

# Patient safety incident response policy

NHS Somerset Integrated Care Board

Published November 2023 v1.7

Reviewed and updated November 2025

	Name	Title	Date
Author	Jennie Tuffin	Quality Improvement Facilitator for Patient Safety	Nov 2023
Reviewer	Emma Savage	Deputy Director of Quality & Improvement	Nov 2023
Authoriser	Shelagh Meldrum	Chief Nursing Officer & Chief Operating Officer	Nov 2023

Version	Updated by	Approved at	Date
2	Quality Governance and Patient Safety Facilitator		

## Contents

1. Introduction .....	4
2. Purpose .....	4
3. The Patient Safety Incident Response Framework (PSIRF) .....	5
3.1. Who does PSIRF apply to? .....	6
3.2. Secondary care providers that are not NHS Trusts .....	6
4. PSIRF organisational roles and responsibilities .....	6
4.1. NHS England national team .....	6
4.2. NHS England regional team .....	6
4.3. Integrated Care Boards .....	6
4.4. Providers of NHS-funded care .....	7
4.5. Local Maternity and Neonatal System (LMNS) .....	7
4.6. Care Quality Commission (CQC) .....	8
4.7. Healthcare Services Safety Investigation Body (HSSIB) .....	8
4.8. Maternity and Newborn Safety Investigations (MNSI) .....	8
4.9. Patient Safety Partners (PSPs) .....	8
4.10. Safeguarding .....	8
5. NHS Somerset and the principles of PSIRF .....	9
5.1. Compassionate engagement and involvement of those affected by patient safety incidents including patients, families, carers and staff .....	9
5.2. Application of a range of systems-based approaches to learning from patient safety events .....	10
5.3. Considered and proportionate responses to patient safety events .....	10
5.4. Supportive oversight focused on strengthening response system functioning and improvement .....	10
6. NHS Somerset PSIRF process .....	11
6.1. ICB Patient Safety Specialists (PSS) .....	11
6.3. Responsibility when PSIR plans are challenged .....	12
6.4. Co-ordination of cross-system learning responses .....	12
6.5. PSII interface with other types of review and/or investigation .....	14
7. Management of Mental Health Homicide (MHH) investigations .....	15
8. Sharing and dissemination of learning across the system .....	16
9. Approach to managing serious incidents alongside implementing PSIRF .....	17

9.1. Quality assurance and closure of serious incidents that remain open after PSIRF implementation .....	17
9.2. Monitoring of action plans for serious incidents that were reported under the SIF .....	17
10. NHS Somerset patient safety training requirements .....	17
10.1. Training procurement framework .....	18
10.2. Patient Safety Syllabus .....	18
10.3. Training requirements for those in PSIRF oversight roles .....	18
11. Update and review .....	19
12. Appendix 1: Overview of organisational responsibilities .....	20
13. Appendix 2.1: Priorities for PSII review .....	21
14. Appendix 2.2: National event response requirements table .....	22
15. Appendix 3: Training requirements table .....	24
16. Appendix 4: Patient safety event response pathway .....	26
17. Appendix 5: Patient safety event process wheel .....	27
18. Appendix 6: Mental Health Homicide (MHH) management process .....	28
19. Appendix 7: NHS Somerset ICB's incident management process .....	29
20. Appendix 8: NHS Somerset overview of meeting governance .....	30

## 1. Introduction

This policy supersedes the previous responsibility of NHS Somerset as commissioners in providing oversight for provider organisations for whom the Serious Incident Framework (SIF) 2015 applied.

In August 2022 NHS England published the Patient Safety Incident Response Framework (PSIRF). PSIRF is a key part of the NHS Patient Safety Strategy and supports the strategy's aim to help the NHS to improve its understanding of safety by drawing insight and learning from patient safety events.

The PSIRF replaces the SIF and makes no distinction between 'patient safety events' and 'serious incidents.' Serious incidents and their associated thresholds no longer exist under PSIRF. PSIRF promotes a proportionate approach to responding to patient safety events by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

All organisations providing NHS-funded care nationally are expected to adopt PSIRF as part of the NHS standard contract.

It should be acknowledged that this policy was reviewed during a period of national NHS transition and uncertainty regarding ICB functions. Consequently, any future national guidance or changes in priorities may necessitate amendments to this policy.

## 2. Purpose

This document sets out the general principles and processes for the management of patient safety events (PSEs) occurring within services commissioned by NHS Somerset Integrated Care Board (NHS Somerset/the ICB).

Adherence to this policy supports provider organisations and the Somerset system to transition from the SIF to PSIRF.

This policy defines the responsibilities of NHS Somerset as commissioners in the development and monitoring of the individual provider organisations' Patient Safety Incident Response Plans (PSIRPs). As well as the responsibilities of the ICB for those organisations who continue to investigate historical serious incidents under the SIF.

This policy should be read in conjunction with the following guidance:

- [Revised Never Events policy and framework](#)
- [Never Events list](#)
- [The Patient Safety Incident Response Framework 2022 NHS England \(2022\) and its supporting guidance](#)
- [NHS England » Engaging and involving patients, families and staff following a patient safety incident](#)
- [Framework for involving patients in patient safety \(June 2021\)](#)

- [The NHS Patient Safety Strategy](#)

### 3. The Patient Safety Incident Response Framework (PSIRF)

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

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

PSIRF shifts how the NHS responds to patient safety events for learning and improvement. Unlike the SIF, 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 events. PSIRF embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

PSIRF focusses on improved engagement with those affected by an incident, including patients, families and staff. Ensuring they are treated with compassion and are able to be part of any investigation. The guide to engaging and involving patients, families and staff following a patient safety incident<sup>1</sup>, published alongside PSIRF, sets out expectations for how provider organisations should engage with all those affected by patient safety incidents. Provider organisations should work hard to answer any questions and to involve those affected in patient safety incident investigations.

Provider organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes. To achieve this, each organisation must collect and triangulate data from a wide variety of sources and collate information via a wide stakeholder engagement exercise. The output of this patient safety incident response planning exercise is used to inform the selection of a proportionate response when something goes wrong. This may include a response to generate safety actions for improvement where this does not already exist, or to ensure that a safety improvement plan is put in place where learning from patient safety incident response has already been identified.

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

The principles and practices endorsed by PSIRF are aligned with the National Patient Safety Strategy and wider initiatives under the strategy including:

---

<sup>1</sup> [Engaging and involving patients, families and staff following a patient safety incident](#)

- the introduction of Patient Safety Specialists<sup>2</sup>
- the development of a National Patient Safety Syllabus<sup>3</sup>
- development of the Involving Patients in Patient Safety framework<sup>4</sup>
- and the introduction of the Learn from Patient Safety Events (LFPSE) service<sup>5</sup> (the successor to the National Reporting and Learning System (NRLS)).

### 3.1. Who does PSIRF apply to?

PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract. This includes both secondary and primary care services, though as of November 2025 a national PSIRF pilot remains ongoing within primary care.

### 3.2. Secondary care providers that are not NHS Trusts

Organisations that provide NHS-funded secondary care under the NHS Standard Contract but are not NHS Trusts or Foundation Trusts (e.g. independent provider organisations) are required to adopt this framework for all aspects of NHS-funded care and may apply this approach to their other services for consistency. These organisations may not need to undertake the full analysis required for patient safety incident response planning (e.g. due to organisation size and limitations on data availability), however processes such as stakeholder engagement in preparing plans and applying PSIRF principles when updating governance arrangements are required.

## 4. PSIRF organisational roles and responsibilities

See [appendix 1](#) for further details.

### 4.1. NHS England national team

NHS England's national team oversee the activity of regional teams to support effective response to patient safety events, providing strategic direction and leadership while monitoring effectiveness of PSIRF.

### 4.2. NHS England regional team

NHS England's regional teams support ICB PSIRF leads with the learning system within NHS England and NHS Improvement. They support co-ordination of system-wide responses to patient safety events while identifying events that may require centrally co-ordinated and independent patient safety incident investigation.

### 4.3. Integrated Care Boards

ICBs collaborate, develop and agree provider PSIR policies and plans while overseeing effectiveness of system response to patient safety events, offering co-ordination support in system-wide patient safety incident investigation, and sharing outcomes system-wide to continuously improve safety.

