PSIRF Plan

June 2026

www.bpas.org

Head Office: Orion House, 2 Athena Drive, Tachbrook Park, Leamington Spa, CV34 6RQ

T: 0345 365 5050 or +44 1789 508 211

Document Control

Lead/author	Lisa Aguado
Owner (Chief Officer)	Dianne Brown
Version	V2.0
Status	Approved
Approved by	Quality and Risk Group and ICB endorsement
Approval date	22nd July 2026
Issue date	August 2026
Next review date	April 2028
Target audience	BPAS staff, patients and external agencies
Related policies	PSIRF Policy

Version History

Version	Date	Author	Status	Notes / Comments
V2.0	July 2026	Lisa Aguado	Approved	New patient safety priorities. Expanded to demonstrate progress. Endorsed by lead ICB
V1.0	August 2024			New document

Version	Date	Review Due	Document Owner
V2	April 2026	April 2028	Patient Safety and Risk Lead

Contents

Version	Date	Review Due	Document Owner
V2	April 2026	April 2028	Patient Safety and Risk Lead

1. Introduction

The NHS Patient Safety Strategy (2019) describes the Patient Safety Incident Response Framework (PSIRF) as "a foundation for change." This framework invites us to think and act differently when patient safety incidents occur.

PSIRF represents a significant departure from our historical approach to patient safety. What makes it particularly important, is that it is not a simple revision of previous models - it marks a complete cultural shift in how we understand, respond to, and learn from patient safety incidents to prevent them from happening again.

The challenge for BPAS, as we move into a new phase of patient safety under PSIRF, is to shift our focus away from investigating incidents simply because they meet specific criteria, and instead concentrate on achieving meaningful outcomes that promote learning, drive improvement, and prevent future harm.

It promotes a coordinated, evidence-based approach to enhance learning and drive improvement across the organisation. This Patient Safety Incident Response Plan (PSIRP) outlines how BPAS will respond to patient safety incidents reported by our staff, external agencies, patients, and their families or carers over the next 24 months. Through this, we aim to actively identify opportunities to strengthen the quality and safety of the care we provide.

This plan is not a fixed or static document; we will remain flexible and responsive, taking into account the unique circumstances surrounding each patient safety issue and the needs of those involved. We will regularly review and evaluate the effectiveness of this approach, making adjustments as necessary to ensure it continues to support a culture of learning and continuous improvement. Amendments will be reviewed in partnership with our lead Integrated Care Board (ICB).

This plan has been through BPAS governance process and has had executive oversight through the relevant committees and executive lead supportive oversight.

2. Our Services

BPAS is an independent provider of abortion, contraception and vasectomy services across the UK, with 43 clinics/telemedical hubs and a head office and Booking and Information Centre in Leamington Spa. Our services support patients at some of the most sensitive and complex points in their lives, making patient

safety, compassion and trust central to all aspects of care. Our 24 hour Aftercare service is available to all patients who have accessed care for either the ending of a pregnancy or vasectomy which receives around 1200 calls per week. Emotional support or counselling is also offered to our patients. Our services are commissioned by multiple Integrated Care Boards (ICBs) across England and Wales.

Care is delivered by a skilled and committed multidisciplinary workforce. The knowledge, experience and professionalism of our staff is fundamental to maintaining safe services and responding effectively to patient safety events to focus on learning and improvement. We recognise that supporting our workforce is essential to creating a culture in which patient safety events can be raised openly and addressed constructively.

BPAS is undergoing a period of organisational transformation, with a focus on improving patient pathways and strengthening clinical leadership across the organisation. This includes developing clearer clinical governance structures, enhancing how safety learning is shared, and embedding consistent approaches to learning from patient safety incidents. These changes are intended to support a just and learning culture, improve patient outcomes, and ensure that safety improvement is led and informed by clinical expertise.

