Lancashire and South Cumbria Integrated Care Board

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Patient Safety Incident Response Framework Policy

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Version:	Version 1
Purpose	Policy and procedures for the delivery of the National Patient Safety Incident Response Framework (PSIRF).
Supersedes:	N/A – new policy
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Ratified by:	Lancashire and South Cumbria Integrated Care Board Quality Committee
Cross reference to other Policies/Guidance	NHSE Freedom To Speak Up-Updated November 2024 NHSE Patient Safety Strategy - July 2019 Care Quality Commission (CQC) Regulation 20: Duty of Candour - Update 30 June 2022 NHSE Patient Safety Incident Response Framework and guidance 16 August 2022.
Date Ratified:	7th January 2026
Date Published and where (Intranet or Website):	Website
Review date:	June 2026
Target audience:	It is the responsibility of all staff to support the delivery of the Patient Safety Incident Response Framework (PSIRF). All staff should be trained in the essentials for patient safety and understand how this applies to their area of work.
Link to strategic objectives	• Improve quality, including safety, clinical outcomes, and patient experience. • Meet national and locally determined performance standards and targets.

This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

Document control:		
Date:	**Version Number:**	**Section and Description of Change**
13/01/2026	01	*Final draft approved by Quality and Outcome Committee*

Contents

1. Introduction and Background

This document is a policy which is a set of statements of principles, values and intent in relation to NHS Lancashire and South Cumbria Integrated Care Board's adoption of the national Patient Safety Incident Framework (PSIRF). It is important to recognise that this policy is subject to change in line with the evolving commissioning landscape, as outlined in the Integrated Care Board (referred to as 'the ICB' in this policy) blueprint. The current policy will remain in effect until such time that functions are transferred, or legislative changes are enacted.

The ICB blueprint sets a strategic direction to embed quality management, including safety, into the commissioning process. This includes:

- Building a deep understanding of operational performance, quality of care (safety, effectiveness, user experience), and productivity/unit cost across all providers.
- Using a range of health outcome measures to inform commissioning decisions.
- Identifying and acting on the drivers of improved health, with a focus on population outcomes rather than institutional metrics.
- Targeting health inequalities by improving equity of access, experience, and outcomes.
- Incorporating child death reviews and safeguarding into system-level quality oversight.
- As part of this transition, ICBs are expected to set overall system strategy that informs the allocation of resources to maximise access to high-quality care and improve population health. This shift will require enhanced collaboration, data sharing, and a commitment to continuous learning across all sectors.

The PSIRF policy will be reviewed periodically to ensure alignment with these strategic developments and to maintain its relevance and effectiveness in supporting safe, high-quality care.

2. Purpose / Aims and Objectives

This policy supports the national requirements of the PSIRF and sets out the ICB's approach to developing and maintaining effective systems and processes for responding to patient safety events and issues for the purposes of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data driven response to patient safety events. It embeds the responses to patient safety events within a wider system of improvement and prompts a significant cultural shift towards patient safety management with more engagement and empowerment than the traditional command and control approach.

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

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

The ICB would also recommend that the following local and national guidance is referenced as part of PSIRF guidance:

- Any local agreements for the Management of Reports to Prevent Future Deaths (Coroners' Regulation 28 Rule) NHS England North.
- National Guidance on Learning from Deaths.
- NHS Oversight Framework.
- Guide to responding proportionately to patient safety incidents (england.nhs.uk).
- Patient Safety Incident Response Framework.
- NHS Patient Safety Strategy.
- The Learn from Patient Safety Events (LFPSE) system.
- Health Services Safety Investigations Body (HSSIB).
- Maternity and Newborn Safety Investigations (MNSI).
- Report template - NHSI website.
- National Patient Safety Alerts.

3. Scope of the Policy and Definitions

This policy applies to the ICB and all its employees; as such this policy must be followed by all who work within/as part of the organisation including those on temporary or honorary contracts, secondments, contractors and students.

According to NHS England, patient safety incidents are any unintended or unexpected events which could have, or did, lead to harm for one or more patient's receiving healthcare.

PSIRF fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. It is not an investigation framework to determine the cause of death or to hold any individual or organisation to account but rather aims to embed patient safety incident responses within a wider system of improvement prompting a significant cultural shift towards systematic patient safety management.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component.

These responses do not take a ‘person-focused’ approach where the actions or inactions of people, or ‘human error’, are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes as those listed below and are therefore outside of the scope of this policy:

- Claims handling human resources investigations into employment concerns.
- Professional standards investigations.
- Information governance concerns.
- Estates and facilities concern.
- Financial investigations and audits.
- Safeguarding concerns.
- Coronial inquests and criminal investigations.
- Complaints (except where a significant patient safety concern is highlighted).

For clarity, the ICB considers these processes as separate from any patient safety investigation. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

PSIRF is one element of the NHS Patient Safety Strategy, this policy is about how the ICB discharges its duties in relation to PSIRF.

There are certain patient safety incidents that require interfaces between NHS PSIRF and other national and regional guidance as listed below (or NHS England Serious Incident Framework for those that are still in transition):

- Deaths in custody – where health provision is delivered by the NHS.
- Child Safeguarding Practice Reviews and Safeguarding Adult Reviews.
- Domestic Abuse Related Death Reviews (DARDRs)
- Homicide by patients in receipt of mental health care. (Appendix 1)
- Prevention of Future Deaths report. (Regulation 28) (Appendix 6)
- Mortality.
- Learning Disability Mortality Review.
- Managing Safety Incidents in NHS Screening Programmes.
- Infection, Prevention and Control.

4. Our patient safety culture

“A just culture considers wider systemic issues when things go wrong, enabling professionals and those operating the system to learn without fear of retribution.’’ (Professor Sir Norman Williams)

The ICB have embraced nurturing a just and restorative culture to mirror our organisational values of compassion, integrity, respect and inclusion. These values align to the principles that underpin the oversight of patient safety incident responses:

- Improvement is the focus.
- Blame restricts insight.
- Learning from patient safety incidents is a proactive step towards improvement.
- Collaboration is key.
- Psychological safety allows learning to occur.
- Curiosity is powerful.

The ICB will measure our safety culture through local and national staff survey metrics based on specific safety questions to assess if we are sustaining our ongoing progress in improving our safety culture. Insight from partners and other relevant data sources will also give us awareness into the culture across our system. In addition, our safety culture will help ensure effective oversight and safety governance that is required to ensure we can meet our PSIRF ambitions.

Safety culture is one of the two key foundations of the NHS Patient Safety Strategy. A positive safety culture is defined as one where the environment is collaboratively created and supported so that everybody (individual staff, teams, patients, service users, families, and carers) can succeed to ensure safe care by:

- Continuous learning and improvement of safety risks.
- Supportive, psychologically safe teamwork.
- Enabling and empowering all staff and patients to speak up https://www.england.nhs.uk/publication/the-national-speak-up-policy/ LSCICB_HR29_FTSU_Policy_V2_Feb_24.pdf (healthierlsc.co.uk)

The ICB has a variety of health and social care providers who are contracted and commissioned in different ways including but not limited to NHS Trusts, Primary Care, independent care sector providers, voluntary, community and social enterprise services, the adult and child social care sectors, and individually commissioned packages of care.

To support open and transparent reporting, the ICB worked closely with NHS Trusts and Independent Sector Providers (ISPs). During the implementation phase of the PSIRF, there were monthly NHS Trust PSIRF implementation groups and drop-in sessions with Independent Sector Providers on NHS Standard Contracts led by the ICB patient safety team with the support of the Patient Safety Collaborative hosted by Health Innovation.

Through these forums, we explored what was happening to support open and transparent reporting of patient safety events. This work will continue by creating PSS networks across the region and a learning network.

The ICB encourages and supports patient safety incident reporting where any member of staff (internal or external) feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Openness and transparency is encouraged with a key focus on learning without blame which is essential to improving safety.

Throughout the ICS, we will collectively continue to cultivate a proactive and positive safety culture, fostering an environment of openness and honesty. We will listen to safety concerns, investigate safety events, and learn from them to continuously identify improvements and embed best practice.

