# Patient Safety Incident Response Plan

## St George's University Hospitals NHS Foundation Trust

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| | NAME | TITLE | DATE |
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# Contents

# Introduction

This patient safety incident response plan (PSIRP) sets out how St George's University Hospitals NHS Foundation Trust intends to respond to patient safety incidents as part of our work to continually improve the quality and safety of the care we provide. This is a live document which will guide our patient safety incident activity over the next 12-18 months, however the plan will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan describes how the Trust will focus our resources towards the priorities of:

- Compassionate engagement and involvement of those affected by patient safety incidents to improve the experience for patients, families and staff.
- Expanding our insight into system vulnerabilities which create situations where patient harm can occur, and our insight into system factors that support the delivery of safe care, system performance and human wellbeing.
- Using improvement science methodologies to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

This plan should be read in conjunction with the gesh Patient Safety Incident Response Framework (PSIRF) policy (2025).

Since implementation of PSIRF across the gesh group in 2024, analysis of our current systems has improved our understanding of our patient safety processes and allowed us to use these insights to develop our PSIRP.

# Scope

There are many ways to respond to an incident. Our PSIRP covers responses conducted solely for the purposes of systems-based learning and improvement.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Other types of response exist to deal with specific issues or concerns, and it is outside the scope of PSIRF to review matters to satisfy processes relating to these, examples of which may include complaints, HR matters, legal claims and Coroner's inquests.

Our PSIRP aligns with the gesh strategic objectives of CARE:

- Collaboration and partnership
- Affordable healthcare fit for the future
- Right care, right place, right time
- Empowered engaged staff

# Our Services

SGUH is the largest healthcare provider in South West London. More than 10,000 staff provide secondary and tertiary services to a population of around 3.5 million people across South West London, Surrey and Sussex, across two hospital sites at St George's Hospital in Tooting and Queen Mary's Hospital in Roehampton. Even further afield, we provide care for patients from across England in specialties such as complex pelvic trauma, HIV care and bone marrow transplantation.

St George's is one of the four major trauma centres for London, and home to hyper acute stroke and heart attack centres, as well as being a major centre for cancer services. We are one of London's largest children's hospitals, hosting the only paediatric intensive care unit in South West London. We are one of the top three centres for specialist paediatric surgery in London, and a centre of excellence in foetal medicine.

St George's has 3 clinical divisions:

- Medicine and Cardiovascular (MedCard)
- Surgery, Neurosciences, Cancer and Theatres (SNCT)
- Children's, Women's, Diagnostics, Therapies, Outpatients, Critical Care and Pharmacy (CWDT)

We also host the regional South West London Pathology (SWLP) service.

The integrated corporate division at gesh provides corporate medical and nursing functions to St George's and in addition, the clinical divisions at site are supported by seven non-clinical divisions: communications and engagement, IT, human resources, estates and facilities, finance, strategy, and corporate affairs.

# Defining our patient safety incident profile

We have reviewed and analysed a variety of data and information from 2022-2025 to understand the key safety risks across our organisation. Since we launched PSIRF in a phased approach between August 2023 and June 2024, regular discussions, and engagement with staff at incident governance meetings has provided further insights. The data sources we have looked at include:

- Patient safety incidents recorded on the Trust incident reporting system (Datix)
- Serious Incident, Never Events and Patient Safety Incident Investigations
- GP Quality Alerts
- Complaints and PALS (Patient Advice and Liaison Service) reports
- Legal – Clinical Negligence Claims and Inquests
- Adult and Child safeguarding incidents and case reviews
- Freedom to Speak Up concerns
- Mortality / Learning from Deaths reports and Structured Judgement Reviews
- Staff survey results
- Risk Registers and Board Assurance Framework
- Quality Improvement projects
- Regulatory feedback

In addition to local data, information is available via national patient safety groups and Learn From Patient Safety Events (LFPSE) - formerly the National Reporting and Learning System (NRLS) - themes to inform the local thematic analysis and planning.

Stakeholder engagement and consultation has provided further soft intelligence to inform our patient safety incident profile, planned responses and our improvement profile. We have involved the following stakeholders in the development and approval of this plan:

- Site and care group leadership teams
- Staff within clinical divisions, including subject matter experts
- Internal patient safety incident meetings and groups
- Epsom and St Helier University Hospitals NHS Trust
- South West London Integrated Care Board (SWL ICB) Safety and Quality team

Data analysis from the sources above has identified our key patient safety incidents and risks. Patient safety incident data spanning April 2022- March 2025 was retrieved from the Trust incident reporting system (Datix) and is detailed below.

