



Never Events:
From patient safety signal to
reliable clinical practice

QUALITY, SAFETY AND EXPERIENCE COMMITTEE

October 2026

Situation



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The purpose of this report is to provide the Quality, Safety and Experience Committee (QSEC) with assurance that Never Event learning is being converted into reliable clinical practice through the Health Board's Quality Management System (QMS), Patient Safety Plan and established governance routes.

Assurance offered | Make-safe action, investigation, Duty of Candour and local improvement are in place; QSIG is strengthening the closed loop from learning to implementation and impact.

How assurance is controlled | Quality, Safety Intelligence Group (QSIG) triangulates patient-safety intelligence, subgroups test clinical-effectiveness standards and measures, and Clinical Care Groups (CCG) evidence implementation, compliance and sustained improvement.

QSEC can take assurance | that an accountable cross-site programme is active, with exception reporting through QSIG and escalation where evidence, trajectory or implementation is insufficient.

Safety-II and QMS lens | *learning from harm is combined with insight from everyday work and reliable practice, linking quality planning, control, improvement and assurance.*



Recurring themes are becoming system controls

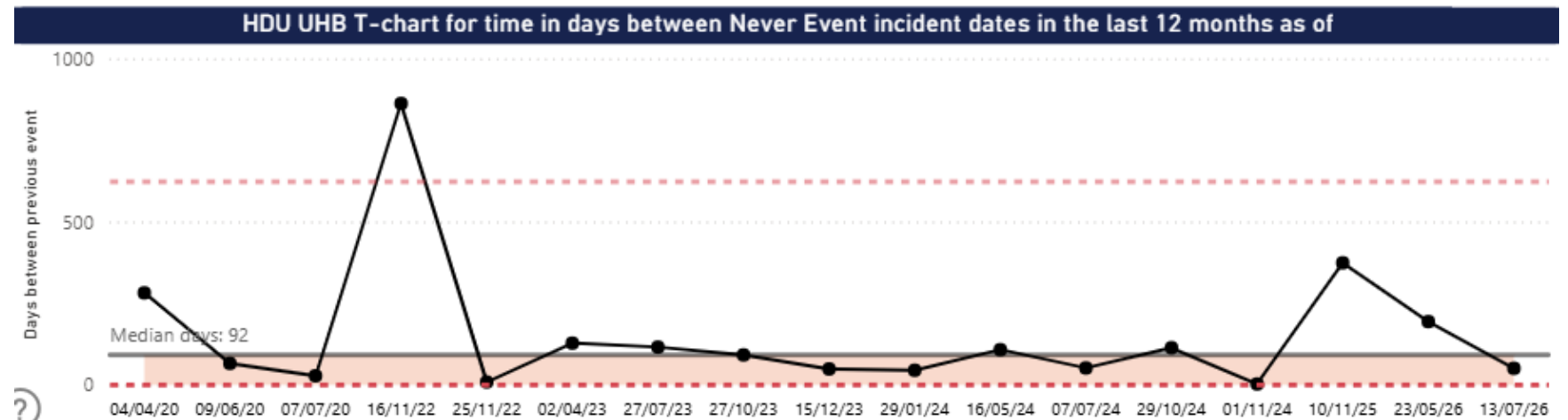


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Recurring Never Events have triggered a structured cross-site assurance and improvement response.

- **Current submitted position:** 16 events over six years; 13 closed and 3 open.
- **2026 concentration:** two retained items, one NG-tube event and one wrong implant.
- **Highest-volume themes:** retained items, wrong implants and NG-tube safety; recurring causes include procedural reliability, competency, documentation, human factors and weak challenge/escalation.
- **The QMS response:** patient safety identifies signals and system conditions; clinical effectiveness tests whether agreed controls are implemented, reliable and sustained.