The ICB is committed to ensuring robust oversight of providers in relation to patient safety incident reviews. We will support and encourage providers to actively engage patients, families, and carers as partners in these processes. Providers will be expected to listen with empathy and respect, ensuring that the experiences and insights of those affected inform learning and drive improvements. The ICB will promote a culture where individuals feel safe to share their perspectives without fear of judgement, and where they are kept informed about outcomes, lessons learned, and changes made. Through this approach, we aim to foster trust, transparency, and meaningful improvements in care across our system.

5. Sharing insights to improve safety.

PSIRF oversight roles and responsibilities specification states that ICBs should seek to identify and share areas of good practice in relation to patient safety incident response. Where relevant, patients, families and carers will be invited to contribute their experiences to these forums to ensure learning is informed by those directly affected by care. As the ICB hold the oversight responsibility for ensuring quality and patient safety within Lancashire and South Cumbria, there are several system learning groups facilitated by the ICB. These include:

- Learning Forums for the Integrated Care System (ICS). The events will focus on learning from patient safety events and the themes identified in the system. This may also include learning from national reports and horizon scanning. All Lancashire and South Cumbria system providers across the ICS will be invited to participate with the main objective of patient safety and quality improvement. This will be held alternately between the Patient Safety Specialist Forum bimonthly.
- CYP Learning and Oversight Group. The purpose is to support collaboration and system learning across the acute and community trusts within the ICB. This system wide forum will provide an opportunity for a co-ordinated approach to

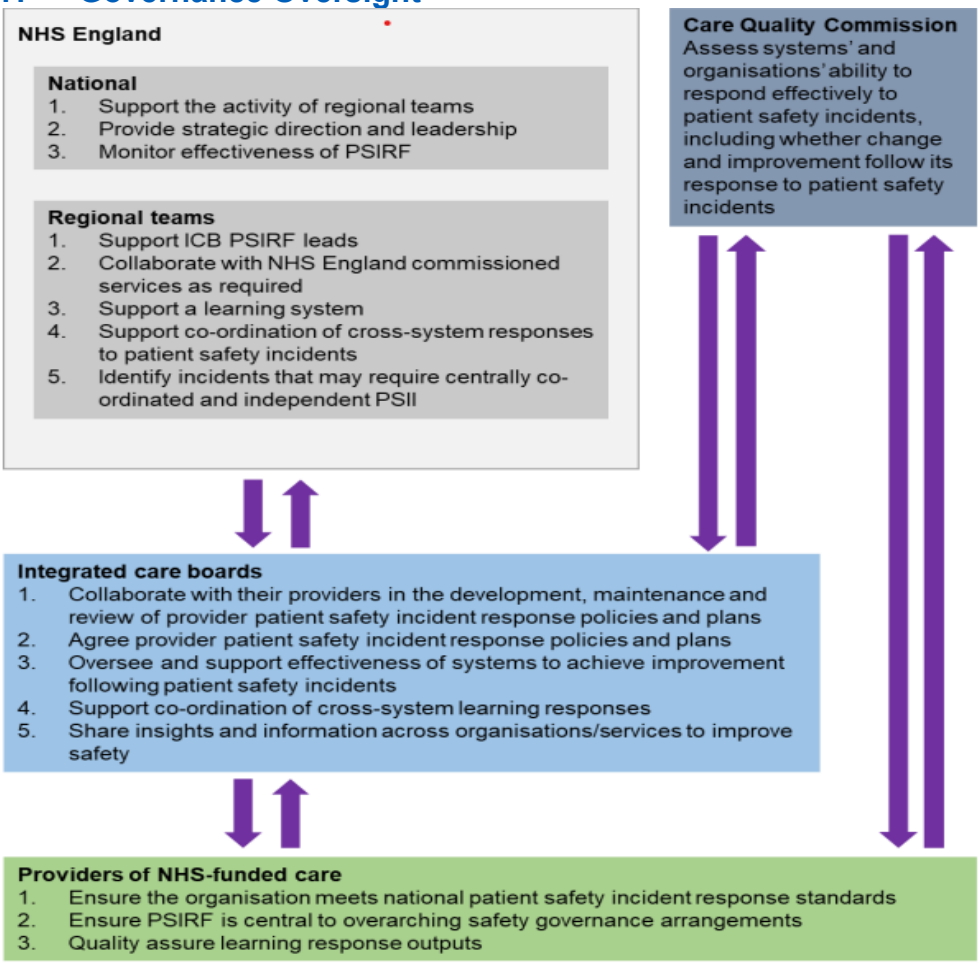
cross-system learning and to share insights and information across organisations to improve safety. This will be held six monthly.

- Local Maternity & Neonatal System Patient Safety Event Learning and Oversight Group. The purpose of the group is to support collaboration and system learning across the four local Trusts and networks within Lancashire and South Cumbria to ensure Safety Action 1 of the Immediate and Essential actions (IEA) from the Ockenden Report (December 2020) is implemented. This will be held bi-monthly and have key partners from across the system in attendance; MNSI, Maternal Medicine Network, North-west Neonatal Operational Delivery Network (NWNODN), Representation from the Regional Maternity Team.

Insights and improvements identified through these groups will be communicated back to patients, families, and staff where appropriate, ensuring transparency and demonstrating that their contributions lead to meaningful change.

6. Roles and responsibilities

6.1 Governance Oversight



6.2 ICB Chief Nursing Officer

This is the person with overall accountability for this policy and the organisational Executive lead for patient safety.

6.3 Director of Nursing, Quality Assurance and Safety and Associate Director of Nursing and Patient Safety

The Director of Nursing and Quality Assurance and Safety and the Associate Director of Nursing and Patient Safety are responsible for the administrative co-ordination of this policy.
They are responsible for but not limited to:

- Ensuring staff, providers of NHS funded activity, and stakeholders are aware of this policy and processes to be followed.
- Ensuring there are ICB arrangements in place for collaborating with NHS healthcare providers in the development, maintenance and review of provider patient safety incident response policies and plans.
- Recommending the approval of provider patient safety incident response policies and plans.
- Overseeing and supporting effectiveness of systems to achieve improvement following patient safety incidents.
- Supporting the co-ordination of cross-system learning responses.
- Sharing insights and information across organisations/services to improve safety.

6.4 ICB Quality and Outcome Committee

The ICB Quality and Outcome Committee is responsible for:

- The approval of this policy document.
- Seeking assurance that the ICB is discharging its duties in relation to PSIRF and the national Patient Safety Strategy.

6.5 Lancashire and South Cumbria (LSC) System Quality Group

The LSC System Quality Group is responsible for receiving and identifying learning for the System.

6.6 ICB Patient Safety Team

The ICB Patient Safety Team is responsible for the operational delivery of the PSIRF and national Patient Safety Strategy in order to ensure the organisation discharges its duties.

6.7 ICB Patient Safety Specialist

The ICB Patient Safety Specialists (PSSs) will provide dynamic leadership on patient safety and play a key role in the local implementation and delivery of the national Patient Safety Strategy and the PSIRF. They will support the development of a patient safety culture, safety systems and improvement activity along with local implementation of nationally identified priorities.

6.8 ICB Patient Safety Partners

The Patient Safety Partner(s) (PSP) role will bring the patient experience to patient safety work by ensuring the people who use our services are at the heart of our learning and improvement. They will contribute to the development of the safety culture and patient safety systems through active involvement in design of safer healthcare and oversight of patient safety across the system. Please refer to Appendix 2.

6.9 All ICB staff

It is the responsibility of all staff to support the delivery of the PSIRF; all staff should be trained in the essentials for patient safety and understand how this applies to their area of work.

7. Addressing health inequalities

The ICB recognises that there is a no one-size-fits-all-approach to support patients, families including unpaid carers and staff in response to a patient safety incident.
The ICB are committed to improving health inequalities across the LSC Integrated care system and acknowledging these inequalities is the first step towards transforming health care.

The ICB is committed to providing equality of opportunity for all individuals involved in an incident and recognise effective engagement and involvement. Considering different needs of individuals, will enable opportunities for learning as well as embedding needed quality improvements at both local and system levels.

