



Patient safety incident response policy

Effective date: 7 June 2024

Reviewed date: 30 September 2025

Contents

Purpose	3
Scope	4
Our patient safety culture	5
Patient safety partners	6
Addressing health inequalities	7
Engaging and involving patients, families and staff following a patient safety incident	8
Patient safety incident response planning	9
Resources and training to support patient safety incident response	10
Our patient safety incident response plan	11
Reviewing our patient safety incident response policy and plan	11
Responding to patient safety incidents	11
Patient safety incident reporting arrangements	11
Patient safety incident response decision-making	12
Responding to cross-system incidents/issues	12
Timeframes for learning responses	12
Safety action development and monitoring improvement	12
Safety improvement plans	13
Oversight roles and responsibilities	14
Complaints and appeals	15

Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **Yewdale Counselling Services** 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 Yewdale Counselling Services.

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

Yewdale Counselling Services embraces a Just and Learning Culture that enables everyone to contribute to a fair, safe and compassionate environment when things don't go as planned. We want to create an environment where our staff/volunteers feel it is safe to report incidents or near misses, so that the organisation is aware of them providing us with an opportunity to learn. As part of our continuous improvement journey, when incidents happen, we focus on what was responsible rather than who was responsible so that our staff feel supported when things go wrong and empowered to learn, rather than feeling blamed.

Patient safety partners

We will continue to engage with GPs, NHS Talking Therapies, ICB patient safety team and other agencies as required to support client safety. Safety incidents to be reported to Practice Manager/Deputy Manager and reviewed at Management/Trustee Board meetings.

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England Improvement to help improve patient safety across the NHS in the UK.

We have received confirmation from LSC ICB that we wouldn't be expected to appoint our own PSP.

Addressing health inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them. The conditions in which we are born, grow, live, work and age can impact our health and wellbeing. These are sometimes referred to as wider or social determinants of health. Yewdale Counselling services aims to reduce inequalities in health by improving access to services and tailoring those around the needs of the local population in an inclusive way.

Engagement of patient, families, carers and staff following a patient safety incident is critical to review of patient safety events and their response. We will ensure that we maximise their potential to be involved in our patient safety incident response.

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 are committed to continuous improvement throughout the service we provide. We want to learn from any event where care does not go as planned or expected by our staff, clients, their families, and other organisations.

Alongside our professional and statutory requirements for Duty of Candour, 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.

Yewdale Counselling Services will be flexible with our investigative approach, informed by the national and local priorities detailed within our Patient Safety Incident Response Plan (PSIRP) and we will take a proportionate approach to its response to patient safety events to ensure that the focus is on maximising improvement.

Resources and training to support patient safety incident response

Yewdale has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

We will have in place governance arrangements to ensure that learning responses are not undertaken by staff working in isolation. Responsibility for the proposal to designate leadership of any learning response sits with Practice Manager who will have an appropriate level of seniority within Yewdale. Staff will be supported and given time to participate in learning responses.

Training:

Yewdale has introduced patient safety training to ensure that all staff/volunteers are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows.

Level one

National – E-Learning for Health patient safety syllabus module.

All staff/volunteers are expected to undertake these on induction and to repeat each three years.

National – Health Education England patient safety syllabus module (Essentials for patient safety)

All staff/volunteers are expected to undertake these on induction and to repeat each three years.

These modules are available as eLearning via ESR access.

National – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams)

This module can be accessed directly from the Health Education England eLearning for healthcare platform or ESR.

Level two

National – Health Education England patient safety syllabus module (Access to Practice).

This is to be undertaken by all staff who have the potential to support or lead patient safety incident management.

This module is available as eLearning via ESR access.

Practice Manager must complete level one and two of the national patient safety syllabuses. Practice Manager will undertake appropriate continuous professional development on incident response skills and knowledge. Records of training will be maintained by Practice Manager. Staff leading on learning responses will be expected to demonstrate competencies in applying human factors and system thinking principles.

Our patient safety incident response plan

Our 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 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.

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.

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 Practice Manager or Deputy Manager 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 Practice Manager will act as liaison with external bodies and partner providers to ensure effective communication and point of contact for the organisation.

Patient safety incident response decision-making

All reported patient safety events will be reviewed by Management Team and Board of Trustees. The meeting will agree appropriate learning responses and share with external agencies.

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.

Duty of Candour disclosure should take place according to organisation policy.

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

Yewdale Counselling Services 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

Following a patient safety event, we will agree and generate safety actions in relation to defined areas for improvement. Following this, the organisation will have measures to monitor any safety action and set out review steps. These actions will be overseen by Management Team and Board of Trustees.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. Yewdale Counselling services patient safety incident response plan has outlined the local priorities for focus of investigation under PSIRF to help to focus our improvement work.

Monitoring of progress regarding safety improvement plans will be overseen by reporting by Practice Manager to the Board of Trustees.

Oversight roles and responsibilities

The table below outlines the roles and responsibilities relating to Yewdale Counselling Service

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 are in place to enable appropriate investigation, analysis and learning and ensuring resources are available 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.
Practice Manager	Practice Manager has responsibility for patient safety within Yewdale 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

Yewdale Counselling services recognises that there will be occasion when the patients, families or carers are dissatisfied with aspects of the care 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.

Yewdale complaints procedure can be found www.yewdalecounsellingservices.com

If a concern cannot be resolved, then the complainant can contact British Association for Counselling and Psychotherapy (BACP). www.bacp.co.uk.