NHS
Liverpool Women's
NHS Foundation Trust

Patient Safety Incident Response Plan (PSIRP)

Patient safety incident response plan

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	NAME	TITLE	SIGNATURE	DATE
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Foreword

The Patient Safety Incident Response Framework (PSIRF) is a much more measured and focussed approach to how The Trust respond to patient safety incidents. There will need to be a clear cultural and systems shift in thinking and how the Trust effectively respond to patient safety incidents, to reduce the risk of an incident happening again as much as possible. Within the Serious Incident Framework, there were set timescales to complete an investigation within 60 days and external organisations often approved the Trust investigative plan and strategy – PSIRF provides the Trust with more autonomy and flexibility in its' approach to patient safety incidents.

Effective initial implementation and ongoing effective development of PSIRF will be achieved through identifying key themes patterns and trends from Trust data, identifying opportunities for effective learning, ensuring those plans in plans in place are progressed immediately, over the medium and longer term. These will be reviewed and re-evaluated where tangible evidence is produced to provide effective assurance that the Trust can demonstrate effective learning, sustainable improvements in the quality and safety of services and improved patient safety outcomes, demonstrable though data.

Effective engagement is a key fundamental of PSIRF. Clear communication from the incident developing (near miss) or occurring cannot be underestimated, with patients, families, carers, or advocacy. Ongoing effective communication to determine the focus of any review or investigation is vital to ensure that the voice of the patient is at the heart of the Trust response throughout and post closure. Documentation of clear communication and engagement is vital.

The process of reviewing or investigating an incident, in accordance with the Trust Fair and Just Culture, and providing psychological safety to encourage openness and transparency throughout, can help colleagues reflect the decisions they made in caring for and treating a patient and facilitate closure.

The Trust acknowledges that PSIRF is a new approach to patient safety incidents but much of the requirements have been part of business as usual for some time. The implementation process will take time to progress and embed and will require regular review to ensure the Trust can demonstrate positive assurance in tangible improvements to the quality and safety of services with improved patient safety outcomes. Data quality and the flexibility of the Trust approach will need to be at the heart of the implementation process to ensure it is continuous evolution.

The Trust in its' entirety is ready to embrace PSIRF and the challenges ahead.

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Introduction

This patient safety incident response plan sets out how Liverpool Women's NHS Foundation Trust (the Trust) intends to respond to patient safety incidents over a period of 24 months.

The plan will not be rigid and will be subject to ongoing review, which will be data driven. The patients' view will be at the heart of the Trust's approach with the focus on the quality and safety of services that the Trust offer and achieving the best possible outcomes for patients and colleagues.

The plan is underpinned by the existing Trust Managing Incidents and Serious Incidents Policy, which is currently under review and the new Trust patient safety incident response policy.

A glossary of terms used can be found at Appendix 1

Our services

Liverpool Women's NHS Foundation Trust (the Trust) specialises in the health of women, babies and their families.

As one of only two such specialist trusts in the UK and the largest women's hospital in Europe the trust holds a unique position.

The main hospital, a modern landmark building, is located on Crown Street in Toxteth and it is here that the team deliver around 8,000 babies and perform some 10,000 Gynaecological procedures each year.

The maternity team cares for women and their babies from conception to birth supported by the neonatal team who provide around the clock care for premature and new born babies needing specialist care.

The trust's fertility team helps families to improve the chance of conceiving babies. In gynaecology, the trust undertakes care of women with the many varied conditions associated with the female reproductive system and is a centre for gynaecology oncology.

The genetics team supports families with the diagnosis and counselling of genetic conditions.

On average 20 babies and three premature babies are born and cared for daily, the trust is primarily known for maternity and neonatal services.

The trust also carries out 30 gynaecology operations and the reproductive medicine unit completes six cycles of IVF treatment every day.

The trust also specialises in clinical and laboratory genetics.

The trust offers choice and flexibility through the provision of both NHS and private care

Defining The Trust patient safety incident profile

Fair and Just Culture is at the heart of all of the Trust Governance processes. This promotes an open and transparent culture to identify and understand patient safety incidents and a desire to learn from and improve the quality and safety of services.