*Table 1: Reporting categories and frequency of SIs, PSIIs and Never Events (April 2022 and March 2025)*

| **Incident category** | **Number** |
|---|---|
| Maternal and neonatal safety | 32 |
| Never Events<br>(includes wrong site surgery, misplaced NG tube, retained foreign object, wrong site block) | 20 |
| Unexpected outcome<br>(includes unforeseen complications during treatment/procedure, unexpected admission to ITU, unforeseen complications post-op, unexpected death, retained specimen) | 11 |
| Delayed diagnosis / treatment<br>(includes treatment / procedure delay, delayed / failure to / lack of assessment / diagnosis, failure to follow-up, failure to act on adverse images, failure to interpret image correctly, failure to commence treatment, delay / failure to act on adverse symptoms, treatment / procedure inappropriate / wrong, misdiagnosis / assessment, missed diagnosis / failure to recognise complication, delay / failure to monitor, delay to perform tests, failure to escalate) | 37 |
| Medication safety | 3 |
| Patient falls | 5 |
| Covid deaths | 3 |
| Admissions / discharge<br>(includes failure to admit, inappropriate discharge, discharge planning failure) | 3 |
| Breach of patient confidentiality | 1 |
| Rapid tranquilisation | 1 |
| **Total** | **116** |

The tables below provide a summary of the top 15 reported patient safety incident types and categories on the Trust incident reporting system (Datix) between April 2022 and March 2025.

*Table 2: Top 15 patient safety incident types (April 2022 and March 2025)*

| | 22/23 | 23/24 | 24/25 | Total |
|---|---|---|---|---|
| **Patient - Access, Appointment, Admission, Transfer, Discharge, Referral** | 2310 | 2569 | 1888 | 6767 |
| **Patient - Medication** | 1868 | 1971 | 2038 | 5877 |
| **Patient - Treatment/Procedure** | 1365 | 1530 | 1446 | 4341 |
| **Patient - Falls** | 1455 | 1370 | 1299 | 4124 |
| **Patient - Clinical Assessment/diagnosis (Investigations, Images and Lab tests)** | 1073 | 1209 | 1127 | 3409 |
| **Patient - Pressure Ulcers** | 1126 | 1060 | 840 | 3026 |
| **Patient - Documentation (Images & Lab Reports, Patients Documentation)** | 859 | 1021 | 828 | 2708 |
| **Patient - Moisture-associated skin damage (MASD)** | 799 | 839 | 848 | 2486 |
| **Patient - Labour/Maternity** | 752 | 870 | 619 | 2241 |
| **ALL - Equipment and Devices (Medical and Non-Medical)** | 492 | 450 | 492 | 1434 |
| **Patient - Patient Monitoring / Patient Care** | 365 | 497 | 506 | 1368 |
| **Patient - Patient Self Harm / Self Risk Behaviours** | 272 | 498 | 356 | 1126 |
| **Patient - Communication** | 300 | 320 | 328 | 948 |
| **Patient & Staff - Confidentiality** | 111 | 138 | 168 | 417 |
| **Patient - Health and Safety** | 90 | 87 | 122 | 299 |

*Table 3: Top 15 patient safety incident categories (April 2022 and March 2025)*

| | 22/23 | 23/24 | 24/25 | Total |
|---|---|---|---|---|
| **Patient Fall** | 1455 | 1370 | 1299 | 4124 |
| **Patient - Treatment & Procedure** | 943 | 1132 | 1019 | 3094 |
| **Administration / Supply of a Medicine from a Clinical Area** | 895 | 933 | 939 | 2767 |
| **Moisture-associated skin damage (MASD) identified after admission** | 785 | 799 | 774 | 2358 |
| **Patient - Labour and Delivery** | 752 | 870 | 618 | 2240 |
| **Patient - Admission** | 885 | 848 | 475 | 2208 |
| **Pressure ulcer identified after admission to the trust** | 752 | 734 | 556 | 2042 |
| **Patient - Documentation/Information/Notes** | 674 | 732 | 597 | 2003 |
| **Patient - Clinical Assessment - Laboratory investigations** | 510 | 623 | 502 | 1635 |
| **Patient - Appointment** | 588 | 552 | 494 | 1634 |
| **Clinician Prescribing Error** | 355 | 411 | 470 | 1236 |
| **Patient - Clinical Assessment** | 365 | 375 | 432 | 1172 |
| **Patient - Medical Device (equipment & consumables)** | 407 | 343 | 382 | 1132 |
| **Patient - Referral** | 210 | 500 | 355 | 1065 |
| **Patient - Transfer** | 358 | 335 | 277 | 970 |

# Defining our patient safety improvement profile

Through the review and thematic analysis of our data, we have identified Trust Priority Improvement areas that we will focus on for the next 12-18 months. These are detailed in Table 4. For each of these there will be a robust improvement plan monitored and tracked by a trust-wide quality committee or a Directorate within a Clinical division. These committees and groups will ensure the contributory factors are known and addressed within the improvement plan. Tracking of the subsequent incident trends and themes against the improvement plan to ensure the plan is appropriate and working is critical. Any incident reported that could provide additional learning or informing of the plan must be considered for an additional learning response. Patient Safety Incident Investigations should be considered for priority improvement incidents where the improvement plan requires further development to address the known patient safety issue.

