Patient Safety Incident Response Plan

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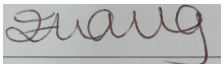
	NAME	TITLE	SIGNATURE	DATE
Author	**Emma Waring**	**Head of Quality and Safety**		**30.10.2023**
Reviewer	**Aaron Flaherty**	**Chief Executive Officer**		**30.10.23**

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Introduction

This patient safety incident response plan sets out how the National Unplanned Pregnancy Advisory Service (NUPAS) intends to respond to and learn from patient safety incidents (PSI's) over a period of 18 months.

The plan is not a permanent rule that cannot be changed and NUPAS will continuously evolve as the organisation transitions and learns from its experience with PSIRF. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan will describe the preparatory phases it has gone through so that we may meet national NHS timeframes in line with NHS England's Patient Safety Incident Response Framework and guidance (see PSIRF preparation guide). The Plan will describe:

- Engagement of those involved in patient safety incidents, including staff, patients, families, and carers.
- Data analysis – looking at collated themes and trends that have occurred in relation to previous PSI's, complaints, and feedback.
- How we have communicated with others as part of formulation of the plan.
- Governance and quality monitoring, to assure how we learn and use our actions to influence quality improvements within the organisation.
- How we ensure our staff understand PSIRF and have the relevant competence, skills, and expertise to deliver PSIRF.

Our plan will enable us to adopt, influence and effectively respond to PSIs through an approach called systems analysis. This will enable us to broadly identify contributory factors from a wide perspective rather than looking for single points of failure.

Our services

NUPAS are an independent provider with 140 directly employed staff, who deliver NHS treatment. We provide Early Medical Abortion for clients under 10 weeks gestation and Surgical abortion for clients up to 24 weeks gestation. NUPAS undertake sexually transmitted infection screening and contraception provision.

This Patient Safety Incident Response Plan (PSIRP) and profiles within this document cover all NUPAS services and are particularly relevant to those that are clinical services. This plan covers all aspects of NUPAS patient safety incident reporting, analysis, and oversight.

NUPAS service span a national portfolio within the United Kingdom, all deliver similar services providing safe, accessible termination of pregnancy. All sites will adhere to the principles of NUPAS's PSIRF policy and plan.

NUPAS has five core values aligning to our strategic objectives in order that we may provide a safe, effective, and person-centred service whilst treating everyone, both staff and patients with kindness, dignity, compassion, and respect. These compliment PSIRFs four strategic aims.

Our main ambition of this PSIRP is to develop a sustainable culture within our organisation that is just, compassionate, and psychologically safe, essential for employees to feel confident, speak up and feel heard.

This will enable NUPAS to form an internal system that reduces the likelihood of PSI occurrence rather than be reactive to what has happened.

Defining Our Patient Safety Incident Profile

The Implementation Process

From December 2022 NUPAS began the process of following the steps in the NHSE PSIRF Preparation Guide (August 2022). An implementation team was formulated consisting of the Chief Executive Officer, Head of Quality and Safety and Quality Team Coordinator. Representatives from all parts of the organisation have formed part of internal developments and engagement of the transition.

NUPAS have the full commitment of our Executive Board with regards to PSIRF.

Stakeholder Engagement.

Stakeholder engagement has been undertaken to develop NUPAS's Patient Safety Incident Response Plan and transition to the Patient Safety Incident Response Framework.

Key stakeholders' consultation was completed as below.

- Integrated Care Boards – via collaborative networks and formal one to one meeting
- All NUPAS Staff – via company day presentations, newsletter communication and an all-staff webinar, involvement in pilot developments.
- NUPAS executive and Senior Leadership team via monthly meeting updates, transition planning proposals and a training webinar
- NUPAS Regional Leadership team (clinical and operation leadership) via company day presentations, and two training webinars.
- Abortion Providers Collaborative Meetings – three independent providers.

Challenges were identified with identifying one Integrated Care Board (ICB) to collaborate with as Lead PSIRF Sign Off on behalf of the organisation. In summer 2023 with guidance from NHSE NUPAS established formal sign off agreement with Staffordshire and Stoke Integrated Care Board after consultation with our largest ICBs and have collaborated in regional PSIRF Implementation meetings.