The ICB are committed to working closely with patients, families and carers to understand their unique needs and experiences when patient safety incidents occur. Their perspectives will help shape responses and improvements, ensuring that patient safety measures are inclusive, equitable and reflective of the people they affect. By listening to those with lived experience, we aim to develop solutions that are practical, compassionate and responsive to the diverse needs of our communities.

The flexible approach for PSIRF also supports addressing concerns specific to health inequalities. It provides an opportunity to learn from patient safety incidents that do not meet the previous definition of a ‘Serious Incident’, whilst tools made available in the patient safety incident response toolkit, also prompt consideration of inequalities in the development and maintenance of patient safety incident response plans.

Following national guidelines, healthcare providers are encouraged to factor in inequalities while formulating their patient safety incident response plans and setting patient safety priorities. This ongoing commitment reflects a positive step towards bridging the gap to a more equal, fairer, health and social care system.

Lancashire and South Cumbria's Provider Collaborative Board sets out a clinical strategy that addresses the five provider trusts working together to allow patients to have equal access to the same high-quality care no matter where they live. The aim is to ensure clinically and financially sustainable services that improve health outcomes, reduce health inequalities, and offer a great place to work. The principles include:

- Work together as one structured system to achieve excellence, ensuring services are accessible and responsive to all communities.
- Have a trusting, transparent and open approach.
- Share data and best practice, learning together when things go wrong.
- Work as part of the Lancashire and South Cumbria system.

The Provider Collaborative Board connects with system partners through Lancashire and South Cumbria Integrated Care Board.

8. Engaging and involving patients, families and staff following a patient safety incident

PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff)

Patients, families, and carers should be actively involved throughout the patient safety incident response process, where appropriate, to share their experiences, raise questions, and provide insight into the care they received. Providers should ensure that they are able to participate safely and without fear of judgement, and that they are kept informed of investigation outcomes, learning, and any changes implemented as a result of their contributions. This approach ensures that the response is thorough, compassionate, and shaped by the perspectives of those directly affected.

The ICB will ensure that PSIRF plans and policies for partner organisations incorporate the need to effectively work with those affected by patient safety incidents and to involve them meaningfully in the investigation process. In addition to involvement and engagement with patients and families, the ICB will look to ensure that all partners are fulfilling their regulatory and professional requirements for Duty of Candour in line with CQC Regulation 20.

The ICB promotes and embraces a just culture to ensure that staff are treated fairly and appropriately following patient safety incidents. When providing system oversight for patient safety reviews and investigations, the ICB will ensure that engagement from staff has been sought and used to inform each investigation.

When the ICB are considering organisations PSIR plans, the ICB will ensure that organisations have systems and structures in place to enable managers and wider staff to:

- Be confident about which incidents are being investigated and why.
- Understand how learning from incidents has been used to support continuous improvement.
- Understand the potential impact of patient safety incidents on staff.
- Recognise and help to manage the signs and symptoms of stress (including those associated with post-traumatic stress disorder) in themselves and colleagues.
- Have access to support following patient safety incidents.

9. Provider/ partner patient safety incident response policies and plans

The ICB currently commission services/contract with a wide range of NHS and non-NHS Trusts through formal contractual arrangements also including smaller providers, Regulated Care providers and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector.

The ICB will work in a supportive and collaborative manner with all providers/ partners to support the development and review of their patient safety incident response plan and policy which is proportionate to the services they deliver ahead of formal consideration of approval both with their own governance arrangements (usually a Board meeting) and the ICB Quality and Outcome Committee. Within the patient safety incident response plan (PSIRP), each organisation must work with the ICB and other stakeholders to identify how it will respond proportionately to all incidents requiring investigation. This includes, where applicable, priority incidents for Patient Safety Incident Investigation (PSII) and those meeting the national requirements for investigation such as those within the Learning from Deaths Framework and Never Events.

Where a provider/partner has multiple commissioners of services, an agreement will be sought for a lead ICB to oversee/support and approve their policy and plan. The Associate Commissioner(s) will be involved in this process along with subject matter experts where applicable proportionate to their level of interest in the provider/partner.

For some smaller/VCFSE providers, who typically report a very small number of incidents/or none annually, a patient safety incident response plan may not be deemed

necessary. The ICB commit to a balanced and proportionate approach for these organisations however prior to organisational approval of this approach the ICB must be consulted and a plan agreed. Where a provider and ICB agree a full PSIRP is not required, that organisation should update their incident management policy to incorporate PSIRF principles and the incident response process.

The ICB, when considering PSIRP's, must ensure that it is clearly stated how the organisation intends to deliver an effective response to patient safety incidents. The response methods the organisation intends to use to respond to patient safety incidents for the purpose of learning and improvement must also be detailed as well as how they will engage with, and support, those directly involved in the incident.

The ICB will seek assurance that there has been engagement with staff, patients and wider stakeholders in the analysis of data, drafting and reviewing of their plan and policy, including identification of local priorities.

When considering organisation's PSIR plans, the ICB will ensure that organisations have systems and structures in place to enable managers and wider staff to:

- understand the potential impact of patient safety incidents on staff.
- recognise and help to manage the signs and symptoms of stress in themselves and colleagues and.
- have access to support following patient safety incidents.

The ICB is required to approve and sign off the incident response policies and plans for commissioned provider organisations (unless agreed otherwise as part of a multi-commissioner agreement). Approval of an organisation's policy and plan demonstrates the ICB acknowledgement that the documents have been developed according to PSIRF guidance and meet (or demonstrate a plan to meet) PSIRF standards. In order to ensure a consistent and standardised approach the ICB will utilise a 'sign off checklist' to assess each policy and plan. Please refer to Appendix 3.

Monitoring and regular review of the PSIRF policy and plan must form part of the overarching quality governance arrangements between the ICB and the providers/partners. The ICB patient safety team will collaborate with the providers/partners to assess whether the systems and processes put in place to respond to patient safety incidents are in accordance with the PSIRF Standards and have achieved demonstrable improvement.

Where a regulator or oversight organisation has concerns regarding the safety of NHS commissioned services, additional information and assurance will be sought from the provider. If this involves the commissioning of an independent investigation or review, this will be additional to those in the provider's PSIRP.

10. Primary Care Patient Safety Strategy

Primary care – general practice, community pharmacy, optometry and dental services delivers 90% of NHS interactions, face to face, by phone or online. The overwhelming majority of these are safe, but according to NHS England data between 20,000 and 30,000 incidents of avoidable significant harm are identified in general practice in England per year, so there is opportunity to continue to improve the safety of care in primary care. We also know that incident data may be an underrepresentation of harm, as incident recording systems are not as well developed in primary care when compared to secondary care.

The Primary Care Patient Safety Strategy launched in September 2024 describes the national and local commitments to improve patient safety in all areas of primary care.

During 2025/26, GP practices will be required to have regard to the patient safety strategy and also register for an administrator account (unless their local risk management system is already connected) with the learn from patient safety events service (LFPSE) for the purposes of:

- recording patient safety events at the practice about the services delivered by the practice, thereby contributing to the national NHS-wide data source to support learning, improvement and learning culture.
- enabling the practice to record patient safety events occurring in other health care settings (for instance if a GP practice wished to record an unsafe discharge from hospital).
- individuals recording patient safety events being able to download a copy of the record for purposes of supporting appraisal and revalidation.

The Primary Care Patient Strategy recommends ICBs support primary care with implementing PSIRF, but this is not mandatory or specifically stipulated in the contract yet. The strategy does recommend that practices have patient safety leads, and all staff have undertaken level 1 and 2 patient safety training.

The ICB are dedicated in the aim of supporting all areas of Primary Care to deliver against these commitments (and the ICB commitments) to continuously improve patient safety through existing processes and structures as much as possible, rather than adding work.

11. Oversight responsibilities and assurance methods

Oversight of patient safety incident responses has traditionally included activity to hold provider/partner organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF brings a new approach and focuses on engagement and empowerment rather than the more traditional command and control. PSIRF has brought a change in the organisational responsibilities for the ICB which can be seen under roles and responsibilities within this policy.