Table 4: Trust priority improvement areas

| **Priority area** | **Rationale** | **Outline Plan** | **Oversight Group / Committee** | **Delivery owner** |
|---|---|---|---|---|
| **Management of skin integrity within inpatient high risk cohorts** | 7% of trust-wide patient related incidents are pressure ulcers (all types) and when combined with MASD incidents, this equates to 13% of all incidents, the 3rd most common incident type (when combined with MASD). | Trust-wide pressure ulcer improvement plan based on learning from incident investigations and learning responses. This improvement plan will cover the Trust and where required, be specific to each clinical division trends / themes.<br><br>Close monitoring and oversight through divisional reporting and the overarching integrated quality & performance report (IQPR) and ward level heatmaps. | Pressure Ulcer Steering Group, Patient Safety and Quality Group (PSQG), annual focus session at quality committee in common (QCiC-Board level) | Tissue Viability Clinical Nurse Specialists (TVNs) (within Fundamentals of Care team) |
| **Treatment / procedure theme:** | Overall, 11% of trust-wide patient related incidents, including some Never Events. | | | |

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|---|---|---|---|---|
| **Surgical and invasive procedures** (systemic failure to conduct and/or complete safety checklist) | These incidents have resulted in variable levels of harm, and we have reported some Never Events related to this category involving safety checklists for surgical or invasive procedures across different specialities. | A comprehensive programme of work covering the 8 Sequential steps to safety (NatSSIPs 8), including review of safety checklists, LocSSIPs, clinical education, culture and communication and equipment factors. | Theatres Transformation Board, PSQG, gesh Quality Group and QCiC | Theatres Transformation Board |
| **Clinical assessment / diagnosis theme:** | Overall 8% of trust-wide patient related incidents. | | | |
| **Failure to escalate deteriorating patient** | This category triangulates with information from Complaints, Legal and Patient Advice and Liaison Service (PALS) enquiries. | Strengthening early recognition and intervention (using NEWS2 and Sepsis Screening tool including REDS scores), enhancing adherence to the Sepsis Six Bundle and utilizing data to drive decision making and performance tracking.<br>Other contributory factors being reviewed include a skills analysis, team culture and hierarchy as barriers to escalation, plus effective use of the Critical Care Outreach Team (CCOT) and Martha's rule. | Deteriorating Patient Group, PSQG, gesh Quality Group and QCiC. | Deteriorating Patient Group with Divisional Leads |
| **Delays in following-up diagnostic findings** | Incidents, complaints and morbidity / mortality data informs us that inpatient diagnostic tests are not always followed up in a timely manner, which triangulates with insight from deteriorating patient incidents. There have also been incidents where outpatient diagnostic procedures (including | Reviewing processes for acting on abnormal results across different diagnostic specialities. | Radiology Events and Learning Meeting (REALM) and PSQG, gesh Quality Group and QCiC | Divisional Leads for affected specialties |

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|---|---|---|---|---|
| **Venous thromboembolism (VTE) management and hospital acquired thrombosis (HAT)** | incidental findings of concern) have not been followed up through an appropriate pathway.<br><br>Incident, inquest and morbidity / mortality data highlight challenges with risk assessment, prescribing and administration of chemical and mechanical prophylaxis, including incidents where the patient was discharged without prevention / treatment medications. | Trust-wide VTE prevention improvement plan based on learning from incident investigations and learning responses. This plan will cover the Trust and where required, be specific to each clinical division trends / themes of contributory factors. | Hospital Thrombosis Group (HTG), Nursing Board, PSQG, Fundamentals of Care Group, gesh Quality Group and QCiC | VTE CNSs (within Fundamentals of Care team) and HTG |
| **Patient falls** | 10% of trust-wide incidents are patient falls, the 4th highest type of incident. Falls has also been highlighted as an area for improvement in external reviews, including by the Care Quality Commission (CQC). | Trust-wide falls prevention improvement plan based on learning from incident investigations and learning responses. This improvement plan will cover the Trust and where required, be specific to each clinical division trends / themes.<br>Close monitoring and oversight through divisional reporting and the overarching integrated quality and performance report (IQPR) and ward level heatmaps. | Falls Steering Group, Fundamentals of Care Group, PSQG, annual focus session at QCiC | Falls CNSs (within Fundamentals of Care team) |
| **Multidisciplinary team meetings across medical and surgical specialities (non-cancer MDTs)** | Incidents, complaints, inquests and morbidity / mortality data, as well as information from external reviews, informs us that these MDTs to support patient care decision-making are not inclusive of all appropriate patients and are not unified in approach. | Gap analysis of MDTs across all specialities including reviewing provision and operational support. Setting standards of behaviour, and communication of MDT outcomes to the patient. | PSQG, gesh Quality Group and QCiC | Divisional Governance Groups |

