Harm Events in the North East and North Cumbria

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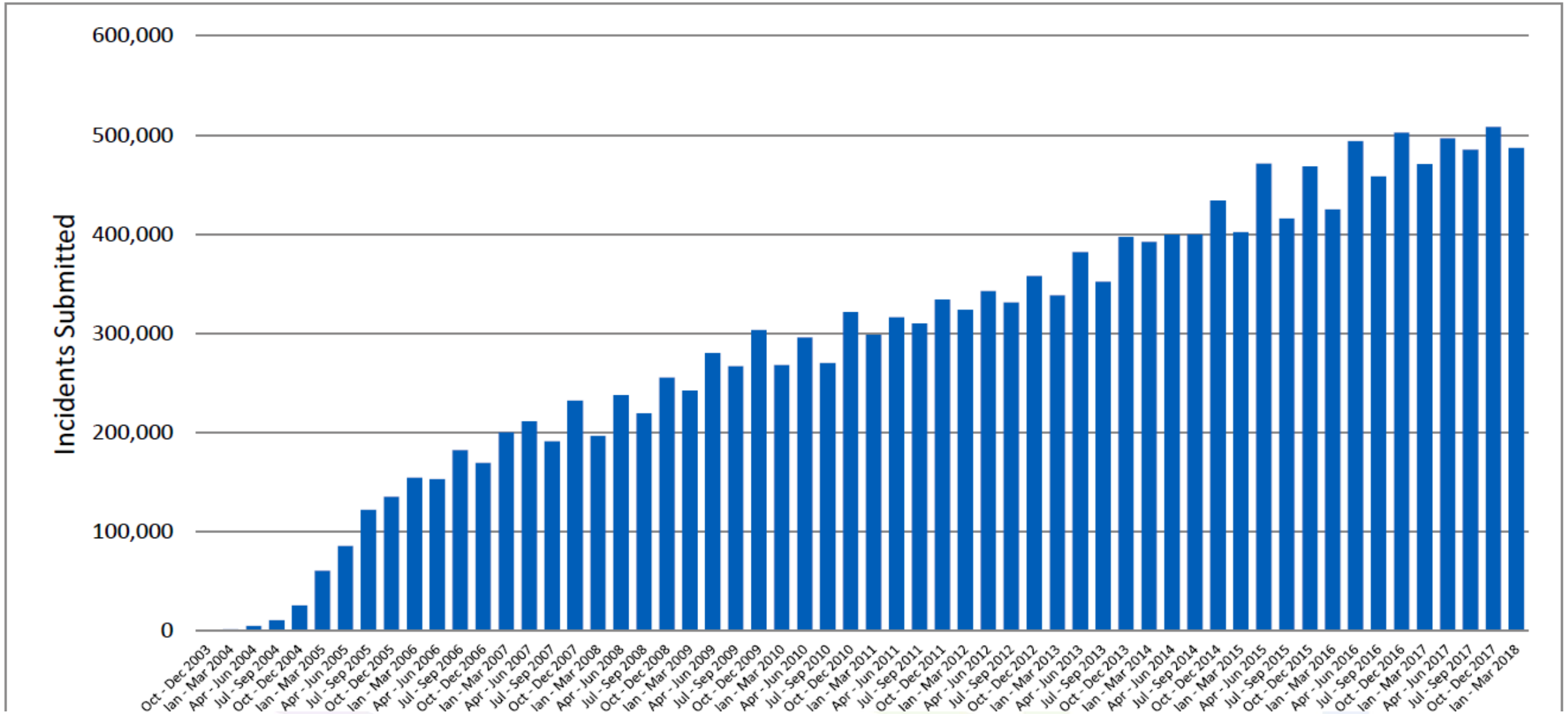
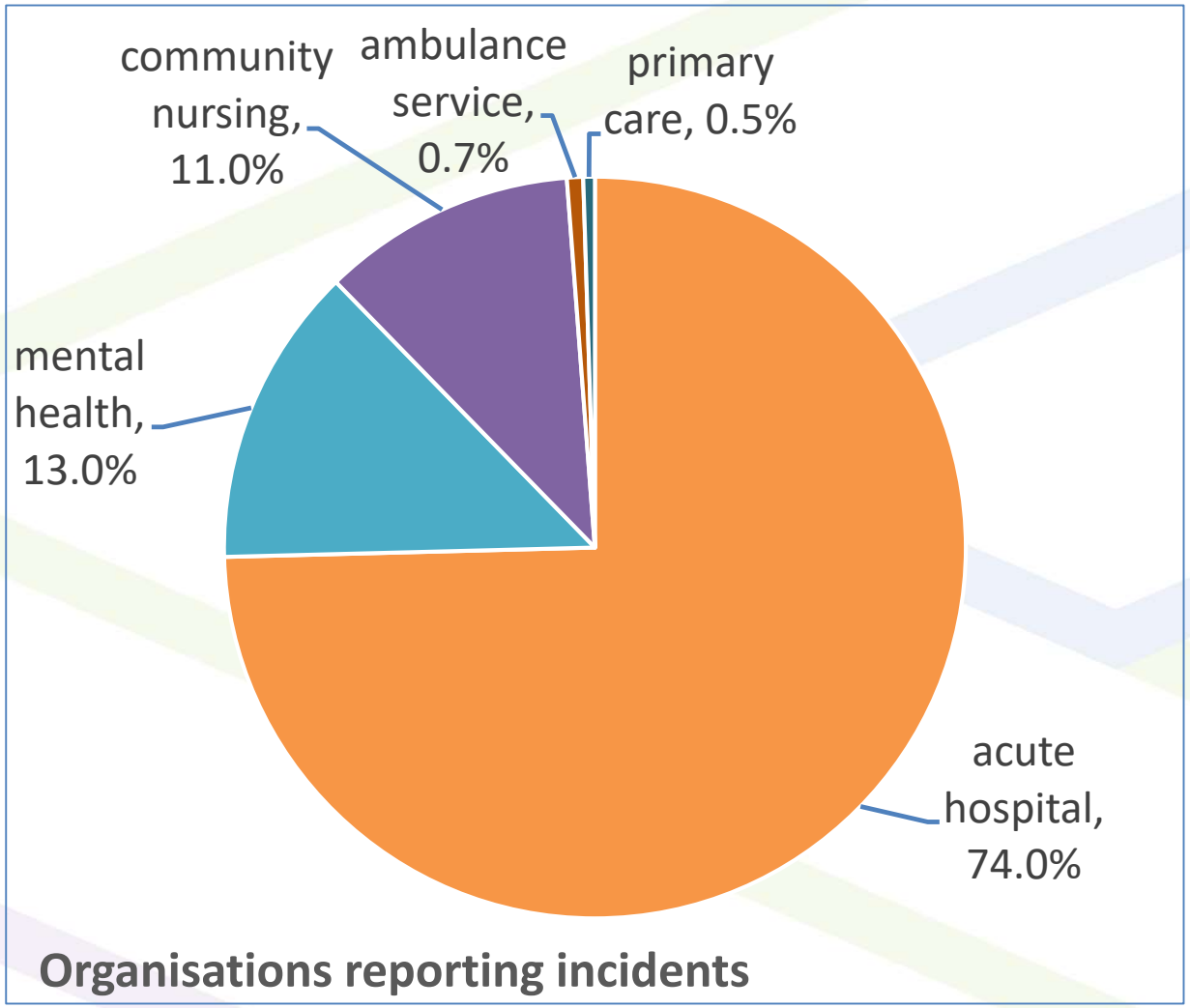
