Spire Healthcare

Patient Safety Incident Response Framework (PSIRF) Plan

PSIRF Patient Safety Incident Response Framework



Contents

1.	Introduction	2
2.	Key principles for setting priorities	3
3.	Our services	3
4.	Defining our patient safety incident profile	4
5.	Our patient safety incident response plan: NHS England national requirements	5
6.	Our patient safety incident response plan: group priorities	7
7.	Spire Healthcare Group priorities (figure 1)	9
Appendix 1: Spire Healthcare hospitals and NHS England ICB regions		10

1. Introduction

The patient safety incident response plan sets out how Spire Healthcare intends to respond to patient safety incidents in 2026. 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 occur and the needs of those affected.

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.

Since its implementation, the patient safety incident profile (and subsequent group priorities) identified issues most pertinent to Spire Healthcare in line with all services we provide as a group. These were initially identified and agreed in 2023 by conducting a stakeholder engagement analysis and a full examination of the data sources available. A further situational analysis was undertaken in 2024 (of 2023 Serious Incident data) to confirm group priorities for 2025; this has again been repeated in 2025 (using 2024 patient safety incident data) to confirm 2026 group priorities.

This document should be read in conjunction with Spire Healthcare's Patient Safety Incident Response Framework Policy.

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. 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. Key principles for setting priorities

- **Data-driven:** Use local incident data, national safety alerts, and thematic reviews to identify high-risk areas.
- **Learning potential:** Focus on incidents where systemic learning can prevent recurrence (e.g., process failures, human factors).
- **Alignment with national priorities:** Consider NHS Never Events, high-harm categories, and emerging risks.
- **Stakeholder engagement:** Involve patients, families, and staff in identifying priority themes.
- **Proportionate response:** Not all incidents require full investigation – apply alternative learning responses where appropriate. [**psirf.co.uk**]



3. Our services

Spire Healthcare is a leading independent healthcare group in the United Kingdom, with 38 hospitals and 50+ 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 993,000 in-patients, out-patients and day case patients in 2024, 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 38 hospitals and 50+ 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. Our organisation is committed to delivering PSIRF to all of our patients therefore the framework is applicable to not just patients who have received NHS funded care. Additionally, this framework is 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.

The patient safety incident profile identified issues most pertinent to Spire Healthcare in line with all services we provide as a group.

4. Defining our patient safety incident profile

The PSRIF plan for 2026 has been developed as a groupwide approach which will be adopted by all areas of the business including all 38 of our hospital sites. Local issues meeting enhanced investigation criteria will be investigated under the "emergent trends" categorisation.

4.1 Data sources:

To define Spire Healthcare's patient safety response profile a detailed situational analysis of incidents reported in the period 15 April 2024 to 31 December 2024 was undertaken.

- 35,215 Patient safety incidents were reported in the period 15 April 202 to 31 December 2024 (15 April was the date the new risk management system DCIQ was implemented).
- The majority were no or low harm incidents. There were 497 incidents reported as moderate or severe harm (excluding the category of Consultant Concern as these incidents are investigated through a different process).
- Data shows that the initial review for the PSIRF Plan 2024 was correct in identifying our Group Priorities.
- KSI reviews cover the main areas of reporting and are used to assess the Group Priorities.

This analysis was completed in parallel with a review of the Quality Improvement (QI) Framework for 2026 in order to ensure that QI work streams were not being duplicated within the PSIRF Plan.

The Spire Healthcare wide QI priorities for 2026 are:

1. Avoidable cancelations
2. Sustainability
3. Theatre Kit Hire

Note: While these priorities address operational improvement, they do not fully represent governance outcomes. Governance Theme Insight: Further analysis identified documentation as the dominant governance theme in 2024–25. Although critical to clinical care, documentation is broad, complex, and challenging to measure for impact.

In addition, Spire Hospitals will create one QI priority which the hospitals can use to drive improvement activity. The hospital priority can 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.

Consultation on Spire's group priorities has taken place internally via Operational Safety, Quality and Risk Committee and Safety Quality and Risk Committee.

5. Our patient safety incident response plan: NHS England national requirements

5.1 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.



5.2 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 (Updated 2021)	AAR/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.	Mortality Case Review (Spire equivalent of 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.	Mortality Case Review (Spire equivalent of 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.	Mortality Case Review (Spire equivalent of 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.		

6. Our patient safety incident response plan: group priorities

6.1 Group Priority incidents

Based on the situational analysis and review of the incident reporting profile in Spire Healthcare, group priorities and associated learning response types for 2026 have been agreed by the organisation and can be found on page 9 (Figure 1).

There may be occasions where the incident response type listed is not required as learning has been captured during the initial response e.g. KSI and associated safety improvement plan. This decision sits with the Patient Safety Incident Review Group (PSIRG).

