Ref: CCG 45245

NHS
Liverpool
Clinical Commissioning Group
Corporate Services
NHS Liverpool Clinical Commissioning Group
The Department
Lewis's Building
Renshaw Street
Liverpool
L1 2SA

Email: foi@liverpoolccg.nhs.uk

26th February 2018

Dear,

Re: Freedom of Information Request

Thank you for your Freedom of Information request that we received on 6th February, with regards to serious incidents and governance.

Request/*Response*

1) **Have you got a Serious Incident (S.I.) policy/SOP/procedure/strategy in place?**
    a. **If so, could you provide a link or copy of it?**

    Response
    The CCG is guided by the NHS England Serious Incident Framework (2015). This is due to be reissued by NHSE in March 2018; the CCG will adopt this new framework when it is available

    The CCG SI policy is in draft and is therefore not available as yet. This will be updated when the revised SI Framework is published, it will then be approved and be made available on the CCG website

2) **How many S.I.'s have you reported in last 4 years (a yearly break- down)?**
    a. **What type of S.I. was it (no detail required)? I.e. the 'heading'**

    Response
    Please see the table attached as Appendix 1.

3) **What training do you have in place for Root Cause Analysis (RCA) / S.I.'s?**
    a. **How many people do you have in the teams dealing with these incidents?**
    b. **How many of them have been trained?**

c. **Who currently provides that training?**
d. **How frequently do you carry out the training (annually, quarterly etc.)?**
e. **Who (which group/body) does your incident /S.I. investigations?**

Response
The CCG does not currently run RCA training.

4) **Do you have an appropriate committee / group / body in place to discuss incidents / SIs?**
   a. **If so, who does that for you?**
   b. **Where do they sit (Federation, CCG, Trust etc.)?**

Response
The CCG has a Clinical Safety and Serious Incident Meeting. This meeting forms part of the CCG governance structure and reports up to the Quality, Safety and Outcomes Committee which is a sub-committee of the Governing Body.

5) **Do you have a CQC standards framework checking process?**
   a. **How frequently is this done?**
   b. **Do you have a patient's experience/participation team? If so, how are they involved?**

Response
All CQC reports for General practice are reviewed by the Primary Care Quality Manager. On publication, for practices with 'requires improvement' or 'inadequate' ratings, the practice is supported to develop and implement an action plan prior to any re-inspection by CQC.

The CCG does not have a patient experience team per se, however patient experience is a focus for all commissioning decisions and is a key area for the CCG quality teams.

6) **CCG relevant - Is there a set GP contract which has elements of incidents /SI compliance in it?**

Response
This is included in the GMS Core Contract Requirements as per 'the Contractor shall have an effective system of clinical governance'.

We wish to take this opportunity to inform you that a formal complaints and internal review procedure is available to applicants who are unhappy with responses provided to FOI requests. You can formally request an internal review within a reasonable period of time (2 calendar months) from the date this response was issued.

Where you are not satisfied with the decision of the internal review you may apply directly to the Information Commissioners Office (ICO) for a further review of that decision. Generally, the ICO cannot make a decision unless you have exhausted our complaints procedure in the first instance.

The ICO can be contacted at:

Information Commissioners Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

www.ico.gov.uk

Should you require any further information, clarification regarding this response or do not feel that your request has been answered as you would expect, please contact us to discuss.

Yours sincerely,

Customer Relations Lead
NHS Liverpool CCG

Appendix 1 – Response to Q2

Year	StEIS Category	Number of reports
2014/15	Pressure ulcer Grade 3	100
	Not available	79
	Pressure ulcer Grade 4	50
	Child Death	24
	Slips/Trips/Falls	24
	Delayed diagnosis	15
	Other	15
	Suicide by Outpatient (in receipt)	15
	Suspected suicide	11
	Wrong site surgery	10
	Confidential Information Leak	8
	Surgical Error	7
	Unexpected Death of Community Patient (in receipt)	7
	Drug Incident (general)	6
	Abscond	5
	Allegation Against HC Professional	5
	Failure to act upon test results	5
	Admission of under 18s to adult mental health ward	4
	Allegation Against HC Professional (assault)	4
	Unexpected Death of Inpatient (not in receipt)	4
	Assault (unknown assailant)	3
	Child Serious Injury	3
	Maternity Services - Intrauterine death	3