BPAS core services:

- Termination of pregnancy which includes:
    - Early Medical Abortion without scan up to 9 weeks and 6 days
    - Early Medical Abortion with scan up to 10 weeks and 0 days
    - Surgical Termination of Pregnancy under local anaesthetic to 13 weeks and 6 days
    - Surgical Termination of Pregnancy under conscious sedation to 17 weeks and 6 days
    - Surgical Termination of Pregnancy under general anaesthetic to 23 weeks and 6 days
- Vasectomy Care
- Contraception counselling and fitting (ICB dependent)

3. Defining Our Patient Safety Profile

BPAS is committed to providing a safe, positive, and inclusive environment for all who use our services, as well as their families, partners, visitors, and colleagues. We have a responsibility to maintain effective systems for identifying, reporting, managing, and responding to patient safety incidents. These systems protect people, safeguard resources, and uphold the quality of our care.

This second Patient Safety Incident Response Plan (PSIRP) outlines how BPAS will learn from patient safety incidents as we continue to embed the principles and ethos of PSIRF. Our approach is guided by systems-based thinking, transparency, and a culture of openness and engagement. We are committed to involving patients, families, and staff compassionately, and to using the insights gained from incidents to strengthen practice, reduce risk, and continuously improve the safety and quality of care we provide.

To determine the patient safety priorities most relevant to our organisation, the patient safety team conducted a thematic review of organisational data collected between August 2024 and August 2025, following the transition to the Patient Safety Incident Response Framework. Subject matter experts were engaged in the refining of these priorities. This plan encompasses all patient safety incidents associated with termination of pregnancy, contraception, and vasectomy services.

Data/Intelligence Resources:

- Insight Incident Management System: 18 months of incident reports were thematically reviewed
- Complications data
- Formal complaints and local concerns were thematically reviewed
- Litigation data
- Patient satisfaction surveys
- Freedom to Speak Up Guardian data
- Professional Midwifery Advocacy themes of Restorative Supervision

Stakeholders: It has been vital to consult and hear the voices of stakeholders throughout the process of identifying BPAS patient safety priorities for this new phase in the embedding of PSIRF.

- Commissioners
- BPAS colleagues across all services and roles
- Patients and their supporters/families
- Patient Safety Partner
- Other abortion providers

We reviewed patterns of incidents, key themes, frequency of recurrence, and levels of harm. This included a thoughtful assessment of existing safety initiatives, staff knowledge, established plans, and current interventions. We also reflected on ongoing and planned quality improvement and transformation activity, including the Digital workstreams and agreed Quality Priorities, to identify further opportunities to strengthen patient safety.

A key challenge identified during the data review was that the incident data did not accurately represent the patient safety concerns being identified through governance pathways and local discussions. One contributing factor was that the existing categories and subcategories lacked sufficient clarity to support accurate analysis and meaningful interpretation of trends. In response, a comprehensive review and redesign of these categories has been completed in collaboration with key stakeholders to ensure that future data more effectively informs improvement activity and priority setting. This work will be implemented from 1 July 2026 and is expected to strengthen the robustness of the next review cycle, supported by a strengthen team with expertise in data analysis.

Other safety issues identified as particularly relevant relate to instances where gestation is greater than expected following EMA, situations where patients are experiencing or are reported to be in mental health crisis, delays in care that affect a patient's ability to access treatment or their preferred method of care, and weaknesses in the recording of medicines dispensed or administered. We have not prescribed fixed learning responses for these areas; instead, we will take a collaborative and proportionate approach, using appropriate learning tools to draw out the richest learning and ensure it is shared effectively. This will be supported by a stronger focus on thematic reviews and more responsive, timely investigations to enable meaningful improvement.

4. Our Patient Safety Profile

Our patient safety improvement strategy is shaped by a comprehensive review of previous work, current initiatives, and planned developments that are expected to strengthen safety over the coming 24 months. This includes participation in national programmes alongside locally led service transformation and Quality Priorities.

At BPAS, the incident profile is predominantly low or no harm. Of the 8,943 incidents categorised by harm level, around 72% (6,434) resulted in no harm and 27% (2,424) in low harm, with a very small proportion resulting in moderate harm at under 1% (83 cases) and severe harm at less than 0.1% (2 cases).

