Circle Health Group

Patient Safety Incident Response Plan

V2.0 Mar 2025

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Summary of key standard operating procedure requirements

1
This Standard operating procedure (SOP) describes Circle Health Group's (CHGs) and Circle Integrated Care's (CIC) arrangements for reporting Incident/ Events of all types and of any significance and the actions expected to manage and follow-up such incidents. This SOP relates to any incidents involving staff, patients, and others. NB: (references to CHG are inclusive of CIC).

2
This SOP details CHG Patient Safety Incident Response Plan (PSIRP) and was created following a review of historical data and uses this data to inform a proportionate response to incidents based on an understanding of contributing factors, and previous or current quality improvement projects.

3
As required by NHS England and regulated by the Care Quality Commission (CQC), it utilises the Patient Safety Incident Response Framework (PSIRF). Where applicable, processes are built into the Governance IT incident management system to underpin this approach.

4
Differences in National Policy for Wales regulated by Healthcare Inspectorate Wales (HIW) and Scotland regulated by Healthcare Improvement Scotland (HIS) are integral to CHGs PSIRP and are described in the procedure. Where applicable, processes are built into the Governance IT incident management system to underpin this approach.

5
The PSIRP is a living document that will be under continuous review.

6
The PSIRP describes the nationally required response for:

- NHS England (NHSE) and the Care Quality Commissions (CQC) - Patient Safety Incident Investigations (PSII).
  - PSII draft reports require formal approval by the Patient Safety Incident Review Group (PSIRG) before they can be disclosed to those involved for review. Once this review is complete, they must be submitted to PSIRG as final before being internally closed. This formal process ensures the quality and proportionality of the response, and the accuracy of the learning and improvement proposals identified.
- Healthcare Inspectorate Wales (HIW) - Root cause analyses (RCA)
  - CHG have consulted with HIW during their PSIRF and PSIRP development, and HIW have agreed to accept PSIRF investigations in lieu of Comprehensive and Concise investigations. Reports require formal sign-off before they can be internally closed. This formal sign off process ensures the quality of the investigation, the accuracy of the investigation, and the robustness of the action plan designed to address the learning identified. This formal process ensures the quality and proportionality of the response, and the accuracy of the learning and improvement proposals identified.
- Healthcare Improvement Scotland (HIS) - Root cause analyses (RCA)
  - CHG have consulted with HIS during their PSIRF and PSIRP development, and HIS have agreed to accept PSIRF investigations in lieu of Comprehensive and Concise Investigations. Reports require formal sign-off by PSIRG before they can be internally closed. This formal sign off process ensures the quality of the investigation, the accuracy of the investigation, and the robustness of the action plan designed to address the learnings identified. This formal process ensures the quality and proportionality of the response, and the accuracy of the learning and improvement proposals identified.

7
The robustness of safety actions, safety improvement plans, after-action reviews, recommendations, and actions designed to address any causative or contributory factors will be assessed using audit methodology.

8
All incident responses will be collated and analysed centrally to inform CHG's future improvement programme and where applicable, iterations of the PSIRP.

Definitions

Term	Explanation
Incident/event	Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm This event type encompasses all patient safety incidents, including "near misses". Select this option if you know that something did not go as intended or expected – whether an act or an omission – and as a direct result the incident could have or did harm one or more patients.
Patient safety incident response framework (PSIRF)	***The patient safety incident response framework*** (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
Patient safety incident investigation (PSII)	A Patient Safety Incident Investigation (PSII) is undertaken when an Incident/Event or near-miss indicates significant Patient Safety risks and potential for new learning. A PSII offers an in-depth review of a single Patient Safety Incident/Event or cluster of Incidents/Events to understand what happened and how. This replaces Root Cause Analysis (RCA) Investigations and reports.
Harm grading	Patient safety incident harm definitions should always be applied based on the best information about the **actual impact** of the incident at the time of recording. If in doubt, it is always better to record a patient safety incident using the available information and best judgement.
Near miss	Event, which could have, but did not lead to harm, loss, or damage.
No harm	• No physical harm, • No psychological harm
Physical Harm	Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm
Psychological Harm	When recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.
Low Harm	Low physical harm is when **all** of the following apply: • minimal harm occurred - patient(s) required extra observation or minor treatment • did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit • did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication • did not or is unlikely to affect that patient's independence • did not or is unlikely to affect the success of treatment for existing health conditions Low psychological harm is when **at least one** of the following apply: • distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit • distress that did not or is unlikely to affect the patient's normal activities for more than a few days • distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Term	Explanation
Moderate Harm	Moderate physical harm is when **at least one** of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention • has limited or is likely to limit the patient's independence, but for less than 6 months LFPSE – Handbook (October 2023) Page 8 of 31 • has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm. Moderate psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that extends for less than six months LFPSE – Handbook (October 2023) Page 9 of 31 • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months
Severe Harm	Severe physical harm is when **at least one** of the following apply: • permanent harm / permanent alteration of the physiology • needed immediate life-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment • has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions • has limited or is likely to limit the patient's independence for 6 months or more Severe psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that continues for more than six months • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

Term	Explanation
Death	Fatal: at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.
LFD	Learning from Deaths.
LeDeR	Learning from Lives and Deaths.
Child Death Overview panel	Child Death Overview Panels (CDOPs) are locally formed panels who CDOPs conduct case reviews to help prevent further child deaths. You can find out more about their responsibilities in the ***working together to safeguard children*** guidance.
Never Event (NE)	Sub-set of Incidents defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Please refer to ***NHS England never event list***
Patient Safety Learning Response Toolkit	The Patient Safety Incident Response Framework (PSIRF) promotes a range of system-based approaches for learning from patient safety incidents. These are defined at section 8.2.3 of the Incident Management Policy (CHG Q&Rpol17) and their use described throughout the PSIRP. The Circle Operating System (COS) advocates the use of Stop the Line (STL) and SWARM. These are defined at section 3.3 of the Incident Management Policy (CHG Q&Rpol17).
LFPSE	Learning from Patient Safety Events.
Independent Investigation	A small number of Events may be externally investigated by a nominated professional.
PSIRG	The Patient Safety Incident Review Group (PSIRG) is a multidisciplinary group commissioned to advise, review, and approve Patient Safety Investigations/Learning responses and event data. Trained in Learning response and Oversight.

1.0
Introduction

1.1
This PSIRP sets out how CHG intends to respond to patient safety incidents over a period of 12 to 18 months and underpins the implementation of PSIRF, outlined in the Incident Management policy CHG Q&Rpol17. The plan is not a permanent rule that cannot be changed. CHG will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

1.2
The activity detailed in the PSIRP is divided into five overarching categories which are detailed below and further illustrated in process flow charts later in this SOP.

1.2 1
Following initial review, some incidents do not require any defined learning response. As they:

- Do not represent an unexpected level of risk.
- Do not form part of CHG's incident profile (PSIRP).
- Do not meet any regulatory reporting criteria.
- Are linked to any ongoing Quality Improvement (QIP) or Safety Improvement (SIP) Programme.

local investigation should be completed to inform future improvement programmes. These incidents can be closed locally. Staff and patient involvement should still be offered.

Options to aid this involvement are listed below:

Technique	Method	Objective
'Being open' discussion	Verbal disclosure of an incident and its outcome	To provide those involved with an opportunity to discuss the incident and respond to any concerns
Sharing an anonymised incident report	Written disclosure of a redacted incident extracted from the Governance IT System	To provide an overview of an incident to those involved in a written format
Incident timeline	Written disclosure of an incident in the form of a chronology	To provide a detailed overview of an incident to those involved in a written format

The process flowcharts at section 1.3 detail this process.

1.2.2
Investigation and response which meet national reporting requirements:

- Never events
- Death thought more likely than not due to problems in care (incident meeting the Learning from Deaths Criteria for Patient Safety Incident Investigations)
- Other regulatory body reportable incidents e.g.: HSE, UKHSA, MHRA, Home Office etc. .
  The process flowcharts at section 5 (5.2, 5.3 and 5.4) outline these processes in full.

1.2.3
Learning to inform improvement - where contributory factors are **not well understood and no SIP/QIPS exist.** A range of tools should be used to understand the required process improvement. The Nationally defined tools are outlined below, and those selected for routine use by CHG shown in bold. Other tools may be recommended by PSIRG. The process flow charts at section 6.1, (6.1.1-6.1.6) outline these processes in full.

Tools for learning to inform improvement	Tools for capturing everyday work	Tools for mapping and synthesising information gathered
PSII	CHG Governance IT System Gateways (triage tool)	Timeline mapping
Incident/event review (MDT)	Observation guide	Work system scan
SWARM	Walkthrough guide	**SEIPS framework – Inclusive of Initial Incident review & After-Action Review**
Post-Incident process review (After Action Review (AAR))	Link analysis guide	**Structured Judgment Review**
	Interview guide	

1.2.4
Improvements based on learning – where contributory factors **are well understood, and QIP/SIP exist.** The Nationally defined tools are outlined below, and those selected for routine use by CHG shown in bold. The process flowchart at section 6.2 outlines this process in full.

Tool	Description
Thematic review	A working document to help create a narrative understanding of a patient safety incident. This can be added to as further information is collected. It is useful for understanding any gaps in information and defining early thoughts on lines of enquiry
Horizon scanning	A checklist and documentation tool to ensure the full breadth of the work system is considered. The tool is used to indicate any aspects of the system design that hinder or support people in the work system to do their job (i.e. barriers and facilitators).

