Spire Healthcare

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Document Name:	Patient Safety Incident Response Framework (PSIRF) Policy
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Please indicate what type of document this is (please check):

☒ Policy
☐ Procedure
☐ Guideline

Spire Healthcare

Document on a Page

CLINI 103 - Patient Safety Incident Response Framework (PSIRF) Policy

Policies can sometimes be hard to digest, but all colleagues need to be aware of their key points.
The key points from this document are on this page.

What Does the Document Cover?

This policy covers Spire Healthcare's patient safety incident reporting and incident response processes.

Non-clinical incidents are covered in HS 03 – Health and Safety Incident Reporting

Who are the key groups who need to be aware of this document (please check)?

☒ Hospital clinical colleagues
☒ Consultants
☒ Non-clinical colleagues
☒ Everyone
☒ Other (please specify) - Coroners, ICB's, Regulators

What Does It Say?

- This policy outlines the organisations PSIRF strategy, **patient safety** incident reporting processes and responses.

What Do I Need to Do?

- Colleagues need to familiarise themselves with a general understanding of the patient safety incident response process and the role that they play in this.

Further Information

- The full policy can be found on the intranet
- Speak to your governance lead
- Deputy Director of Integrated Quality Governance

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1.0 PURPOSE

1.1 This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Spire Healthcare's approach to responding to patient safety incidents (PSIs) for the purpose of learning and improving patient safety.

1.2 NHS England (2022) defined patient safety incidents as:

'…. unintended or unexpected events (including omissions) in healthcare that could, or did, harm one or more patients'.

1.3 PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement and advocates a co-ordinated and data-driven response. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

1.4 This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of PSIRF:

Compassionate engagement and involvement of those affected by patient safety incidents	A system-based approach to learning	Considered and proportionate responses	Supportive oversight focused on strengthening response systems and improvement

1.5 This policy should be read in conjunction with our current patient safety incident response plan (Appendix 1). The PSIRF plan details the organisation's patient safety priorities for the year.

1.6 Spire Healthcare implemented PSIRF in 2024. We have used the NHS England patient safety response standards (2022) to frame the resources and training required for all our colleagues including specific training for those involved in patient safety incidents. A programme is also detailed within the training needs analysis Appendix 24.

2.0 SCOPE

2.1 This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all of Spire Healthcare's clinical services including:

- 38 hospitals (England (34), Scotland (2) and Wales (2)) delivering all, or a selection of, the following:
    - planned surgery to adults.
    - planned surgery to children and young people.
    - cancer services
    - diagnostic services (e.g., imaging or pathology)
    - decontamination (sterilisation) services
    - critical care (for example, intensive care, following surgical or medical procedures).
- Spire Clinics
- Primary Care services
- Patient Support Centres (PSC)

2.2 This policy relates to responses to patient safety incidents that are solely for the purpose of learning and improvement. Any response that seeks to find liability, accountability or causality is beyond the scope of this policy (see below at 2.3).

2.3 Other processes, such as those shown below differ from those of a patient safety incident response and are not included in this policy:

- Legal Claims (FIN14)

- Duty of Candour (FIN05)
- Coroners' investigations
- Police investigations
- Quality Improvement Strategy
- Human Resources investigations (HR15)
- Complaints (HOP02)
- Financial investigations (FIN 24)
- Medical Professional Standards investigations (MED06)
- Safeguarding concerns (Clini10)
- Spire Standards for Hospital Integrated Quality Governance (Clini01)
- Non-Patient Safety incident responses (HS03)
    - Health and Safety
    - IT (including information governance)
    - Estates and facilities issues

2.4 Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

2.5 PSIRF does not look for who is to blame or at fault, it forms part of our commitment to developing a just and learning culture, building openness and transparency, ensuring everyone is treated fairly and that we learn from any errors.

2.6 The PSIRF policy gives us the opportunity to promote a system-based approach (principally systems engineering initiative for patient safety, SEIPS) to learn from incidents and events. By using a systems approach will help to remove a focus on individuals and human error when investigating incidents and instead focus on learning.

3.0 OUR PATIENT SAFETY CULTURE

3.0 At Spire Healthcare, our purpose is to "make a positive difference to people's lives through outstanding personalised care". A culture of safety is fostered throughout the organisation, with a one of our key strategic pillars being to build on quality. We reflect our commitment in our values: driving clinical excellence, we recognise that a strong patient safety culture is essential to providing high-quality care and preventing adverse events. This is also reflected in Spire's Quality Strategy 2025-2027.

3.1 In Spire Healthcare, PSIRF enables us to further embed the management of patient safety incidents within our learning and Quality Improvement agenda. Within PSIRF it is important that those impacted (patients/family, colleagues, Consultant partners) by a patient safety incident are involved as soon as possible to ensure that as much learning is taken from the incident as possible. This timely collaboration in working with all those involved will ensure that the organisation continues to grow its patient safety culture.

3.2 Spire Healthcare's safety culture can be defined under the following categories:

- Leadership Commitment
    - Our leadership team is dedicated to patient safety and Quality Improvement.
    - They lead by example, emphasizing the importance of safety in all aspects of our operations.

- They provide the necessary resources and support to ensure that patient safety initiatives are successful.

- Open Communication

We encourage open and transparent communication 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 and are required to participate in learning responses. We believe that every voice matters in ensuring patient safety.

- Reporting and Learning
  - Our PSIRF policy plays a central role in our patient safety culture and developing a restorative just culture across Spire Healthcare.
  - It provides a structured framework for reporting and documenting incidents, near-misses, and unsafe conditions.
  - We use these reports as opportunities for continuous learning and improvement.

- Training and Education
  - We provide ongoing training and education to our colleagues on patient safety principles, best practices, and the use of the PSIRF system as detailed within the PSIRF training needs analysis (TNA) and associated training materials.
  - The training programme is designed to ensure that colleagues are confident in PSIRF processes. Participation data will be monitored to evidence compliance.
  - All employees are empowered to actively contribute to patient safety and Quality Improvement processes

- Continuous Improvement
  - Patient safety is a dynamic and evolving field.
  - We are committed to continuous improvement in our patient safety practices and ongoing training, reinforced with a strong QI Strategy and Framework which is supported by a programme of education, training and learning.
  - Regular reviews of incident data, analysis of trends, and the implementation of evidence-based solutions are essential components of our approach (and PSIRF tools are provided to support these processes).