Existing quality improvement work is centred on building service resilience and increasing capacity, so that care continues to be safe, effective, and easy to access while responding to evolving client needs and wider pressures affecting abortion and contraception services.

This plan also reflects our commitment to fostering an open, learning-focused culture. We aim to ensure staff feel supported to speak up, report incidents or near misses, and contribute to shared learning that leads to meaningful and lasting improvements in patient safety.

BPAS Formal Learning responses since the implementation of PSIRF

Learning Response	Total completed since August 2025
PSII	7
AAR	9
MDT	3
Thematic Review	5
SWARM	4

Through our review of PSIRF activity, we identified a need to increase the use of learning and improvement approaches such as AARs, Local Learning Reviews and SWARMs, alongside strengthening collaboration with partner agencies. This will support more timely, proportionate learning and help embed shared improvement across services.

The priorities identified within the original plan have been reviewed against the available incident data, intelligence from governance processes, and current patient safety challenges. This review demonstrated that the existing data does not support these priorities remaining within the revised plan, as they are not reflective of the themes and risks being identified through governance channels or local safety discussions. The updated priorities have therefore been developed to better align with the current patient safety landscape and the issues most frequently identified through incident review and organisational learning processes. We have also placed 'working with external partners' as an overarching priority rather than as an individual standalone priority. So although this is no longer contained within the table, it is still a clear focus.

A core focus for BPAS in this next phase of PSIRF is strengthening a culture of local ownership of learning, aligned to the priority of increasing the visibility and uptake of local learning responses to strengthen patient safety improvements. Divisional teams are encouraged and supported to identify patient safety learning opportunities within their own services, share learning openly, and work collaboratively with other divisions, teams, and partner agencies. This shared approach to learning and improvement will help embed continuous improvement in everyday practice and drive meaningful change to make care safer for patients.

5. Our Patient Safety Incident Response Plan: National Requirements

Some healthcare incidents require a formal and clearly defined response. In certain situations, this may involve undertaking a mandatory Patient Safety Incident Investigation (PSII), or seeking input from an appropriate external organisation or specialist service, depending on the seriousness and characteristics of the event. The table below explains how BPAS manages incidents classified as national events that relate to our services.

Within the PSIRF framework, there are no additional nationally set criteria that determine which type of response must be used to promote learning and improvement. This allows BPAS to apply professional judgement, ensuring a balanced approach between investigating individual incidents and identifying broader patterns or opportunities to strengthen practice across the organisation.

Patient Safety Incident Type	Required Response	Anticipated Improvement Route
Incidents meeting the Never Events criteria Never events applicable to BPAS: ○ Implantation of an intrauterine contraceptive device different from the one in the procedural plan. ○ Retention of a foreign object in a patient after a surgical/invasive procedure.	Proportionate response to be determined at PSERG in conjunction with relevant ICB.	Create local and organisational action plans that are used to inform service improvement and transformation.
Deaths clinically assessed as more than likely than not due to problems in care provided by BPAS.	PSII Refer to the necessary external bodies as per BPAS policy to establish external investigation requirements. If the incident involves the death of a child: refer to the Child Death Overview Panel review.	Create local and organisational action plans that are used to inform service improvement and transformation.

Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the learning from deaths criteria)	PSII	Create local and organisational action plans that are used to inform service improvement and transformation. BPAS may not be the lead on incidents of this nature but will collaborate with other agencies
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel	Create local and organisational action plans that are used to inform service improvement and transformation. BPAS may not be the lead on incidents of this nature but will collaborate with other agencies
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	Externally led PSII
Maternity and neonatal incidents meeting the HSIB criteria	Refer to HSIB for independent PSII	For independent or joint investigations, BPAS will work with external partners, act on recommendations, and embed learning into the quality improvement strategy. Where no external investigation is needed, local and organisational actions will still inform ongoing quality improvement and transformation.
Safeguarding incidents in which:	Refer concerns to the local authority safeguarding lead and engage with any required safeguarding processes. This	Create local and organisational action plans that are used to inform service improvement and transformation.