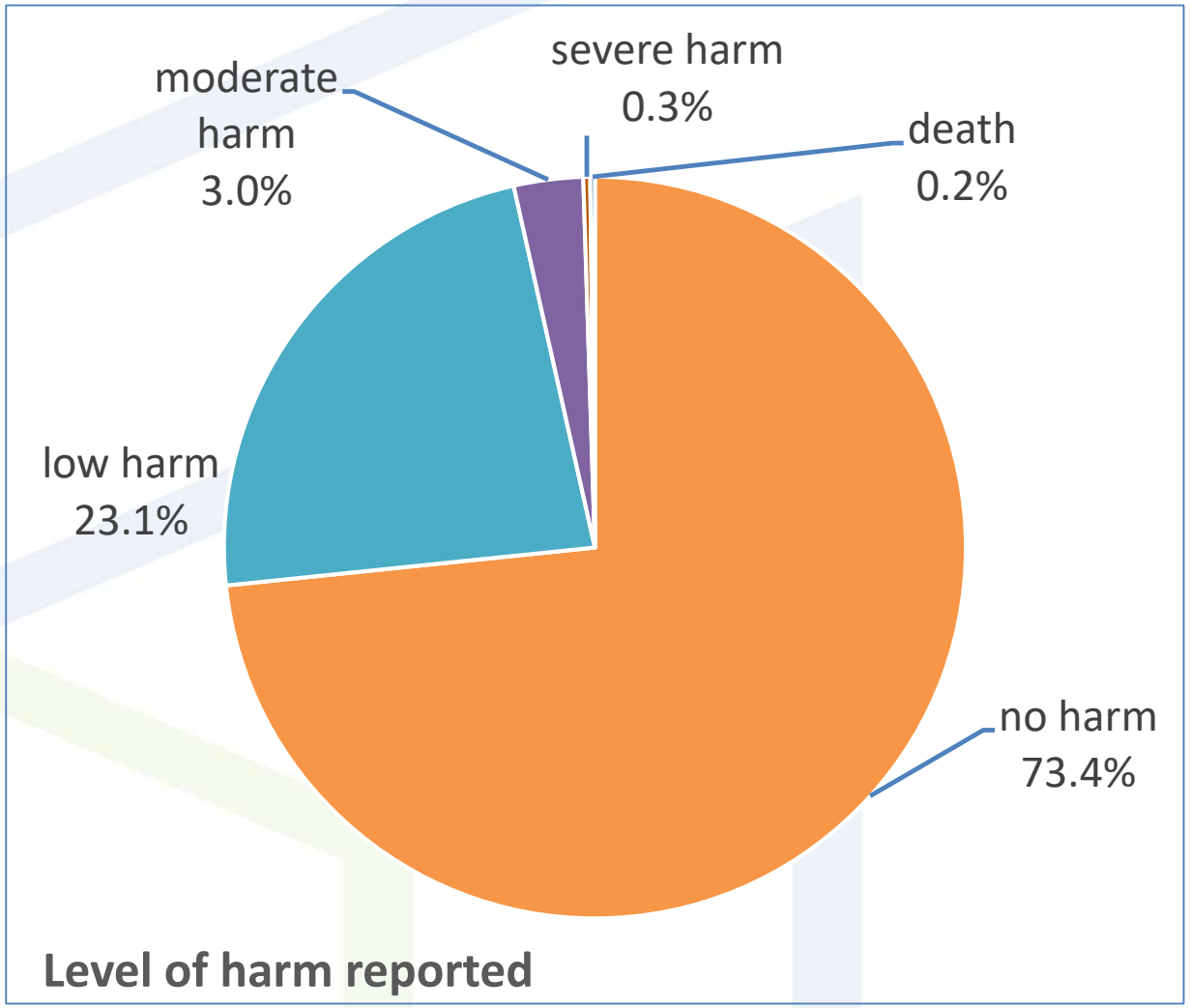
Number of incidents reported to the NRLS in England.



