MSI Reproductive Choices UK

Patient Safety Incident Response Plan

Version	V.1
Applies to:	All colleagues
Approved by:	Policy Approval Group
Executive Director Sign Off:	
Ratified by:	Integrated Governance Committee
Date Written/Updated:	March 2024
Review Date:	March 2025
Written by:	Senior Quality & Governance Business Partner
Accountable Team Member:	Director of Nursing, Midwifery & Quality
Consulted with:	Director of Nursing, Midwifery & Quality
Uploaded by:	Policy and Client Information Administrator
Linked Policies	Incident Reporting including Patient Safety Incident Response Framework, Never Events and Information Governance incidents Duty of Candour Policy Freedom to Speak Up Policy Risk Management Policy Safeguarding Adults, Children and Young People
Communicated via:	Business Update Bulletin

Review and amendment log

Version No	Type of Change	Date	Description of change
V.1	New	March 2024	New policy and plan due to the transition from the NHSE Serious Incident Framework 2015 to the Patient Safety Incident Response Framework

Contents

Introduction

MSI Reproductive Choices UK provides reproductive services to clients under the NHS Standard Contract. The NHS Serious Incident Framework (2015) provided structure and guidance on how we identify, report and investigate patient safety events. The Patient Safety Incident Response Framework replaces the Serious Incident Framework and is a new approach to managing and responding to patient safety incidents. It advocates a coordinated and data-driven response for wider learning and improvement. This patient safety incident response plan (PSIRP) sets out how **MSI Reproductive Choices UK** intends to respond to patient safety incidents reported by staff, clients, their families and carers over 12 to 18 months. This supports us to proactively seek opportunities to continually improve the quality and safety of the care we provide. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected. We will continue to monitor the impact and effectiveness of this new approach and respond and adapt as necessary. This plan is underpinned by our Incident Management Policy and will be reviewed at least annually with our lead Integrated Care Board (ICB) but can be more often as this is a live, evolving document.

Our services

MSI Reproductive Choices UK (MSI UK) is a specialist independent provider of sexual and reproductive health services in the UK. We are part of the world's leading reproductive and sexual health charity, based in 37 countries around the world. We have over 60 locations in the UK and strive to provide a local supportive reproductive health service.

Through our team of highly skilled doctors, nurses, midwives, counsellors, and healthcare assistants, we provide abortion, vasectomy, and contraception fitting services. We are focused on maintaining and growing our capacity across the country to respond to the mounting pressures on abortion care nationally. We have invested in our One Call Centre operations, clinical recruitment and digital infrastructure to maintain, protect and grow the organisation, to enable us to offer these essential services to more clients.

Defining our patient safety incident profile

MSI UK recognises and is committed to creating a positive and safe environment for the people who use our services, their families/partners, visitors and staff. We have a responsibility to ensure that there are systematic measures in place for identifying, reporting, managing and investigating incidents to safeguard people, property, resources and reputation. This includes the responsibility to learn from these incidents to minimise the risk of them happening again and improve practice and organisational culture.

We have seen very few serious incidents over the last three years, with a rate of 0.01% against activity 2021-2023, attributed to our processes to identify, learn, report and investigate to improve clinical pathways. We embrace an open and learning culture to ensure we have opportunities to learn from incidents and enhance safety. We have maintained an incident reporting rate greater than 2% and have seen a small decrease in clinical incidents reported year on year due to continual improvements in our clinical pathways and reducing complications. All incidents reported are reviewed by a multi-disciplinary team, Complaints, Litigation, Incidents, Patient Feedback and Safeguarding (CLIPS) on a weekly basis to ensure that they are graded correctly, responses required are appropriate and systems learning is promoted rather than looking at individual/departmental errors. Panel meetings are attended by subject matter experts, where the information is discussed, analysed, and next steps agreed.

To identify patient safety issues most pertinent to our organisation, an internal project team undertook a thematic analysis approach of organisational data from January 2021 to December 2022 and engaged with key stakeholders. This plan applies to all patient safety incidents relating to termination of pregnancy, contraception and vasectomy services.