○ 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	includes contributing to domestic homicide reviews, child safeguarding practice reviews, joint targeted area inspections, domestic independent enquiries, and any other reviews requested by local safeguarding partnerships for children or safeguarding adults boards.	

6. Our Patient Safety Incident Response Plan: Local Focus

PSIRF enables organisations to focus on patient safety incidents that are most relevant to their services and the communities they support. Utilising our analysis of patient safety insights and a detailed thematic review of our current safety profile, BPAS has identified six key patient safety priorities that will form the focus of our local work. For these areas, a full multidisciplinary discussion will be held in the weekly Patient Safety Event Response Group meeting to determine the learning response that will elicit the most effective improvement actions and will always be focussed on the learning potential of incidents.

The findings and learning from these investigations will directly inform our ongoing patient safety improvement activity and help shape future priorities to strengthen the quality and safety of the care we provide.

Through the application of the PSIRF toolkit, including structured thematic reviews and analysis of patient safety insights, BPAS has identified a gap in consistent local ownership of learning from patient safety events. In particular, opportunities exist to strengthen how learning is interpreted, shared, and translated into practical service improvement. Addressing this is now a key local priority. By utilising PSIRF methodologies

to support open discussion, thematic learning, and multidisciplinary engagement, BPAS aims to embed a stronger culture where patient safety learning is visible, actionable, and recognised as a shared responsibility across all teams.

BPAS is committed to meaningful, compassionate and proportionate involvement of patients, families and carers throughout patient safety incident investigations and other learning responses. Patients and families will be offered appropriate opportunities to share their experience, perspective and concerns during investigations and other learning responses, including Patient Safety Incident Investigations, After Action Reviews and other proportionate reviews. Their views and experiences will be considered when understanding what happened, identifying contributory factors, determining learning and developing improvement actions. Engagement will be tailored to individual circumstances and preferences and may include telephone or written communication, discussion with those involved in the learning response, or participation in relevant review processes. Where direct involvement is not possible or appropriate, available patient experience, complaints, correspondence and other relevant sources of patient voice will be considered to ensure that the patient perspective informs learning and improvement.

BPAS recognises that patient safety incidents can have a practical and emotional impact on patients, families, carers and staff. Patients and families will receive compassionate communication, appropriate information about the incident and learning response, and opportunities to ask questions or raise concerns. Where appropriate, individuals will be offered or signposted to practical, emotional, clinical or wellbeing support according to their needs. Staff involved in or affected by a patient safety incident will be supported through their line manager and established organisational wellbeing arrangements, including access to appropriate debriefing, occupational health, employee assistance or other professional support where required. BPAS will promote a compassionate and just culture in which patients, families and staff are supported to contribute openly to learning and improvement.

Local Priorities

In addition to the below defined patient safety priorities, any incident or clinical complication where the learning is felt to be significant and/or contributory factors are not well understood – including groups of incidents with similarities, regardless of level of harm can be considered for a formal learning response through the governance pathway.

These priorities will be supported by the increased visibility and uptake of local learning responses to strengthen patient safety improvements. How local teams, learn from and translate this learning into meaningful improvement will be constantly evaluated and shared organisationally.

Patient Safety Incident Type or concern	Planned Response Options	Anticipated Improvement Route
Gestation larger than expected following a no scan EMA.	Local Learning Review SWARM Patient Safety Meeting to determine proportionate learning response if identified omissions in care or any learning opportunities following Local Learning Review.	Learning from this work to be utilised in improvement work to be shared organisationally and outside of the organisation and used to inform service improvement.
Incidents involving patients reporting or being reported as being in mental health crisis	SWARM Local Learning Review Thematic review	Quality Improvement Plan to be created and findings used within existing transformation work and for local service improvements.
Delays in care that result in a patient not receiving their choice of treatment or being able to access treatment.	SWARM Local Learning Review Thematic review after 6 months to inform quality improvement work MDT/AAR	Quality Improvement Plan to be created and findings used within existing transformation work and for local service improvements.
Incidents where documentation of medication dispensed or administered is inadequate or incorrect.	Local Learning Review Thematic Review by medicines management team.	Quality Improvement Plan to be created and findings used within existing transformation work and for local service improvements.

