NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Patient Safety Incident Response Framework Policy (PSIRF)

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Target audience:	ICB Colleagues

CONSULTATION SCHEDULE		
Name and Title of Individual	**Groups consulted**	**Date Consulted**
All members	System Quality Group	5/4/24
All members	Quality and Safety Committee	10/4/24

RATIFICATION SCHEDULE	
Name of Committee approving Policy	**Date**
Quality and Safety Committee	12/6/24

VERSION CONTROL			
Version	**Version/Description of amendments**	**Date**	**Author/amended by**
1	NEW Policy	12/6/24	Cath Marsland

IMPACT ASSESSMENTS – available upon request			
	Stage	Complete	Comments
QIA			Not required as a system process rather than impacting on users
EIA			Not required as a system process rather than impacting on users

Contents

This policy applies to the Staffordshire & Stoke-on-Trent Integrated Care Board.

Where the term Staff is used this includes Non-executive Directors, Clinicians and contractors working on behalf of the ICB.

1.0 Purpose

1.1 The leadership and management functions of the Patient Safety Incident Response Framework (PSIRF) are multifaceted and cover all ages. The framework advocates oversight that enables organisations delivering NHS funded care to demonstrate improvement rather than compliance with prescriptive, centrally mandated measures. To achieve this, oversight of patient safety incident response under PSIRF must focus on engagement and empowerment rather than more traditional command and control.

1.2 This policy is based on NHS England » Patient Safety Incident Response Framework and sets out Staffordshire and Stoke on Trent's approach to fulfilling the roles and responsibility requirements for Integrated Care Boards as defined in the PSIRF:

- Collaborate with providers in the development, maintenance and review of provider patient safety incident response policies and plans.
- Agree provider patient safety incident response policy and plans.
- Oversee and support effectiveness of systems to achieve improvement following patient safety incidents.
- Support co-ordination of cross-system learning responses
- Share insights and information across organisations/services to improve safety.

1.3 The implementation of the PSIRF prompts a significant cultural shift towards systematic patient safety management across the whole system in an open, honest, and transparent way.

- This policy supports development and maintenance of an effective System-wide patient safety incident response process that integrates the four key aims of the 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 responses, system functioning and improvement.

2.0 Scope

2.1 Conducted solely for the purpose of learning and improvement across all the NHS services commissioned by Staffordshire and Stoke on Trent Integrated Care Board (SSOT ICB).

2.2 The following principles underpin the oversight of patient safety incident response:

- Improvement is the focus.lame 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.

2.3 Roles and responsibilities under this policy support a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety emerges from interactions and not from a single component. Actions or inactions of people, or 'human error', are not accepted as the cause of an incident.

2.4 Investigations outside the scope of the providers patient safety incident response plan include but are not limited to:

- Complaints,
- Human resource investigations,

- Professional standards investigations,
- Coronial inquests,
- Criminal investigations,
- Claims management,
- Financial investigations and audits,
- Safeguarding concerns,
- Information governance concerns,
- Estates and facilities issues.

2.5 The framework and this policy are not a substitute for the statutory responsibilities of the ICB. Any response that seeks to find liability, accountability or causality is beyond the scope of this policy.

3.0 PSIRF

3.1 The PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

3.2 Patient safety incidents are unintended or unexpected events (including omissions), in healthcare that could have or did cause harm to one or more patients.

3.3 PSIRF fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. Unlike the Serious Incident Framework, PSIRF is NOT an investigation framework that prescribes what to investigate. PSIRF advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents. PSIRF embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

3.4 The PSIRF approach is flexible and adapts as organisations learn and improve to ensure organisations can explore patient safety incidents relevant to their context and the populations they serve.

3.5 The principles and practices endorsed by PSIRF are aligned with the NHS Patient Safety Strategy and wider initiatives under the strategy including the introduction of Patient Safety Specialists, the development of a National Patient Safety Syllabus, development of the Involving Patients in Patient Safety framework and the introduction of the Learn from Patient Safety Events service (the successor to the national reporting and learning system (NRLS).

4.0 Roles and Responsibilities

4.1 **NHS England (NHSE)** national team will oversee the activity of regional teams to support effective response to patient safety incidents, providing strategic direction and leadership while monitoring effectiveness of PSIRF.