The Trust has a daily huddle to discuss all reported incidents across the Divisions, a weekly safety check in meeting to discuss quality and safety issues, Executive Led weekly Trust Harm meeting, a Quality Improvement Group with the focus on actions from learning, audit and effectiveness, and a monthly Safety and Effectiveness Sub Committee to review, discuss and have oversight of key safety issues. All these collectively, underpin the Trust quality strategy.

PSIRF sets the national requirements listed within the plan. The remainder of the plan is data driven, covering the last 3 years which has provided an insight into the key patient safety incident themes, patterns and trends, repeat causality and the greatest opportunities for learning to improve patient safety outcomes.

The Corporate Governance Team has engaged with internal and external key stakeholders, having reviewed Trust wide data from various sources to determine the Trust safety profile and identify the optimum methods of review to ensure maximum learning and effective plans to improve the quality and safety of services.

The team commenced planning for PSIRF in September 2022 and have consulted with East Lancashire NHS Trust as an early adopter to assist with the planning process and to learn from them what went well, what didn't work well and what guidance they could provide. This was in addition to consultations with Birmingham Women's and Children's NHS Trust as the other specialist Trust to Liverpool Women's in the Country and all local Trusts who were commencing their PSIRF implementation journey.

The team have had a number of regular engagement meetings with the Integrated Care Board (ICB) both on a one-to-one basis whilst still the Clinical Commissioning Group (CCG) and regularly as part of a local collaborative with other Trusts since the implementation of the ICB.

Internally, a number of presentations have been presented to Board colleagues to ensure that they were fully appraised and understood the impact and PSIRF and their associated responsibilities. Presentations have also been taken to the Trust Safety and Effectiveness Sub Committee, Quality Committee and Trust Safety Meeting to ensure that all colleagues had oversight on the progress of PSIRF implementation.

Divisional engagement meetings on a weekly basis have been undertaken with Divisional Governance Colleagues and have been presented on a scheduled basis to Divisional Boards and Senior Leadership Teams to determine and agree Divisional profiles and to ensure that they were too appraised and understood the impact and PSIRF and their associated responsibilities

The data sources used to define the trust profile are outlined below. In order to determine the focus and priorities for PSII, there have been a number of stakeholder engagement sessions to prioritise, agree and finalise the Trust priorities (subject to ongoing review).

The Trust utilise the Ulysses Incident Management System to manage incidents. The Corporate Governance Team collated data on all incidents from 01 April 2020 to 31 March 2023 to ensure the data was reflective of pre / during and post Covid incident reporting to minimise any potential impact from the pandemic on incident reporting.

In addition to incidents, a number of data sources were collated and reviewed to ensure that the Trust focus included but was not limited to those incidents reported on to the Ulysses System. These sources included:

- Serious Incident Investigations (last 5 years)
- Health inequalities data (associated with SI review)
- Formal Reviews
- HSIB investigations
- Complaints / PALS / PALS+
- Safeguarding reviews
- Mortality reviews
- Freedom to speak up concerns
- Trust staff survey annual results
- Legal claims (new / ongoing / settled)
- Inquests
- Quality improvement and Service evaluation projects
- Clinical audits – initial and reaudit
- PMRT

The Ulysses data for the reporting period contained 19920 incidents, of which, 18363 were deemed to be patient safety incidents. Of these, there were 18021 clinical incidents, that were as follows by Division / Directorate:

- Maternity Directorate – 9378
- Neonates Directorate – 1658
- Gynaecology Division – 5444
- Clinical Support Services Division - 1541

This data was considered during the divisional engagement sessions with incident categories (cause group) and subcategories (cause group 1) within the themes to determine the overall Trust profile. The Trust profile, in turn, is underpinned by Divisional priorities for Patient Safety Incident Investigations.

