Patient Safety Incident Response Policy

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out the **National Unplanned Pregnancy Advisory Service's (NUPAS)** approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

NHS England (2022) define patient safety incidents as "unintended or unexpected events (including omissions) in healthcare that could or did harm one or more patients".

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

PSIRF wants responses to safety incidents to drive quality improvements that lead to changes in the way things are done to reduce the risk of safety incidents occurring at all, through a meaningful process which addresses concerns raised by staff or patients.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of PSIRF which are:

- ➢ compassionate engagement and involvement of those affected by patient safety incidents – being kind and involving others.
- ➢ application of a range of system-based approaches to learning from patient safety incidents - using different learning methods
- ➢ considered and proportionate responses to patient safety incidents and safety issues – not trying to apportion blame.
- ➢ supportive oversight focused on strengthening response system functioning and improvement. – collaborative partnership improvement.

The purpose of this policy is to ensure that all NUPAS employees.

- ✓ Understand the new NHSE Patient Safety Incident Response Framework
- ✓ Receive training to ensure they understand PSIRF and apply it in their everyday work to improve patient safety.
- ✓ Understand NUPAS's Patient Safety Incident Response Plan.
- ✓ Report patient safety incidents, including low/no harm events or near misses in order that the organisation can clearly identify its most frequently occurring incidents and those which may cause harm if preventative safety actions are not identified.

- ✓ Are confident to speak out about any patient safety incidents, or risks which they believe could develop into incidents, to learn from them to help prevent future harm to patients.
- ✓ Are confident to ask patients and their families what they think about the service and care they have received to improve patient safety.
- ✓ Follow the PSIRF guidance for being kind to (and involving) those affected by a patient safety incident – this is inclusive of patients, families, their carers and staff.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all NUPAS's patient facing services and departments**.**

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response. If it is found that someone did something unsafe, which led to patient harm, then this may be dealt with in a formal way outside of the patient safety response process.

Our Patient Safety Culture

Nupas promotes a fair and just culture within the organisation and in all work undertaken that improves safety culture. This is in line with the NHS Just Culture Guide NHS England » A just culture guide . A Just Culture is "*one that balances fairness, learning and accountability" (Nursing and Midwifery Council (NMC), 2021).* Accountability means a person taking responsibility for their own decisions and actions.

Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety. An environment where staff feel valued, well supported, and enjoy and understand their work is most likely to lead to one where patient safety is of the highest importance.

There have been many well-known court cases in healthcare in the last few decades that have highlighted the failures of some providers to be open and honest with patients and their families in response to patient safety incidents that have caused harm, examples of these include.

- The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Enquiry Feb 2013).
- The Report of the Morecombe Bay Investigation, March 2015) (Kirkup Report 2025).
- The Ockenden Review (March 2022).

NUPAS actively encourage and support incident reporting where an incident may have or is likely to occur which has caused, contributed to, or may lead to harm of a patient, visitor or colleague.

Psychological safety underpins openness and transparency to encourage incident reporting and raising concerns. *Psychological safety is created in an environment where there is openness and trust that allows team members to feel comfortable taking risks and making mistakes. To be able to work in a psychologically safe environment, it is vital for healthcare professionals and patients to feel comfortable in sharing their concerns, fears or any other issues that might hinder (reduce) the quality of patient care (Psychological Safety Academy, 2022).*

Patient Safety Partners (PSPs)

Nupas are currently underway in our recruitment process to recruit Patient Safety Partners in line with the NHSE guidance Framework for involving patients in patient safety and have 1 partner within our recruitment process.

Patient Safety Partners (PSP) will have a fundamental role in supporting PSIRF providing a perspective through a patient lens to support developments and innovations to drive continuous improvement in respect of quality and safety of services. Engaging with patients and their families about patient safety is one of the most important parts of PSIRF.

PSPs fulfil the role that patients and their carers can play in advocating and contributing to NUPAS's oversight of patient safety incidents or concerns. They will use their experience as a patient, patient representative or member of the local community to provide support, guidance, and challenge.

Our PSP's will be involved in the designing of safer healthcare at all levels in the organisation, to promote safety and maximise opportunities for effective and embedded learning.

