



**BRITISH ASSOCIATION
OF DERMATOLOGISTS**
HEALTHY SKIN FOR ALL

Skin Cancer Surgical Never Events

Learning from 85 cases occurring in English hospitals between
April 2018 and March 2022

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Summary

Never Events in the NHS are defined as ‘patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers’ (NHS Improvement, 2018a).

This national learning report attempts to capture the many facets which are catalysts to Never Events in wrong site surgery for Dermatology. It also looks at the common main causes which lead to wrong site surgery in dermatology and their relationship to a serious incident.

It presents an analysis of contributory factors reported in local investigation reports for 63 of the 85 surgical never events from across England that occurred between April 2018 and March 2022. Further data has been obtained from a BAD wrong site surgery survey sent to the 20 hospitals who experienced 27 wrong site surgical Never Events during the first year of COVID (2020-21). The survey also asked trusts to clarify if they had had preceding incidents between 2018-2020. We have also carried out an in-depth analysis of 5 never events that occurred at two of the hospitals during 2020 –2021 to provide two cumulative case studies (Appendix 2). This identified a number of common safety critical processes as contributing factors which also featured across all of the 63 never events.

The main causes identified in 63 of the 85 reported Never Event reports and other contributory factors are set out in Section 2 of this report. Information on the specific details for the 22 never events during 2021-2022 is presently being gathered and will be updated as part of the ongoing nature of this report.

It is clear from this analysis that fundamental challenges remain in preventing reoccurrence in wrong site surgery for dermatology. These are given in more detail in Section 4 and include:

- a receptive team culture where questioning related to safety is welcomed and all staff are encouraged to speak up when they have concerns.
- enhancing awareness of safety in situations where team members are unfamiliar with each other or with the theatre facilities or procedure
- ensuring the consistent use of safety checks by all surgical staff and regular quality audits of this process.
- skin specific impact factors which include the clear marking and recording of multiple lesions or blemishes on many of our patients. There is a need to clearly identify and record, in a manner that allows patients identity to be confirmed regardless of the surgeon carry out the procedure. Photographs are ideal for this purpose (but not fool proof). Standardisation of photograph records may be required.
- patient specific factors which include high numbers of elderly populations requiring skin surgery. This cohort of patients frequently have impaired eyesight, impaired

hearing and impaired understanding of their procedure(s) (younger adults and children may also lack insight into their treatment).

- Surgeon specific process factors which specifically related to another clinician, surgeon or non-dermatologist undertaking the surgical treatment, and the patient not being seen by that surgeon prior to surgery. It cannot be assumed that a non-dermatological surgeon has the competency to make a dermatological diagnosis and check the lesion site is correct.
- NHS England & Improvement considers Never Events to be 'red flags'; they highlight potential weaknesses in how an organisation manages fundamental safety processes. The investigation reports reviewed in our two cases summaries (Appendix 2) provided more in-depth evidence of the common safety critical themes and how these failings occurred. These themes also occurred in trusts with repeated never events between 2018 -2021 where the organisations had either not addressed the safety issues or had not fully considered their approach to the implementation of relevant national guidance for:
 - **Patient factors:** reliance alone on patients to confirm their lesion site when undergoing a surgical procedure is unrealistic and unsafe. Using a mirror to confirm the lesion site with the patient without clinical notes being present has also led to wrong site surgery. Surgeons should have the requisite clinical information and be able to confirm the skin lesion diagnosis before carrying out any procedure(s).
 - **Site marking:** more work is needed to identify the best way to mark surgical sites for skin including the use of indelible pens, supporting photographs and body maps. The interpreted use of the WHO checklist and LocSSIPs allow variation in key safety-critical processes in dermatology surgery.
 - **Team factors:** In 6 of the reported Never Events cases between 2018-2021, a lack of communication between staff was cited as a main cause that led to the incidents. This includes a case in 2019/20 where after the consultant marked the site of surgery, the nurse rubbed it off by accident, leading to the wrong lesion being excised.
 - **Poor documentation:** One of the more prevalent causes behind these never events is the lack of clear documentation regarding the lesions to be excised or biopsied. Often this has happened due to confusion, such as confusion with the body map, especially where there are multiple lesions (not all of which were to be operated on). This has also often involved photographs, which should be a fundamental part of the pre-surgery checklist. All in all, there were 19 never events between 2018-2021 where either there was no photo present of the lesion site, or the photo was ignored. 9 of these occurred in 2021/21.

To achieve a continual reduction in harm, we must persist in reducing unwarranted variation, better shared learning from mistakes and from measured quality improvement outcomes, with mandated provider and professional responsibility. While it may not be possible to ensure that never events never happen, more stringent measures are required to address the common safety themes which regularly reoccur. Increased safety for patients requires the NHS to increase standardisation of specific safety-critical steps that are common across all surgical

procedures. The following safety recommendations are made to NHSE to address these safety critical themes:

1. Safety recommendation

Having reviewed the information provided by hospitals to NHSE it has been difficult to fully ascertain the grade and specialty of all the clinicians responsible for these never events. It is important for NHSE Never Events reporting to have a standardised reporting format that all hospitals use as part of recording DATIX incidents. In particular, the NHS has recognised clinical grades for doctors and nurses which should be recorded accurately along with their specialty of practice. This has a particular bearing on dermatology departments who are reliant on other surgical specialties to carry their surgical work. We need to be able to assess the direct impact of using other surgical specialties to reduce the scope for error in practice.