Stakeholder engagement:

Key stakeholders have been consulted throughout the process to agree on identified priorities including:

- Commissioners
- Members of staff
- Clients, relatives/families and carers
- Other independent providers for reproductive health

Data Sources:

- Client safety incident and investigation reports
- Treatment Outcome dashboards for complications including infections
- Complaints – informal and formal
- Data from quality surveillance dashboards
- Legal Claims
- Staff survey results
- Client experience surveys
- Digital feedback
- Risk registers both local and corporate
- Freedom to speak up guardians

Incident types, themes, recurrence, and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and interventions already in place. We considered current and future quality improvement projects which includes our Digital Strategy and Quality Priorities.

Safety issues identified as most pertinent are delayed management of ectopic pregnancy, mismanagement of pregnancy remains and surgical site infections for vasectomy.

Defining our patient safety improvement profile

To identify and agree our patient safety improvement profile, we have considered past, current, and future improvement work that has or is expected to improve patient safety within the next 12 – 18 months. This includes national and locally driven transformation programmes. Current and ongoing quality improvement work focuses on building resilience and capacity within our service to continue providing accessible, safe and effective care whilst responding to the evolving client demand and wider challenges within the abortion and contraception sector.

This plan supports our efforts over the last two years to develop an open, learning and just culture whereby staff feel safe to raise concerns, report and contribute to learning from patient safety incidents.

Our 2020-2023 Digital Strategy was developed in line with the NHS Long Term Plan , to transform our digital services and provide people with the information and tools to manage their care in a way that suits them. By making services more easily accessible, wait times and procedure risk are reduced.

Transformation Area	Detail	Known or expected impact on patient safety
Just and Learning Culture	In September 2021, we completed a benchmarking exercise against the Just and Learning Culture Framework. This included surveying our colleagues, reviewing our policies, procedures and processes including recruitment, induction, training, incident reports and investigations. Actions taken to further develop the culture include the introduction of Human Factors and Values, Clarification, and Transformation training, decoupling RCA investigations from line management, focussing our weekly CLIPS forum on shared learning within our systems and processes and surveying colleagues when they have been involved in an investigation. Since then, we have continued to assess our organisational culture through bi-annual colleague surveys and well-led surveys during supportive quality assurance review which take place at least once per year for each Centre. In 2022, 81% of colleagues agreed or strongly agreed that they feel comfortable in raising a concern. During the most recent staff survey in 2023, a net promotor score of 40 (high) was achieved when	• Positive incident reporting culture • Continuous learning and improvement of safety risks

Transformation Area	Detail	Known or expected impact on patient safety
	asked if colleagues felt comfortable raising concerns and confident that concerns would be listened too. In the same year, 79% of colleagues surveyed through well-led surveys agreed there was an open culture which supports learning and honesty. Improvements identified from surveys are added to local and organisational improvement plans.	
Digital Strategy	Introduction of a Client Portal: this is a secure place for clients to access their record, personalised care information, book, cancel and amend appointments online.	• Improved, instant access to appointments bookings and cancellations. • Reduction in 'Did Not Attend' (DNA's) which improves capacity utilisation and further reduces wait times by avoiding empty appointment slots. • Reduced service delivery incidents relating to incorrect bookings which can contribute to patient safety events
Digital Strategy	Website transformation: **Gestation calculator and map:** Helping clients understand treatment options based on their gestation and see what clinics may be able to attend. **Treatment timelines:** Setting expectations about treatment journeys: how many steps are involved,	• Transparent and quick access to information in multiple languages, including pre-treatment and aftercare advice, which informs clients of expectations and reduces avoidable delays.

Transformation Area	Detail	Known or expected impact on patient safety
	what happens next, how long will it take. **Comparison tables:** Helping clients feel informed to choose between medical and surgical abortion (when eligible for both) and different contraception methods. Introduction of Webchat, which is a discreet and accessible service for clients to contact our team to discuss any questions prior to and during their treatment pathway. A Google Translate bar is available on our MSI UK website, from both desktop and mobile devices, to ensure website visitors can read key information in their preferred language.	
Digital Strategy	Automated text messaging service for appointment reminders	• Reduction in DNA's
Digital Strategy	In July 2021, we successfully introduced a new client record system, Maxims. Since then, the system has been continually reviewed and developed to ensure it is effective and safe. This has reduced the use of paper forms by adding them to Maxims, including risk assessments for safeguarding, STI, Venous	• A well-documented, accessible client medical record reduces multiple patient safety risks as all necessary information is available in one place to multiple teams with role-based access.