Initially our PSPs will be members of NUPAS Patient Safety and Risk Oversight Committee (PROC) which monitors quality, patient safety, clinical effectiveness and risk management within the organisation and will be core membership of the Patient Information Group which design and review patient information within NUPAS.

Over time the intention is PSPs will evolve from central committee involvement into quality improvement project work and learning response review at local level.

Full role descriptions will be provided for PSPs in line with NHSE framework along with any training and support requirements identified so that they can fulfil their role to its' full potential and ensure the best patient safety outcomes for all patients.

Addressing Health Inequalities

NUPAS have specialised in providing safe, effective surgical and medical abortions to thousands of women each year for over 50 years.

As a provider of NHS care which delivers care across the UK NUPAS has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. NUPAS are taking specific actions to address health inequalities including.

- ✓ Gendered Intelligence Trans Awareness Training
- ✓ Oliver McGowan Training
- ✓ LGBTQ+ Training
- ✓ Equality and Diversity Training
- ✓ Ask Listen Do Standards Compliance

Through implementation of PSIRF, we will utilise data and learning from investigations to enable us to identify actual and potential health inequalities to which we will identify through system oversight and analysis in each region.

NUPAS's holistic approach to patient safety under PSIRF will enable us to continually collaborate within the wider integrated healthcare system in particular relation patient experience and inclusivity and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

As part of our local incident response process, we will engage with patients, families and carers in a meaningful way that recognises individual and diverse needs that ensure inclusivity for all. We will identify any potential issues as part of our incident response process for example during Duty of Candour. When a patient safety incident occurs staff will ensure they understand any factors that may impact the patient, family or carer to be fully engaged in any learning response. This is particularly relevant for the nine protected characteristics below.

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex, and sexual orientation.

Engaging And Involving Patients, Families and Staff Following a Patient Safety Incident

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if the right supportive systems and processes are in place in a way that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

NUPAS will fully engage with patient's, families, carers, and staff in a meaningful way from the outset of the organisation being made aware that something has gone wrong. This will be in an understanding and compassionate way and align to PSIRF's four steps to engagement identified as per the standards.

- ✓ To be fully informed about what happened
- ✓ Given the opportunity to provide their perspective on what happened.
- ✓ Communicated with in a way that takes account of their needs.
- ✓ Given an opportunity to raise questions about what happened and to have these answered openly and honestly.
- ✓ Helped to access counselling or therapy where needed.
- ✓ Given the opportunity to receive information from the outset on whether there will be specific learning response and what to expect from the process.
- ✓ Be signposted to where they can obtain specialist advice and/or advocacy and/or support from independent organisations regarding learning response processes.

And those affected should be:

- ✓ Provided with a named main contact within the organisation with whom to liaise about any learning response and support.
- ✓ Allowed to bring a friend, family member or advocate of their choice with them to any meeting that is part of the learning response process they are involved in.

- ✓ Informed who will conduct any learning response and of any changes to that arrangement.
- ✓ Given the opportunity to input to the terms of reference for the learning response, including being given the opportunity to request the addition of any questions especially important to them (note this does not mean that their requests must be met, but they must have any decision not to meet their request explained to them).
- ✓ Given the opportunity to agree a realistic timeframe for any learning response.
- ✓ Informed in a timely fashion of any delays with the learning response and the reasons for them.
- ✓ Updated at specific milestones in the learning response should they wish to be.
- ✓ Given the opportunity to review the learning response report with a member of the learning response team while it is still in draft and there is a realistic possibility that their suggestions may lead to amendments. Note this does not mean that their suggestions must be incorporated but any decision not to incorporate their suggestions must be explained to them.
- ✓ Invited to contribute to the developments of safety actions resulting from the learning response.

The nine protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation need to be considered and appropriate adjustments made if required (e.g., involvement of an interpreter). Wider health inequality variables (e.g., mental health conditions) that can affect care that people receive will also be considered.

Patients, families, patient representatives and staff often provide a unique, or different perspective to the circumstances around patient safety incidents and may have questions or needs to that of the organisation that will need to be incorporated into the investigation ensuring that the process is patient centred throughout.

This policy refreshes and prioritises the existing guidance relating to the duty of candour and ‘being open and honest’ and recognises the need to involve patients, families and patient representatives as soon as possible in all stages of any investigation, or improvement planning, unless they express a wish not to be involved.