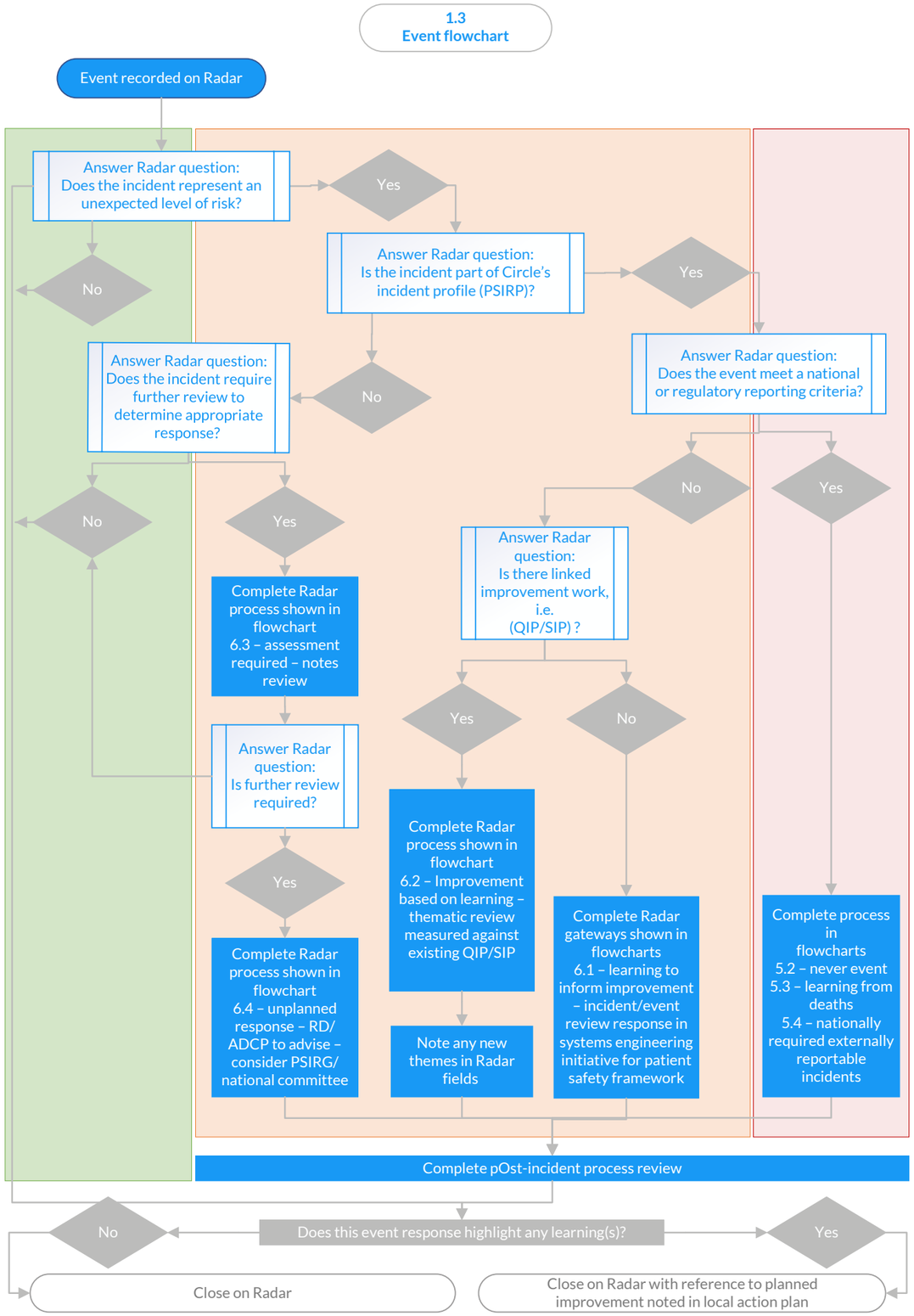
1.2.5
Assessment required to determine response – where the learning response required is unclear. The Nationally defined tools are outlined below, and those selected for routine use by CHG shown in bold. The process flowchart at section 6.3 outlines this process in full.

- **Case record/notes review**
- **SJR**

1.2.6
Unplanned responses, refer to the process flowchart at section 6.4.

The PSIRF Guide to responding proportionately to patient safety incident, states; 'while planning supports proactive allocation of patient safety incident response resources, there will always need to be a reactive element in responding to incidents. A response should always be considered for patient safety incidents that signify an unexpected level of risk and/or potential for learning and improvement but fall outside the issues or specific incidents described in an organisation's plan.' The process flow chart at section 6.4, outlines this process in full.

1.3
Event flowchart



2.0
Our services

2.1
CHG offers the UK's largest national network of private hospitals. Founded in 2004, Circle has always invested in the patient experience, combining clinical excellence with peaceful surroundings where patients are treated as individuals. The group has grown through building new, high-spec hospitals, the acquisitions of Nations Healthcare and BMI Healthcare, and joint ventures. In 2024, Circle was named Private Hospital Group of the Year and one of the Top 5 Best Big Companies to Work For.

UK's LARGEST
independent hospital group

UK's most
PATIENT-FOCUSSED
healthcare organisation

UK's most INNOVATIVE
and technologically advanced hospital provider

SIGNIFICANT INVESTMENT
in robotics, AI, fully digital pathways, and online booking

First UK purpose-built
STATE-OF-THE-ART
rehabilitation hospital

90% of adults in the UK live within 90 MINUTES of a Circle hospital

CIRCLE IN NUMBERS

- c. £1bn revenue
- 50+ hospitals
- Over 2,000 beds
- Over 150 theatres
- Over 6,500 Consultants
- Over 8,200 employees
- 2 million visits per annum
- Over 60 specialties
- Over 500 treatments

2.2
Our values:

As an international healthcare company with strong humanitarian values, we honour our responsibility to give back to people and the community as much as possible. Our values are shaped by what our employees say they want from the business they work for.

Our purpose

To provide the high quality, safe and compassionate care our patients need and expect.

Our principles

We believe that **patients** come first.

We believe in our **people.**

We believe that **"good enough" never is.**

We believe in being **open-minded** and **innovative.**

Our values

We value people who are **selfless** and **compassionate.**

We value people who are **collaborative** and **committed.**

We value people who are **agile** and **brave.**

We value people who are **tenacious** and **creative.**

3.0
Defining our patient safety incident profile

3.1
Stakeholder engagement

Various stakeholders have been engaged in activities throughout the implementation process. Internally these activities include specialist advice, gap analyses, collaborative decision making, alpha testing of processes, and documentation review

Internal stakeholders:

- Central Governance and Quality Improvement team
- Hospital site staff from Senior Management Teams (SMTs), including Executive Directors (EDs), Directors of Clinical Services (DCSs) and Quality and Risk Managers (QRMs)
- Central clinical and operational subject matter experts (SMEs)
- Site level clinical and operational teams

Externally stakeholders have been made aware of internal processes and have where appropriate provided advice.

- IHPN
- ICB's
- HIW
- HIS
- CQC

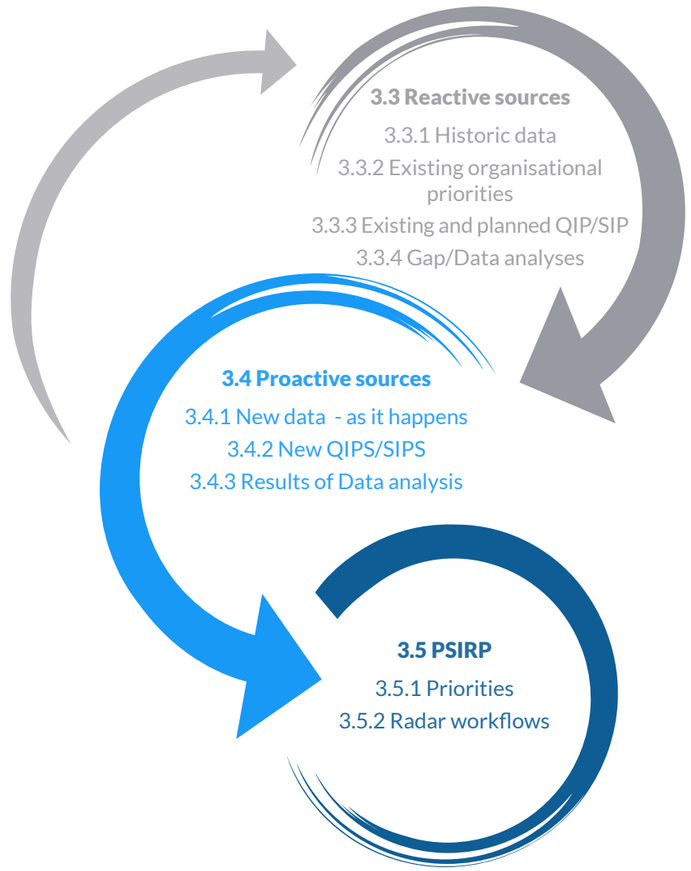
3.2
Patient Safety Partner

As detailed in the Incident management Policy, The Patient Safety Partner (PSP) role is a new and innovative role within CHG, and the wider NHS. The purpose of the role is to develop safer organisations by ensuring the patient's/ family's voice are appropriately represented and to provide a questioning approach This role should be active from January 2024. It is envisaged that the role will evolve through the first iteration of the PSIRP.

This role is active from Jan 2025. It is envisaged that the role will evolve through the interaction of the PSIRP.

3.3
Interactive diagram

Review at 12-18 months to create new PSIRP: where the proactive data set becomes the reactive data set and contemporaneous data becomes the proactive source



3.3
Reactive sources:

3.3.1
Historic data

Description	Analysis methodology	Process
Extracted from the incident management system, covering the full period of activity recorded on the Governance IT System. Sep 2023 – Feb 2025. Data analysis and heat mapping was completed	• Heat mapping of the raw data to establish the most frequent incident by number. • Categories were calculated as a % of all incidents.	• Comparison and verifications of Sep 2023-Feb 2025 data set, against the 2018-2023 data set.

3.3.2
Existing organisational priorities

A number of group priorities were established during PSIRF Implementation detailed below:

National priorities:

- Never events
- Death - meeting the Learning from Deaths criteria

Organisational Priorities:

- VTE
- Cancelled operations (on the day)
- Falls with Harm
- Medication incidents
- Re-admissions
- Unplanned Transfer out to a higher level of care (inclusive of deterioration, sepsis, AKI etc.)

3.3.3
Existing QIP/SIP

Description
A natural consequence of previous identification of trends and themes.

3.3.4
Gap analysis

Description	Analysis methodology	Process
A review of the outcomes of PSIRG including the number of incidents escalated A review of the categories highlighted in both data sets, to establish if the thresholds for the creation of gateways as a method incident of triage, remain appropriate.	**National Priorities:** Proportionality: does the outcomes of PSIRG indicate that formal investigations are more proportionate under PISRF. **Local Priorities:** Event triage questions, for each incident category were reviewed to establish if the current learning/ investigation thresholds were eliciting the appropriate responses.	Volumes of incident discussed at PSIRG, and their outcomes were compared to outcome prior to the implementation of PSIRF. Event triage questions reviewed during planning process for: • VTE • Cancelled operations (on the day) • Falls with Harm • Medication incidents • Re-admissions • Unplanned Transfer out to a higher level of care (inclusive of deterioration, sepsis, AKI etc.)

National Priorities - Results of Data analysis – PSIRG outcomes

To establish proportionality, PSIRG recommended investigations were compared year on year: 2023-2024. The data sets reviewed the first 6 months of each year. During 2023, the methods of formal investigation were Comprehensive and Concise investigations. The PSII wasn't used until 2024. In the 2024 data set there was a mixture of Comprehensive, Concise and PSII investigations.

There was a 41% increase in Incidents reviewed by PSIRG during Jan-Jun 2024, as compared to those reviewed in Jan-Jun 2023.

Despite this increase, the recommended investigations were more proportionate:

- In 2023, a total of 136 incidents resulted in a formal investigation (Comprehensive and Concise investigations), compared to 79 incidents in 2024 (PSII). This is a decrease of 57 PSIRG commissioned formal investigations.
- Recommended local investigation increases from 17 in 2023 to 89 in 2024. This is an increase of 72 local investigations.