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|---|---|---|---|---|
| **Patient discharge** | Complaints, inquests and safeguarding enquiries highlight poor compliance with established discharge procedures, particularly for patients in receipt of / needing a package of care at home. This is compounded by a general increase in the level of complexity of our patients and hospital-acquired frailty for those with long stays. | Trust-wide discharge improvement plan, focussing on individuals with care and support needs as those most at risk, including reviewing communication pathways across internal and external teams and discharge processes. | Flow Transformation Programme, NM&AHP, PSQG, gesh Quality Group and QCiC | Medical and nursing colleagues with safeguarding leads and wider system partners |

In addition to the Trust-wide improvement priority areas above, each of the clinical divisions are developing Divisional Improvement Plans for 2025/26, informed by known patient safety risks and incidents occurring within the divisions, utilising PSIRF principles and the SEIPS (System Engineering Initiative for Patient Safety) framework to adopt a systems approach. Whilst some improvement areas identified to date are very specific to a particular service / speciality, others are applicable within and across different divisions, for example:

- Violence and aggression towards staff
- Care of vulnerable patients especially those with mental health needs
- Medication safety

# Our patient safety incident response plan (PSIRP): local focus

SGUH will take a proportionate response to patient safety incidents in order to maximise learning. It is important to note that not all types of patient safety incidents will automatically be investigated as a PSII. Whether an incident is investigated as a PSII or not will depend on the circumstances surrounding the incident and whether or not there are new opportunities for learning.

An appropriate, proportionate response should be selected based on factors including;

- Whether the contributory factors are already understood, both in general for the type of incident and for the circumstances of the specific event.
- The expected potential for new insight (e.g. a new, emerging, or escalating safety challenge).
- Alignment with the local patient safety priorities listed above.
- Whether improvement work is already underway to address the identified contributory factors and whether there is evidence that improvement work is having the intended effect / benefit.
- The views of those affected, including patients and their families.
- Which type of learning response (or combination of learning response methodologies) will provide the richest insight into the underlying system factors.
- Capacity available to undertake a learning response versus the capacity to implement improvement work.

Where a learning response is deemed appropriate, a "systems-based approach" to learning will be applied. This means that investigations will focus on examining the components of the "work system" (e.g. person(s), tasks, tools and technology, the internal and external environment, the wider organisation), understanding their interdependencies and those interdependencies that may contribute to patient safety. As such, different learning responses and investigation techniques will be adopted to patient safety incidents, depending on the intended aim and required outcome.

The table in Appendix A represents the types of patient safety themes identified through thematic analysis and outlines the suggested Trust response to ensuring learning and improvement. While this does not capture every possible patient safety incident, it does provide a framework for the commonest or most significant types of incident encountered which are clearly linked to organisational safety. The key areas we have identified through this analysis include:

- Patients lost to follow up which could or did lead to harm
- Patients who have experienced significant diagnostic delays which could or did lead to harm
- Avoidable hospital acquired thrombosis
- Incidents that could or did lead to harm for vulnerable adults or children
- Incidents where communication across multiple specialties or professional groups was a significant factor

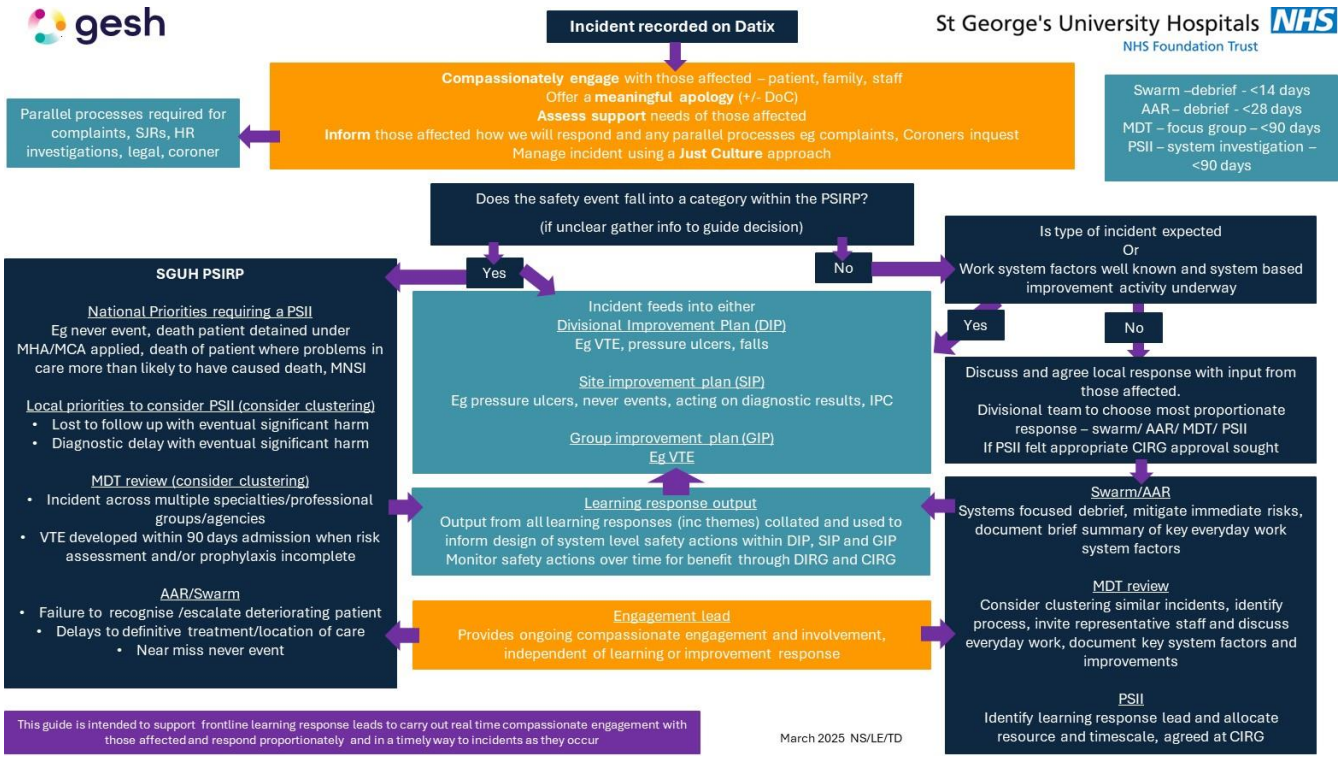
This PSIRP will have the flexibility to manage emergent risks or new incidents that signify extreme levels of risk.