6.2 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.

6.3 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.

Hospitals may choose to review incidents which do not meet the National or Group Priorities by using appropriate and proportionate techniques using any of the following incident response types:

- **Swarm huddle**
- **After action review**
- **Thematic Review**

6.4 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.

6.5 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 the Just Culture guide (Being Fair Tool) 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.

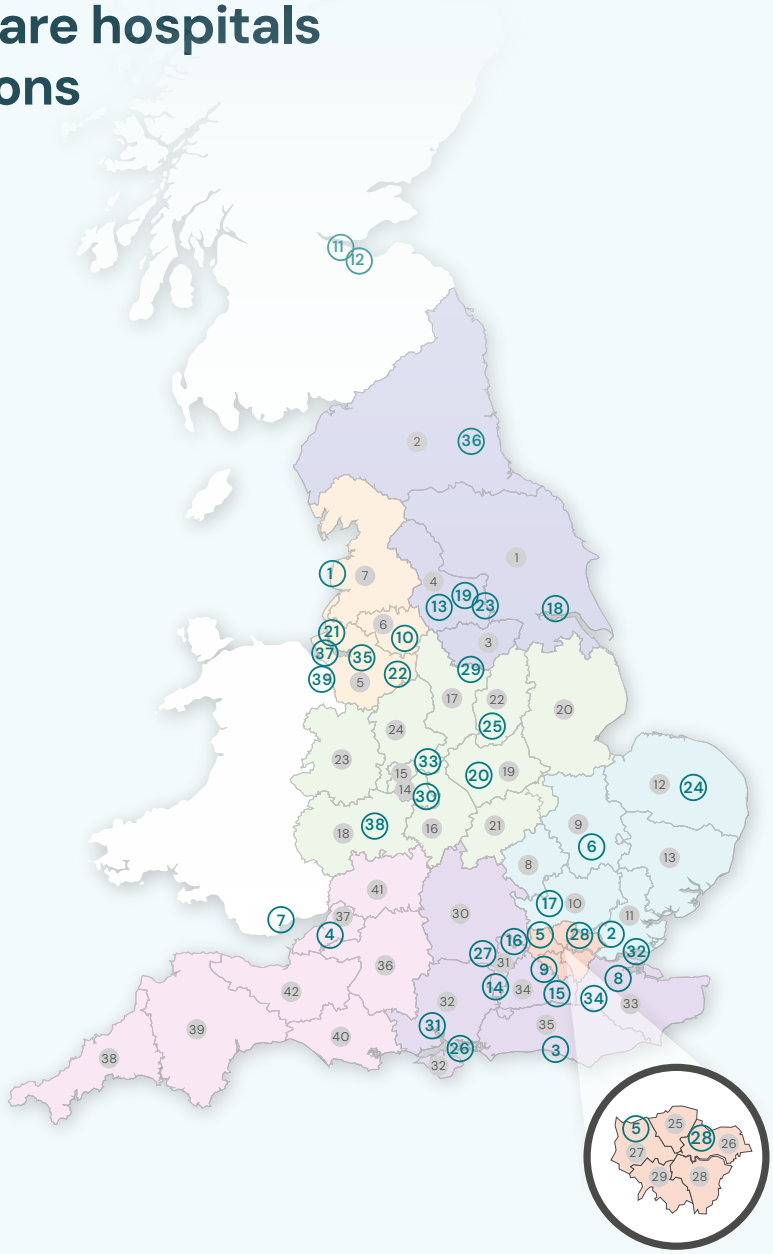


7. Spire Healthcare Group priorities (figure 1)

	Theme	Patient Safety Incident Type or Issue	Example	Suggested Response Type	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.	AAR/PSII	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.	AAR/PSII	
3	Peri-operative complications (leading to injury)	Cases where a significant unexpected injury has occurred during surgery.	A skin burn or laceration requiring non conservative further management or surgery.	AAR/PSII	
4	Inpatient Falls	Patient fall resulting in significant injury.	Fall resulting in a fractured neck of femur.	SWARM/Falls Case Review (refer to HS03 - may require Accident Investigation)	
5	Blood transfusion incident SABRE reportable	Blood transfusion incidents which require reporting externally (SHOT).	Adverse incidents as defined by SHOT	Use Blood Transfusion and Laboratory Medicine Investigation template CLINI 103 – Appendix 9. This is required in line with MHRA requirements	
6	Near Miss Never events	Near miss incidents that could have led to a Never Event as per the criteria set in the Never Events list 2018	A “near miss” never event would have met the criteria for a Never event and potentially caused harm but didn’t, due to chance or timely intervention.	AAR/SWARM	

Appendix 1: Spire Healthcare hospitals and NHS England 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		

Notes

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