2. Safety recommendation:

All external surgeons providing 18-week wait surgical waiting lists for dermatology departments must have the same induction and training on LocSSIPs as new clinical staff. Clinic lists for surgical patients should not exceed the recommended numbers defined in the BAD job planning guidance. We are aware of some surgical waiting list companies' proposal to exceed numbers which place patients at risk and will lead to more surgical Never Events.

3. Safety recommendation:

It is recommended that the BAD reviews and revises the National Safety Standards for Invasive Procedures (NatSSIPs) policy to increase standardisation of safety-critical steps that are common across all dermatology procedures. These should be set against quality indicators which are reported nationally. The degree of autonomy given to Trusts in developing Local Standards for Safety Standards for Invasive Procedures (LocSSIPs) leads to variation in practice and Never Events.

4. Safety Recommendation:

National Quality reported indicators for wrong site surgery Never Events must be agreed by NHSE to ensure:

- policies used by hospitals are detailed with specific processes which are measurable and consistently reported when Never Events do occur.
- all surgery staff removing skin lesions are able to diagnose skin cancer or are able to confirm a diagnosis from a dermatologist where uncertainty of the skin lesion site occurs prior to any surgery taking place.

- skin specific, patient specific and surgeon specific indicators are included within standard skin cancer surgery protocols.

There are common factors which occurred in the 85 cases reviewed (Table 6) which may also explain the unchanging yearly rates of wrong site surgery despite implementation of LocSIPP protocols.

1. Introduction

Definition

The definition of Never Events is set by the current version of the Never Events policy and framework. This states:

‘Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.’(NHS Improvement, 2018a).

Data about reported Never Events demonstrates that they continue to occur and that the risk of them recurring remains (NHS England).

Context and summary of relevant literature

Never Events are patient safety incidents that are considered preventable when national guidance or safety recommendations that provide strong systemic protective barriers [1] are implemented by healthcare providers. Their prevalence remains low in relation to the total volume of surgery undertaken in the NHS: about one in every 20,000 procedures.

The [World Health Organization](#) (WHO) launched its [Surgical Safety Checklist](#) in June 2008 to improve communication, clinical teamwork and ensure critical safety measures are performed before, during and after an operation. The checklist was mandated for use in the NHS in January 2009. It is now in standard use across the UK as well as worldwide.

In October 2012, NHS England set up “a taskforce to look at surgical Never Events in order to make sure that these events are eradicated from NHS surgery”. The taskforce proposed a strategy of three interlocking elements to reduce harm and variation in practice:

- Standardisation of generic operating department procedures
- Systematic education and training for operating theatre environments
- Harmonising activity to support a safer environment for patients

Similarly, the Berwick Report 2013 (Mid Staffordshire Hospital) concluded vigilance is needed to constantly assess and improve the safety of NHS care by:

- placing the quality of patient care, especially patient safety, above all other aims;
- engaging, empowering, and hearing patients and carers at all times;
- fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work; and
- embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

In September 2015, a set of National Safety Standards for Invasive Procedures (NatSSIPs) were published to help prevent Never Events, with all relevant NHS organisations in England instructed to develop and implement their own local standards based on the national principles. The standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice.

The Care Quality Commission undertook a thematic review in collaboration with NHS Improvement to get a better understanding of what can be done to prevent the occurrence of Never Events, with the resulting report '[Opening the door to change](#)' published in December 2018.

The CQC's findings demonstrate that the harmonisation of activity to support patient safety in hospitals as recommended by the NHS England Never Events Taskforce in 2014 had not occurred (NHS England, 2014).

The report also included a recommendation that "NHS Improvement should review the Never Events framework and work with professional regulators and Royal Colleges to take account of the difference in the strength of different kinds of barrier to errors (such as distinguishing between those that should be prevented by human interactions and behaviours such as using checklists, counts and sign-in processes; and those that could be designed out entirely such as through the removal of equipment or fitting/using physical barriers to risks).

The 'In Safe Hands' interactive guide (Patient safety toolkit), was produced by Health Education England (HEE) in 2019 to support safer clinical practice across the NHS. This guide was produced in response to the 12 recommendations made in the March 2016 report 'Improving Safety Through Education & Training' report.

A BAD Wrong Site Surgery Working Party stakeholder group was formed in 2021 to explore the common themes and main causes for skin cancer Never Events and why these increased during COVID. Subsequent data has been provided by the NHS England Never Events team to provide

comparative data on dermatology specific incidents for wrong site surgery during April 2018 to March 2021.

A survey was sent out to each of the hospitals with reported wrong site surgical Never Events in each year to confirm if their dermatology department had an incident. They were asked to provide us with the main and secondary causes for each Never Event and if they had also had any reported serious incidents within 2018 to 2021. All information provided by the hospital trusts in our survey is anonymised and summarised throughout this report with data tables contained in Appendix 1. Two case summaries from two of the trusts in this report are included in Appendix 2.

