Patient Safety Incident Response Plan

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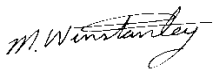
Review Authoriser	Mark Winstanley	Chief Executive		12/05/25

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Introduction

This patient safety incident response plan sets out how Rethink Mental Illness 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.

The Patient Safety Incident Response Framework (PSRIF) sets out the NHS's approach to developing and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The Rethink Mental Illness Communities that Care Strategy aims to influence the quality of care that people receive at a national and local level and there is a clear link between the physical health outcome detailed within our strategy and our patient safety incident response processes. Patient safety investigations are conducted to identify whether there are any interconnected causal factors that lead to the incidents. Actions are identified from the investigations to prevent or continuously and measurably reduce patient safety risks and incidents.

Our services

Rethink Mental Illness provides over 100 services across England. We offer:

Carers Support – offering support to maintain and improve carers wellbeing and providing tailored information and advice about the care and support available.

Advocacy – offering support to people when important decisions are being made about their care and treatment and helping people to understand their rights and options and to express their views and wishes.

Helplines – offering emotional support to those experiencing severe mental illness, their carers and relatives.

Crisis Support – offering 24/7 care home services that provide a safe, stable environment and specialist support to people who are facing a mental health crisis or have left hospital after being an inpatient.

Community Support – offering access to personalised help that can rebuild confidence, help people stay in or return to work and take part in social activities they enjoy.

Criminal Justice – providing primary mental health services in prisons across England. These services are aimed at people who have less severe mental illnesses such as mild or moderate anxiety or depression.

Housing – delivering a range of supported housing services that offer a safe environment in which people can recover and build confidence, helping them feel better equipped to live independently in the community.

Nursing – offering 24/7 nursing care home services that provide a safe environment and specialist support to people with severe and enduring mental illness.

Programmes – delivering and promoting programmes that have an impact and improve people's lives and wellbeing through ensuring everyone has the tools they need to live their best possible life.

We have a register detailing which of our services hold an NHS contract; however, we have chosen to apply the principles of PSIRF across the charity when a patient safety incident occurs.

Defining our patient safety incident profile

The patient safety incident response framework is overseen through the Quality and Safety Board which reports on its progress to the Audit and Assurance Committee. The Quality and Safety Board consists of relevant senior leaders from the Operations directorate, Quality and Business Intelligence, People and OD and External Affairs.

A thematic review was undertaken using data from between 2021 and 2023, with a further review of data in 2024. Patient safety incident risks have been profiled using the following data:

Quality Audits: Two years of data has been reviewed and a thematic analysis undertaken.

Integrated Governance Overview Group: Data and investigations regarding safeguarding, service user death, Duty of Candour, complex complaints and whistleblowing.

Human Resources: Two years of data has been reviewed and a thematic analysis undertaken.

The principles of PSIRF will be applied across the charity following a patient safety incident.

Defining our patient safety improvement profile

The improvement and service transformation work already underway and identified as part of the thematic review includes:

- medication administration practice
- record keeping
- practice issues (inappropriate placement)
- workforce development (skills and training)
- recruitment
- Human Resources matters (performance and conduct)
- Health and safety
- Quality and compliance

Actions identified from patient safety incidents are reviewed and signed off by the Quality and Safety Board. Actions are completed at a local or where applicable a national level with support from the Quality and Service Support Team, if necessary. Completion of actions is overseen by the Quality and Service Support Team and monitored by the Quality and Safety Board. Progress against actions is reported to the Audit and Assurance Committee on a quarterly basis.

Where Rethink Mental Illness is working with Trusts (ICBs), commissioners, and working in partnership, we have reporting mechanisms in place to ensure actions identified from patient safety incidents and learning are communicated.

Our patient safety incident response plan: national requirements

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria (specifically falls from upper windows resulting in serious injury)	PSII	Quality and Safety Board Quality and Business Intelligence Team
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	Quality and Safety Board Quality and Business Intelligence Team
Deaths of persons with learning difficulties	PSII	Quality and Safety Board Quality and Business Intelligence Team

The above patient safety incident types have been selected as national requirements as they are potentially most relevant to Rethink Mental Illness based on service provision and the thematic review which was undertaken.

The response has been determined by the Never Events criteria.

Our patient safety incident response plan: Rethink Mental Illness

Patient safety incident type	Required response	Anticipated improvement route
Medication errors where harm has occurred	PSII	Duty of Candour Panel Quality and Safety Board Quality and Business Intelligence Team
Safeguarding concerns resulting in the harm of a service user	PSII	Safeguarding Nominated Lead Quality and Safety Board Quality and Business Intelligence Team
Whistleblowing concerns resulting in the harm of a service users	PSII	Quality and Safety Board Quality and Business Intelligence Team

The above patient safety incident types have been selected as requirements that are potentially most relevant to Rethink Mental Illness based on service provision and the thematic review which was undertaken.

Rethink Mental Illness have chosen to respond with a patient safety incident investigation to the above due to harm having occurred to a service user.

Our patient safety incident response plan: local focus

There are assurance systems in place to ensure the oversight of incidents at a local level. Operational managers ensure the:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risk and issues, e.g. CQC concerns
- Identification of any incidents requiring external reporting or scrutiny
- Identification of any other incidents of concern such as serious near-misses or significant failures in established safety procedures

Patient safety themes and learning are discussed at a local level via Team Meetings and Group Supervisions.

The current structure for responding to and oversight of patient safety incidents at a local level and how this is escalated to a national level is detailed below: