Patient safety incident response plan

Effective date: December 2025
Estimated refresh date: August 2027

	NAME	TITLE	SIGNATURE	DATE
Author	James George	Safeguarding Lead		03/02/2026
Reviewer	Christine Ankers	Clinical Director		06/02/2026
Authoriser	Michelle Lyons	Chief Executive		03/02/2026

Contents

Introduction....3
Our services....4 & 5
Defining our patient safety incident profile....6 & 7
Defining our patient safety improvement profile....6 & 7
Our patient safety incident response plan: national requirements....8 & 9
Our patient safety incident response plan: local focus....10 & 11

Introduction

At Listening ear we are committed to fostering a culture of safety, transparency, and continuous learning.

This document outlines our Patient Safety Incident Response Plan, which sets out how we intend to respond to patient safety incidents over t/he next 12 to 18 months.

This plan provides a structured approach to identifying, investigating, and learning from patient safety incidents. It is designed to support our staff, safeguard those who use our services, and ensure that we meet our legal and ethical responsibilities, including those under the Duty of Candour and Safeguarding legislation.

Importantly, this plan is not a fixed or inflexible rule. We recognise that each incident occurs within a unique context, and we are committed to adapting our response to reflect the specific circumstances and the needs of those affected. Our approach will remain dynamic, informed by ongoing learning, feedback from service users and staff, and developments in best practice.

We will review and refine plan to ensure it remains relevant, effective, and aligned with our core values of compassion, accountability, and person-centred care.

Our Services

Listening Ear is a BACP-accredited mental health charity and growing social enterprise, established in 2006 and based in Knowsley, Merseyside. We deliver trauma-informed services locally and nationally to individuals, groups, and communities during times of emotional distress, bereavement, and recovery.
Our services include:

Butterflies: 1:1 and group support for children and young people experiencing bereavement, family breakdown, or loss, delivered in schools, colleges, community settings, or our venue. Crisis intervention is available following sudden deaths within school communities.

DiAmond: Emotional support and domestic abuse intervention for adults, children, and young people, including counselling, DASH assessments, and MARAC referrals. Sessions are offered face to face, online, or by phone.

Titanium: Counselling for cared-for children and their foster carers to support placement stability, delivered over 6–12 months in schools, community venues, or remotely. Referrals are made via St Helens Multi-Agency Emotional Wellbeing Panel.

Vida: Occupational health counselling for employees of Liverpool City Council, Knowsley, Sefton, St Helens, and Torus, using modalities such as person-centred, CBT, solution-focused, and EMDR.

Aftercare Groups: Ongoing support following counselling, including FAB (Friendship After Bereavement) and EYC (Emotional Youth Club), with drop-in access to counsellors to reduce re-referral needs

Each service is designed to meet specific contractual requirements with sensitivity and care, helping clients build resilience and improve mental wellbeing. Our Aftercare model encourages continued recovery through the 7 Ways to Wellbeing.

Amparo: is a free, confidential support service for anyone affected by suicide—family, friends, colleagues, and more. Run by Listening Ear (Merseyside), with over 25 years of bereavement expertise, it operates in regions covering 26% of England's population, including Cheshire & Merseyside, Kent & Medway, and Thames Valley, and is also available to British Armed Forces personnel.

Amparo also act as a Gateway service for British Transport Police. If there is a suspected suicide anywhere within England on the British Transport system referrals are received through Amparo from British Transport Police. If referrals fall within our area of coverage support is offered. If any referrals fall outside our area of coverage we manage an onwards referral to local services.

Support is tailored and flexible: one-to-one, family, or group sessions delivered in person, by phone, video, 'walk and talk', or at community venues. Amparo also helps with police and coroner liaison, media enquiries, inquest preparation, and referrals to local services. Referrals can be made directly or via professionals, with contact typically within 24 hours.

By offering early intervention, Amparo reduces the risk of suicide clusters and imitative behaviour. In its first four years in Cheshire & Merseyside, no supported individuals died by suicide. With each suicide estimated to cost £1.67 million, Amparo also helps lessen the wider societal impact.

Beyond crisis support, Amparo hosts remembrance events, combats stigma, and provides community response services for schools, workplaces, and institutions. Professionals can access free 40-minute briefings via Teams to better support those affected.

