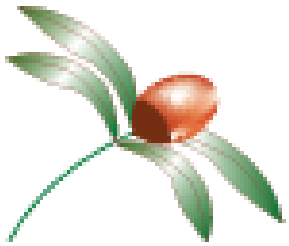
YEWDALE COUNSELLING SERVICES	

Patient safety incident response plan

Effective date: 7 June 2024

Reviewed date: 30 September 2025

Contents

Introduction

This patient safety incident response plan sets out how Yewdale Counselling Services 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

Yewdale Counselling Services are commissioned by Lancashire and South Cumbria Integrated Care Board to provide one to one therapy for adults who are registered with a GP in West Lancashire. Clients are referred into our service from NHS Talking Therapies, they will have already been assessed by LSCFT and deemed to need a talking therapy. Yewdale Counselling services offer counselling for depression, anxiety, bereavement, low self-esteem, abuse, relationship difficulties and other personal issues.

Defining our patient safety incident profile

Yewdale Counselling Services 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 is at risk. There was no stakeholder involvement although discussion 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 profiled, we have reviewed our incidents for any themes and trends and considered feedback from clients/patients and complaints. Where possible 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

Yewdale Counselling Services 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 Yewdale are extremely low and we have to date not 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 programme

	LeDeR – organisations should liaise with this	
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.	Identify greatest potential for learning. Create local safety actions
Safeguarding	Refer to Local Authority safeguarding lead	Identify greatest potential for learning. Create local safety actions

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