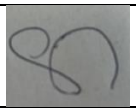
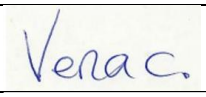
Liverpool Women's
NHS Foundation Trust

Patient safety incident response plan 2025/26

Effective date: March 2025 Estimated review date: March 2026

	NAME	TITLE	SIGNATURE	DATE
Author(s)	Clare-Louise Murray	Head of Governance		**28/03/2025**
	Rachel McFarland	Associate Medical Director for Patient Safety and Quality		**07/03/2025**
Reviewer	Vera Cabral	Deputy Director of Nursing & AHPs		07/03/2025
Authoriser	Dianne Brown	Director of Nursing		**08/04/2025**

Liverpool Women's NHS Foundation Trust

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Introduction

This patient safety incident response plan sets out how Liverpool Women's NHS Foundation Trust (referred to as the Trust) intends to respond to patient safety incidents reported by staff, patients and their families over a period of 12 months to March 2026. The Trust is part of University Hospitals of Liverpool Group which includes Liverpool University Hospitals NHS Foundation Trust, Aintree University Hospital, The Royal Liverpool University Hospital, Broadgreen Hospital, Liverpool University Dental Hospital and Liverpool Clinical Laboratories.

This specific plan relates to the activity undertaken at the Liverpool Women's NHS Foundation Trust and does not currently include PSIRF related activity undertaken at the other sites that are part of the Group. Consideration will be given to the development of a joint plan and this will take place on or before the date of the next annual PSIRP review.

The plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected. This will be supported by the work that is done at the Trust to continually improve the quality and safety of the care that is provided across the services.

This document should be read in conjunction with the Trust's Patient Safety Incident Response Policy which supports the core aims of the Patient Safety Incident Response Framework:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-cased approaches to learning from patient safety incidents
- Considered and proportionate response to a patient safety incident
- Supportive oversight focused on system improvement

The policy sets out how the Trust will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

Focusing on the four aims of PSIRF the Trust strive to improve the experience of anyone involved in a patient safety incident. Compassionate engagement and involvement of those affected by patient safety incidents and the application of a range of system-based approaches to learning from patient safety incidents allow the maturing of the Just Culture at the Trust.

Liverpool Women's
NHS Foundation Trust

Our Services

Liverpool Women's NHS Foundation Trust specialises in the health of women, babies and their families both in the hospital and in the community. The Liverpool Women's Hospital joined the University of Liverpool Hospitals Group in November 2024 with a shared vision to work together to deliver outstanding healthcare.

The Liverpool Women's Hospital has a range of specialist services and is the UK's largest single site maternity hospital. The main hospital, a modern landmark building, is located on Crown Street in Toxteth and it is here that the team deliver around 7,200 babies, perform some 50,000 Gynaecological inpatient and outpatient procedures each year, care for over 1,000 poorly and premature newborns, perform around 1,000 IVF cycles and conduct over 4,000 genetics appointments. The Trust has an extensive portfolio of research and innovation supported by a dedicated team.

The maternity team care for pregnant people from conception to the birth of their babies. On average there are 20 babies born per day at the Trust, with an additional three babies born prematurely and requiring care in the Neonatal Unit. The Trust is one of three Maternal Medicine Centres in the Northwest Maternal Medicine Network, facilitating safer outcomes and better birth experience for mothers and babies with medical conditions. The Neonatal Unit is a recognised centre of excellence and is part of the Cheshire and Mersey Neonatal Network providing care for babies form the local community, the Isle of Man, North Wales and other areas of the country.

The Trusts fertility team help provide families with the best chance of a successful pregnancy. There has been significant financial investment allowing the Hewitt Centre for Fertility to develop as one of the largest units in the country, performing over 3,000 treatment cycles a year across its two sites.

The Trust offer an extensive range of specialist gynaecology services, undertaking care of patients with the many varied conditions associated with the female reproductive system. The Trust is a regional centre for cancer services and part of the Cheshire and Mersey Cancer Network. Gynaecology encompasses specialist services including: Urogynaecology, early pregnancy, recurrent miscarriage, endometriosis and adolescent services.

The Trusts hosts the Liverpool Centre for Genomic Medicine serving a population of 2.8 million across Merseyside, Cheshire and the Isle of Man. This is supported by the Genetic Laboratory Service based at the Trust.