Further analysis of each hospital trusts (see Appendix 1: Table 2) total outpatient activity data, 2 Week Waits (2WW) and Referral to Treatment Times (RTT) between 2018 – 2021 has been used to inform this report.

2. Underlying Causes to Never Events

Current Never Events

Table 1 lists the Never Events reported to the BAD via our Never Event survey and directly from NHS England for 2018-2021.

During the first year of COVID 2020-2021, incidences of wrong site lesion excisions in dermatology nearly doubled in number on the previous year. These numbers reduced during the second year of COVID 2021-2022 to reflect case numbers during 2018-2019.

Table 1: NHS England Never Events - Dermatology Wrong Site Surgery

Wrong site surgery type	2018-2019	2019-2020	2020-2021	2021-2022*	Grand Total
Wrong Site Biopsy	2	4	6	6	18
Wrong Site Lesion Excision	19	11	21	16	67
Grand Total	21	15	27	22	85

**Information on the specific details for the 22 Never Events during 2021-2022 is presently being gathered and will be updated as part of the ongoing nature of this report.*

In all, a total of 27 incidences in 2020-2021 were generated by 20 hospital departments as demonstrated in Table 2: Dermatology Wrong Site Surgery by Hospital Trust. Of these 20 hospitals, 13 had no prior incidents to 2020-2021. They shared a total of 19 incidences between them with 4 hospitals experiencing 2 to 3 Never Events.

During 2019-2020, 13 hospitals reported 15 Never Events. 11 of the 13 hospitals had a singular Never Event with 3 hospitals also having another singular Never Event during 2020-2021.

There were 21 Never Events that occurred in dermatology between 2018-2019 in 18 hospitals. Only two hospitals had multiple events (5). Four trusts also had incidents during COVID 2020-2021, with one trust having a singular incident in each year between 2018-2021.

Dermatology Activity

Dermatology outpatient services were reduced to seeing urgent and essential 2-week wait patients in the COVID period (April 2020 to March 2022). 17 of the 20 Hospitals with Never Events during 2020-2021 experienced between a 5% to 50% reduction in their overall outpatient activity (see Table 3: Dermatology yearly outpatient attendances). 2 hospitals experienced an increase in their outpatient activity during this period of 17% and 26% due to mergers taking place in 2020. Of the 14 hospitals with no prior Never Events to 2020-2021, 12 experienced reduced outpatient activity. 8 of the 18 known hospitals who had Never Events during 2018-2019 had higher outpatient activity compared with the following years. All of the known trusts who experienced Never Events in 2018-2019 had lower 2-week wait activity that year than 2019-2020. Only 1 trust experienced a significant increase in 2-week wait numbers.

A comparative review of the total 2-week wait activity data for the 20 hospitals during 2020-2021 showed a total reduction of 13,318 referrals on the previous year. The total number of breaches to treatment times remained largely the same (a decrease of 137). Only three of the 13 hospitals with no previous Never Events experienced a significant breach to their treatment times (Table 4: Dermatology yearly 2WW Skin Cancer Attendances).

During 2020-21, when COVID was at its peak, the mean average wait time for dermatology appointments was 4.2 weeks. For trusts B and J who we looked at in close detail as case studies, their median average wait time was 7.3 and 3.6 weeks respectively. The average 95th percentile waiting time for dermatology this year was at an average of 38 weeks. Trust B's 95th percentile was higher, at 43.5 weeks, whereas Trust J's was lower at 28.1. These statistics may show the added pressure that Trust B faced, with the increased amount of time patients had to wait for treatment during 2020-21.

Workforce

The NHS is the largest employer in England, with [1.2 million full-time equivalent \(FTE\)](#) staff working in hospital and community services¹. Workforce shortages are a critical barrier to increasing NHS capacity and are reportedly a key reason why the Nightingale field hospitals during COVID were not fully mobilised despite the intense pressure on health services.² This coupled with increased staff absences due to sickness along with the mental and physical fatigue during the COVID period placed already overstretched clinical teams and patients in the way of harm.

Unfortunately, it was not possible to obtain specific dermatology departments data on average rates of sickness during the COVID period. However, we have reviewed the hospitals with Never Event overall 'Average rate of sickness' (see Appendix 1: Table 5). Of the 14 hospitals who only experienced Never Events during the COVID period, 13 had increased staff rates of sickness between 4.17% to 5.65%. These departments were also reliant on additional surgical support from other surgical specialties with 8 out of the 27 Never Events attributed to this group. There were an additional 5 unknown cases which may also be fall under this group. During 2019-2020, the 8 known hospitals contained in Table 2 experienced staffing absences between 3.31% to 4.61%. Only one trust had a case attributed to another surgical specialty of out the 15 Never Events (see Table 7: Surgeon for Wrong site Surgery). The trusts who had Never Events in 2018-2019 experienced lower workplace absences than in the following years.

Main and Secondary Causes

The following information contained in Table 6. Main and Secondary Causes has been grouped into common safety critical themes reported for each Never Event during 2018 –2021.

