Patient Safety Incident Response Policy

Effective date: 3rd September 2025

Estimated refresh date: 3rd March 2027

Contents

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Lancashire Mind's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system 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 response system functioning and improvement.

Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across Lancashire Mind.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Our patient safety culture

Lancashire Mind embraces an open and honest learning culture that enables everyone to contribute to a fair, safe and compassionate environment. We create a safe environment where our staff and volunteers feel confident to speak up if things go wrong. Staff will feel empowered to report incidents and near misses, so that we can learn and continue to improve our services. Staff are actively encouraged and supported to feedback on where improvements can be made so that if incidents happen, we focus on taking action to make our services better, rather than casting individual blame. With that in mind, we prioritise the safeguarding of children and vulnerable adults that use our services.

Patient safety partners

We will continue to engage with GPs, Lancashire Adult and Child Care Services, ICB Patient Safety team and other agencies as required to support client safety. Safety incidents will be reported to the Head of Children and Young People Services and such incidents and actions reviewed at Senior Manager Team meetings held on a weekly basis and reported quarterly to the Board of Trustees.

People who use our services are given opportunities to improve and develop our services collaboratively, through lived experience and user groups. Our co-production approach means that adults, children and young people have a true stake in how our service are run.

Addressing health inequalities

Health inequalities are preventable differences in health within and between groups in society. They affect life expectancy, health conditions, and access to care. Factors like where and how we live shape health outcomes, often called social determinants of health. We acknowledge the importance of the unique experiences of people from diverse backgrounds, such as race, gender, class, sexuality, and disability) and how this creates unique experiences of discrimination and privilege for individuals and groups.

Lancashire Mind aims to address these inequalities by making services accessible and responsive to local needs. We do this by embedding equitable equality, diversity and inclusion measures through our organisational Strategy and policies, right the way through to the services we provide, by involving those with lived experience of mental health in coproducing our services.

We encourage staff and volunteers from diverse backgrounds, to represent Lancashire and ensure our staff gain the training and knowledge they need to provide accessible services and get the best mental health outcomes for everyone.

The involvement of patients, families, carers, and staff after a patient safety incident is essential for effectively reviewing patient safety events and formulating appropriate responses, this includes reflective practice both internally and externally through supervision. We are committed to fully enabling their meaningful participation in our patient safety incident response process.

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

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

We will do this by:

- Encouraging feedback about our services, through feedback forms and anonymously through questionnaires.
- Encourage open feedback from staff though reflective practice and supervision.
- Dealing with complaints and concerns effectively, timely and in a fair manner.
- Enabling co-productive collaboration on ways to improve services through lived experience groups.
- Deal with safety incidents in an open and transparent way, with care and compassion, engaging effectively with those affected, sharing our learning and what we intend to do to improve.
- Continually monitor and improve our safety response standards through our quality and performance measures.
- Liaise with LSCFT and the ICB to aid learning and improve practices.

We commit to being open and transparent regardless of the level of harm caused by an incident.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

Lancashire Mind will adapt its investigative approach based on national and local priorities in the Patient Safety Incident Response Plan (PSIRP), focusing proportionally on responses that maximise improvement in patient safety.

Resources and training to support patient safety incident response

Lancashire Mind is working to embed PSIRF and align with its requirements. The organisation has referenced the NHS England patient safety response standards (2022) to guide the development of necessary resources and training for implementation.

Governance will ensure staff do not conduct learning responses alone. The Head of CYP Services Lead, who holds sufficient seniority in Lancashire Mind, is responsible for assigning leadership to any learning response and will report directly to the Services Director. Staff will receive support and time to participate.

Training:
Lancashire Mind arranges mandatory eLearning on patient safety so that all staff and volunteers are informed about their responsibilities for reporting and managing safety incidents, following the NHS England Health Education England Patient Safety Training Syllabus. The organisation utilises the NHS England patient safety response standards (2022) to guide the development of resources and training, supporting the implementation of PSIRF principles across its activities.

Course https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/	**Who**
Patient safety syllabus level 1: Essentials for patient safety	**All staff at induction (expect boards and senior leaders)**
Patient safety syllabus level 1: Essentials	**All board and senior leadership team members**
Patient safety syllabus level 2: Access to practice	**All staff (within 3 months of induction)**

The DSL must complete levels one and two of the national patient safety syllabuses and pursue ongoing professional development in incident response. The Operations Team maintain training records. Staff responsible for learning responses must show competence in human factors and system thinking principles.

Governance arrangements will be established to ensure that learning responses are not carried out by staff in isolation. The responsibility for proposing leadership of any learning response will lie with the DSL, who will have the appropriate level of seniority within the organisation. Staff will receive support and allocated time to participate in learning responses.