7. Working and Learning Collaboratively with NHS Trusts and Other External Agencies

Working and learning collaboratively with NHS Trusts and other external agencies remains an essential priority when considering potential learning. Many patient safety issues span organisational boundaries, and meaningful improvement often relies on shared understanding, joint reflection, and coordinated action. By engaging proactively with external partners, BPAS can strengthen the quality of its learning, ensure alignment in care pathways, and contribute to wider system improvements. This collaborative approach supports the PSIRF principle of system-based learning and reinforces BPAS's commitment to working collectively to enhance safety for all service users.

8. Appendix 1: Glossary of Terms

Patient Safety Incident Response Framework (PSIRF)

PSIRF is a national framework that applies to all NHS-commissioned services, including independent providers outside of primary care. Informed by evidence and recognised best practice across the sector, it sets out four core aims to support a risk-based approach to managing patient safety incidents:

- ensuring compassionate engagement with, and involvement of, people affected by patient safety incidents
- using a range of system-focused methods to support learning from safety events
- delivering thoughtful, proportionate responses to incidents and emerging safety concerns
- providing supportive oversight that strengthens how organisations respond, learn, and improve their safety systems

Patient Safety Incident Response Plan (PSIRP)

This local plan outlines how BPAS will implement PSIRF in practice, including the locally agreed patient safety priorities. These priorities have been developed through a collaborative process involving internal teams, external partners, subject matter experts, and risk leads, informed by analysis of local data. Learning responses may be used both to recognise examples of effective, positive care and to identify opportunities where further improvement is needed.

Never Event

A Never Event is a serious patient safety incident that is considered wholly preventable because national guidance and strong safety barriers exist to stop it from happening. If a Never Event occurs, it indicates a significant failure in the systems and processes designed to keep patients safe and requires prompt reporting, review, and learning to prevent recurrence. Any learning response outside of a PSII will be discussed with the relevant ICB with rationale.

Proportionate Response Explanations:

Patient Safety Incident Investigation (PSII)

Patient Safety Incident Investigations (PSIIs) aim to explore the wider system issues that may have contributed to an incident, rather than focusing solely on individual events. The insights gained are used to develop meaningful and lasting improvements by bringing together learning from multiple investigations and other responses linked to similar types of incidents. Based on this collective understanding, recommendations and improvement plans are created to address the identified system factors in a sustainable way, ultimately supporting safer care for patients.

Thematic Review

A thematic review within PSIRF is a structured learning response that examines themes, patterns, and trends across multiple patient safety incidents, investigations, or sources of safety information, rather than focusing on a single event. It brings together qualitative and quantitative data to explore common system factors, contributory issues, and areas of risk. The purpose is to generate wider organisational learning, identify opportunities for improvement, and support the development of targeted, sustainable actions that strengthen patient safety across similar incident types.

Multidisciplinary Review (MDT)

A collaborative round-table review involving multiple stakeholders, including both internal and external organisations connected to the patient safety incident. This is typically held as a remote Teams meeting, where participants explore what best practice would look like, review what actually occurred, and identify any barriers by comparing the ideal scenario with the real events. The discussion produces a set of clear action points, which are then used to help shape a letter that is shared with the patient or their family.

After Action Review (AAR)

An evaluation approach used when the results of an activity or event have been notably positive or negative. Its purpose is to draw out key learning from these experiences, helping to highlight areas for improvement and ways to create more opportunities for successful outcomes.