---

<sup>2</sup> [NHS England » Patient Safety Specialists](#)

<sup>3</sup> [Patient Safety | NHS England | Workforce, training and education](#)

<sup>4</sup> [Framework for involving patients in patient safety](#)

<sup>5</sup> [NHS England » Learn from patient safety events \(LFPSE\) service](#)

Further information pertaining to the ICB's statutory requirements for quality include:

- Support GP, dental, optometry and community pharmacy services to undertake relevant incident response. Support the relevant incident response in relation to NHS-funded patients in other relevant healthcare sectors (e.g. independent, CHC).
- Ensure there is a system in place to support the processing of the SI backlog identified during transition from CCG to ICB.
- Continue oversight of patient safety incident response in line with SIF, whilst transitioning to fulfil oversight requirements of PSIRF.
- Collaborate with providers in the development, maintenance, and review of the provider Patient Safety Incident Response Policies and Plans.
- Agree provider Patient Safety Incident Response Policies and Plans.
- Oversee and support effectiveness of systems in place in achieving improvement following patient safety incidents.
- Support co-ordination of cross-system Patient Safety Incident Investigations (PSIIs).
- Share insights and information across organisations/services to improve safety.
- Investigations of deaths of people with a learning disability or autistic people are managed in line with PSIRF and not as part of LeDeR which is not an investigatory process but a service and quality improvement process.

It will be the role of NHS Somerset's Quality Committee to oversee the risks to, and the improvements made in regard to, patient safety. The Somerset System Quality Group (SQG) will have a role in overseeing any high level system risks with regards to patient safety.

#### 4.4. Providers of NHS-funded care

Ensure organisations meet national patient safety incident response standards<sup>6</sup> with PSIRF central to governance arrangements, while receiving assurance of learning response outputs.

During early 2023, as part of NHS Somerset's orientation phase of implementing PSIRF, the ICB engaged with independent, charitable and voluntary and community sector organisations. Some of these provider organisations joined the ICB for final PSIRF training or sought their own training through a PSIRF training provider.

There should be an understanding between provider organisations and the ICB that the ICB should be notified as soon as possible of any patient safety events that occur where there is a risk of media attention or reputational damage.

#### 4.5. Local Maternity and Neonatal System (LMNS)

The Somerset LMNS and other local support networks play a crucial role in supporting improvement and facilitating review of patient safety incident responses. The ICB should ensure that partner organisations demonstrate their commitment to engaging

---

<sup>6</sup> [NHS England » Patient safety incident response standards](#)

with the LMNS and other local support networks as key stakeholders within their Patient Safety Incident Response Plan. In addition, partner organisations should use their LMNS and support networks to facilitate review of incident responses between peers. This will support organisations to learn from each other's incident response approaches, reduce the risk of organisations becoming isolated, and help to bring a level of standardisation regarding how patient safety events are reviewed.

#### 4.6. Care Quality Commission (CQC)

The CQC's assessment of a provider's leadership and safety considers an organisation's ability to respond effectively to patient safety events, including consideration of whether change and improvement follow its response to patient safety events. CQC teams will apply the PSIRF and associated patient safety incident response standards as part of their assessment of the strength of an organisation's systems and processes for preparing for and responding to patient safety events.

#### 4.7. Healthcare Services Safety Investigation Body (HSSIB)

HSSIB investigations identify the contributory factors that have led to harm or have the potential to cause harm to patients. HSSIB recommendations aim to improve healthcare systems and processes to reduce risk and improve safety. HSSIB aims to improve patient safety through effective and independent investigations that do not apportion blame or liability.

#### 4.8. Maternity and Newborn Safety Investigations (MNSI)

The Maternity and Newborn Safety Investigations (MNSI) programme is part of a national strategy to improve maternity safety across the NHS in England, it is hosted by the Care Quality Commission (CQC). All NHS trusts are required to tell the MNSI about certain patient safety incidents that happen in maternity care. The MNSI carry out independent investigations and where relevant, make safety recommendations to improve services at local level and across the whole maternity healthcare system.

#### 4.9. Patient Safety Partners (PSPs)

In line with the NHS Patient Safety Strategy, the NHS is committed to the ongoing employment of two PSPs, who play an important role during oversight committees where patient safety events or concerns are discussed. More information is provided in the Framework for involving patients in patient safety.

#### 4.10. Safeguarding

Everyone has the right to live their lives free from abuse, neglect, violence and exploitation. Some people, because of their circumstances, may not be able to exercise this right and are unable to protect themselves from abuse and neglect.

The ICB has a duty to take appropriate steps to support and protect babies, children, young people and adults who may be at risk of abuse or neglect. As part of a response to any patient safety event, it is expected that any safeguarding concerns will be identified and that the appropriate response will be provided in line with:

- the provider's own safeguarding policies and procedures;

- and the ICB's safeguarding policies and procedures.

When any patient event raises concern about abuse or neglect arising from the actions of paid staff, the employing organisation will follow their own policy and procedure for responding to allegations made against staff. This must include consideration of whether to refer to the Local Authority's Designated Officer for children.

For adults, the organisation will consider whether to refer to the council officer responsible for overseeing allegations made against people in positions of trust.

In the ICB, we ensure we are able to discharge our duties to respond to safeguarding concerns that arise from a patient safety incident, by providing ICB lead or designated professional oversight of all relevant patient safety events and appropriate attendance at system partner meetings. The lead and designated professionals also provide information and advice on responding to concerns about abuse or neglect.

## 5. NHS Somerset and the principles of PSIRF

NHS Somerset is aligned to the development and maintenance of an effective patient safety incident response system across Somerset which integrates four key aims:

### 5.1. Compassionate engagement and involvement of those affected by patient safety incidents including patients, families, carers and staff

NHS Somerset will ensure that PSIR plans and policies developed by Somerset organisations seek to work with those affected by patient safety incidents and involve them meaningfully in the investigation process.

NHS Somerset promotes and embraces a just culture to ensure that staff are treated fairly and appropriately following patient safety events. When providing system oversight for patient safety reviews and investigations, NHS Somerset will ensure that processes for the engagement with staff are in place and used to inform investigations.

When considering provider organisations' PSIR plans, NHS Somerset 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 events 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 events.

NHS Somerset will have its own guidance on how to meaningfully involve those affected by patient safety incidents, for occasions when the ICB manages or facilitates a learning response.

## 5.2. Application of a range of systems-based approaches to learning from patient safety events

PSIRF promotes a range of systems-based approaches for learning from patient safety events, rather than methods that assume simplistic, linear identification of a single cause.

Several national systems-based learning response tools and guides<sup>7</sup> have been developed to encourage a systems-based approach, which explores contributory factors in relation to patient safety events to inform improvement. NHS provider organisations are encouraged to apply national tools or similar systems-based equivalents.

NHS Somerset will ensure that PSIR plans detail the provision of education and training for staff to ensure that they have the specific knowledge and experience required to lead patient safety incident investigations or reviews. NHS Somerset will also ensure that those involved in the oversight of PSIRF have the knowledge and skills required to undertake this role effectively.

As a Somerset system, we collaborated together when the PSIRF was published in August 2022, engaging with system partners, project managing the roll out of PSIRF, and arranging training.

## 5.3. Considered and proportionate responses to patient safety events

NHS Somerset recognises that organisations have finite resources available for patient safety incident response. PSIRF supports organisations to use their incident response resources to maximise improvement, rather than repeatedly responding to patient safety events based on subjective thresholds and definitions of harm, where limited new learning is possible.

If an organisation is satisfied that improvement work is ongoing to address known contributory factors in relation to an identified patient safety event, and that safety actions are being monitored, it is acceptable to not undertake a detailed investigation into an incident other than engaging with those affected and recording that it occurred.

## 5.4. Supportive oversight focused on strengthening response system functioning and improvement

NHS Somerset will work collaboratively, with a common understanding of the aims of the PSIRF, to provide an effective governance structure around the Somerset system response to patient safety events.

NHS Somerset will facilitate collaboration at both place and local system level to support provider PSIR plans to be strong and effective.

---

<sup>7</sup> [NHS England » Patient safety learning response toolkit](#)

## 6. NHS Somerset PSIRF process

### 6.1. ICB Patient Safety Specialists (PSS)

NHS Somerset has three PSSs who work collaboratively with system partners to offer patient safety leadership and facilitate escalation of patient safety concerns.

The PSSs are responsible for developing, maintaining and reviewing our Somerset providers' Patient Safety Incident Response Policies and Plans.