- Patient Involvement
  - We actively involve patients and their families in our safety efforts. Their perspectives and insights are invaluable in identifying potential risks and improving the patient experience, reinforced with a strong patient experience and patient engagement framework.

- Safety is a priority.
  - Patient safety deeply embedded in our organisational culture.
  - Safety principles guide our decision-making, policies, and procedures, ensuring that the well-being of our patients remains at the forefront of all we do.
  - By promoting a patient safety culture characterized by leadership commitment, open communication, reporting and learning, training and education, accountability, continuous improvement, patient involvement, and safety as a core value, Spire Healthcare aims to provide the highest standard of care while minimising the risk of adverse events.

3.3 Restorative Just Culture

- Restorative Just Culture has 3 main elements

- Restorative – Restores relationships and teams harmony, ease and trust
- Just – Ensures accountability and fairness, acknowledging context
- Learning – Enables organisations to embed organisational and systems change where necessary.

3.4 Psychological safety

Psychological safety is created in an environment where there is openness and trust that allows team members to feel comfortable taking risks and making mistakes. To be able to work in a psychologically safe environment, it is vital for healthcare professionals and patients to feel comfortable in sharing their concerns, fears or any other issues that might hinder (reduce) the quality of patient care.' (Psychological Safety Academy, 2022).

4.0 PATIENT SAFETY PARTNERS

4.1 The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England / Improvement to help improve patient safety. The main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

4.2 It is recognised that the role of the Patient Safety Partner is a new role in both the NHS and the independent sector. Spire Healthcare has worked with NHS England and IHPN to define how this role will function within the independent sector. Clear guidance for the independent sector is yet to be confirmed however we are exploring this opportunity to fully understand how our patient safety partners will integrate within our services. Spire Healthcare will ensure that this new role compliments the patient engagement and experience framework to enable us to further add to the opportunity to hear our patients in patient safety event.

4.3 During recruitment of PSPs consideration will be given to diversity and where gaps in partners with specific characteristics are identified, active recruitment will be led to ensure diversity in this key stakeholder group.

5.0 ADDRESSING HEALTH INEQUALITIES

5.1 Addressing health inequalities is an organisational priority as seen through our purpose, 'making a positive difference to people's lives, through outstanding personalised care'. This will include but not be limited to the implementation of the PSIRF.

5.2 Learning identified through patient safety incident investigations will ensure effective communication with all patients including those who have additional requirements due to physical or learning disabilities. Patient safety responses will continue to support health equalities through a variety of routes including quality improvement, lessons learned forums, systems, and process.

5.3 DCIQ will allow for the details of patients to be directly drawn from associated patient administration and electronic health record systems, and Incident/Events can then be analysed by the nine protected characteristics (of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) to give insight into any apparent inequalities.

5.4 Spire Healthcare will directly address, as part of our response, any features of an incident which indicate that health inequalities may have contributed to harm or demonstrate a risk to a particular population group. This will include a tailored approach to different protected characteristics and appropriate adjustments made if required. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

5.5 Engagement of patients, families, colleagues, and Consultant partners following a patient safety incident is critical to the review of patient safety incidents and their response. Spire Healthcare is committed to ensuring our colleagues have appropriate training (e.g. Oliver McGowan and National Autistic Society) to ensure reasonable adjustments are made and that available tools such as easy read, translation and interpretation

services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident responses.

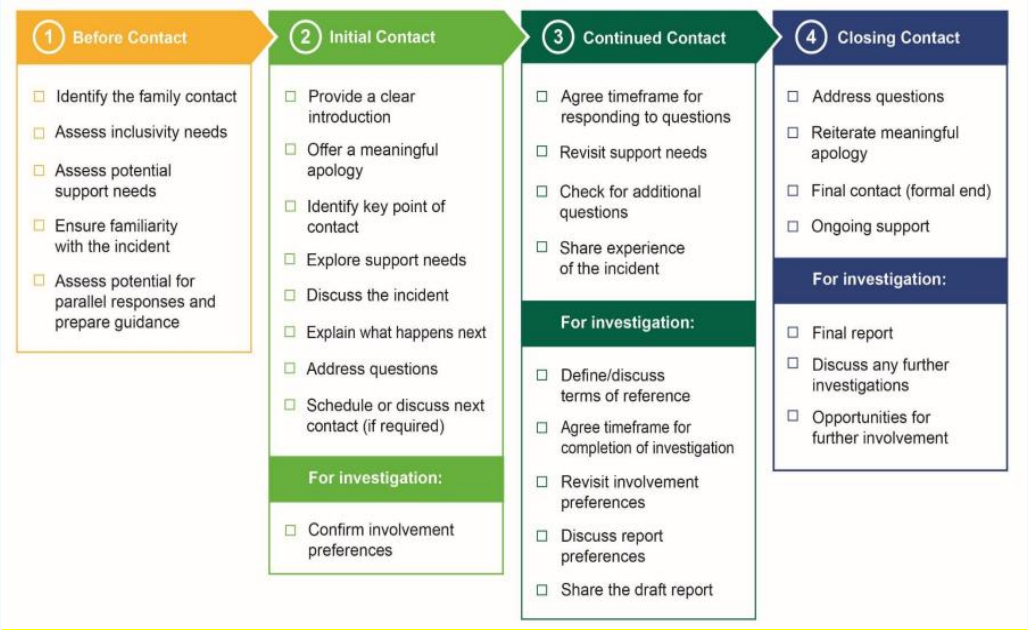
6.0 ENGAGING AND INVOLVING PATIENTS, FAMILIES, COLLEAGUES and CONSULTANT PARTNERS FOLLOWING A PATIENT SAFETY INCIDENT

6.1 PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, colleagues, and consultant partners). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. Information leaflets have been developed for colleagues, patients and families involved in the incident and can be ordered via Studio.