Recommended Investigation	2023 (SI Framework)	2024 (PSIRF)
Formal Investigations		
PSII	0	7
Comprehensive	49	25
Concise	65	29
SJR	22	18
Grand Total	136	79
Local Investigations		
Local Investigation	17	89
Grand Total	**17**	**89**

Organisational Priorities - Results of Data analysis - IT Governance System Outcomes

Further data analysis of the organisational outputs from the first iteration of the PSIRP are shown below:

Incidents that have seen a decrease as a percentage of total incidents reported:	2018-2023	2023-2025	% decrease
Cancelled Operation (on the day)	23.626%	17.546%	6.080%
As an element of Clinical Deterioration: • Surgical Complication	6.321%	2.331%	3.990%

Incidents that have plateaued as a percentage of total incidents reported:	2018-2023	2023-2025	Movement
Falls with Harm	1.461%	1.453%	0.008%
As an element of Clinical Deterioration: • AKI	Not recorded	0.061%	Nil
As an element of Clinical Deterioration: • Sepsis	Not recorded	0.176%	Nil

Incidents that have seen an increase as a percentage of total incidents reported:	2018-2023	2023-2025	% increase
VTE	0.571%	0.953%	0.436%
Medication	5.841%	7.241%	1.373%
Unplanned Transfer to a higher level of care	1.372%	1.446%	0.074%
Re-admissions	1.384	2.010%	0.626%
Clinical Deterioration	3.699%	4.257%	0.558%

Whilst these % increases are minimal, it shows a direction of travel, which doesn't indicate a reduction in occurrence.

3.4
Proactive Sources

During the Gap/data analyses an emerging theme was noted in Clinical Communication incidents. Although these incidents do relate to communications, they have secondary themes including

- Cancelled clinics
- Cancelled procedures
- Equipment
- Incorrect referrals/Bookings
- Failures in attendance of Consultants, Patients or Interpreters

Although not formally included in the Organisational priorities, monitoring will continue throughout the term of this PSIRP, with a view to including in future iteration of the PSIRP.

3.5
PSIRP

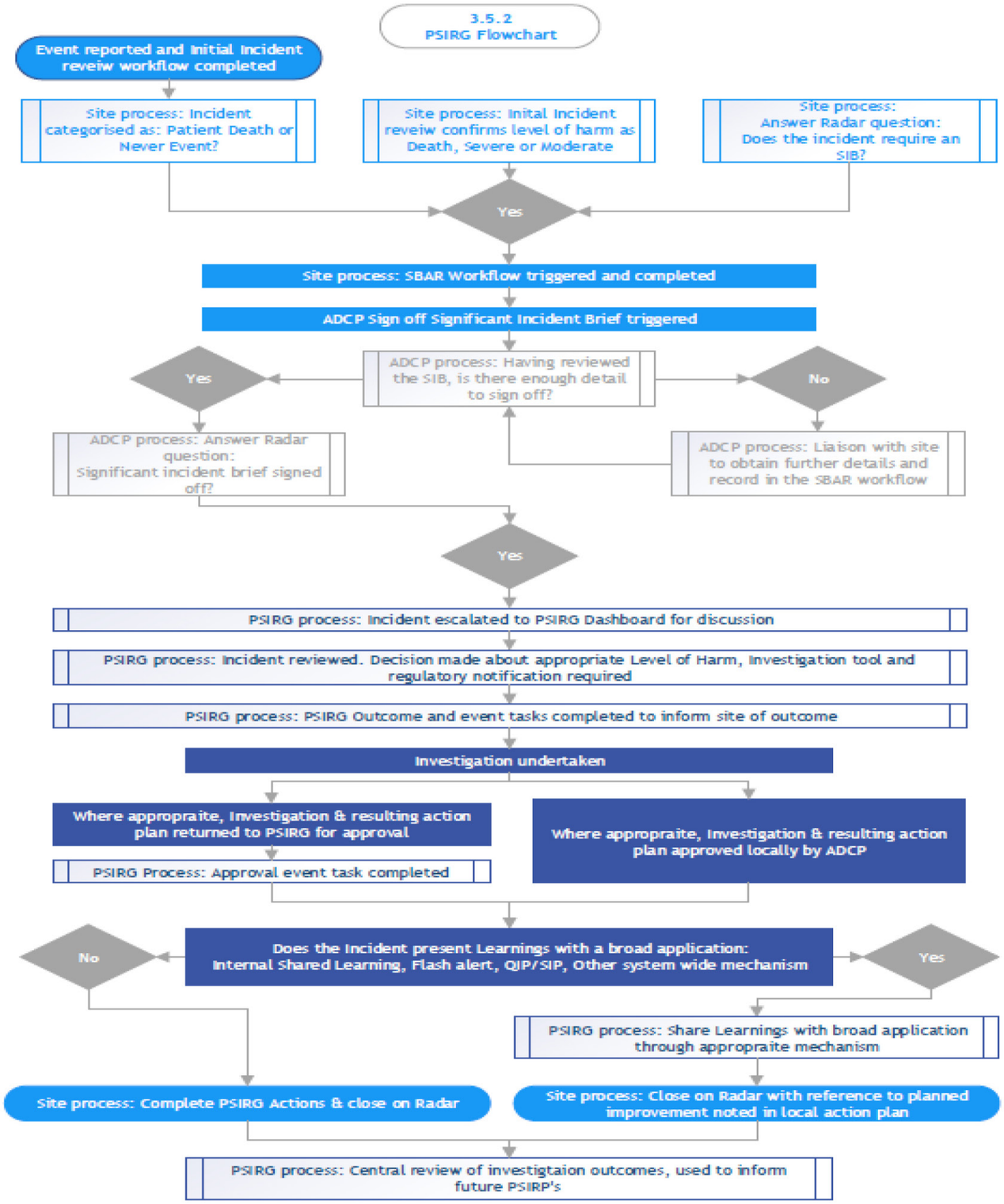
3.5.1
Priorities

Following comparison and verifications of the 2018-2023 and 2023-2025 data sets, a mix of positive and negative outcomes were noted in terms of volume of incidents reported. Therefore, these priorities will remain for the next PSIRP term

3.5.2
Radar Workflows

Throughout the life of the first iteration of the PSIRP, as a consequence of the embedding of PSIRF at CHG, changes have been made to the processes embedded within the Governance IT system. It is recognised that the closing of the loop and evaluation of actions post incident investigation both at a national and local level has not been fully embedded. These processes are illustrated within the PSIRG process for future assurance. This process will now include the use of tags in the Governance IT system to enable analysis through dashboards. This aligns to Objective 3 within the Patient Safety Strategy - Establishing a Patient Safety Learning Loop.

The PSIRG process is illustrated in the workflow included below:



4.0

Defining our patient safety improvement profile

4.1.1

QIP/SIPs:

CHG developed a Quality & Improvement strategy from which 3 areas of focus were identified and agreed to be the improvement initiatives for the year. These were made up of Group Quality Improvement Programme (Group QIP) and Group Safety Improvement Programme (Group SIP).

The existence of Improvement projects is noted in the PSIRP, and related incidents/events are measured against these to establish if any new themes or trends emerge. New themes and trends are noted in the Governance IT System, for ongoing analysis and shared with sites to support learning and prevent future similar incidents.

4.1.2

PSIRP

Throughout the life of this iteration of the PSIRP, emerging National and Local priorities and any emerging themes and trends will be captured through the output from PSIRG, the Governance IT System and any other relevant source to establish the priorities for future PSIRPs.

5.0

Our patient safety incident response plan: national requirements

5.1

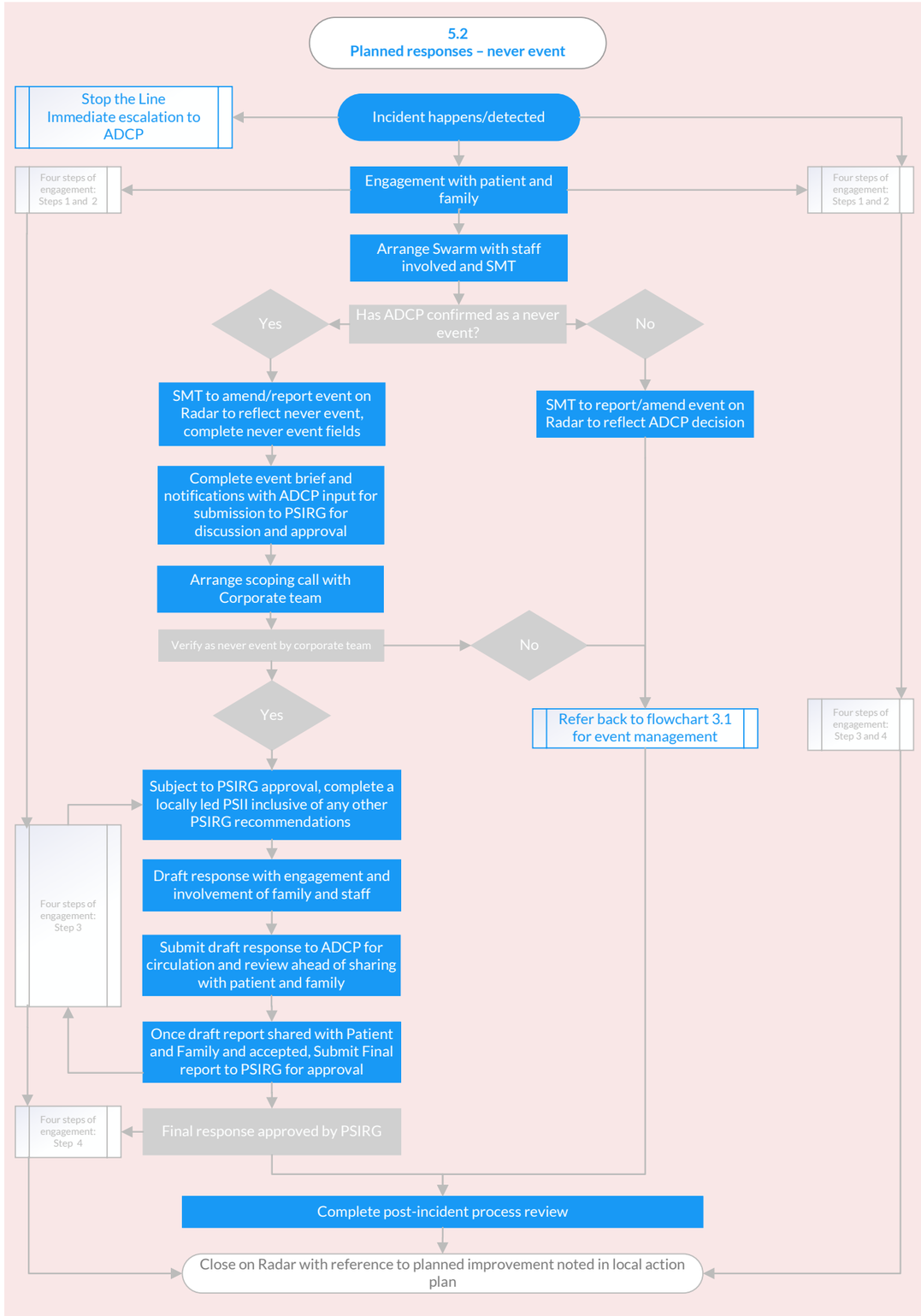
Planned responses in line with national requirements