Incident data – source and severity



Organisations reporting incidents



Level of harm reported

Incidents reported by category in England over the last two years

Incident category	April 2016 to March 2017		April 2017 to March 2018		% change
	N	%	N	%	
Patient accident	307,975	16.5	296,194	15.3	–3.8
Implementation of care and ongoing monitoring/review	252,640	13.6	270,416	13.9	7.0
Access, admission, transfer, discharge (including missing patient)	197,540	10.6	225,713	11.6	14.3
Medication	198,943	10.7	204,162	10.5	2.6
All other incident categories	904,483	48.6	945,694	48.7	4.6
Total	**1,861,581**	**100**	**1,942,179**	**100**	**4.3**

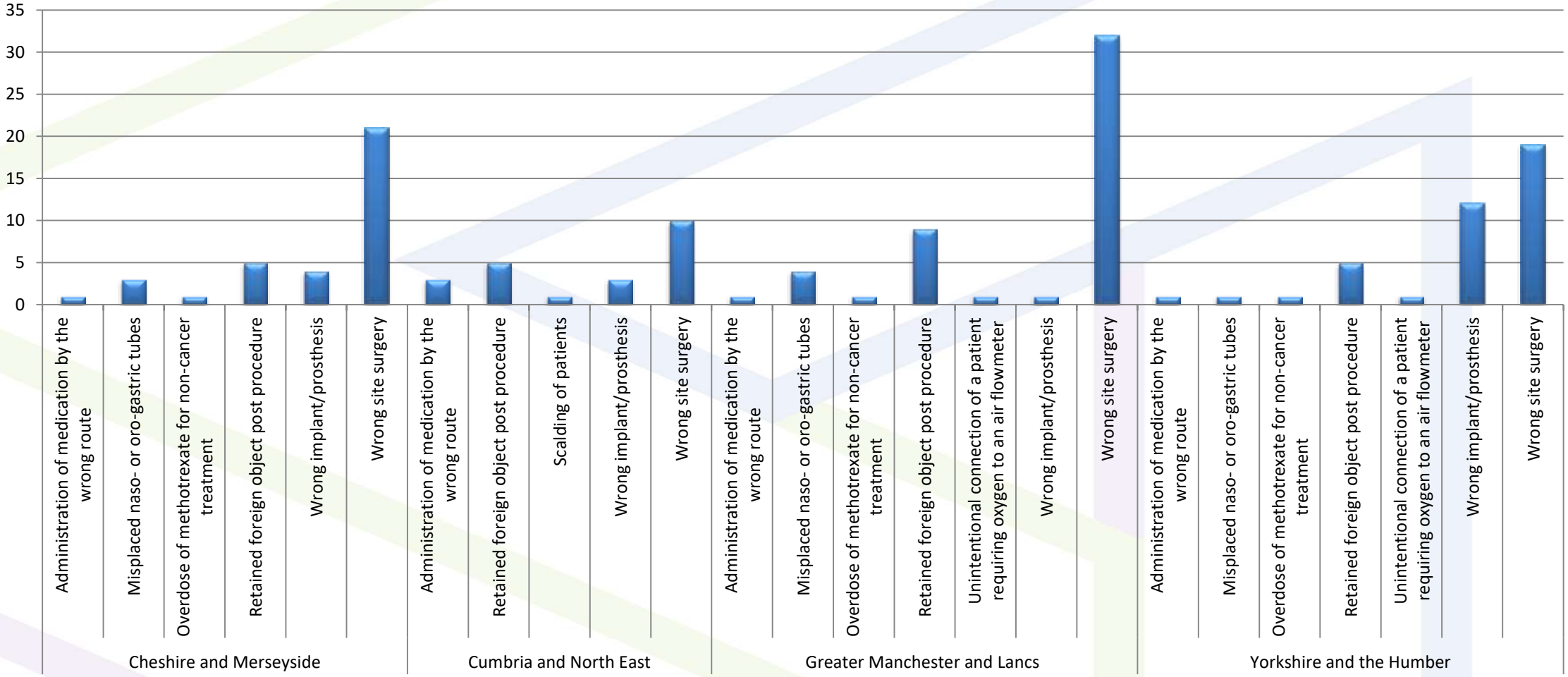
Serious Incidents

"serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response."