6.2 Spire Healthcare is committed to creating a culture of openness with patients, families, and carers particularly when clinical outcomes are not as expected or planned. There is a responsibility as well as a statutory requirement under CQC Regulation 20, Duty of Candour for all healthcare organisations to be open and transparent with patients and their families when things go wrong with treatment or care delivery. Registered professionals should also refer to their professional guidance with reference to Duty of Candour requirements. This forms the basic principle of our policy. For more information see FIN05 Duty of Candour policy.

6.3 Patients and their families will be given the opportunity to ask questions and express their concerns. They will be kept informed of the progress of the incident response and the results of any recommendations. Additionally, they will be invited to participate in efforts to improve patient safety.

6.4 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.



6.5 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.

7.0 PATIENT SAFETY INCIDENT RESPONSE PLANNING

7.0 As per the ethos of PSIRF, Spire Healthcare will ensure that we take a proportionate approach in our incident responses to solidify our commitment to improving our services for patients.

7.1 Our PSIRF planning is aligned to Quality Improvement throughout.

7.2 Additionally, we will continue to review safety activity information from a range of sources to ensure that we are focusing on appropriate areas (Appendix 1). This will continue the work that went into establishing our patient safety profile and plan.

7.3 National (as defined by the NHS) and group (Spire) priorities are contained within the PSIRF Plan and will be updated annually. These priorities will have a clearly defined incident response type including:

- Patient Safety Incident Investigation – NHS England
- Swarm huddle- NHS England
- After action Review – NHS England

8.0 PATIENT SAFETY INCIDENT RESPONSE PLAN

8.1 Our plan sets out how Spire Healthcare intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent rule, therefore changes can be made as and when required. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

8.2 National (as defined by the NHS) and group (Spire) priorities are contained within the PSIRF Plan and will be updated annually. These priorities will have a clearly defined incident response type including:

- Patient Safety Incident Investigation – NHS England
- Swarm huddle- NHS England
- After action Review – NHS England

8.3 Spire Healthcare's PSIRF plan (Appendix 1) describes how the plan was developed including:

- Engagement with key stakeholders internally and externally
- Profiling by analysing historic patient safety incidents, Business Intelligence analytics, complaints, claims, colleague feedback and risk assessments.
- Reviewing the Quality Improvement (QI) Framework and projects
- Agreeing the Spire Healthcare Group (local) priorities
- Agreeing the patient safety incident response methods

9.0 REVIEWING OUR PATIENT SAFETY INCIDENT RESPONSE POLICY AND PLAN

9.1 Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

9.2 Updated plans will be published on our website, replacing the previous version.

10.0 RESPONDING TO PATIENT SAFETY INCIDENTS

10.1 Patient safety incident reporting arrangements

Incident reporting is currently the responsibility of all colleagues and is done so via the organisation's incident reporting system; DCIQ. DCIQ allows us to record incidents, investigations and participate in the NHS England 'Learn from Patient Safety Events' (LFPSE) service, which learns from patient safety events for NHS England commissioned patients.

Department managers are responsible for ensuring that colleagues are supported when reporting incidents and escalating to the senior management team at the hospital where appropriate.

The Hospital Director (or PSC Lead equivalent for clinics and some GP services) is responsible for ensuring suitable committee arrangements are in place to review incidents, complaints and claims in line with Spire Standards for Hospital Governance CLIN 01.

The Group have an agreed process for determining the initial level of incident response. Incidents will be reviewed using this flowchart at the weekly hospital rapid response meetings.

For all incidents, the Hospital Director or Director of Clinical Services (or an individual appropriately designated to do so) is responsible for confirming that any action which is deemed necessary in immediate response to the incident (particularly to secure the safety of patients, colleagues and consultant partners and others) has been completed.

10.2 Initial levels of patient safety incident response

- DCIQ (No enhanced investigation required)
  The focus on learning should be maintained with any key learnings actioned and shared.
  The incident will be closed and will be included in analysis of trends quarterly.

- Patient Safety Incident Review (PSIR)
  Where an incident immediately meets the criteria for a Patient Safety Incidents Investigation (PSII - as detailed in the PSIRF Plan and Appendix 2). PSIR form will be completed within 5 working days and sent for review to the Patient Safety Incident Response Group (PSIRG) via $HospSeriousAdverseEventNotification@spirehealthcare.com

- KSI Review (Appendix 8)
  The Key Safety Indicators (KSI) process uses the round table or MDT meeting methodology and will involve a review of the following incident types:

  1. Unplanned Readmission
  2. Unplanned Return to Theatre
  3. Unplanned Transfer Out (which will also include unplanned internal transfer to ITU for our Level 3 sites)
  4. IPC incidents follow the IPC KSI process

  The hospital can conduct a triage of the incident first to determine if a full KSI review is required. A regular (at least monthly) KSI meeting (attended by key leads) to be arranged which will look at each of the incidents reported focussing on the key aspects of the patient's journey as detailed in the KSI TOR.
  Following the KSI review the incident can be concluded as avoidable or unavoidable.

- Case review (e.g. Blood transfusion, VTE, IPC, Pressure Ulcer, Falls)
  A case review will be carried out by the hospital clinical team, to determine whether there were any safety issues, learning and improvement opportunities.
  - Blood transfusion and laboratory medicine incident investigation (Appendix 9)
  - VTE Case Review (Appendix 10)
  - Pressure Ulcer Case Review (Appendix 11)
  - Falls Case Review (Appendix 27)

10.3 Case Review / KSI Review – Unavoidable incident

Following the initial review, where an incident is deemed unavoidable the rationale for this should be documented within DCIQ and where appropriate the actual harm caused downgraded. The outcome of any review must be recorded on the appropriate template and attached to DCIQ. For unavoidable incidents, the focus on learning should be maintained with any key learnings actioned and shared.

The incident will be closed and will be included in analysis of trends quarterly.

