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PRESS RELEASE

New recommendations to further improve surgical safety

A new report published today by the Surgical Never Events Taskforce has made a series of recommendations for new standards and systems to further improve the safety of surgery in English hospitals.

In response, NHS England has committed to identifying practical ways to take forward the report’s recommendations to eradicate never events from surgical procedures.

The Surgical Never Events Taskforce was commissioned by NHS England last year to examine why currently available preventative tools and guidance are not succeeding in completely eliminating surgical never events - a number of identified types of serious errors that should never occur, such as surgery on the wrong part of the body.

In its report, the taskforce has recommended much greater consistency between different hospitals in all areas of the country, focusing on three themes:

- **Standardise** - The development of high-level national standards of operating department practice that will support all providers of NHS-funded care to develop and maintain their own more detailed standardised local procedures. The report also recommends the establishment of an Independent Surgical Investigation Panel to externally review selected serious incidents;

- **Educate** - Consistency in training and education of all staff in the operating theatres, development of a range of multimedia tools to support implementation of standards and support for surgical safety training including human factors; and

- **Harmonise** – Consistency in reporting and publishing of data on serious incidents, dissemination of learning from serious incidents and concordance with local and national standards taken into account through regulation.

Never events are events that should never happen because there is sufficient guidance to prevent them. The taskforce found that the 255 incidences of wrong-site surgery, wrong implant or prosthesis used, or objects being mistakenly left inside patients that were reported in 2012/13, were caused by a combination of factors. In the context of the 4.6 million hospital admissions that lead to surgical care each year in England, these incidents are rare. However, each and every never event is one too many.
Key to the taskforce’s recommendations will be the development and implementation of national standards on the prevention of surgical never events.

These national standards will be overarching frameworks and high level descriptions of what should constitute standard practice for various aspects of peri-operative procedures. The standards will be further developed locally to create standardised practices within organisations on an organisation by organisation basis.

Dr Suzanne Shale, Chair of the Surgical Never Events Taskforce, said:

“Surgery is an inherently risky process, and surgical systems are highly complex. This risk and complexity means that despite a genuine commitment to safe practice and a high degree of technical competence, error occurs in surgery in health systems across the world.

“But while surgery is a risky business, it is also possible to make it safer. What we found when we looked at NHS data and international research, is that surgical never events almost always occur as a result of systems that are not safe enough, combining with behaviours that are not safe enough. So as well as making underlying systems safer, we want to make sure that everyone understands how safety is built into systems, and we want to enable everyone - from the front line to the boardroom, including patients - to play their part in upholding safety. And when harm does happen – as, sadly, it will – we want those affected by it to be better supported.

“The NHS became the first and only healthcare system in the world to mandate the use of the World Health Organisation’s Surgical Safety Checklist in 2009. This is already helping to build a safer culture. But to promote deep-seated and systematic change the checklist has to be embedded into wider practices and protocols. This is exactly what some NHS trusts have done, and many of our recommendations build on their good practice.

“Our recommendations are designed to reduce unwarranted variation, better share learning from mistakes and successful improvements, and to support provider and professional responsibility. We now look forward to a wider conversation between NHS England, patient organisations, professional organisations, regulators, service leaders and others about how our recommendations for safer surgery can be implemented.”

Clare Marx, Council Member and Patient Safety Lead at the Royal College of Surgeons, said:

“We welcome the Never Events Taskforce Report and the proposal to develop national standard operating procedures to avoid variation in surgical practice and reduce the risk of never events occurring.

“Educating the entire surgical team is fundamental to learning about and preventing never events. The way we deal with the aftermath of these events is also very important – both for the patient and the staff involved. We must be able to speak to
patients in a compassionate, caring and honest way and create a culture where all staff feel they are able to learn from incidents that lead to failures in care."

Dr Mike Durkin, Director of Patient Safety at NHS England, said:

“Patient safety has come a very long way in the past few years, and there has been a real revolution in how we monitor, manage and learn from incidents and build systems to minimise the risks of surgery. But every single never event is one too many. Many cause severe, life-changing harm and all of them damage confidence and trust in healthcare services.

“We are determined to make the NHS the safest healthcare system in the world, and we have made even further strides towards that in the last year, with a new National Patient Safety Alerting System to make sure lessons and warnings can be shared much more quickly, and a new programme of monthly publication of data about never events.”


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Notes to Editors

• The Surgical Never Events Taskforce is a sub group of the NHS England Surgical Services Patient Safety Expert Group. They consulted key stakeholders, carried out an evidence review, staff and public online engagement, and commissioned narrative accounts of patient and staff experience.

Taskforce members

• Suzanne Shale, Chair
• Clare Marx, Royal College of Surgeons, Vice Chair
• Fran Watts, NHS England
• Murray Anderson Wallace, Strategic Communications Adviser
• Emma Boakes, NHS England
• Clare Bowen, Patient Representative
• Susan Burnett, Imperial College London / Clinical Human Factors Group
• Tracy Coates, Association for Perioperative Practice
• Tom Clutton – Brock, Royal College of Anaesthetists
• Rhona Flin, University of Aberdeen / Clinical Human Factors Group
• Mervi Jokinen, Royal College of Midwives
• Danny Keenan, Care Quality Commission / NICE
• Bill Kilvington, College of Operating Department Practitioners
• Marisa Mason, National Confidential Enquiry into Patient Outcome and Death
• Edward Morris, Royal College of Obstetricians and Gynaecologists
• Cate Quinn, Care Quality Commission
• Tracey Radcliffe, Royal College of Nursing
• Andrew Reed, NHS Midlands and East
• Susan Robinson, Royal College of Physicians
• Stephanie Russ, Imperial College London
• Frank Smith, Confidential Reporting System for Surgery
• Isabeau Walker, Association of Anaesthetists of Great Britain and Ireland

About NHS England

• NHS England is the body, established in April 2013, which leads the NHS in England. It allocates funding to England’s 211 GP-led Clinical Commissioning Groups, and directly commissions primary care, specialised services and healthcare services for offenders. Its main aim is to improve the health outcomes for people in England, and it will set the overall direction and priorities for the NHS as a whole.

• For further information, please email the NHS England media team at nhsengland.media@nhs.net or call 0113 825 0958 / 0113 825 0958. For urgent out of hours media enquiries, please call 07768 901293.