Defining our patient safety incident profile

Listening Ear is committed to fostering a culture of continuous learning and improvement in line with the NHS Patient Safety Incident Response Framework (PSIRF). As part of our 12 to 18-month Patient Safety Incident Response Plan, we are defining our Patient Safety Improvement Profile—a focused set of safety priorities that reflect the specific risks, themes, and learning needs within our service.

This profile is informed by a comprehensive analysis of our incident data, safeguarding concerns, staff insights, and feedback from those who use our services. It enables us to identify the most pressing areas for improvement, such as enhancing communication with individuals at risk of harm, strengthening our safeguarding referral pathways (e.g., timely MARAC referrals), and improving the consistency of our incident response processes.

By clearly articulating these priorities, we aim to ensure that our improvement efforts are targeted, measurable, and aligned with both local needs and national safety expectations. The profile will be reviewed regularly and adapted as new learning emerges, ensuring our approach remains responsive, person-centred, and evidence-informed.

This work supports our broader commitment to the principles of PSIRF—particularly around compassionate engagement with those affected by harm, system-focused learning, and the development of a just and restorative culture.

Defining our patient safety improvement profile

At Listening Ear, patient safety is at the heart of everything we do. As a safeguarding-focused organisation, we are committed to creating a safe, responsive, and supportive environment for every individual who accesses our services. Our Patient Safety Improvement Profile outlines our approach to identifying risks, learning from incidents, and continuously improving our practices.

We prioritise:

- Safe access to services, especially for vulnerable adults and children.
- Robust safeguarding procedures, informed by policy and lived experience.

- Staff training and supervision, ensuring our team is equipped to respond to safety concerns.
- Learning from feedback and incidents, using data and reflection to drive improvement.
- Collaborative working, engaging with partners and service users to co-produce safer care.

Our patient safety incident response plan: National

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 Listening Ears are extremely rare and to date we haven't met the national criteria to undertake 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
Death thought more likely than not due to problems in care	PSII	Would support larger organisation to develop local
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 – organisations should liaise with this.	LeDeR programme

LISTENING EAR
someone to talk to

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

LISTENING EAR
someone to talk to

Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served.

All reported patient safety events will be reviewed by Senior Management Team, CEO and Board of Trustees. The meeting will agree appropriate learning responses and share with external agencies. Learning responses available include: The most proportionate action will be taken following review . All incidents will be reported through LFPSE regardless of level of investigation required.

Patient Safety Incident Investigation (PSII) , After-Action Review ,Swarm Huddles

Patient safety incident type or issue	Planned response	Anticipated improvement route
Delayed or missed referral to MARAC following a high-risk DASH assessment	Immediate review of DASH risk score and professional judgment Initiate 1. Statutory Duty of Candour	Provide staff training on DASH and MARAC processes 1. Introduce audit and monitoring of DASH-to-MARAC timelines
Delayed or missed referral to MARAC following a high-risk DASH assessment	Immediate review of DASH risk score and professional judgment Initiate 1. Statutory Duty of Candor 2. Swarm Huddle 3. After Action Review (AAR) 4. Patient Safety Incident Investigation (PSII) if required	Provide staff training on DASH and MARAC processes 1. Introduce audit and monitoring of DASH-to-MARAC timelines 2. Escalate systemic issues to PSIRF 3. Management Group for oversight 4. Strengthen multi-agency collaboration and feedback loops with MARAC partners

		Review findings through PSIRF Management Group to identify systemic issues

LISTENING EAR
someone to talk to

Patient Safety Incident Response Plan

Final Audit Report 2026-02-06

Created:	2026-02-05
By:	Wayne Malcolm (wayne@breadmedia.co.uk)
Status:	Signed
Transaction ID:	CBJCHBCAABAA4LU6c7rihq0g3qZYTzWJtUKbhY7LjOxa

"Patient Safety Incident Response Plan" History

Document created by Wayne Malcolm (wayne@breadmedia.co.uk)
2026-02-05 - 8:05:00 PM GMT- IP address: 90.221.168.132

Document emailed to Christine Ankers (christine.ankers@listening-ear.co.uk) for signature
2026-02-05 - 8:05:05 PM GMT

Email viewed by Christine Ankers (christine.ankers@listening-ear.co.uk)
2026-02-06 - 1:03:44 PM GMT- IP address: 104.47.85.62

Document e-signed by Christine Ankers (christine.ankers@listening-ear.co.uk)
Signature Date: 2026-02-06 - 1:24:14 PM GMT - Time Source: server- IP address: 81.140.218.234

Agreement completed.
2026-02-06 - 1:24:14 PM GMT