Under PSIRF, the ICB has a responsibility to establish and maintain structures to support a co-ordinated approach to oversight of patient safety incident responses in all the services within their system. The mechanisms the ICB has in place to ensure oversight assurance are as follows:

- Review of quality evidence and submitted reports.
- Quality and Safety meetings with Providers/Partners.
- Feedback from Providers.
- Joint Commissioner meetings.
- Patient safety and Quality Assurance visits.
- Provider/partner internal quality and patient safety meetings.
- Collaboration with the Medical Examiner workstream and the coroner's office.
- Escalation process through quality and outcome committee.
- PSIRF Policy and plan meeting.
  https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf

The ICB Quality and Outcome Committee will receive regular reports on the discharge of the organisation's responsibilities through risk and escalation report and the Integrated Performance Report (IPR). Please refer to Appendix 7 for the ICB Patient Safety Governance Meetings.

Provider Patient safety meetings 	Clinical patient safety and quality focus visits 
Provider Learning responses 	ICS learning forum 

12. Oversight of Maternity PSIRF

As with all aspects of incident response under PSIRF, a provider board / leadership team are accountable for the quality of incident response and most importantly for reducing risk as a result. This is particularly relevant to the organisation's board-level maternity safety champion and the non-executive appointed to work alongside them.

ICBs are responsible for agreeing and signing off an organisations' patient safety incident response plan, including relevant maternity content.

Regional maternity teams should be involved in developing and agreeing organisations' patient safety incident response plan, as should LMNSs.

Organisations should also use their LMNSs to facilitate peer review of maternity incident responses and encourage partnership with another organisation to support collaborative learning.

13. Reporting of incidents through the Learning from Patient Safety Events platform

Under PSIRF, providers/partners should record all patient safety events on the national Learn from Patient Safety Events (LFPSE) platform (which has superseded the National Reporting and Learning System) and share these details, as appropriate, with the ICB.

Where appropriate, patient safety incidents must be reported to the Strategic Executive Information System (StEIS) either by the provider/partner (should they have access to the system) or directly to the ICB who will facilitate the reporting. The caveat is that the providers are working towards the role out of version 6 on LFPSE and following this StEIS platform will no longer be utilised.

Reported Patient Safety Incidents will be reviewed by the ICB and form part of the discussion at the provider meetings. The ICB will review the themes and trends within PSIIs and utilise this information to inform shared learning opportunities across the Integrated Care System and be considered for the ICBs learning forum or trigger any additional work that may be required.

14. Escalation to NHS England (NHSE)

NHSE have developed a standard operating procedure for management of patient safety incidents to outline the process and to clarify roles and responsibilities for the oversight and management of patient safety incidents within NHS England Northwest.

The ICB will notify NHSE Northwest of patient safety incidents that meet the agreed criteria referenced in the NHSE ‘’Guide to responding proportionately to patient safety

incidents''. This will include incidents that meet both national and local priorities for the providers. In addition, it has been agreed that the following incidents will be notified to NHSE-Northwest:

- Incidents which may attract media attention.
- Incidents that straddle multiple organisations / wider than one system.
- Incidents where it is suspected an NHS staff member has died by suicide.

Patient safety incidents are often alerted in several ways; therefore, it is prudent that effective communication channels are maintained across providers and NHSE Northwest.

15. Responding to cross-system incidents/issues and supporting system learning.

There is frequently more than one organisation involved in the care and service delivery in which a patient safety incident has taken place; all providers and commissioners must have a process in place to recognise incidents that require a cross system learning response.

All healthcare organisations providing and overseeing NHS-funded care must work collaboratively, with a common understanding of the aims of the PSIRF framework, to provide an effective governance structure around the NHS response to patient safety incidents. PSIRF expects ICBs to facilitate collaboration at both place and local system level to ensure cross-system response. PSIRF requires regulators and ICBs to consider the strength and effectiveness of NHS providers' incident response processes. Accountability for the quality of learning responses to individual incidents sits with the providers. They must be open with information relating to patient safety incidents and findings from incident responses, including formal reports, to support continuous development of an effective incident cross-system response.

The organisation that identifies the incident is responsible for recognising the need to alert other providers, commissioners, and partner organisations via their respective risk management or governance teams. A lead organisation should be identified to coordinate the investigation; this should be agreed by all organisations involved. Responses should be managed as locally as possible to facilitate the involvement of those affected by the incident and those responsible for delivery of the service where the incident occurred.

The incident should be reported onto the LFPSE system by the organisation who identified this. All providers are expected to respond and participate in joint investigations when requested.

A set of principles for cross organisational incidents have been developed collaboratively and agreed, please refer to Appendix 4. These principles will guide each

organisation on expectations and ways of working that puts the patient/family/carer at the centre of the investigation.

Providers and ICBs are expected to work together to establish and undertake cross-system learning responses, but where issues arise, support must be sought from the NHS England regional team.

The ICB will seek the views of local system partners to ensure that learning responses are co-ordinated at the most appropriate level of the system. The ICB will also ensure that providers have systems in place to support a coordinated and measured, systems-based response to high profile or complex incidents such as mental health homicides which includes how to support the needs of those affected during the investigation.

The ICB will work with the NHS England Regional Independent Investigations Team where appropriate, including working with providers to ensure referral of relevant cases.

16. Patient Safety Training

16.1 Patient Safety Training and Patient Safety Syllabus Training

The Patient Safety Syllabus, Curriculum Guidance and e-learning has been developed following the publication of the NHS Patient Safety Strategy. The syllabus sets out a new approach to patient safety emphasising a proactive approach to identifying risks to safe care while also including systems thinking and human factors.

16.2 Level 1 Essentials for Patient Safety training

Level 1 (e-learning for Health) Essentials for Patient Safety training is mandatory for all ICB staff.

16.3 Level 1b Essentials for Patient Safety for Boards and senior leadership teams

Level 1b training is mandatory for all Executive Directors, non-executive members and the senior leadership team.

16.4 Level 2 Access to Practice training

Level 2 Access to Practice training is mandatory for all ICB Nursing and Medical directorate and all other clinical and patient facing staff. This module must be completed before staff can access further Level 2 training.

16.5 Level 2 Sector Specific training

Management and Administration training within the Level 2 Sector Specific training is mandatory for all Nursing and Medical directorate staff and all other clinical and patient facing staff.

For all other Sector Specific sessions (Mental Health, Primary Care, Maternity and Acute) eligible staff may complete this training as part of their development and/or relevant to their job role.

16.6 Levels 3 and 4 training

In addition to the Level 1 and 2 training, all Patient Safety Specialists working in NHS organisations and registered with NHS England will be required to undertake Level 3 and 4 training via a blended learning approach.

16.7 PSIRF Specific Training

The ICB recognises that those involved in the review of patient safety incidents and investigations and those providing an oversight function require specific knowledge and skills. This includes knowledge of systems thinking and system-based approaches to learning from patient safety incidents.

NHS England has developed training for staff in PSIRF specific roles, and a national procurement framework has been developed and training suppliers identified. Training includes two days training for staff involved in reviewing and investigating systems incidents, one day training for those staff that will engage with both staff and patients involved in incidents and one day training for those staff that have organisational wide oversight roles.

The ICB is committed to ensuring that all relevant staff have access to appropriate, high quality patient safety training in line with national requirements.

