Gloucestershire Hospitals
NHS Foundation Trust

Patient Safety Incident Response Plan

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	NAME	TITLE	SIGNATURE	DATE
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Reviewer	Quality Delivery Group	Including Chief Nurse & Director for Quality & Director for Safety & Medical Director	QDG	09th June 2026
Authoriser	Quality & Performance Committee	Delegated Authority from Trust Board	QPC	25th June 2026

REVISION	AUTHOR(S)	SUMMARY	DATE
1	Victoria Wills & Jo Mason-Higgins	New Document - First Issue	1st March 2024
2	Victoria Wills & Jo Mason-Higgins	Local safety priorities updated. Strategy, improvement profile & quality priorities updated. Never Event mandated response updated.	1st June 2026

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Introduction

This patient safety incident response plan (PSIRP) sets out how **Gloucestershire Hospitals NHS Foundation Trust** intends to respond to patient safety incidents over a period of 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgery services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provides services at the satellite oncology centre in Hereford County hospital.

Gloucestershire Hospitals NHS Foundation Trust is one of the largest hospital trusts in the country and provides high quality acute elective and specialist healthcare for a population of more than 660,000 people. Our hospitals are district general hospitals with a great tradition of providing high quality hospital services; some specialist departments are concentrated at either Cheltenham General or Gloucestershire Royal Hospitals, so that we can make the best use of the expertise and specialist equipment needed.

Our Trust employs around 9000 staff. Our success depends on the commitment and dedication of our colleagues. Many of our staff are world leaders in the fields of healthcare, teaching and research and we aim to recruit and retain the best staff possible. Our patients are cared for by more than 2,390 registered nurses and midwives, 905 Healthcare Assistants and 992 medical staff. 257 Healthcare Scientists and 527 Allied Health Professionals. In addition, our estates are looked after by 763 NHS Gloucestershire Managed Services staff,

Further details, including our organisational chart can be found on our website https://www.gloshospitals.nhs.uk/about-us/our-trust/who-we-are-and-what-we-do/

Defining our patient safety incident profile

Data Sources

This is the first revision of our Patient Safety Incident Response Plan. Since initial publication, a further data review has been carried out, using the sources listed below for the period 2024 – 2025.

- Patient safety incidents,
- Claims
- Complaints
- Patient Advisory & Liaison (PALs) themes
- Audits
- Quality Improvement projects

Stakeholder Engagement

Data related to our initial safety priorities was reviewed, to determine whether the work undertaken as part of our initial period under PSIRF had any impact on any of the data sources. All sources were reviewed and triangulated to identify whether the themes had changed, and whether other topics now warranted attention. This data was reviewed at a PSIRF workshop with the patient safety team, to allow greater analysis, challenge and sense checking with local knowledge. Where new priorities were considered, these were discussed with subject matter experts to understand whether existing work was underway to address these themes.

The proposed amendments to the priorities were then reviewed with the Divisional Directors for Quality & Nursing, members of Quality Delivery Group and approved by Quality Performance Committee.

The amended list of safety priorities for 2026-2027 is shown in Table 1

Inpatient Falls	**Pressure Ulcers**
Staffing	**Communication**
Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery	

Table 1: GHNHSFT Local Safety Priorities 2026 - 2027

Defining our patient safety improvement profile

Our Trust's five-year strategy is closely aligned with our Patient Safety Incident Response Framework (PSIRF) plan and policy to ensure that safety, learning, and continuous improvement remain at the heart of our organisational priorities. The strategy sets out our commitment to delivering safe, effective and compassionate care, and our PSIRF policy provides the structure for how we respond to patient safety incidents in a way that promotes openness, learning, and system-wide improvement. By embedding PSIRF principles within our strategic objectives, we strengthen our culture of safety, support staff in effective incident response, and drive improvements that contribute to achieving our long-term vision for excellence in patient care.

The improvement programmes and projects identified below have been agreed as part of the Trust strategic priorities and the Trust quality priorities for 2025/2026.

The strategic priorities are developed through the Strategy & Transformation Group and agreed through the Trust Leadership Team, the programmes and projects agreed then make up the Improvement and Delivery portfolio for the year. The items below are only those which impact on the quality of care delivered by GHT and therefore do not constitute the entire portfolio of the organisation.

The quality priorities have been developed using a range of information and sources (safety, experience and clinical effectiveness data) with consultation from staff, senior leaders and our Executives. We have reviewed our performance, incidents, the learning that has taken place and how we want to take this to the next level in our Trust.