NHS Somerset's PSSs work as an integral collaborator with system providers to:

- review the application of the national PSIRF standards;
- establish roles, responsibilities, and structures for oversight within the system;
- and establish mechanisms for escalation of incidents and risks that may require support or action at system or regional level.

NHS Somerset, when considering PSIR plans, must ensure that it is clearly stated how the provider organisation intends to deliver an effective response to patient safety events. The response methods the organisation intends to use to respond to patient safety events for the purpose of learning and improvement must also be detailed.

The designated ICB PSSs will work collaboratively with partners across the system as they develop and review their PSIR plans to:

- understand the patient safety incident and improvement profile of provider organisations;
- support the selection of appropriate response methods for anticipated patient safety events based on an understanding of potential for new learning and ongoing safety improvement work;
- and support provider organisations to work in collaboration to identify themes and trends across the wider system to inform learning.

### 6.2. Agreement of provider Patient Safety Incident Response Policies and Plans

NHS Somerset is required to approve and sign off the incident response Policies and Plans for provider organisations in their system. Approval of an organisation's Policy and Plan demonstrates NHS Somerset's acknowledgement that the documents have been developed according to PSIRF guidance and meet (or demonstrate a plan to meet) PSIRF standards.

NHS Somerset's PSSs, PSPs and quality leads will collaborate with partner organisations to assess whether the systems and processes put in place to respond to patient safety events have achieved demonstrable improvement.

Considerations for ICB oversight includes ensuring:

- patient safety response teams are being trained/resourced appropriately and in line with standards;
- responses to patient safety events are timely;

- the experience of those affected is sought and is positive/improving (e.g. via verbal feedback, interviews, review of complaints data, survey response);
- incident response output is high quality (e.g. blame is avoided, contextual factors are prioritised);
- areas for improvement and safety actions identified are systems-based;
- evidence that insight from incident response is being used to inform improvement (locally, across the system, and nationally as appropriate);
- safety improvement plans are being strategically developed (e.g. is there strategic alignment with other areas of the business/QI strategy?);
- a clear plan for criteria of incidents requiring Patient Safety Incident Investigation (PSII) including nationally defined incidents, (see appendix [2.1](#) and [2.2](#)).

### 6.3. Responsibility when PSIR plans are challenged

Where a partner's systems and processes for responding to patient safety events are challenged, NHS Somerset will provide support for safety improvement. This may be through seeking support from colleagues in regional teams, by sharing expertise or by linking with other organisations whose systems and processes are more developed.

Where a provider organisation or NHS Somerset identifies a recurrent theme of patient safety events occurring and ongoing improvement work does not appear to be having the desired effect, the ICB can offer collaborative improvement support. Decision may also be taken to escalate the issue via the National Quality Board's risk response and escalation framework<sup>8</sup>. Where possible, this decision should be made in collaboration between the provider organisation and NHS Somerset.

### 6.4. Co-ordination of cross-system learning responses

Sometimes there is more than one organisation involved in the care and service delivery in which a patient safety event has taken place, all providers must have a process in place to recognise events that require a cross-system learning response.

If an organisation identifies such an event, that organisation is responsible for recognising the need to alert other relevant partners, including the ICB/other commissioners and partner organisations. The incident should be sent to the relevant partners as soon as possible and NHS Somerset can support with this process if needed.

A lead organisation should be identified to coordinate the learning response. The ICB can facilitate discussion regarding which is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

However, where an incident involving multiple providers and/or services across a care pathway is too complex or costly to be managed by a single provider, NHS Somerset will support the co-ordination of a multi-disciplinary learning review.

---

<sup>8</sup> [National Guidance on Quality Risk Response and Escalation in Integrated Care Systems](#)

When requested, all partners are expected to respond and participate in multi-disciplinary learning reviews. 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 learning review will focus on identifying learning with a no blame approach. It will be a confidential and honest space for the providers (and where appropriate, family members or representatives) involved in the patient safety event to get together. The review is a space to discuss the patient's journey, recognise any good practice, identify gaps in care and support, and distinguish learning that can drive improvements, together as a system.

The review will be facilitated by an appropriate Chair, with an aim to answer the following:

- What could we have done less of?
- What could we have done more of?
- What do we want to start doing?
- What do we want to keep doing?
- What themes and risks have we identified?
- Next steps

The review may not result in a standard investigation report, but what is discussed at the review will be captured in an appropriate way and shared with attendees.

Recommendations and actions to help support people with similar complex needs from experiencing similar safety issues in the future will be agreed during the review and articulated within an action plan. All those taking part in the review will be asked to take ownership to ensure the implementation and monitoring of these within their own organisations.

NHS Somerset will share the learning via internal governance processes and encourage providers to do the same. NHS Somerset may share the learning wider, i.e. across the county, region, or with NHSE to share nationally, but will ensure that what is shared is anonymised and non-identifiable.

NHS Somerset may choose to revisit the recommendations and actions with those who attended the learning review in due course, to understand how the learning has been embedded and effective at improving patient safety in practice.

NHS Somerset will also ensure that partners have systems in place to support a co-ordinated and measured, systems-based response to high profile or complex events, such as Mental Health Homicides (MHHs).

NHS England regional teams are available to provide support if challenges arise (see NHS England and NHS Improvement responsibilities in [appendix 1](#)).

### 6.5. PSII interface with other types of review and/or investigation

Certain types of patient safety events trigger specific responses described in other legislation (e.g. where a person dies in prison or an incident that affects patients participating in a national screening programme). NHS Somerset is committed to contributing to and supporting system partners to engage in external PSII or investigations led by agencies such as the police, coroners, Health and Safety Executive, HSSIB, MNSI, etc (see appendix [2.1](#) and [2.2](#)).

NHS Somerset acknowledges that there are occasions where the PSIRF processes will coincide with other procedures, such as:

- Domestic Homicide Reviews
- Mental Health Homicides
- Child Safeguarding Practice Reviews
- Child Death Reviews
- Safeguarding Adults Reviews
- or another externally led investigation.

In such circumstances, co-operation and collaborative working between partner agencies is essential for minimising duplication, uncertainty and/or confusion relating to the investigation process. Ideally, only one investigation should be undertaken (by a team comprising representatives of relevant agencies) to meet the needs/requirements of all parties. However, in practice this can be difficult to achieve as investigations may have different aims/purposes which may inhibit joint investigations. The undertaking of parallel processes may also be required by law. Where this is the case, NHS Somerset will make every effort to ensure duplication of effort is minimised. In such cases, discussion should take place to agree how the interfaces between reviews will be managed.

In the event of criminal proceedings, wherever possible, patient safety investigations should continue alongside criminal proceedings to maximise patient safety learning. Any immediate actions required to keep people safe should not be delayed if a delay would mean people experiencing significant and avoidable harm. It is important that any patient safety enquiries do not prejudice any investigations undertaken by agencies who have powers of prosecution. This includes but is not limited to:

- Police
- Care Quality Commission (CQC)
- Office for Standards in Education (Ofsted)
- Medication and Healthcare Products Regulation Agency (MHRA).

If there is a possibility that any agency may be undertaking a process of criminal investigation, the ICB safeguarding team must be contacted for advice.

A request must be sent to any involved agencies to request a strategy meeting to coordinate all investigations. This meeting should clarify and agree which agency has primacy in relation to the investigation. It should also clarify if the patient safety investigation should be put on hold or continued, and under what parameters. If a

decision is made to suspend progress, arrangements to review this position must also be agreed.

It is recognised that the timing of such reviews is not within the control of NHS organisations. However, the NHS has a duty of care to future patients and should therefore not unduly delay any necessary action pending the outcome of separate reviews. This principle should always be applied to any decisions regarding parallel processes. The patient safety event report may be utilised to form the basis of other reports. In these cases a conversation needs to be had as soon as possible between the provider and NHS Somerset to ensure all parties are clear regarding terms of reference and the approach being taken.

## **7. Management of Mental Health Homicide (MHH) investigations**

In April 2013 NHS England (NHSE) became responsible for commissioning independent investigations into homicides (sometimes referred to as Mental Health Homicide reviews) that are committed by patients being treated for mental illness. The purpose of an independent investigation is to review thoroughly the care and treatment received by the patient so that the NHS can:

- be clear about what, if anything, went wrong with the care of the patient;
- minimise the possibility of a reoccurrence of similar events;
- make recommendations for the delivery of health services in the future.