Table 6: Main and Secondary Causes for Never Event

Main and secondary causes	2018-2019	2019-2020	2020-2021	*2021-2022	Grand Total
Incorrect documentation			4		4
No photo of site lesion	5	4	7		17
Photo of lesion site ignored	1	1	2		4
Lack of communication between staff	1	2	3		6
Lesion site not checked with patient prior to surgery	2	2	5		9
No mirror for patient to check lesion site	2	1	2		4

¹ The Kings Fund – NHS Workforce Our Position updated February 2022 <https://www.kingsfund.org.uk/projects/positions/nhs-workforce>

² [health Foundation -staff shortages left the NHS vulnerable to the COVID-19 storm](#) 12 January 2021

WHO and safety checklist not followed correctly	8	1	9	17
Incorrect skin lesion site marked		3	4	7
No lesion marking recorded	1	2	6	9
Site marking smudged by face mask			1	1
Patient confirmed benign lesion without checks			1	1
Patient confirmed wrong site in mirror			1	1
Unknown		4		4

**Information on the specific details for the 22 Never Events during 2021-2022 is presently being gathered and will be updated as part of the ongoing nature of this report.*

The main and secondary causes reported for dermatology Never Events during 2018 to 2020 relate to the failure to comply with operational policies and procedures. While the reasons for this failure vary from hospital to hospital there are core safety themes which continue to occur in dermatology surgical services. These include the interpreted use of the WHO checklist (18), not recording the lesion site in the patient record (8) and the incorrect lesion site marked on the patient (9), no photographs to confirm the skin lesion site (17) and the lesion site not being checked by the patient before surgery (9).

Surgical Specialty for wrong site surgery

During the COVID period, dermatology services were more reliant on other surgical specialty resources (internal and external to the hospital) to maintain surgical lists. In at least 8 of the Never Events, the wrong site surgery was not carried out by a dermatology clinician. This is one of the main reasons for the significant increase in wrong site surgery on the previous year (2019-2020). There are another 4 cases where the clinician has been reported as unknown which may also be attributed to this group of surgeons. The main causes and themes for this occurring are covered as above. The main and secondary causes relating to the surgical specialities were largely down to a lack of photos of the lesion site and a failure to follow WHO and safety checklists.

Table 7: Surgeon for Wrong site Surgery

Surgery undertaken by:	2018-2019	2019-2020	2020-2021	*2021-2022	Grand Total
Consultant	4	1	1		6
Dermatologist			3		3
Dermatology nurse	1	1	4		6
General surgeon			1		1

Specialist Registrar		1		1
Specialty Doctor	1		3	4
Surgeon		4	3	7
Plastic Surgeon		1	4	5
Plastic Surgery Registrar	1			1
Registrar	1			1
Locum Consultant	1			1
External Surgeon			1	1
Clinical nurse specialist	1	1	3	5
Clinical Research Fellow	1			
Post-CCT Mohs Fellow	1			
Unknown	9	6	4	20
Grand Total	21	15	27	85

**Information on the specific details for the 22 Never Events during 2021-2022 is presently being gathered and will be updated as part of the ongoing nature of this report.*

Of the 12 wrong site biopsies reported during 2018 –2021 (Table 1) 6 were undertaken by a nurse, 1 by a plastic surgeon, 2 by a dermatologist with a further 3 reported as unknown. The 51 wrong site excisions during this period were carried out by 6 clinical nurse specialists, 14 other surgical specialty consultant surgeons, 16 by a dermatologist, consultant, or specialty grade doctor with a further 15 cases reported as unknown.

Serious Incidents

Some of the trusts described in Table 2 have had serious incidences in addition to the Never Events they had. Of the 20 trusts who experienced Never Events during COVID, 8 also had serious incidents in the same or surrounding years. 4 of these trusts had multiple serious incidents, one of whom (Trust L) experienced 6 incidents between 2018 and 2021. Half of these incidents, which took place in 2020, related to safety checklists not being adhered to. The Never Events at this same trust also named the lack of adherence to safety checklists as a main cause. Many of the serious incidents were caused by a delay to treatment, such as the case experienced by Trust B in 2018 where the patient experienced a delay of nearly 6 months for the excision of a lesion.

3. Actions Taken to Prevent Re-occurrence

Formulating corrective actions to identify all the root causes of a Never Event is often difficult and follow up on outcomes is rare. A sign of the incomplete adoption of recommendations is

that despite having recently completed an RCA [root cause analysis] for a specific incident, hospitals commonly experience repeat events.

We saw this in the 6 hospitals with Never Events prior to and during the COVID period with another 4 trusts with 2 to 3 Never Events without previous incidences in 2018 – 2019. A review of investigation reports and action plans in our two case studies show the term ‘reflective practice’ is used consistently without any substance behind this outcome. Reflective practice does not stop repeat practice occurring, despite it having connotations of individual error rather than systems failure. In both Trusts used as case studies, they have undertaken stringent RCAs with actions plans and follow up outcomes measured as part of their standard operating procedures (SOP).

Actions to reduce recurrence mainly focused on safety checks/‘sign in’ and ‘time out,’ and site marking. The purpose of the immediate preoperative checks in some of the cases appeared not to be fully appreciated; they were done because they had to be, not for conscious control and focus at a crucial point in the surgical process. This includes the use of the WHO checklist as a list rather than a procedure check.

Developing standard operating procedures (SOPs) for the optimal way to mark skin lesions will help to resolve the variation in practice. Allowing images to be recorded and made available to the surgeon at the time of the procedure will also reduce confusion of the lesion site. The use of an indelible marker when marking surgical sites is essential to avoid site transference and accidental removal by the patient.

