MSI Reproductive Choices UK

Patient Safety Incident Response Plan

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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

Review and Amendment Log

Version No	Type of Change	Date	Description of change
V2	Major	August 2025	Safety profile, current and future quality improvement work updated Local safety priorities and responses updated following a review and analysis of 12 months safety data
V1	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

1. Introduction

MSI Reproductive Choices UK provides reproductive services to clients under the NHS Standard Contract. The Patient Safety Incident Response Framework replaces the Serious Incident Framework (2015) 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 the next 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, responding and adapting as necessary. Our Incident Management Policy underpins this plan and will be reviewed every 12-18 months with our lead Integrated Care Board (ICB) but can be more often as this is a live, evolving document.

2. 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, healthcare assistants and client care coordinators, 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 contact 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.

3. 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 our colleagues. 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, 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 each year since 2021 to -2025, 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 a clinical incident reporting rate greater than 2%, assuring us that our colleagues feel psychologically safe to report clinical complications and incidents, supporting our efforts of

continuous improvement 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. Learning responses and panel review meetings are attended by those involved and 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 since the transition to the Patient Safety Incident Response Framework in March 2024 to March 2025. During the review, we engaged and consulted with key stakeholders. This plan applies to all patient safety incidents relating to termination of pregnancy, contraception and vasectomy services.

4. Stakeholder Engagement:

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

- Commissioners
- Our colleagues
- Clients, relatives/families and carers
- Other independent providers for reproductive health

5. 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
- Colleague 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, along with careful consideration of safety improvement opportunities, knowledge, plans, and interventions already in place. We considered current and future quality improvement projects, including our Digital Strategy and Quality Priorities.

Safety issues identified as most pertinent are mismanagement of pregnancy remains, perforated uterus not recognised before discharge, where discharge policy/process is not followed, Information governance breach that has or had the potential to put the client at

significant risk of harm, failure to safeguard a client resulted in harm or any incident or complication that has caused or has the potential to result in moderate or greater harm, where the learning is felt to be significant and/or contributory factors are not well understood.

6. 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 diligent efforts to foster an open, learning culture, whereby staff feel psychologically safe to raise concerns, report safety incidents and near misses, and actively contribute to learning from patient safety incidents.

Transformation Area	Detail	Known or expected impact on patient safety
Digital	Our Client Portal 'Blue Door' introduced in August 2025. This is a secure place for clients to create their digital record and submit their medical history at a time that is convenient for them. The portal guides clients through eligibility checks, collects their demographics and medical history, and enables them to request an appointment. The portal will triage clients for an ultrasound scan or medical review for pre-existing conditions. The portal provides clients with all necessary information, including pre-booking checklists and treatment information. Phase 2 of this project will allow clients to book, reschedule, or cancel appointments and view their record.	• Improved, instant access to information and appointment requests online, which is accessible, convenient and discreet. • Reduction in documentation errors, missed Right Care referrals or failure to follow pre-existing conditions guidance, which can impact timely access to services. • Reduced service delivery incidents relating to incorrect bookings and failed communication, which can contribute to patient safety events. • Reduction in 'Did Not Attend' (DNAs), which improves capacity utilisation and further reduces wait times by

Transformation Area	Detail	Known or expected impact on patient safety
		avoiding empty appointment slots.
Digital	We continue to evolve our website; the most recent improvements include: <u>Eligibility Checker:</u> Our new eligibility checker removes a key barrier to accessing care by simplifying NHS contracts and NHS eligibility for clients. At MSI UK, we have long been advocating for a change to the way abortion care is commissioned across England, and the "postcode lottery" that it creates, with different eligibility criteria in different parts of the country. With our new eligibility checker, clients can use their GP postcode to find out if MSI is the commissioned provider in their area. <u>Booking Information</u> Our new booking pages are designed to support clients understanding their options: Request a call back via our quick online booking form Fill in their health information and request an appointment with our new client portal, Blue Door Or an option that will always remain available to anyone looking to access care with us - give us a call and speak with our Client Care Coordinators.	• Improved information and access to reduce avoidable delays.
Electronic Record System	A HSA1 form is signed by two medical practitioners to confirm that a person meets the criteria for an abortion under the abortion act 1967. The form is a legal requirement and must be in place prior to a medical or surgical abortion taking place. Since the introduction of our client record system 'Maxims' in 2021, the HSA1 certificate changed from a paper form to an electronic document held on each client record under 'referral details'. The HSA1 signatures, date	• Whilst an incomplete HSA1 form is an extremely rare event and unlikely to impact on patient safety, this improvement ensures clinicians will be unable to proceed with prescribing medications for medical or surgical abortion without a complete HSA1 form.