NB: (Brackets) show PSIRF element

Patient safety incident type	Required response	Anticipated improvement route	Process
Incidents meeting the Never Events criteria	• **PSII** • **Appropriate tool for capturing everyday work** (Observation guide, Walkthrough guide, Link analysis guide, Interview guide) • **Appropriate tool for mapping and synthesising information gathered** (Timeline mapping, Work system scan, SEIPS framework)	Create local or organisational actions and feed these into the quality improvement strategy via PSIRG	Outlined in **flowchart 5.2**
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs))	• **PSII** • **Appropriate tool for capturing everyday work** (Observation guide, Walkthrough guide, Link analysis guide, Interview guide) • **Appropriate tool for mapping and synthesising information gathered** (Timeline mapping, Work system scan, SEIPS framework)	Create local organisational actions and feed these into the quality improvement strategy via PSIRG	Outlined in **flowchart 5.3**
Regulatory reportable incident	To be defined by PSIRG/other GAF committee. Any tools outlined in the PSIRP.	Create local or organisational actions and feed these into the quality improvement strategy via PSIRG	Outlined in **flowchart 5.4**

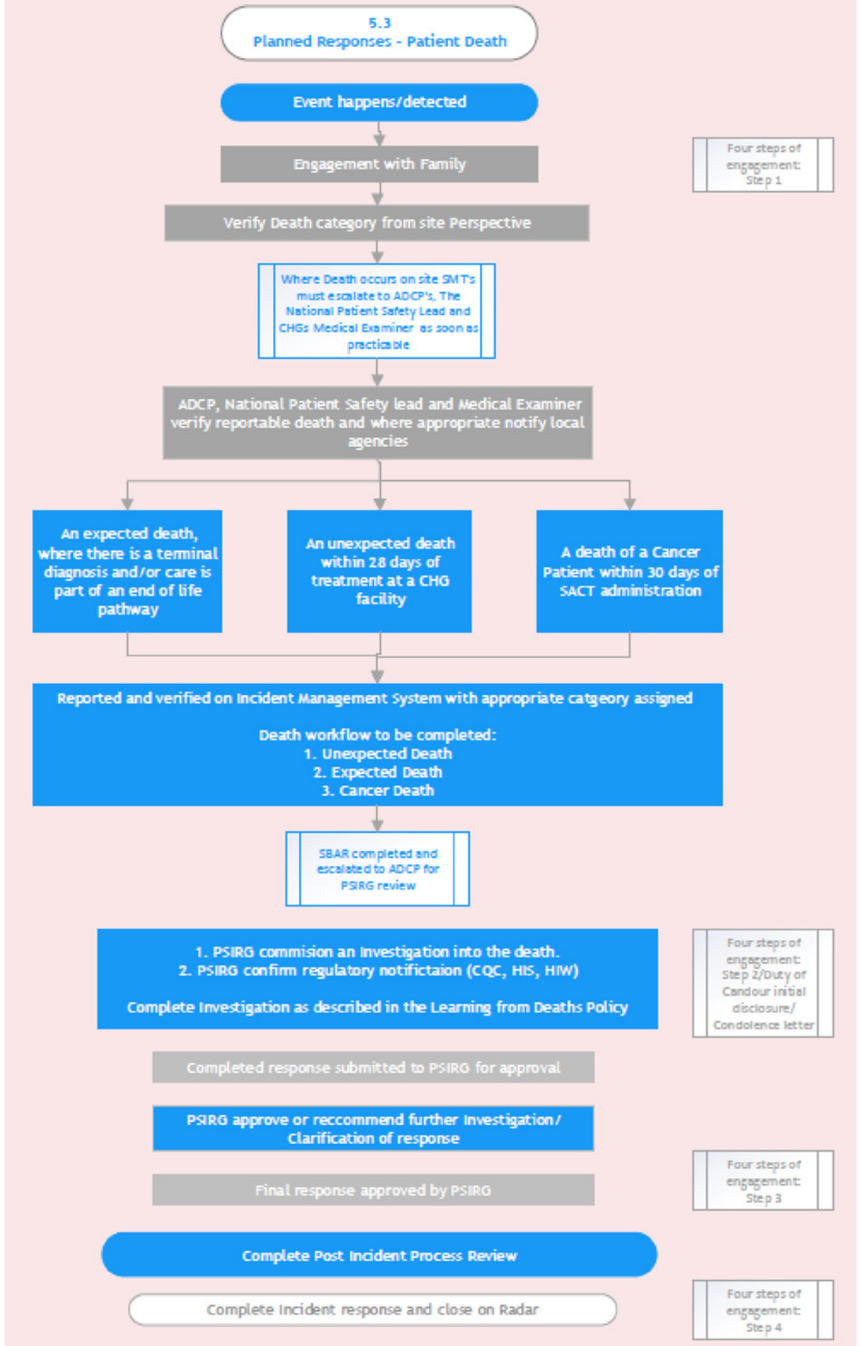
5.2

Nationally required planned response - NE flowchart



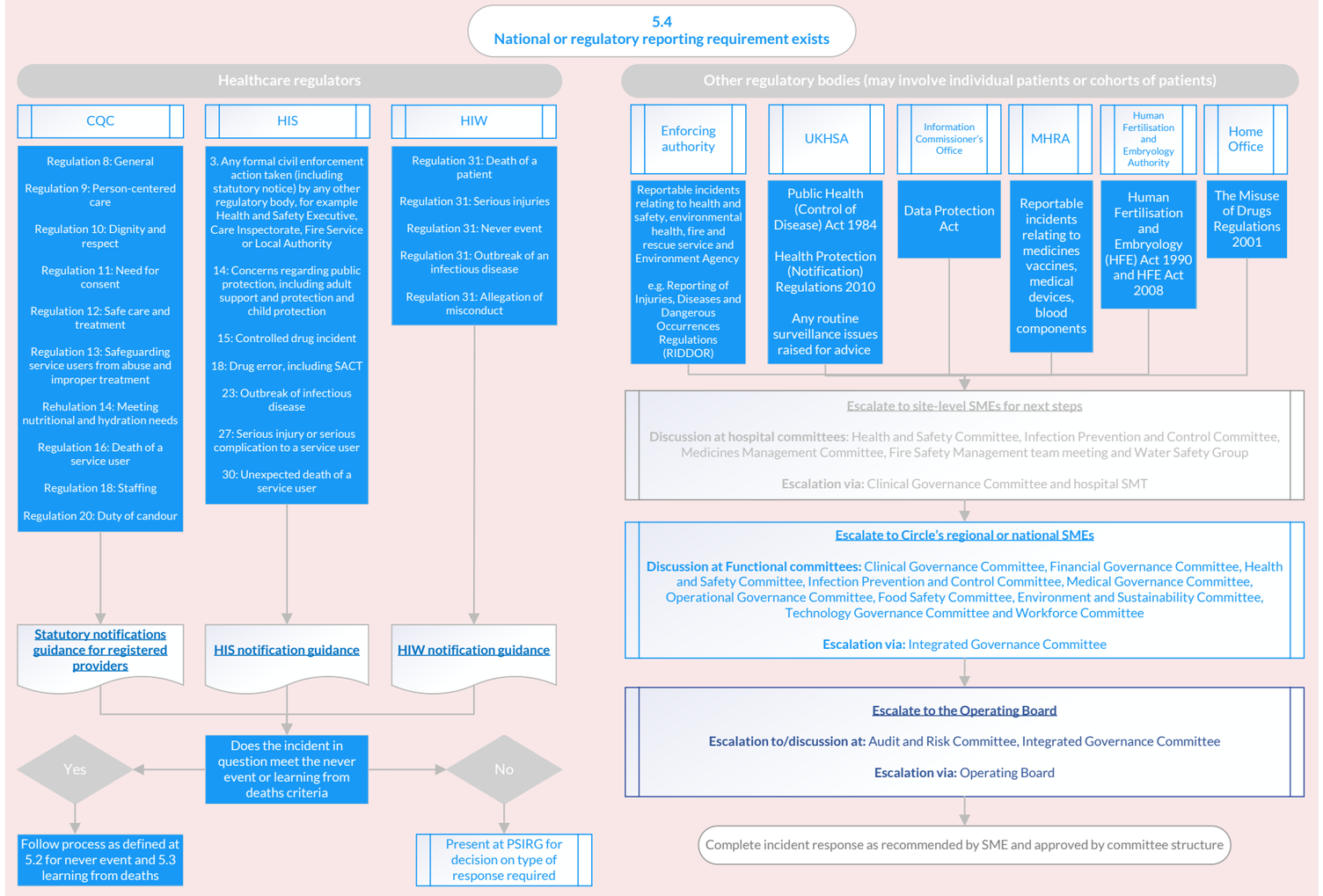
5.3

Nationally required planned response - death flowcharts



5.4

Nationally required planned response - Externally Reportable Flowchart – including non-PSIRF/PSIRP defined incidents/Events



In the event of the onsite a death of a patient, CHG NURpol27 Management of the Deceased Patient and Reporting Requirements policy should be followed in the first instance for any incident involving the death of a patient. This details the process for reporting and notification of deaths.

In the event of an unexpected patient death a scoping meeting (see section 9.3) will be undertaken with the site to review the circumstances of the patient's death, ensure notifications and duty of candour with the relevant person has been undertaken and to provide support and agree the next steps Whether any equipment needs quarantining/isolating. (If a medical device was involved in the Incident/Event, please refer to guidance within CHG ENGpol08).

