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Summary Report for the Leng Review

Significant and Never Events Involving Medical Associate Professionals

CMAPs College of Medical Associate Professionals

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Abstract

This study presents the findings from a Freedom of Information (FOI) request that was sent to 215 UK NHS Trusts requesting data on patient safety incidents (Significant and Never Events) for a six-year period, with details on the involvement of any PAs and AAs. The total number of doctors, nurses, PAs, and AAs employed over those years was also requested. Based on data from 39 responding trusts, PAs accounted for a very small proportion of the reported workforce (0.34%) and were involved in only three Significant Events (0.02%) and no Never Events across the six-year period. There were no responses from trusts with AAs in their workforce.

Introduction

In response to the Leng Review, the College of Medical Associate Professionals (CMAPs) have initiated a national data request to NHS trusts across the UK to gather patient safety information regarding Physician Associates (PAs) and Anaesthesia Associates (AAs) (collectively termed Medical Associate Professionals or MAPs). The primary objective of this study is to analyse the frequency of Significant and Never Events reported within NHS trusts and to investigate any potential associations between these events and the presence of MAPs within clinical teams. Additionally, this review seeks to determine whether MAPs are directly involved in these safety incidents, thereby providing insights into their role in patient safety outcomes.

Patient safety is a fundamental priority for the NHS. Never Events - defined as serious, wholly preventable patient safety incidents that should never occur if proper procedures are followed (1) - serve as key indicators of system vulnerabilities, alongside reporting of Patient Safety Incidents.

These are defined as unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients (and include incidents previously known as Serious Incidents) (2). By systematically reviewing trust-level data, this study aims to assess whether there is any measurable impact of MAPs on significant and never events, contributing to ongoing discussions about their role in NHS service delivery and safety.

An effective patient safety incident response system integrates four key principles according to NHS England Patient Safety Incident Response Framework (PSIRF) (2):

1. Compassionate engagement and involvement of those affected by patient safety incidents;
2. Application of a range of system-based approaches to learning from patient safety incidents;
3. Considered and proportionate responses to patient safety incidents; and
4. Supportive oversight focused on strengthening response system functioning and improvement.

The emphasis is therefore on learning from events and addressing vulnerabilities in the system to improve patient safety, as well as transparency and accountability, rather than focusing on blaming individuals; and hence it may be difficult to demonstrate individual culpability from the way the data is reported.

This research is a critical component of the wider Leng Review, which seeks to provide a comprehensive evidence base for evaluating the integration and effectiveness of MAPs within the NHS workforce. The findings will contribute to policy discussions and workforce planning efforts aimed at optimising patient safety and care quality.

Methodology

An FOI request was sent to 215 NHS Trusts within the UK asking for data for the six financial years 2019/20 to 2024/25. The request sought information on the number of significant and never events recorded in each trust, using definitions provided by NHS England (1,2). For each event and category, they were asked to report the involvement of PAs or AAs in any significant events or never events. Trusts were also asked to include total number of doctors, nurses, PAs, and AAs employed over those years.

Descriptive statistics were analysed using Microsoft Excel. Incomplete datasets were included in the analysis.

Results

To date, 39 trusts (18%) responded to the information request, and responses are included in Appendix 1. None of the responding trusts have any AAs in their workforce.
There were 14065 Significant Events and 430 Never Events recorded. The trusts employed a total of 398 PAs and 116,338 doctors and nurses in total, meaning PAs account for 0.34% of the workforce reported on these forms.

Some trusts do not record details of staff involved in Never Events. Of the 23 trusts who do record details of staff involved in events, three Significant Events involved PAs (0.02%). These came from three different trusts, two which employed an unknown number of PAs and one which employed 20 PAs. None of the Never Events involved a PA.