Year	StEIS Category	Number of reports
	Maternity Services - Unexpected admission to NICU (neonatal intensive care unit)	3
	Medical equipment failure	3
	Sub-optimal care of the deteriorating patient	3
	Suicide by Inpatient (in receipt)	3
	Unexpected Death (general)	3
	Adverse media coverage or public concern about the organisation or the wider NHS	2
	Assault by Inpatient (not in receipt)	2
	Attempted Suicide by Outpatient (in receipt)	2
	C.Diff & Health Care Acquired Infections	2
	Communication issue	2
	Death in custody	2
	Homicide by Outpatient (in receipt)	2
	Maternity service	2
	Maternity Services - Intrapartum death	2
	Safeguarding Vulnerable Child	2
	Serious Self Inflicted Injury Inpatient	2
	Suicide	2
	Unexpected Death of Inpatient (in receipt)	2
	Ward Closure	2
	Admission of under 16s to adult mental health ward	1
	Assault by Inpatient (in receipt)	1
	Assault by Outpatient (in receipt)	1
	Attempted Suicide by Inpatient (in receipt)	1
	Child Abuse (family)	1

Year	StEIS Category	Number of reports
	Critical Care Transfer	1
	Drug incident (Insulin)	1
	Fire (accidental)	1
	Maternity Services - Unexpected neonatal death	1
	MRSA Bacteraemia	1
	Outpatient appointment delay	1
	Premature discharge	1
	Radiology/Scanning incident	1
	Safeguarding Vulnerable Adult	1
	Screening issues meeting SI criteria	1
	Serious Incident by Inpatient (in receipt)	1
	Serious Incident by Inpatient (not in receipt)	1
	Serious Incident by Outpatient (in receipt)	1
	Serious Incident by Outpatient (not in receipt)	1
	Slips/trips/falls meeting SI criteria	1
	Sub-optimal care of the deteriorating patient meeting SI criteria	1
	Suicide by Inpatient (not in receipt)	1
	Suicide by Outpatient (not in receipt)	1
	Unexpected Death of Community Patient (not in receipt)	1
	Unexpected Death of Outpatient (not in receipt)	1
2015/16	Pressure ulcer meeting SI criteria	108
	Apparent/actual/suspected self-inflicted harm meeting SI criteria	50
	Slips/trips/falls meeting SI criteria	22
	Pending review (a category must be selected before incident is closed)	19
	Pressure ulcer Grade 3	19

Year	StEIS Category	Number of reports
	Surgical/invasive procedure incident meeting SI criteria	17
	Disruptive/aggressive/violent behaviour meeting SI criteria	14
	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	12
	HCAI/Infection control incident meeting SI criteria	11
	Unauthorised absence meeting SI criteria	11
	Medication incident meeting Si criteria	9
	Abuse/alleged abuse of adult patient by staff	8
	Abuse/alleged abuse of adult patient by third party	7
	Confidential information leak/information governance breach meeting SI criteria	7
	Slips/Trips/Falls	7
	Treatment delay meeting SI criteria	7
	Sub-optimal care of the deteriorating patient meeting SI criteria	6
	Adverse media coverage or public concern about the organisation or the wider NHS	5
	Maternity/obstetric incident meeting SI criteria: baby only (this includes foetus neonate and infant)	5
	Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	4
	Suspected suicide	4
	Child Death	3
	Pressure ulcer Grade 4	3
	Retained foreign object post-procedure	3
	Abscond	2
	Abuse/alleged abuse of child patient by third party	2
	Attempted Homicide by Outpatient (in receipt)	2
	Attempted Suicide by Inpatient (in receipt)	2
	Death in custody	2
	Environmental incident meeting SI criteria	2

Year	StEIS Category	Number of reports
	Radiation incident (including exposure when scanning) meeting SI criteria	2
	Screening issues meeting SI criteria	2
	Surgical Error	2
	Wrong site surgery	2
	Abuse/alleged abuse of child patient by staff	1
	Admission of under 18s to adult mental health ward	1
	Apparent/actual/suspected homicide meeting SI criteria	1
	Assault by Inpatient (in receipt)	1
	Assault by Outpatient (in receipt)	1
	Attempted Homicide by Outpatient (not in receipt)	1
	Attempted Suicide by Outpatient (in receipt)	1
	Blood product/transfusion incident meeting SI criteria	1
	Confidential Information Leak	1
	Delayed diagnosis	1
	Drug Incident (general)	1
	Failure to obtain appropriate bed for child who needed it	1
	Homicide by Inpatient (in receipt)	1
	Maternity service	1
	Maternity Services - Intrauterine death	1
	Maternity/obstetric incident meeting SI criteria: mother and baby (this includes foetus neonate and infant	1
	Maternity/obstetric incident meeting SI criteria: mother only	1
	Medical equipment failure	1
	Medical equipment/devices/disposables incident meeting SI criteria	1
	Misplaced naso or oro-gastric tubes	1
	MRSA Bacteraemia	1

