Patient Safety Incident Response Management (PSIRF) Policy

Lead author name and role	Nina Winter – Risk, Quality and Patient Safety Lead
Co-author/s	Michael Nevill – Clinical Director
Team / service	All NUPAS Services
Status - draft / final	Final
Version number	3
Document Category	Quality
Superseded documents	Patient safety Incident response Policy Version 2.0
Consultation Confirmation Date	14/04/2026
Approving Committee	Interim approval by SLT prior to Patient Safety and Risk Oversight Committee
Ratified date	Interim Approval: TBC
Review / expiry date	31/04/2029
Record of Changes: Update the latest version from the Portal – list changes made and delete previous changes	
Page / Section:	**Brief description of changes made:**
	This policy has fully superseded V2.0 and has been labelled as Version 3 in view of this.
Throughout	Editorial changes and updates to reflect current process post implementation.

Impact Assessment:	
How does this affect staff?	The policy applies to all staff, including its independent practitioners offering health care services on behalf of NUPAS.
How does this affect working practices?	All staff have a responsibility to read this policy and understand its impact on their area of work. Staff should be able to respond appropriately to a patient or their representative in the event of a complaint or patient safety incident and endeavor to achieve immediate resolution. If this is not possible, all staff have the responsibility to escalate the concern / complaint or patient safety incident in accordance with this policy.

Patient Safety Incident Response Management (PSIRF) Policy

Version 3.0

Effective date: 01/05/2026

Estimated refresh date: 31/04/2029

	NAME	TITLE	SIGNATURE	DATE
Author	**Nina Winter**	**Risk, Quality and Patient Safety Lead**		**14/04/2026**
Reviewer	**Kate Devonport**	**Co-Chief Executive Officer**		**16/04/26**

Contents

Roles and Responsibilities

Staff Group/Role	Responsibilities
Chief Executive (Responsible Person)	• Holds overall executive accountability for compliance with the Patient Safety Incident Response Framework (PSIRF). • Provides strategic leadership and ensures a culture of openness, transparency, and psychological safety. • Receives notification of serious patient safety incidents and Patient Safety Incident Investigations (PSIIs). • Provides executive oversight and final sign-off for PSIIs alongside the Clinical Director. • Ensures appropriate resources and capacity are available to deliver effective patient safety incident responses.
Risk, Quality and Patient Safety Lead	• Has operational responsibility for the implementation, oversight, and assurance of PSIRF across NUPAS. • Acts as PSIRF Executive Lead alongside the Chief Executive Officer. • Oversees the Patient Safety Summit and Learning from Patient Safety Events (LFPSE) meetings. • Allocates proportionate learning response methods following incident review. • Provides sign-off for Case Reviews, MDT Reviews, Thematic Analyses, and safety action plans. • Ensures compassionate engagement with patients, families, and staff is undertaken in line with PSIRF and Duty of Candour requirements. • Escalates concerns, risks, or delays in learning responses to the Senior Leadership Team where required.
Clinical Director / Medical Director	• Provides senior clinical oversight and expert input into patient safety incident responses. • Supports decision-making on learning response pathways and escalation for complex or high-risk incidents. • Reviews and signs off After-Action Reviews and PSIIs in collaboration with the Patient Safety Specialist. • Works collaboratively with the Risk, Quality and Patient Safety Lead to ensure learning is embedded into clinical practice.
Head of Nursing	• Provides professional leadership and oversight for nursing-related patient safety incidents. • Supports staff involved in incidents and promotes a fair and just approach in line with the Being Fair framework. • Contributes to learning response reviews and implementation of safety actions relevant to nursing practice.