Transformation Area	Detail	Known or expected impact on patient safety
	Thrombosis (VTE) and WHO Surgical Safety assessments.	
Client Booking Experience	True One Call process – clients are provided with an opportunity to proceed direct to phone assessment at the time of the booking call	• Reduces the number of contacts a client has before treatment to improve access and client experience. • Reduction in service delivery incidents related to appointment delays and incorrect bookings. •
Surgical Strategy – Access to services	In addition to our digital strategy improvements above, one of our key priorities for improvement is to ensure all clients are offered an appointment within 5 working days of referral and a treatment appointment within five working days of deciding to proceed. As the abortion sector is experiencing unprecedented demand with limited opportunity to increase capacity across providers, we will continue to monitor patient safety incidents where access is a contributory factor. Our Surgical Strategy task and finish team will review current performance to identify areas for improvement, align services to meet the demands of clients and the sector and	• Drive down wait times for surgical abortions and greater capacity and resilience within the service. • Procedure complications and risk is reduced the earlier the abortion procedure is carried out. • Reduce inequalities in accessing our services

Transformation Area	Detail	Known or expected impact on patient safety
	enhance capability and resources to increase our impact.	
Clinical Pathways – Telemedicine	The telemedicine service has recently been reviewed following patient safety incident investigations and a thematic analysis of incidents to ensure controls are effective. We have seen increased capacity with an additional telemedicine hub. A pharmacy service has been implemented to supply telemedicine medication directly to clients. Our pathway has been updated to ensure Clients that have had a previous abortion in the last 3 months or have an LMP of 3 weeks or less, are brought in for an ultrasound assessment.	• The number of incidents relating to gestation greater than expected within MSI is lower than known risk nationally (0.1%) at 0.02%. • Reduction in medicines management incidents. • Clients attending the Centre for an ultrasound assessment if they have had a previous abortion or taken Emergency Contraception in the last 3 months or an LMP of 3 weeks or less to confirm pregnancy gestation.
Clinical Pathways – Surgical Abortion	We have significantly reduced serious incidents and harm, resulting in improved quality of care through our work on Just and Open Culture and our appetite to investigate and learn from patient safety events and clinical complications in an environment that provides physiological safety for our colleagues. Our Clinical Education team introduced in-house, regular training courses, which include haemorrhage	• Swift recognition and management of known surgical abortion complications results in minimal intervention and improved outcomes. • Dedicated RightCare team and pre-existing conditions guidance ensures clients are treated in an environment which meets their needs and reduces risk. • Cervical preparation changes will improve client experience with less side effects, reduced

Transformation Area	Detail	Known or expected impact on patient safety
	workshops, emergency simulations and human factors. We have well-established pre-existing guidance to ensure clients receive safe care in the appropriate environment and a dedicated team, 'RightCare', to manage onward referrals and complex medical information. We see very few serious incidents due to improvements in Haemorrhage management, Emergency Care Pathways and early recognition and management of deteriorating clients. Our Cervical preparation pathway review will see misoprostol replaced with mifepristone as the first choice agent for gestations before 19 weeks which aligns to national practices. There will be three cervical preparation pathways dependant on the clients pregnancy gestation.	pre-op wait times in the centre and improved surgical list efficiencies.
Vasectomy Service	A project is underway to transform the Vasectomy service. The project will review four areas of the service: Colleagues, Sustainability, Quality, and Service Delivery.	• The project aims to enhance clinical effectiveness by proactively identifying and managing clients at a greater risk of a complication including a surgical site infection through enhanced risk assessing, development

Transformation Area	Detail	Known or expected impact on patient safety
		of increased infection protocols and routine post-operative follow ups.
Clinical Pathways - Ultrasound	Following a review of the Ultrasound service, transvaginal ultrasound for all clients with an estimated pregnancy gestation of 6 weeks and 6 days is now routinely offered to all clients as the preferred over transabdominal ultrasound. The Ultrasound Policy and standard operating procedure have been reviewed, including the treatment decision algorithm in line with NICE best practice guidance.	• Whilst we cannot prevent ectopic pregnancies from occurring, our processes and pathways should identify timely care at the earliest opportunity, resulting in a reduction in delayed management of ectopic pregnancy incidents.