Further guidance in relation to involving patients, families and staff following a patient safety incident is available from NHSE at: B1465-2.-Engaging-and-involving...-v1-FINAL.pdf (england.nhs.uk) .

Please also refer to NUPAS's Duty of Candour Standard Operating Procedure to which the organisation upholds in line with professional and statutory obligations.

All patient safety incidents will be reported utilising NUPAS's incident reporting and management system. Patients, and families as appropriate, will be provided with full details of the patient safety incident and offered support initially by the clinical team involved in their care. Further support for patients and their families following a patient safety incident will be undertaken by the Learning Response Lead.

All patient safety incidents that are deemed to require further investigation (beyond Managerial Case Review) will see a Learning Response Lead allocated to review and to support the patient and family to be engaged with as part of a collaborative investigation and learning process. For those patient safety incidents managed solely through Managerial Review support will be provided via the local clinical team.

The Learning Response Lead role is fully defined within NUPAS's Duty of Candour Standard Operating Procedure; however, Learning Response Leads will provide a single point of contact for a patient and family during a learning review to ensure they have every opportunity to input into the process whilst ensuring that their unique perspective and understanding is included in the findings.

The support from a Learning Response Lead will vary depending on the nature of the Patient Safety Incident Response but may include telephone calls, written correspondence or meetings and could be provided over a few days to several months.

Support for staff following a Patient Safety Incident will initially be through their line manager support but access to NUPAS's employee wellbeing support and Occupational Health will all be available. All staff who feel unfairly treated following a Patient Safety Incident will be encouraged to liaise with the organisations Freedom to Speak Up Guardian or they can liaise directly with the Head of Quality and Safety.

Patient Safety Incident Response Planning

PSIRF provides support and guidance for organisations to respond to patient safety incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm.

There are national requirements, set by statutory bodies, for certain types of Patient Safety Incidents which NUPAS must adhere to. NUPAS can choose to also specify certain types of patient safety incidents that have occurred the most frequently to investigate in greater depth, even if they have caused no or low harm.

Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

There are different types of incident reviews that NUPAS will use to identify learning and we will choose the best method depending on the type of patient safety incident that has occurred.

NUPAS's Patient Safety Incident Response Plan (PSIRP) provides full details regarding when an incident triggers a learning response to undertake.

- A managerial Case Review, a learning response lead who is in a managerial position will proportionately review the patient safety incident to identify any immediate learning.
- A Hot Debrief, a facilitated gathering of staff based in a surgical setting together immediately or within 48 hours of the patient safety incident occurring to discuss what each person thinks may have contributed to the incident occurring. A report will be required within 20 days.
- An After-Action Review (AAR), gathering all the people who were involved in the patient safety incident for a facilitated discussion by an accredited learning response lead to identify what safety actions may be needed. This will occur as soon as possible after the event and a report completed within 30 days.
- A Patient Safety Incident Investigation (PSII), a detailed investigation report undertaken by an accredited learning response lead for patient safety incidents such as though that meet national statutory guideline. Thie report will take on average 90 days but no longer than 6 months.

- A Thematic Analysis, a review undertaken when a cluster or theme of patient safety incidents are identified and data, patient and staff information are triangulated to gain insight and improvement in future safety. This will commence as soon as possible and take no longer than 90 days.

NUPAS will utilise a Systems Engineering Initiative for Patient Safety (SEIPS) learning response methodology which will be embedded through all learning response methods. A four-question approach will be fundamental throughout to understand.

- What should have happened?
- What actually happened?
- Why was there a difference?
- What can we learn from this?

Resources And Training to Support Patient Safety Incident Response.

To enable effective learning from Patient Safety Incidents and ensure actions leading to sustainable improvements it is important to ensure those involved in the responses have adequate capacity and competence.

NUPAS's PSIRF training plan has been created to meet the requirements of the NHSE PSIRF Standards 2022 and include.

- Online learning for all staff

- Online learning for those in leadership roles

- Face to face/virtual training provided by external trainers for those who carry out learning responses, those who work closely with staff, patients and or their families to support them when a patient safety incident occurs and those senior leaders who oversee clinical governance within the organisation.