The Trust recognises that maternity services are an area of high risk and high focus with multiple external reporting requirements. Therefore, the table in Appendix B outlines the specific local focus for responding to patient safety incidents in maternity services at SGUH.

## All other patient safety incidents

How we will respond for the purposes of learning will be based on the factors above. Many incidents will still be patient safety areas we are aware of with known contributory factors, however many of these should be incidents to monitor at this stage as there is limited resource to act and improve all areas of patient safety. This PSIRP has the flexibility to manage emergent risks or new incidents that signify high levels of risk or future risk to patients, staff or the organisation. These will require a proportionate response to understand system contributory factors, prior to consideration of department or Trust action and these safety concerns will be escalated through Trust governance structures.

The decision to undertake a learning response is supported by the decision-making tree below.



# Our patient safety incident response plan (PSIRP): National requirements

Some events in healthcare require a specific type of response as set out in national policies or regulations. These responses may include review by or referral to another body or team, depending on the nature of the event.

The table below sets out the national mandated responses. As St George's does not directly provide mental health or custodial services, the organisation will be a participant rather than a lead for those incident types where the patient has been in our care. The anticipated improvement route in these incidents will be to consider any learning and recommendations relevant to the Trust.

| | National priority | Response | Anticipated Improvement Route |
|---|---|---|---|
| 1 | Incidents meeting the Never Events criteria 2018, or its replacement. | Locally led PSII | Incorporate within Divisional Improvement Plans (where relevant) and feed these into the gesh Quality & Safety strategy |
| 2 | Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII) | Locally led PSII | Incorporate within Divisional Improvement Plans (where relevant) and feed these into the gesh Quality & Safety strategy |
| 3 | Maternity and neonatal incidents meeting the Maternity and Newborn Safety Investigations (MNSI) criteria | Refer to MNSI for independent PSII | Respond to recommendations as required and feed actions into relevant Divisional Improvement Plan |
| 4 | Child Deaths | Refer for Child Death Overview Panel review.<br>Locally led-PSII (or other response) may be required alongside the Panel review - organisations should liaise with the panel | Incorporate within Divisional Improvement Plans (where relevant) and feed these into the gesh Quality & Safety strategy |
| 5 | Death of persons with learning disabilities | Refer for Learning Disability Mortality Review (LeDeR)<br>Locally-led PSII (or other response) may be required alongside the LeDeR review | Incorporate within Divisional Improvement Plans (where relevant) and feed these into the gesh Quality & Safety strategy |
| 6 | Safeguarding incidents in which: | Refer to local authority safeguarding lead. | Incorporate within Divisional |

