Spire Healthcare

Patient Safety Incident Response Framework (PSIRF) Plan

PSIRF Patient Safety Incident Response Framework

Looking after you.

Contents

1.0 Introduction

The Patient Safety Incident Response Framework (PSIRF) is a new approach to responding to patient safety incidents developed by NHS England. It is designed to help organisations learn from incidents and improve patient safety. As part of implementing PSIRF organisations must first develop a PSIRF plan which will highlight the key areas of patient safety concerns.

Spire Healthcare are committed to learning from patient safety incidents and improving our care. We believe that the PSIRF will help us to achieve this goal across the whole organisation.

This patient safety incident response plan sets out how Spire Healthcare intends to respond to patient safety incidents over a period of 12 months from 1 November 2023. 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.

This plan has been created with Just Culture in mind. Just Culture is a principle that promotes a blame-free environment where people feel comfortable reporting errors and near misses without fear of reprisal. It is based on the understanding that accidents and incidents are often the result of multiple factors, including human error, system failures, and organisational culture. Just Culture is at the very foundation of all what we do in the organisation and will enable Spire Healthcare to achieve its learning and improvement aims.

This document should be read in conjunction with Spire Healthcare's Patient Safety Incident Response Framework Policy. The Patient Safety Incident Response Framework Policy will be reviewed over Q3 of 2023 to align with PSIRF requirements.

For PSIRF Plan and Policy approval Spire Healthcare have engaged with one lead ICB as per NHS England's recommendations. A communication strategy is being developed which will provide PSIRF implementation progress reports to all the ICBs that sit across our service regions.

In order to comply with the health regulators that work across our services (Care Quality Commission in England, Healthcare Inspectorate in Wales and Healthcare Improvement in Scotland) Spire Healthcare will continue to work with these partners to ensure a consistency of care and service once PSIRF has been implemented. Spire Healthcare will also ensure compliance with patient safety policies that originate from outside of NHS England for example the National Policy on Patient Safety Incident Reporting in Wales.

2.0 Our services

Spire Healthcare is a leading independent healthcare group in the United Kingdom, with 39 hospitals and 33 clinics, medical centres and consulting rooms across England, Wales and Scotland.

Working in partnership with over 8,700 experienced consultants, Spire Healthcare delivered tailored, personalised care to around 926,500 in-patients, out-patients and day case patients in 2022, and is the leading private provider, by volume, of knee and hip operations in the United Kingdom. The Group's well-located and scalable hospitals have delivered successful and award-winning clinical outcomes, positioning the Group well with patients, consultants, the NHS, GPs and Private Medical Insurance ("PMI") providers. 98% of Spire Healthcare's inspected hospitals and clinics are rated 'Good,' 'Outstanding' or the equivalent by health inspectors in Wales and Scotland.

From our 39 hospitals and 33 clinics, medical centres and consulting rooms across England, Wales and Scotland, we provide diagnostics, inpatient, day case and outpatient care in areas including orthopaedics, gynaecology, cardiology, neurology, oncology, paediatrics and general surgery. We also operate a network of private GPs and provide occupational health services to over 700 corporate clients. We are the principal independent provider, by volume, of knee and hip operations in the United Kingdom.

Spire Healthcare also provides NHS funded care to patients across all of our services. In 2022 NHS activity accounted for 21% of Spire Healthcare's overall activity (Self-funded 32.9% and Insured 46.1%). Our organisation is committed to delivering PSIRF to all of our patients therefore the new framework will be applicable to not just patients who have received NHS funded care. Additionally this framework will be applied in our sites that sit within Wales and Scotland. Through active collaboration with the health boards and regulators that have not yet implemented PSIRF we will ensure that our services deliver a consistent patient safety experience.

3.0 Defining our patient safety incident profile

The patient safety incident profile identified issues most pertinent to Spire Healthcare in line with all services we provide as a group. These were identified and agreed by conducting a stakeholder engagement analysis and a full examination of the data sources available.

The PSRIF plan has been developed as a groupwide approach which will be adopted by all areas of the business including all 39 of our hospital sites. Local issues meeting enhanced investigation criteria will be investigated under the “emergent trends” categorisation.

3.1 Stakeholder engagement:

PSIRF stakeholders in Spire Healthcare were established via a collaborative approach with hospital governance teams. Four hospitals completed stakeholder mapping which was then shared with the remaining hospitals. From these maps a final stakeholder tool was created. The stakeholder mapping tool allowed us to easily assess who our stakeholders are, what their level of interest and influence would be. The final tool was then shared to with the hospital governance teams. A list of agreed PSIRF group wide stakeholders can be found on Appendix 1.

A series of engagement meetings have been held from March 2023 onwards with key PSIRF stakeholders from various staff groups to outline the impact that PSIRF might have and to understand what colleagues felt the organisation’s safety priorities might be.