The Learning from Deaths (ref) policy outlines the different management of Unexpected Expected or Cancer Deaths

6.0

Our patient safety incident response plan: local focus

6.1

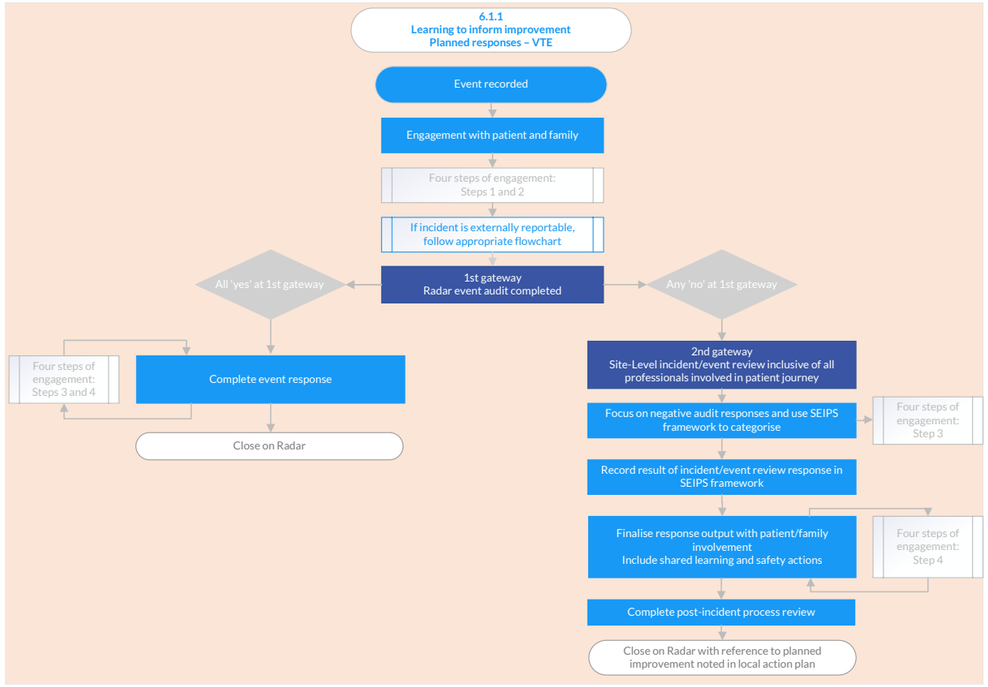
Planned responses: Learning to inform improvements

NB: (Brackets) show PSIRF element

Patient safety incident type or issue	Planned response	Anticipated improvement route	Process
VTE	**Governance IT system gateway** (triage method) **Incident/Event review** (MDT) **SEIPS model** (information synthesis) **Post Incident process review** (AAR of investigative process)	• Create local safety actions and record these in the Governance IT System and populate Local shared learning templates • Escalation of themes and learnings through the Governance and Assurance Framework (GAF): from Site Clinical Governance committee to Corporate Governance Committee • Share learning with CHG as appropriate, using existing Frameworks: Flash alerts • Central data analysis via PSIRG to inform the quality improvement strategy and future PISRP.	Outlined in **flowchart 6.1.1**
Cancelled operations (on the day)	**Governance IT system gateway** (triage method) **Incident/Event review** (MDT) **SEIPS model** (information synthesis) **Post Incident process review** (AAR of investigative process)		Outlined in **flowchart 6.1.2**
Falls with Harm	**Governance IT system gateway** (triage method) **Incident/Event review** (MDT) **SEIPS model** (information synthesis) **Post Incident process review** (AAR of investigative process)		Outlined in **flowchart 6.1.3**
Medication incidents	**Governance IT system gateway** (triage method) **Incident/Event review** (MDT) **SEIPS model** (information synthesis) **Post Incident process review** (AAR of investigative process)		Outlined in **flowchart 6.1.4**
Re-admissions	**Governance IT system gateway** (triage method) **Incident/Event review** (MDT) **SEIPS model** (information synthesis) **Post Incident process review** (AAR of investigative process)		Outlined in **flowchart 6.1.5**
Unplanned transfer to a higher level of care – internal or external	**Governance IT system gateway** (triage method) **Incident/Event review** (MDT) **SEIPS model** (information synthesis) **Post Incident process review** (AAR of investigative process)		Outlined in **flowchart 6.1.6**
Communication issues	Although not formally included in the Organisational priorities, monitoring will continue throughout the term of this PSIRP, with a view to including in a future iteration of the PSIRP.		Nil

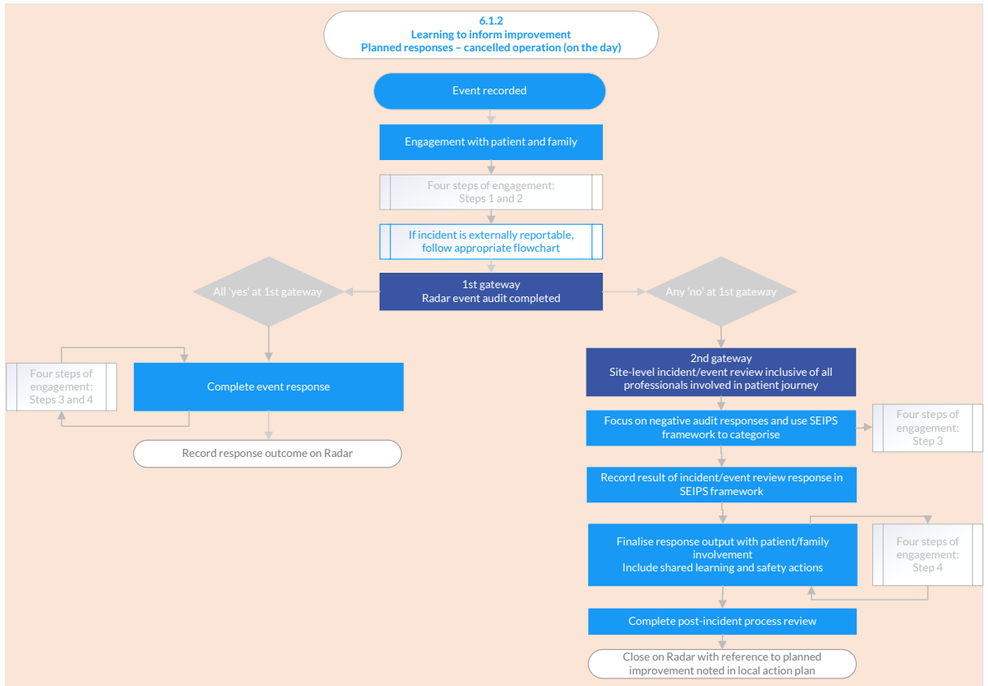
6.1.1

Planned responses: Learning to Inform Improvements - VTE flowchart



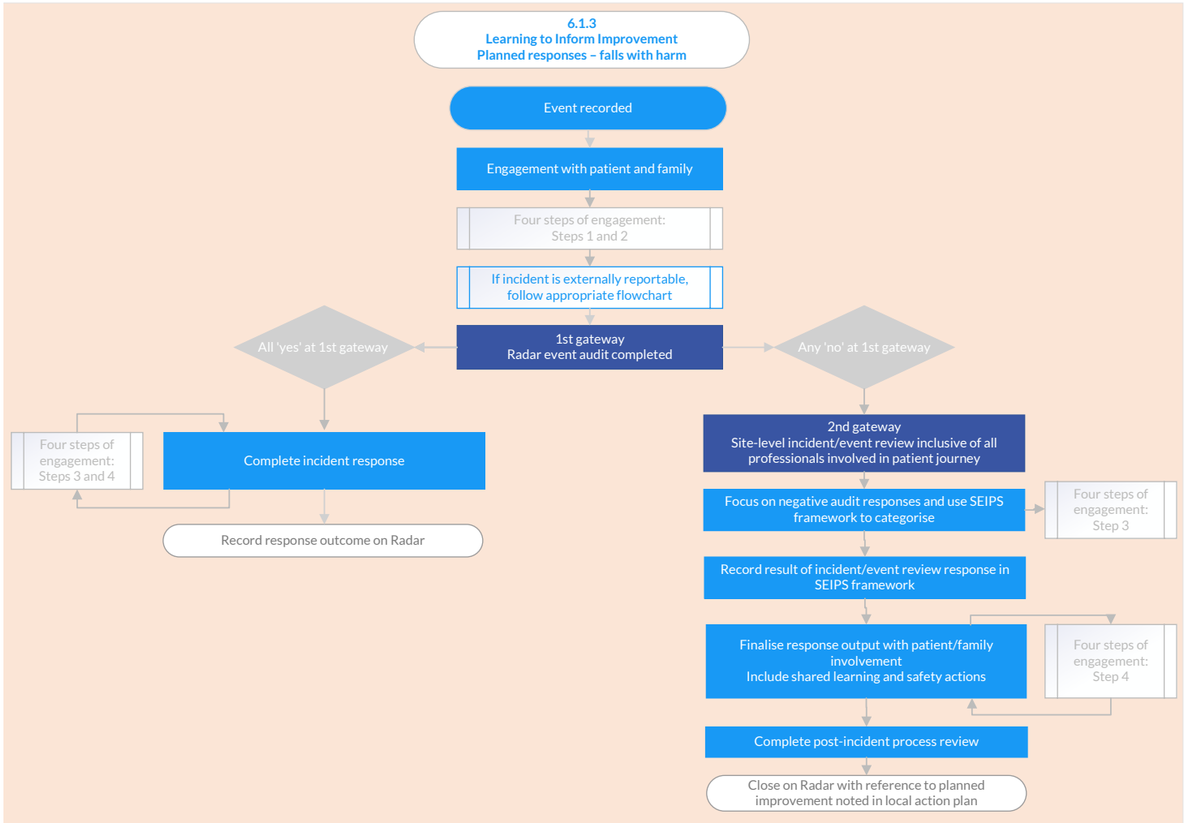
6.1.2

Planned responses: Learning to Inform Improvements - Cancelled Operations flowchart