Training Module	Staff Group	Type	Length of Training	Delivery Method	Delivered By	Records of Attendance Held By
Level 1 – Essentials for Patient Safety	All ICB staff	Mandatory	1 hour	E-Learning (eLfH)	NHS England	ICB L&D ESR
Level 1b – Essentials for Boards & Senior Leaders	Exec Directors, NEDs, SLT	Mandatory	1 hour	E-Learning (eLfH)	NHS England	ICB L&D ESR
Level 2 – Access to Practice	Nursing & Medical Directorates. Clinical patient facing staff	Mandatory	1 hour	E-Learning (eLfH)	NHS England	ICB L&D ESR

Level 2 – Sector Specific Modules	Clinical & patient facing staff (Mgmt/Admin module)	Mandatory	1 hour	E-Learning (eLfH)	NHS England	ICB L&D ESR
Level 3 & 4 – Patient Safety Specialist Training	Registered Patient Safety Specialists	Mandatory	Up to 9 months	Blended learning	NHSE accredited providers	ICB Quality Team/ESR
PSIRF Specific Training	Staff in PSIRF investigation, engagement, or oversight roles	Mandatory	1-2 day modules	Face to face & virtual	NHSE PSIRF curriculum providers	ICB Quality Team/ESR

17.0 Complaints and appeals

The ICB recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided or commissioned. All complaints and concerns received are managed in line with the ICB's Complaints Concerns and Patient Feedback Policy which can be found at: https://www.healthierlsc.co.uk/download_file/6739/11285

Complaints can be valuable aids in developing and maintaining standards of care and lessons learnt from complaints can be used positively to improve services. The ICB Nursing and Quality Directorate will work to ensure learning from complaints, concerns and patient feedback is triangulated with patient safety learning to support system improvement.

To support this, the ICB ensures access to free, confidential, independent advocacy, providing guidance and support throughout the complaints process. This helps individuals to have their voices heard and contributes to learning and improving the quality and safety of care.

18. Review of the ICB PSIRF Policy

The current policy will remain in effect until such time that functions are transferred, or legislative changes are enacted. The ICB will review this policy on an annual basis as a minimum, or when national or regional published PSIRF guidance is updated.

19. Equality and Health Inequalities Impact Risk Assessment (EHIIRA)

An Equality and Health Inequalities Impact and Risk Assessment (EHIIRA) Stage 1 has been completed for this policy in line with Section 8 of the LSCICB Policy for Policies.

An EHIIRA has been completed for the policy. The assessment identified no adverse equality or human rights impacts and highlights positive impacts across several protected and Inclusion Health groups, with the policy expected to contribute to reducing health inequalities through inclusive, systems-based patient safety responses.

20. Implementation and Dissemination

The policy will be:

- Published on the ICB staff intranet and made available on the public website.
- Circulated to all clinical and corporate teams with responsibility for patient safety oversight.
- Shared with commissioned providers via established patient safety networks, PSIRF forums and quality review meetings.
- Referenced during training for staff in patient safety, governance, quality assurance and commissioning roles.

The ICB Patient Safety Team will be responsible for ensuring staff and partners are aware of the policy and understand its requirements.

21. Monitoring and Review Arrangements

The implementation and effectiveness of this policy will be monitored through the ICB's established quality governance structures. Oversight will be provided by the ICB Patient Safety Team and formal assurance will be sought through the Quality and Outcomes Committee.

22. Consultation

In accordance with Section 10 of the ***LSCICB Policy for Policies***, appropriate consultation has been undertaken to ensure this policy reflects statutory requirements, operational needs, and the views of key stakeholders.

Engagement included staff responsible for policy implementation, patient safety specialists, patient safety partners, and representatives from commissioned providers. Feedback received during the consultation process has been considered and incorporated where appropriate. List of Stakeholders Consulted:

Date	Name of Individual or Group	Designation	Were comments received, considered and incorporated Yes/no	If not incorporated record reason why
10/11/2025	David Brewan	Head of Patient Experience	yes	N/A
27/10/2025	Lindsay Graham	Designated Safeguarding Lead and family/patient view(Health watch)	yes	N/A
17/04/2025	Steph purcell	Head of Quality & Safety Children, Young People & Maternity Team	yes	N/A
07/01/2025	Caroline Marshall	Associate Director of Nursing and Patient Safety	yes	N/A
22/10/2025	Jane scattergood	Interim Chief Nurse	yes	N/A
25/11/2025	Kathryn Lord	Director of Nursing, Quality Assurance and Safety	yes	N/A
17/09/2024	Naveed Shariff Travis peters	Associate Director of Culture and Inclusion; Inclusion Business Partner | The Inclusion Team	yes	N/A
17/09/2025	Rebecca Power	Senior Quality Assurance Manager – Primary Care, Community, MH/LD/Autism	yes	N/A

23. References and Bibliography

All sources used to inform and support this policy are listed below. This includes national legislation, statutory guidance, and relevant NHS patient safety publications.

- NHS England (2022). Patient Safety Incident Response Framework (PSIRF).
- NHS England (2019). The NHS Patient Safety Strategy.
- NHS England (2024). Freedom to Speak Up Guidance.
- Care Quality Commission (2022). Regulation 20: Duty of Candour.
- NHS England. Guide to Responding Proportionately to Patient Safety Incidents.
- NHS Oversight Framework.
- Learning from Patient Safety Events (LFPSE) Service Guidance.
- Health Services Safety Investigations Body (HSSIB) Guidance.
- Maternity and Newborn Safety Investigations Service (MNSI) Guidance.

24. Associated Documents

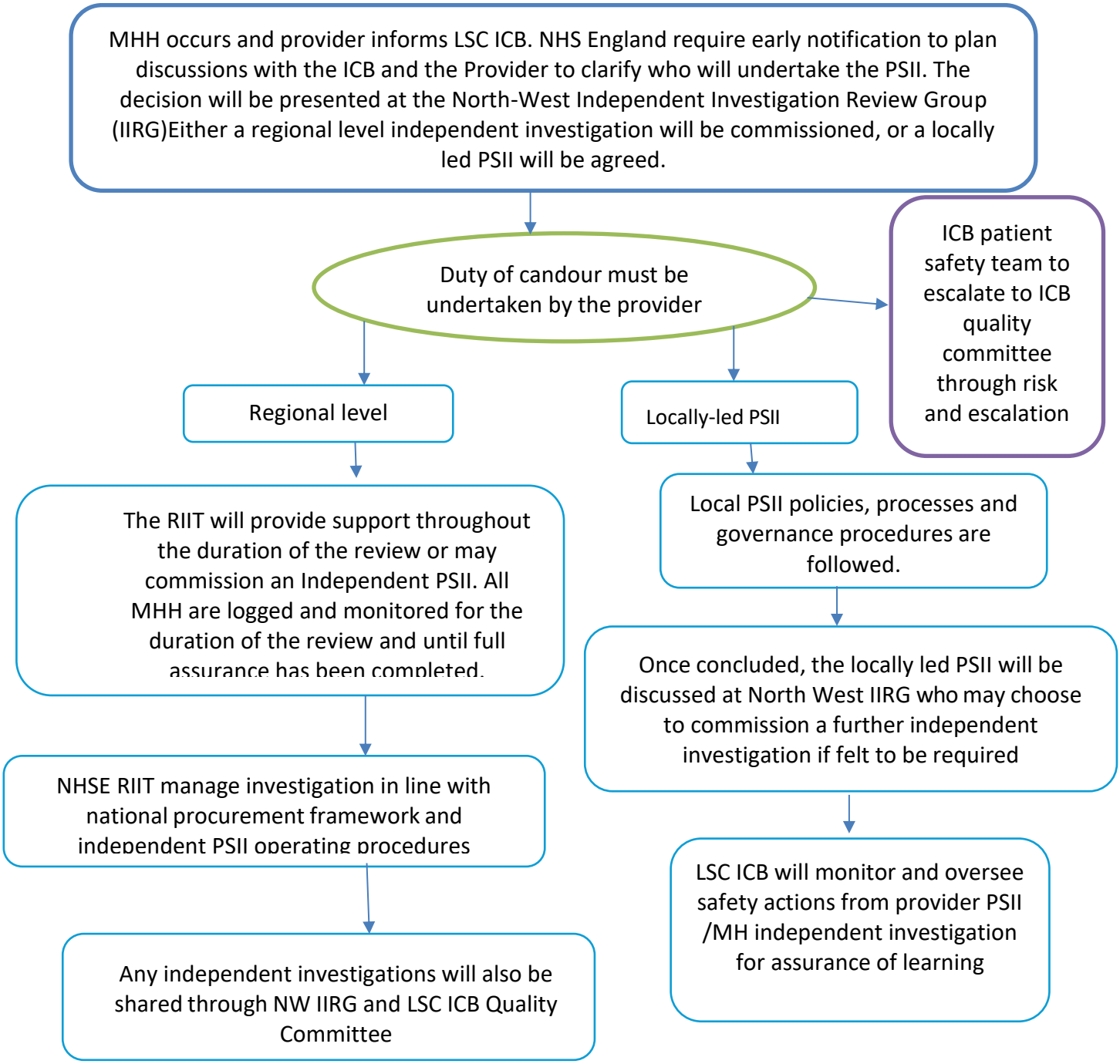
This policy should be read in conjunction with the following LSC ICB and national documents:

- LSCICB Complaints, Concerns and Patient Feedback Policy
- LSCICB Freedom to Speak Up Policy
- LSCICB Quality Strategy (where applicable)
- NHS England National Speak Up Policy
- National Guidance on Learning from Deaths
- Serious Incident Transition Guidance (where applicable)
- Provider Patient Safety Incident Response Plans (PSIRPs)
- NHS Standard Contract requirements for patient safety
- Local safeguarding policies and procedure
- LMNS Governance and Safety Documents

Additional associated documents may be added as required.