As well as the services outlined above there are dedicated imaging, pharmacy and physiotherapy teams. The Liverpool Women's Hospital opened the Community Diagnostic Centre (CDC) in December 2022 with a permanent on site CT and MRI scanner which supports all divisions and reduces the transfer to patients off-site for diagnostic tests. In 2025 the CDC will be able to support imaging of babies from the Neonatal Unit further improving the services offered on site.

Defining The Trust Patient Safety Incident Profile

The Trust is committed to undertaking high quality learning responses to all incidents, to ensure continuous improvement across our services and sustainable reductions in the frequency of incidents and their associated opportunity to harm our patients. The national Patient Safety Incident Response Framework (PSIRF) sets out the opportunity for us to ascertain our local highest risk areas, and to ensure both investigation focus, and improvement resource is directed towards those areas of greatest risk and therefore need. These local priorities sit alongside national priorities that require continued focus, for example, incident that meets the criteria of a 'never event.'

A core element of the development and annual review of our Patient Safety Incident Response Plan was to undertake a retrospective analysis of previously reported incidents together with data from claims, complaints, and cultural surveys. As part of the 12-month review, a further analysis of data, covering the first 12 months under PSIRF has been completed.

Data Sources

The data analysis reviewed multiple sources covering the key areas below:

- Serious Incident Investigations (last 5 years, prior to PSIRF)
- Health inequalities data (associated with SI review, now under the LSPFE)

- MNSI investigations (and prior HSIB reports)
- Complaints / PALS / PALS+
- Safeguarding reviews
- Mortality reviews
- Freedom to Speak Up concerns
- Trust Staff Survey annual results
- Legal Claims (new / ongoing / settled)
- Inquests (including local and national Regulation 28 notices)
- Quality Improvement and Service evaluation projects
- Clinical audits (initial and reaudit)

The data source has been enhanced by the themes from incidents reported during the first 12 months implementation of PSIRF at the Trust and with oversight of the new data from the multiple sources listed above. The development of the PSIRF plan continues a collaborative approach and in 2025 the Trust intend to further strengthen this position with the engagement of Patient Safety Partners.

The Trust profile must retain flexibility in its approach to risk and learning. 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 Patient Safety Incident Investigation (PSII) outside of the Trust profile where required. In retaining flexibility, the Trust will consider emerging issues that arise through the divisional and Trust level reporting processes. Feedback from patients and staff will also be considered and escalated. The Divisional Meeting structure, supported by the PSIRF steering group and the Hospital Quality and Safety Group, will allow discussion and action of emerging themes. The themes will be considering in line with Trust Improvement Projects.

Key safety themes that have continued to be prominent across the Trust, in all aspects of data sources, include:

- Delays in provision of care, with potential to impact on safety
- Medicines safety
- Unplanned admissions or readmissions, including those outside the organisation
- Communication leading to a patient safety incident
- Operational or administrative issue leading to missed appointments/delayed patient contact
- Digital systems issues that result in an impact to care delivery

The Trust continues to manage risks associated with standalone site and lack of on-site services. Transfers to Critical Care or another Trust due to lack of on-site services, that result in harm, will continued to be investigated as a priority.

Addressing Inequalities

In defining the safety incident profile, the Trust recognise the need to ensure that through PSIRF, the data is utilised to learn from investigations to identify actual and potential health inequalities, leading to recommendations that can tackle these issues.

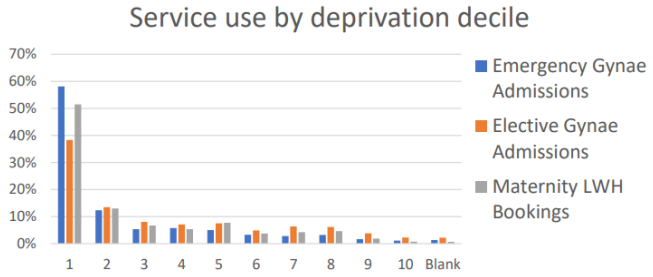
Through work undertaken by the Public Health Team, it has been identified that for the adult population accessing maternity and emergency gynaecology services at the Trust, 75% have at least one risk factor for adverse outcome due to unfair and avoidable health inequalities. A significant percentage of service users across the Trust are from areas that fall into the lowest decile for deprivation.