Regional Managers / Regional Clinical Leads	• Ensure all patient safety incidents within their area are reported promptly and accurately. • Review incident records to confirm immediate actions have been taken and documented. • Support Case Reviews and other proportionate learning responses as assigned. • Provide ongoing support to staff involved in patient safety incidents. • Ensure agreed safety actions are implemented and embedded locally.
Risk, Quality and Patient Safety Team	• Coordinate the operational delivery of PSIRF processes, including incident review, learning response allocation, and monitoring. • Maintain oversight of data quality, reporting accuracy, and LFPSE requirements. • Provide expert advice and guidance to managers and staff on PSIRF processes. • Support engagement with patients, families, and Patient Safety Partners during learning responses. • Monitor progress of learning responses and safety action implementation.
Learning Response Leads (Accredited)	• Lead assigned learning responses in line with PSIRF principles and timescales. • Apply systems-based methodologies (including SEIPS) to identify contributory factors and learning. • Act as the named point of contact for patients and families during learning responses, where applicable. • Ensure compassionate, inclusive, and transparent engagement throughout the process. • Produce high-quality learning response reports and contribute to safety action development.
Patient Safety Partner (PSP)	• Provides an independent patient perspective to support learning and improvement. • Participates in relevant governance forums and learning response reviews. • Offers challenge and insight to ensure patient experience and safety remain central to PSIRF processes.
All Staff (including independent practitioners)	• Have a responsibility to report patient safety incidents, near misses, and risks promptly using the incident reporting system. • Participate openly and honestly in learning responses when required. • Engage with patients and families in a compassionate manner in line with Duty of Candour. • Contribute to a positive patient safety culture by speaking up about concerns and improvement opportunities.

All colleagues are expected to understand their role within the Patient Safety Incident Response Framework and to act in accordance with the principles of openness, learning,

and system improvement. Roles and responsibilities under PSIRF do not replace professional, regulatory, or contractual obligations.

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 coordinated 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 requires that responses to safety incidents drive quality improvements and lead to changes in process to reduce the risk of safety incidents occurring. A PSIRF learning response is a meaningful process which addresses concerns raised by staff or patients and considers all elements of the workplace system rather than focusing on blame of individuals concerned.

This policy supports the 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 NHSE's Patient Safety Incident Response Framework
- Receive training to ensure they understand PSIRF and apply it in their everyday work to improve patient safety.
- Receive necessary refresher training in roles that stipulate the requirement of this.
- Understand NUPAS's Patient Safety Incident Response Plan.
- Report patient safety incidents, including no or low harm events or near misses so 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 and help prevent future potential 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 the compassionate engagement of those affected by a patient safety incident, inclusive of patients, families, their carers and staff (subject to appropriate consent).

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 principal aim of each of these responses differs 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 using relevant formal process outside of the patient safety incident 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. NUPAS aligns to the Being Fair framework having transitioned away from the previous Just Culture framework during 2025. This aims to support decision-making for patient safety incidents that refer to the involvement of colleagues, and to ensure that they are not treated unfairly after a patient safety incident.

https://www.england.nhs.uk/publication/being-fair-tool/

Organisational Safety and the Importance of a Transparent Culture

Research into organisational safety consistently demonstrates that fostering an open and transparent culture, where colleagues feel confident in reporting incidents and raising concerns without fear of blame or retribution, is vital for improving safety. An environment in which staff feel valued, well-supported, and both enjoy and understand their work is far more likely to prioritise patient safety.

Several high-profile legal cases in healthcare over recent decades have highlighted the consequences of providers failing to be open and honest with patients and their families following patient safety incidents resulting in harm. Notable examples include:

- The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Francis Inquiry, February 2013)
- The Report of the Morecambe Bay Investigation (Kirkup Report, March 2015)
- The Ockenden Review (March 2022)

At NUPAS, we actively promote and support the reporting of any incident or risk that has occurred, is likely to occur, or has the potential to cause harm to a patient, visitor, or colleague.

Psychological safety is fundamental to encouraging openness and transparency. It is cultivated in a working environment characterised by trust and openness, where team members feel secure in risk assessment, decision making and acknowledging mistakes. In such psychologically safe settings, healthcare professionals and patients alike are more likely to share concerns, fears, or other issues that may compromise the quality of patient care (Psychological Safety Academy, 2022).

- Patient Safety Partners (PSPs)

NUPAS has engaged the support of a Patient Safety Partner to remain aligned with the NHSE Framework for involving patients in its patient safety framework.

Our Patient Safety Partner (PSP) has a fundamental role in supporting our PSIRF processes, providing a patient's perspective to support developments and innovations that drive continuous improvement in respect of the quality and safety of our services.

Engaging with patients and their families regarding patient safety is fundamental to PSIRF and our PSP fulfils the role that patients and their carers can play in advocating and contributing to NUPAS oversight of patient safety incidents or concerns. They use their experience as a patient, patient representative and member of the local community to provide support, guidance, and challenge to NUPAS.