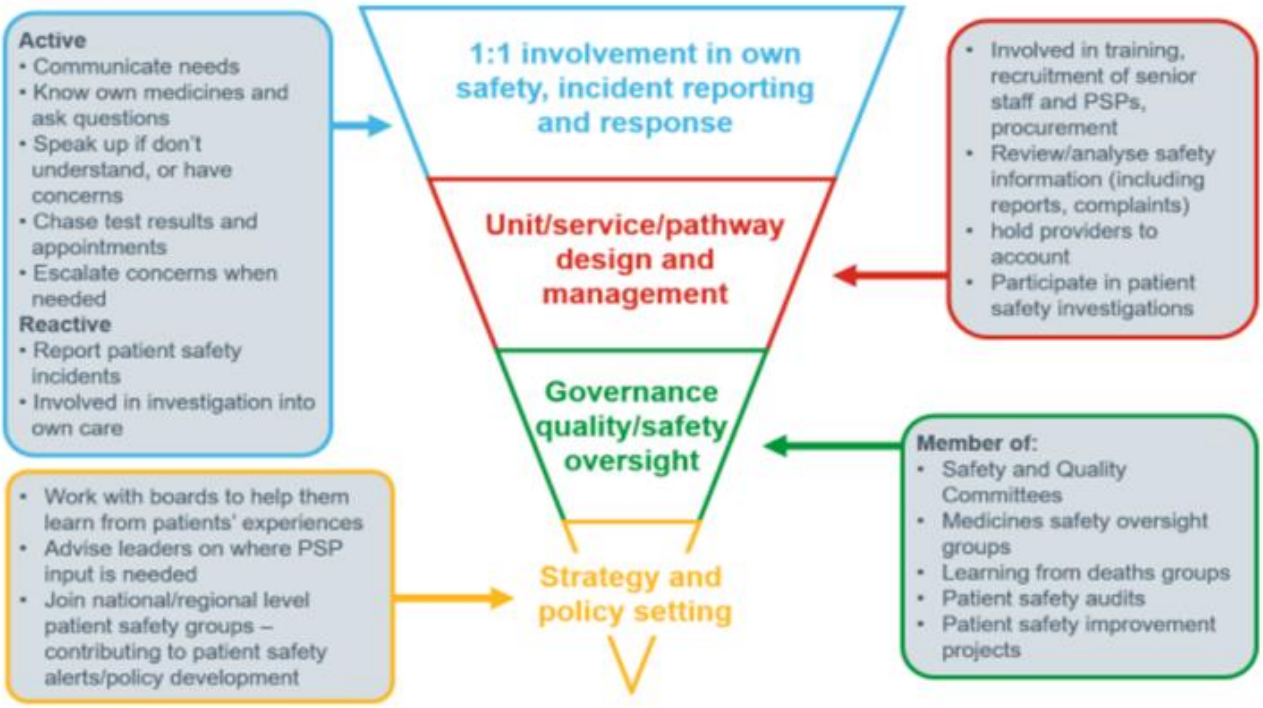
Appendix 1

Flow Chart - Mental Health Homicide (MHH) management.



Appendix 2

PSP roles



Appendix 3

Sign off checklist.

Lancashire and South Cumbria Integrated Care Board
Patient Safety Incident Response Plan (PSIRP) Sign off Checklist.

What do we expect?	Yes/No?
Signed Board Paper, approving your patient safety implementation plan	
Transition for Close Down of Serious Incident Plan	
Patient Safety Incident Response Plan	
Patient Safety Incident Response Policy	

Provider: **Date:**

Required in the above documents	Yes/No?
Incident prioritisation process	
Patient Safety Incident Investigations (PSIIs) – including how to evaluate & monitor outcomes following PSIIs, for progress against the PSRIF to be measured and safety risks effectively mitigated	
PSIRF national priorities	
Local priorities	
Responding to patient safety	
Engaging & involving of patient, families and carers following patient safety incidents	
Statutory Duty of Candour	
Patient Safety Partners	
Involvement & support from staff following incidents	
Resources, learning and improving to support patient safety incident response	
Patient Safety Culture	
Addressing health inequalities	
Patient safety incident investigations	
Patient safety incident response planning	
Patient safety incident reporting arrangements /LFPSE	
Patient safety incident response decision-making	
Responding to cross-system incident/issues	
Timeframes for learning responses	
Safety action development and monitoring improvement	
Safety improvement plans	
Mortality Issues	
Oversight roles and responsibilities	
Complaints & appeals	
LFPSE reporting	

Required evidence of	Yes/No?
Whistleblowing evidence	
Case notes reviews	

Staff survey results	
Claims	
Staff suspensions	
Risk assessments	
Organisation patient safety reports	
Identification of the interventions (or alternative review techniques) available and planned for incidents that fall outside the patient safety incident investigation plan but require action or new insight, e.g.: 1. 'Being open' conversations. 2. incident timelines (to inform Duty of Candour disclosure and being open conversations) 3. structured judgement review/case note review/clinical review (to identify whether issues of concern and to inform Duty of Candour disclosure and being open conversations) 4. after-action review (for rapid local team review) 5. audit (to measure/monitor compliance against policy/guidance/expectations)	

Series of Events	Yes/No
Creation of above documents and requirements	
Request sign off from Provider Board	
Once approved by Provider Board, request review from ICB panel	
Sign off from ICB panel and presented to ICB Quality & Performance Committee	
PSIRP documents uploaded to the organisation's website	
Check-ins for progress with the implementation of PSIRF and closure of Serious Incidents	

Appendix 4

Cross Organisational Incident Operating Principles (May 2024)

1.We will all commit to 1 patient 1 learning response rather than silo working for cross organisational incidents. We will agree collaboratively through an MDT approach how to allocate defined roles and responsibilities across all organisations involved including leadership/oversight, co-ordination and will agree a method of escalation.

2. We will ensure patient, family, and staff involvement as part of cross Trust delivery of PSIRF, ensuring co-design of a jointly owned safety culture within a well-functioning safety system

3. We will promote openness and transparency to share concerns and allow for growth with clearly defined roles/leads for each area to promote consistency and adapt as required. We will be flexible and adapt our communication methods to ensure that everyone included. and has access and We will encourage sharing of information and ideas, promoting kind provocation.

4. We will create a safe space where we can have open and honest discussions, and we will demonstrate mutual respect focussing on the collective goal embracing what other organisations can bring

5. We will provide a safe environment for all to be open/transparent to share learning from events.

6. Compassion and empathy will underpin our approach, ensuring we provide support with kindness when interacting with patients, families, staff, and colleagues

7. We will commit to being honest and disclose all relevant information. We will be upfront about challenges we have faced and what we have learned and make our goals and outcomes visible to all who are affected.

