Policy Name:	CANW Patient / Service User Safety Incident Policy and Plan
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Other Related Documents	See CANW Policies referenced within the Policy Framework Safeguarding Policy Whistleblowing Policy Health & Safety Policy

1. Approval

This procedure has been approved by the undersigned, and it will be reviewed on at least an annual basis

2. Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Child Action Northwest's approach to developing and maintaining effective systems and processes for responding to all client and service user safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a coordinated and data-driven response to patient safety incidents. It embeds patient/service user 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/service user 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.

This Policy is written to directly align with CANW existing Safeguarding Policy and reporting Framework. (See Safeguarding Policy and Procedure January 2025)

This Policy should be used in conjunction with CANW existing Health & Safety Policy and reporting framework. (See H&S Policy and Procedure January 2025)

This Policy is aligned to the existing agreed risk reporting frameworks in relation to our OFSTED registration and Charity Commission regulation frameworks.

CANW delivers non-clinical services only at the time of writing this report therefore this policy refers to "Patient/Service User" for the purpose of accuracy and context.

2. Scope

This policy is specific to service-user safety incident responses conducted solely for the purpose of learning and improvement across Child Action Northwest. It applies to all employees, workers, contractors, volunteers including those involved in direct service delivery and staff in support roles.

Responses under this policy follow a systems-based approach. This recognises that service user safety is an emergent property of the broader community 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.

3. Definitions

- Patient/Service user Safety Incident: Any unintended or unexpected incident that could have or did lead to harm for one or more patient/service user.
- Near Miss: A safety incident that did not reach the patient/service user.
- Harm: Injury (physical or psychological), disease, suffering, disability, or death.

4. Our Safety Culture

Child Action Northwest promotes a nurturing, safe, caring and learning culture that enables a safe and compassionate environment and allows all staff to be open and transparent about incidents. With a learning culture, we encourage an environment where all staff feel it is safe to report incidents and/or near misses so that the organization can learn from them with a 'no blame' policy.

Senior Leadership Team and our Health and Safety committee meet on a regular basis to discuss reported incidents and the outcomes to ensure we have taken all appropriate corrective action.

We provide feedback and training to all staff to ensure incidents are reported correctly with the correct level of information.

5. Patient Safety Partners

Child Action Northwest will engage with the ICB patient safety team and appropriate partners and agencies to support service user safety.

6. Addressing health inequalities

Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society.

Child Action Northwest aim to reduce inequalities in health outcomes by improving access to available services and tailoring those services around the needs of the local community in an inclusive way.

Child Action Northwest will engage with service users, families, carers and staff following a PSI to fully review the incident events and outcome and include them in our safety response.

7. Engaging and involving service users, families and staff following a safety incident.

The PSIRF recognises that learning and improvement following a patient/service user safety incident can only be achieved if supportive systems and processes are in place.

It supports the development of an effective patient/service user safety incident response system that prioritises compassionate engagement and involvement of those affected by patient/service user safety incidents (including service users, 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.

Child Action Northwest have regular health and safety group meetings where all incident reporting is shared and discussed to ensure corrective measures are adequate and learning is shared.

CANW are committed to continuous improvement throughout the organization and services we provide. CANW will learn from any incidents and will listen to any concerns of staff, service users, families where services haven't gone as planned allowing them a safe space to feed back.

Child Action Northwest commit to being open and transparent regardless of the level of harm caused by an incident in line with our statutory responsibilities for Duty of Candour.

8. 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.

Child Action Northwest will take a balanced approach to the investigation and response of a incident and be flexible with our approach.

9. Resources and Training

Child Action Northwest are committed to ensure that we embed the requirements of PSIRF and meet the requirement where required.

Child Action Northwest will share learning from incident from Senior Leadership Team down to all staff within the service to promote learning and any preventative measures.

Child Action Northwest will provide training to ensure all staff, volunteers and workers are aware of their responsibilities in reporting and responding to PSI's and to comply with NHS England Health Education England Patient Safety Training Syllabus including:

- Patient safety syllabus level 1: Essentials for patient safety.
- Patient safety syllabus level 2: Access to practice.

Training is accessible to all relevant staff, volunteers and workers via : NHS Patient Safety Syllabus training - elearning for healthcare (e-lfh.org.uk)

10. Our Patient Safety Incident Response Plan

Our plan sets out how Child Action Northwest 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.