Deprivation = Core 20

71% of emergency gynae admissions

64% of maternity bookings

52% of elective gynae admissions

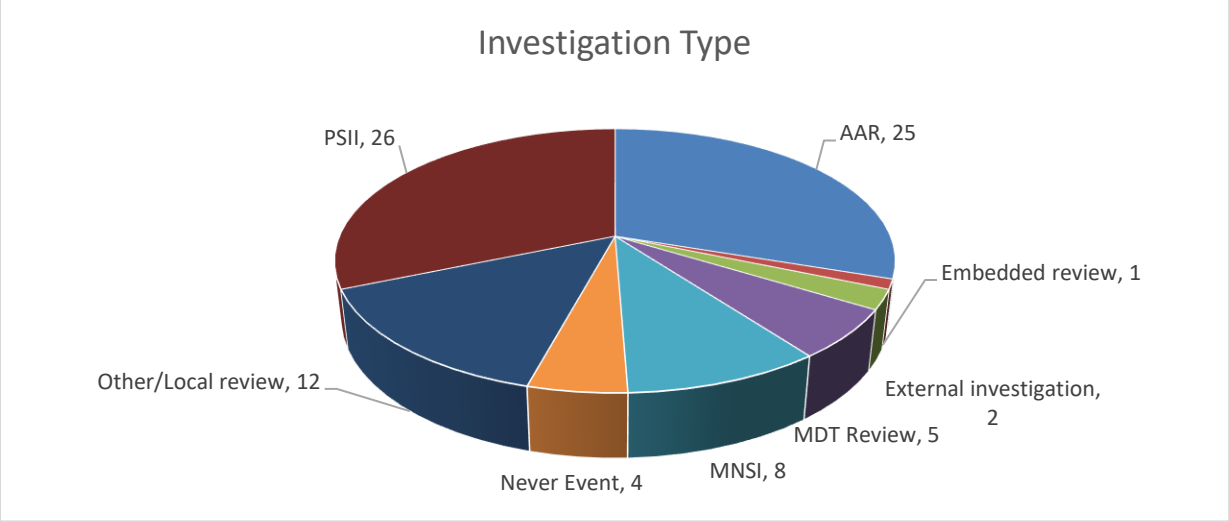


The data reflects that for those accessing maternity and emergency gynaecology, more that 18% are from non-white ethnicity and more than 15% have a primary language other than English.

The Trust recognise that to start to address these inequalities further work is required through review of the data and engagement with patients, families and carers. The Trust plan to utilise that data captured through PSIRF and the LFPSE, to break down incidents looking for inequalities by deprivation and ethnicity. The Trust will continue to enhance engagement with patients and families, ensuring improved communication and access to learning response processes.

Learning from the first year of PSIRF

Since the implementation of PSIRF in September 2023, the following Incident response types have taken place as part of LWH significant incident reviews:

