

National Patient Safety Agency

A Never Events policy in England

Dr Tanya Huehns
Patient Safety Strategy Adviser
National Patient Safety Agency

Putting Patient Safety First

National Patient Safety Agency

We've come a long way...

Global context
- patient safety WHO work

National context
- patient safety strong feature of Darzi report
- Strong reporting system (3.5m reports)
- NPSA as agency supporting agenda in NHS

Regional/Local context: England
- Providers raising the profile
- Board understanding
- Commissioning for safety, accountability

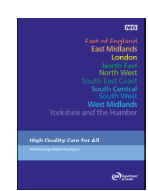


Putting Patient Safety First

National Patient Safety Agency

The Darzi report

Quality
= Patient experience
+ Clinical effectiveness
+ Patient safety



Putting Patient Safety First

National Patient Safety Agency

Never Events

Darzi report:
High quality care for all

56. In some parts of the United States, events that are serious and largely preventable such as "wrong-site" surgery have been designated "Never Events", and payment withheld when they occur. The NPSA will work with stakeholders in this country to draw up its own list of "Never Events". From next year, PCTs will choose priorities from this list in their annual operating plan.



Putting Patient Safety First

National Patient Safety Agency

Reportable events in the US

- Concept originated from US
- Related to insurance
- MEDICARE/MEDICAID use

CATEGORIES OF REPORTABLE EVENTS AS DEFINED BY LAW


<p>MEDICAL/OTHER HEALTH PROVIDER EVENTS</p> <ul style="list-style-type: none"> • Significant adverse performance in quality of care • Significant adverse performance in patient safety • Significant adverse performance in patient care • Significant adverse performance in patient care • Significant adverse performance in patient care • Significant adverse performance in patient care 	<p>CARE MANAGEMENT EVENTS</p> <ul style="list-style-type: none"> • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability
<p>INDEPENDENT EVENTS</p> <ul style="list-style-type: none"> • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability 	<p>PROVIDER OR DEVICE EVENTS</p> <ul style="list-style-type: none"> • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability
<p>PATIENT PROTECTION EVENTS</p> <ul style="list-style-type: none"> • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability 	<p>CRIMINAL EVENTS</p> <ul style="list-style-type: none"> • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability • Patient death or serious disability

Putting Patient Safety First


National Patient Safety Agency

Adverse Health Events in the US

- Reported annually



Putting Patient Safety First

National Patient Safety Agency 

Adverse Health Events in the US

FAIRVIEW RIDGES HOSPITAL


Address: 201 East Nicollet Boulevard
Burrhead, MN 55337-5799
Website: www.fairview.org
Phone number: 612.872.6396

Number of beds: 150
Number of surgeries performed: 19,292
Number of patient days: 65,313

How to read these tables:
These tables show the number of events reported at each facility. They include the reported number for each of the 27 event types, organised under six categories. Categories and event types are not shown if no events were reported.


REPORTED ADVERSE HEALTH EVENTS (OCTOBER 7, 2006-OCTOBER 6, 2007)		
CATEGORY AND TYPE	NUMBER	BACKGROUND
SURGICAL/OTHER INVASIVE PROCEDURE EVENTS		
Surgery/other invasive procedure performed on wrong body part	2	Deaths 0; Serious Disability 0; Neither 2
CARE MANAGEMENT		
Death or serious disability associated with:		
A medication error	1	Deaths 0; Serious Disability 1; Neither 0
TOTAL EVENTS FOR THIS FACILITY	3	Deaths 0; Serious Disability 1; Neither 2

Putting Patient Safety First

National Patient Safety Agency 

The policy in England


- Healthcare is commissioned in England
- Commissioned by organisations that are responsible for patients in their areas (called Primary Care Trusts (PCTs))
- Local contracts set up
- Contract contains statements around quality and safety



BUT is there really discussion?

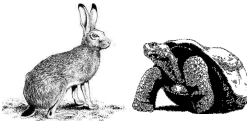
The Never Events policy aims to support openness and commissioner/provider discussions

Putting Patient Safety First


National Patient Safety Agency 

Working with the concept

- Commissioning already incorporates patient safety
- Contracts contain reference to sharing information on "Serious Untoward Incidents" and discussion of quality and safety
- Commissioners and providers at varying levels with regard to sharing issues and commissioning for safety




Putting Patient Safety First

National Patient Safety Agency 

Introduction of the Never Events policy

- Feedback exercise in 2008
- Worked with NHS on possible process and core events
- Eight core events for testing in first year


Putting Patient Safety First

National Patient Safety Agency 

Core list for 09/10

- 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 of transferred prisoners from medium or high secure mental health services
- In-hospital maternal death from post-partum haemorrhage after elective caesarean section
- IV administration of misselected concentrated potassium chloride

Putting Patient Safety First


National Patient Safety Agency 

The policy in practice

- Promotes discussions between commissioners/providers
- Discussion around best practice and safe systems
- Raises profile of reporting locally
- Increase Board understanding
- Commissioners to use own Never Events in time
- National accurate data to be used for follow up and drive further policy/guidance

www.npsa.nhs.uk/nrls/neverevents


Putting Patient Safety First

National Patient Safety Agency 


Public reporting of Never Events

Nationally
NPSA will give an overall view of reports and learning

Locally
Commissioners need to report on providers' Never Event occurrence, investigations and systems in place to prevent Never Events.




Putting Patient Safety First


National Patient Safety Agency 

Criteria for adding other Never Events

- Results in actual/potential severe harm/death
- Evidence that occurred in the past
- Existing national guidance and/or national safety recommendations on how to prevent, along with support for implementation
- Never Event is preventable if advice implemented
- Occurrence can be easily defined, identified and measured on an ongoing basis




Putting Patient Safety First


National Patient Safety Agency 

Principles for implementation

- *Clear leadership in commissioner and provider**
- *Open discussion of the core list and other NE**
- *Build shared commitment**
- *Inform and educate Boards**
- *Report annually**



Putting Patient Safety First


National Patient Safety Agency 

Evaluation

Locally

- how are commissioners using it?
- what do providers think?
- are investigations being better shared?
- how are commissioners planning to report?
- do they want changes to core list?

Putting Patient Safety First


National Patient Safety Agency 

Evaluation

Nationally

- what are the numbers of Never Events occurring nationally?
- what is the quality of investigations?
- what do the numbers and investigations tell us about implementation?
- does it affect NPSA guidelines for NHS?
- what are the insights for next year's core list?

Putting Patient Safety First


National Patient Safety Agency 

Next steps

- Learn in 09/10
- Penalties/incentives?
- Response of public
- Board understanding – enough?
- Will and skills in place?
- How to contribute to/learn from national picture?
- International learning

Putting Patient Safety First



National Patient Safety Agency 

Thank you

Tanya Huehns

Tanya.huehns@npsa.nhs.uk

Putting Patient Safety First