Homicides committed by those in receipt of mental health care have devastating consequences for the family of the victim(s), the patient(s) who committed the homicide, and their families, as well as a profound impact for all parties involved. These events are defined nationally as a priority to be investigated as a PSII (see appendix [2.1](#) and [2.2](#)).

In the event of a MHH, duty of candour must be undertaken, by the reporting organisation, to the patient (alleged perpetrator), the patient's family, and the victim's family. And as with the PSIRF core values, the aforementioned will all be offered the opportunity to participate in each stage of the investigation, to inform system learning.

When a MHH occurs, the event is referred to NHSE's Regional Independent Investigation Team (RIIT) who may choose to commission a regional level independent investigation, or agree that a locally-led PSII is appropriate.

MHHs often require complex, multi-agency collaboration and engagement involving internal and external stakeholders across geographical and organisational boundaries. Where a locally-led PSII is agreed by the RIIT, NHS Somerset will support the provider organisation if required, to engage external organisations and provide investigation support where needed, i.e. terms of reference setting, arranging a multi-agency meeting.

Following completion of any locally-led MHH PSII, the report will be shared with the RIIT who will consider if a further external investigation is needed.

Any independent investigator must be given access to all the information and reports about the alleged perpetrator's care and treatment (within the usual patient confidentiality rules), and can also request interviews with any NHS staff involved.

The criteria for an independent investigation to be carried out is:

- to investigate the care and treatment of patients to establish whether or not a homicide could have been prevented and whether there are lessons for the future;
- to increase public confidence;
- and to provide an assurance framework for organisations providing specialist mental health services.

Where the RIIT agree a PSII should be managed at an independent regional level, the RIIT will:

- commission and manage the investigation in line with the national procurement framework, patient safety incident response standards and independent PSII operating procedures;
- determine the terms of reference for the PSII and ensure that the patient safety incident response standards are followed;
- manage the interface with other statutory investigations and work with other bodies to support a collaborative approach;
- ensure agreement with internal and external stakeholders, including the police, probation, local authorities, Health and Safety Executive, local safeguarding boards and/or other agencies as required regarding:
  - timing of investigations;
  - sharing of information and confidentiality issues;
  - involvement, support and communication with families, carers, staff and the media. The standards outlined in the Engaging and involving patients, families and staff guidance must be upheld;
  - completion and sign-off of the PSII report;
  - PSII report publication strategy (including assessment of the impact of publishing sensitive, confidential, and identifiable information);
  - arrangements for the ongoing monitoring and/or escalation of actions and delivery of improvement;
  - dissemination of learning and subsequent improvement efforts.

Please see [appendix 6](#) for NHS Somerset's MHH process flow chart.

## **8. Sharing and dissemination of learning across the system**

NHS Somerset have a responsibility to ensure that relevant insight and learning from patient safety events is shared and disseminated across the Somerset system, and wider where applicable, in order to promote improvements in care and patient safety.

## 9. Approach to managing serious incidents alongside implementing PSIRF

### 9.1. Quality assurance and closure of serious incidents that remain open after PSIRF implementation

In October 2023, NHS Somerset supported the handover of serious incidents to the reporting providers, meaning the providers took on the responsibility for quality assurance and closure of their serious incidents that remained open after PSIRF adoption. This approach was reviewed and discussed with providers on an individual basis and a formal agreement developed. The ICB chose to retain the quality assurance role for specific serious incidents where required, such as those meeting the never event criteria, and all decisions were formally reviewed by NHS Somerset's Quality Committee.

NHS Somerset has representation at our main provider's (Somerset NHS Foundation Trust) Patient Safety Board, where updates in relation to the sign off and closure of incidents is provided. ICB attendance at other provider organisations' equivalent meetings is also in place.

### 9.2. Monitoring of action plans for serious incidents that were reported under the SIF

NHS Somerset support the approach of handing over the ongoing monitoring of serious incident action plans to the provider, underpinning the principles of PSIRF.

The ICB may choose to retain the monitoring role for specific serious incident action plans where required.

Where actions to mitigate recurrence of a patient safety issue do not appear to be having the desired effect, NHS Somerset may choose to collaborate with the provider to make any necessary interventions for improvement.

## 10. NHS Somerset patient safety training requirements

NHS Somerset recognises that those involved in the review of patient safety events 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 events.

Those involved in the quality assurance of patient safety incident response (i.e. provider boards/executive leads) must have knowledge to constructively challenge the strength and feasibility of recommendations and safety actions to improve underlying system issues. They must be able to recognise when safety actions following patient safety incident response do not take a systems-based approach, for example, inappropriately focusing on individual behaviours or not appreciating why an adaptation to the system was necessary, with recommendations targeted at 'retraining' or additional policies and checklists.

Those in system oversight roles (i.e. provider board PSIRF leads, ICS PSIRF leads, 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.

Staff in oversight roles must receive appropriate training to support the practical application of PSIRF oversight principles and standards.

### 10.1. Training procurement framework

An NHS suppliers training framework<sup>9</sup> has been developed to assist with identifying training suppliers for the following required PSIRF training courses:

- Systems approach to learning from patient safety incidents
- Involving those affected by patient safety incidents in the learning response process
- Oversight of learning from patient safety incidents

### 10.2. Patient Safety Syllabus

As part of the NHS Patient Safety Strategy, the National Patient Safety Syllabus was published by Health Education England in May 2021 covering five levels of training.

Level 1 (essentials for patient safety) and Level 2 (access to practice) became available for all NHS staff via the eLearning for health platform in October 2021. In June 2022, NHS Somerset mandated the requirement for all ICB staff to complete the Level 1 training, this is monitored via the ICB’s Electronic Staff Record.

Levels 3 and 4 are completed by PSSs and explore topics such as unpacking system issues, managing patient safety risks, understanding cultural, legal, and regulatory factors, and designing solutions.

See below table for a breakdown of PSIRF training requirements, further information can be found in [appendix 3](#).

### 10.3. Training requirements for those in PSIRF oversight roles

Topic	Minimum duration	Content
Systems approach to learning from patient safety Incidents	2 days/12 hours	<ul style="list-style-type: none"> <li>• Introduction to complex systems, systems thinking and human factors</li> <li>• Learning response methods: including interviewing, and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews</li> <li>• Safety action development, measurement, and monitoring</li> </ul>
Involving those affected by patient	1 day/6 hours	<ul style="list-style-type: none"> <li>• Duty of Candour</li> <li>• Just culture</li> </ul>

<sup>9</sup> [NHS suppliers PSIRF training framework](#)