Our PSP is involved in the review of safer healthcare at all levels in the organisation, to promote safety and maximise opportunities for effective and embedded learning. They are active within the following NUPAS committees:

- Risk, Quality and Patient Safety Committee which monitors quality, patient safety, clinical effectiveness and risk management within the organization.
- Patient Information Forum (PIF) which plans, designs and reviews patient information used within the organization.
- Corporate and Clinical Governance Committee.

Our PSP has key involvement in quality improvement project work and learning response

reviews at national level and a core member of the fortnightly Learning from Patient Safety Events meeting, a multi-disciplinary meeting reviewing all learning response submissions for quality assurance and oversight of safety actions.

A full role description is provided for our PSP in line with NHSE framework and any training or support requirements identified so that they can fulfil their role.

- Addressing Health Inequalities

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

As a provider of NHS 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 have taken specific actions to address health inequalities and plan to refresh non mandatory training below in 2025/26. These include:

- Gendered Intelligence Trans Awareness Training (non-mandatory)
- Oliver McGowan Training
- LGBTQ+ Training (non-mandatory)
- Equality and Diversity Training
- Ask Listen Do Standards Compliance

Within the previous year, NUPAS has determined that the Oliver McGowan training will be delivered every three years as opposed to a one-off course.

NUPAS has planned to launch an EDI strategy and policy during 2026/27.

Through PSIRF, we utilise data and learning from investigations to enable us to identify actual and potential health inequalities to which we will identify thorough 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 relating to 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 (subject to appropriate consent) in a meaningful way that recognises individual and diverse needs and 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 our staff will ensure that they understand any factors that may otherwise 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
- 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 and in a way that prioritises compassionate engagement and involvement of those affected (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 patients, families, carers (subject to appropriate consent), and staff in a meaningful way from the outset of 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 for these to be responded to with openly and with transparency.
- Helped to access counselling or therapy where needed.
- Given the opportunity to receive information from the outset on whether there will be a 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 development 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 different questions or needs to that of the organisation. These will need to be incorporated into the investigation to ensure that the process is patient centered throughout.

This policy continues to refresh 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 Duty of Candour Policy regarding both professional and statutory obligations.

All patient safety incidents will be reported utilising NUPAS 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, or whoever is determined to be an appropriate subject matter expert.

All patient safety incidents that are deemed to require further investigation (beyond a proportionate Case Review) will see a Learning Response Lead allocated to review and to support the patient and family with compassionate engagement as part of a collaborative investigation and learning process. For those patient safety incidents managed solely through a Case Review; support will be provided via the regional management teams.

The Learning Response Lead role is fully defined within NUPAS Duty of Candour policy;

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 the 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 but access to NUPAS employee wellbeing support and Occupational Health will also be available. Any staff who feel that they have been 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 Risk, Quality and Patient Safety Lead.

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. See Appendix One for details.

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 Patient Safety Incident Response Plan (PSIRP) provides full details regarding when an incident triggers one of the following learning response;

- A Hot Debrief, a facilitated gathering of staff based in a clinical 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 30 working days.
- A Multi-Disciplinary Team Review, to agree, through open discussion, the key contributory factors and system gaps in patient safety incidents for which it is more difficult to collect staff recollections of events either because of the passage of time or staff availability or to identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents). An example may be to explore a safety theme, pathway,

or process relating to delayed recognition of deteriorating patients.

- A Case Review, a learning response lead who is in a managerial position will proportionately review the patient safety incident to identify any immediate learning and submit a report within 30 working days.
- A Structured Judgement Review, a standardised and structured clinical judgement-based review undertaken by an accredited clinical learning response lead that is completed for intra and post-surgical complications at NUPAS. This will be completed and a report provided within 35 working 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 35 working days.
- A Patient Safety Incident Investigation (PSII), a detailed investigation report undertaken by an accredited learning response lead for patient safety incidents that meet national statutory guidelines. The report will take on average 90 working days but no longer than 6 months.
- Medication errors. This will occur as soon as possible after the event and a report completed within 30 working days.
- 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 working 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 PSIRF training plan has been created to meet the requirements of the NHSE PSIRF Standards 2022 and includes:

- 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,
  - Work closely with staff, patients and their families to support them when a patient safety incident occurs.

- who oversee clinical governance within the organisation (Senior Leaders).

Our Patient Safety Incident Response Plan

Our plan sets out how NUPAS intends to respond to Patient Safety Incidents.
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.

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.