4. Challenges for Prevention in the Future

This section draws together the main challenges identified in the cases, to highlight the further work needed to prevent dermatology surgical Never Events in future.

“The RCA process is designed to answer three basic questions: what happened, why did it happen, and what can be done to prevent it from happening again? What is missing in medicine is a fourth question: has the risk of recurrence actually been reduced? The fact that it generally is not known whether risk has been reduced is causing concern that some of the considerable resources and efforts expended on RCA are being wasted.” (Wu et al 2008 [10]).

As set out in the introduction to this report, NHS Improvement considers Never Events to be ‘red flags’ – indicators of potential weaknesses in how an organisation manages fundamental safety processes.

Much work has been done in the last 10 years to develop safety checklists and to improve handover. However, our concerns remain about how these checklists have been implemented and how they are used. The challenge is to understand better why safety checks are not being used in certain circumstances; or not being used as intended; or not being used by the intended team members.

More work is needed nationally to guide trusts on the best way to mark surgical sites in dermatology and secondary diagnostic checks by those surgical specialties carrying out the removal of skin lesions. These protocols must be consistent for all surgeons operating in this multidisciplinary way to undertake necessary safety checks to avoid wrong site surgery.

It is unknown during the first year of COVID 2020-2021 how many of the 20 hospitals with Never Events were directly affected by changes to their work environment. For example, many hospital departments were moved or had their surgical facilities reduced to accommodate COVID patients. This would have a direct impact on those surgical staff operating from unfamiliar sites with different processes, equipment, and other surgical teams where resources were pooled together. Having a common baseline for standard operating procedures which are common to all surgical teams is essential to ensure surgical specialties can safely support each other.

Before the pandemic, there were workload pressures and workforce shortages across several NHS dermatology departments. Demand for services remains high and will increase in coming years despite new way of working to see patients virtually and streamline care pathways. The NHSE development of partnerships with the independent sector to support long-term contracting of surgical waiting and use of surgical hubs for low- risk high volume skin cancer must also guarantee safe surgical outcomes for patients (11).

5. Conclusions and Recommendations

To date, the BAD has carried out a review of the common themes and main causes leading to 63 of the 85 reported Never Events. We have included two surgical service case studies from two of hospitals with multiple Never Events. These have been informed by a separate surgical review the two hospitals surgical services.

Having reviewed the main and secondary causes reported by the 41 known hospitals (44 reported) during 2018 -2021 there are common safety critical themes across multiple or singular events. In 6 of the hospital trusts with previous Never Events prior to and during COVID, the same safety critical themes reoccurred. In another 8 hospitals during 2020-2021, reliance on other specialty surgeons and external surgeons to the department was one of the

main causes for the increase in numbers of Never Events. Comparatively in 2018-2019, there were only 1 known trust reliant on other surgical support, with 10 unknown cases yet to be determined. Variation in practice between surgical specialties and their individual standard operational and safety processes provided scope for error.

Our Skin Surgery Never Events Working Party Group concluded that despite a genuine commitment to safe practice and a high degree of technical competence, there is ample scope for error. A single surgical Never Event is almost invariably caused by several factors, often combining unsafe systems and unsafe behaviours. This continued toleration of variation in practice does not promote organisational and professional responsibility in reducing the scope for error.

While some variation is required to adapt to changes and challenges in clinical care, certain components of processes could be standardised nationally. These components include those safety-critical checks that must be undertaken effectively to minimise the risk of incidents in wrong site surgery.

The BAD Skin Surgery Never Events WPG has made the following safety recommendations to NHSE:

1. Safety recommendation

Having reviewed the information provided by hospitals to NHSE it has been difficult to fully ascertain the grade and specialty of all the clinicians responsible for these Never Events. It is important for NHSE Never Events reporting to have a standardised reporting format that all hospitals use as part of recording DATIX incidents. In particular, the NHS has recognised clinical grades for doctors and nurses which should be recorded accurately along with their specialty of practice. This has a particular bearing on dermatology departments who are reliant on other surgical specialties to carry their surgical work. We need to be able to assess the direct impact of using other surgical specialties to reduce the scope for error in practice.

2. Safety recommendation:

All external surgeons providing 18 week wait/ surgical waiting lists for dermatology departments must have the same induction and training on LocSSIPs as new clinical staff. Clinic lists for surgical patients should not exceed the recommended numbers defined in the BAD job planning guidance. We are aware of some surgical waiting list companies' proposal to exceed numbers which place patients at risk and will lead to more surgical Never Events.

3. Safety recommendation:

It is recommended that the BAD reviews and revises the National Safety Standards for Invasive Procedures (NatSSIPs) policy to increase standardisation of safety-critical steps that are common across all dermatology procedures. These should be set against quality indicators which are reported nationally. The degree of autonomy given to Trust in developing Local Standards for Safety Standards for Invasive Procedures (LocSSIPs) leads to Never Events.