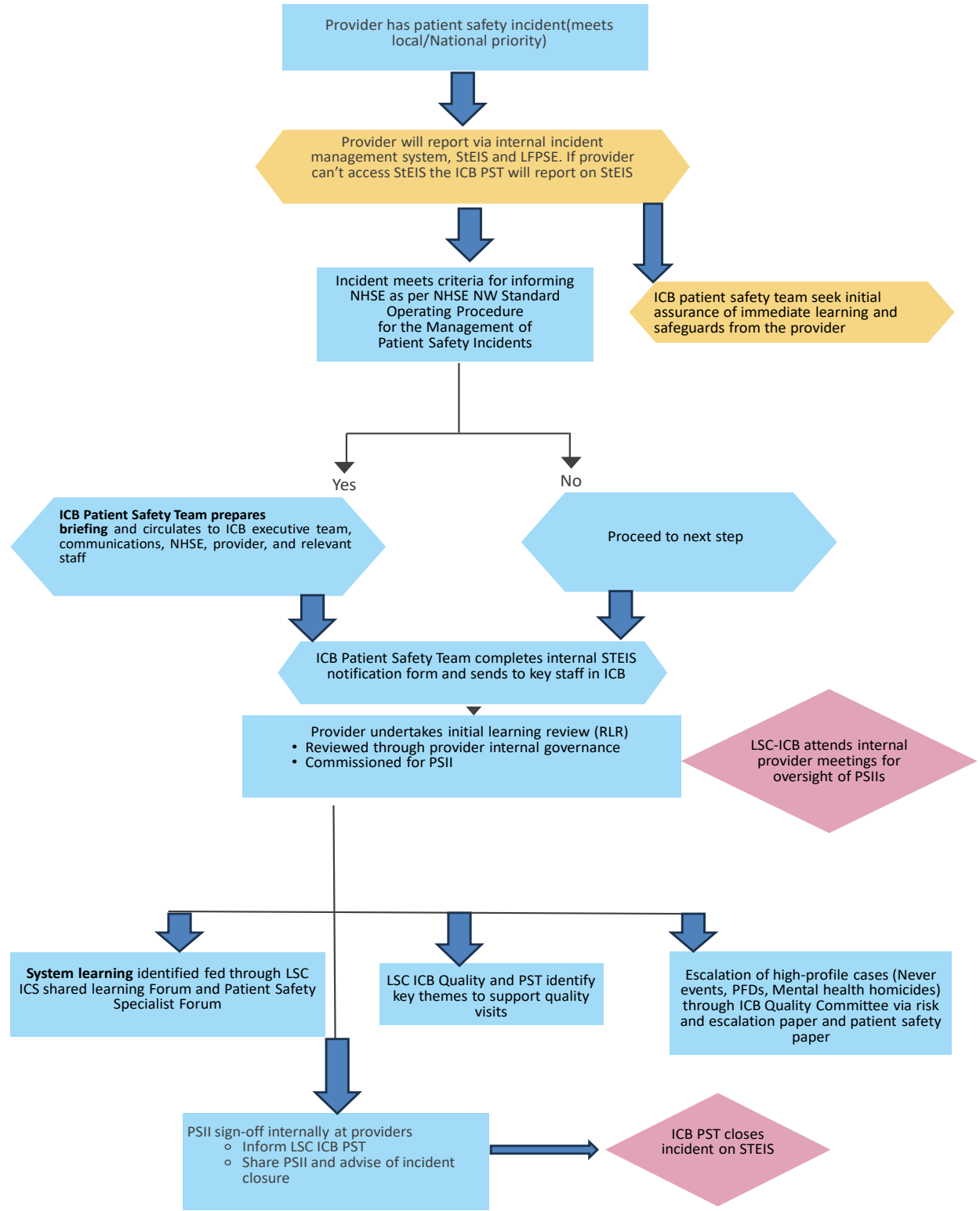
8. We will agree our shared goals and the principles and values we need in place to make these happen and we will adapt as we learn and progress

9. We will actively connect and collaborate on these shared goals. To help us achieve this we will collectively create a safe, responsive space where a culture of civility and constructive feedback is the norm.

10. We will continue to reflect on and respond to the lessons we learn to ensure we are continuously improving our health system at scale.

Appendix 5 - ICB PSIRF Process

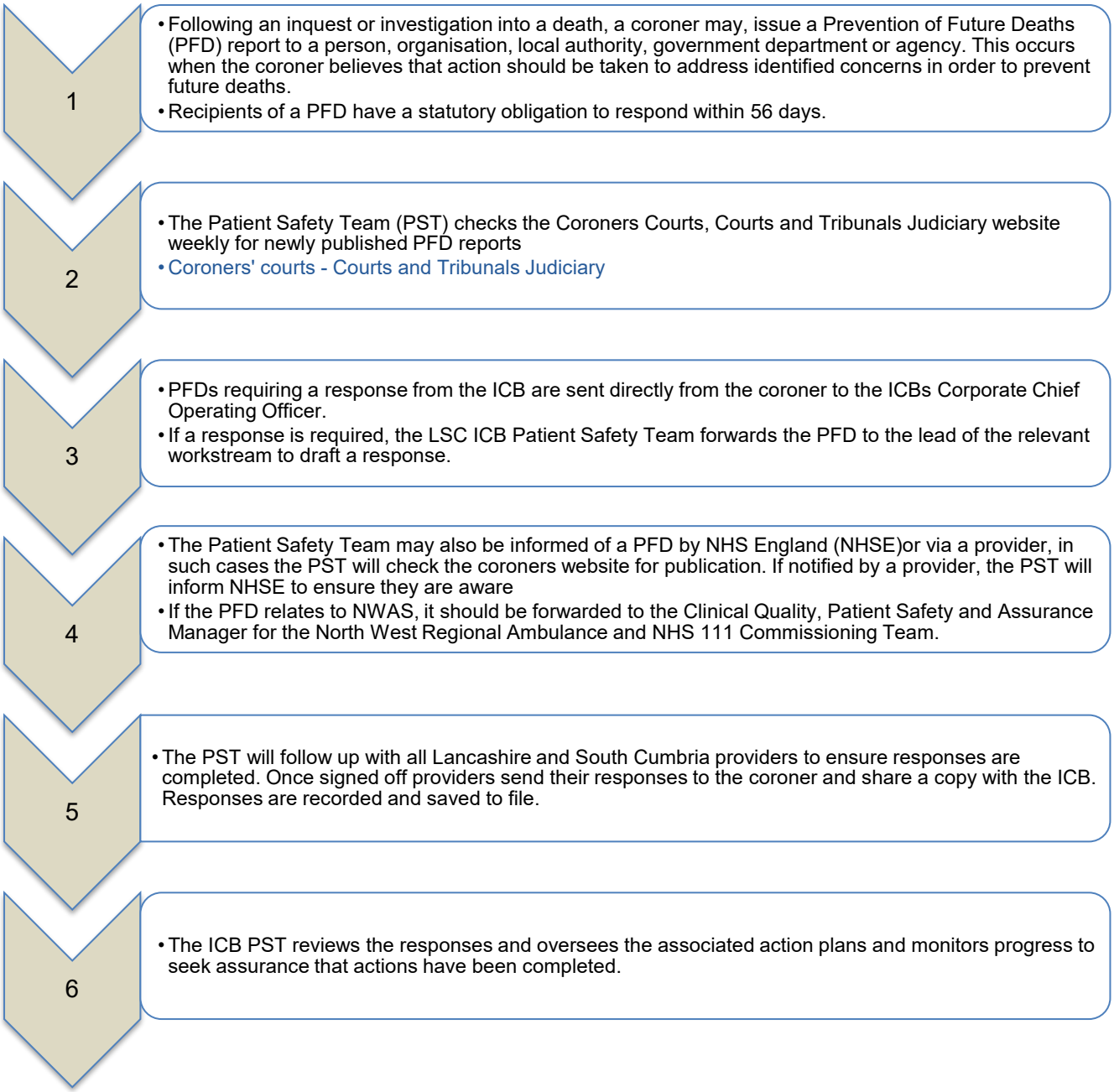
ICB PSIRF PROCESS



Appendix 6

ICB Process for Handling Regulation 28 Prevent Future Deaths (PFD) Reports.

This document contains a visual flowchart diagram illustrating the ICB process for handling Regulation 28 Prevent Future Deaths (PFD) reports.