Assurance is active while impact evidence develops



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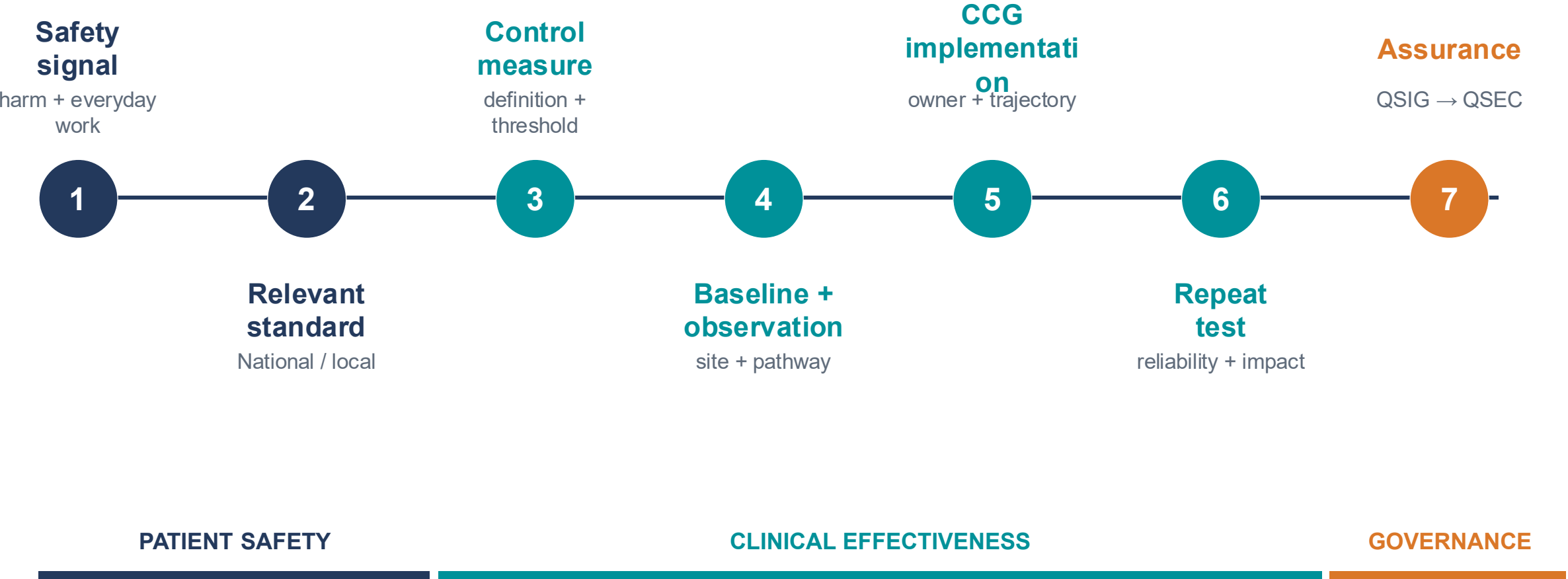
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Assurance available now: make-safe actions, investigations, Duty of Candour, NG huddles/checks and local control changes are in place.

- **Clinical-effectiveness strengthening:** QSIG is using the Effective Clinical Practice Advisory Panel and subgroup routes to define measures, test compliance and review repeat audit.
- **Clinical Care Group accountability:** CCGs own implementation, evidence controls, explain variation and confirm remedial action, ownership and timescales.
- **Safety-II approach:** event learning is combined with observation of everyday work, human factors and examples of reliable practice so changes fit the clinical system.
- **Governance route:** CCGs implement and report; subgroups provide expert scrutiny; QSIG triangulates and challenges; QSEC receives exception-based assurance.
- **QMS assurance:** planning, control, improvement and assurance are linked so activity is distinguished from measurable and sustained impact.



The QMS closes the loop from learning to assurance



QSEC receives assurance through QSIG (via the the Quality Assurance Report) when CCG implementation, subgroup scrutiny and repeat measurement show that learning is embedded and controls are reliable.

Clinical effectiveness tests delivery and impact



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Expected outcome: reliable safety-critical controls, reduced recurrence and confidence that learning is embedded in everyday practice.

- **1 Standard and control** | link each event to the national/local requirement and the safety-critical process that protects patients.
- **2 Measure set** | agree outcome, process, competency, exception and balancing measures with thresholds and reporting frequency.
- **3 Baseline and Safety-II insight** | combine audit with observation of how work is actually done across CCGs, sites, pathways and conditions.
- **4 CCG implementation** | standardise controls, build competence, address system barriers and evidence ownership, trajectory and local delivery.
- **5 Subgroup scrutiny** | the Effective Clinical Practice Advisory Panel and relevant groups test evidence, re-audit, exceptions and sustainability.
- **6 Assurance** | QSIG triangulates delivery and impact, holds CCGs to account and reports assurance or exceptions to QSEC (through the Quality Assurance Report).



Never events: 2020 to 31 August 2026



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16

REPORTED EVENTS CLOSED

11

CLOSED

3

LISTED OPEN

Scope: 16 reported Never Events from 2020–2026.

- **Organisational spread:** Planned Care (6), Integrated Medicine (5), Women & Children (4), and Mental Health & Learning Disabilities (1).
- **Reconciled category summary:** 7 retained items, 4 wrong implants, 3 NG-tube events, 1 wrong-route medication, 1 inpatient suicide.
- **Open line list:** 1 wrong implants, 1 NG-tube events, 1 retained item. They are all are dated 2026 and open within agreed investigation timescales.
- **Assurance implication:** QSIG is holding CCGs to account for implementing learning, with clinical-effectiveness scrutiny and repeat measurement used to evidence reliable practice.