4. Safety Recommendation

National Quality reported indicators for wrong site surgery Never Events must be agreed by NHSE to ensure:

- policies used by hospitals are detailed with specific processes which are measurable and consistently reported when Never Events do occur.
- all surgery staff removing skin lesions are able to diagnose skin cancer or are able to confirm a diagnosis from a dermatologist where uncertainty of the skin lesion site occurs prior to any surgery taking place.
- skin specific, patient specific and surgeon specific indicators are included within standard skin cancer surgery protocols.

There are common factors which occurred in the 85 cases reviewed (Table 6) which may also explain the unchanging rates of unchanging rates of wrong site surgery despite implementation of LocSSIPs protocols.

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Appendix 1: Data Tables (2-5)

Table 2: Dermatology Wrong Site Surgery by Hospital Trust

Trust	2018-2019	2019-2020	2020-2021	*2021-2022	Grand Total
Trust A*			2		2
Trust B*	1		3		4
Trust C*			1		1
Trust D**	1	1	1		3
Trust E*			1		1
Trust F**			1		1
Trust G**		1	1		2
Trust H*			2		2
Trust I**			1		1
Trust J**			1		1
Trust K**	1		1		2
Trust L*			2		2
Trust M*			1		1
Trust N*			3		3
Trust O**			1		3
Trust P*			1		1
Trust Q**	1		1		2
Trust R**		1+			1
Trust S**		1	1		2
Trust T*			1		1
Trust U***		2			2
Trust V*			1		1
Trust W***		1			1
Trust X***		1			1
Trust Y**		2			2
Trust Z		1			1
Trust AA		1			1
Trust AB		1			1
Trust AC		1			1

Trust AD	2				2
Trust AE	3				3
Trust AF	1				1
Trust AG	1				1
Trust AH	1				1
Trust AI	1				1
Trust AJ	1				1
Trust AK	1				1
Trust AL	1				1
Trust AM	1				1
Trust AN	1				1
Trust AO	1				1
Unknown Trust 4		1			1
Unknown Trust 5	1				1
Unknown Trust 6	1				1
Grand Total	21	15	27	22	85

**Information on the specific details for the 22 Never Events during 2021-2022 is presently being gathered and will be updated as part of the ongoing nature of this report.*

Table 3: Dermatology yearly outpatient attendances.

Trust	2018-2019	2019-2020	2020-2021	Reduction 2019/20- 2020/21	% change 2019/20 – 2020-21
Trust A	15,090	13,875	9,230	-4,645	-33%
Trust B*	48,465	45,370	53,075	+7,705	+17%
Trust C	17,065	13,955	9,165	-4,790	-34%
Trust D	7,800	13,590	11,345	-2,245	-17%
Trust E	35,780	37,935	27,670	-10,265	-27%
Trust F	8,150	9,560	10,035	+475	+5%
Trust G	32,840	32,720	23,445	-9,275	-28%
Trust H	30,920	28,010	16,210	-11,800	-42%
Trust I	14,680	14,545	11,750	-2,795	-19%
Trust J	63,490	64,005	48,220	-15,785	-25%
Trust K**	51,655	54,395	37,825	-16,570	-30%
Trust L	27,070	27,670	18,555	-9,115	-33%

Trust M	21,595	21,860	18,780	-3,080	-14%
Trust N	18,575	18,790	15,775	-3,015	-16%
Trust O	17,855	17,415	14,670	-2,745	-16%
Trust P	18,575	22,180	18,065	-4,115	-19%
Trust Q	45,600	48,110	38,635	-9,475	-20%
Trust R*	19,740	17,975	22,610	+4,635	+26%
Trust S	12,125	12,315	10,115	-2,200	-18%
Trust T	16,775	15,645	14,730	-915	-6%
Trust U***	55,130	62,135	39,750	-22,385	-36%
Trust V	58,300	58,120	43,590	-14,530	-25%
Trust W	2,935	3,695	2,290	-1,405	-38%
Trust X	15,040	14,880	14,165	-715	-5%
Trust Y	16,870	16,055	11,470	-4,585	-29%
Trust Z	32,640	33,860	16,900	-16,960	-50%
Trust AA	20,900	19,420	16,300	-3,120	-16%
Trust AB	38,395	36,260	26,140	10,120	28%
Trust AC	19,730	18,515	14,375	4,140	22%
Trust AD	32,480	31,685	23,060	8,625	27%
Trust AE	46,945	42,000	19,450	22,550	54%
Trust AF	19,495	15,035	8,655	6,380	42%
Trust AG	58,175	56,375	34,290	22,085	39%
Trust AH	2,235	2,960	2,335	625	21%
Trust AI	101,915	110,655	92,620	18,035	16%
Trust AJ	22,645	23,165	20,515	2,650	11%
Trust AK	17,045	15,835	12,005	3,830	24%
Trust AL	38,010	35,430	26,645	8,785	25%
Trust AM	116,225	114,945	85,950	28,995	25%
Trust AN	34,095	35,660	29,715	5,945	17%
Trust AO	12,930	12,460	10,410	2,050	16%

* Trust merged during 2020. ** Trust merged during 2019. *** Trust merged during 2018.
Data source: Hospital episode statistics - outpatient attendances 2018-2021

Table 4: Dermatology yearly 2WW Skin Cancer Attendances.