Local learning review (LLR)

A Local Learning Review is undertaken by a Clinical Lead, Deputy, or Quality Matron to identify learning through a structured review of care following an incident. The process is also used to recognise examples of excellence and effective practice. With a clear systems-focused approach, key learning is shared within divisional patient safety huddles and through ShELS sessions to support wider organisational learning and improvement.

SWARM

A SWARM approach is used within healthcare to enable a rapid review of an incident. Staff come together quickly, often at the location where the event occurred to explore what happened from a systems perspective and provide immediate support to those involved, helping to identify early learning and actions. At BPAS there is a proforma on Microsoft Forms available to all staff that is then collated by the clinical risk and quality governance leads to identify themes and trends.

9. Appendix 2: Purpose of Groups/Meetings

Divisional Patient Safety Huddle (DPSH):

This group brings together divisional clinical, operational and governance representatives to review incidents reported within each division. It provides a forum to consider levels of harm, patient safety priorities, Duty of Candour and initial compassionate engagement with patients and families. Local learning reviews and SWARMs are shared, with opportunities for learning highlighted, and decisions are made about escalation to PSERG where appropriate. Agreed learning actions are documented and monitored to support improvement.

Weekly Patient Safety Meeting:

This meeting brings together senior leaders from medical, nursing, midwifery and operational teams, alongside clinical leaders, governance colleagues, patient experience and complaints, safeguarding and relevant subject matter experts. Staff affected by incidents are also welcomed to attend. Incidents

escalated for organisational oversight are considered in this forum, with proportionate learning responses agreed. The group also provides oversight of statutory Duty of Candour and CQC notifications, ensuring these are applied consistently and appropriately.

Learning Response Review Group (LRRG):

LRRG is a senior panel that provides assurance on PSII reports once they have been accepted by affected staff and patients. Using a research-based evaluation tool, the panel offers supportive oversight and constructive challenge to ensure final reports align with the principles and aims of PSIRF. Subject matter experts and external stakeholders also may attend this meeting.

Sharing to Ensure Learning (ShELS):

ShELS is an expanding and responsive forum for sharing learning from patient safety events across BPAS. It is delivered remotely and brings together presenters from a wide range of services, with sessions chaired by the governance team to support consistent learning and engagement.

Patient Safety Dashboard:

This meeting is open to colleagues across the organisation and provides transparent insight into patient safety at BPAS. The Patient Safety and Risk Lead, or a member of the Patient Safety team, presents the patient safety dashboard in line with commissioning guidance, with a clear focus on using data to drive improvement. The dashboard includes the mortality tracker and provides updates on learning responses as they progress towards completion.

Quality and Risk Group:

The Quality and Risk Group is the main governance forum for the organisation, providing oversight and approval of policies, escalation decisions and assurance reports, and offering senior-level assurance on quality and patient safety. The patient safety dashboard is presented here for oversight and to allow this to be integrated into board committee reporting and scrutiny.

10. Link to PSIRF Policy

All flowcharts are contained within the Supporting Information section of the PSIRF Policy and these documents should be used in conjunction with the other.

Version	Date	Review Due	Document Owner
V2	April 2026	April 2028	Patient Safety and Risk Lead

10. Reference List

Care Quality Commission (CQC) (2023) *Regulation 20: Duty of Candour*. Available at: https://www.cqc.org.uk

NHS England (2022) *Patient Safety Incident Response Framework (PSIRF)*. Available at: https://www.england.nhs.uk/patient-safety/incident-response-framework/

NHS England (2022) *Patient Safety Incident Response Plan (PSIRP) Guidance*. Available at: https://www.england.nhs.uk

NHS England (2023) *Learning from Patient Safety Events (LFPSE) Service Guidance*. Available at: https://www.england.nhs.uk

NHS England (2021) *A Just Culture Guide*. Available at: https://www.england.nhs.uk

Health Services Safety Investigations Body (HSSIB) (formerly HSIB) (2022) *Learning Response Toolkit*. Available at: https://www.hssib.org.uk

Version	Date	Review Due	Document Owner
V2	April 2026	April 2028	Patient Safety and Risk Lead