Patient Safety Incident Response Plan

Effective date: 3rd September 2025

Estimated refresh date: 3rd March 2027

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Introduction

This Patient Safety Incident Response Plan sets out how Lancashire Mind intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Our services

Lancashire Mind are commissioned by Lancashire and South Cumbria Integrated Care Board (ICB) to provide a programme called Resilient Minds across all areas of Lancashire (excluding Blackburn). Resilient Minds is an early intervention whole school approach programme; supporting young people, parents and school staff to develop resilience and positive coping strategies.

Delivery in focussed on areas of Lancashire with higher-than-average levels of deprivation and where schools don't currently have a Mental Health in Schools team. Schools are identified by both Lancashire Mind and the ICB to initially approach and offer the programme to. Lancashire Mind will then discuss with the individual school what their needs are and delivery will be planned accordingly.

Defining our Patient Safety Incident Profile

Lancashire Mind has a continuous commitment to learning from patient safety incidents. Safety incidents would include suicide, harm to self or others, a child or vulnerable adult who is at risk.

Stakeholder Engagement:

There was no stakeholder involvement although discussions have taken place with the board and consulted with the ICB patient safety team to fully understand the requirements of PSIRF and to understand the practicalities of planning and implementation.

Data sources:

To define our Patient Safety Response profile, we have reviewed our safety and safeguarding incidents for any themes and trends and considered feedback from people who use our services and any complaints received. Where possible we have considered what the data tells us about inequalities in patient safety and will support larger organisations with patient safety incident investigations and the ICB when necessary, where learning emerges, and improvement can be made.

Defining our Patient Safety Improvement profile

Lancashire Mind has a commitment to learning from patient safety incidents. At the point that an improvement has been identified, improvement plans will be produced to identify actions which would be shared with staff.

Our Patient Safety Incident Response Plan: national requirements

Some patient safety incidents, such as Never Events and deaths thought more likely than not due to problems in care will always require a Patient Safety Incident investigation (PSII) to learn and improve. Reported incidents at Lancashire Mind are extremely rare and to date we haven't met the national criteria to undertaken investigations. However, we will remain flexible and consider improvement plans as required where a risk or a patient safety issue emerges from our own and external intelligence.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Incidents meeting the Never Events criteria	PSII	Would support larger organisation to develop local organisational actions
Death thought more likely than not due to problems in care (incident meeting the learning from deaths criteria for patient safety incident investigations (PSIIs)	PSII	Would support larger organisation to develop local organisational actions
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII Locally-led PSII may be required	As decided by the RIIT
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR) Locally-led PSII (or other response) may be required alongside the LeDeR – organisations should liaise with this	LeDeR programme

Domestic homicide	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 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. 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 DHR	CSP

Our Patient Safety Incident Response Plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. We have identified the patient safety priorities set out below:

Patient safety incident type or issue	Planned response	Anticipated improvement route
Delay in referral into the service	**Action Review (AAR)** A structured approach for reflecting on the work of a group and identifying what went well, strengths, weaknesses and areas for improvement. Usually takes the form of a facilitated discussion following an event or activity.	Identify greatest potential for learning. Create local safety actions
Documentation/IG breach	**Action Review (AAR)** Facilitated discussion following an event or activity and internal procedure followed	Identify greatest potential for learning. Create local safety actions
Safeguarding incident or alert	Facilitated discussion and internal procedure followed. Escalated if needed to Safeguarding Team (Blackburn, Lancashire or Blackpool) and duty of care passed on.	Identify greatest potential for learning. Create local safety actions

All incidents will be reported through LFPSE regardless of level of investigation required.