Our Patient Safety Incident Response Plan

Our plan sets out how NUPAS intends to respond to Patient Safety Incidents over a period of 12 to 18 months from 30th November 2023. The plan is not a permanent set of rules that cannot be amended. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. The plan includes the engagement steps taken with stakeholders and staff, the data analysis completed, and identification of service safety improvement works currently underway within NUPAS.

Reviewing Our Patient Safety Incident Response Policy and Plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change.

This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our lead sign off integrated care board (ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding To Patient Safety Incidents

Patient safety incident reporting arrangements

All Patient Safety Incidents (PSI) are reported into an electronic incident management system. Reporting occurs as timely as practicable following identification of the incident and in all cases by the end of the next working day.

Upon submission a trigger alert is sent to the relevant Regional Manager to inform them of a reported PSI within their area. The regional manager will confirm they have reviewed the submission and that all immediate actions have been reviewed and update where applicable. The PSIRF Executive Leads (Head of Quality and Safety and Chief Executive Officer) receive a trigger alert to all submitted PSI's. This enables identification of the need for an urgent rapid review where appropriate.

Patient safety incident response decision-making

The Quality and Safety Team will undertake a tri weekly Patient Safety Summit to review submitted PSI's consisting of the Head of Quality and Safety/Patient Safety Specialist, Quality and Safety Lead Nurse and Quality Team Coordinator. The summit group will ensure that focus is given to accuracy of reporting and will.

- Ensure the description of the incident is accurate.
- That staff and patient identifiable information is only included in the appropriate sections of the form.
- That the category is as accurate as possible
- Accurate harm levels have been identified.
- That all immediate actions taken have been reviewed by the manager.
- All incident fields required at the initial stage are complete.

Following this initial review, the summit group will indicate the need for a rapid review where required and allocate the most appropriate learning response method based on NUPAS's Patient Safety Incident Response Plan or rapid review findings.

A new Learning Response Forum has been created to recognise the importance of patient safety improvement measures to the nest of our abilities. The forum will consist of our Head of Quality and Safety/Patient Safety Specialist, Patient Safety Partner, Quality and Safety Lead Nurse, Quality Team Coordinator and Head of Nursing. The group will review completed investigations and assure all potential

learning has been identified to reduce the chance of similar incidents happening again in the future.

Other shared learning opportunities utilised are.

- ✓ Quality Newsflashes – these are urgent and routine newsflashes via email that are monitored for compliance by the Senior Leadership Team. Newsflashes may contain details of serious incidents that have occurred, or a risk to patient safety that has been identified with immediate actions, or more routine case studies and patient safety learning and communication.
- ✓ Team Meeting Discussions – with Regional Managers to reflect on patient safety incidents that may have occurred, themes and trends within the region and action that may be required to prevent reoccurrence in the future.

Responding to cross-system incidents/issues

NUPAS are working collaboratively with regional partners within our local healthcare systems to agree standard operating processes that enable effective cross-system joined up incident responses. Several Standard Operating Procedures are in place through collaborative groups with ICB oversight.

The independent sector recognises the importance of cross system collaboration and as an organisation we have committed to partnership approaches to patient safety incident responses and learning opportunities in a proactive manner. NUPAS are one of three abortion providers who have created a formal collaboration with meetings commencing December 2023 to share learning, agree standard operating procedures for partnership learning responses and facilitate collaborative quality improvement across the abortion sector.

Timeframes for learning responses

All learning responses will start as soon as possible after a patient safety incident has occurred within the organisation and align to NHSE's Guide to responding proportionately to patient safety incidents.

It is essential that any response to a patient safety incident is completed within an agreed timeframe with the patient and/or representative. As a provider that covers

nationally within the United Kingdom NUPAS has based learning response timeframes as below

- Hot Debrief, will take place on the day as soon as possible after the event has occurred and within a maximum of 2 days it occurred. A report will be submitted within 20 days of the event.
- After Action Reviews will take place within 20 days of the incident occurring. A report will be submitted within 30 days of the event.
- Case Reviews will take place within 20 days of the incident occurring.
- Patient Safety Incident Investigations should take a maximum of six months but in general should be completed within 3 months of the incident occurring.
- Thematic Analysis will be completed within 3 months of the identification of a theme or cluster of incidents.

Safety action development and monitoring improvement.

A safety action is an action taken to reduce the risk of harm happening again and improve the safety for patients and staff within healthcare.