Transformation Area	Detail	Known or expected impact on patient safety
	and time are included on the form and visible for all relevant colleagues to review at multiple checkpoints in the client's journey. This process is audited to ensure all forms are completed prior to an abortion. A new system control has been designed and approved for implementation in 2026 to support our current procedures and processes.	
Client Booking Experience	We continue to develop our call centre workforce at MSI Connect with multi-skilled agents, to ensure clients are provided with an opportunity to proceed directly to a phone consultation 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.
Access to services	Timely access to face-to-face abortion services remains one of our key priorities for improvement. Our priority is to offer assessment appointments within five working days of referral and a treatment appointment within five working days of deciding to proceed. To support this, we have opened three new community treatment hubs in Merry Hill, Chesham, and Reading, and two new regional treatment centres in Oxford and South Yorkshire, to enhance accessibility to our services significantly. In 2026, a new regional treatment centre with open in the West Midlands region. We continue to lead on addressing the long-standing skills shortage in the abortion sector by training doctors in these vital skills. This has contributed to strengthening workforce capacity within our organisation and the NHS, improving access to essential surgical abortion services.	• Drive down wait times for face-to-face abortion services by increasing capacity and resilience within the service. • Additional centres across the country to improve local access, reducing travel for clients. • Procedure complications and risk are 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
Clinical Pathways - Ultrasound	We have reviewed and updated our electronic systems, training and information provided to clients to ensure: • all clients with an estimated gestation of 3 weeks 6 days at the time of booking receive a trans-vaginal ultrasound scan • Information is provided to clients in advance of their appointment to advise if a trans-vaginal scan maybe required • Ultrasound training has been updated to expand on the incidences of fluid and ectopic pregnancy • Implemented and updated audit programme for ultrasound • Updated training to include further information on the incidence of fluid in the uterus and the possible indication of an ectopic pregnancy (along with other ectopic features/indications)	• Whilst we cannot prevent ectopic pregnancies from occurring, our processes, training, pathways and information should identify timely care at the earliest opportunity, resulting in a reduction in delayed management of ectopic pregnancy incidents.

7. 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, as well as 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 • Incorrect coil device • Retained Surgical Swab	PSII	Create local and/or organisational action plans which feed into our 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 the necessary external bodies as per the MSI UK Incident Management Policy to establish external investigation requirements. If child - refer to the Child Death Overview Panel review	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.
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 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	Refer to the local authority safeguarding lead. Participate and contribute towards domestic independent enquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews or inquiries as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards	Create local and/or organisational action plans.

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

8. 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 four 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**
1. 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.	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
2. Mismanagement of Pregnancy Remains		

which resulted in the patient not being able to have their chosen management. 3. Perforated uterus not recognised before discharge, where discharge policy/process is not followed 4. Information governance breach that has or had the potential to put the client at significant risk of harm 5. Failure to safeguard a client which resulted in harm		
Spontaneous miscarriage in the centre following cervical preparation, where learning is indicated following local review by the Clinical Services Matron or Registered Manager	After Action Review (AAR) Annual thematic analysis for all cases over a 12 month period	
Telemedicine Gestation Greater than Expected that has resulted in a moderate increase in treatment For incidents that have had a minor increase in treatment (no or low harm) a local incident review will be undertaken which includes call audits by the Clinical Services Matron for the relevant Centre	After Action Review (AAR) Annual thematic analysis over a 12 month period	Inform ongoing monitoring and service improvement efforts for a specific service

Continuing with an unwanted pregnancy due to a local service delivery incident i.e. incorrect documentation of pregnancy gestation or booking error	After Action Review (AAR) or multi-disciplinary team (MDT) review if multi agency involvement	Create both local and organisational recommendations and actions feeding into patient safety and service delivery priorities
Clinical complications resulting in an emergency transfer from the Centre, as a direct result of treatment	SWARM AAR may follow	To identify any local or organisational patient safety improvement actions
Abortion, Vasectomy or Long Acting Reversible Contraception (LARC) complications including infection where the contributory factors are well understood and there are no known learning opportunities indicated	Local incident review	To identify and inform any local or organisational patient safety improvement actions
Low/no harm and high frequency incidents	Local incident review 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

9. 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.

Feedback:

- 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)

For informal or formal Complaints:

- by telephoning the relevant centre to speak with a manager or supervisor
- 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
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

MSI's published report about the quality of services and improvements offered: MSI-UK-Quality-Accounts-2024-2025.pdf

The Abortion Act 1967 Abortion Act 1967