10.4 Case Review / KSI Review – Avoidable incident

Following the initial review, where an incident is deemed avoidable, the outcome must be recorded on the appropriate template and escalated to the Patient Safety Incident Review Group (PSIRG) and further investigation will be determined and undertaken where appropriate.

10.5 Patient safety incident response

- PSIIs (as defined in Plan)

  Following a reported PSII, the Hospital Director/ Unit Manager or Director of Clinical Services will appoint a colleague to undertake the incident response within 60 working days.

- All avoidable Incidents (including near misses) falling below the threshold of a PSII

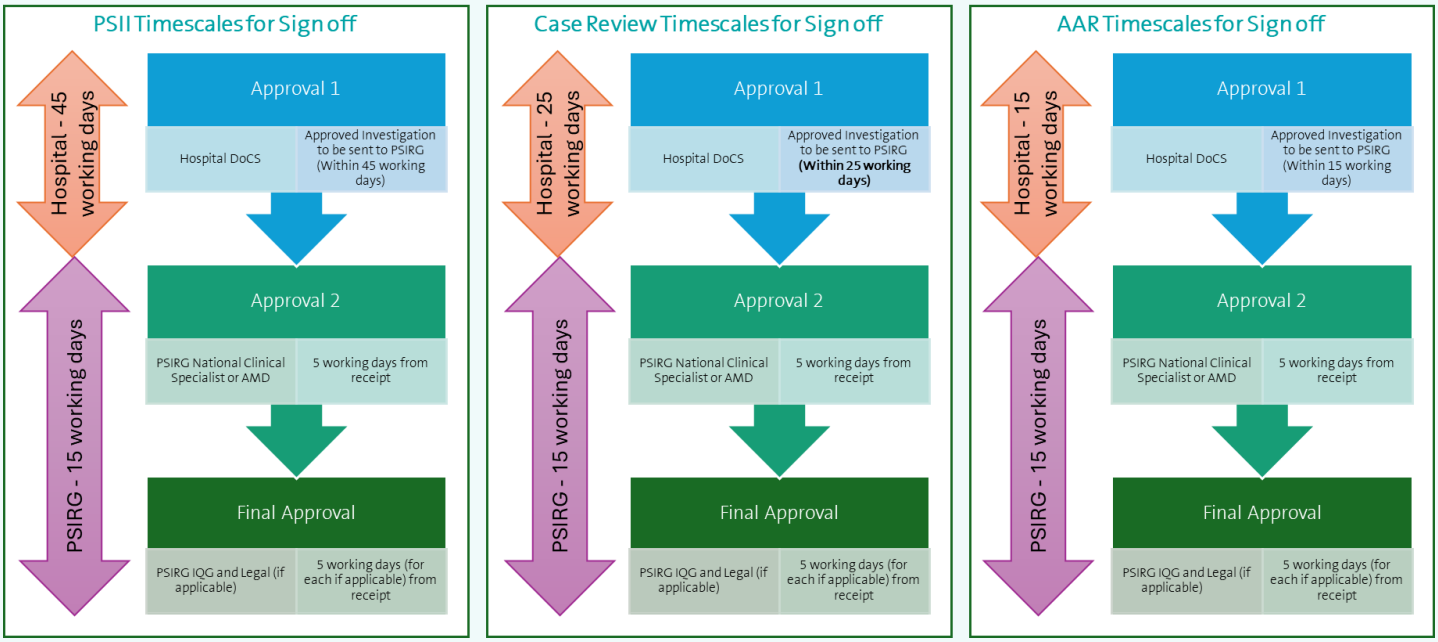
  All avoidable incidents will require an incident response by an appropriately trained colleague to ensure that any learning from the event and subsequent actions are completed. The methods of incident responses can include those detailed in Spire Healthcare's PSIRF Plan and are listed as follows:
  - Swarm huddle.
  - After Action Review
  - Safety Improvement Plan only

10.6 Timeframes for learning responses

- Timeframes for Patient Safety Incident Investigation (PSII)

  Where a PSII has been declared the investigation should be submitted to PSIRG within 45 working days (the full review including approval should take no longer than 60 working days).
  Any extension to an investigation should be agreed with the Integrated Quality Governance Team and with the affected parties.

- Timescales for non PSII incident responses to be submitted to PSIRG:
  - Swarm huddle - as near to the time the incident occurs as possible but, as a maximum, within 24-72hrs of it occurring.
  - After Action Reviews - within 15 working days of the incident being declared an AAR.
  - Case Reviews - within 25 working days of the incident occurring.
  - KSI – within 15 working days of the incident occurring (upload documents to DCIQ within 25 working days).



10.7 Safety action development and monitoring improvement

Fully informed and engaged action plans will be crucial to all our incident responses and are included on all enhanced investigation templates. This is vital when trying to reduce the risk of recurrence and making meaningful improvements.

A Safety Action is an action taken to reduce the risk of harm happening again and improve the level of safety for patients, colleagues and consultant partners within healthcare.

All actions will be documented in DCIQ and monitored as part of the quality review.

Spire Healthcare Hospitals will use the NHS England 'Safety Action Development Guide' to support their safety action plans. This can be found at NHSE Safety Action Development Guide 2022

10.8 Trend analysis and Thematic Reviews

All incidents logged on to DCIQ will be regularly analysed for trends and considered for thematic reviews. A thematic review template and walk through analysis tool are included in the PSIRF toolkit.
A quarterly focussed learning report is produced based on thematic review of completed incident investigations and is presented to the National Safety, Quality and Risk Committee (SQR) before being shared with all sites.