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|---|---|---|---|
| | Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence.<br>Adults (over 18 years old) are in receipt of care and support needs by their Local Authority<br>The incident relates to FGM, Prevent (radicalisation to terrorism, modern slavery & human trafficking or domestic abuse/violence. | Healthcare providers must contribute towards domestic independent inquiries, joint targeted area inspections, domestic homicide reviews and any safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards | Improvement Plans (where relevant) and feed these into the gesh Quality & Safety strategy |
| 7 | Incidents in NHS screening programmes | Refer to local Screening Quality Assurance Service for consideration or locally led learning response<br>See : Guidance Managing safety incidents in NHS screening programmes - GOV.UK (www.gov.uk) | Respond to recommendations as required and feed actions into relevant Divisional Improvement Plan |
| 8 | Deaths in custody (e.g. police custody, in prison, etc) where heath provision is delivered by the NHS | In prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the independent Office for Police Conduct (IOPC) to carry out the relevant investigations.<br>Healthcare providers must fully support these investigations where required to do so. | Respond to recommendations as required and feed actions into relevant Divisional Improvement Plan |
| 9 | 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) | Locally led PSII by the provider in which the event occurred with STG / ESTH participation if required | Respond to recommendations as required and feed actions into relevant Divisional Improvement Plan |
| 10 | Mental health related homicides | Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII<br>Locally led PSII may be required with mental health provider as lead and STG / ESTH participation | Respond to recommendations as required and feed actions into relevant Divisional Improvement Plan |
| 11 | Domestic Homicide | A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the | Respond to recommendations as required and feed actions into relevant |

| | | | |
|---|---|---|---|
| | | overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews. | Divisional Improvement Plan |

# Organisational response capacity

Based on analysis of the data provided above it is anticipated that the organisation will be required to undertake the following number of patient safety incident investigations in the following 12 months based on the national requirements above and historic data analysis;

- 6 incidents meeting the Never Events criteria
- 8 incidents meeting MNSI criteria

**This does not include an assessment of 'Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)' as this is not easily comparable when analysing historic data.*

In addition to the above it is also intended that the Trust will undertake 5 PSIIs based on locally identified priorities.

It is therefore anticipated that capacity for patient safety incident investigations will be required for 19 investigations to be undertaken over the following 12 months, although this will be kept under review should circumstances change.
It should also be acknowledged that based on historic data a significant number of these investigations will be led externally by MNSI.

# Cross-system learning responses

Learning responses will generally be managed by the Trust to facilitate the involvement of people affected and those responsible for delivery of the services. However, if SGUH, another Trust or the South West London Integrated Care Board (SWL ICB) identify that a cross learning response is required, a shared agreement on the lead and delivery of this response and subsequent improvement will be confirmed with the ICB.

# Governance & Oversight

Governance and oversight of patient safety incidents is established at divisional, Trust and gesh Group levels and outlined in the table below.

The Governance structure:

- Details the routine response within all Divisions to identifying patient safety incidents and compassionately support staff involved in incidents.
- Enables the systematic review of patient safety incidents, both within Divisions and across the Trust
- Supports the identification of associated learning responses using the core principles of PSIRF
- Supports shared learning across the gesh group
- Enables appropriate assurance from ward to Board that the Trust is learning from patient safety incidents
- Enables appropriate assurance from ward to Board that the trust is undertaking safety improvement work.


A number of governance groups within the Trust and gesh group will work alongside the established incident review groups to utilise the learning from incidents and oversee associated improvement work. These are listed in the table below and illustrated in the governance chart in Appendix C.

| Patient Safety Theme | Improvement Group | Reports to |
|---|---|---|
| Fundamentals of care: falls | Falls Improvement Group | Gesh Quality Group |
| Fundamentals of care: VTE prevention | Gesh Hospital Thrombosis Group | Gesh Quality Group |
| Fundamentals of care: pressure ulcers | Pressure Ulcer Group | Gesh Quality Group |

| | | |
|---|---|---|
| Fundamentals of care: Nutrition and hydration | Nutrition and Hydration Group | Gesh Quality Group |
| Fundamentals of care: Dementia and delirium | Dementia and Delirium Group | Gesh Quality Group |
| Blood transfusion | Hospital Transfusion Committee | Patient Safety Quality Group |
| Medication Safety | Medicines Safety Group & Medicines Governance Group | Patient Safety Quality Group |
| Radiation Safety | Radiation Safety Group | Patient Safety Quality Group |
| Infection Prevention & Control (IPC) | Gesh IPC Meeting | Quarterly IPC Strategy Meeting |
| Deteriorating patients | Deteriorating Patient Group | Patient Safety Quality Group |
| End of Life Care (EoLC) | EoLC group | Gesh EoLC steering group |
| Maternal and neonatal Safety | Maternity moderate cases review | CWDT Divisional Governance Board |
| Safeguarding | Trust safeguarding group | Gesh safeguarding group |
| Violence and aggression | Violence & Aggression working group | Health & Safety Non-Clinical Risk Group |