Serious Incident Framework 2015

In 2017/18 there were 826 serious incidents reported in Cumbria and the North East

Never Events by sub-region

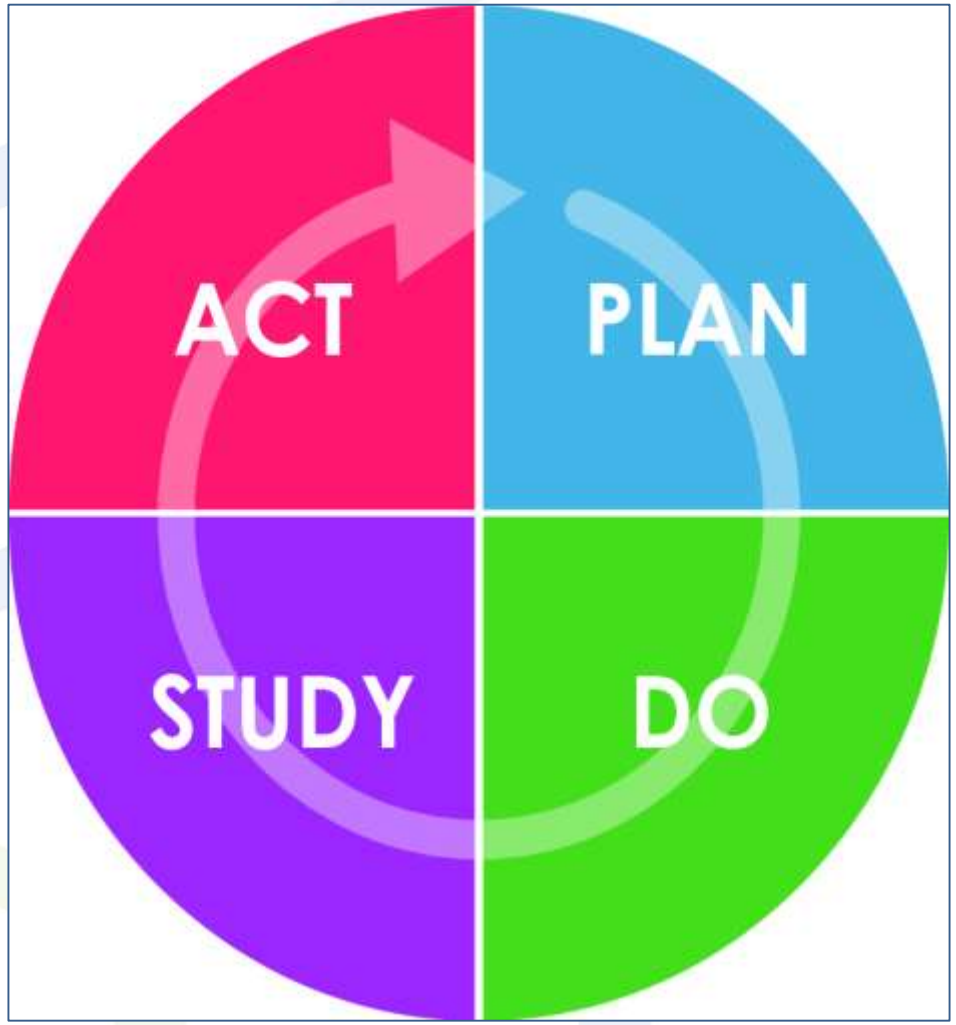


Never Events in Cumbria and the North East 2017/1819

- 3 wrong administration of medicine
- 5 retained foreign object
- 1 scalding of patient
- 3 wrong implant / prosthesis
- 10 wrong site surgery

