DETAILED REPORT

Plymouth Health and Adult Social Care Overview and Scrutiny Committee

26 September 2018

Subject	**Never Events update**
Prepared by	Steve Mumford
Approved by	Phil Hughes

Purpose

To provide HASC OSC an update on Never Events as reported in June 2018.

Background

As a Trust we continue to have an open culture of reporting patient safety related incidents, recognising that learning from these incidents will help us to improve our services and make them safer.

We've continually demonstrated a positive reporting culture, with our incident reporting rate which continues to place us firmly within the national upper quartile. In healthcare, a high incident reporting rate is associated with a strong patient safety culture.

If you look at the percentages of reported patient safety incidents here in Plymouth, which have resulted in severe harm or death, they have continued to fall in recent years:

- 0.80% in 2013/14
- 0.67% in 2014/15
- 0.43% in 2015/16
- 0.24% in 2016/17

Our latest data from Aug 17 – Jul 18 shows the percentage of incidents that have resulted in severe harm or death is 0.45%. This continued low rate is thanks to our staff, who continue to work incredibly hard delivering half a million patient episodes per year.

We put patient safety at the heart of everything we do and whilst no one comes to work to cause harm, for a small minority of our patients, mistakes do happen and things do not go as planned. When mistakes happen it is essential that we are open and honest about them and, importantly, that we use them as learning opportunities to help us improve our services and make them safer.

In line with this, we reported two Never Events through our Trust Board papers for June 2018. Below is what was reported in the June Board paper:

> * May 2018 W138992, Wrong Site Surgery Never Event; Patient attending Outpatient Department (OPD) for planned insertion of left grommet. ENT SpR cleans out right ear canal and finds an extruded grommet, previously placed and continues to insert grommet in right ear. The patient then indicates that hearing is still muffled on the opposite side at which point the planned insertion of the left ear was then completed.

* June 2018 W141559, Wrong Site Surgery Never Event; The patient attended for removal of a lesion to his right ear (lower lobe). A wide excision of lesion was performed to the top of the patient's right ear. At the end of the procedure the patient indicated they were expecting removal of lesion on the right lower lobe as illustrated in the patient records.

No harm came to either of the patients and they were informed immediately of what had happened. The Never Events were both minor procedures carried out in outpatients areas; we are currently rolling out our National Safety Standards for Invasive Procedures which set out the key steps necessary to deliver safe care for patients undergoing invasive procedures and will allow organisations delivering NHS-funded care to standardise the processes that underpin patient
Safety.

Update

Immediate actions have been taken to prevent a recurrence of the two never events pending final investigations.

Patients and families are asked to participate in this process and will often contribute to the investigation and design of solutions to prevent future incidents.

As a Trust, in line with our commitment to openness and transparency with the public, we report our never events in our public board meetings and give details as soon as they have been confirmed through the national reporting route.

You can never say 'never' where human beings are concerned. This is why the Human Factors Training field has developed, a field in which some of our own health professionals at Plymouth have lead roles, looking at systems and processes to reduce the likelihood of anything going wrong.

We want to reassure the committee that patients waiting to come in to be treated and something untoward happening as a result of our safety processes, is very, very small indeed. You can be reassured of our strong safety culture because we learn from the rare occasions that things do go wrong.

Current Investigation status on outstanding Never Events investigations

Root Cause Analysis (RCA) for W138992

The final investigation report was submitted to the Clinical Commissioning Group (CCG) week commencing Monday 10th September.

Root Cause Analysis (RCA) W141559

The draft investigation report is due for review week commencing Monday 17th September.