11. Reviewing our PSIR 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, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate to ensure efforts continue to be balanced between learning and improvement.

This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

12.Responding to patient safety incidents

All staff, workers and volunteers are responsible for reporting any potential or actual incident to their immediate line manager or next available manager at the time of the incident along with the level of harm that has been experienced by the person affected.

Incidents must be reported using the Accident/incident reporting form within 24 hours of occurrence. The supervisor or a nominated independent service manager must conduct an initial assessment within 24 hours to determine the severity of the incident.

If the supervisor/senior person at the scene of the incident is unsure of what safety action to take, they have access to their Head of Service during regular office hours or during weekends and evenings, CANW provide a 24/7 out of hours advice rota.

All forms will be returned to HR who will log the incident/accident detail and follow up any onward notifications to CANW Insurers if appropriate for specialist advice. Incidents will then be investigated and responded to efficiently and as quickly as possible.

Learning logs from all incidents will be analysed by CANW H&S Operational Group or escalated to Senior

Leadership Team to identify any future or current training needs that will be added to our Learning Management system

Where the opportunity for learning and improvement is significant, incidents will be escalated to the ICB for support where cross system working can support with a collaborative response. Where applicable, the head of service will act as liaison with external bodies and partner providers to ensure effective communication and point of contact for the organisation.

13. Patient safety incident response decision-making

HR will report all incidents to any appropriate external bodies/regulators if meet Threshold of risk and severity in line with Government Guidance and legislative frameworks.

If immediate corrective action is required, it must be taken to ensure patient/service user safety. Our priority will always be the immediate needs of the affected individual/s.

If the supervisor/senior person at the scene of the incident is unsure of what safety action to take, they have access to their Head of Service during regular office hours or it at Weekends and evenings, CANW provide a 24/7 out of hours advice rota.

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

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

14. Responding to cross-system incidents/issues

Child Action Northwest will work with partner providers and the relevant ICBs to maintain efficient and effective procedures and responses.

If an incident is deemed to be reported to OFSTED under our Foster Care Regulatory Framework, then the Registered Fostering Manager will escalate the incident report to OFSTED and notify the Chief Operating Officer and CEX.

Investigation and reporting of any incident/accident involving a child or vulnerable adult/ service user and deemed to be a Safeguarding risk will be reported via the agreed Safeguarding protocol and procedure flow chart**.**

15.Timeframes for learning responses

A learning response must be started as soon as possible after the incident is identified and should be completed within one to three months of the report. No learning response should take longer than six months to complete.

16. Safety action development and monitoring improvement

Following an incident, Child Action Northwest will agree safety actions in relation to defined areas for improvement.

Following this, Child Action Northwest will have measures to monitor any safety action and set out review steps. These actions will be overseen by the Senior Leadership Team and Board of Trustees.

17. Safety Improvement Plan

Safety improvement plans are used to compile and review responses to patient safety incidents and issues. Child Action Northwest PSIR Plan has outlined the local priorities for focus of investigation under PSIRF to allow us to reflect and improve. Monitoring of progress regarding the safety improvement plans will be overseen and reported to the Board of Trustees.

18. Roles and Responsibilities

Board of Trustees / Directors	The Board of Trustees has the ultimate responsibility for all aspects of patient/service user 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.
Senior Leadership Team (SLT)	SLT 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.
Head of Service	Head of Service has responsibility for patient safety within CANW and is accountable for ensuring an adequate system is in place to enable appropriate responses to safety incidents that occur.
Staff / Volunteers / Workers	All staff/volunteers across the organisation are responsible for ensuring any patient safety events are reported within 24 hours of occurrence and participate in investigation and responses. All staff should take up advice and guidance from incidents in their supervisions and engage with mandatory and service specific training. All staff will be required to adhere to this policy.

19. Complaints and appeals

Child Action Northwest recognizes that there will be occasion when the patients, families or carers are dissatisfied with our services. Child Action Northwest are committed to deal with any complaints efficiently and effectively. Complaints will be handled with care and will ensure that all parties concerned feel involved in the process and assured that the findings and outcome will be shared.

Child Action Northwest complaints procedure can be found at Home page - CANW.