NUPAS have also built strong partnership links into other regional collaboratives as part of PSIRF transition to maintain local working profiles wherever possible.

NUPAS have taken the opportunity to engage proactively in webinars from NHSE, the Patient Safety Managers Network (PSMN), Independent Health providers network (IHPN) and with HSSIB. This has enabled cascade of information through the organisation based on learning provided.

Training Accreditation and Competence

NUPAS have created an internal training plan following a training needs analysis. Our training plan is inclusive of future in house training by a patient safety specialist following accredited third-party training provision via providers from PSIRF guidance.

Training Type	Delivery Method	Duration	Who needs to complete the training
Freedom to Speak Up – Speak Up	E Learning	25 mins	All staff
Freedom To Speak Up – Listen Up	E Learning	30 mins	All Managers, Senior Leadership Team, Executive Board
Freedom To Speak Up – Follow Up	E Learning	30 mins	Senior Leadership Team, Executive Board, Regional Leadership Team
Essentials of patient safety for all employees	E Learning	30 mins	All staff
Essentials of patient safety - Access to practice	E Learning	30 mins	Regional Leadership Team, Learning Response Leads, Senior Leadership Team.
Essentials of patient safety for boards and senior leadership teams	E Learning	45 mins	Heads of Service, Senior Leadership Teams, Executive Board
Level 2 Systems Approach to Patient Safety Incident Investigations	External Module, Virtual Classroom	12 weeks	Quality and Safety Team Learning Response Leads, Head of Quality and Safety/Patient Safety Specialist, Chief Executive Officer. Regional Leadership Team internal training 2 days
PSIRF Engaging and Involving Others	Virtual Classroom	1 day	Learning Response Leads, Head of Quality and Safety/Patient Safety Specialist, Regional Leadership Team.
PSIRF Oversight	Virtual Classroom	1 day	Regional Leadership Team, Senior Leadership Team, Executive Board.

Data Analysis – Themes from Complaints, Feedback, Incidents and Litigation.

NUPAS have completed a comprehensive review of data from May 2021 to May 2023 to inform this plan. The review has been undertaken by the Head of Quality and Safety, Quality and Safety Lead Nurse and Quality Team Co-ordinator. NUPAS are continually evolving our data led processes to compliment the fundamentals of PSIRF and will continue to do so over the next 18 months.

Findings of the data review have been presented to the Regional Leadership Team (both clinical and non-clinical) and the Senior Leadership Team (both clinical and non-clinical) as part of PSIRF engagement processes and to ensure the plan aligns to actual data and soft intelligence (information from staff groups).

Table 1 – Yearly Analysis of NUPAS Incidents 2021 - 2023

The below table shows the annual number of incidents reported in NUPAS alongside the Level of Harm the incident was reported at.

Year	Near Miss	No Harm (Level 0)	Low Harm (Level 1)	Moderate Harm (Level 2)	Significant Harm	Death
2021	1	147	34	5	0	0
2022	10	253	74	20	4	0
2023	8	180	84	4	0	0

Table 2 – Top Eight Incident Themes (based on Table 1)

The below table shows the top eight key themes utilised to create NUPAS's Patient Safety Incident Response Profile following analysis of the information evidenced in Table 1. (Data from May 2021 – May 2023). This has led to development of this 18-month transitional plan.

Theme	Report Type	Total Reports 2021-2023
Ruptured Ectopic	Complaint/Incidents	2
Ectopic not identified by NUPAS	Incident	3 plus 1 near miss
Unexpected Complications (non-surgical)	Incident	14
Non-Clinical for example, booking error	Incident	112
Clinical Delays to Care	Incident/Complaint	230
Medicines Management	Incident	64
Post Abortion Haemorrhage	Incident/Serious Incident/Complaint	4
Sepsis	Incident/Serious Incident	2 (1 mortality review)

Defining Our Patient Safety Improvement Profile

As an organisation we are very committed to service transformation and quality improvements that positively benefit our patient outcomes nationally and locally and service transformation approaches that better our staff working practice.