Investigations	3332
Clinical Management	2819
Admission / Discharge / Transfer	1361
Staffing Levels	1311
Communication	1300
52 Week RTT Breach	1282

Medication	1219
Diagnosis	746
Appointments	743
Patient Records / Identification	677
Equipment	662
Haemorrhage	438
Blood Transfusion	291
Injury	211
Infection	171
Cancellations - Theatres	149
Unexpected Death	114
Invasive Procedure Problem	110
IT Problems	108
Service Provision And/or Interruption	107
Failed Instrumental Delivery	102
Patient Safety / Experience	92
Covid-19	73
Resuscitation	70
Complaint	70
Unattended Birth	69
62 Day Cancer Breach	67
Safeguarding Children	65
Feeding Issue	61
Slips Trips And Falls	54
Environment	48
Safeguarding Adults	41
Standard/audit Deficit	37
104 Day Cancer Breach	34
Pressure Ulcer	31
Information Governance	27
Midwifery Red Flag	27
Interpretation Services	26
Security	23
Non-Physical Assault	20
Allergic Reaction	19
Transport Problem	18
Ambulance Related	15
Access To Gynaecology Emergency Theatre	15
Expected Death	15
Sharps	14
Surgical Count	10
Peripartum Morbidity	9
Medicines Fridges	8
Convulsions	8
Thromboembolism	8
Failed Regional Technique	6

Manual Handling	5
COSHH	5
Self-Harming Behaviour	4
Professional Registration Issue	3
Unexplained Organ Damage	3
Human Resources	3
Fire Incident	2
Nursing Red Flag	1
Collision/Contact	1
Physical Assault	1
Pulmonary Oedema	1
Splash	1
Grand Total	**18363**

The Trust profile, however, must retain flexibility in its approach to risk and learning, and therefore, where there is significant risk, opportunities for significant new learning and impacts on quality and safety of services, the Trust will retain capacity for additional PSII outside of the Trust profile where required.

Defining the Trust patient safety improvement profile

The Trust has developed strong governance processes across the Clinical divisions and the Corporate Governance Team and continues to review its' governance processes to ensure that they remain fit for purpose, ensure that patient safety is the focus and that there remains an ongoing process of effective learning, continuous improvement within a fair and just culture. The Trust will also continue to embrace national and regional guidance and support from NHS organisations, Regulators, Commissioners and Partner Agencies.

The Trust Quality Committee will retain oversight of quality improvement measures and safety improvement plans to ensure that they remain of the highest standard. Its' subcommittee, The Safety and Effectiveness Sub Committee will ensure that the clinical and corporate divisions provide robust assurance to learning and safety improvement plans, ensuring that the process of embedded learning from PSIRF continues. The quality Improvement Group will ensure that the clinical and corporate divisions provide robust assurance to quality improvement, in accordance with the Trust Quality Strategy.

The Trust will continue to ensure that quality and safety of services is paramount to the investigations that it undertakes in accordance with National and Local Priorities and that its' approach remains flexible to new risk and significant opportunities for learning.

Patient safety incident response plan: national requirements

Quality and Safety of services and effective learning will remain the focus for the Trust, improving patient safety outcomes and reducing repeat causality of incidents.

Never events and deaths, where there are perceived deficiencies in care, will clearly require a Patient Safety Incident Investigation to identify and maximise opportunities for learning. Other incident types will also require a Patient Safety Incident Investigation mandated nationally.

All investigations will be undertaken in accordance with the Trust fair and just culture.

In addition to a Patient Safety Incident Investigation, some incident types will require specific reporting and/or review processes to be followed. All types of incidents that have been nationally defined as requiring as specific response will be reviewed according to the suggested methods.

Incident	Process	Quality and Safety Improvement
Maternity and neonatal incidents meeting HSIB, PMRT and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to Healthcare Safety Investigation Branch (HSIB) & PMRT	Respond to recommendations from external referred agency/organisation as to underpin the Trust Quality Strategy
Child death	Refer for Child Death Overview Panel (CDOP) and liaise with panel as locally led PSII may be required	
Death of a person who has lived with a Learning Disability or autism	Refer for Learning Disabilities Mortality Review (LeDeR) liaise with ICB (LeDeR Local Area Co-ordinator) as locally led PSII may be required	
Safeguarding incidents in which: Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. Adults over 18 years old are in	Refer to local authority safeguarding lead via LWHFT named safeguarding lead LWHFT will contribute to domestic independent inquiries, joint targeted area	