Surveys have been sent to Consultant Governance Leads and hospital governance colleagues.

Initially proposed group priorities have been shared with SMT, Consultant Governance Leads, MAC Chairs and members of the executive team.

3.2 Data sources:

To define Spire Healthcare’s patient safety response profile a variety of data sources were examined across a wide date range in order to ensure that trends could be identified.

The patient safety incident risks for the organisation have been profiled using organisational data from patient safety incident reports, serious incident reports, Root Cause Analysis Reports, Business Intelligence analytics, complaints, claims, colleague feedback and risk assessments. Data was reviewed alongside other intelligence which was gathered regarding safety concerns in the organisation.

Consultation on Spire’s group priorities has taken place internally via PSIRF Operational Group, PSIRF Programme Board, Safety Quality and Risk Committee, Board Clinical Governance and Safety Committee.

Date ranges:

- SI reports from 2021 and 2022 were reviewed totaling 194 individual RCA reports
- Patient safety incident data was reviewed from 2018 to 2022
- In 2022 there were 45,335 incidents reported across Spire Healthcare. 1,503 of these incidents were referred to the RCA investigation route. 69 incidents were referred as SIs

A detailed situational analysis was undertaken of Serious Incidents to develop the draft Patient Safety Incident Response Plan and Patient Safety Incident Response Framework (PSIRF) policy. This analysis was completed in parallel with a review of the Quality Improvement (QI) Framework for 2023 in order to ensure that QI work streams were not being duplicated within the PSIRF Plan.

The Spire Healthcare wide QI priorities for 2024 are:

1. Improving patient experience
2. Improving capacity through reducing length of stay
3. Reducing incidence and improving recognition and care of VTE

In addition, Spire Hospitals will create one QI priority per quarter which the hospitals can use to drive improvement activity. This could be changed at the end of each quarter or rolled on, dependant on the status of the project.

The hospital priority could be identified from several sources such as incidents, complaints, audit results or actions from an investigation as part of PSIRF. QI lends itself to effective actions in all of these areas and is Spire’s chosen methodology for response.

4.0 Our Patient Safety Incident Response Plan: NHS England national requirements

4.1 Criteria for selection of incidents for Patient Safety Incident Investigation (PSII)

The findings from incident reviews, PSIIs or other related activities must be translated into effective and sustainable action that reduces the risk to patients. For this to happen, Spire Healthcare must be able to apply knowledge of the science of patient safety and improvement to identify:

— Where improvements are needed

— What changes need to be made

— How changes will be implemented

— How to determine if those changes have the desired impact (and if they do not, how they could be adapted)

The following aspects were considered in the development of this PSIRF plan:

A. Actual and potential impact of outcome of the incident (for example: harm to people, service quality and public confidence)

B. Likelihood of recurrence

C. Potential for learning in terms of:

— Enhanced knowledge and understanding

— Improved efficiency and effectiveness (control potential)

— Opportunity for influence on wider systems improvement

D. Consideration of patient safety incidents where the contributory factors and systems gaps that have led to the incident are not well known and there is potential for identifying new learning by carrying out a PSII.

Additionally, informed feedback and drawing on good practice supports a systemic, compassionate and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability and continuous improvement.

4.2 NHS England Nationally-defined incidents requiring PSII (adopted for all Spire hospitals):

Patient safety incident type	Required response	Anticipated improvement route
Incidents that meet the criteria set in the Never Events list 2018	PSII	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
Incidents that meet the 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care.	PSII	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
Deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's mortality review tool and which have been determined by case record review to be more likely than not due to problems in care.	PSII	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
Deaths of persons with learning disabilities where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review.	PSII	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
Deaths of patients in custody, in prison or on probation where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/ problems in the healthcare provided by the NHS	n/a to Spire	
Suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.		

5.0 Our Patient Safety Incident Response plan: Group priorities

5.1 Group priority incidents requiring PSII

Based on the situational analysis and review of the incident reporting profile in Spire Healthcare, group priorities for PSII have been agreed by the organisation for the duration of this current plan (anticipated as 12 months from 1st November 2023) and can be found below (Figure 1).

— Patient safety incident investigation

5.2 Emergent patient safety incidents requiring PSII

An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, colleagues or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response which is not featured within Spire Healthcare's Group Priorities.

5.3 Patient safety incidents requiring investigation

Spire remains committed to learning from incidents and excellence. To ensure that we continue to capture and act on a wide range of incidents, the Key Safety Indicators (KSI) process will allow a filtering of incidents which will enable decisions to be made regarding next steps.

Incidents which do not meet the organisation's Group Priorities will be investigated using appropriate and proportionate techniques using any of the following planned responses:

— Swarm huddle

— After action review

— Round table (MDT meeting in NHS England PSIRF Framework)

Where a number of similar incidents have occurred, a thematic review can be undertaken. Using the appropriate investigation response.