4.2 **NHSE regional teams** will support ICB PSIRF leads with the learning system within NHSE. To support co-ordination of system wide responses to patient safety incidents.

4.3 **Integrated Care Board will:**

- Agree provider patient safety incident response policy and plans including regular review of updated plans and progress against improvement plans.
- Will ensure oversight and support effectiveness of systems to achieve improvements following patient safety incidents.

- Assess effectiveness of systems and processes to respond to patient safety incidents in NHS funded provider services as demonstrated by the behaviours of openness and transparency; the existence of a just culture; evidence of continuous learning and improvement.
- Ensure that insights and information across services/providers are shared to improve safety including examples where providers have improved care.
- Work with system partners to identify and share system learning and local themes and learning to drive improvement, including supporting and co-ordination of any cross-learning responses.

4.4 **ICB Patient Safety Specialists (PSS)** with support from the wider Nursing Therapies and Quality Team will work collaboratively with the provider services across the system to develop, maintain and review each providers patient safety response policy and plan.

The designated ICB PSS will work with system providers to:

- Establish roles and responsibilities, and processes for system oversight.
- Ensure the application of PSIRF standards.
- Ensure mechanisms are in place for escalation of incidents and risk that may require support/action at a system or regional level.

The Designated ICB PSS will work collaboratively with provider organisations as they develop and review their PSIR plans to understand each provider patient safety profile. Support the selection of appropriate response methods for anticipated patient safety incidents based on the organisations profile and improvement plans.

Support will be given to provider organisations to work in collaboration and co-ordination of cross-system learning to promote learning and improvement.

5.0 Our patient safety culture

5.1 A patient safety culture is the extent to which an organisation's culture supports and promotes patient safety. It refers to the values and beliefs that are shared by staff throughout the organisation that influence their actions and behaviours.

5.2 Patient safety culture can be measured by determining the values, beliefs, norms, and behaviours related to patient safety that are rewarded, supported, expected, and accepted in an organisation. It is also important to note that culture exists at multiple levels, from the unit level to the department, organisation, and system levels. The promotion and embedding of a patient safety culture and climate develops and fosters a just culture.

5.3 A Just Culture is one that balances fairness, learning and accountability. The fair treatment of all staff supports a culture of fairness, openness and learning by making staff feel confident to speak up when things go wrong, rather than fearing blame. NHS England » A just culture guide

5.4 The ICB promotes and embraces a just culture to ensure that staff are treated fairly and appropriately following patient safety incidents.

5.5 When considering organisation's PSIRF 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 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.

5.6 Within the ICB there are a limited number of staff who could be involved in a patient safety incident as the ICB are not providers of care. It is however essential that in their PSIRF Oversight role ICB staff ensure that all processes undertaken within the PSIRF remit meet the required obligations to ensure a Just Culture.

5.7 Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. In any organisations or teams where a blame culture is still prevalent, this guide will be a powerful tool in promoting cultural change.

5.8 The patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk (not accountability, liability, avoidability and cause of death); they do not undermine just culture by requiring inappropriate automatic suspension of staff involved in patient safety incidents or their removal from business-as-usual activities.

5.9 The ICB supports and encourages open and transparent reporting by Providers to the following systems and forums: -

- Learning From Patient Safety Events (LFPSE) national system
- Risk conversations
- System learning
- Local response groups
- Soft Intelligence
- Freedom to speak up.

5.10 The ICB Freedom to Speak Up Guardian will assist with promoting an open and transparent culture of speaking up, listening, and following up thereby improving the working experience of our staff.

5.11 Freedom to Speak Up Ambassadors will support the Freedom to Speak Up Guardian, as a point of contact for individuals who require advice, and to direct individuals to the support available, will signpost, communicate, engage, and promote the Freedom to Speak Up culture.

6.0 Patient Safety Partners

6.1 The Patient Safety Partners (PSP) will work within the ICB and collaborate with PSP's situated/located within health care providers across the Integrated Care System.