10.9 Monitoring and Reporting

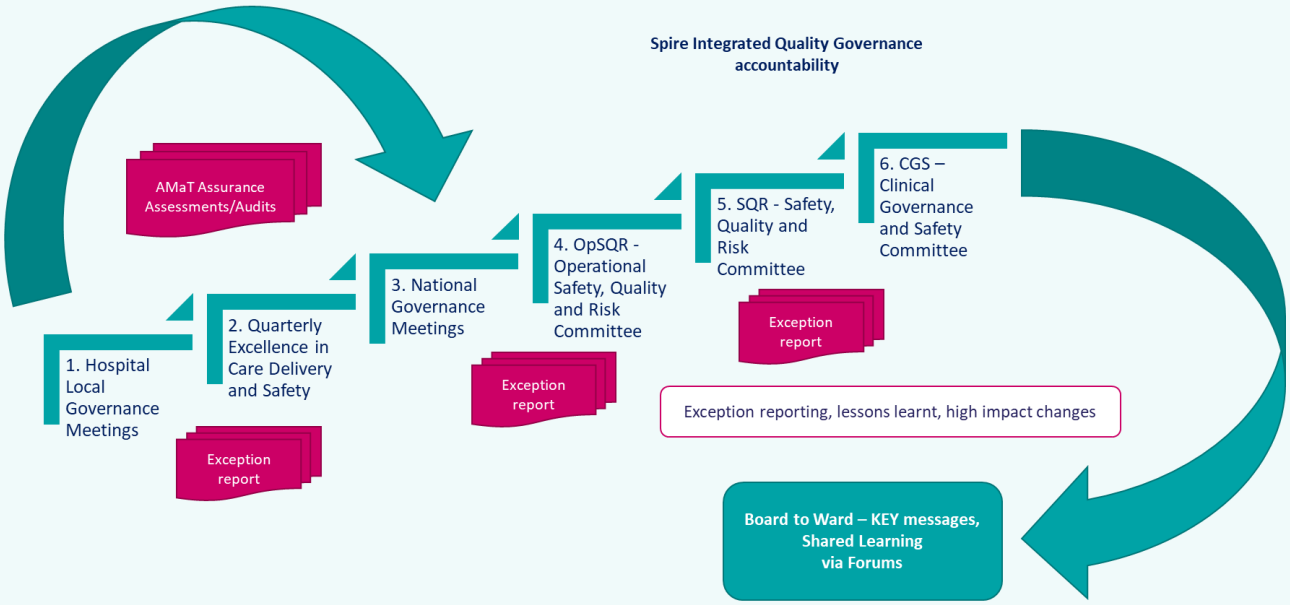
The national Patient Safety Incident Response Group (PSIRG) members review and approve every enhanced investigation submitted by hospitals within 15 working days. The PSIRG recommends national actions, such as changes to policy, training, or care pathways, arising from individual incidents or trends, and these are reported to SQR.

The Spire Healthcare Executive Committee receives weekly reports of PSII and other enhanced patient safety incident responses which are also monitored by the Operational Safety Quality and Risk Committee, the Safety, Quality and Risk Committee and the Clinical Governance and Safety Committee.

Incident data will be reviewed regularly (weekly) within the National Integrated Quality Governance Team to ensure data integrity, quality (including quality of actions), and compliance with timeframes. This structured approach to incident data monitoring will make sure that the reported incident data is correctly represented on the incident reporting system. Please see Appendix 26 - DCIQ Validation and Integrity SOP. As part of the

data validation process assistance and guidance will be provided to individual hospital sites (where required) to improve incident data quality.

The National Integrated Quality Governance Team will ensure regular monitoring of this policy and escalate any episodes of non-compliance with Spire Healthcare's incident reporting standards through the ward to board accountability and assurance model.



10.10 Responding to cross-system incidents/issues

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 is undertaken to ensure cross system incident investigation and shared learning. ***N.B. How this is done must be agreed in writing.***

11.0 MORTALITY REVIEW PROCESS

11.1 The PSIRF covers all patient safety incidents including expected and unexpected deaths. A Mortality Reporting Process Flowchart and guidance to support hospitals in respect of action required following a patient death (Medical / Surgical / Oncology) can be found in Appendix 14.

- Expected / Unexpected Death (CQC - Regulation 16: Notification of death of service user).
- An 'Expected Death' is defined as a death, that was the expected outcome of an illness or physical condition.
- An 'Unexpected Death' is defined as any death that is not an Expected Death.
  For example:
  - A death not anticipated during the treatment, intervention, or pathway the patient was admitted for,
  - A death of any patient that is not related to the natural course of their illness,
  - A death of a full-term and viable foetus, or neonate, where there was no underlying pathology,

- A death of any other person arising out of or in connection with Spire Healthcare activities; where there was a similar unexpected collapse or incident leading to or precipitating the events which led to the death.

Structured Judgement Review

The Associate Medical Director undertakes a Structured Judgment Review of all deaths within 30 days of surgery (and others where issues were identified) using the Case Review and medical records. The outcome will be sent to the hospital for inclusion in their Mortality Case review.

- Avoidability Scores
  1 Definitely avoidable
  2 Strong evidence of avoidability
  3 Probably avoidable (more than 50:50)
  4 Possibly avoidable but not very likely (less than 50:50)
  5 Slight evidence of avoidability
  6 Definitely not avoidable

- Overall Care Scores
  1 Very Poor Care
  2 Poor Care
  3 Adequate Care
  4 Good Care
  5 Very Good Care

Case Review (Mortality)

A structured review of a case record/note, carried out by the hospital clinical team, to determine whether there were any safety issues, learning and improvement opportunities in the care provided to a patient. Case record review will be undertaken to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or colleagues raise concerns about care.

The case review will be deemed "approved" by PSIRG once reviewed by clinical specialists, integrated governance and legal (if required).

Independent Mortality Advisor (IMA) Review

An independent review of care to identify any concerns within the delivery of care using a Structured Judgement Review methodology (Royal college of Physicians) to assess & identify whether there were any factors in relation to avoidability of the death and also provide an overall care score. The decision to refer an incident to the Spire IMA will be determined by PSIRG on a case-by-case basis, contingent upon the severity and potential issues identified in patient care. The Spire IMA remains available as required for advice.

Oncology Specialist Review

A review of the treatment provided to a patient accessing oncology care (whose death is within 30 days of SACT or Haematology treatment) performed by a nominated cancer specialist clinician from within the Spire Healthcare group. A Structured Judgement Review methodology will be used to identify whether the plan of care and management of the patient was appropriate to the diagnosis / prognosis of the patient and to identify whether there were any factors in relation to avoidability of the death providing an overall care score.