Appendix 7 ICB Patient Safety Governance Meetings

Meeting	Basic info and Purpose of meeting	Where this meeting feeds into
Weekly Provider meetings	**Frequency**: Held weekly **Format**: Informal catch-up; no formal minutes recorded **Attendees**: • Representatives from across the ICB Quality and Safety Team • Provider leads. **Purpose**: • Discuss emerging issues. • Build and strengthen professional relationships. • Provide mutual support as subject matter experts. • Share insights and updates across teams.	Patient Safety Team (PST) oversight meeting and risk and escalation paper for Quality and outcome committee
ICB patient safety oversight meeting	**Frequency**: Held weekly **Attendees**: Patient Safety Team **Purpose**: • Triangulate emerging themes and intelligence from various sources. • Discuss patient safety events. • Provide oversight of Serious Incidents (SIs) and PSIRF implementation in provider organisations. • Share updates from meetings attended.	Escalations to the ICB Quality and outcome committee via Integrated performance report and systems quantity group if appropriate
ICS Patient safety Specialist	**Frequency:** Held bi-monthly **Format:** Formal meeting with minutes and an action tracker **Attendees:** • Representatives from across the ICS • ICB Quality and Safety Team • NHSE Patient Safety Specialist • Leads from acute and mental health providers. • NWAS (North West Ambulance Service) • Independent hospital representatives **Purpose:** • Share new patient safety insights from the week.	Escalations to the ICB Quality and outcome committee via Integrated performance report and systems quantity group if appropriate

	• Provide updates in response to previously shared patient safety incidents. • Triangulate emerging themes and intelligence from sources beyond patient safety events. •	
ICB Quality and Outcome committee	**Frequency**: Held bi-monthly **Format**: Formal meeting with minutes and an action tracker **Attendees**: • ICB Executive Team • Local Authority representatives • Healthwatch **Purpose**: • Review and provide assurance on: ▪ **Integrated Performance, Quality and Health Equity Report** ▪ **NHS Oversight Framework** ▪ **Safeguarding** ▪ **Access, Advice and Action (AAA)** and **Independent Provider Assurance (IPA)** ▪ **Primary Care Quality** ▪ **System Quality Group (SQG)** ▪ **Patient safety risks and escalation** ▪ **Risk management** ▪ **Clinical effectiveness** • Ensure the ICB is delivering its functions in line with the **Shared Commitment to Quality** and the **Health and Care Act 2022**, securing continuous improvement in service quality. • Promote a culture of **patient safety**, **safeguarding**, and **quality improvement** across the Lancashire and South Cumbria ICS • To provide assurance on ICS NHS Provider services' governance arrangements and patient safety and quality performance, through receiving exception reports on quality and safety issues, patient experience and safeguarding concerns and alerts for health services.	System risks related to patient safety are escalated via the Advise, Alert, Assure (AAA) process to the ICB Board These risks also feed into RQG (Risk and Quality Group) reporting mechanisms for oversight and monitoring

ICB PSIRF policy and plan Group	**Frequency:** Held every 2 weeks **Format:** Formal meeting with agenda and outcome tracker **Attendees:** • ICB Patient Safety Team • ICB Patient Safety Specialist (as required) **Purpose:** • Record attendance and actions of the ICB Patient Safety Team Validate and sign off provider patient safety-related policies and plans. • Allocate policies and plans for review by appropriate team members. • Escalate any outstanding or overdue policies and plans for resolution.	Patient safety oversight meeting and Quality and Outcomes committee
Provider Quality Review Meetings	**Frequency:** Quarterly following submission of quarterly quality returns. **Format**: Formal meeting with agenda and papers **Attendees:** • **LSCICB** • Associate Director – Quality Assurance – LSCICB (Chair) • Senior Quality Assurance Manager – LSCICB (Deputy Chair) • Senior Quality Officer – LSCICB • Performance Manager – LSCICB • Quality Support Officer (Minutes) **Provider** • Members of the meeting should have sufficient delegated authority to take the necessary decisions and represent their organisations appropriately. The titles of attendees vary from Trust to Trust and is highlighted in the individual TOR. **Purpose.** Ensure that providers carry out obligations in respect to quality and	Feeds into Formal provider contract meetings and exception report via the integrated performance report to the Quality and outcome committee

	information requirements details within their NHS Standard Contract. • To ensure that providers adhere to the law and deliver services in accordance with NHS Constitution, good clinical practice and the Care Quality Commission standards of registration. • To identify and respond to areas of concern and opportunities in respect to quality improvement. • Review quality indicators flagged as a concern through escalation / exception reporting. • Ensure robust governance structures are in place and are effective for reporting and escalating concerns. • Monitoring and assurance of specific areas of focus including specialities. Specific reports will be used for escalation where exceptions occur. • To recommend services reviews, investigations and remedial action plans as appropriate and to recommend remedial actions in response to failure to meet required standards. • Ensure a consistent approach to quality assurance and improvement in the commissioning and contracting functions. • Report progress against key national standards. • Consideration of the NHS Oversight Framework (NOF) requirements, with any emerging concerns being escalated where required. • Consideration of any Quality Impact Assessments (QIAs) or Equality Impact Assessments (EIAs) from the provider that may have an impact the ICB or other Partners. • To highlight, share and spread good practice, learning and innovation and thematic learning from investigations.	

Primary care quality group	**Frequency:** Monthly, although additional meetings may be convened at the discretion of the Chair for urgent matters **Format; Formal** meeting with agenda and papers circulated before the meeting. **Attendees.** • Director of Nursing and Quality (Chair) • Associate Medical Director for Primary Care (Vice Chair) • Director of Primary Care • Associate Director of Medicines Optimisation and Research • Clinical Effectiveness Committee member with specialist • interest in quality • Associate Director Quality Assurance • Associate Director of Patient Safety • Head of Patient Experience • Head of Delivery Assurance (Primary Care) • General Practice Clinical Advisor • Dental Clinical Advisor • Optometry Clinical Advisor • Pharmaceutical Clinical Advisor • Representation of Place Directors • Director of Safeguarding **Purpose:** • To improve the quality of primary care services for the Lancashire and South Cumbria population. Ensuring robust assurance processes are in place regarding the quality of primary care delivery with a drive for quality improvement. • To provide assurance on the quality of primary care services contracted by NHS Lancashire and South Cumbria Integrated Care Board. • To drive continuous Improvement and learning across all Primary Care Services • To link with relevant committees and groups, including contracting sub-groups.	Reports to the LSC Quality Committee. It will be required to report to the Clinical Effectiveness Committee and/or Primary Care Commissioning Committee regarding anything relevant to their Terms of Reference. It will also report to the LSC Quality and outcome Committee using the 3 A's (Advise, Assure and Alert) Template highlighting any areas of concern. It will report any serious incidents into the appropriate statutory body. Any learning / good practice identified by the Primary Care Quality Group will be disseminated across the system for shared learning.

	• To ensure compliance with relevant local and national policies, procedures, and targets. • To ensure delivery of locally agreed quality priorities. • To ensure robust processes are in place to review and monitor appropriate actions for patient safety, clinical effectiveness, and patient experience. • To provide a forum for testing new ideas, sharing learning and celebrating best practice. • To provide a forum where concerns about the quality of services can be discussed, assessed and where necessary improvement action identified, and delivery overseen. • To provide regular reports and where necessary escalation to the Quality Committee, Clinical Effectiveness Committee and Primary Care Commissioning Committee in accordance with their respective responsibilities.	
Insights Ulysses meetings	**Frequency:** Monthly with an extended quarterly meeting with optional attendance from Medicines Optimisation, Safeguarding, Regulated Care and Commissioning Teams. **Format**: Formal meeting with agenda and papers **Attendees:** • Patient safety • Patient experience, • Quality assurance leads • Primary care Quality assurance • Others by invitation at quarterly meeting. • Purpose • Triangulation and sharing of intel across quality directorate to identify any themes. • To identify any escalations of patient safety to providers and internal in ICB	Feeds into the QRM, Primary care quality group weekly and informal provider catch-up meetings. Also, escalation via risk and escalation paper and/or integrated performance report to Quality and outcome committee