6.2 The role of the ICB PSPs will include: -

- Engagement with system wide PSPs to ensure system wide learning.
- Membership of safety and quality committees whose responsibilities could include the review and
- analysis of safety data.
- Involvement in patient safety improvement projects.
- Working with organisation boards to consider how to improve safety.
- Involvement in staff patient safety training.
- Participation of investigation oversight groups.
- Involvement in implementation of the PSIRF

7.0 Addressing health inequalities.

7.1 Staffordshire and Stoke-on-Trent ICB recognise 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.

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

7.3 The PSIRF approach helps support 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.

7.4 The ICB will support all provider organisations to:

- Apply a more flexible approach and intelligent use of data to help identify any disproportionate risk to patients with specific characteristics.
- Explore and respond to issues related to health inequalities as part of the development and maintenance of their patient safety incident response plan.
- Use learning response tools that prompt consideration of inequalities, including when developing safety actions.
- Engage and involve patients, families and staff following a patient safety incident with consideration of their different needs.
- Uphold a system-based approach (not a 'person focused' approach) and ensure staff have the relevant training and skill development to support this approach.

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

8.1 ICB Support for Providers

8.2 PSIRF promotes systematic, compassionate, and proportionate responses to patient safety incidents, anchored in the principles of openness, fair accountability, learning and continuous improvement to reduce risk of associated harm.

8.3 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). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

8.4 The ICB will seek a formative (continuous) understanding of engagement and involvement within our provider organisations. This will be undertaken via a monthly collaborative monthly meeting for NHS Trusts in the Integrated Care System as well as including independent and small Providers.

8.5 ICB patient safety leads will collaborate with their providers to assess whether the systems and processes put in place to respond to patient safety incidents are for the purpose of learning and improvement. They will also support safety improvement where a provider's systems and processes to respond to patient safety incidents are not leading to improvement. This may be through seeking support from colleagues in regional teams or linking with other organisations whose systems and processes are more developed.

8.6 As part of working with those affected by patient safety incidents the ICB will ensure Patient Safety Partners (PSP) are actively involved in contributing to the design of safer healthcare at all levels in an organisation. Advocating for patients, carers, and families to ensure that their perspectives and considerations are prioritised. PSPs can support organisational boards, internal committees and those staff leading safety improvement work in defining, designing, and delivering safety

objectives and monitoring outcomes that are patient centered. The role is to support existing clinicians and governance structures by providing alternative perspectives on safety.

8.7 **ICB Mechanisms**

8.7.1 Learning responses should be managed as locally as possible to facilitate the involvement of those affected by and those responsible for delivery of the service in which the incident or issue relates to. However, where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, ICB's should support the co-ordination of a cross-system response.

8.7.2 All providers must have a process to recognise incidents or issues that require a cross system leaning response. They must use their judgement and seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system. Where there is insufficient capacity, and/or capability, providers must engage early with the ICB, for the right support to be co-ordinated.

8.7.3 The ICB patient safety lead will liaise with relevant providers (and other ICBs if required) to agree how the learning response will be led and managed, how safety actions will be developed and how the implemented actions will be monitored for sustainable change and improvement.

8.7.4 ICB leads appointed to support cross system learning responses must have the required time and training. Training requirements can be found within the patient safety incident response standards.

9.0 Reviewing our providers patient safety incident response policy and plan.

9.1 The ICB will work collaboratively with providers to support development and review of their patient safety incident response plan and policy ahead of formal approval by the provider Board and ICB.

9.2 The agreed lead ICB will be an important collaborator during the development of the patient safety incident response plan. The draft should be shared with all ICBs (including the lead ICB) prior to submission at the organisations Board for internal sign off.

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

9.4 In collaboration with other ICBs, the lead ICB will comment on the draft prior to sign off by the organisation internal Board and help ensure it is robust. A meeting between the provider and ICB(s) may be required to discuss the plan in detail to support the completion of an effective response plan. Following this meeting further revisions of the PSIRP may be required. Where a meeting takes place and it is deemed the PSIRP requires revision, the updated version should be re circulated to the lead ICB for further comment prior to submission to the organisations board for final approval.

9.5 Collaboration during the development of the plan may reduce the need for further meetings. Following this the plan should then be submitted to the organisation's Board for review and agreement. The draft PSIRP should only be submitted to the provider board for final approval when the lead ICB has agreed the draft PSIRP is proportionate and supports a robust level of patient safety incident response. After Board review and agreement, the plan will be re submitted to the ICB's Patient Safety Specialist who will review and send to the ICB Quality Committee followed by sign off at the ICB Board. The checklist in *Appendix 1* will be used to ensure that national criteria for the PSIRP plan are met.