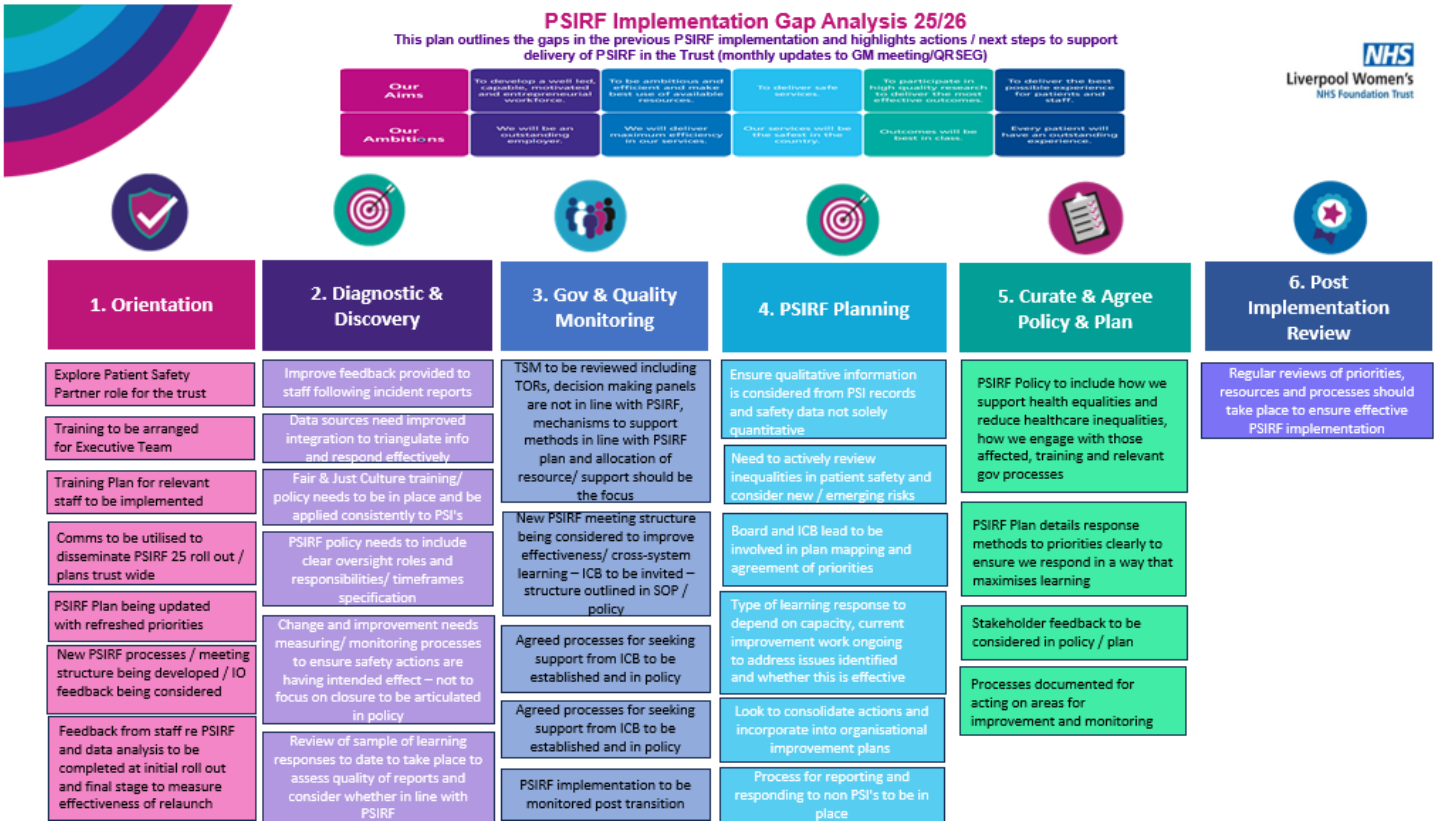


Investigation types: September 2023 to December 2024

The Trust have had a much higher than the anticipated learning response under the PSII methodology. There is an element of complexity in the decision making for investigations due to the specialist nature of the services provided at the Trust as well as external stakeholder requirements. The Trust have been supported by the ICB and the LMNS in the review of complex maternity and neonatal cases. The Trust recognise that the balance of learning responses has not allowed the true potential of PSIRF to be reflected in the current safety incident profile.

The Trust has completed a GAP analysis to learn from the experiences related to PSIRF in the last 12 months. The aims of PSIRF were at the centre of this review process and will look to shape the PSIRF plan and policy. The Trust GAP analysis is supported by a detailed actions plan.

The Trust have made changes to the Governance structure which has seen the introduction of two Patient Safety Learning Lead (PSLL), who will work across the divisions. These lead roles will support the development of a clear and rejuvenated PSIRF policy, and a new meeting structure giving greater oversight and Trust wide input on how learning is completed, including involvement from the QI team. Included below is the outline of the GAP analysis and summary of the proposed next steps.

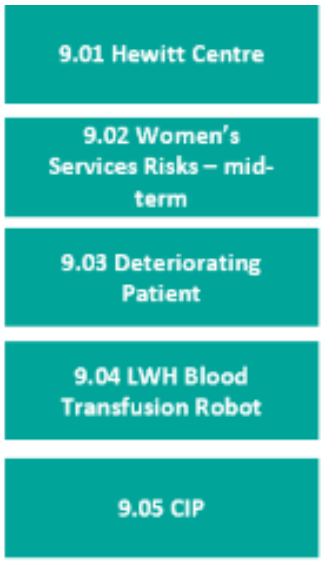


Defining our patient safety improvement profile

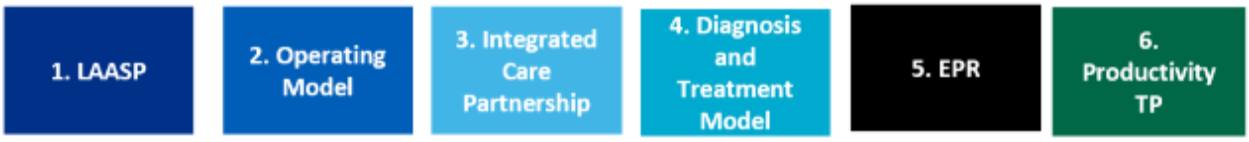
The Trust has developed an improvement plan focusing on the immediate priorities and the longer-term strategy for the next 3-5 years. The improvement plan has a vision of continuous improvement and safety for all, minimising risks and ensuring high-quality, sustainable services through collaboration, challenge, and openness. The Trust recognise that themes from the annual review of PSIRF, will link into some of the already established improvement plans. These improvement plans will support recommendations and actions that have been developed from PSIRF investigations in the last year and allow continued proportionate response in 2025.