receipt of care and support needs from their local authority. The incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence.	inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and the local safeguarding adults boards	
Domestic homicide	Identified by the police usually in partnership with the local community safety partnership with whom the overall responsibility lies for establishing review of the case. Where the CSP considers that the criteria for a domestic homicide review are met and establishment of a DHR panel, LWHFT will contribute as required by the DHR panel.	
Incidents in screening programmes	Work with partners to ensure cases are referred to Public Health England (PHE)	
Patient Safety incidents meeting the Never Event criteria 2018 or its replacement	Patient Safety Incident Investigation	Local / Divisional / Trust wide recommendations and actions to underpin the Trust Quality Strategy
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies, where there is reason to think that the death may be linked to problems in care	Patient Safety Incident Investigation	Respond to recommendations from external referred agency/organisation as to underpin the Trust Quality Strategy
Patient safety incidents resulting in death where the death is thought more likely than not to be due to problems in care	Patient Safety Incident Investigation	Respond to recommendations from external referred agency/organisation as to underpin the Trust Quality Strategy

Trust patient safety incident response plan: Divisional focus

Trust requires 6 patient safety priorities as local focus based on the analysis of the data that has driven and underpinned this Patient Safety Incident Response Plan in addition to 2 Trust Priorities relating to being an isolated site and the host of the Regional Community Diagnostic Centre. All outcomes from Patient Safety Incident Investigations and other learning responses will be used to inform and underpin Patient Safety and Quality workstreams and associated Trust Policies and Strategies.

Incident	Process	Quality and Safety Improvement
Future Generations isolated site incidents including critical care transfers	Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
Community Diagnostic Centre associated incidents (to be queried on a case-by-case basis)	Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	
1. Admission / discharge / transfer issues (Communication, appointments, delays in discharge, delays in admissions/transfers)	Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
2. Clinical management / Diagnosis (including deteoriating patients and escalation) / Treatment (including retained products) / delays to follow up / imaging incidents	Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
	Patient Safety Incident	Local / cross divisional /

3. Skin injuries (grade2, 3 and 4 pressure ulcers / unexplained injuries)	Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
4. Invasive procedure problems including injury following surgery	Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
5. Medication prescribing and administration	Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
6. Equipment failure	Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy
Incident resulting in moderate or severe harm to patient	Statutory Duty of Candour and: Patient Safety Incident Investigation where agreed or appropriate learning response tool kit, I.e. After Action Review, MDT or Swarm Huddle (detail provided in associated LWHFT policies)	New / ongoing improvement plan focussing on Quality and Safety Thematic review where required (data driven) Local / cross divisional / Trust wide / National recommendations and actions and these will underpin the Trust Quality Strategy

No/Low Harm Patient Safety Incident	Local and thematic review	New / ongoing improvement plan focussing on Quality and Safety Thematic review where required (data driven)

Glossary of terms

PSIRF - Patient Safety Incident Response Framework. This is a national framework applicable to all NHS commissioned outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents, and sustainably reducing future risk.

PSIRP - Patient Safety Incident Response plan. The Trust Local plan sets out how we will carry out the PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads supported by analysis of local data.

PSII - Patient Safety Incident Investigation. PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to effectively and sustainably address those system factors and help deliver safer care for our patients.

AAR – After action review. A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

SJR - Structured judgement review Originally developed by the Royal College of Physicians. The Trust follows the Royal College of Psychiatrists model for best practice in mortality review. The SJR blends traditional, clinical judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase. This allows the Trust to identify deaths assessed as more likely than not due to problems in care. This allows the Trust to identify those deaths which may need to progress to PSII according to the given national priorities.

SWARM - Used within Healthcare in the UK and US, a SWARM approach allows for the rapid review of an incident – staff swarm to a discussion and where possible the location of an incident to allow for it to be explored on a systemic basis and to support those immediately involved.

Never Event - Patient safety incidents that are considered to be 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 provider