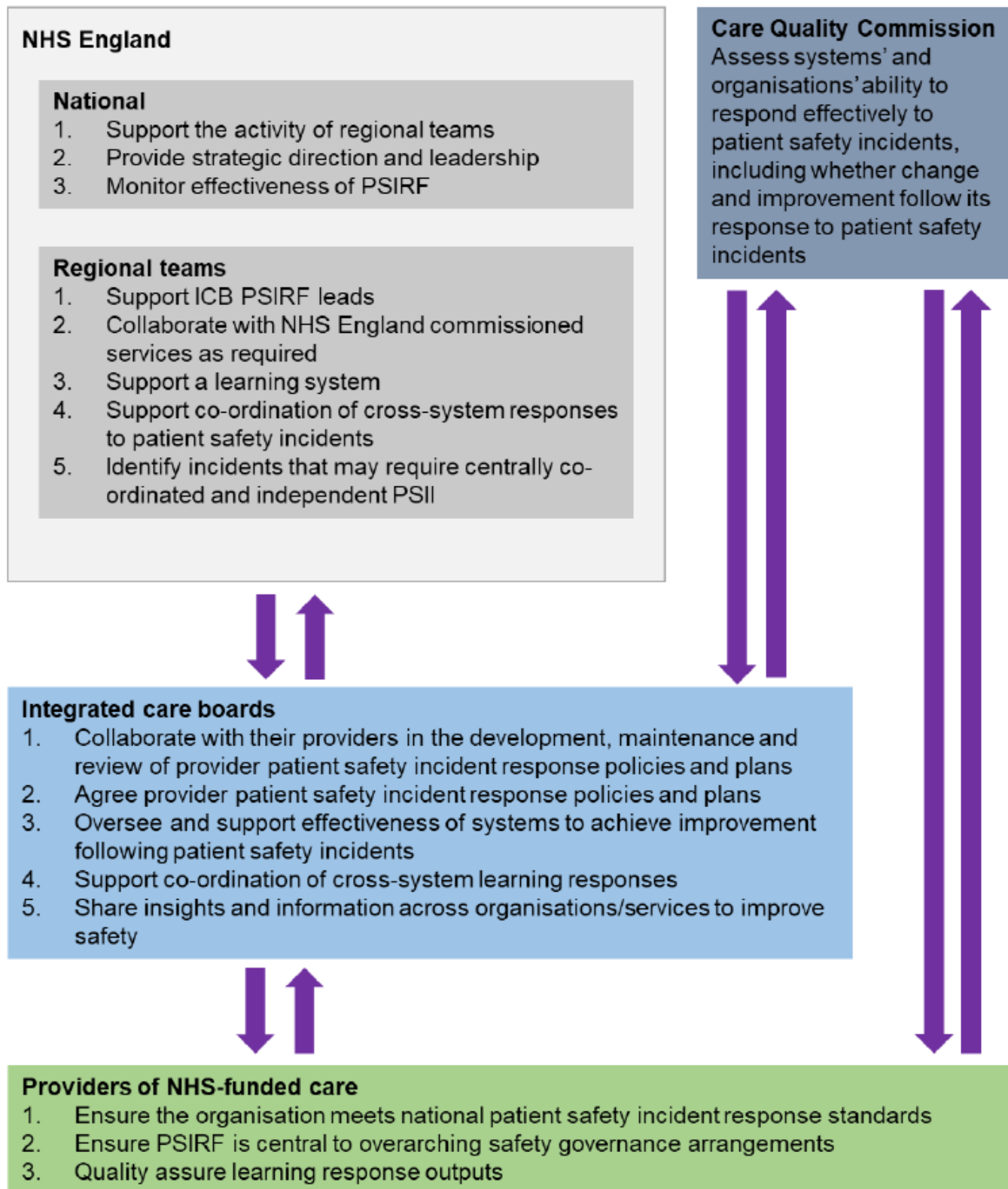
safety incidents in the learning process		<ul style="list-style-type: none"> <li>• Being open and apologising</li> <li>• Effective communication</li> <li>• Effective involvement</li> <li>• Sharing findings</li> <li>• Signposting and support</li> </ul>
Systems approach to learning from patient safety Incidents oversight training	1 day/6 hours	<ul style="list-style-type: none"> <li>• Effective oversight and supporting processes</li> <li>• Improvement focussed culture</li> <li>• Commissioning and planning investigations</li> <li>• Complex investigations and stakeholder boundaries</li> </ul>
Patient Safety Syllabus Level 1: Essentials for patient safety	eLearning (30 minutes)	<ul style="list-style-type: none"> <li>• Listening to patients and raising concerns</li> <li>• The systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work</li> <li>• Avoiding inappropriate blame when things don't go well</li> <li>• Creating a just culture that prioritises safety and is open to learning about risk and safety</li> </ul>
Patient Safety Syllabus Level 2: Access to Practice	eLearning	<ul style="list-style-type: none"> <li>• Introduction to systems thinking and risk expertise</li> <li>• Human Factors</li> <li>• Safety culture</li> </ul>
Continuing professional development	At least annually	<ul style="list-style-type: none"> <li>• To stay up to date with best practice (e.g. through conferences, webinars etc.)</li> </ul>

## 11. Update and review

NHS Somerset's PSSs are responsible for ensuring that this policy reflects current national guidance, with assistance from the Quality Governance team.

The ICB's Quality Committee have responsibility for the governance of this policy.

## 12. Appendix 1: Overview of organisational responsibilities



### 13. Appendix 2.1: Priorities for PSII review

#### Nationally defined priorities for external PSII review

- Maternity and neonatal for MNSI led PSII
- Mental health related homicides (MHHs)
- Child deaths
- Death of a person with a learning disability
- Safeguarding
- Incidents in screening programmes
- Deaths of patients in custody, in prison or on probation where healthcare was/is NHS funded and delivered through an NHS contract. These are reviewed by the Prisons and Probation Ombudsman who will work with NHS England and NHS Improvement to commission an independent clinical review of the healthcare received.

#### Nationally defined priorities for local PSII review

- Never events
- Deaths of patients that meet the learning from deaths criteria
- Death of a person with a mental illness or a learning disability where the patient safety incident may have contributed
- Suicide/self-harm of person in state care
- Deaths of patients in custody, in prison or on probation where there is reason to believe problems in healthcare may have impacted

#### Locally defined priorities for PSII review

- Emergent incidents which justify a heightened level of response because the consequences for patients, families and carers, staff or organisations are so significant and the potential for learning is so great
- Locally predefined incidents prioritised based on all of the following criteria:
  - actual and potential impact of incident
  - likelihood of recurrence;
  - potential for learning.

See further detail of national event response requirements in table on following page in appendix 2.2.

## 14. Appendix 2.2: National event response requirements table

Event	Action required	Lead body for the response
Deaths thought more likely than not due to problems in care	<ul style="list-style-type: none"> <li>Locally-led PSII.</li> </ul>	The organisation in which the event occurred
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care	<ul style="list-style-type: none"> <li>Locally-led PSII.</li> </ul>	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement	<ul style="list-style-type: none"> <li>Locally-led PSII.</li> </ul>	The organisation in which the Never Event occurred
Mental health-related homicides (MHHs)	<ul style="list-style-type: none"> <li>Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII.</li> <li>Locally-led PSII may be required.</li> </ul>	As decided by the RIIT
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) criteria	<ul style="list-style-type: none"> <li>Refer to MNSI or SpHA (or Special Healthcare Authority (SpHA) when in place) for independent PSII.</li> </ul>	HSSIB (or SpHA)
Child deaths	<ul style="list-style-type: none"> <li>Refer for Child Death Overview Panel review.</li> <li>Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.</li> </ul>	Child Death Overview Panel
Deaths of persons with learning disabilities	<ul style="list-style-type: none"> <li>Refer for Learning Disability Mortality Review (LeDeR).</li> <li>Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this.</li> </ul>	LeDeR programme
Safeguarding incidents in which: <ul style="list-style-type: none"> <li>babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence</li> <li>adults (over 18 years old) are in receipt of care and support needs from their local authority</li> <li>the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence</li> </ul>	<ul style="list-style-type: none"> <li>Refer to local authority safeguarding lead.</li> <li>Healthcare organisations must contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.</li> </ul>	Refer to your local designated professionals for child and adult safeguarding
Incidents in NHS screening programmes	<ul style="list-style-type: none"> <li>Refer to local screening quality assurance service for consideration of locally-led learning response.</li> </ul>	The organisation in which the event occurred