See appendix for further detail

Controls are defined and implementation is under scrutiny



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Theme	Required control	Evidence now	Clinical-effectiveness test	Assurance
NG tubes	LocSSIP, care plan, competency, escalation	Briefings, huddles and checks reported; cross-site compliance not consolidated	Audit checklist adherence, competency and exceptions; repeat three-monthly	DEVELOPING
Implants	Three checks, final compatibility, loan-stock control	Changes reported; no consolidated observational compliance	Observe checks by site; audit loan stock, exceptions and corrective action	DEVELOPING
Retained items	Protected two-person count, reconciliation, escalation / imaging	Actions reported; sustained count reliability not yet proven	Observe count compliance; review escalation exceptions and recurrence	DEVELOPING

QSIG is tracking these evidence gaps through CCG assurance, the Effective Clinical Practice Advisory Panel and relevant subgroups; delayed implementation or weak evidence is escalated.

NG-tube assurance is being built through closed-loop testing



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- 1 Safety signal** Recurrent NG-tube events and vulnerability at verification, documentation and escalation.
- 2 Standard** Patient Safety Alert/Patient Safety Notice/NG standards, LocSSIP, care plan, competency and escalation controls.
- 3 Measures** Checklist adherence, competency coverage, point-prevalence, exceptions and site variation.
- 4 Change** Briefings, huddles, pilot and local controls — each with an accountable owner and date.
- 5 Proof** Repeat cross-site audit at the agreed threshold, exceptions closed and no preventable recurrence.

CURRENT POSITION

ACTIVE OVERSIGHT

Controls and improvement activity are in place.
QSIG and subgroups are consolidating sustained cross-site compliance.

CCGs evidence implementation; clinical effectiveness tests measures and re-audit; QSIG escalates exceptions.

Safety-II learning combines event review with how reliable care is achieved in everyday practice.

Safety-II and QMS strengthen reliability across the system

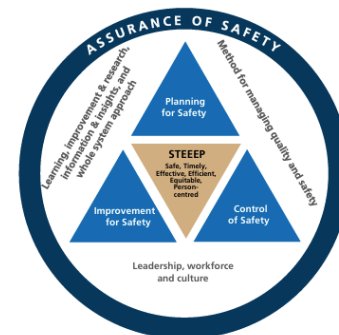


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Cross-cutting assurance: the response combines learning from harm with insight into how care succeeds, using the QMS to plan, control, improve and assure practice.

- **Safe** — standardised verification, counting, confirmation and escalation controls are being tested across NG, implant and retained-item pathways.
- **Timely** — QSIG tracks open investigations, exceptions and delayed implementation so learning cycles and risk reduction remain visible.
- **Effective** — clinical-effectiveness scrutiny links standards, competence, observation, audit and outcomes rather than relying on policy or training completion alone.
- **Efficient** — one controlled evidence route reduces duplicate reporting and directs improvement effort to variation, system barriers and unreliable controls.
- **Equitable** — CCG and site-level evidence identifies unwarranted variation and tests whether the same protection is dependable for every patient.
- **Person-centred** — Duty of Candour, patient/family experience and the practical impact of change remain part of the assurance judgement.
- **Human factors and culture:** the focus is on system conditions, speaking up, adaptability and spreading reliable practice—not attributing failure to individuals.



QSIG and subgroups assure QSEC



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Established cross-site programme — one controlled evidence base, one measure set and one governance route.

1 Controlled evidence | Quality Assurance Team and CCG leads reconcile Datix Cymru, action tracking, audit and local intelligence; QSIG reviews gaps, contradictions and confidence.

2 Open-case oversight | CCG owners maintain trajectories, remove barriers and provide evidence for investigations and improvement actions within agreed timescales.

3 Reliable controls | NG, implant and retained-item controls are standardised and tested through audit, observation, competency evidence and exception review.

4 CCG accountability | CCGs implement learning, evidence compliance and impact, explain variance, and confirm remedial action, ownership and timescales.

5 Clinical effectiveness | the Effective Clinical Practice Advisory Panel and relevant subgroups scrutinise standards, measures, audit/re-audit and sustainability.

6 QSIG to QSEC | QSIG triangulates Safety-II intelligence, tests delivery confidence, holds CCGs to account and escalates material exceptions to QSEC.

Assurance rule: QSEC receives confidence on the system and delivery route now, with the strength of impact assurance increasing as repeat evidence matures.