# Appendix A – Local focus for responding to patient safety incidents at SGUH

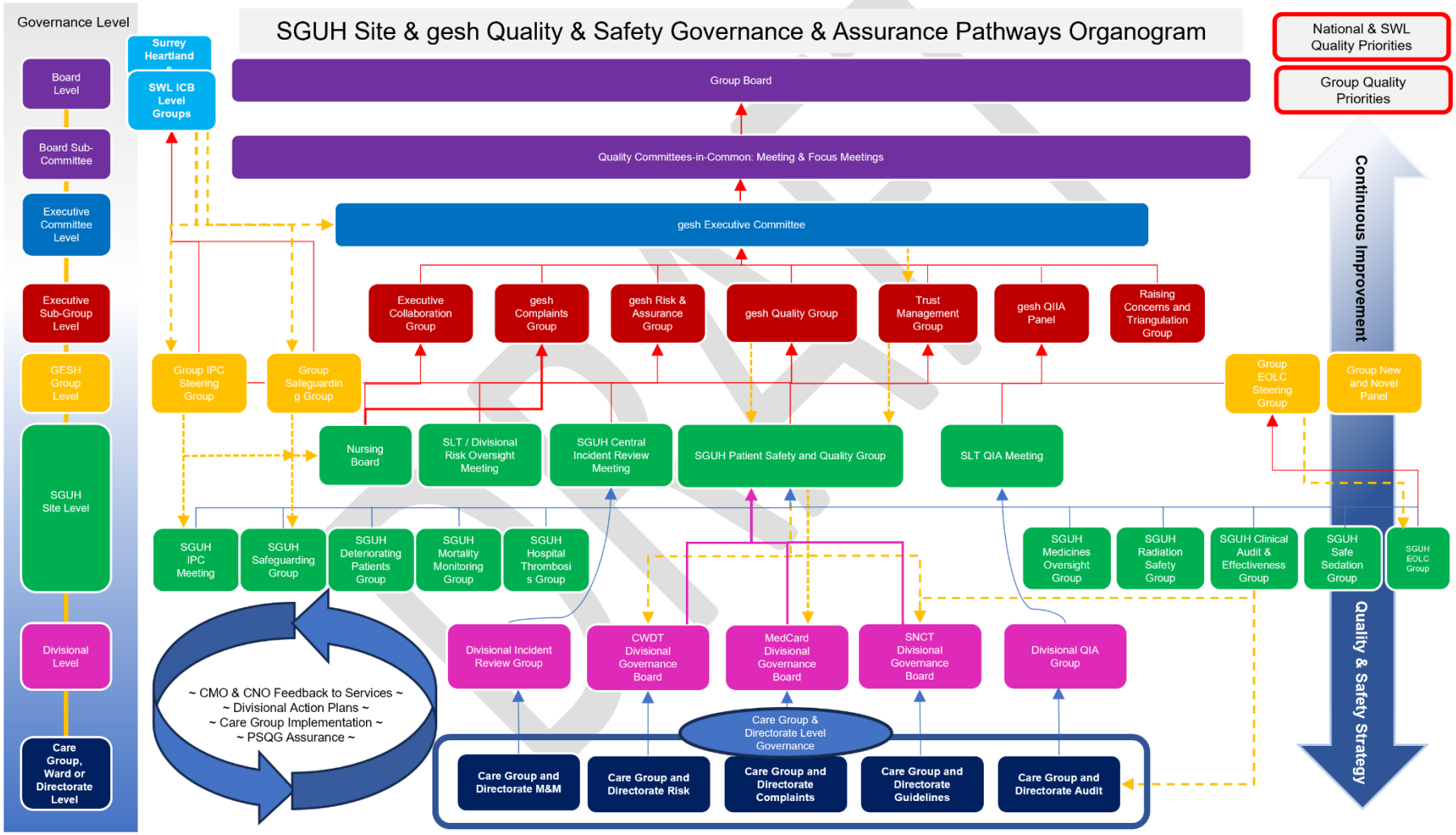
| Patient Safety Theme | Subtheme | Planned response | Anticipated improvement route |
|---|---|---|---|
| Diagnosis / Assessment | Delay to diagnosis which could or did lead to moderate or above harm | PSII | System learning across the pathway including capacity, processes and communication, to inform operational improvements and transformation work |
| Referral / Appointment | Lost to follow up which could or did lead to moderate or above harm | PSII | System learning across the pathway including capacity, processes and communication, to inform operational improvements and transformation work |
| Treatment / Procedure | Delays to definitive treatment / location of care | AAR / SWARM | System learning across the pathway including capacity, processes and communication, to inform operational improvements and transformation work |
| Discharge | Inappropriate discharge / discharge planning failure which could or did lead to moderate or above harm | AAR / SWARM | System learning across the pathway including capacity, processes and communication, to inform operational improvements and transformation work |
| Communication and teamworking | Incident across multiple specialties / professional groups / agencies which could or did lead to moderate or above harm | MDT review | System learning across the pathway including capacity, processes and communication, to inform operational improvements and transformation work |
| Theatre safety | Harm or near miss harm due to safety procedures in theatres not being fully implemented | AAR / SWARM | System learning across the pathway including capacity, processes and communication, to inform operational improvements and transformation work |
| Medication safety | Administration, delays or omission of medication which could or did lead to moderate or above harm | AAR / SWARM | System learning across the pathway including capacity, processes and communication, to inform improvement plans and training |

