportive or constructively critical) was ‘air embolism’ (68% of 28 comments) followed by ‘kernicterus’ (67% of 18 comments) and ‘overdose of opioid’ (62% of 61 comments). ‘Overdose of opioid’ received the single highest number of unsupportive comments (38)

For most proposed events, the majority of comments we received were either supportive or offered constructive criticism of the definition we proposed. However, for the following events a majority of comments received were unsupportive of inclusion;

- Wrongly prepared high-risk injectable medication (53%, 25 comments, unsupportive)
- Air embolism (68%, 19 comments, unsupportive)
- Kernicterus (67%, 12 comments, unsupportive)
- Overdose of opioid (62%, 38 comments, unsupportive)
- Overdose of midazolam (57%, 23 comments, unsupportive)

Respondents suggested the addition of events that corresponded to roughly 25 categories of incident. The most common suggestion for an event not included in the proposed list was for a ‘failure to facilitate organ donation’ event, which was proposed in 20 responses, although it was also specifically opposed in a further 10 responses.

Age

Comments were received from two groups with an interest in the needs of different ages; the British Geriatrics Society and the Association of Paediatric Anaesthetists. Comments were also received from a number of NHS organisations and medical professionals commenting on the proposed “never events” with impacts on different age groups, principally the ‘entrapment in bedrails’ event or suggesting additional events with impacts on different age groups.

The British Geriatrics Society was supportive of the policy proposals, commenting ‘’*We welcome this proposal as a positive step forward towards improving patient safety across the NHS*. ‘’ They were also specifically supportive of all the suggested events, but did provide specific comments on some, highlighting potential risks and issues with a few of them. They did not propose any further events.

The Association of Paediatric Anaesthetists was less supportive, stating ‘’*We believe that the extended definition of “Never events” may in principle be useful. However “Never” is a very nonspecific and potentially emotive term in this context and leads the general public and media to a conclusion that gross (individual) neglect has invariably occurred. This is unhelpful*.’’ They provided comments on specific event highlighting risks and issues. They did not suggest additional events.

For older people, as discussed earlier, ‘entrapment in bedrails’ may have a specific impact given the increased likelihood of incidents occurring with the elderly (NPSA, 2005). 85% of responses that commented on this were supportive or constructive about its inclusion.

Wrong route chemotherapy, may have more relevance for older people. 73% of responses that commented on this were supportive or constructive about its inclusion.

A new event, ‘severe scalding of a patient’ has been included in the list following a proposal by a respondent. This could again have a specific impact on older people as discussed earlier.

For the very young, the most relevant proposed “never event” was ‘Death or occurrence of kernicterus associated with failure to identify and treat hyperbilirubinemia in neonates’. Inclusion of this event was clearly not supported, with 67% of respondents being unsupportive and/or critical of its inclusion. Concerns centred on the preventability of the event, demonstrating that poor care had occurred and also suggesting unintended consequences which could lead to delays in discharge, defensive testing behaviours and disruption to home birthing and breast feeding initiatives. For these reasons, this event was removed from the list.

Disability
Responses were received from number of organisations with an interest in certain disabilities including St Andrew’s Healthcare, MIND, Royal College of Psychiatrists, British Pain Society and Marie Curie Cancer Care.

St Andrew’s Healthcare commented ‘’[we] *welcome the proposals to expand the national list of “never events” and to develop the contractual framework to include cost recovery following a “never event” occurring.*’’ They provided constructive comments on events relevant to mental health (‘death during restraint’, ‘falls from windows’ and inpatient suicide using non-collapsible rails’) but did not suggest any additional events.

MIND provided constructive comments and support for the proposed events related to mental health (‘death during restraint’, ‘falls from windows’ and inpatient suicide using non-collapsible rails’). They also suggested additional events be included; ‘serious sexual assault in a health care setting’ and ‘Death or serious harm attributable to lack of provision of basic life support in mental health and learning disability settings’. These demonstrate support for the principle of “never events”.

The Royal College of Psychiatrists was generally unsupportive of the policy proposal. They commented ‘’*In general, the Royal College of Psychiatrists fears that the extended list of proposed “never events” risks causing more harm than good to patient care, from the psychiatrist’s perspective at least. Furthermore it may severely and unfairly penalise mental health services providers for isolated incidents*.’’ They commented on ten of the events.

The British Pain Society restricted its comments to the ‘overdose with opioid’ event and provided constructive criticism of the suggested definition and ways that it could be improved.

Marie Curie Cancer Care welcomed the expanded list of “never events”, providing supportive comments and only questioning the inclusion of the midazolam overdose event.

As with age, the single event with most relevance to those with disabilities is ‘entrapment in bedrails’ (see discussion earlier). 85% of responses that commented on this were supportive or constructive about its inclusion.

