Department of Health

# Expanding the list of “never events”

*Equality Impact Assessment*

NHS

## 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 will not be tolerated, especially where there are clear guidelines and procedures in place to support organisations in preventing serious incidents and where serious failings still occur, organisations should be subject to serious sanctions.

Therefore the Government has committed to expand the current list of incidents that are considered to be never events and impose contractual penalties when these never events occur. This will act as a further incentive for NHS organisations to ensure never events never happen.

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

**Age**

Errors in health care are limited to 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)., although not specifically “never events”. This 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 for a small subset of these errors (ie “never events”) about which there is no available evidence demonstrating a greater impact on particular age groups – not least, as the sample sizes are too small to draw statistically significant conclusions.

There is a theoretical possibility that expanding the “never event” list with its associated contractual penalties could discourage providers from reporting “never events” and learning from them – hence potentially increasing the risk of serious errors. This in turn could, in theory, affect older people proportionally more than the rest of the population. However, cost recovery is unlikely to be punitive enough to discourage reporting. 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**

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, 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.

For example, the inclusion of a proposed "never event" related to the potential development of kernicterus due to a failure to act on hyperbilirubinemia in neonates will have a specific impact on neonates. Inclusion of this "never event" should reduce further the incidence of this event, therefore benefitting this group. However, the incidence of this particular "never event", and indeed that of all "never events" is by definition very low. NICE (NICE 2010) have estimated an occurrence of kernicterus of 5-7 cases per year. This means that any impact on neonates as a whole will be very small.

In terms of specific impacts on other age groups, the following proposed events may also 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 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.

- In-hospital maternal death from 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.

**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 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.

**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 - in-hospital maternal death from 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

**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

**Age**

At this particular policy stage, this equalities impact assessment has been prepared prior to an external engagement process. We will therefore be able to say more about any comments we receive on the document following this process.

More widely, the policy on never events as represented by the *Never Events Framework 2009/10* and the *Update for 2010/11* have been publicly available since their launch in 2009 and 2010 respectively. To our knowledge, no concerns or issues have been raised with respect to equalities.

This assessment applies to all equality areas listed immediately below

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

See above

## 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 NRLS 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 will therefore enable analysis for an annual report on never events.

Responses to the engagement process will be used, where relevant, to update this equalities impact assessment as discussed earlier.

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**
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 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. This will therefore enable analysis for an annual report on never events.

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

## 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.

**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 is about ensuring NHS professionals and external partners with relevant views are able to understand the policy.

Understanding the policy, from an NHS perspective, will be enhanced by the planned interrogation of never event data from an equalities perspective.

## Summary

A positive impact is clearly intended and very likely for a very small number of people

What the policy will do however is have a significant impact on those individuals who potentially could have suffered from a never event occurring. In addition, the reputation of the NHS could potentially benefit from a reduction in these most serious incidents

## Action plan

| Category | Actions | Target date | Person responsible and their Directorate |
|---|---|---|---|
| **Involvement and consultation** | The policy proposal is to be disseminated to a wide group of external partners for comment and views. The results of this process will be used to inform the final policy for inclusion in the Operating Framework | By mid-November 2010 | M Fogarty<br>Medical Directorate |
| **Data collection and evidence** | Interrogation of the "never event" data for information on equalities and any evidence of differential impacts | By mid-November 2010 | M Fogarty<br>Medical Directorate |
| **Assessment and analysis** | More widely, 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. | By summer 2011 | M Fogarty<br>Medical Directorate |
| **Monitoring, evaluating and reviewing** | The policy will be reviewed on an annual basis. | Annually | M Fogarty<br>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)