Assurance to QSEC

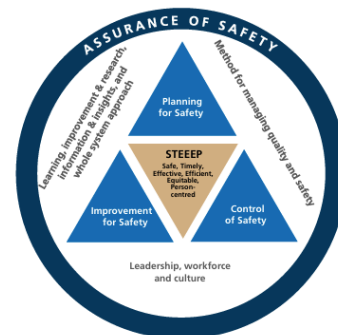


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The QSEC is asked to:

- **TAKE ASSURANCE** | that active QMS governance arrangements connect Never Event learning, clinical-effectiveness scrutiny, CCG implementation and exception escalation.
- **NOTE** | reasonable assurance is available on response, governance and improvement controls; evidence of sustained clinical impact is developing through repeat measurement.
- **RECOGNISE** | the Effective Clinical Practice Advisory Panel and relevant QSIG subgroups are testing standards, measures, audit, competence and sustainability.
- **NOTE CCG ACCOUNTABILITY** | CCGs own implementation of learning and must evidence compliance, improvement, impact, remedial action and trajectories through QSIG.
- **RECEIVE** | exception-based assurance from QSIG (through the Quality Assurance Report), including material gaps, off-trajectory delivery or unresolved barriers requiring QSEC visibility.
- **CONFIRM ALIGNMENT** | with Safety II, the Health Board Patient Safety Plan and the QMS disciplines of planning, control, improvement and assurance.



Appendix: reconciled Never Event register

Ref	Date reported	Type of Never Event	CCG	Service	Status of investigation
HDD31339	2022	Wrong implant	Planned Care	T&O	Closed
HDD28883	2022	Retained product	Women's & Child	Gynaecology	Closed
HDD36192	2023	Retained product	Women's & Child	Obstetrics	Closed
HDD42362	2023	Wrong implant	Integrated Medicine	Medicine	Open
HDD47110	2023	Wrong implant	Planned Care	Ophthalmology	Closed
HDD49612	2023	Retained product	Women's & Child	Obstetrics	Closed
HDD51775	2024	Retained product	Integrated Medicine	Cardiology	Closed
HDD56679	2024	Wrong route medication	MH&LD	Inpatient Bryngolau	Closed
HDD58850	2024	Retained product	Women's & Child	Obstetrics Planned	Closed
HDD63532	2024	Inpatient Suicide	Integrated Medicine	Emergency Services	Closed
HDD72355	2024	NG	Planned Care	Critical Care	Open
HDD79894	2025	NG	Integrated Medicine	Emergency Services	Closed
HDD85819	2026	Retained	Planned Care	Theatres	Closed
HDD89857	2026	NG	Integrated Medicine	Gen Medicine	Open
HDD89763	2026	Wrong implant	Planned Care	Orthopaedics	Open
HDD90025	2026	Retained	Planned Care	Theatres	Open

Source: Datix Cymru 07/09/2026

HDU UHB Never Events occurring (by incident date, Jan-20 to Aug-26)																			
Year	2020												2021						
Never Event	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	.
Administration of medication by the wrong route	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Retained foreign object post procedure	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
Self harm - in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Wrong implant/prosthesis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Wrong site surgery	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Total Never Events	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	

HDU UHB Never Events occurring (by incident date, Nov-22 to Mar-24)																		
Year	2022					2023								2024				
Never Event	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Retained foreign object post procedure	1	0	0	0	0	1	0	0	1	0	0	0	0	1	1	0	0	
Wrong implant/prosthesis	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	
Total Never Events	2	0	0	0	0	1	0	0	1	0	0	1	0	1	1	0	0	

HDU UHB Never Events occurring (by incident date, Apr-24 to Aug-26)																				
Year	2024										2025									
Never Event	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Administration of medication by the wrong route	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	
Retained foreign object post procedure	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Self harm - in-patient	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	
Wrong implant/prosthesis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total Never Events	0	1	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	

HDU UHB Never Events occurring (by incident date, Sep-25 to Aug-26)														
Year	2025					2026								
Never Event	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug		
Misplaced naso- or oro-gastric tubes	0	0	0	0	0	0	0	0	1	0	0	0		
Retained foreign object post procedure	0	0	1	0	0	0	0	0	0	0	0	0		
Wrong implant/prosthesis	0	0	0	0	0	0	0	0	0	0	1	0		
Total Never Events	0	0	1	0	0	0	0	0	1	0	1	0		

Source: Beacon Dashboard 11/09/2026



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The Duty of Candour

Openness and honesty should be at the heart of every relationship between those providing treatment and care and those experiencing it.



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SAFE | SUSTAINABLE | ACCESSIBLE | KIND