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Discussion & Conclusion

The PSIRF key principles of maintaining an effective patient safety incident response system on learning from events in a compassionate manner, addressing vulnerabilities in the system to improve patient safety, as well as transparency and accountability, rather than focusing on blaming individuals. The various trust incident reporting systems such as Datix and IRIS may not therefore facilitate the reporting of an individual to 'blame' for incidents, but rather whether they were involved in the case in some way. Unfortunately, in a small number cases where a MAP has been involved in a patient safety incident, this has attracted significant negative media attention on the whole profession, in a way that does not happen for other professions. Individual MAPs have been blamed wholly and the lack of compassionate engagement with those affected by patient safety incidents goes against the key principles of the PSIRF.

This study provides an initial insight into the relationship between PAs and patient safety incidents within NHS Trusts. Based on data from 39 responding trusts, PAs accounted for a very small proportion of the reported workforce (0.34%) and were involved in only three Significant Events (0.02%) across the six-year period. No Never Events were reported to involve a PA. Due to the time constraints of the Leng Review we did not request data on the nature of these Significant Events so currently there is no information available as to the type of event or details of the impact of the PAs' quality of work and professional practice on patient safety.

Due to the limited number of responses, we cannot determine if number of PAs employed in a trust has an association with an increase in Significant or Never Events, however the few events recorded in association with a PA (0.02%) is reassuring. The limitations of this study - including incomplete trust responses, and a small number of respondents - necessitate cautious interpretation.

Additionally, there was no AA data reported, so we cannot draw any conclusions on MAPs overall. Further research, incorporating a broader dataset and qualitative investigation, is needed to comprehensively assess the impact of MAPs on patient safety. We will be following up this preliminary study with further FOI requests on the nature of any adverse events involving MAPs, and their involvement, that were identified from the initial responses.

Declaration of Interest

All authors are MAPs.

References

1. NHS Improvement Never Events Policy and Framework, revised January 2018.
2. NHS England Patient Safety Incident Response Framework (PSIRF) 23rd July 2024.

Appendix 1: Significant Events and Never Events reported by NHS Trusts and number of Doctors, PAs, and nurses employed

NHS Trust	Significant events (N)	Never Events (N)	PAs employed (N)	Doctors employed (N)	Nurses employed (N)	Significant Events caused by PAs (N)	Never Events caused by PAs (N)	Significant Events caused by PAs (%)	Never Events caused by PAs (%)	PA proportion of workforce (%)
Alder Hey Children's NHS Foundation Trust	55	10	10	400	1400	0	0	0	0	0.552
Barnsley Hospital NHS Foundation Trust	144	--	--	--	--	1	0	0.69	--	--
Blackpool Teaching Hospitals NHS Foundation Trust	251	11	7	631	2888	0	0	0	0	0.199
Bolton NHS Foundation Trust	107	8	<5**	442	2200	--	--	--	--	0.189
Croydon Health Services NHS Trust	--	1	--	--	--	--	0	--	0	--
East Cheshire NHS Trust	945	7	1	270	883	--	--	--	--	0.087
East Lancashire Hospitals NHS Trust	476	18	--	--	--	0	0	0	0	--
East Sussex Healthcare NHS Trust	174	15	6	802	2460	0	0	0	0	0.184
Alder Hey Children's NHS Foundation Trust	55	10	10	400	1400	0	0	0	0	0.552

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NHS Trust	Significant events (N)	Never Events (N)	PAs employed (N)	Doctors employed (N)	Nurses employed (N)	Significant Events caused by PAs (N)	Never Events caused by PAs (N)	Significant Events caused by PAs (%)	Never Events caused by PAs (%)	PA proportion of workforce (%)
Frimley Health NHS Foundation Trust	426	24	0	--	--	0	0	0	0	--
George Eliot Hospital NHS Trust	71	8	13	409	820	0	0	0	0	1.047
King's College Hospital NHS Foundation Trust	720	28	20	2760	5179	--	--	--	--	0.251
Lancashire Teaching Hospitals NHS Foundation Trust	396*	--	--	--	--	1	0	0.25	--	--
Leeds Teaching Hospitals NHS Trust	367	<5**	49	3090	5438	--	--	--	--	0.571
Liverpool Heart and Chest Hospital NHS Foundation Trust	29	2	4	148	674	0	0	0	0	0.484
Liverpool Women's NHS Foundation Trust	628	5		140	878	0	0	0	0	0.000
Medway NHS Foundation Trust	--	10	7	796	1522	--	--	--	--	0.301
Mid Cheshire Hospitals NHS Foundation Trust	230	9	17	464	1565	--	--	--	--	0.831