The Trust continue to invest in QI and in the following year look to ensure that learning can be maximised and sustained. As QI forms an integral part of the PSIRF learning responses and will support in recognising and establishing improvement projects to maximise output, with proportionate response.

Below is the Trust improvement plan 2025-26:



There are five workstreams that are included in the LWH Improvement Plan, all of which are associated with the Trusts patient safety improvement profile. As part of the University Hospitals of Liverpool Group, the Trust is also linked in with the wider group Improvement Plan with key areas as listed below:



Further details on the LWH and UHL Group Improvement plans can be found on the Trust's webpage.

Patient safety incident response plan: national requirements

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 risks and significant opportunities for learning.

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.

Patient safety incident type	Required response	Anticipated improvement route
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations)	Patient Safety Incident Investigation (PSII)	Cross systems learning with the University of Liverpool Hospitals Group Shared Learning & Improvement Forum (from April 2025) LMNS Maternity & Neonatal Safety Group Mortality Assurance Group
Incidents meeting the Never Events Criteria 2018 or its replacement.	PSII/NE notification	Shared Learning and Improvement Forum (from April 2025) LMNS Maternity & Neonatal Safety Group Medical Procedures Group
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of a Trust-led learning response. Guidance for managing incidents in NHS screening programmes should be consulted.	Local site governance meetings with escalation to the HLT Safety and Quality Group
Death of a person with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS.	Refer for Learning Disability Mortality Review (LeDeR) PSII (or other response) may be required alongside LeDeR.	Mortality Assurance Group Shared Learning and Improvement Forum (from April 2025)
Safeguarding Incidents in which • babies, children, or young people are on a child protection plan; looked after plan	Refer to local authority safeguarding lead via the LWH Safeguarding Lead.	Trust safeguarding plan Shared Learning and Improvement Forum (from April 2025)

or a victim of wilful neglect or domestic abuse/violence. • adults (over 18 years old) are in 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.	An initial review, PSII, After Action Review or Section 42 Review may be required. The Trust contributes towards domestic independent inquiries, joint targeted area 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 local safeguarding adults boards.	Local site governance meetings with escalation to HLT Quality and Safety
Domestic Homicide	A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs	Safeguarding Group Plan Shared Learning and Improvement Forum (from April 2025) LMNS Maternity & Neonatal Safety Group
Maternity and neonatal incidents meeting MNSI (Maternity and Newborn Safety Investigations) and Special Healthcare Authority referral criteria	Work with partners to ensure cases are referred to MNSI	Respond to recommendations from external referred agency/organisation Shared Learning and Improvement Forum (from April 2025) LMNS Maternity & Neonatal Safety Group
Unexpected deaths of people under the Mental Health	PSII/ potential for cross system collaborative review	Mortality Assurance Group

Act (1983) or the Mental Capacity Act (2005) where problems in care identified		Shared Learning and Improvement Forum (April 2025)
Child deaths (all deaths for children aged 0-17)	PSII/potential for cross system collaborative review	Mortality Assurance Group Shared Learning and Improvement Forum

Patient safety incident response plan: Local focus

Not all patient safety incidents require a comprehensive investigation (e.g. a PSII) but may benefit from different types of learning response to gain insight from queries that have been raised by the patient, family, carers and staff. The learning response techniques are likely to mature as the Trust moves into a reflective period following the transition to PSIRF. The PRISF steering group will support with selection of learning responses, education and training to ensure that these are not based solely on harm or risk score. The PSIRF policy will add the Trust in assigning the appropriate learning response. The Patient Safety Incidents below will all be subject to an in-depth review and the response decision will be made with the key stake holders and supported by the weekly Trust Safety Meeting.

The Trust will continue to review and respond to every incident report and ensure the most appropriate learning response is initiated. The Trust will ensure that there is strengthening of the compassionate engagement with additional training and resources to the Family Liaison Officers. These officers when assigned to an incident can provide clear times scales and an understanding of the PSIRF learning response for both staff, patients, and their families. Full details will be outlined in the linked policy.