Other events with relevance relate to those with mental health issues. There was strong support for the inclusion of an event on ‘inpatient suicide suing non-collapsible rails’ (78%

supportive or constructive) with most calling for the extension of the scope of the event. Escape from secure services of a transferred prisoner was supported with 86% of responses offering support or in most cases constructive criticism, generally around the range of settings this should apply to.

The case with physical restraint was less clear-cut. Eight responses were supportive with nine offering constructive criticism. However, 15 responses objected to this event. Many of these objected to the suggestion that death was always avoidable and preventable given the impact of underlying health conditions and other factors. There were also concerns raised about the utility of existing guidance and the suggestion that by following this advice, all cases of death following restraint could be avoided. For these reasons it was felt that the proposed “never event” did not meet the criteria required and so the event was removed.

As with older people, inclusion of the new event ‘severe scalding of a patient’ following a suggestion during the engagement exercise could have a specific impact on those with disabilities if they are bathed by immersion in water and their ability to remove themselves or indicate if they are distressed is compromised.

Finally the ‘falls from unrestricted windows’ event was clearly supported with 73% of responses offering support or constructive criticism of the definition.

Gender (including transgender)
Only one event had particular relevance for different genders, specifically the ‘maternal death due to post partum haemorrhage after elective caesarean section’ event. Comments were received from groups with a particular interest, such as the Royal College of Obstetricians and Gynaecologists, and Obstetric Anaesthetists Association. In all, there was a 50:50 split in the responses received between those in support and those who were objecting. Those who were unsupportive generally argued that many factors can underlie post-partum haemorrhage and that these mean that its incidence is not always predictable and preventable. We accept these points but safety experts and maternity advisors are clear that while haemorrhage may not be preventable in all cases, death should not result in cases where the caesarean section was elective and there was ample opportunity to investigate any risk factors and ensure appropriate resources are in place to deal with a massive haemorrhage. We have also amended the definition to exclude certain circumstances where it was felt control of any haemorrhage may be compromised.

Ethnicity, Religion or belief, Sexual Orientation, Socio-economic disadvantage.
None of the comments received were relevant to the above groups, apart from in the case of ‘death from post-partum haemorrhage following elective caesarean section’. It was pointed out by a number of respondents that if a patient refuses to receive blood transfusions for religious or other reasons of faith, this could compromise the ability of healthcare workers to deal with a major haemorrhage. This particular scenario was therefore excluded from the definition of the “never event” to ensure that there is no risk of health care workers being discouraged from caring for these patients by the “never event” framework or indeed feeling unfairly blamed for any death where the use of all measures to prevent death was not possible.

Existing good practice

Age

To inform future iterations of the “never event” policy we would be keen to ensure that data on equalities areas is collected and reported on at a national level for each of the updated never events that are proposed. At present, interrogation of the National Reporting and Learning System for “never event” data is time-consuming, however, work is underway to simplify this process, which will enable greater detail about the circumstances of never events to be derived. This should enable analysis for an annual report on never events, although there is a risk to this work and a likely delay due to the transition of responsibility for the NRLS from the NPSA, which is being abolished.

In general, when implementing new policies on a local basis, as could conceivably result from this national policy proposal, NHS organisations must undertake equality impact assessments relevant to the specific changes proposed. These will provide much greater detail and appropriate information than is possible at the national level.

Disability, Ethnicity, Gender (including transgender), Religion or Belief, Sexual orientation, socio-economic disadvantage,
See above

The promotion of equality and the elimination of discrimination

Age, Disability, Ethnicity, Gender (including transgender), Religion or belief, Sexual orientation, Socio-economic disadvantage

To inform future iterations of the “never event” policy we would be keen to see data on equalities areas collected and reported at a national level for each of the “never events”. At present, interrogation of the NRLS system for “never event” data is time-consuming and complex, however work is underway to simplify this process, which will enable greater detail about the circumstances of “never events” to be derived more easily. This should facilitate analysis for annual reporting on “never events” but there is the likelihood of delay due to the transfer of responsibility for the NRLS from the NPSA.

It should also be noted, however, that there is no ability at present to systematically interrogate the NRLS for data on ethnicity, disability status, religion or belief, sexual orientation or socio-economic group. The system only allows data to be recorded for age and gender, and these fields are not compulsory. It may be possible to include fields to capture equalities information in the future but some of this data is not available for patients in many cases and there is a balance to be struck between increasing the amount of data captured and ensuring the NHS is not discouraged from collecting and reporting data on safety incidents. The system is also a confidential one to ensure frank and full disclosure of patient safety incident information thereby maximising learning. It will be important that any changes made to the NRLS in the future do not compromise the system’s ability to encourage reporting of incidents.