Our patient safety incident response plan

Our 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 set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months.

Updated plans will be published on our website.

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A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Responding to patient safety incidents

Patient safety incident reporting arrangements

All staff are responsible for reporting any potential or actual patient safety incidents to the Designated Safeguarding Lead or a Deputy, within 24 hours of the incident and will record the level of harm they know has been experienced by the person affected.

Patient safety incidents will be responded to proportionately and in a timely fashion. This should include consideration of Duty of Candour. If there is an incident these could only require local review within the service, however for some, where it is felt that the opportunity for learning and improvement is significant, these should be escalated to the ICB for support where cross system working can support with a collaborative response.

The Designated Safeguarding Lead, or Deputy in their absence, will act as liaison with external bodies and partner providers to ensure effective communication and a point of

contact for the organisation. Where deemed necessary, a report will be submitted to The Learn from patient safety events (LFPSE) service.

Patient safety incident response decision-making

All reported patient safety events will be reviewed by the Senior Management Team, who will agree a proportionate response and in line with our safeguarding policy and procedures. Emergent issues may be escalated to the Board of Trustees and resources allocated to deal with urgent issues in a timely and sufficient manner. Any learning and shared with external agencies where relevant.

Learning responses available include:

Patient Safety Incident Investigation (PSII)
A Patient Safety Incident Investigation (PSII) is a comprehensive investigation which will utilise the System Engineering Initiative for Patient Safety (SEIPS) framework. These investigations may be initiated when it is felt a patient safety event meets the criteria to be defined as a national or local priority.

After-Action Review
An After-Action Review is a method of evaluation that is used when outcomes of an activity or event. It aims to capture learning from these tasks to avoid failure and promote success for the future. Everyone should feel they are able to contribute without fear of blame or retribution. After Action Reviews are about learning, not holding people to account.

Responding to cross-system incidents/issues

Lancashire Mind will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.

Timeframes for learning responses

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

After a patient safety event, we will identify areas for improvement and agree on safety actions. The organisation then monitors these actions and outlines review steps. The Senior Management Team is responsible for this process, with oversight from the Board of Trustees. The Designated Safeguarding Lead will have ownership of this process.

Safety improvement plans

Safety improvement plans synthesise findings and lessons from various responses to patient safety incidents and issues. The Lancashire Mind patient safety incident response plan identifies local investigation priorities under PSIRF to guide improvement efforts.

This process may include:

- Developing an organisation-wide safety improvement plan that summarises ongoing improvement work
- Creating targeted safety improvement plans for specific services, pathways, or locations
- Reviewing outputs collectively from responses to single incidents when there is adequate insight into the interconnected system issues
- Designing a safety improvement plan to address broad areas identified for enhancement (such as overarching system challenges).

Progress on safety improvement plans will be monitored by the Designated Safeguarding Lead and reported to the Board of Trustees.

Oversight roles and responsibilities

The table below outlines the roles and responsibilities relating to Lancashire Mind.

Role	Responsibility
Chair of Trustees	The Chair of Trustees has the ultimate responsibility for all aspects of patient safety which includes the management of incidents. This includes ensuring that appropriate structures and resources are in place to enable appropriate investigation, analysis and learning to comply with this policy.
Board/Stakeholders	Board/stakeholders will receive assurance regarding the implementation of PSIRF and associated standards to ensure that the Board has an understanding of organisational safety. This will include reporting on ongoing monitoring and review of the patient safety incident response plan and delivery of safety actions and improvement.
Designated Safeguarding Lead	The DSL has responsibility for patient safety within Lancashire Mind, with support from the Senior Management Team, and is accountable for ensuring an adequate system is in place to enable appropriate

	and proportionate responses to safety incidents that occur.
All Other staff/volunteers	All staff/volunteers across the organisation are responsible for ensuring any patient safety events are reported within 24 hours of occurrence. All staff will be required to adhere to this policy.

Complaints and appeals

Lancashire Mind recognises that there will be occasion when people who use our services are dissatisfied with aspects of the service provided.

The organisation is committed to deal with any complaints as quickly as possible. Complaints will be handled respectfully ensuring that all parties concerned feel involved in the process and assured that the issues raised have been comprehensively reviewed and the outcomes shared in an open and honest manner.

Full details of the Lancashire Mind complaints policy and process can be found on our website Complaints Policy. To request a copy of the Complaints Policy, or if you have a question about this policy, please email admin@lancashiremind.org.uk or call 01257 231660 and leave a message.