9.6 A formal sign off email will be issued determining a mutually agreed 'go live' date for PSIRF implementation. The ICB cannot sign off any PSIRP without assurance this has first been reviewed and agreed by the provider board. An updated organisational policy should also be completed to support PSIRF sign off. The PSIRP should then be published on the providers website.

9.7 Monitoring and regular review of the PSIRP must form part of the overarching quality governance arrangements.

9.8 For smaller independent providers (such as Independent providers of NHS care under a NHS contract e.g. Care Homes and Hospices, Private funded Hospitals and Independent Mental Health, Learning Disability and Autism Provision,) ICB's will need to ensure as part of the sign-off process they can demonstrate that full organisational data has been reviewed in order to determine a workable incident response plan which prioritises significant risks for more robust and detailed systems based responses (e.g. PSII).

9.9 Additionally, there must be a rationale for determining which incident types will be responded to using alternative methods, and how decision will be made for an unexpected incident which is not represented by the plan but offers significant opportunities for learning and system improvement.

9.10 For some smaller providers, who typically report a very small number of incidents annually, a patient safety incident response plan may not be required. Where a full PSIRP is not intended to be completed this will be agreed with the ICB as soon as possible during the PSIRF preparation. However, where provider and ICB agree a full PSIRP is not required, that organisation should update their incident management policy to incorporate PSIRF and the incident response process.

9.11 For larger independent providers, who may also have standard contracts with multiple ICBs, one PSIRP may be appropriate for the entire organisation. Providers will need to co-ordinate with the ICBs involved to determine which ICB is best placed to collaborate in the development of and to sign off the plan to enable transition to PSIRF. The provider should inform each ICB of how they intend to produce their plan for the whole organisation.

9.12 Any associated PSIRF implementation papers taken to the organisations public boards should be shared with the ICB. Each organisation may wish to invite the ICB to attend any governance discussions or internal meeting where the PSIRP is presented for internal sign off. This will help evidence PSIRF preparedness.

10.0 Supporting the effectiveness of systems to achieve improvements (oversight)

10.1 When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures". To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (e.g., panels to declare or review Serious Incident investigations)."

10.2 Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control.

10.3 Specific knowledge and experience are required for those leading learning responses and those in oversight roles; this includes knowledge of systems thinking and system-based approaches to learning from patient safety incidents.

10.4 Those involved in the quality assurance of patient safety incident response (i.e., provider boards/executive leads) must have the knowledge to constructively challenge the strength and feasibility of safety actions to improve underlying system issues. They must be able to recognise when the proposed safety actions following a patient safety incident response do not take a system-based approach; for example, where they inappropriately focus on revising policies without understanding 'work as done' or involve self-reflection for certain individuals rather than reviewing wider system influences.

10.5 Those in system oversight roles (i.e., provider board PSIRF lead(s), ICB PSIRF leads, the Care Quality Commission (CQC) relationship managers and inspectors) must have knowledge of effective oversight and supporting processes, including effective use of data for assurance and patient safety incident response system development.

10.6 SSOT ICB staff in oversight roles will therefore be appropriately trained to support the practical application of PSIRF oversight principles and standards.

10.7 The ICB will implement a system designed to allow all organisations to demonstrate improvement, rather than compliance with mandated prescriptive measures. This system will be based upon the following principle as advocated in NHSE oversight roles and responsibilities specifications:

1. **Focus on Improvement**
   PSIRF oversight should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.

2. **Blame restricts insight.**
   Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.

3. **Learning from patient safety incidents is a proactive step towards improvement.**
   Responding to a patient safety incident for learning is an active strategy towards continuous improvement, not a reflection of an organisation having done something wrong.

4. **Collaboration is key.**
   A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.

5. **Psychological safety allows learning to occur.**
   Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.

6. **Curiosity is powerful.**
   Leaders have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

10.8 Following the launch of PSRIF by all providers the PSIRF Implementation group will step down and be replaced by:

- Monthly PSIRF Check in meeting between the PSIRF lead for the ICB and the PSIRF lead for each provider Where collaboration will continue. (See appendix 2 for Standards to guide ICBs from NHSE)
- A bi-annual PSIRF System learning Group with all providers to share learning and improvement and review of plans where indicated.
- Resources and training to support oversight.
- ICB PSIRF Leads will be required to have the required skills and competencies in system-based approaches to learning from patient safety incidents and oversight. To do this, the ICB and its three main providers have sourced training from the same provider and adhered to the guidance in NHSE Patient Safety Incident Response Standards.