NUPAS will use the NHSE “Safety Action Development Guide” to support learning response plans within the organisation. This can be found at Safety action development guide

It is recognised that patient safety learning responses (safety actions) can be distressing and emotive for those involved in a patient safety incident and we recognise the importance of sensitivity and supportive measures so that staff can facilitate the improvements recommended from learning responses.

NUPAS will adapt the SHARE debrief Tool recommended by NHSE (SHARE debrief Tool, 2022) to.

- Engage teams and staff who may be affected by the outcome of a learning response.
- Present findings from a learning response.
- Collaborate and reflect on learning response actions before implementation.
- Collate staff feedback after completion of learning response actions to improve our process.

The Learning Response Group has been newly formulated and reports key information to the Patient Safety and Risk Oversight Committee which monitors all aspects of risk, quality and safety across the organisation and forms part of NUPAS Clinical

Governance structure. Learning Response Recommendation monitoring and oversight will ensure all safety actions are used within the services identified.

Safety improvement plans

The Learning Response Forum has been developed to oversee what is learned from patient safety incidents, complaints, and concerns within NUPAS is shared and embedded across the organisation.

Safety improvement plans will include actions from learning response recommendations useful to the whole organisation and pivotal to make meaningful improvements to patient safety.

Oversight roles and responsibilities

NUPAS have created an internal training plan following a training needs analysis. Our training plan is inclusive of staff in oversight roles to ensure the principles of PSIRF are in place in line with NHSE Patient Safety Incident Response Standards (2022). Any future in house training will be completed 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
Access to practice	E Learning	30 mins	Head of Service, 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 of 2 days.
PSIRF Engaging and Involving Others	Virtual Classroom	1 day	Learning Response Leads, Head of Quality and Safety/Patient Safety Specialist
PSIRF Oversight	Virtual Classroom	1 day	Regional Leadership Team, Senior Leadership Team, Executive Board.

Our training will continue to evolve over the next 12 months as new developments are expected to be released for Levels 3 to 5 of NHS wide safety training.

The above training plan will allow leaders in oversight roles within NUPAS to:

- Know how and when to ask the right questions when gaining insight in relation to patient safety.
- Understand and apply systems thinking principles.
- Offer constructive challenge in relation to safety actions and system issues identified and recognise when actions do not follow a system-based approach.

Within the organisation monitoring of improvements will occur in the below ways.

- Via formal clinical governance committee for example Infection Prevention and Control, Patient Safety and Risk Oversight and Clinical Consultative Committee's
- Via Learning Response Group

- Quality Visits (internal mock inspection process)
- Local Team Meeting Discussions

External oversight will take place via NHS commissioning organisations (ICBs) who have procured healthcare from NUPAS in the form of contractual reviews held by the relevant ICB.

NUPAS are currently awaiting on updated guidance from the Care Quality Commission who regulate, monitor, and inspect healthcare in England on how their inspections will change with the implantation of PSIRF. Our document will be updated once this is received.

NUPAS's Head of Quality and Safety is the organisations identified Patient Safety Specialist. This role will be expanded as implementation embeds over the next 18 months and accreditation is secured in line with PSIRF standards.

As an organisation we have taken a dual approach to our PSIRF Executive Leadership sign off with the Head of Quality and Safety and Chief Executive Officer responsible for oversight and sign off within the organisation. NUPAS will ensure the Head of Quality and Safety undertakes a comprehensive review of all learning responses within Patient Safety Summitt and Learning Response Meetings prior to formal sign off. All PSII reviews will receive dual sign off from the Chief Executive Officer and Head of Quality and Safety.

NUPAS's Senior Leadership Team will ensure oversight via the Clinical Governance reporting structure within the organisation inn line with PSIRF oversight principles.

Complaints and appeals

NUPAS Complaints Procedure is separate from PSIRF.

Appendices

Appendix One

Nupas will follow NHSE Patient Safety Incident Response Standards in line with national guidance below.

B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)

The standards ensure that we uphold and meet minimum expectations of the Patient Safety Incident Response Framework (PSIRF) in the following areas.

- Policy planning and oversight.
- Competence and capacity
- Engagement and involvement of those affected by patient safety incidents.
- Proportionate responses to a patient safety incident.