The Trust recognise that the different methodology and complexity of the learning responses can result is varied lengths to completion. The Trust will ensure that they link in with the patient, family and staff members during any investigation. The Trust aim for completion of learning responses as soon as possible with timescales proposed at the initial review meetings.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Unsafe external transfers: • that results in significant harm to one or more persons. • where there is the potential for significant improvements in care	Response decision will be made by the key stake holders, supported by the TSM and in line with the PSIRF methodology	• Shared Learning and Improvement Forum • LMNS Maternity & Neonatal Safety Group • Quality and Safety Group
Delay in provision of care: • that leads to potential or actual harm to one or more persons • where there is the potential for significant improvements in care		• Shared Learning and Improvement Forum • Trust Improvement Projects • Quality and Safety Group
Medicines management: • Medication errors resulting in significant harm to one or more persons or failure of systems		• Shared Learning and Improvement Forum • Quality and Safety Group • Improvement plan – medicines safety

• Medication issues where there is potential for significant improvements in care		
Identification of digital system issues that potentially or directly results in harm to one or more persons		• Trust improvement projects • Divisional learning sessions • QI response
Unplanned admission or readmission to the Trust of another provider with omissions in care leading to significant harm or potential for wider improvements in care.		• Shared Learning and Improvement Forum • LMNS Maternity & Neonatal Safety Group • Quality and Safety Group
Skin injuries (grade 2,3,4 pressure ulcers or unexplained) where this is potential for improvements in care impacting of the service		• QI response • LMNS Safety Group • Shared Learning and improvement Forum • Divisional learning sessions
Operational or administrative issues: • that result in significant level or harm • that wider systems improvements can be identified		• Shared Learning and Improvement Forum • LMNS Maternity & Neonatal Safety Group • Quality and Safety Group

Cross-systems learning

It is critical to learn from incidents and patient safety improvement work. With this in mind, the Trust are looking to maximise learning and this will be outlined in the PSIRF policy.

Shared Learning from Patient Safety Incidents	
Areas of Learning	Shared learning opportunity
Patient and Family	• Ensure dedicated Family Liaison Officer accessible • Maximise engagement in learning responses • Ensure findings of learning responses are shared with the patient and family
Individual staff members	• Support reflective practice • Ensure access to governance support • Ensure findings of learning responses are provided
Teams/Ward level	• Promotion of learning methodology with increase in update of SWARM huddles

	• Strengthen safety messages at ward level safety huddles
Trust Wide	• Regular safety updates through the weekly safety check-in • Quarterly learning for all • Divisional M&M meetings • Governance and safety newsletters
Networking	• Join the Shared Learning and Improvement Forum hosted by LUFT • Establish a quarterly learning group for the University Hospitals Group • LMNS hosted Maternity and Neonatal Safety Group • Local and national patient safety specialist groups • Regular review and updates with the ICB for sharing of learning and feedback