Group Mortality Review Committee

The committee undertakes a systematic review of individual case records using a structured methodology to identify any issues in care delivery and extract learning to inform improvement actions. Reviews are

undertaken on a bimonthly basis and aim to identify trends, recurring themes, and opportunities for group-wide learning. Findings from these reviews are used to enhance the quality of care within the service and for specific patient cohorts.

In addition, all oncology mortality reviews will be discussed at the Group Mortality Committee.
Following this a thematic review of patient deaths to promote learnings / actions group wide, with a particular focus on all deaths within 30 days of surgery/treatment/medical care is undertaken. The Committee reports into Safety Quality & Risk Committee.

- External reporting of deaths
    - CQC/HIS/HIW – notification of a person who has died during an activity provided by Spire Healthcare; or where the person's death may have been a result of the activity or how it was provided.
    - Private Healthcare Information Network (PHIN) – To ensure transparency, hospitals are required to provide PHIN with data about incidents in their care. From February 2024 this will include mortality split by 'expected' or 'unexpected'.

12.0 OVERSIGHT ROLES AND RESPONSIBILITIES

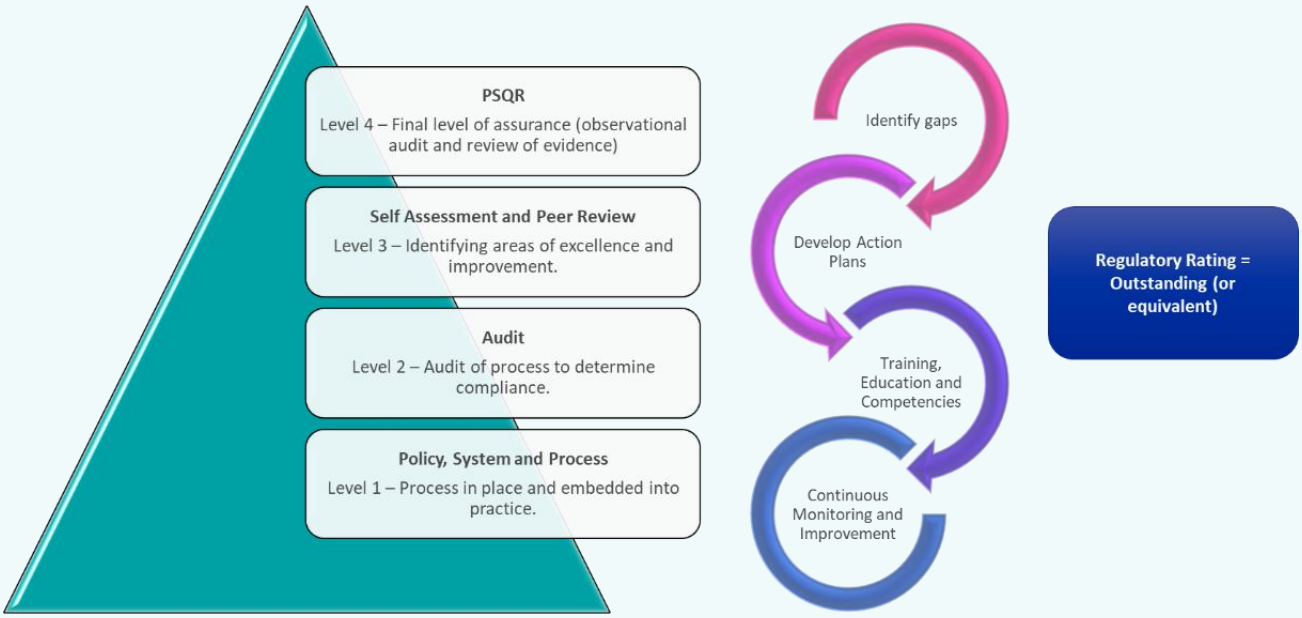
12.1 Spire Healthcare have followed the NHS England Oversight mindset principles which will underpin the oversight of patient safety incident responses:

1. Improvement is the focus of PSIRF.
   Oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring incident response quality.
2. Blame restricts insight.
   Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
3. Learning from patient safety incidents is a proactive step towards improvement.
   Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.
4. Collaboration is key.
   A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.
5. Psychological safety allows learning to occur.
   Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
6. Curiosity is powerful.
   Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

12.2 Internal Oversight

The Group Clinical Director will serve as overall Oversight Lead for the organisation.

Spire Healthcare has developed a National Meeting and Assurance structure including a 'Ward to Board Levels of Assurance' model which will be used to monitor and provide assurance of improvements made in response to patient safety incidents at both hospital and group level. Please see CLINI 01



Spire Healthcare Ward to Board Assurance Model.

12.3 Appendix 26 - DCIQ (Patient Safety Events) Validation and Integrity SOP outlines the process for validating patient safety events in DCIQ to ensure:

- the integrity of all internal and external reports.
- oversight of validation and why it is required.
- a consistent approach to DCIQ patient safety events validation is performed.
- IQG audits both locally and at national level are completed accurately.

Overdue patient safety incidents are monitored weekly by the Central IQG team

12.4 External Oversight

The Hertfordshire and West Essex Integrated Care Board (ICB) an NHS organisation involved in the purchasing of healthcare from the Independent Sector and NHS Trusts for a local population, in agreement with NHS England, has provided support (and will continue to do so) with the Spire Healthcare PSIRF Plan.

For Hospital sites, the Directors of Clinical Services and Hospital Directors, will ensure that they have a relationship with their local ICB equivalents so that they participate in sharing of learning across the wider healthcare network as specified within PSIRF. This policy will be updated as this process becomes clearer during the transition.

NHSE have indicated that they are working with the Care Quality Commission (the government body who regulates, monitors, and inspects healthcare in England) to provide guidance to healthcare providers on how their inspections will change with the implementation of PSIRF. Again, this policy will be updated once that guidance has been received.

Our PSIRF plan and policy has been designed to ensure that we fulfil our requirements to Health Inspectorate Wales (HIW) and Health Improvement Scotland (HIS). The organisation has participated in meetings with IHPN and both regulators and governments who have been supportive with our PSIRF arrangements.