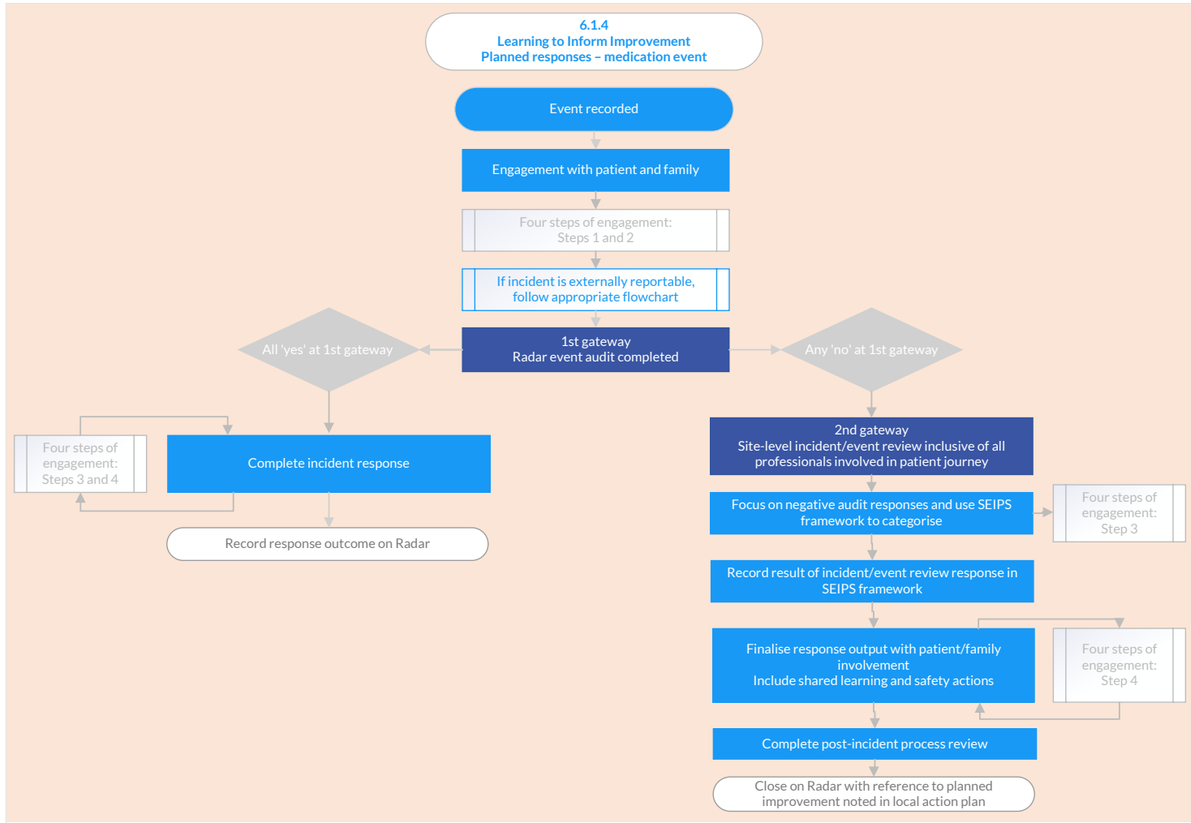
6.1.3

Planned responses: Learning to Inform Improvements - Falls with Harm flowchart



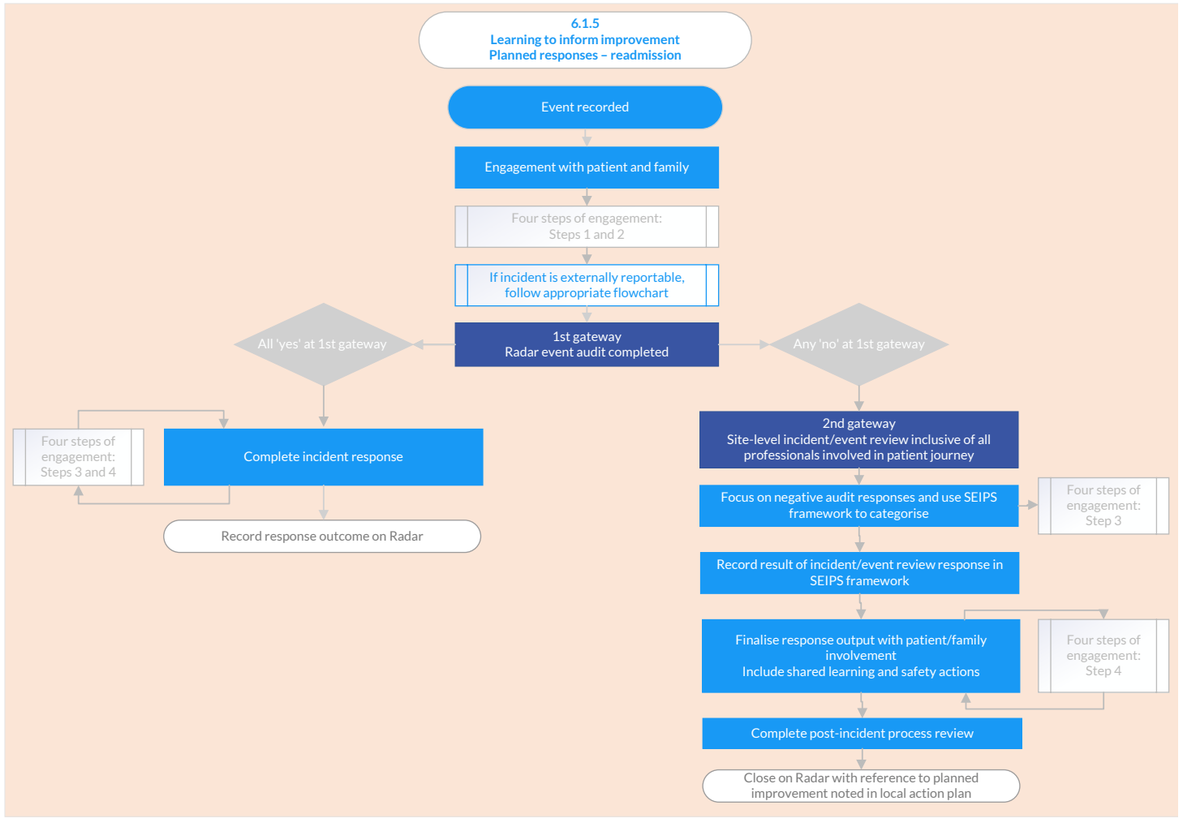
6.1.4

Planned responses: Learning to Inform Improvements - Medication Incidents



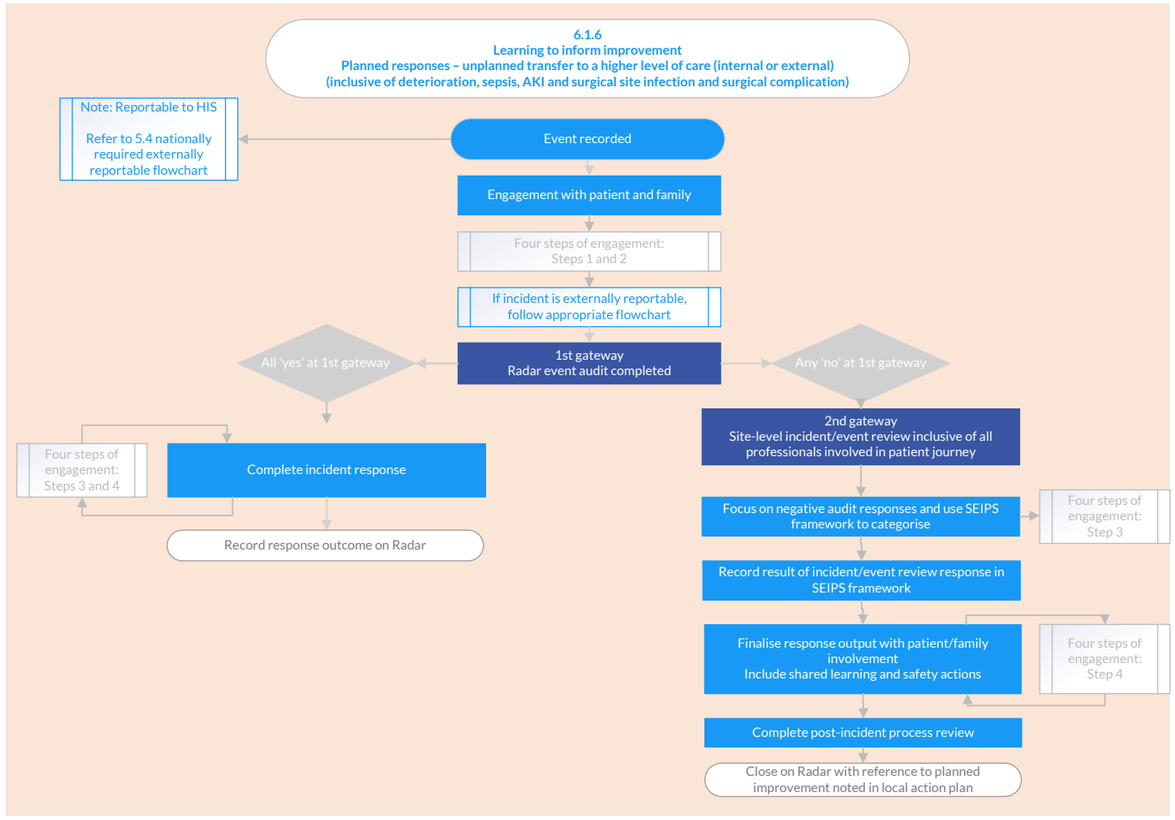
6.1.5

Planned responses: Learning to Inform Improvements – Re-admissions



6.1.6

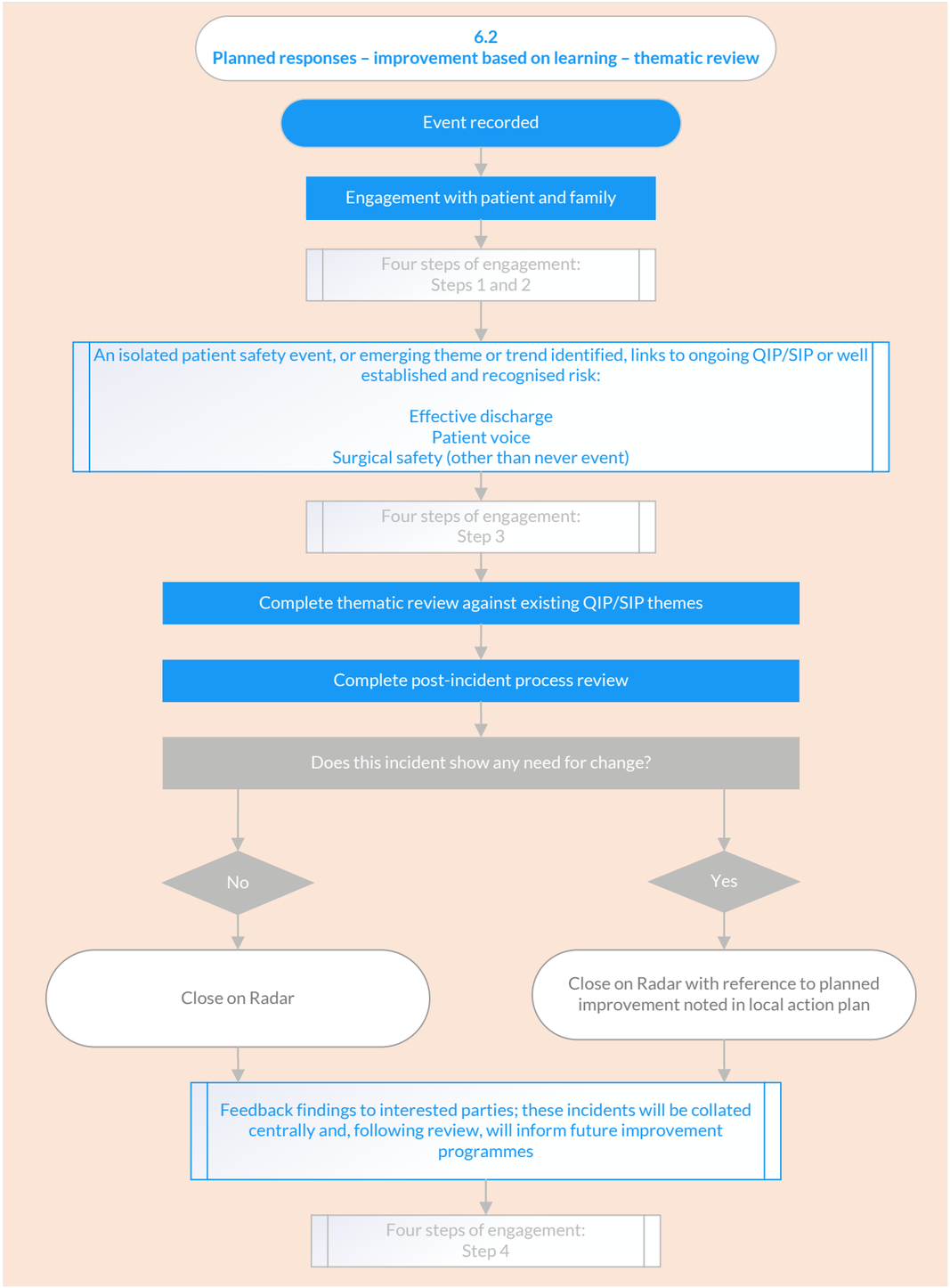
Planned responses: Learning to Inform Improvements – Unplanned Transfer to a higher level of care - (inclusive of deterioration, sepsis, AKI, Surgical Site Infection, and surgical complication) *NB: this applied to internal and external transfers*



6.2
Planned responses: Improvements based on learning

Patient safety incident type or issue	Planned response	Anticipated improvement route	Process
Where QIP/SIP exists, risks are recognised and well established	Thematic review of isolated incident against existing QIP/SIP Or, of an emerging trend	Create local safety actions and feed these into CHG's Quality Improvement Strategy via central analysis and PSIRG reporting	Outlined in flowchart 6.2.