Our patient safety incident response plan: national requirements

Some events in healthcare require a specific type of response. These include mandatory patient safety investigations (PSII) in some circumstances or review by or referral to. Another body or ream, depending on the nature of the event. The table below summarises how MSI Reproductive Choices UK will respond to incidents defined as national events applicable to our service.

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, we are now able to balance effort between learning through responding to incidents or exploring issues and improvement work.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria 2018 Never Events within MSI – 'Retained Surgical Swab'	PSII	Create local and/or organisational action plans which feed into the quality improvement strategy
An incident that has resulted in death thought more likely than not due to problems in care provided by MSI *(Incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))*	PSII Refer to necessary external bodies as per MSI UK Incident Management Policy to establish external investigation requirements.	For independent or joint investigations, work with external partners, responding to organisational action recommendations and feed these into the quality improvement strategy If an external investigation is not required, local and organisational actions should feed into the quality and improvement strategy
Child deaths	Refer to Child Death Overview Panel review PSII maybe required alongside the panel review	For independent or joint investigations, work with external partners, responding to organisational action recommendations and feed these into the quality improvement strategy
Safeguarding incidents in which • Babies, children or young people are on a child protection plan; looked after plan or victim of wilful neglect or domestic abuse/violence • adults over 18 years old are in receipt of	Refer to local authority safeguarding lead Participate and contribute towards domestic independent enquires, joint targeted are inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews or inquires as required to do	Create local and/or organisational action plans

care and support needs from the local authority • the incident related to FGM, Prevent, (radicalisation to terrorism), modern day slavery and human trafficking or domestic abuse/violence	so by the local safeguarding partnership (for children) and local safeguarding adults boards	
Maternal death of a patient within 42 days of the end of the pregnancy (excludes cases where suicide is the cause of death)	Refer to the Healthcare Safety Investigation Board for independent PSII	Respond to recommendations from externally referred agencies/organisations as required and feed actions into the quality improvement strategy

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. Through our analysis of our patient safety insights and based on the review of our patient safety profile, we have agreed five patient safety priorities as local focus, whereby a full patient safety incident investigation should be undertaken. We will use the outcomes of PSII to inform our patient safety improvement planning and work.

We have identified a further six priorities that may not meet the PSII criteria, however the planned response will be a method from the PSIRF toolkit to enable a learning response. For those incidents where the themes and system factors are well known, we propose to manage these at a local level with ongoing thematic analysis to inform and supplement existing improvement work. Learning responses listed can also be applied to good or positive care to understand what was particularly successful and how this can be applied elsewhere. Learning responses to incidents will be initially agreed by local centre management teams supported by their Quality & Governance team. CLIPS will review all incidents and learning responses each week and may request a different learning response

if required. Learning response outcomes will be reviewed by CLIPS and through our UK Governance Structure.

Patient safety incident type or issue	Planned response	Anticipated improvement route
Any incident or clinical complication including infection, that has caused or has the potential to result in moderate, severe or catastrophic harm, including psychological harm, where the learning is felt to be significant and/or contributory factors are not well understood. As these types of incidents are rare within our services, a PSII will be undertaken.	Patient Safety Incident Investigation (PSII). And a thematic review if a trend is identified by incident type of three or more incidents within the region in a 12 month period.	Create organisational wide safety improvement recommendations and actions or individual safety improvement plans for a specific service, pathway or location
Delayed Management of Ectopic Pregnancy, where there is a missed opportunity to identify and manage inline with our policy / SOP		
An incident defined as zero tolerance relating to patient safety: • Mis-Management of Pregnancy Remains • Two signatures not included on the HSA1 certificate • Safeguarding: Client not adequately Safeguarded		
Continuing with an unwanted pregnancy due to a local service delivery incident i.e. incorrect documentation of	After Action Review (AAR) or multi-disciplinary team	Create both local and organisational recommendations and actions