10.9 This has been undertaken within the NHS Training Procurement Framework where training providers were identified.

10.10 All ICB staff who will be involved in the oversight of PSIRF will have undertaken the Patient Safety Syllabus Level 1 and 2 and all will have completed *Systems approach to learning from patient safety Incidents*, *Oversight of learning from patient safety incidents* and *Involving those affected by*

patient safety incidents in the learning process training by December 2023. Determinations related to annual updates for those staff will be agreed in the 2023/2024 year. See training matrix Appendix 3.

11.0 Responding to cross-system incidents/issues.

11.1 Learning responses should be managed as locally as possible to facilitate the involvement of those affected by and those responsible for delivery of the service in which the incident or issue relates to. However, where a response involving multiple providers and/or services across a care pathway is too complex for a single provider to manage, the ICB will support the co-ordination of cross-system response.

11.2 All providers within the system are asked to ensure that they have a process to recognise incidents or issues that require a cross-system learning response. Then they will be asked to their judgement and seek the views of local partners to ensure learning responses are co-ordinated at the most appropriate level of the system.

11.3 Where there is insufficient capacity and/or capability, providers must engage early with the ICB, who will identify the right person to support the co-ordination of a cross-system learning response.

11.4 The ICB lead will liaise with relevant providers (and other ICBs if necessary) to agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

11.5 The ICB and its providers will work together to establish and undertake cross-system learning responses. Where issues arise if these cannot be resolved within the system escalation will be required to the NHS England regional teams to ensure such responses are delivered as required.

11.6 The ICB will support its partners and other providers in ensuring that timescales are set for all response methods ensuring that a response is commenced as soon as possible after the event and that it is usually completed within 1 to 3 months.

11.7 **Local maternity and neonatal system (LMNS)** LMNSs provide a crucial role in supporting improvement and facilitating review of patient safety incident responses within maternity and neonatal incidents. The ICB will ensure that provider organisations demonstrate their commitment to engaging with LMNSs and other local networks as key stakeholders within their patient safety incident response plan. In addition, providers organisations should use their LMNS and support networks to facilitate review of incident responses between peers supporting the learning from each other's incident response approaches.

11.8 **Infection Prevention and Control (IPC)** NHS Midlands have developed an Infection Prevention and Control Patient Safety Incident Response Framework Matrix. The plan is for this to be a Midlands wide framework and guidance, with the option to review and refine as we move forward with a full review of the document as a minimum annually. The current version must always be referred to.

11.9 Alignment of IPC with the PSIRF does not impact or change current methods of mandatory reporting through the HCAI Data Capture System of key alert infections such as MRSA, E. coli, Pseudomonas aeruginosa, Klebsiella, MSSA bacteraemia's and C. difficile. There remains a zero tolerance for MRSA bacteraemia and thresholds in place for C. difficile and the Gram-Negative bacteraemia.

11.10 Residential Homes, the ICB recognises the challenge of implementation of PSIRF for smaller organisations however is keen to ensure parity for all NHS Patients in the period 2024/2025 the ICB will work with a pilot group of Residential homes who care for patients under an NHS Contract to develop a PSIRF process which ensure the principles of PSIRF are attained in these areas.

12.0 Supporting High Profile Cases

12.1 When there is a possibility of high-profile incidents or issues that are likely to attract media attention (e.g., due to the nature, size, and scale of the incident) the ICB communication team will liaise with the relevant provider/stakeholders to co-ordinate communication activities and a joint response.

12.2 The ICB have connections with local safeguarding leads, local authorities, police etc. There are several strategic forums and links whereby discussions and responses can be co-ordinated.

12.3 NHS Trusts are encouraged to advise the ICB Chief Nursing and Therapies Officer when potentially high-profile incidents occur to ensure the ICB quality team can offer support.

13.0 Responding to patient safety incidents for those providers not currently using the PSIRF process.

13.1 Primary Care and some small providers will remain under the Serious Incident Framework until it is decided that they will transition onto PSIRF.