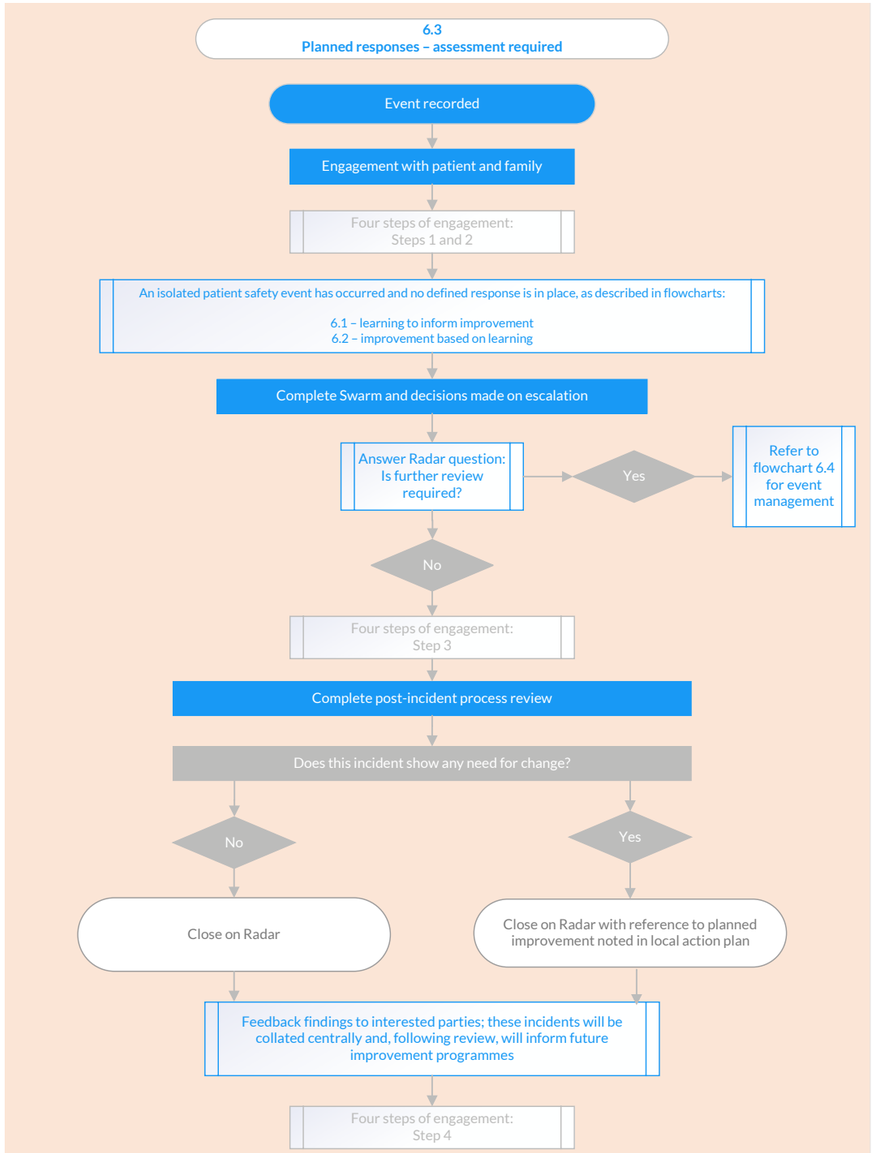
6.2.1
Planned responses: Learning to Inform Improvements – Thematic review



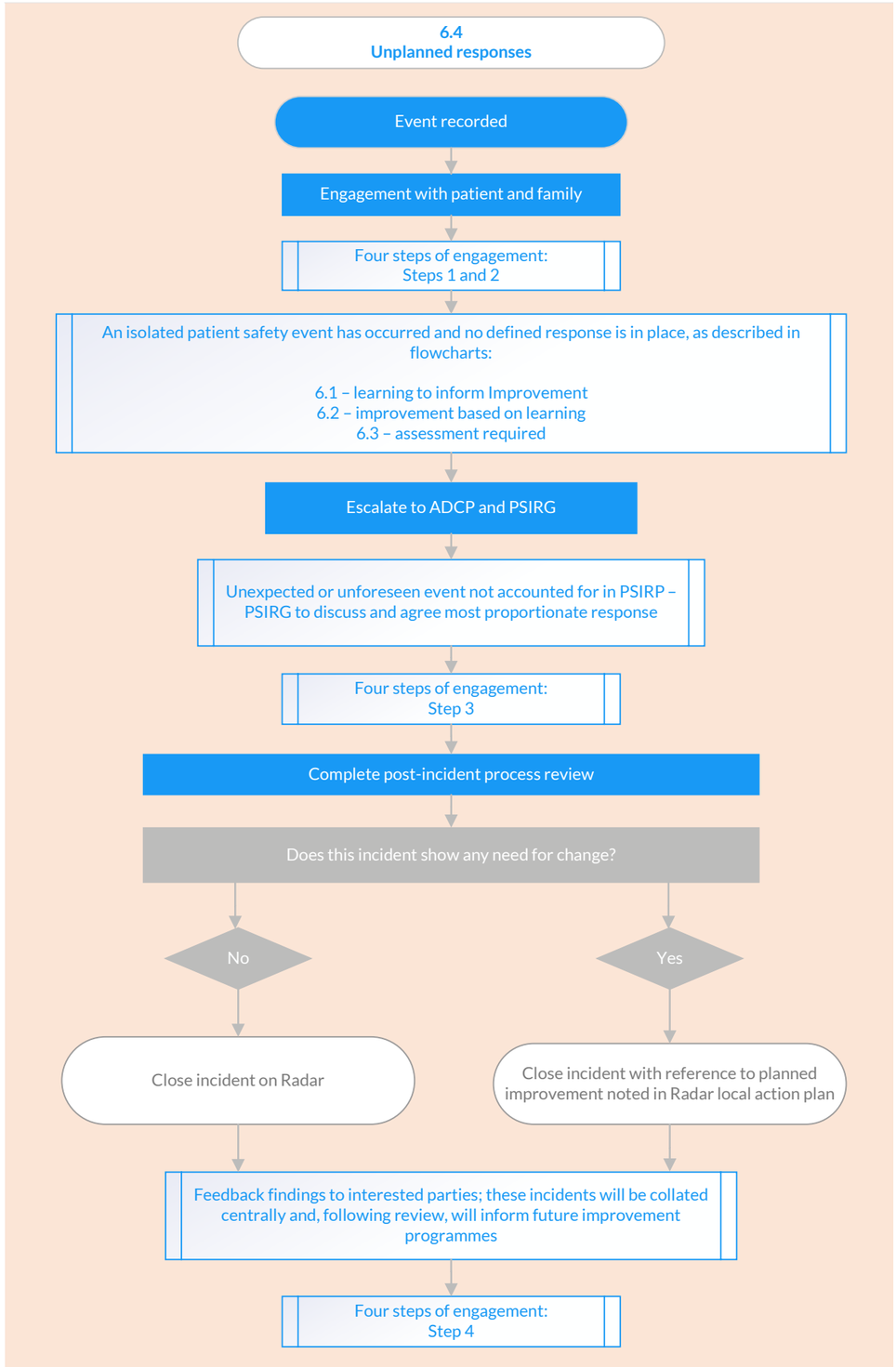
6.3
Planned responses – assessment required

Patient safety incident type or issue	Planned response	Anticipated improvement route	Process
Where Event doesn't meet a defined response in the PSIRP - National or Organisational Priority	Case note review and completion of SBAR escalate to PSIRG for guidance and approval of further investigation	Create local safety actions and feed these into the quality improvement strategy	Outlined in flowchart 6.3 and 6.4

6.3.1
Planned responses: Assessment required – case note review escalated to SJR



6.4
Unplanned responses



VERSION UPDATE

What was the previous version number of this document?	V1.0
Changes since previous version [brief details]	Summary of Key SOP Requirements. • References to Root Cause removed and replaced with 'investigation' and 'learnings identified'. Definitions: • Harm definitions - Updated to LFPSE definitions. 1.0: Introduction: • 1.2.3: Learning to inform improvement - Structured Judgement review added. 2.0: Our Services: • Narrative updated to remove references to China 3.0: Defining our patient safety incident profile: • 3.3: Reactive sources: Numbering and narrative updated to reflect 2023-2025 data set. • 3.4: Proactive source: Numbering and narrative updated to reflect 2023-2025 data set. • 3.5: PSIRP: Numbering and narrative updated to reflect 2023-2025 data set. • 3.5.2: Radar workflow: New workflow added to reflect PSIRG processes. 5.0: Our patient safety incident response plan: • 5.3: Nationally required planned response – Updated Death flow chart and narrative to include the Learning from Deaths Policy and ME office process. • 5.3.1: Expected Patient Death – Workflow removed, and reference made to Learning from Deaths Policy. • 5.3.2: Unexpected Patient Death - Workflow removed, and reference made to Learning from Deaths Policy. 6.0: Our patient safety incident response plan: local focus: • 6.1: Planned responses: Learning to Inform Improvements – Updated to include recognition of Clinical Communication incidents. • 6.3: Planned responses – assessment required – Updated to include SBAR. References: • LFPSE Online Record Patient Safety Event Service added. Associated Documents: • CHG Learning from Deaths Policy added. Appendices: • Appendix 2 – Levels of Harm - descriptions & examples – removed. • Appendix 3 – Harm/Impact Matrix examples – removed. • Appendix 4 – - Escalation of Incident/ Events Matrix (internal and External) Renumbered to Appendix 2. • Appendix 5 – RIDDOR Guidance – Updated & Renumbered to Appendix 3.
How confidential is this document?	CHG Public Can be shared freely within and outside of Circle Health Group CHG Restricted Can be shared freely within Circle Health Group but NOT outside CHG Confidential Contains commercial information and should NOT be released outside or within Circle Health Group unless authorised by senior management

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The learning from deaths criteria, Last Accessed: 18th September 2023.