Trust	Total treated 2018-19	Total breaches 2018-19	Total treated 2019-20	Total breaches 2019-20	Total treated 2020-21	Total breaches 2020-21	Total treated 2021-22	Total breaches 2021-22
Trust A	4013	238	4682	216	4089	700	4089	700
Trust B*	5943	718	8408	423	11446	858	11446	858
Trust C	2926	35	3316	52	2836	27	2836	27
Trust D	3395	134	4028	111	3654	147	3654	147
Trust E	7128	409	7371	101	6848	103	6848	103
Trust F	3786	460	4161	98	3743	193	3743	193

Trust G	5395	165	5962	351	4795	730	4795	730
Trust H	4956	399	5590	592	3773	111	3773	111
Trust I	1630	57	1998	53	1539	73	1539	73
Trust J	8083	262	8935	328	8042	340	8042	340
Trust K**	6118	348	3488	661	5662	156	5662	156
Trust L	5035	152	5296	43	4500	118	4500	118
Trust M	1875	143	1823	48	951	27	951	27
Trust N	5784	160	6521	52	5550	126	5550	126
Trust O	2881	90	2973	165	2413	61	2413	61
Trust P	5393	635	6303	564	4747	165	4747	165
Trust Q	3864	180	4243	249	4006	225	4006	225
Trust R*	3725	139	3777	1887	1083	475	3011	642
Trust S	1895	42	2261	32	1974	79	1974	79
Trust T	3369	100	3630	169	3337	407	3337	407
Trust U***	4965	172	5932	269	5435	189	5435	189
Trust V	7889	508	8594	562	7134	1921	7134	1921
Trust W	188	28	152	22	106	36	106	36
Trust X	2237	152	2581	192	2150	76	2150	76
Trust Y	4613	734	5153	424	4047	184	4047	184
Trust Z	4897	382	5415	496	4503	1314	4503	1314
Trust AA	4964	992	5516	1534	4623	432	4623	432
Trust AB	8338	420	9036	527	6229	1187	6229	1187
Trust AC	2185	43	2359	52	2013	73	2013	73
Trust AD	7053	347	7395	407	6288	300	6288	300
Trust AE	7315	346	6564	625	5616	315	5616	315
Trust AF	3358	301	3762	403	3235	120	3235	120
Trust AG	5119	136	5268	113	4691	291	4691	291
Trust AH	1924	751	2146	73	1532	65	1532	65
Trust AI	5016	51	5337	53	3803	43	3803	43
Trust AJ	4488	764	5125	961	4538	70	4538	70
Trust AK	1808	86	2247	198	1891	188	1891	188
Trust AL	3383	965	3463	706	2487	137	2487	137
Trust AM	8608	423	9233	2599	8664	1840	8664	1840
Trust AN	4746	52	4926	96	3592	48	3592	48
Trust AO	3910	140	4140	228	2982	637	2982	637
Grand Total	184198	12659	199110	16735	170547	14587	172475	14754

* Trust merged during 2020. ** Trust merged during October 2019. *** Trust merged during July 2018.

Data Source: NHS England Cancer Waiting Time Statistics 2018 -2021

Table 5: Average rates of sickness by Trust

Trust	2018-2019 Average	2019-2020 Average	2020-2021 Average
Trust A	3.89%	3.94%	5.13%
Trust B* (after merge)	3.79%	3.80%	4.95%
Trust B* (before merge)	3.79%	4.01%	-
Trust C	3.83%	3.94%	4.46%
Trust D	4.46%	4.40%	4.80%
Trust E	4.01%	4.32%	5.22%
Trust F	4.19%	4.56%	4.84%
Trust G	2.94%	3.32%	4.15%
Trust H	3.73%	3.85%	3.67%
Trust I	4.75%	4.72%	5.00%
Trust J	4.18%	4.52%	4.84%
Trust K **(after merge)	4.71%	5.02%	5.94%
Trust K** (before merge)	4.76%	4.77%	-
Trust L	4.71%	5.26%	5.65%
Trust M	4.34%	4.92%	5.28%
Trust N	4.22%	4.56%	4.06%
Trust O	3.88%	4.21%	4.43%
Trust P	4.44%	4.37%	5.02%
Trust Q	3.39%	3.65%	3.59%
Trust R* (after merge)	-	-	5.22%
Trust R* (before merge)	4.26%	4.22%	4.78%
Trust S	4.81%	4.84%	5.28%
Trust T	4.61%	5.09%	5.54%
Trust U***	4.29%	4.61%	4.79%
Trust V	3.20%	3.50%	4.17%
Trust W	2.96%	3.31%	3.55%
Trust X	4.90%	5.26%	4.62%
Trust Y	4.14%	4.47%	4.90%
Trust Z	4.65%	4.59%	4.99%
Trust AA	4.19%	4.45%	4.00%
Trust AB	3.87%	4.26%	3.58%
Trust AC	-	-	4.77%
Trust AD	4.38%	4.54%	4.89%
Trust AE	4.62%	5.24%	6.12%
Trust AF	4.06%	4.26%	4.70%
Trust AG	3.60%	4.06%	4.58%
Trust AH	3.47%	3.82%	3.61%
Trust AI	3.46%	3.74%	3.93%
Trust AJ	4.81%	5.00%	5.16%
Trust AK	4.00%	4.46%	5.52%
Trust AL	4.43%	4.56%	5.26%
Trust AM	4.08%	4.48%	5.05%
Trust AN	3.23%	3.54%	3.77%
Trust AO	4.73%	4.97%	4.35%

* Trust merged during 2020. ** Trust merged during October 2019. *** Trust merged during July 2018.