Updated plans will continue to 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 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 are reported into an electronic incident management system. Reporting occurs as contemporaneously 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 patient safety incident within their area. The regional manager will confirm they have reviewed the submission and that all immediate actions have been reviewed and updated where applicable. The PSIRF Executive Leads (Chief Executive Officer and Risk, Quality and Patient Safety Lead) receive a trigger alert to all submitted patient safety incidents. This enables identification of the need for urgent rapid review where appropriate.

- Patient safety incident response decision-making

The Quality and Safety Team will undertake a biweekly Patient Safety Summit to review submitted patient safety incidents consisting of the Risk, Quality and Patient Safety Lead,

Quality Assurance Lead and Risk, Quality and Patient Safety Team Coordinator. The membership will also include leadership from both clinical and operational teams. 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.
- Appropriate categorisation of the incident. (The Risk, Quality and Patient Safety Team will ensure the consistent and appropriate selection of category to strengthen reporting and data collection).
- Accurate harm levels have been identified, according to the options and the explanatory notes offered within RADAR.
- That all immediate actions taken have been reviewed by the manager.
- All incident fields required at the initial stage are complete.
- Data integrity for LFPSE

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 Patient Safety Incident Response Plan or rapid review findings.
The Learning from Patient Safety Events (LFPSE) meeting was established to review the efficacy and appropriateness of patient safety improvement measures identified within each learning response and to challenge whether there is a retained risk of similar incidents occurring in the future. This takes place fortnightly.

The forum consists of the Risk, Quality and Patient Safety Lead, Clinical Director, Quality Assurance Lead, Quality Coordinator, Patient Safety Partner, and Head of Operations.

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.
- Organisation Wide Learning Newsletter. 'OWLS' – a quarterly bulletin distributed across the whole workforce that shares key Risk, Quality and Patient Safety messages, which summarises Quality activity within the last quarter as well as future improvement plans, and that shares learning opportunities from recent investigations.
- Team Meeting Discussions – with Regional Managers to reflect on patient safety incidents, themes and trends within the region and to identify actions to prevent reoccurrence in the future.
- Clinical Supervision – an opportunity for all clinical staff to reflect on shared cases for applied learning and reflection.

- 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 which commenced in 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 be assigned at the next Patient Safety Summit following identification of a patient safety incident and will 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 their representative. NUPAS has based learning response timeframes as below.

Learning Response	Execution, Delivery and Sign Off
Hot Debrief	To take place on the day of the event, as soon as possible following occurrence and within a maximum of 2 days. A report is to be submitted within 30 working days of the event. Attached to the incident record, unless recommended for further investigation.
Case Reviews	A report to be submitted within 30 working days of the event. Reviewed at LFPSE. Sign off by Risk, Quality and Patient Safety Lead
Structured Judgement Review	To be completed and a report submitted within 35 working days of the event. Attached to the incident record, unless recommended for further investigation.
After Action Reviews (AAR)	On declaring an AAR the Risk, Quality and Patient Safety Lead (or Clinical Director if required) will inform the SLT, providing a synopsis of the incident, any immediate actions taken or assigned and any imminent threat to the business. Exploratory meetings should be convened within 10 working days of the event occurring, where possible. If this is not

	achievable, separate meetings should be held to capture detail whilst these are fresh in peoples thoughts. Alternatively, written statements / 1:1s can be utilized. Where individuals are not available due to planned / unplanned absence there should not be a delay in gathering information from other individuals. If information gathering will be compromised due to the availability of individuals concerned the Risk, Quality and Patient Safety Lead will seek advice from the Patient Safety Specialist on the appropriate options to ensure a proportionate and effective learning response. Call recordings should be listened to, audited as necessary, and consideration given to recording a transcription for file to refer back to and protect the integrity of memory. A report is to be submitted within 35 working days of the event. Reviewed at LFPSE. Sign off by Clinical Director following review by the Patient Safety Specialist.
Patient Safety Incident Investigation (PSII)	On declaring a PSII, the Risk, Quality and Patient Safety Lead (or Clinical Director if required) will inform the SLT, providing a synopsis of the incident, any immediate actions taken or assigned and any imminent threat to the business. In addition to informing the SLT, the Quality Team will submit a Serious Incident Report form (see Appendix Two) to the relevant ICB so that they can report to StEIS. **Once NUPAS has transferred to LFPSE v6 this will no longer be required.** Call recordings should be listened to, audited as necessary, and consideration given to recording a transcription for file to refer back to and protect the integrity of memory. To be completed and a report submitted within a maximum of six months of the event occurring (or being escalated) but ideally within three months. To be ratified at SLT following review by the Patient Safety Specialist. Sign off by Clinical Director and the Chief Executive.
MDT Review	MDT meetings should be convened within 10 working days of the event occurring, where possible. A report is to be submitted within 35 working days of the event.