5.4 Multi organisation and cross system investigations

Spire Healthcare hospitals which provide care to NHS patients must agree with their local NHS organisations how they will report and investigate patient safety incidents which affect a patient that has received care in both places. For example, where a patient has their surgery in a Spire Healthcare Hospital but is then moved into the NHS for another part of their care.

Where parts of a patients care pathway is provided in any other provider, including the independent sector, this must also be considered. Collaboration with the relevant ICB should be undertaken to ensure cross system incident investigation and shared learning.

5.5 Engaging and involving patients, families, colleagues and consultant partners following a patient safety incident

All response types will address the views of those effected including patients, their families, colleagues and consultants. Our patient engagement, and colleague wellbeing processes are detailed in our PSIRF Policy.

For all patient safety incident investigations (or other learning responses where applicable), a patient engagement lead will be identified who will be responsible for initial contact with either the patient and/or their family/carer. The patient engagement lead will ensure the patient and/or their family/carer is kept informed of the progress with investigation timelines and ensure that any concerns identified are addressed. For all engagement with patients and/or their family/

carer Spire Healthcare will adopt the NHS England four steps of engagement, of which training has been provided.

Colleagues and Consultant partners impacted by a patient safety incident will be supported by the hospital and central management teams and in line with our Just Culture and psychological safety processes. In addition to this Spire Healthcare offers a colleague support service which can be utilised by all colleagues. Support is available 24/7 365 days a year which includes professional counselling.

We encourage open and transparent communication for colleagues and consultants at all levels of the organisation with initiatives including:

— Freedom to speak up guardians and ambassadors

— Surgical safety guardians

Colleagues and consultant partners are encouraged to speak up about safety concerns, near-miss incidents, or adverse events. We believe that every voice matters in ensuring patient safety.

6.0 Spire Healthcare Group priorities (figure 1)

	Theme	Patient safety incident type or issue	Example	Anticipated learning route
1	Management of the deteriorating patient	Patient requiring transfer to a higher level of care within Spire Healthcare or transfer to an NHS provider AND which has been deemed potentially avoidable following Key Safety Indicator (KSI) review.	Lack of escalation of NEWS score leading to deterioration of the patient.	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
2	Post-operative complications	Cases where a patient has experienced an unexpected post-operative complication of surgery requiring significant further treatment.	A complication that results in a prolonged inpatient stay or further surgery.	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
3	Injury sustained during surgery	Cases where a significant unexpected injury has occurred during surgery.	A skin burn or laceration requiring non conservative further management or surgery.	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
4	Inpatient falls	A patient fall resulting in significant injury.	Fall resulting in a fractured neck of femur.	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.
5	Blood transfusion	blood transfusion incidents which require reporting externally (SHOT).	Adverse incidents as defined by SHOT	Create local and organisational recommendations and actions and feed these into the quality improvement strategy.