pregnancy gestation or booking error	(MDT) review if multi agency involvement	feeding into patient safety and service delivery priorities
Telemedicine Gestation Greater than Expected that has resulted in a moderate increase in treatment	Multi-disciplinary team review Proceed to PSII if contributory factors are not known or well understood Annual thematic analysis over a 12 month period	Inform ongoing monitoring and service improvement efforts for a specific service
Clinical complications resulting in an emergency transfer, as a result of treatment, from the Centre	SWARM /De-brief AAR may follow	To identify any local or organisational patient safety improvement actions
Surgical abortion, Vasectomy or LARC complications where the contributory factors are well understood and there are no known learning opportunities indicated	SWARM /De-brief	To identify and inform any local or organisational patient safety improvement actions
Low/no harm and high frequency incidents	Local review Local thematic analysis every 6/12 months from each region which is presented to CLIPS group	To identify any local or organisational improvement actions or inform ongoing improvement projects
Medication incidents including controlled drugs and anti-d errors which result in no or low harm	Local incident review AAR if required	To identify and inform any local or organisational patient safety improvement actions
Any other low/no harm incidents that are infrequent/uncommon	Local incident review	To identify and inform any local or organisational patient safety improvement actions

Complaints and Feedback

MSI Reproductive Choices UK aims to provide the best possible service and care to all our patients.

We understand, however, that there will be occasions where complaints will be made. We appreciate feedback of this nature in order for us to address any area/s of our service that require improvement and make changes where necessary. Making a complaint will not have a negative effect on care or treatment provided. Complaints and feedback can be made in several ways:

- by completing our 'Tell Us About Your Experience' questionnaire Tell Us About Your Experience (office.com)
- Share Your Story Abortion stories from our clients - MSI Reproductive Choices UK (msichoices.org.uk)

Contact us by webchat Contact Us - MSI Reproductive Choices UK (msichoices.org.uk) or email services@msichoices.org.uk

For Formal Complaints:

- by telephoning the relevant centre to speak with a manager or supervisor
- in writing to Head of Quality and Customer Services
- by e-mail to Quality.customerservice@MSIChoices.org.uk
- by contacting your local ICB or NHS England (NHS complaint process

For further information please see our Statement of Purpose Statement of Purpose - MSI Reproductive Choices UK (msichoices.org.uk)

Appendix A

Glossary of terms

Patient Safety Incident Response Framework (PSIRF)

This is a national framework applicable to all NHS commissioned services including independent providers outside of primary care. Building on evidence gathered and wider industry best-practice, the PSIRF has four key aims to enable a risk-based approach to responding to patient safety incidents;

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Patient Safety Incident Response plan (PSIRP)

This is our local plan which sets out how MSI UK will carry out the PSIRF locally including our list of identified local priorities. These have been developed through a collaborative approach internally and externally with subject experts and risk leads supported by analysis of local data. Learning responses can be applied to identify good or positive care as well as looking for improvement opportunities.

Patient Safety Incident Investigation (PSII)

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

After Action Review (AAR)

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

Multi-Disciplinary Review (MDT)

A multi stakeholder round table review with internal / external organisations that have been involved in the patient safety event. The meeting is usually held as a remote team's meeting for 1 hour. The team discuss what would good look like, what happened in this situation,

what were the barriers and compare good to the actual situation. The meeting generates a bullet point list of actions and this informs a letter to share with the patient / family.

SWARM / De-brief

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

Never Event

Patient safety incidents that are considered to be wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Appendix B

References

MSI Reproductive Choices website: MSI Reproductive Choices UK – Your Choice, Our Support (msichoices.org.uk)

NHS England's Patient Safety Strategy NHS England » Patient safety

NHS England PSIRF Guidance - NHS England » Patient Safety Incident Response Framework and supporting guidance

NHS Long term plan to ensure the service is fit for the future: NHS Long Term Plan

MSI's published report about the quality of services and improvements offered: MSI UK Quality Account 2022-2023 (msichoices.org.uk)