In addition to these improvement priorities the Trust has an active programme of improvement carried out by staff and supported by the Gloucestershire Safety and Improvement Academy (GSQIA). A list of these improvement activities is maintained and updated by the Clinical Effectiveness and Improvement Team. Further information about the Academy and Improvement projects can be found on our website: Quality Improvements (gloshospitals.nhs.uk)

Origin	Improvement Programme	Improvement Projects / workstreams
Improvement & Delivery	**Colleague Experience and Culture Programme**	Leadership & team working Delivering transformational change and improvement People policies, processes and practises Board to ward - integrated quality
Quality Priorities 2025/2026	**Patient Safety Incident Response Plan - safety priorities**	Continuing our improvement work within the 8 safety priorities and linking them to the transformation work within the organisation.
	Outpatient transformation	Improving how outpatient care is delivered, with the goal of providing more patient centred and more efficient services. Workstreams across: Estates optimisation Referrals optimisation Community utilisation Patient pathways
	Clinical Vision of Flow	Improving how we minimise wait times, reduce bottlenecks across all services and improve the quality of care delivered to our patient:

		Workstreams across: Emergency Department Assessment & Short Stay Specialties Frailty
	Fire prevention and safety	To safeguard the lives and wellbeing of patients, staff and visitors by minimising the risk of Compliance with our training targets across all our hospital sites Gloucestershire Hospitals NHS Foundation Trust Quality Account 2024–2025 8 Priorities Focused on Metrics/ improvement we want to achieve fire and ensuring safe evacuation in case of a fire.
	Maternity service improvements	Focused improvement in the Safety Plan priority for maternity – prevention and detection of deterioration: Meeting all of the objectives of our maternity transformation plan, including all regulatory requirements
	Emergency Department service improvements	Getting care right in the emergency department is crucial because timely and effective treatment can be the difference between life and death.

Table 2: GHNHSFT Local Safety Improvement Profile

Our patient safety incident response plan: national requirements

	Patient safety incident type or issue	Description	Planned response and anticipated improvement route
National Safety Priorities	Never Events	Incidents meeting the Never Events criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions. Proportionate learning response. Create local organisational actions and link with any existing improvement work.
	Death thought more likely than not due to problems in care	Incident meeting the learning from deaths criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions. Structured judgement review triggering PSII. Create local organisational actions and link with any existing improvement work.

	Incident meeting Each Baby Counts criteria	Incident meeting Each Baby Counts criteria	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation. Refer to NHS Resolution as required. Respond to recommendations as required and link with any existing improvement work.
	Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	Incidents meeting the learning from deaths criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour. PSII Create local organisational actions and link with any existing improvement work.
	Mental health-related homicides	Mental health-related homicides	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions Referred to the NHS England Regional Independent Investigation Team (RIIT) for

			consideration for an independent PSII
	Maternity and neonatal incidents	Maternity & Newborn Safety Investigation (MNSI) criteria	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour. Refer to MNSI for independent PSII
	Child deaths	Death of a child	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour Refer for Child Death Overview Panel Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel
	Deaths of persons with learning disabilities	Death of a person with learning disabilities	Review at Patient Safety Review Panel to confirm criteria met & immediate safety actions & consider Duty of Candour

			Refer for Learning Disability Mortality Review (LeDeR). Locally-led PSII (or other response) may be required alongside the LeDeR
	Safeguarding incidents	Where: babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence adults (over 18 years old) are in receipt of care and support needs from their local authority the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	Refer to safeguarding lead & to local authority lead, as required.
	Incidents in NHS screening programmes		Refer to local screening quality assurance service for consideration of locally-led learning response

			See: Guidance for managing incidents in NHS screening programmes

Table 3: National Safety Priorities and Improvement Approach

Our patient safety incident response plan: local focus

	Patient safety incident type or issue	Description	Planned response and anticipated improvement route
Local safety priorities	**Staffing**	Risks and incidents where inadequate numbers of staff or skill mix have been identified.	Trends used to inform the workforce sustainability workstream of the people and organisational development strategy.
	Communication	Risks and incidents that relate to communication between staff and patients and their families	Trend analysis used to inform quality improvement efforts
	Patient Falls	Patient fall	Incidents reviewed and trends identified Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at falls learning hub. Learning, trends and annual audit used to inform improvement programme. Quality summit, as required.

	Pressure Ulcers	Hospital acquired pressure ulcers	Incidents reviewed and trends identified. Moderate/ severe harms and deaths plus those with other learning opportunities reviewed at pressure ulcer learning hub. Learning & trends used to inform improvement programme. Quality summit as required.
	Delay to recognition and/or escalation of deterioration during pregnancy and/or delivery	Risks and incidents where delays in recognition and/or escalation of deterioration during pregnancy and/or delivery have or could have affected the safe care and outcome for mother or baby.	Trends identified and incidents reviewed by the maternity governance team; Individual incidents that meet national (mandated) criteria for PSII to be referred to MNSI and Patient Safety Review Panel. Emerging risks/ issues that do not meet criteria for referral to MNSI or Patient Safety Review Panel to be identified for Quality Summits and inform ongoing improvement efforts.

Table 4: GHNHSFT Local Safety Priorities and Improvement Approach