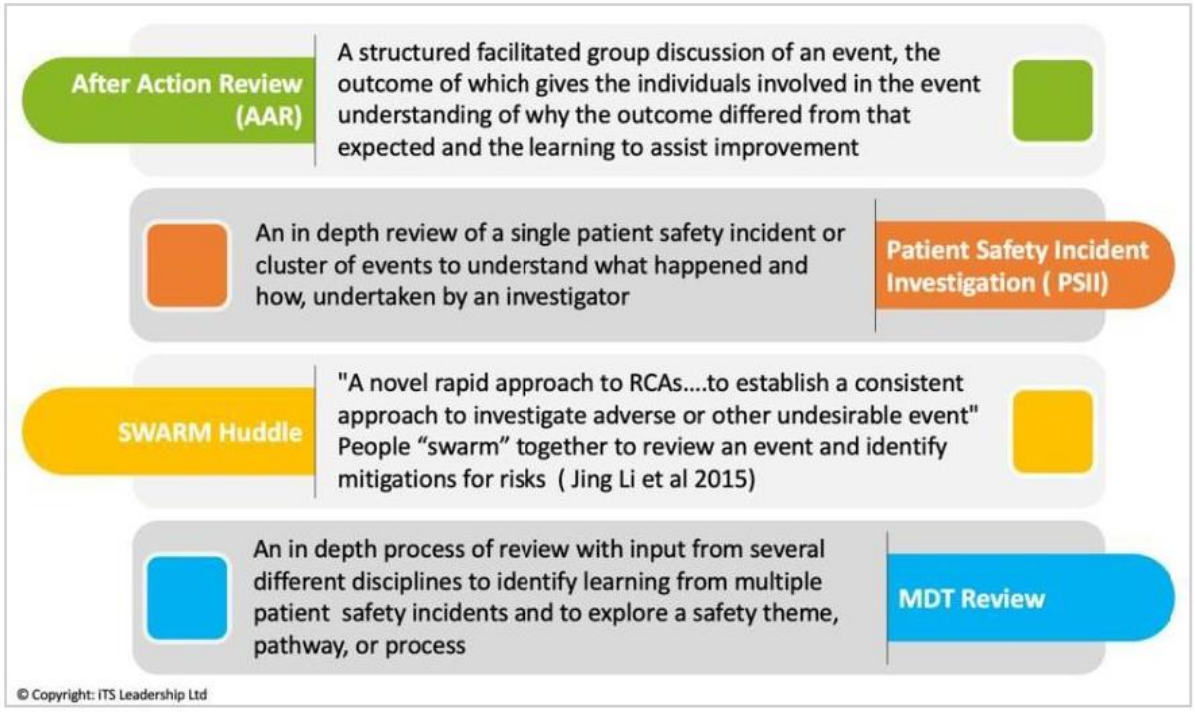
Proportionate Responses

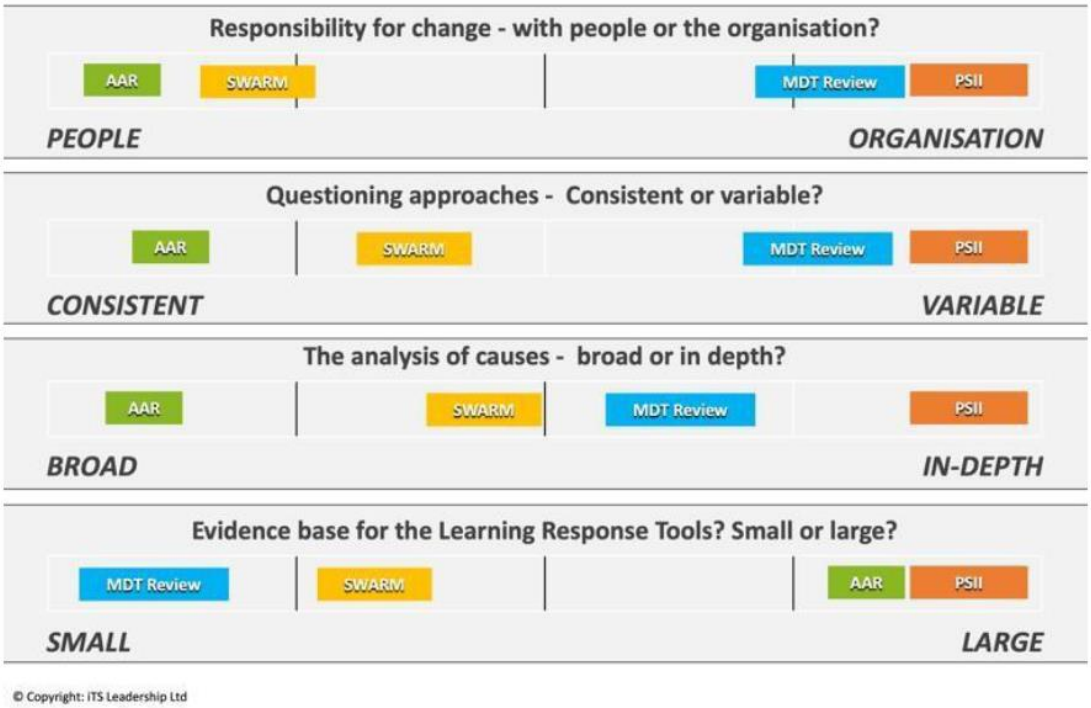
PSIRF enables the Trust to undertake a flexible approach to patient safety incidents. Incident response activity may include investigation of an individual incident where contributing factors are not well understood, or a thematic review of past learning responses to inform the development of a safety improvement plan.

If the Trust and Integrated Care Board (ICB), are satisfied risks are being appropriately managed and/or improvement work is ongoing to address know contributing factors in relation to an identified patient safety incident type, and the effectiveness of actions is being monitored, it is acceptable not to undertake an individual learning response to an incident.