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NHS Trust	Significant events (N)	Never Events (N)	PAs employed (N)	Doctors employed (N)	Nurses employed (N)	Significant Events caused by PAs (N)	Never Events caused by PAs (N)	Significant Events caused by PAs (%)	Never Events caused by PAs (%)	PA proportion of workforce (%)
Norfolk and Norwich University Hospitals NHS Foundation Trust	1213	27	15	1359	2660	0	0	0	0	0.372
North Cumbria Integrated Care NHS Foundation Trust	4	7	10	647	2443	0	0	0	0	0.323
Northern Care Alliance NHS Foundation Trust	1200	10	20	1800	6200	1	0	0.08	0	0.249
Oxford University Hospitals NHS Foundation Trust	337	22	12	3149	4870	0	0	0	0	0.149
Royal Cornwall Hospitals NHS Trust	167	16	8	1081	1960	--	--	--	--	0.262
Royal National Orthopaedic Hospital NHS Trust	18	6	2	231	440	--	--	--	--	0.297
Royal Papworth Hospital NHS Foundation Trust	140	2	3	281	781	0	0	0	0	0.282
Royal United Hospitals Bath NHS Foundation Trust	514	12	8	770	1835	--	--	--	--	0.306
Sheffield Children's NHS Foundation Trust	88*	--	3	520	1085	0	0	--	--	0.187

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NHS Trust	Significant events (N)	Never Events (N)	PAs employed (N)	Doctors employed (N)	Nurses employed (N)	Significant Events caused by PAs (N)	Never Events caused by PAs (N)	Significant Events caused by PAs (%)	Never Events caused by PAs (%)	PA proportion of workforce (%)
South Tees Hospitals NHS Foundation Trust	461	--	2	1075	3464	--	--	--	--	0.044
The Clatterbridge Cancer Centre NHS Foundation Trust	18	2	1	128	502	0	0	0	0	0.158
Rotherham NHS Foundation Trust	240	<5**	<5**	400	1500	--	--	--	--	0.262
The Royal Wolverhampton NHS Trust	527	6	28	1500	3200	--	0	--	0	0.592
University Hospitals Coventry and Warwickshire NHS Trust	1999	23	10	1400	3200	0	0	0	0	0.217
University Hospitals of Derby and Burton NHS Foundation Trust	425	--	8	1602	4469	--	--	--	--	0.132
University Hospitals of Leicester NHS Trust	208	32	21	2534	5270	--	--	--	--	0.268
University Hospitals of North Midlands NHS Trust	--	28	4	1500	3773	0	0	--	0	0.076
University Hospitals Plymouth NHS Trust	390	25	46	1540	3086	--	--	--	--	0.985

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NHS Trust	Significant events (N)	Never Events (N)	PAs employed (N)	Doctors employed (N)	Nurses employed (N)	Significant Events caused by PAs (N)	Never Events caused by PAs (N)	Significant Events caused by PAs (%)	Never Events caused by PAs (%)	PA proportion of workforce (%)
Worcestershire Acute Hospitals NHS Trust	707	27	22	--	45	--	--	--	--	32.836
Wrightington, Wigan and Leigh NHS Foundation Trust	24	4	10	500	2000	0	0	0	0	0.398
Wye Valley NHS Trust	366	10	11	613	1156	--	--	--	--	0.618
York and Scarborough Teaching Hospitals NHS Foundation Trust	--	5	10	1047	2463	--	0	--	0	0.284
Total	14065	430	398	34029	82309	3	0	0.021	0	0.34

** Trusts reported <5 for these values, but 5 was used for analysis
*The serious events and never events were collectively reported as serious events by these Trusts

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