	Attached to the incident record, unless recommended for further investigation. To be reviewed and signed off by the Risk, Quality and Patient Safety Lead. If escalated as an AAR / PSII sign off will be as stipulated above.
Thematic Analysis	To be completed within 90 working days of the identification of a theme or cluster of incidents. Attached to the cluster of incidents under review. To be reviewed and signed off by the Risk, Quality and Patient Safety Lead in conjunction with either a Clinical or Operational Senior Lead.

- Safety action development and monitoring improvement.

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

NUPAS will use the NHSE "Safety Action Development Guide" to support learning its response plans. This can be found at Safety action development guide.

Patient safety learning responses (safety actions) can be distressing and emotive for those involved in the patient safety incident. NUPAS recognises the importance of sensitivity and of employing supportive measures so that staff can facilitate the improvements recommended from learning responses.

The Learning Response Group reports key information to the Risk, Quality and Patient Safety 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 will ensure that all the safety actions identified are embedded.

- Safety improvement plans

The Risk, Quality and Patient Safety Committee provides oversight of learning from patient safety incidents, complaints, and concerns raised within NUPAS and ensures that this is both shared and embedded across the organisation.

Safety improvement plans will include actions from learning response recommendations that impact the wider organisation and would prove pivotal to delivering meaningful improvements to patient safety.

Oversight roles and responsibilities

NUPAS has reviewed its internal training plan post implementation and following input from our Patient Safety Specialist we have refined our approach to PSIRF training and which

colleagues would benefit from it. 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 will complete the training
Essentials of patient safety for all employees Level 1	E Learning for Health	30 mins	All staff mandatory training
Essentials of patient safety – Access to practice Level 2	E Learning for Health	30 mins	Regional and Corporate Clinical Leadership Learning Response Leads Senior Leadership Team Quality Team
Essentials of patient safety for boards and senior leadership teams	E Learning for Health or via nationally approved PSS presentation.	45 mins	Senior Leadership Team
Level 2 Systems Approach to Patient Safety Incident Investigations	External PSIRF accredited trainer	12-hour program of study Or 1 day / 6-hour oversight training	Learning Response Leads LFPSE panel

Training plans will evolve to accommodate new internal and / or external requirements.

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

- Know how and when to ask the right questions to gain insight into 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 or SMART approach.

Within the organisation monitoring improvements will occur in the following ways.

- Formal clinical governance committee for example Infection Prevention and Control; Risk, Quality and Patient Safety Committee; and Clinical Consultative Committee.
- 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 currently procures expert Patient Safety Specialist advice from an external supplier. Training will be procured to upskill key colleagues within the business to bring the expertise back in-house.

NUPAS has taken a dual approach to our PSIRF Executive Leadership sign off with the Chief Executive Officer and the Risk, Quality and Patient Safety Lead responsible for oversight and sign off of PSIRF activity within the organisation. NUPAS will ensure the Risk, Quality and Patient Safety Lead undertakes a comprehensive review of all learning responses within Patient Safety Summitt and Learning from Patient Safety Event Meetings prior to formal sign off.

All PSII reviews will receive dual sign off from the Chief Executive Officer and the Clinical Director.

NUPAS Senior Leadership Team will ensure oversight via the Clinical Governance reporting structure in line with PSIRF oversight principles.

Complaints and appeals

NUPAS Complaints Procedure is separate from PSIRF.

Appendices

Appendix One – NHSE Patient Safety Incident Response Standards

NUPAS will follow NHSE Patient Safety Incident Response Standards in line with national guidance below (NHSE 2024).

NHS England » Patient safety incident response standards

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.

Appendix Two - Reporting PSII incidents to StEIS

- Recording responses to patient safety incidents during the transition to LFPSE and PSIRF – NHS England

Download form directly from Radar using the following link
https://live.radarhealthcare.net/documents/27/DownloadDocument/2284

- SSOT Serious Incident Reporting Form

Download form directly from Radar using the following link

https://live.radarhealthcare.net/documents/27/DownloadDocument/2283