It is, however, critical that engagement is undertaken with those affected and the incident is recorded. The proportionality process is critical in ensuring that available investigation and improvement capacity is optimised by ensuring duplication is minimised.

Learning Responses:





Source: Learning response tools in the NHS, PSIRF explained, Oct 2022

Involvement of patients, families, carers, and staff

We acknowledge the potential impact that patient safety investigations can have on patients, families, carers, and staff. Our Framework has been established to ensure that those affected by incidents are engaged at all stages in a meaningful, compassionate way, with opportunities to ask questions or seek clarification about the incident. To facilitate this process, we will appoint Family Liaison Officers (FLOs), who will be provide guidance and information throughout the investigation, as well as to assist those affected. This approach not only supports our learning and improvement efforts but also ensures that those impacted are kept informed and can contribute to the investigation. Our Trust has worked diligently to shift away from a blame culture in response to incidents, focusing instead on fostering a well-established Just Culture.

We are committed to conducting Patient Safety Incident Investigations with the aim of learning and improvement. This will include support measures for staff involved in incidents, as well as review of Human Factors and promoting psychological safety to reinforce a strong Patient Safety Culture. We value our staff and provide additional support through our exceptional Health and Wellbeing services, as well as our Freedom to Speak Up services, for anyone with concerns.

Duty of Candour

Our Trust is committed to being open, honest, and transparent throughout any patient safety incident investigation. This involves acknowledging when things go wrong, offering an apology, taking necessary steps to correct the issue, and ensuring a secure record of the events is maintained. All staff members are responsible for ensuring compliance with these principles, as part of their clinical registration requirements. We will uphold the Statutory Duty of Candour for any incident that meets the national criteria. To do so, we will:

- Inform the individual(s) involved, including the family when appropriate, about the incident.
- Offer an apology and express our regret.
- Provide an accurate account of what occurred, clarifying the information available at that time.
- Clearly explain the steps we will take to investigate the incident (such as conducting a Patient Safety Incident Investigation or Patient Safety Review).
- Follow up by providing this information and our apology in writing.
- Maintain secure written records of all meetings and communications.

By adhering to the Duty of Candour, we can also gain valuable insights and learning from incidents, which will be shared with those affected.

Roles and responsibilities

Our staff will play crucial roles in this new framework, and we have outlined some of the key positions that will contribute to supporting the changes in patient safety investigations.

All **Directors** have responsibility for ensuring incidents are investigated in a timely manner and responded to in accordance with this plan and appropriately signed off.

The **Patient Safety Specialists** support the Directors in carrying out their responsibilities for the management of PSII investigations, associated key learning and assurance to Group and system partners

The **Patient Safety Incident Investigation Officer** is responsible for carrying out investigation into patient safety incidents in accordance with the plan, working closely with the family liaison officer to ensure patient/family/carers are appropriately involved in the investigation, kept informed of the progress and outcome of the investigation.

A **Family Liaison Officer** will be the point of contact for the patient/family/carers and confirming any questions or concerns to include as part of an investigation and ensuring that they are given the opportunity to provide relevant information that may inform the outcome of the investigation.

Divisional Managers, Clinical Directors/Leads, Head of/Matrons/ Service Managers Ensure that relevant experts are available to support the Patient Safety Incident Investigation Leads to carry out investigations within the relevant division and departments. To ensure that all investigations are completed in a timely manner, prioritising releasing all staff involved within an incident to attend any investigation discussions/meetings. They will also conduct Patient Safety Reviews using the appropriate toolkits and lead on action progression and embedding of changes from PSIRF learning.

The **Patient Safety Learning Leads** support the Trust's governance teams in ensuring adequate oversight and learning from incidents. Working closely with the Investigating Leads and ensuring that risks and trends from incidents are escalated through the risk management process. Any learning is reported to the Governance Meetings so learning can be cascaded through the Quality and Safety processes within the and wider throughout the Trust.

The Divisional **Governance Team** are responsible for reviewing all incidents reported on the incident management system, obtaining additional information and amending incident details as necessary. They will manage and co-ordinate the triage of all incidents assigning the correct level of investigation in conjunction with the Patient Safety Learning Leads. The Team is required to report incidents to relevant internal and external stakeholders in accordance with their reporting requirements.

Appendix 1

The Figure below illustrates how the LWH PSIRF plan is mapped in line with the National Patient Safety Incident Response Framework. Please also refer to the Trust's **Patient Safety Incident Response Framework Policy**