PCT action plan

To help your PCT implement the Never Events policy, the following action plan can be used as an implementation checklist.

Preparation actions: February – March 2009	☑
Identify a member of staff who will be responsible for leading on implementing the Never Events Framework within your PCT.	☐
Finalise the list of Never Events that your PCT will be using during 2009/10. The core list of Never Events should be used in its entirety; however there is scope for PCTs to identify additional, locally defined Never Events using the guidance in Note 1, opposite.	☐
Gain organisation-wide sign up to the list of Never Events and commitment to public reporting of these within annual reporting arrangements.	☐
Ensure contracts with providers cover the list of Never Events that your PCT will be using and discuss requirements with them. Use the Provider action plan (Appendix B) to assist you with these discussions.	☐
Implementation actions: April 2009 – March 2010	☑
Monitor any Never Events that have occurred and discuss them with providers during the regular reviews of serious incidents (see Note 2, opposite).	☐
Monitor and regularly discuss provider implementation of action plans developed from root cause analysis investigations.	☐
Ensure that the frequency and types of incident being reported are reviewed regularly by your PCT board together with the actions providers are implementing to prevent further occurrence.	☐
Publicly report on Never Events as part of annual quality reporting arrangements, identifying: • the frequency and type of Never Events that have occurred in commissioned providers; and • a summary of the types of actions that these providers have implemented following a root cause analysis or significant event audit.	☐

*Extract from the National Patient Safety Agency's *Never Events Framework 2009/10* (page 8-9).
For full document, go to **www.npsa.nhs.uk/nrls/neverevents**

Note 1: *To take into account local circumstances and priorities, PCTs can identify additional incident types to include in the list of Never Events as part of the implementation process. It is important that your proposed additional events meet the following national criteria:*

- *The Never Event may or does result in severe harm or death to patients and/or the public.*
- *There is evidence that the Never Event has occurred in the past, that is it is a known source of risk (data sources: NPSA Reporting and Learning System and other Serious and Untoward Incident reporting systems).*
- *There is existing national guidance and/or national safety recommendations on how the Never Event can be prevented, along with support for implementation.*
- *The Never Event is preventable if national guidance and/or national safety recommendations are complied with.*
- *Occurrence of the Never Event can be easily defined, identified and measured on an ongoing basis.*

PCTs should use discussions about Never Events with all of their providers to get a common understanding of the list of Never Events that will be used, reinforce expectations and clarify the arrangements in place to meet these.

*N**ote 2:** Two requirements are central to the success of implementing Never Events:*

- *Providers should continue to report patient safety incidents to the NPSA's Reporting and Learning System.*
- *Providers should meet regularly with their commissioning PCT(s) to report and discuss serious incidents that have occurred and the learning from them.*

These requirements are already included in standard provider contracts.

Risk management

As with all new initiatives, robust risk management should be in place. This is particularly true for implementation of the Never Events policy as organisations are likely to be implementing a number of different patient safety initiatives simultaneously.

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