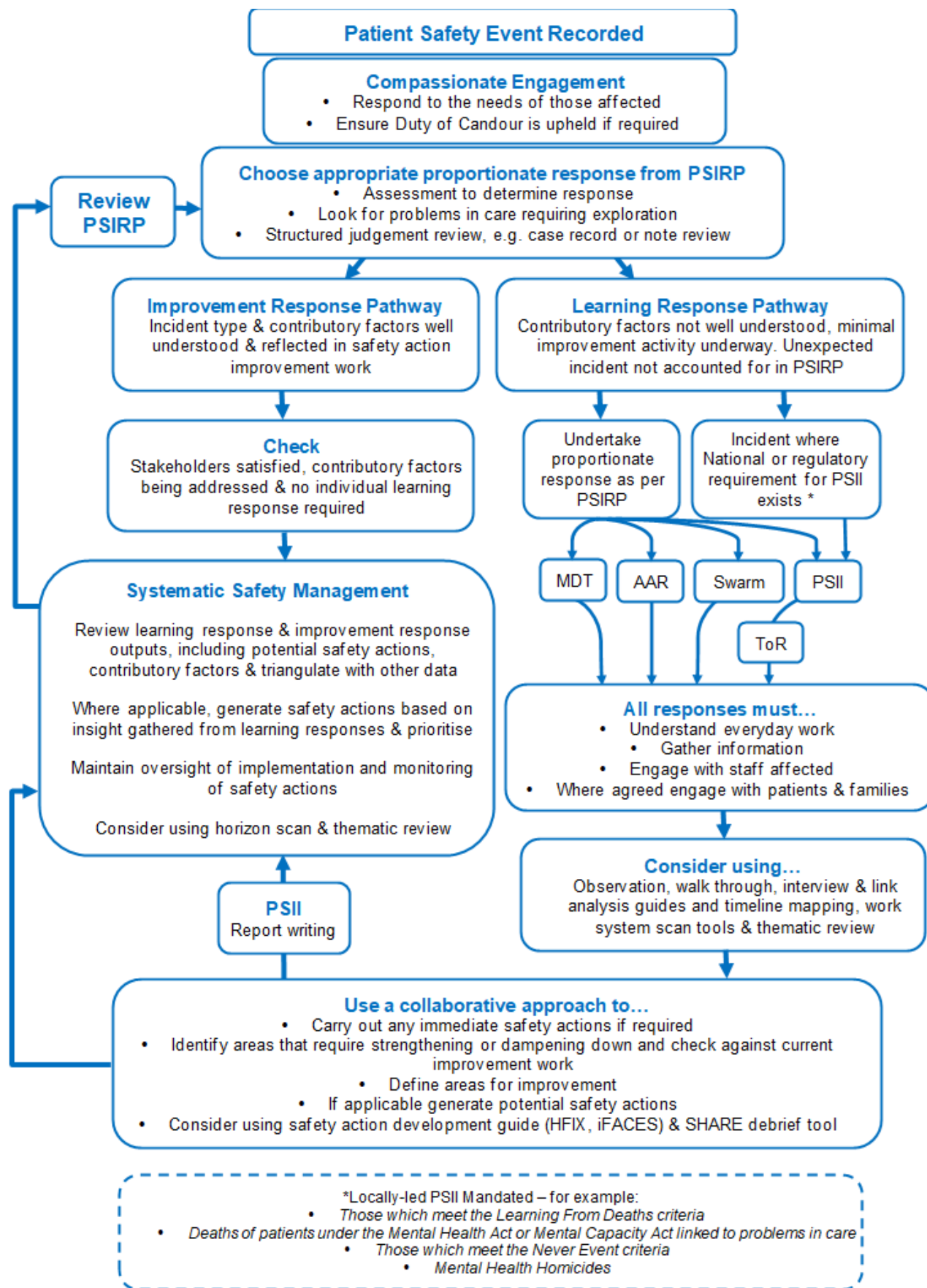
<p>Deaths in custody (eg police custody, in prison, etc) where health provision is delivered by the NHS</p>	<ul style="list-style-type: none"> <li>• Any death in prison or police custody will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) to carry out the relevant investigations.</li> <li>• Healthcare organisations must fully support these investigations where required to do so.</li> </ul>	<p>PPO or IOPC</p>
<p>Domestic homicide</p>	<ul style="list-style-type: none"> <li>• A domestic homicide is identified by the police usually in partnership with the community safety partnership (CSP) with whom the overall responsibility lies for establishing a review of the case.</li> <li>• Where the CSP considers that the criteria for a domestic homicide review (DHR) are met, it uses local contacts and requests the establishment of a DHR panel.</li> <li>• The Domestic Violence, Crime and Victims Act 2004 sets out the statutory obligations and requirements of organisations and commissioners of health services in relation to DHRs.</li> </ul>	<p>CSP</p>

### 15. Appendix 3: Training requirements table

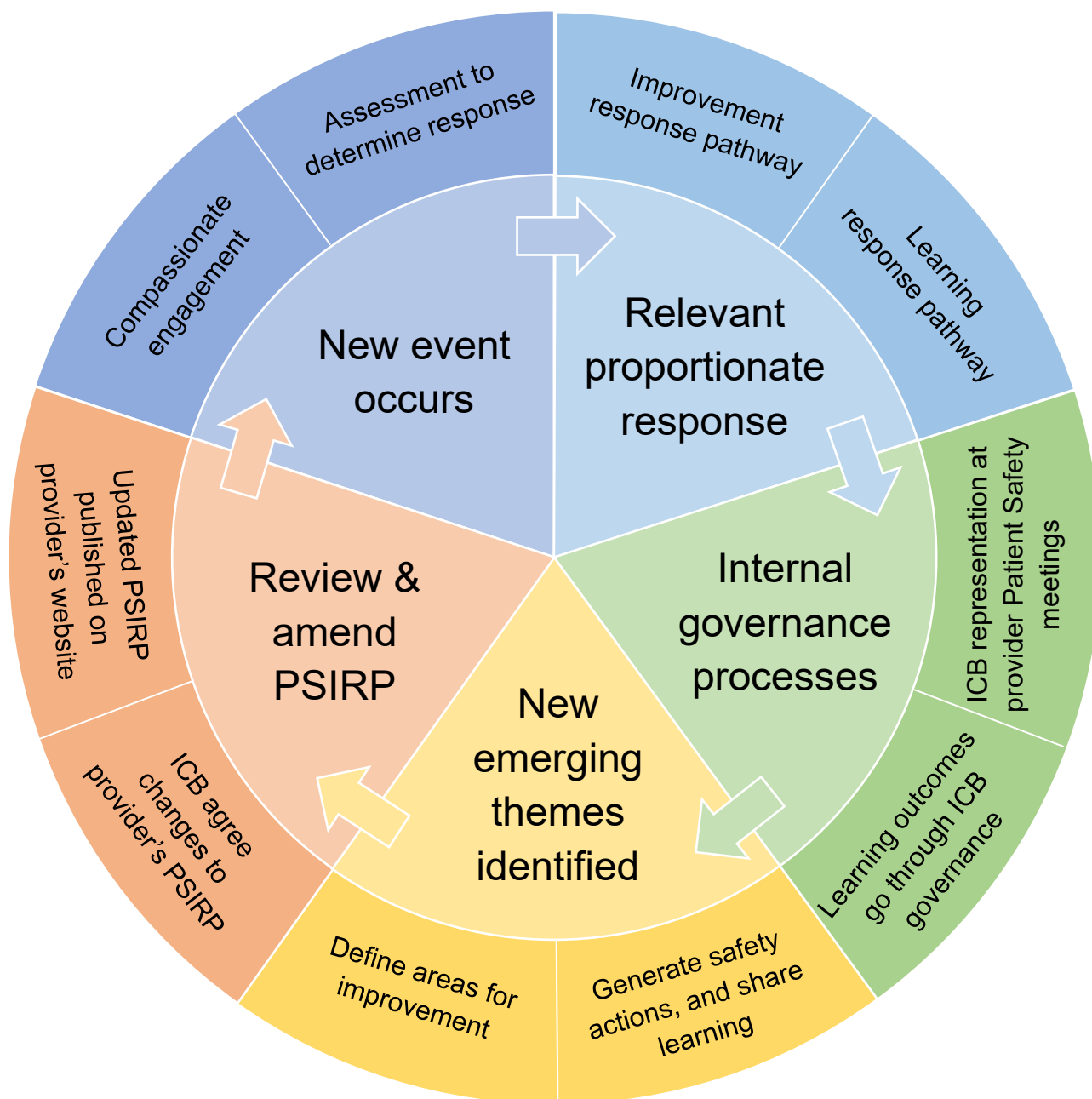
Systems approach to learning from patient safety incidents training for health and social care providers, commissioners, and executives					
LOT 4a		LOT 4b		LOT 4c	
Systems approach to learning from patient safety incidents		Systems approach to learning from patient safety incidents oversight training		Engaging with patients, families, and staff following a patient safety incident training	
2-day/12 hours (minimum duration)		1-day/6 hours (minimum duration)		1-day/6 hours (minimum duration)	
<b>For:</b> All learning response leads All those in PSIRF oversight roles (see Lot 4b)		<b>For:</b> All those in PSIRF oversight roles: Provider boards; Integrated care boards; NHS England regional leads		<b>For:</b> All engagement leads All those in PSIRF oversight roles (see Lot 4b)	
Description	Requirements of all presenters delivering training	Description	Requirements of all presenters delivering training	Description	Requirements of all those delivering training
<i>Training to support the development of core understanding and application of systems-based patient safety incident response throughout the healthcare system - in line with NHS guidance, based upon national and internationally recognised good practice.</i>  <b>Delivery of:</b> Thorough, credible, systems-based patient safety incident response training, based upon the NHS PSIRF and to include:	Training must be conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses. Accreditation with a recognised organisation (such as a Chartered Human Factors Specialist (CErgHF) or similar) is preferred. Must demonstrate evidence of recent CPD	<i>Training to support the development of expert understanding and oversight of systems-based patient safety incident response throughout the healthcare system - in line with NHS guidance, based upon national and internationally recognised good practice.</i>  <b>Delivery of:</b> Thorough, credible, systems-based patient safety incident response oversight training, based on the NHS PSIRF and to include:	Training must be conducted by those who have attended courses in learning from safety incidents amounting to more than 30 days, are up to date in learning response best practice and have both conducted and reviewed learning responses. Must demonstrate evidence of recent CPD  <b>Relevant training and qualifications in</b> Systems-based approaches to patient safety incident response	<i>Training to support the development of expertise in engaging and involving patients, families, carers and staff affected by patient safety incidents, in line with NHS guidance, based upon national and internationally recognised good practice. To include the duty of candour, and 'Engagement' principles</i>  <b>Delivery of:</b> Thorough, credible, training, based on the NHS PSIRF to include: Duty of Candour regulations	Training must be conducted by those who are up to date in engagement best practice and have both conducted and reviewed learning responses. Must demonstrate evidence of recent CPD  <b>Skills and experience in:</b> Applying duty of candour Applying Being Open or PSIRF principles Effective communication including dealing with conflict and difficult conversations