Appendix 1: Spire Healthcare regions by ICB

Spire Healthcare

Spire hospitals and NHS ICB regions

1. **Blackpool**
Spire Fylde Coast Hospital
01253 308 031

2. **Brentwood**
Spire Hartswood Hospital
01277 266 761

3. **Brighton**
The Montefiore Hospital
01273 828 120

4. **Bristol**
Spire Bristol Hospital
0117 980 4080

5. **Bushey**
Spire Bushey Hospital
0208 901 5505

6. **Cambridge**
Spire Cambridge Lea Hospital
01223 266 929

7. **Cardiff**
Spire Cardiff Hospital
029 2054 2509

8. **Chatham**
Spire Alexandra Hospital
01634 662 866

9. **Cheam**
Spire St Anthony's Hospital
0208 337 6691

10. **Didsbury**
Spire Manchester Hospital
0161 232 2303

11. **Edinburgh**
Spire Murrayfield Hospital
0131 316 2507

12. **Edinburgh**
Spire Shawfair Park Hospital
0131 654 5600

13. **Elland**
Spire Elland Hospital
01422 324 065

14. **Farnham**
Spire Clare Park Hospital
01252 895 490

15. **Gatwick**
Spire Gatwick Park Hospital
01293 778 906

16. **Gerrards Cross**
Spire Thames Valley Hospital
01753 665 404

17. **Harpenden**
Spire Harpenden Hospital
01582 714 420

18. **Hull**
Spire Hull and East Riding Hospital
01482 672 412

19. **Leeds**
Spire Leeds Hospital
0113 218 5977/67

20. **Leicester**
Spire Leicester Hospital
0116 265 3021

21. **Liverpool**
Spire Liverpool Hospital
0151 522 1805

22. **Macclesfield**
Spire Regency Hospital
01625 505 412

23. **Methley**
Spire Methley Park Hospital
01977 664 245

24. **Norwich**
Spire Norwich Hospital
01603 255 614

25. **Nottingham**
Spire Nottingham Hospital
0115 828 1696

26. **Portsmouth**
Spire Portsmouth Hospital
023 9245 6172

27. **Reading**
Spire Dunedin Hospital
0800 328 3026

28. **Redbridge**
Spire London East Hospital
0208 709 7817

29. **Sheffield**
Spire Claremont Hospital
0114 263 0330

30. **Solihull**
Spire Parkway Hospital
0121 704 5530

31. **Southampton**
Spire Southampton Hospital
023 8091 4471

32. **Southend-on-Sea**
Spire Wellesley Hospital
01702 447 926

33. **Sutton Coldfield**
Spire Little Aston Hospital
0121 580 7119

34. **Tunbridge Wells**
Spire Tunbridge Wells Hospital
01892 741 150

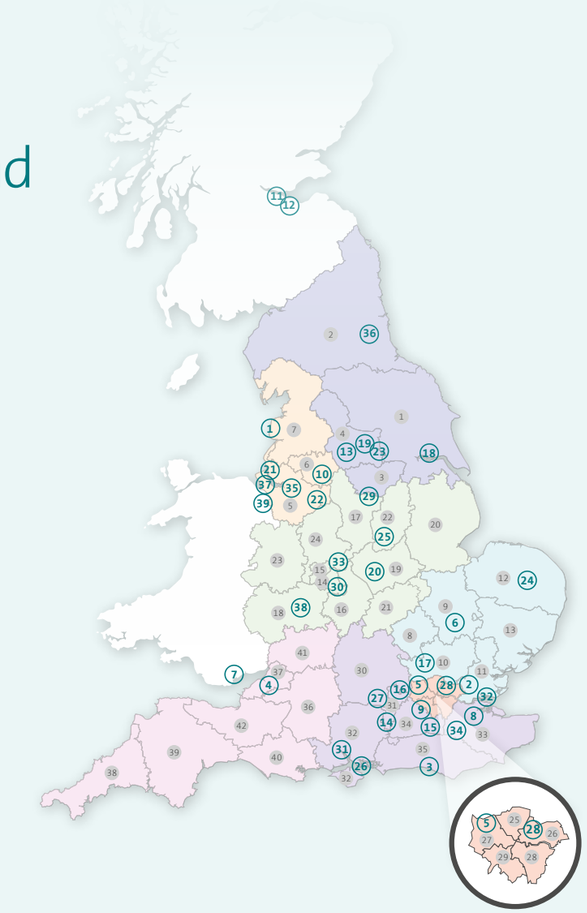
35. **Warrington**
Spire Cheshire Hospital
01925 215 029

36. **Washington**
Spire Washington Hospital
0191 418 8687

37. **Wirral**
Spire Murrayfield Hospital
0151 929 5408

38. **Worcester**
Spire South Bank Hospital
01905 362 252

39. **Wrexham**
Spire Yale Hospital
01978 262 462



	North East and Yorkshire		Midlands		South East
1	NHS Humber and North Yorkshire	14	NHS Birmingham and Solihull	30	NHS Buckinghamshire, Oxfordshire and Berkshire West
2	NHS North East and North Cumbria	15	NHS Black Country	31	NHS Frimley
3	NHS South Yorkshire	16	NHS Coventry and Warwickshire	32	NHS Hampshire and Isle of Wight
4	NHS West Yorkshire	17	NHS Derby and Derbyshire	33	NHS Kent and Medway
	North West	18	NHS Herefordshire & Worcestershire	34	NHS Surrey Heartlands
5	NHS Cheshire and Merseyside	19	NHS Leicester, Leicestershire and Rutland	35	NHS Sussex
6	NHS Greater Manchester	20	NHS Lincolnshire		**South West**
7	NHS Lancashire and South Cumbria	21	NHS Northamptonshire	36	NHS Bath and North East Somerset, Swindon and Wiltshire
	East of England	22	NHS Nottingham & Nottinghamshire	37	NHS Bristol, North Somerset and South Gloucestershire
8	NHS Bedfordshire, Luton and Milton Keynes	23	NHS Shropshire, Telford and Wrekin	38	NHS Cornwall and The Isles Of Scilly
9	NHS Cambridgeshire & Peterborough	24	NHS Staffordshire and Stoke-on-Trent	39	NHS Devon
10	NHS Hertfordshire and West Essex		**London**	40	NHS Dorset
11	NHS Mid and South Essex	25	NHS North Central London	41	NHS Gloucestershire
12	NHS Norfolk and Waveney	26	NHS North East London	42	NHS Somerset
13	NHS Suffolk and North East Essex	27	NHS North West London		
		28	NHS South East London		
		29	NHS South West London		

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