| | | | |
|---|---|---|---|
| Fundamentals of care | VTE within 90 days of admission when risk assessment and/or prophylaxis incomplete | MDT review (consider cluster) | To inform ongoing improvement plans at a Divisional and site level to avoid preventable hospital acquired thrombosis |
| Fundamentals of care | Grade 3 or above pressure ulcer | SWARM (findings feed thematic review) | To inform ongoing improvement plans at a Divisional and site level to reduce avoidable tissue damage |
| Fundamentals of care | Fall resulting in moderate or above harm | SWARM (findings feed thematic review) | To inform ongoing improvement plans at a Divisional and site level to reduce avoidable falls and harm caused by falls |
| Deteriorating patients | Failure to recognise or escalate a deteriorating patient | AAR / SWARM | To identify immediate safety actions and inform improvement plans |
| Infection prevention control | Hospital acquired infection | SWARM | To inform ongoing improvement plans at a Divisional and site level |
| Never Event | Near miss Never Event | AAR / SWARM | Identify positive factors preventing harm and inform ongoing improvement plans |
| Mental health | Harm or worsened outcomes for vulnerable adults or children | AAR / SWARM | To identify immediate safety actions and inform improvement plans |

# Appendix B – Local focus for responding to patient safety incidents in maternity services at SGUH

| Patient Safety Theme | Subtheme | Planned response | Anticipated improvement route |
|---|---|---|---|
| Maternal and neonatal safety | Stillbirth after 36 completed weeks not meeting the Maternity and Newborn Safety Investigations (MNSI) criteria where care concerns have been identified | PSII | To inform local improvement plans |
| Maternal and neonatal safety | Incident where there have been concerns over the interpretation of CTG recordings before or during labour which could or did lead to moderate or above harm | AAR | To inform local improvement plans |
| Maternal and neonatal safety | Concerns relating to triage / assessment which could or did lead to moderate or above harm | MDT Review | To inform local improvement plans |
| Maternal and neonatal safety | Post partum haemorrhage over 1500mls | MDT Review | To inform local improvement plans |
| Maternal and neonatal safety | Perineal tears – Grade 3 and 4 | MDT Review | To inform local improvement plans |
| Maternal and neonatal safety | Baby falls | MDT Review | To inform local improvement plans |

# Appendix C – SGUH Quality & Safety Governance & Assurance Pathways Organogram (April 2025)



# Glossary of terms

**PSIRF** - Patient Safety Incident Response Framework
Building on evidence gathered and wider safety-critical industry best-practice, the PSIRF is designed to enable a risk-based approach to responding to patient safety incidents, prioritising support for those affected, effectively analysing incidents using a range of tools to identify systems-based learning, and sustainably reducing future risk by focussing efforts on improvements to safety.

**PSIRP** - Patient Safety Incident Response plan
Our local plan sets out how we will conduct PSIRF locally including our list of local priorities. These have been developed through a coproduction approach with the divisions and specialist risk leads, supported by analysis of local data.

**SEIPS** - Systems Engineering Initiative for Patient Safety
A foundation of PSIRF that recognises patient safety is an outcome from a complex work system and processes. SEIPS is made up of six elements that comprise a work system: external environment, organisational factors, internal environment, tools and technology, tasks, and people. SEIPS helps us understand how interactions between different components of the work system contribute to the end outcome. All the learning response tools are based on SEIPS.

**PSII** - Patient Safety Incident Investigation (a learning response tool)
PSIIs are conducted to identify underlying system factors that contributed to an incident. These findings are then used to identify effective, sustainable improvements by combining learning across multiple patient safety incident investigations and other responses into a similar incident type. Recommendations and improvement plans are then designed to address those system factors and help deliver safer care for our patients effectively and sustainably.

**AAR** - After action review (a learning response tool)
A structured, facilitated discussion that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve, thereby increasing the occasions where success occurs.

**SWARM** - A huddle where people 'Swarm' together (a learning response tool)
A rapid, multidisciplinary response to a patient safety incident, where staff "swarm" to the site to quickly analyse the event, identify lessons learned, and develop immediate actions for improvement.

**MDT review** - Multidisciplinary team review (a learning response tool)
A multidisciplinary focus group to explore a safety theme, pathway or process using multiple perspectives to identify contributory system factors.

**Never Event** - Patient safety incidents that are considered to be preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

**Deaths thought more likely than not due to problems in care** - Incidents that meet the 'Learning from Deaths' (LfD) criteria. Deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan or following reported concerns about care or service delivery.

**LeDeR** - Learning from Lives and Deaths of People with a Learning Disability and Autistic People
A national service improvement program in the NHS that aims to improve the health of and reduce health inequalities for people with learning disabilities and autistic people by learning from their death, to identify areas for service improvement.

**SJR** - Structured Judgement Review
A method for reviewing patient care, particularly in cases of death, which uses a structured format to identify strengths and weaknesses in care delivery, aiming to learn from both successes and failures to improve future practices.