13.0 COMPLAINTS AND APPEALS

13.0 Spire Healthcare's Complaints Management Policy (HOP02) is separate from PSIRF and outlines the process for both private patients overseen by the Independent Sector Complaints Adjudications Service (ISCAS) and NHS patients overseen by the Parliamentary and Health Service Ombudsman. It is hoped that patients and their families will not feel the need to complain about how a patient safety incident, in which they were involved, is managed because colleagues at the site will have offered them the opportunity to be involved in the learning response. However, colleagues must still provide patients with a copy of the 'Please Talk to Us' Leaflet which details the way patients can provide feedback to Spire Healthcare and how they can expect any concerns or complaints to be managed.

The leaflet details the process for England, Scotland, and Wales, which includes how patients/their families can appeal which includes locally (at the hospital the incident occurred), organisationally (Spire Healthcare Central Customer relations Manager) or externally (by an Independent Adjudicator).

14.0 REFERENCES

Learn from patient safety events (LFPSE) service. Available at: NHS England » Learn from patient safety events (LFPSE) service [accessed 14.3.2024]

NHSE Patient Safety Incident Response Framework (2022). Available at: NHSE PSIRF 2022

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NHSE (2022) Guide to responding proportionately to patient safety incidents. Available at: NHSE Guide to responding proportionately to PSIs 2022

NHSE (2022) patient safety Incident Response Standards. Available at: NHSE PSIRF Standards 2022

Oversight roles and responsibilities specification (2022). Available at: NHSE Oversight roles and responsibilities 2022

Psychological Safety. Available at: Psychological Safety – Workplace Training, Workshops and Consultancy on Psychological Safety, Just Culture, Resilience and High Performing Teams (psychsafety.co.uk) [accessed 21.2.2024]

RCP Using the structured judgement review method. Available at: https://www.rcplondon.ac.uk/sites/default/files/media/Documents/NMCRR%20guide%20England_0.pdf

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15.0 ASSOCIATED POLICIES

CLINI 01	Spire Healthcare Standards for Hospital IQG Implementation Guide
CLINI 09	Prevention and management of pressure ulcers
CLINI 29	SSD Vigilance Policy
CLINI 45	Reducing the risk of DVT and PE (VTE) in patients admitted to hospital
CLINI 52	Management of Blood Transfusion Policy
CLINI 57	Adult Supportive and End of Life Policy
CLINI 59a	Safe Standards in the Perioperative Environment
CLINI59b	Reducing Surgical Site Infections in the Perioperative Environment
CLINI 64	Prevention and Management of Falls
CLINI 83	Surveillance for HCAI Policy
FIN 03	Enterprise Risk Management Policy
FIN 05	Duty of Candour
FIN 14	Management of Claims and Legal Notification Policy
HOP 02	Complaints Policy

HS 03	Health and Safety Incident Reporting Policy
HS 09	Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)
MED 02	Consultants' Handbook
MED 06	Managing Consultant Performance Concerns
MED 11	Patient Notification Exercise Policy

16.0 GLOSSARY OF TERMS:

After Action Review (AAR)	A structured approach for reflecting on the work of a group and identifying strengths, weaknesses, and areas for improvement.
Candour	The quality of being open and honest.
Duty of Candour	Responsibility to be open and transparent in relation to a safety incident
Integrated Care Boards (ICBs)	A statutory NHS organisation which is responsible for developing a plan for meeting the health needs of the population, managing the NHS budget, and arranging for the provision of health services in a geographical area. Formerly known as a CCG.
Just Culture	A culture that balances fairness, learning and accountability.
Learning from Patient Safety Events	National NHS service for the recording and analysis of patient safety events that occur in healthcare.
Learning Response	Any response to a patient Safety incident that incorporates a system-based approach to capturing learning to inform safety actions for improvement. The system here is the 'Work System' (see below).
Patient Safety Incident (PSI)	Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm.
Patient Safety Incident Investigation (PSII)	A PSII is undertaken when an adverse event or near-miss indicates significant patient safety risks and the potential for new learning.
Psychological Safety	An environment characterised by openness and trust that allows team members to feel comfortable taking risks and making mistakes.
Safety Actions	Actions to reduce risk following the identification and agreement of the aspects of a work system (see below) where change could reduce risk and the potential for harm.
Swarm Huddle	A quick analysis occurring immediately (or within 24 hrs) of an incident to understand what happened, how it happened and what needs to be done to reduce the risk of it happening again. Includes all those involved in the incident 'swarming' together.

17.0 APPENDICES

APPENDIX 1 - PSIRF PLAN
APPENDIX 2 - PSIR TEMPLATE INCLUDING GUIDANCE
APPENDIX 3 - PSII TEMPLATE INCLUDING GUIDANCE
APPENDIX 4 - PATIENT SEIPS REVIEW TEMPLATE
APPENDIX 5 - THEMATIC REVIEW TEMPLATE
APPENDIX 6 - AFTER ACTION REVIEW TEMPLATE
APPENDIX 7 - SWARM HUDDLE TEMPLATE
APPENDIX 8 - KSI REVIEW GUIDANCE
APPENDIX 9 - BLOOD TRANSFUSION AND LABORATORY MEDICINE INCIDENT INVESTIGATION
APPENDIX 10 - VTE CASE REVIEW
APPENDIX 11 – PRESSURE INJURY SWARM HUDDLE AND CASE REVIEW
APPENDIX 12 - SSI CASE REVIEW
APPENDIX 13 - PATIENT SAFETY INCIDENT RESPONSE FLOWCHART
APPENDIX 14 - MORTALITY REPORTING PROCESS FLOWCHART
APPENDIX 15 - MORTALITY CASE REVIEW
APPENDIX 16 - MORTALITY REVIEW – SACT
APPENDIX 17 - MORTALITY REVIEW IMA
APPENDIX 18 - MORTALITY STRUCTURED JUDGEMENT REVIEW
APPENDIX 19 - EXAMPLE CONDOLENCE LETTER TEMPLATE
APPENDIX 20 - MEDICAL EXAMINER PROCESS
APPENDIX 21 - LEVELS OF HARM – CLINICAL
APPENDIX 22 - INQUEST STATEMENT TEMPLATE AND GUIDANCE
APPENDIX 23 - INVESTIGATION OF ERROR (RADIOLOGY)
APPENDIX 24 - PSIRF TRAINING NEEDS ANALYSIS
APPENDIX 25 - ACCOUNT OF EVENTS TEMPLATE
APPENDIX 26 - DCIQ (PATIENT SAFETY EVENTS) VALIDATION AND INTEGRITY STANDARD OPERATING PROCEDURE
APPENDIX 27 - FALLS CASE REVIEW
APPENDIX 28 - NEVER EVENT REPORTING PROCESS
APPENDIX 29 - KSI REVIEW IPC INCIDENT RESPONSE FLOWCHART
APPENDIX 30 - KSI REVIEW CLOSTRIDIOIDES DIFFICILE
APPENDIX 31 - KSI REVIEW BACTERAEMIA