Data Source: Processed using data taken from the Electronic Staff Record Data Warehouse

Serious Incidents 2018-2021, as described by trusts in the Never Events survey

Trust	Year	Degree of harm	Category	Main cause 1	Main cause 2
Trust A	2020/21	Unknown	Unknown	Unknown	
Trust B*	2018	Moderate risk	Inappropriate treatment or delay	Lack of communication between staff	
Trust I	2021	Moderate risk	Clinical assessment error	Team co-ordination issues	Inappropriate melanoma treatment Inappropriate outcome record for SCC follow up
Trust I	2019	High risk	Documentation error	Lack of communication between staff	
Trust K**	2020	Moderate risk	Communication issue	Lack of communication between staff	
Trust K**	2021	Moderate risk	Communication issue	Lack of communication between staff	
Trust L	2020	Unknown	Inappropriate treatment or delay	Safety checklists not adhered to	
Trust L	2020	Unknown	Inappropriate treatment or delay	Safety checklists not adhered to	
Trust L	2021	High risk	Inappropriate treatment or delay	Unknown	
Trust L	2019	High risk	Inappropriate treatment or delay	Wrong site lesion recorded	
Trust L	2019	Unknown	Inappropriate treatment or delay	Lack of communication between staff	
Trust L	2018	Unknown	Inappropriate treatment or delay	No photo of lesion site	
Trust N	2020	Moderate risk	Serious health and safety incident	WHO checklist not followed correctly	
Trust R*	2020	High risk	Inappropriate treatment or delay	Team co-ordination issues	1 year delay for melanoma surgery, overlooked by MDT 5 year delay to BCC treatment led to extensive plastic surgery
Trust R*	2018	Moderate risk	Inappropriate treatment or delay	Incorrect documentation	
Trust T	2018	Unknown	Inappropriate treatment or delay	Unknown	

* Trust merged during 2020. ** Trust merged during October 2019.

Data source: BAD Wrong Site Surgery Survey sent out to trusts who experienced Never Events in 2020/21

Appendix 2: Case Studies

Trust B

Dermatology Services for Trust B is provided across multiple sites with surgical procedures taking place at 3 of the main sites. Due to the geographical challenges and complexity of the service there is variation in service delivery due to staffing (locums and agency staff), facilities, medical illustration/photography, patient pathways, administrative processes, availability of medical records, IT (connectivity, hardware and software), management support and governance/safety.

A recent run of Serious Incidents (SI) and wrong-site surgery Never Events (NE) in the Dermatology Department in 2020 followed on from 3 wrong site surgical Never Events in 2017 and 2018.

Common themes occurring in these Never Events included the failure to follow the WHO safety checklist (especially regarding the site mapping of lesion sites and confirming said sites with photographs on file). Other issues arose around the use of teledermatology. In one case, the patient was unable to confirm which lesions were the ones for removal due to the initial appointment being conducted via teledermatology, leading to confusion as only one lesion was due to be removed and yet three were photographed.

Another factor to consider in these cases is that a locum plastic surgeon undertook two of the three operations, who may not have met the requisite standard of practice. Nursing staff were not listened to when the site for surgery was queried. Processes and checks were also not followed by the plastic surgeon.

The Dermatology Department undertook a BAD-led surgical service review which looked at all aspects of its service. The review found a Department and Service under severe strain with staff shortages, difficulty recruiting and retaining staff, reliance on temporary staff (locums and agency staff), variation – in processes, protocols, technical language, training, and team member status, a fragmented service in terms of multiple sites, multiple providers and management personnel and structure in transition, all during a period increasing demand. As with all healthcare services, this has been compounded by the Coronavirus Pandemic.

The recent wrong site surgery incidents are a symptom of all the above factors which increases greater opportunities for error. Reliable and resilient systems are built by reducing variation, promoting the development of safe behaviours, and supporting the exercise of responsibility and accountability.

Trust J

Dermatology Services for Trust J is provided across multiple sites with surgical procedures taking place at 2 of its main sites. Over the past decade, following 4 incidents of wrong site surgery, the trust has made significant changes to minimise risk through development of a protocol driven service implemented via our departmental clinical governance processes.

The trust's Standard Operating Procedure (SOP) was revised to capture all aspects of the skin surgery pathway, including special circumstances when deviation from initial protocol may be required. They have simplified and combined surgical and photography requests to avoid duplication, standardised lesion marking protocols and introduced an adapted WHO checklist in theatre. The trust has also recognised the importance of education and developed a mandatory e-learning package to reflect the SOP.

However, despite these measures, a further wrong site surgery was reported in 2020 (during COVID). Root cause analysis confirmed the surgical SOP had been adhered to with correct lesion marking, photography and multisource site identification. However, adaptations in the wake of the COVID-19 pandemic had not been considered, with mask wearing leading to smudging of the surgical marker. This incident demonstrates that despite reliable and resilient system development, the need to continually reevaluate and reassess services is paramount in a changing health care environment.