

# WELSH HEALTH CIRCULAR



**Issue Date:** 22 July 2022

Llywodraeth Cymru  
Welsh Government

**STATUS: COMPLIANCE / ACTION / INFORMATION**

**CATEGORY: QUALITY & SAFETY**

**Title:** Never Events – Policy and Incident List July 2022

**Date of Review :** Continuous review and update in line with work being undertaken to systemically review barriers and safety recommendations for each type of never event.

**For Action by:** Local Health Boards and NHS Trusts

**Action required :** with immediate effect.

**Sender:** Professor Chris Jones, National Clinical Director NHS Wales and Deputy Chief Medical Officer, Welsh Government

**HSSG Welsh Government Contact(s) :**  
Nursing and Quality Directorate - [populationhealthcare@gov.wales](mailto:populationhealthcare@gov.wales)

**Enclosure(s):** Link to Never Event List published on the NHS Wales Delivery Unit web page – [Never Events - Delivery Unit \(nhs.wales\)](#)

Dear Colleagues,

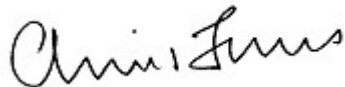
Never Events and how they are investigated and actioned forms part of the wider drive to improve care quality and patient outcomes, as set out in the *Quality and Safety Framework*, issued in September 2021.

Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes within existing systems. It is important therefore when a Never Event occurs any failings in care are identified and investigated fully, but proportionately, regardless of the outcome, in line with the *Patient Safety Incident Reporting Policy* issued in May 2021. This ensures an understanding of where in the system safety measures have failed and by looking at what went wrong in the system will help organisations to learn lessons and take targeted actions to help prevent recurrence.

The NHS Wales Delivery Unit will continue to engage with NHS England/Improvement on reviews to the list of Never Events.

A recent review resulted in the decision to remove 'wrong tooth extraction' from the list of Never Events as conveyed in my letter of 22 July 2021. Incidents of this nature must continue to be reported and investigated locally and nationally if they meet the *Patient Safety Incident Reporting Policy* criteria. The Never Event list has therefore been updated to take account of this decision and supersedes WHC 2018/012. It also suspends undetected oesophageal intubation from the list whilst further work is undertaken.

The updated list can be found on the NHS Wales Delivery Unit website [Never Events - Delivery Unit \(nhs.wales\)https://du.nhs.wales/patient-safety-wales/](https://du.nhs.wales/patient-safety-wales/). This list will continue to be updated to reflect any further changes and a WHC will be issued to bring any changes to the attention of the NHS in Wales.  
Yours sincerely



**Professor Chris Jones**  
**National Clinical Director, NHS Wales and Deputy Chief Medical Officer,**  
**Welsh Government**

## Policy Statement

Never Events are defined as serious incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death, but serious harm or death does not have to have happened because of a specific incident for it to be categorised as a Never Event.

As with all patient safety incidents Never Events require full but proportionate investigation in line with the *Patient Safety Incident Reporting Policy* and are applicable to all NHS funded care. This includes the need to engage meaningfully with patients, families and carers at the beginning of and throughout any investigation ensuring openness and transparency.

## Learning from incidents

Learning from what goes wrong in healthcare is fundamental to preventing future harm occurring. All incidents must be reported and investigated locally and where they meet the criteria they should be reported nationally to the NHS Wales Delivery Unit. Any investigation should be proportionate to the incident being reviewed with immediate make safes put in place, targeted action agreed and lessons learnt shared across the organisation.

Repeated Never Events, particularly those of the same type, may indicate on going system problems in a specific service area, which may not have been highlighted in previous investigations. Following investigation, additional targeted intervention may be required to ensure systemic problems are addressed and to prevent similar events from happening in the first place.

Patients and families form an important part of the investigation process and lessons learnt, providing valuable lived experiences to be shared locally and nationally depending on the reporting criteria.

Learning from incidents should be viewed as an opportunity for openness and transparency and requires timely incident reporting within a fair and open culture. It is not about apportioning blame, as patient safety incidents relate to the system in which individuals are required to work rather than being linked to specific individuals involved in a patient safety incident.

The Health and Social Care (Quality and Engagement) (Wales) Act 2020 incorporates a Duty of Candour which will come into force in April 2023, for NHS commissioned care. This requires NHS organisations to engage with patients and families when more than minimal harm occurs, which is unexpected and unintended.

It is important the patient or their family's voice is heard and that they remain at the centre of any investigation being undertaken.

## **Reporting and Governance**

As with all patient safety incident reporting NHS organisations must assure their Boards that Never Events have been investigated appropriately, in line with the national reporting policy and appropriate actions taken with any lessons learnt shared throughout the organisation to help reduce the risk of similar Never Events happening again.

Robust monitoring processes should be in place to support implementation and delivery of agreed actions and to ensure sustainability of those actions going forward. As part of quality assurance processes the NHS Wales Delivery Unit will monitor and review all Never Events, including lessons learnt and the timely implementation of corrective actions. Where appropriate the NHS Wales Delivery Unit will engage with individual organisations to provide support and, or escalate any unresolved matters through existing escalation frameworks.