Challenges and opportunities

Addressing existing patterns of discrimination, harassment or inequality
As discussed, there is the theoretical possibility that certain groups, that could be disproportionately affected by patient safety errors in general, or particular proposed “never events”, and could benefit from an overall reduction in their incidence. However, it must be noted that the numbers of never events are tiny in the context of the activity of the NHS. For 2009/10, there were 111 events in total for the whole of England. Therefore the direct

application of this policy to specific groups is limited to a very small number of individuals – which is problematic in terms of looking at enough incidents to represent a meaningful and statistically significant volume of data on equalities. This will remain a challenge to assessing the impact of this policy on equalities.

The impact on community relations
There is no impact.

Improving access to, and take-up of, services and understanding the policy
This policy is aimed at NHS professionals. It is not related to improving access to or take-up of services. The whole engagement process was about ensuring NHS professionals and external partners with relevant views are able to understand the policy.

Understanding the policy, from an NHS perspective, could be enhanced by interrogation of “never event” data from an equalities perspective, but as discussed this is hampered by the data available and the small numbers of individuals involved.

Summary

A positive impact is clearly intended.

The policy will have a significant positive impact on those individuals who potentially could have suffered from a “never event” occurring but for whom it was avoided due to improved prevention.

For the record

Name of person who carried out this assessment: M Fogarty
Date assessment completed: 4 February 2011
Name of responsible Director/Director General: G Hetherington
Date assessment was signed: 4 February 2011

Action plan

Category	Actions	Target date	Person responsible and their Directorate
Involvement and consultation	Significant amendments to the "never events" policy should be the subject of external engagement processes and shaped by the contributions of the NHS and wider interested parties as they were for 2011/12.	Autumn 2011 if appropriate	M Fogarty Medical Directorate
	People will also be able to continue to comment on the policy via the dedicated mailbox – neverevents@dh.gsi.gov.uk –on an ongoing basis	Ongoing	M Fogarty Medical Directorate
Data collection and evidence	Interrogation of the "never event" data for information on equalities and any evidence of differential impacts will be explored. This is likely to be delayed however by the abolition of the NPSA and the transfer of responsibility for the NRLS.	Ongoing	NPSA
	More widely the NRLS will continue to receive reports of "never events" from the NHS for analysis.	Ongoing	NPSA
Assessment and analysis	Discussions will be held on the practicalities of initiating work to use the NRLS system to explore the wider relationship between safety and equalities in health care, but the impact of the abolition of the NPSA is likely to delay significant changes.	Autumn 2011	M Fogarty Medical Directorate
	Analysis of the number and type of "never events" reported to the NRLS will continue on an ongoing basis, with a national report published annually.	Ongoing and report published annually in Autumn	NPSA/M Fogarty, Medical Directorate

Monitoring, evaluating and reviewing	The “never events” policy will be reviewed on an annual basis using information from the “never events” annual report and feedback from external parties. In the short term responsibility for the policy will remain with the Department although this will be reviewed following the establishment of the NHS Commissioning Board	Annually, Autumn 2011	M Fogarty Medical Directorate

References

Coffey RM. Andrews RM, Moy E, 2005, Racial, Ethnic, and Socioeconomic Disparities in Estimates of AHRQ Patient Safety Indicators. Medical Care: 43(3) - pp I-48-I-57

NICE Guidance 2010– *Recognition and management of neonatal jaundice,* http://guidance.nice.org.uk/CG98

National Patient Safety Agency, 2004, *Understanding the patient safety issues for people with learning difficulties.*

NPSA 2005, *Bedrails – Reviewing the Evidence; A systematic literature review*, available at http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=61400&type=full&servicetype=Attachment

NPSA, 2007, *Bedrails Safer Practice Notice* and associated research, available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59815

NPSA *The Never Events Framework 2009./10*, February 2009. Available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=59859&q=0%c2%acnever+events%c2%ac

NPSA *'Never Events – Framework: Update for 2010-11'*, March 2010. Available at http://www.nrls.npsa.nhs.uk/resources/?entryid45=68518

Shimada SL**,** Montez-Rath ME, Loveland SA, Zhao S, Kressin NR, Rosen AK, 2008, *Racial Disparities in Patient Safety Indicator (PSI) Rates in the Veterans Health Administration* Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 1: Assessment) http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=aps2v1&part=advances-shimada_65

Thornlow DK, 2009, *Increased risk for patient safety incidents in hospitalized older adults*, MedSurg Nursing, Sept-Oct. (http://findarticles.com/p/articles/mi_m0FSS/is_5_18/ai_n45031856/?tag=content;col1)