13.2 All patient safety incidents will be reported onto the national reporting platform, LFPSE. All Serious Incidents will continue to be reported onto STEIS until this system is disbanded.

13.3 Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
  - Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death, and homicide by a person in receipt of mental health care within the recent past.
  - Unexpected or avoidable injury to one or more people that has resulted in serious harm.
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional to prevent: the death of the service user; or serious harm.
  - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery where:
  - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.
  - This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR) Child Death Overview Panel (CDOP), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation LeDeR as well? where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information).

14.0 Complaints and Appeals

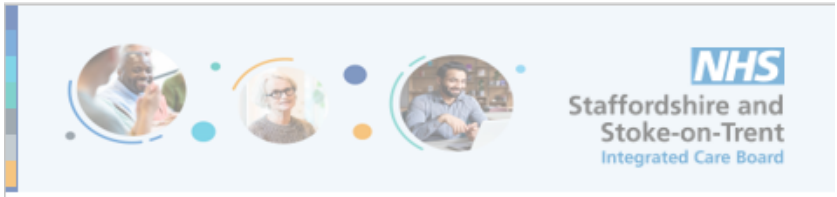
14.1 Staffordshire and Stoke-on-Trent ICB recognise that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided or commissioned.

14.2 It is important to understand that there is a distinction between complaints and concerns and that someone expressing a concern may not automatically mean they wish to enter the complaints process.

14.3 Complaints can be valuable in developing standards of care and that 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.

14.4 The ICB is committed to dealing with any complaints that may arise as effectively as possible and will ensure all complaints and concerns received are managed in line with the ICB's Complaints process. Patient advice and liaison service / complaints - Staffordshire and Stoke-on-Trent ICB

Appendix 1 Provider Policy and Plan checklist



Staffordshire and Stoke-on-Trent Integrated Care Board
Patient Safety Incident Response Framework
Provider Policy and Plan Assurance Checklist

Provider		Draft ☐ Final versio ☐ PSIRF Policy ☐ PSIRF Plan ☐
Date Reviewed	Click or tap to enter a date.	
Reviewer Title		

If Final Version	
Review undertaken by:	Date Click or tap to enter a date.
Committee Approval by:	Date: Click or tap to enter a date.

Status	
1. **Approved** with no minor amendments suggested.	☐
2. **Approved** with minor typographical errors for correction.	☐
3. **Approved** with minor amendments suggested.	☐
4. **Not Approved:** Failure to meet standards needs full review, see comments.	☐
5. **Not Approved:** Some essential requirements missing needs specific review, see comments.	☐

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NHS Staffordshire and Stoke-on-Trent Integrated Care Board

General Feedback
Must include page number and paragraph/section number if applicable:

2 | Provider PSIRF Plan and Policy review V1

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Standard Feedback and Comments	
Standard	**Feedback**
Patient safety incident response policy standards Providers are required to create a patient safety incident response policy that describes the systems and processes they have in place to learn and improve following a patient safety incident. Creating the right foundations for effective incident response is critical. Where patient safety incident response standards are not met at the time the policy is approved, an achievable roadmap for meeting these must be set out.	
Patient safety incident response plan standards Providers are required to create a patient safety incident response plan that describes how they intend to respond to patient safety incidents, including the methods to be applied and rationale.	Has done through review of safety incident profile

Standard Feedback and Comments	
Oversight Oversight under PSIRF focuses on engagement and empowerment rather than more traditional command and control. When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures".	
Oversight Roles and Responsibilities Here	
Oversight Approach The following principles should be considered when designing and maintaining PSIRF oversight systems and processes, including when designing or using any metrics or questions implemented for patient safety incident response oversight.	
Competence and Capacity	

Standard Feedback and Comments	
Engagement and Involvement of those affected by patient safety incidents.	
Meaningful involvement of those affected in a learning response. When a learning response takes place, those affected should be involved in a meaningful way. The following standards are endorsed for all learning responses but must be upheld where a patient safety incident investigation is undertaken.	
Proportionate responses	
Cross-system responses	
Safety Action and Improvement Organisations are required to develop safety actions to address areas for improvement identified in learning responses. Safety actions can relate to the local context or broader system issues.	