Investigations and learning

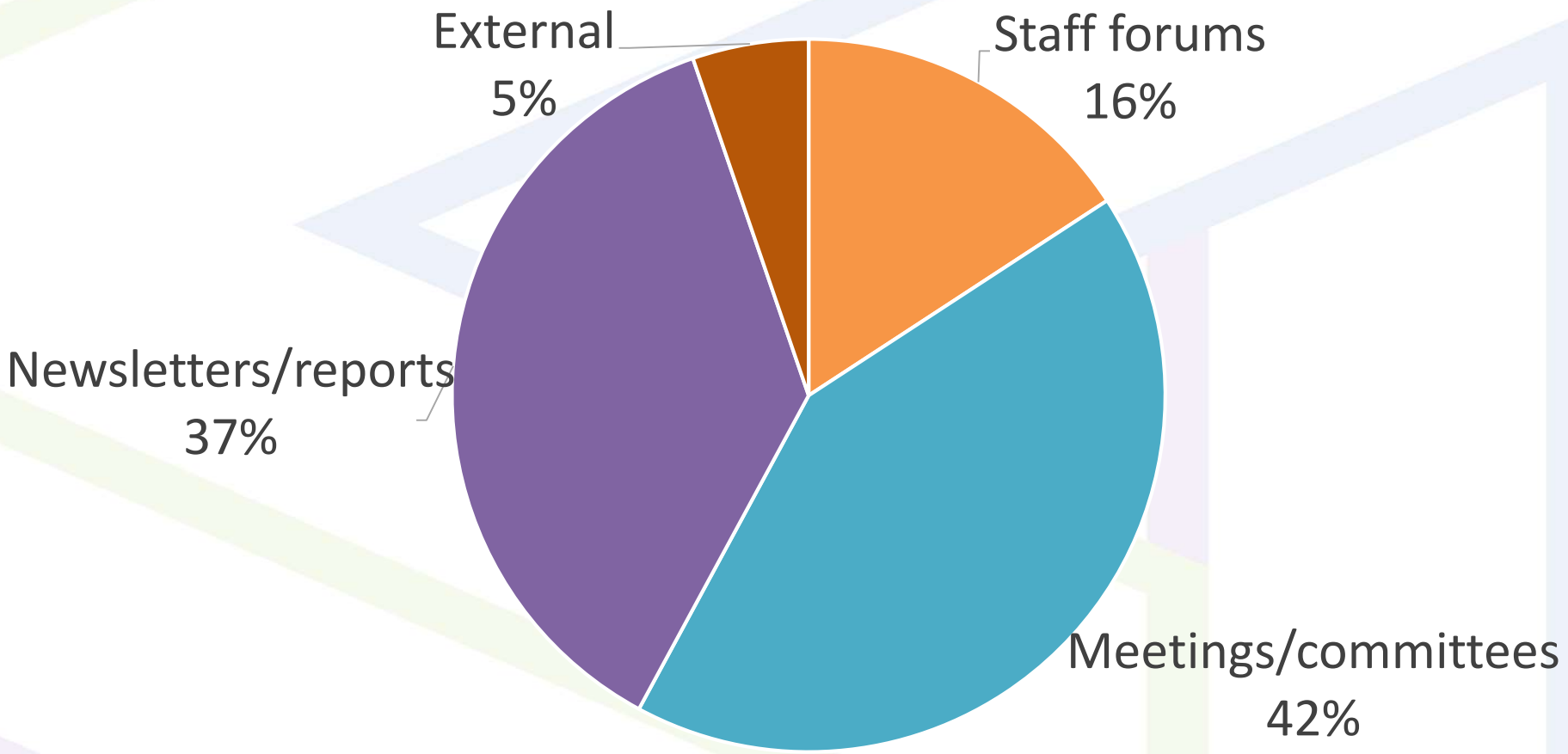
In 2017/18 the equivalent of 881 working days was spent investigating and reporting serious incidents and never events in Cumbria and North East.



Are we making a difference?

What works?

Safety Culture Survey Findings – how are lessons from investigations shared



Sharing problems and solutions

"There is clearly a need for more effective ways of sharing problems and solutions across trusts: for example, when issues relating to medical devices are identified, what alternatives do other trusts use and what is included in their count policies, etc.."

Surgical Never Event Review, NHSI Sept 2018

"Patients may suffer harm in one healthcare setting, despite the fact that others have knowledge, systems and processes that could have avoided it."

Patient Safety Learning Green Paper September 2018