We are currently planning the below service developments to improve patient safety and drive quality throughout the care we provide.

- ✓ After care service quality improvement task and finish group
- ✓ Clinical communication consistency improvement
- ✓ Expansion of our quality management system

We currently have the below transformation work underway.

- ✓ Greater London Pills by Post quality improvement project.
- ✓ Transformation of our prescribing and record keeping procedures for Surgical Termination of Pregnancy.
- ✓ Service Transformation of our Sexually Transmitted Infection Screening procedures.

Our patient safety incident response plan: local focus

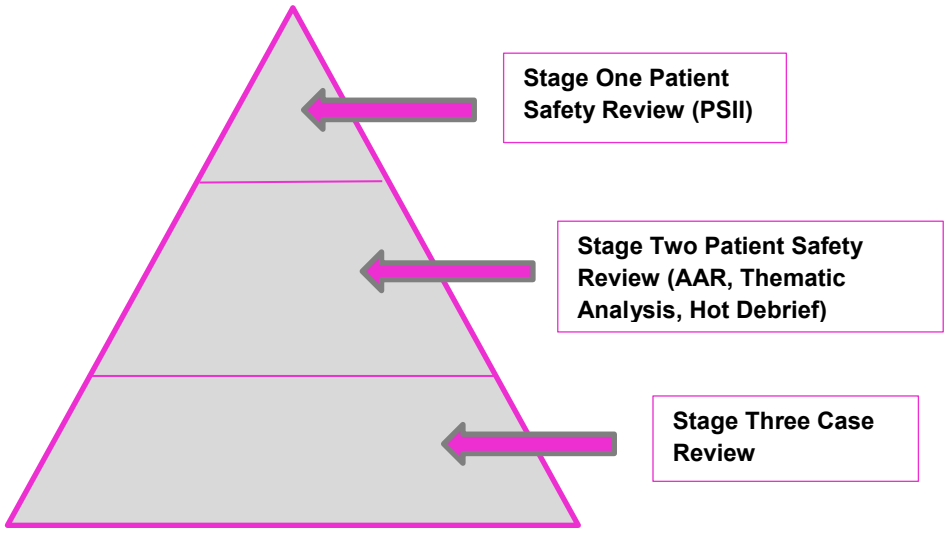
Our Patient Safety incident response activity aligns to the key objectives within the national profile for the Patient Safety Incident Response Framework (PSIRF). The key objectives are that NUPAS will.

- Continuously seek to learn in a way that informs improvement.
- Implement learning that is in an informed improvement manner.
- Assess our Patient Safety Events and determine an appropriate and proportionate response.

Learning From Improvement

PSIRF enables flexibility in the methods which can be used in response to a PSI, the aims of all methods are the same. These are to, respond, understand, identify learning, and improve safety to prevent future reoccurrence of incidents.

We will undertake a three staged approach to responding to Patient Safety Incidents within NUPAS. The methods applied will be a systems-based approach to either an individual patient safety event or a cluster of events and applied when contributory factors are not well known or if the theme of the event has been identified within our data analysis to require a specific method of review (these will be Stage One and Two methods).



Stage One and Two methods will be when local improvement has the greatest potential for learning. Within NUPAS will identify the methods below as a Patient Safety Review (PSR).

PSR's will be undertaken by an accredited staff member dedicated to the Quality and Safety directorate and may fall into one of the review methods seen in Table 3. NUPAS have one full time learning response lead and one full time Head of Quality and Safety.

Stage Three response methods will be undertaken by a member of the Regional Leadership Team accredited in line with PSIRF requirements to a minimum of the Patient Safety Syllabus training in systems-based approaches.

Patient Safety Reviews that fall within NUPAS Stage Three methodology will be undertaken for patient safety incidents that already have local improvement priorities listed in this plan. The response method will utilise a proportionate case review that enquires What was expected to happen? What did happen? What was the difference between what was expected and what did happen? and what can we learn?