Appendix 2. Questions to guide ICB understanding the effectiveness of provider learning response systems

taken from Oversight-roles-and-responsibilities NHSE

Oversight Questions	
Engagement and involvement of those affected by patient safety incidents	▪ What is the provider's understanding of engagement and involvement? ▪ What improvement work is ongoing to facilitate quality engagement and involvement? Is there evidence of continuous work in progress? ▪ Is compassionate engagement equitable for all? ▪ How extensive is the evidence of a just culture (e.g., does 'blame', or focusing on individual actions or omissions in investigations still occur)? ▪ What do external data sources (e.g., NHS staff survey, GMC training survey, Health Education England (HEE) reviews) say about staff experience? ▪ Is the organisation aware of its successes and challenges Regarding staff support in response to incidents?
Policy, planning and governance	▪ Is the patient safety incident response plan being updated as required and in accordance with emerging intelligence and Improvement efforts? ▪ Does the patient safety incident response plan accurately address the known patient safety-related challenges for this organisation? ▪ Is patient safety and improvement work across the organisation aligned? ▪ Is work progressing to fulfil any gaps identified in meeting national patient safety incident response standards? ▪ What learning is emerging through collaborative external (peer) review? How is this contributing to improvement? ▪ What is the quality management process for the outputs of patient safety incident response (e.g., PSII reports)? ▪ Does quality management involve key stakeholders (e.g., safety experts, patient safety partners, staff representatives)?
Competence and capacity	▪ Are oversight training and competence requirements met within the ICS? ▪ Can the organisation describe its capacity to effectively deliver its patient safety incident response plan? ▪ Is staff time protected or dedicated full-time roles in place for patient safety incident response? Do the organisational stakeholders (e.g., patient safety partners, clinical teams, support staff) have continuous professional development opportunities to enable them to participate effectively? ▪ Can the organisation describe where the capacity is to implement improvement based on patient safety incident response? ▪ Are learning response leads empowered to act independently? ▪ Is access to expertise and support provided?

Proportionate responses	▪ Is the organisation's leadership clear in communicating to teams that an individual learning response should not be conducted for every incident that results in moderate or more severe harm? And do leaders support teams where this policy is challenged? ▪ Is there evidence that teams are attempting to conduct a learning response to every incident, and therefore resources are spread too thinly? ▪ Are there opportunities for teams to learn from when things do and do not go well? ▪ Is there evidence of filtering or censorship of findings or suggested improvements? ▪ Is learning and improvement work adequately balanced? (i.e., balance of horizon scanning, thematic work, and individual learning responses) ▪ Are learning responses completed in a timely manner in line with expectations of those affected?
Safety actions and improvement	▪ Is learning triangulated across the range of incident response methods used to inform improvement? ▪ Can the organisation describe safety improvement in progress, what they aim to achieve and their interim successes and challenges? ▪ What is the provider board doing to support local teams on challenges in patient safety improvement?

Appendix 3 Training Matrix

Topic	Minimum duration	Content	Learning response leads	Engagement leads	Those in PSIRF oversight roles
Systems approach to learning from patient safety Incidents	2 days/12 hours	• Introduction to complex systems, systems thinking and human factors • Learning response methods: including interviewing and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews • Safety action development, measurement, and monitoring	✓		✓
Oversight of learning from patient safety incidents	1 day/6 hours	• NHS PSIRF and associated documents • Effective oversight and supporting processes • Maintaining an open, transparent and improvement focused culture • PSII commissioning and planning			✓
Involving those affected by patient safety incidents in the learning process	1 day/6 hours	• Duty of Candour • Just culture • Being open and apologising • Effective communication • Effective involvement • Sharing findings • Signposting and support		✓	✓
Patient safety syllabus level 1: Essentials for patient safety	eLearning	• Listening to patients and raising concerns • The systems approach to safety: improving the way we work, rather than the performance of individual members of staff • Avoiding inappropriate blame when things don't go well • Creating a just culture that prioritises safety and is open to learning about risk and safety	✓	✓	✓
Patient safety syllabus level 2: Access to practice	eLearning	• Introduction to systems thinking and risk expertise • Human factors • Safety culture	✓	✓	✓
Continuing professional development (CPD)	At least annually	• To stay up to date with best practice (eg through conferences, webinars, etc) • Contribute to a minimum of two learning responses	✓	✓	✓