Year	StEIS Category	Number of reports
	Operation/treatment given without valid consent	1
	Other	1
	Serious Self Inflicted Injury Outpatient	1
	Sub-optimal care of the deteriorating patient	1
	Unexpected Death of Community Patient (in receipt)	1
	Unexpected Death of Outpatient (in receipt)	1
	VTE meeting SI criteria	1
2016/17	Pressure ulcer meeting SI criteria	101
	Pending review (a category must be selected before incident is closed)	69
	Apparent/actual/suspected self-inflicted harm meeting SI criteria	46
	Surgical/invasive procedure incident meeting SI criteria	21
	Slips/trips/falls meeting SI criteria	19
	Treatment delay meeting SI criteria	12
	Unauthorised absence meeting SI criteria	11
	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	10
	Disruptive/aggressive/violent behaviour meeting SI criteria	8
	Abuse/alleged abuse of adult patient by third party	7
	Maternity/obstetric incident meeting SI criteria: baby only (this includes foetus neonate and infant)	7
	Confidential information leak/information governance breach meeting SI criteria	6
	Abuse/alleged abuse of adult patient by staff	4
	Environmental incident meeting SI criteria	4
	Maternity/obstetric incident meeting SI criteria: mother and baby (this includes foetus neonate and infant	4
	Maternity/obstetric incident meeting SI criteria: mother only	4
	Medication incident meeting Si criteria	4

Year	StEIS Category	Number of reports
	Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	3
	Apparent/actual/suspected homicide meeting SI criteria	3
	HCAI/Infection control incident meeting SI criteria	3
	Sub-optimal care of the deteriorating patient meeting SI criteria	3
	VTE meeting SI criteria	3
	Abuse/alleged abuse of child patient by third party	2
	Commissioning incident meeting SI criteria	2
	Major incident emergency preparedness resilience and response/suspension of services	2
	Medical equipment/devices/disposables incident meeting SI criteria	2
	Failure to obtain appropriate bed for child who needed it	1
	Screening issues meeting SI criteria	1
	Substance misuse whilst impatient meeting SI criteria	1
	Wrong implant/prosthesis	1
	Wrong route administration of medication	1
2017/18 to date	Pressure ulcer meeting SI criteria	109
	Apparent/actual/suspected self-inflicted harm meeting SI criteria	59
	Pending review (a category must be selected before incident is closed)	22
	Surgical/invasive procedure incident meeting SI criteria	17
	Diagnostic incident including delay meeting SI criteria (including failure to act on test result)	16
	Medication incident meeting SI criteria	14
	Treatment delay meeting SI criteria	14
	Slips/trips/falls meeting SI criteria	15
	Unauthorised absence meeting SI criteria	8
	Confidential info leak/IG breach meeting SI criteria	7
	Abuse/alleged abuse of adult patient by staff	6

Year	StEIS Category	Number of reports
	Sub-optimal care of the deteriorating patient meeting SI criteria	6
	Accident e.g. collision/scald (not slip/trip/fall)meeting SI criteria	5
	Disruptive/aggressive/violent behaviour meeting SI criteria	4
	HCAI/infection control incident meeting SI criteria	4
	Abuse/alleged abuse of adult patient by third party	3
	Commissioning Incident Meeting SI criteria	3
	Maternity/Obstetric incident meeting SI criteria: baby only	3
	VTE meeting criteria	3
	Adverse media coverage or public concern about the organisation or the wider NHS	2
	Apparent/actual/suspected homicide meeting SI criteria	2
	Diagnostic incident including delay meeting SI criteria	2
	Maternity/Obstetric incident meeting SI criteria: mother and baby	2
	Maternity/Obstetric incident meeting SI criteria: mother only	2
	Medical equipment/ devices/ disposables incident meeting SI criteria	2
	Environmental incident meeting SI criteria	1
	Operation/treatment given without valid consent	1