Table Four - NUPAS Methods of Review

Method of Review	Description of how the review takes place
Patient Safety Incident Investigation (PSII) with Rapid Review	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how.
Multi- Disciplinary Team (MDT) Review	An MDT review supports health and social care teams to learn from patient safety incidents that occurred in the significant past and/or where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care.
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning
Thematic Review	A thematic review may be useful for understanding common links, themes, or issues within a cluster of investigations, incidents, or patient safety data. Themed reviews seek to understand key barriers or facilitators to safety
Hot Debrief or SWARM huddle	The debrief/huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' together to gather information about what happened and why it

	happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

The below PSI types will have a planned Patient Safety Response category defined and has been based on the data analysis within this document.

The categories below will undergo a systems-based approach to either an individual patient safety event or a cluster of events and will be completed for near miss, low harm, and moderate harm events.

PSI's that may have a significant patient safety risk and have the potential for new learning will have a PSII method applied in the first 18 months.

Upon receipt of a PSI report a Rapid Review will be completed to ensure that a PSII is the most appropriate and proportionate response method and enable a clear and auditable governance trail.

These have been based upon data analysis for previous Serious Incidents and or nature of harm. NUPAS will identify these as a Stage 1 response method.

All other Patient Safety review methods will have an internally applied stage 2 response method.

Table 3 – Patient Safety Review Method (PSR)

Patient safety incident type or issue	Planned response	Anticipated improvement route
Sepsis – Hospital admission that has related to an episode of NUPAS treatment (for example post abortion)	PSII	To create local safety actions and feed these into the quality improvement strategy within NUPAS.
Fatality	PSII	To create local safety actions and feed these into the quality improvement strategy within NUPAS.
Near Miss leading to catastrophic injury	PSII	To create local safety actions and feed these into the quality improvement strategy within NUPAS.
Safeguarding Serious Case Review	PSII	To create local safety actions and feed these into the quality

		improvement strategy within NUPAS.
Safeguarding Event	AAR	
Delay to Care resulting in client requiring an avoidable surgery	AAR or Thematic review if a cluster	
Delay to Care – Pills by Post	AAR or Thematic review if a cluster	
Delay to Care – Correct Process not followed impacting on an available treatment option	AAR or Thematic review if a cluster	
Ruptured Ectopic	PSII	To create local safety actions and feed these into the quality improvement strategy within NUPAS.
An ectopic not identified by NUPAS	AAR	
Later than anticipated gestation	AAR or PSII dependent on risk.	
After Care	AAR or Thematic review if a cluster	
Surgical Complications – post surgical haemorrhage	AAR/SWARM	
Post EMA Complication resulting in hospital admission for example haemorrhage	AAR	
Live birth following Pills by Post/EMA (later gestation)	PSII	To create local safety actions and feed these into the quality improvement strategy within NUPAS.

Our Patient Safety Incident Response Plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	PSII	Create local organisational actions and feed these into the quality improvement strategy
Deaths of patients detained under MHA or where MCA applies	PSII	Create local organisational actions and feed these into the quality improvement strategy
Mental Health related homicides	PSII	Create local organisational actions and feed these into the quality improvement strategy
Maternity/Neonate incidents meeting HSIB criteria	PSII	Create local organisational actions and feed these into the quality improvement strategy
Child deaths	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death of a persons with learning disabilities	PSII	Create local organisational actions and feed these into the quality improvement strategy
Safeguarding incidents i.e., those on child protection plan, looked after plan or cases of willful neglect	PSII	Create local organisational actions and feed these into the quality improvement strategy
Incidents in NHS screening programs	PSII	Create local organisational actions and feed these into the quality improvement strategy
Deaths in custody	PSII	Create local organisational actions and feed these into the quality improvement strategy

Domestic Homicide	PSII	Create local organisational actions and feed these into the quality improvement strategy

Patient Safety Incident Response Framework Oversight.

NUPAS will undertake PSIRF oversight in accordance with NUPAS Patient Safety Incident Response Policy. Please refer to this for information.