Please complete the quality assessment below.

Quality Assessment

Reference:	CLINI 103
Document name:	PSIRF Policy
Name of the person completing:	Tracey Thacker
Who has been consulted on this document:	All stakeholders overseen by PSIRF Programme Board
Director owning the document (job title):	Spire Healthcare Group Director of Integrated Quality Governance
Directors name:	Cathy Cale

Has the executive responsible for this document seen and approved this document? Yes ☒ No ☐

Name of Director	Dr Cathy Cale	Date	22/01/2023

Which stakeholders have been involved in the development / review of this document?

Please detail	Group Medical Director, Director of Integrated Quality Governance, Governance Leads and Lead ICB

How will compliance with this document be monitored / audited?

Please detail	Patient Safety Incident Review Working Group (PSIRG) oversight Compliance with MED06 – Managing Consultant Performance Concerns process Reporting of incidents to Operational SQ&R, SQ&R and CG&S Committees

Is training required to implement this document? Yes ☒ No ☐

Please detail	Ongoing drop in PSIRF related sessions, induction for new starters

Is there a cost implication in the implementing of this document? Yes ☐ No ☒

If there is a cost implication has this been agreed? Yes ☐ No ☒

Please detail	N/A

Is there a resource implication in the implementation of this document? Yes ☐ No ☒

Please detail	N/A

Please complete the equality assessment below.

Equality Assessment

Positive impact: *a policy / document where the impact on a particular group of colleagues / patients is more positive than for other colleagues. It can also include legally permitted positive action initiatives designed to remedy workforce imbalance, such as job interview guarantee schemes for disabled people.*

Negative impact*: a policy / document where the impact on a particular group of colleagues / patients is more negative than for other colleagues (e.g., where the choice of venue for a colleague social occasion precludes members of a particular faith or belief group from participating).*

Neutral impact: *a policy / document with neither a positive / negative impact on any group or groups of colleagues / patients, compared to others.*

Group: Colleague / Patient	Considerations (examples)	Impact (check box)
Sex		☐ Positive ☒ Neutral ☐ Negative
Pregnancy / maternity		☐ Positive ☒ Neutral ☐ Negative
Disability	*Do we need to consider large print or adapt for colleagues with Dyslexia?*	☐ Positive ☒ Neutral ☐ Negative
Race (inc. ethnicity /nationality)	*Is the document inclusive and take into account different groups of people?*	☐ Positive ☒ Neutral ☐ Negative
Age	*Are their ways older / younger people might find it difficult to engage with the document?*	☐ Positive ☒ Neutral ☐ Negative
Gender reassignment / trans / non-binary	*The language used inclusive of all groups e.g. they instead of he/she.*	☐ Positive ☒ Neutral ☐ Negative
Marriage /civil partnership		☐ Positive ☒ Neutral ☐ Negative
Lesbian / gay / bisexual groups	*Is the language used inclusive of LGBTQ+?*	☐ Positive ☒ Neutral ☐ Negative
Faith / belief groups:	*Do faith groups experience a disadvantage in relation to the document?*	☐ Positive ☒ Neutral ☐ Negative
Welsh language	*Level of fluency?*	☐ Positive ☒ Neutral ☐ Negative
Social deprivation	*Are their social factors to consider?*	☐ Positive ☒ Neutral ☐ Negative

If there is a negative impact on any equality target groups, can this impact be legally and objectively justified?

Please detail	No

Does this document promote equality? Consider, does the document eliminate unlawful or unjustifiable discrimination, promote equality of opportunity, promote positive attitudes, eliminate harassment and bullying or victimisation, promotes inclusion and participation and eliminate health inequalities for both colleagues and patients?

Please detail	Yes – See section 5.0 ADDRESSING HEALTH INEQUALITIES

If there is no evidence that the document promotes equality, what changes, if any, could be made to achieve this?

Please detail	N/A

Author Declaration

Please confirm you have thoroughly assessed the policy / document against the above criteria

Signed	Tracey Thacker

Policy / Document Guide (for reference only)

All policies and appendices (new and updated) should be approved at the Policy Approval Committee (PAC). The committee meets each month and final papers should be sent for consideration no later than 10 days prior to the next meeting. For example if the meeting is taking place on the 24th of the month the last date for papers will be the 14th. Dates of meetings and final dates for papers can be found at: https://intranet.spirehealthcare.net/integrated-quality-governance/policy-management/

CHECKLIST

☒ Consultation has taken place prior to final papers being submitted. Details of who to consult with can also be found on the above link.

☒ I can confirm that the legal team have been consulted on this document prior to the final copy being submitted to PAC.

☒ All policies and appendices have been assigned to a relevant committee and executive director and that both have been consulted and are aware of the document / appendix prior to submission to PAC.

GUIDANCE NOTES

Reference:	CLINI 103
Document Name:	PSIRF Policy
Directorate:	Clinical and Medical
Committee:	OpSQR
Author Name:	Tacey Thacker
Author Job Title:	Deputy Director of Quality Governance
Issue Date:	January 2026
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