<p>General content: Purpose of patient safety incident response Introduction to complex systems, system thinking and human factors Just culture Improvement science and developing system improvement plans</p> <p>Response techniques Interviewing and asking questions Conducting observations, understanding work as done Systems frameworks Must include Patient Safety Incident Investigation Learning response planning Analysis Report writing</p> <p>Contingency/backup cover required, consistent with the requirements for trainer knowledge, skills, and expertise</p>	<p><b>Relevant training and qualifications in</b> Systems-based approaches to patient safety incident response Complex systems, systems thinking and human factors Improvement science/quality improvement Teaching, coaching, feedback and/or delivery of learning</p> <p><b>Skill and experience</b> Conducting high quality, complex investigations spanning different organisations, settings, and stakeholder boundaries Providing high quality training in systems-based safety incident response Presenting to executive board members, clinicians, and multi-disciplinary teams</p> <p><b>Up to date knowledge of relevant:</b> NHS patient safety incident response policy and guidance NHS and organisation policies and processes</p>	<p>Effective oversight and supporting processes related to incident response Maintaining an open, transparent and improvement focused culture Patient safety incident investigation (PSII) commissioning and planning Complex investigations spanning different organisational, care setting, and stakeholder boundaries</p> <p>Contingency/backup cover required, consistent with the requirements for trainer knowledge, skills, and expertise</p>	<p>Complex systems, systems thinking and human factors Improvement science/quality improvement Teaching, coaching, feedback and/or delivery of learning</p> <p><b>Skill and experience</b> Conducting high quality, complex investigations spanning different organisations, settings, and stakeholder boundaries Providing high quality training in systems-based safety incident response Presenting to executive board members, clinicians, and multi-disciplinary teams Measurement and monitoring safety using both qualitative and quantitative data</p> <p><b>Up to date knowledge of relevant:</b> NHS patient safety incident response policy and guidance NHS and organisation policies and processes</p>	<p>Being open and apologising Effective communication including dealing with conflict and difficult conversations Engaging with patients, families, carers, and staff following a patient safety incident Effective involvement of those affected by a patient safety incident throughout the incident response process to ensure a thorough and richer learning response</p> <p>Contingency/backup cover required, consistent with the requirements for trainer knowledge, skills, and expertise</p>	<p>Engaging with patients, families, carers, and staff following a patient safety incident Effective involvement of those affected by a patient safety incident throughout the incident response process to ensure a thorough and richer learning response Systems-based approaches to learning from patient safety incidents Complex systems, systems thinking and human factors Providing high quality training / coaching in engagement or related subjects</p> <p><b>Up to date knowledge of relevant:</b> NHS patient safety incident response policy and guidance NHS and organisation policies and processes</p>
---	--	--	---	---	---

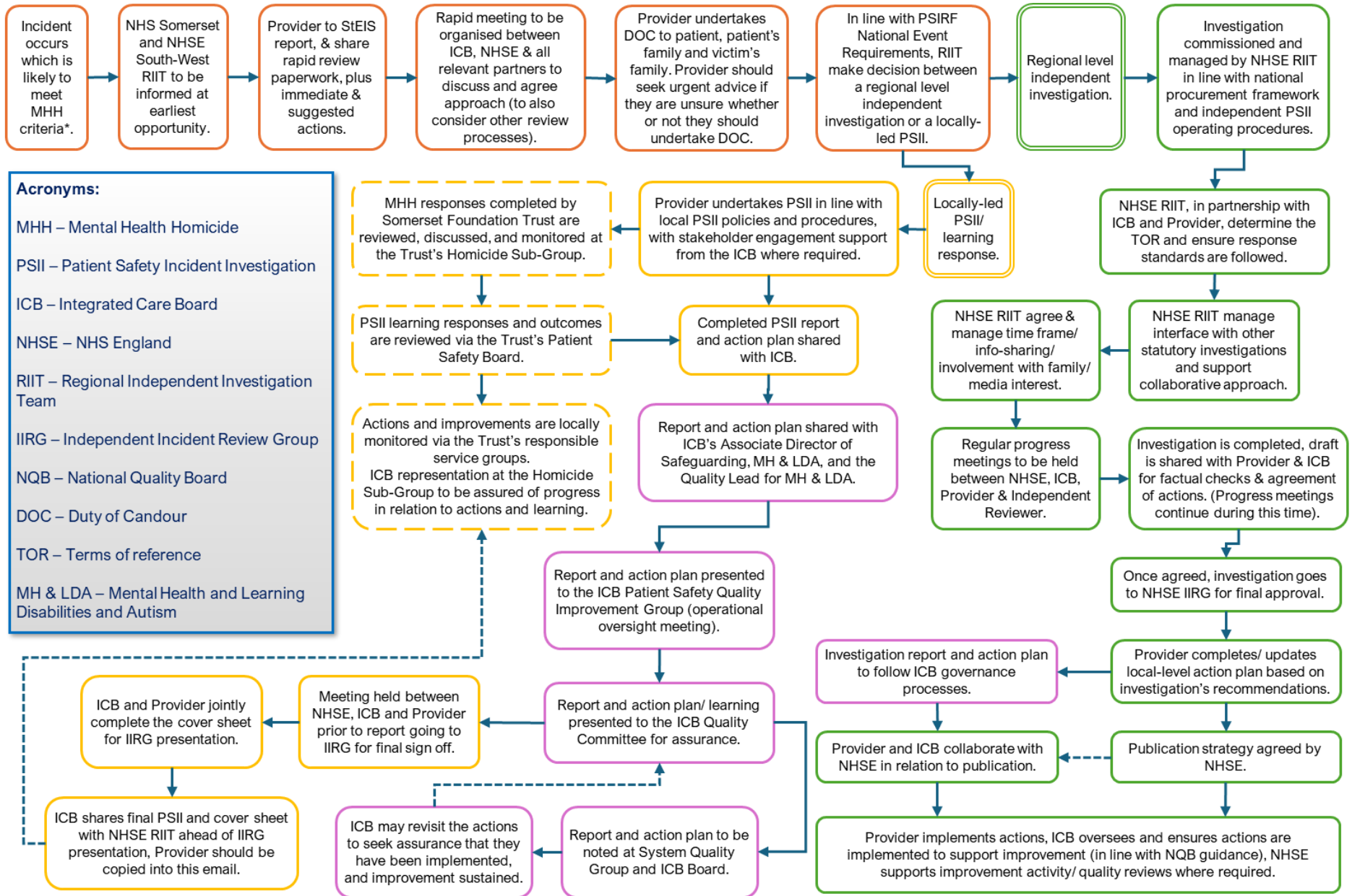
16. Appendix 4: Patient safety event response pathway



