The Bereavement Counselling service

Patient safety incident response plan

Effective date: 23 October 2024

Estimated refresh date: October 2025

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Introduction

This patient safety incident response plan sets out how The Bereavement Counselling Service 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.

Prior to this policy The Bereavement Counselling Service has had no previous incidents of patient safety reported and will monitor incidents through this plan to build transparent evidence to share with our partners, staff team and clients in our service.

Our services

The Bereavement Counselling service is a registered charity, with over thirty years' experience of providing support to people suffering with complex grief, trauma and loss. We offer Person Centred therapy which, by definition, has the client at the heart of our service. Being open and honest is the bedrock of our practice, and this applies equally to our partner agencies, families, staff and volunteers.

A specialist confidential counselling service is available for patients and their families who are anticipating grief and who are terminally ill and bereaved. Counselling gives people the opportunity to talk through their experience with trained counsellors who enable patients and families to make more sense of their feelings.

We provide one to one personal therapy which is commissioned by Lancashire and south Cumbria Integrated Care Board. Clients are referred to our service through NHS Talking Therapies and allocated to a counsellor suited to the clients' individual needs.

Defining our patient safety incident profile

The Bereavement Counselling Service regularly works with vulnerable people who have experienced a significant loss. This loss could lead to potential safety related issues, suicide or harm to self or others, drug and alcohol issues, depression and anxiety.

There has been no stakeholder involvement in the implementation of this plan, although, discussion have taken place with the board, staff team and consulted with the ICB patient safety team to fully understand the requirements of PSIRF and to understand the practicalities of planning and implementation.

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.

By reviewing our incident data and collaborating with the ICB and partners, we've laid a foundation for our PSIRF plan and identified our areas of focus. This process will continue to evolve as we implement the framework. As a living document, our PSIRF plan may see adjustments to targets based on ongoing analysis and feedback, ensuring our approach remains dynamic and responsive to the needs of those we serve.

Defining our patient safety improvement profile

Our data collection will encompass various sources, capturing a comprehensive snapshot of incidents and complaints within The Bereavement Counselling service. This information will be instrumental in identifying key areas for improvement and setting focused priorities as we embark on our PSIRF journey. We have also commenced work on moving to an additional incident reporting module (LFPSE - Learning from Patient Safety Events), which has been incorporated into our current incident reporting system.

Data sources

Incident reports: A data review of the 'Incidents & Risk Assessment.
Complaints: Complaints made between October 2024 and February 2024 were reviewed and a thematic analysis undertaken which was linked to corresponding incident categories.

Our patient safety incident response plan: national requirements

Local patient safety risks and/or events that fall within the national priority and reporting scope. There are other events that have a recommended response (mental health related homicide, death in custody and domestic custody). These have not been separately stated in this PSIRP as they are unlikely to occur due to the nature of care offered by The Bereavement Counselling service. Should such an event occur, the recommended action set out by NHS England will be followed.

There have been no reported Incidents at The Bereavement Counselling Service prior to this plan being implemented and so, have not met the national criteria to undertake investigations. However, we will remain vigilant and consider improvement plans as required where a risk or a patient safety issue emerges from our assessments or informed externally.

Patient safety incident type	**Required response**	**Anticipated improvement route**
Eg incidents meeting the Never Events criteria	PSII	Would support larger organisation to develop local organisational actions and feed these into the quality improvement strategy.
Eg 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 and feed these into the quality improvement strategy.
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
Safeguarding incidents Possibly due to staff actions/inaction	Liaise with Local Authority Designated Officer (LADO) to agree	Liaise with LADO to agree outcomes. Create local organisational actions and

	response type and timelines. TCT internal investigation and/or PSII	feed these into the quality improvement strategy
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	LeDeR programme

Our patient safety incident response plan: local focus

The Bereavement Counselling Service, in collaboration with ICB, has established local patient safety priorities for 2024/2025. This process involved a comprehensive analysis of our patient safety profile, incorporating insights and feedback to define these priorities. A chief aim of PSIRF is to undertake higher quality patient Safety Incident Investigations (PSII) employing system review methodology to maximise effective and sustained learning and improvement. This will may mean fewer but more significant investigations for the national and local priorities detailed in this plan. When deciding whether to investigate and which methodologies to employ we will consider the following factors.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Any incidents resulting in moderate or severe physical or psychological harm (as per LFPSE definitions)	Either and/or • Statutory duty of candour • Swarm huddle • After action review • PSII	Patient Safety Oversight Group (PSOG) to review a decide level of response. Liaise with LADO Create local safety actions and feed these into the quality improvement strategy.
Documentation or Identity breach	Action Review (AAR) Facilitated discussion following an event or activity.	Patient Safety Oversight Group (PSOG) to review a decide level of response in partnership with ICP lead. Create local safety actions and feed these into the IPC meeting and quality improvement strategy
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	Patient Safety Oversight Group (PSOG) to review a decide level of response. Create local safety actions and feed these and quality improvement strategy

	following an event or activity.	
Infection prevention Control incidents (IPC)	Either and/or • Swarm huddle • After action review • MDT review • Thematic review • PSII if indicated	Patient Safety Oversight Group (PSOG) to review a decide level of response in partnership with ICP lead. Create local safety actions and feed these into the IPC meeting and quality improvement strategy