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LFPSE Online Record Patient Safety Events Service; Last accessed 04th February 2025

Associated documents

- Clinical / Restorative Supervision and Clinical Advocacy CHG NURcg02
- Freedom to Speak Up: Raising Concerns (Whistleblowing) CHG HRpol68
- Disciplinary Policy CHG HRpol29.
- Responding to Concerns about Medical Practice CHGLegpol10
- Risk Management and Risk Register CHG GOVman01
- Being open and Duty of Candour Policy CHG Q&Rpol11
- Complaints Policy, CHG Q&Rpol09
- Patient Safety Incident Response Plan (PSIRP) CHG Q&Rsop01
- Management of the Deceased Patient and Reporting Requirements CHG NURpol27
- ***Learning from Deaths policy – once published***
- ***Patient safety Strategy***

Appendices

Appendix 1 – Glossary of terms.

Appendix 2 – Escalation of Incident Matrix (Internal and External).

Appendix 3 – RIDDOR Guidance.

Appendix 1 – Glossary of terms

Previous term	PSIRF term
Incident	Event
Investigation	Learning Response
Investigator	Learning Response Lead
Patient point of contact during investigation	Engagement and Involvement Lead
• Level 1 (Completed on Riskman)	• An isolated event which is compliant with Policy and doesn't represent any unexpected level of risk • Learning to inform improvement at 1st gateway • Improvement based on learning (Completed on the Governance IT System)
• Level 2 • Concise investigation (Completed on Concise report template)	• Learning to inform improvement at 2nd gateway • +SEIPS Model (Completed on the Governance IT System – 6.1 Learning to Inform improvement template)

• Level 3
• Comprehensive investigation
• Serious Incident Investigation (SI)
• Root Cause Analysis (RCA)
(Completed on Comprehensive report template)
	• Patient Safety Incident Investigation (PSII)
	• + Tool for capturing everyday work
	  • Observation guide, Walkthrough guide, Link analysis guide, Interview guide
	• + Tool for mapping and synthesising information
	  • Timeline mapping, Work system scan, SEIPS framework
	(Completed on the Governance IT System PSII template)

• Level 4 Investigations	• External investigation
Serious Incident	N/A
Never Event	Regulatory Reportable Incident - Never Event
Riskman - Closure comments/Lesson learned	The Governance IT System – Event workflows
STEIS (Strategic Executive Information System)	LFPSE (Learning from Patient Safety Events)
NRLS (National Reporting and Learning System)	LFPSE (Learning from Patient Safety Events)
Riskman	The Governance IT System
Being Open & Duty of candour	Engaging and involving patients, inclusive of Being Open & Duty of Candour
Significant Incident Multidisciplinary Review Panel (SIMRP)	Patient Safety Incident Review Group (PSIRG)

Appendix 2 - Escalation of Incident/Events Matrix (internal and External)

The following types of Incident/Events may require internal and external escalation (outside of the Governance IT system), where contact is made from an external source, this should also be escalated internally by the responsible person.

Incident/Event type	Internal	External (consider)	Responsible individual
Abuse of Adults	• Group Clinical Director. • Area Director of Clinical Performance. • Director of Clinical Governance & Improvement.	• Social Services. • Local Safeguarding authority. • GP. • CQC/HIS/HIW.	• Adult Safeguarding Lead. • Director of Clinical Services.
Blood Transfusion	• National Pathology Manager. • National Pathology Coordinator. • Patient Safety Lead. • National Lead – Blood Transfusion.	• MHRA • SHOT (Serious Hazards of Transfusion).	• Site Pathology lead. • Quality and Risk Manager.
Children and Young People Safeguarding	• Group Clinical Director. • Area Director of Clinical Performance. • Director of Clinical Governance & Improvement. • National Lead – Children and Young People.	• Social Services. • Local Safeguarding authority. • Local Education. • Authority/child's school (dependent on local child protection policy. • GP. • CQC/HIS/HIW.	• Child Safeguarding Lead. • Director of Clinical Services.
Death (Unexpected)	• Group Clinical Director. • Regional Director. • CHG Medical Examiner • Area Director of Clinical Performance. • Director of Clinical Governance & Improvement. • Patient Safety Lead.	• CQC/HIS/HIW. • Coroner/procurator fiscal by the treating clinician. • Commissioner (NHS patients).	• Director of Clinical Services • Quality and Risk Manager
Emergency Plan (Business Continuity) Evoked	• Corporate Leads (dependant on type of emergency). • Regional Director. • Area Director of Clinical Performance.	• Dependant on the Incident/Event type: • Police. • Affected local services.	• Executive Director. • Director of Clinical Services. • Health & Safety Coordinator/Lead.
Health Protection – including reportable disease / infections	• Patient. • Group Clinical Director. • Area Director of Clinical Performance. • Group Head of Infection Prevention and Control & Specialist Services. • Employee. • Regional Health & Safety Manager. • Group Head of Infection Prevention and Control & Specialist Services.	• Dependant on the Incident/Event type: • UK Health Security Agency. • Public Health Wales. • Health Protection Scotland. • Health & Safety Executive. • CQC/HIS/HIW.	• Director of Clinical Services • Quality and Risk Manager. • Health & Safety Coordinator/Lead. • Infection Prevention and Control Lead.
Imaging – including IR(ME)R	• Area Director of Clinical Performance. • Director of Clinical Governance & Improvement. • Patient Safety Lead. • National Lead – Imaging.	• CQC/HIS/HIW. • Health & Safety Executive. • Medicines & Healthcare products Regulatory Agency. • (MHRA).	• Director of Clinical Services. • Quality and Risk Manager. • Imaging Manager.
Information Security / Governance	• Head of Information Governance. • Chief Information Officer. • IT Director. • SIRO. • Caldicott Guardian. • Legal Team. • Regional Director.	• Information Commissioners Office. • Contracting organisations: NHS, insurers.	• Executive Director. • Director of Clinical Services.
Media Issues	• National Head of PR and Communications. • Regional Director. • Chief Executive Officer. • Chief Financial Officer. • Chief Medical Director.	• CQC/HIS/HIW.	• Executive Director. • Sales and Marketing Manager.
Medical Devices	• Group Clinical Director. • Group Chief Engineer. • Area Director of Clinical Performance. • Regional Director. • Regional Health & Safety Manager. • Director of Clinical Governance & Improvement. • Patient Safety Lead.	• Medicines & Healthcare products Regulatory Agency (MHRA). • Health & Safety Executive. • Manufacturer.	• Director of Clinical Services. • Quality and Risk Manager. • Health & Safety Coordinator/Lead.

Incident/Event type	Internal	External (consider)	Responsible individual
Medicines and serious adverse drug reactions	• Group Chief Pharmacist • Medical Director	• Medicines & Healthcare products Regulatory Agency (MHRA) • Manufacturer • Home Office	• Director of Clinical Services • Quality and Risk Manager • Pharmacy Manager
Fraud/theft (including suspected)	• Depending on severity: • Regional Director • Executive Director • Chief Financial Officer • Group Finance Director • CBS Finance Director • National Finance Director • Local Counter Fraud Specialist	• Head of Internal Audit • Police • NHS or insurer (where their funds impacted)	• Individual receiving the allegation.
Premises / Equipment	• Group Chief Engineer. • Regional H&S Manager.	• MHRA. • HSE. • Police.	• Executive Director. • Head engineer. • H&S Coordinator/ Lead.
Professional misconduct (including financial professional misconduct)	• Group Clinical Director. • Area Director of Clinical Performance. • Regional Director. • Chief Financial officer.	• CQC/HIS/HIW. • Professional bodies (NMC, GMC, HCPC).	• Executive Director. • Director of Clinical Services.
RIDDOR	• Head of Health, Safety and Environment. • Regional HSE Manager. • Regional Director.	• HSE. • Health Protection Scotland (HPS) - In Scotland, the diagnostic laboratory has a duty to notify the local health board and Health Protection Scotland of any identified cases of Legionnaires'.	• Executive Director. • Director of Clinical Services. • Quality and Risk Manager. • H&S Coordinator/ Lead.
Regulator	• Group Clinical Director. • Area Director of Clinical Performance. • Regional Director. • Director of Clinical Governance & Improvement. • Patient Safety Lead.	• CQC/HIS/HIW.	• Executive Director. • Director of Clinical Services. • Quality and Risk Manager.

Appendix 3 – RIDDOR Guidance

This guide is designed to provide guidance on whether a patient related incident is reportable under RIDDOR. RIDDOR requires employers to certain categories of patient injury that 'arise out of or in connection with work'.

Remember – seek guidance from the corporate HSE Team, and a report to the Enforcing authority must not be submitted until signed off by the corporate HSE team.

What is meant by 'work-related'?

RIDDOR only requires you to report accidents if they happen 'out of or in connection with work'. The fact that there is an accident at work premises does not, in itself, mean that the accident is work-related – the work activity itself must contribute to the accident. An accident is 'work-related' if any of the following played a significant role:

- the way the work was carried out
- any machinery, plant, substances or equipment used for the work or
- the condition of the site or premises where the accident happened.

What are 'reportable' injuries and ill health involving patients?

The following examples will help you decide about reportability in relation to patient incidents:

Reportable

- A patient is scalded by hot bath water and taken to hospital for treatment. The patient was vulnerable, and adequate precautions were not taken.
- A service user sustains a fractured arm when their arm becomes trapped in a bed rail.
- A service user requires hospital treatment after sliding through a sling after being hoisted from a chair. The wrong-sized sling was used.

Not Reportable

- A patient is injured by an act of physical violence from another patient.
- A patient receives a healthcare-associated infection while receiving treatment in hospital.
- A patient admitted to hospital for treatment contracts Legionnaires' disease in hospital.

Patient fall incidents

A fall is reportable under RIDDOR when it has arisen out of or in connection with a work activity and results in a specified injury. The following examples will help you decide about reportability under RIDDOR in relation to patient falls:

Reportable

- A confused patient falls from a hospital window on an upper floor and is badly injured.
- A patient falls in the lounge area, there is previous history of fall incidents, but reasonably practicable measures to reduce the risks have not been put in place.
- A patient falls out of bed, is injured and taken to hospital. The assessment identified the need for bedrails but they, or other preventative measures, had not been provided.

Not reportable

- A patient falls and breaks a leg. They were identified as not requiring special supervision or falls prevention equipment. There are no slips or trips obstructions or defects in the premises or environment, nor any other contributory factors.
- A patient falls out of bed and is taken to hospital. There was a detailed assessment in the care plan identifying that fall protection was not required.
- A patient is found on the floor, no-one has seen it happen, and/or there are no obvious work-related contributing factors. There was a detailed assessment in the care plan, which identified that fall protection was not required.

Exposure to biological agents

RIDDOR requires the reporting of any disease caused by an occupational exposure to a biological agent.

Biological agents include transmission of blood borne viruses, for example those contracted following a needlestick incident.

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