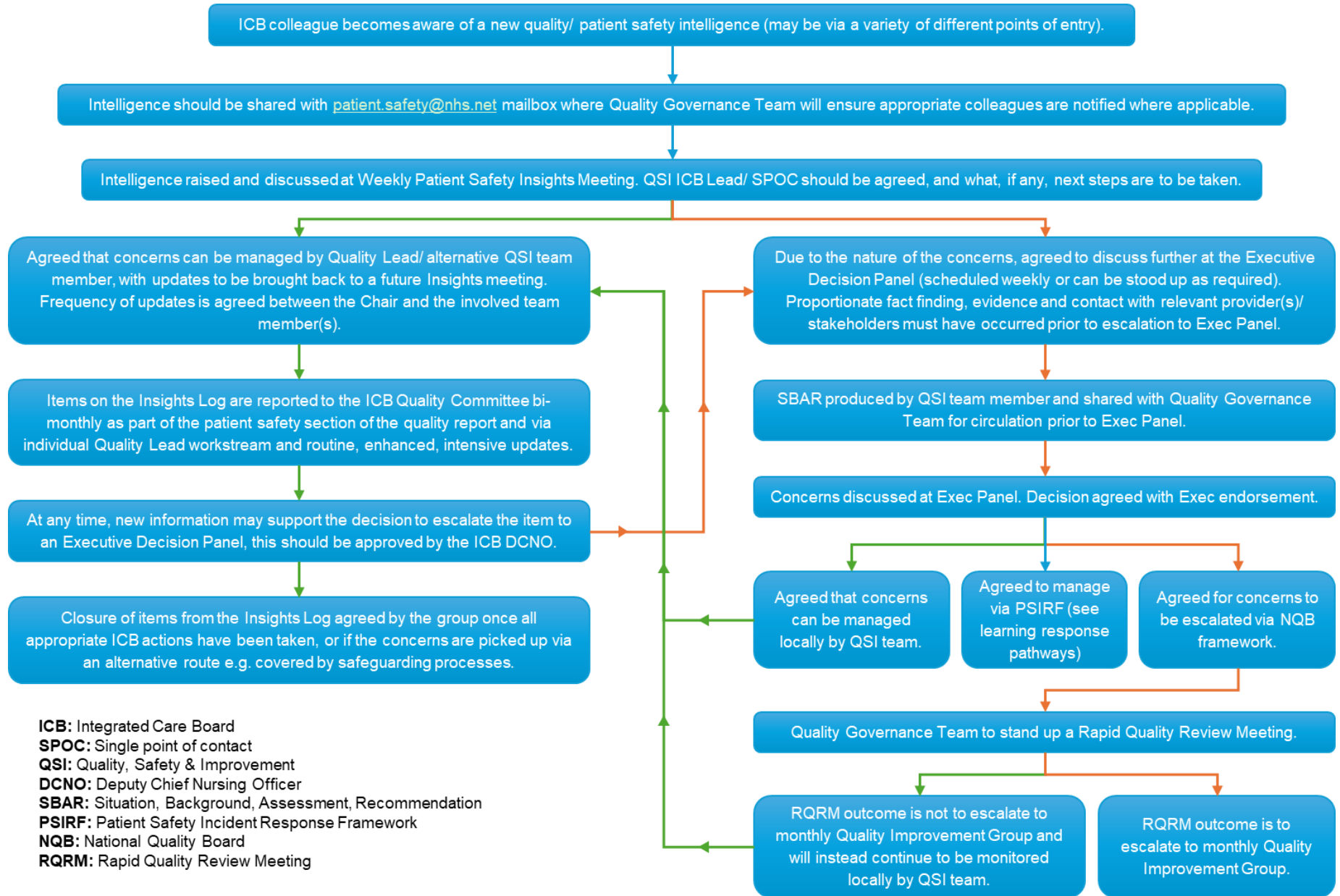
17. Appendix 5: Patient safety event process wheel



## 18. Appendix 6: Mental Health Homicide (MHH) management process



## 19. Appendix 7: NHS Somerset ICB's incident management process



## 20. Appendix 8: NHS Somerset overview of meeting governance

Meeting	Basic info	Purpose of meeting	Where this meeting feeds into
Weekly Patient Safety Insights Meeting	<ul style="list-style-type: none"> <li>Meeting held weekly.</li> <li>No formal minutes but decisions made are captured within an excel log.</li> <li>Attended by representatives from across the ICB's Quality Directorate and Patient Safety Partners.</li> </ul>	<ul style="list-style-type: none"> <li>Share new patient safety insights from that week.</li> <li>Agree any action to be taken, decisions to be logged.</li> <li>Provide updates in response to previously shared patient safety insights.</li> <li>Triangulate emerging themes and intelligence from other sources besides patient safety events.</li> </ul>	Escalations to the Patient Safety, Quality and Improvement Group (PSQIG)
Patient Safety, Quality and Improvement Group (PSQIG)	<ul style="list-style-type: none"> <li>Formal meeting held four-monthly.</li> <li>Formal minutes and action tracker.</li> <li>Attended by representatives from across the ICB's Quality Directorate and Patient Safety Partner.</li> </ul>	<ul style="list-style-type: none"> <li>To review what is happening in focussed areas of the Quality, Safety &amp; Improvement Team's work.</li> <li>To identify and triangulate emerging themes, trends and risks from reported data and soft intelligence, and take appropriate action where needed.</li> <li>To share identified learning with team members.</li> <li>To seek support and challenge from team members where needed.</li> <li>To identify any shared learning to be cascaded wider, whether across county, regionally, or nationally.</li> <li>To formally take policies, reports, and procedures through internal governance sign-off processes.</li> <li>To make decisions in relation to the completion and sign off of our own (NHS Somerset reported) Patient Safety Events.</li> <li>To review RIIT commissioned independent investigations prior to them going into the public domain.</li> </ul>	Escalations to the ICB Quality Committee
ICB Quality Committee	<ul style="list-style-type: none"> <li>Formal meeting held bi-monthly.</li> <li>Formal minutes and action tracker.</li> <li>Attended by representatives from across the ICB's Quality Directorate, Chief Nursing Officer, Non-Executive Directors, and Patient Safety Partner.</li> </ul>	<ul style="list-style-type: none"> <li>To provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and in the Health and Care Bill 2021.</li> <li>To promote a culture within Somerset Integrated Care System (ICS) that focuses on Patient Safety, Patient Experience, Safeguarding and Quality Improvement.</li> <li>To provide assurance on all NHS Provider services' governance arrangements and patient safety performance, through receiving exception reports on quality and safety issues, patient experience and safeguarding concerns and alerts for health services.</li> <li>To note closure of our own (NHS Somerset reported) Patient Safety Events.</li> <li>To note RIIT commissioned independent investigations prior to them going into the public domain.</li> </ul>	System risks with regard to patient safety escalated to Somerset System Quality Group (SQG)

<b>Rapid Quality Review Meetings (RQRM)</b>	<ul style="list-style-type: none"> <li>• Multi-stakeholder.</li> <li>• ICB-led where possible.</li> <li>• Set up to facilitate rapid diagnosis of quality concerns/issues and to agree next steps.</li> <li>• Defined under the National Quality Board framework.</li> </ul>	<ul style="list-style-type: none"> <li>• To give specific and focused consideration to quality concerns/risks raised, share intelligence, including with providers where quality risks have been identified.</li> <li>• To facilitate rapid, collective judgement to be taken about quality within the provider/sector/pathway in question.</li> <li>• To identify actions needed as a result of the risk identified, summarised in an action/improvement plan, which may be taken forward by a Quality Improvement Group (QIG). May include actions at provider, sector or pathway level.</li> <li>• To have clear success criteria must in the Action/Improvement Plan, which aligns with NHS Oversight Framework criteria.</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Improvement Group (QIG)</li> <li>• ICB Quality Committee</li> <li>• SQG</li> </ul>
<b>Quality Improvement Groups (QIG)</b>	<ul style="list-style-type: none"> <li>• Multi-stakeholder.</li> <li>• Usually the next step following a RQRM.</li> <li>• Instigated by ICB, local authority, NHSE, or regulators.</li> <li>• ICB-led where possible, may be led by NHSE region if necessary.</li> <li>• Supports planning, coordination and facilitation of sustained delivery of actions.</li> <li>• Defined under the National Quality Board framework.</li> </ul>	<ul style="list-style-type: none"> <li>• To provide advice and support to the provider/ICB to address quality risks and concerns, including identifying required responses and planning for mitigation of risks.</li> <li>• To provide a mechanism for facilitating direct assurance of the achievement of milestones within the action/improvement plan, including ensuring that there are clear arrangements for confirming that the action/improvement has been successfully delivered.</li> <li>• To review and challenge outstanding actions, ensuring that the most robust approaches are being considered.</li> <li>• To ensure that learning is embedded in ongoing continuous improvement.</li> </ul>	<ul style="list-style-type: none"> <li>• ICB Quality Committee</li> <li>• SQG</li> <li>• Regional Quality Group (RQG)</li> <li>• Wider partners where applicable. e.g. (NHSE, Local Authority, CQC)</li> </ul>