Patient Safety Incident Response

Plan

Applicable Company: The Calico Group

Owner: Lily Pangan-High

Version Number: 2.0

Signed Off By:
Review Cycle: Annually
Revision Date: 04/09/2026
Next Review Date: 04/09/2027

Contents

1.0 Change History

Version number	Change details	Date
2.0	Full review undertaken to align the Plan with updated PSIRF guidance and the revised PSIRF Policy, including updates to scope, systems-based learning, patient and family involvement, national response requirements and local learning response arrangements.	04/09/2026

2.0 Introduction

This patient safety incident response plan sets out how the Calico Group 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.

This plan applies specifically to the NHS-commissioned Peer Support contract, delivered through the Zest partnership. The Calico Group service currently involved in the delivery of this contract is Acorn Recovery.

There are many ways to respond to an incident. This document covers responses conducted solely for the purpose of systems-based learning and improvement. There is no remit within this Plan or PSIRF to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

The PSIRF process will be managed on behalf of the Calico Group by the Syncora Governance & Assurance Team, for further information or guidance please contact the team syncoragovernance@calico.org.uk.

3.0 Our services

The Calico Group is commissioned by Lancashire and South Cumbria Integrated Care Board and will head the Mental Health Wellbeing Partnership, in collaboration with Acorn Recovery, Red Rose Recovery and An Inclusive Future.

The service is known as Zest and provides peer to peer support, working together to offer mental health support through people with lived experience across Lancashire and South Cumbria.

Under the terms of the NHS contract, The Calico Group will ensure that it is able to report patient safety incidents to the LFPSE (Learn from Patient Safety Events

Service) so that we contribute to the recording and analysis of patient safety events.

3.1 Defining our patient safety incident profile

The Calico Group has a continuous commitment to learning from patient safety incidents. Learning responses will adopt a systems-based approach, recognising that patient safety incidents often arise from multiple interacting factors within complex systems.

Examples of patient safety incidents may include the death of a client, harm to self or others, or situations where a child or vulnerable adult is at risk, although this list is not exhaustive. There was no stakeholder involvement although discussions have taken place within the organisation, and we have 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, we have reviewed our incidents for any themes and trends and considered feedback from clients/patients and from complaints. 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.

3.2 Defining our patient safety improvement profile

The Calico Group is committed to learning from patient safety incidents. At the point that an improvement has been identified, improvement plans will be produced to identify actions which will be shared with staff.

Where appropriate, patients, families and staff affected by a patient safety incident will be given opportunities to contribute their perspectives, inform the learning response and support the identification of learning and improvement actions.

3.3 Our patient safety incident response plan: national requirements

Certain categories of patient safety event are subject to nationally mandated response, review or referral requirements, as detailed below. Where a Patient Safety Incident Investigation (PSII) is required under national guidance, this will

be undertaken. In other circumstances, the Calico Group will determine the most appropriate and proportionate response to support learning and improvement.

Such reported incidents within the Calico Group are extremely low and we have to date not met the national criteria to undertake investigations. We will, however, remain flexible and consider improvement plans as required where a risk or a patient safety issue emerges from our own and external intelligence.

Event	Action Required	Lead body for the response
Deaths thought more likely than not due to problems in care (incidents meeting the learning from deaths criteria for PSII)	Locally led PSII	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 (incidents meeting the learning from deaths criteria)	Locally led PSII	The organisation in which the event occurred
Incidents meeting the Never Events criteria 2018, or its replacement.	Appropriate learning response determined in accordance with current national guidance and local circumstances.	The organisation in which the Never Event occurred
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
Child deaths	Refer for Child Death Overview Panel review Locally-led PSII (or other response) may be required alongside the panel review – organisations should liaise with the panel.	Child Death Overview Panel
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
Safeguarding incidents in which:	Refer to local authority safeguarding lead Healthcare	Refer to your local designated

• babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence • adults (over 18 years old) are in receipt of care and support needs from their local authority • the incident relates to FGM, Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/violence	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.	professionals for child and adult safeguarding
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 DHRs.	CSP

4.0 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
Safeguarding (Adults) where the trigger event is identified as a statutory category of abuse or neglect.	• Refer to Local Authority safeguarding Adults. • A proportionate learning response will be undertaken in conjunction with relevant agencies and services as appropriate. • Capturing patient wishes, beliefs and desired outcomes as part of the learning event. • Consideration of a wider 'think family' agenda.	• Improved patient safety. • Improved joint working with other services involved in the care. • Improved experience for those involved. • Strengthened Governance and oversight.
Safeguarding (Children) where the trigger event is identified as a statutory category of abuse or neglect.	• Refer to Local Authority safeguarding Children. • Proportionate learning response to be undertaken in conjunction with relevant agencies and services as appropriate. • Capturing patient wishes, beliefs and desired outcomes as part of the learning event.	• Improved child safety. • Improved joint working with other services involved in the care. • Improved experience for those involved. • Strengthened Governance and oversight.
Delays into service: When the number of active referrals exceeds waiting more than 28 days, from referral to first session.	• Contact referring agency • Contact patient • Prioritisation of care • Caseload audit	• Managing caseloads and management of current caseload numbers. • Improved customer experience. • Review discharge process of current caseloads.