Policy Name:	CANW Patient / Service User Safety Incident Policy and Plan
Author:	Amy Jackson HR Manager
Reviewer:	Michelle Dixon Operations Director
Approver:	Naomi Hollinshead Chief Operating Officer
Current Date:	April 2025
Next Review Date:	September 2026
Other Related Documents	See reference to CANW Safeguarding Policy 2025 CANW Whistleblowing Policy April 2025 CANW Complaints Policy January 2025

1. Approval

This plan has been approved by CANW Board, and it will be reviewed on an annual basis in line with CANW Board rolling practice improvement cycle

2. Introduction

This patient safety incident response plan sets out how Child Action Northwest intends to respond to patient/service user 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/service user safety issues and incidents occurred and the needs of those affected and feed learning in to associated policy, procedure, reporting and recording training for all staff and volunteers as appropriate.

2. Our Services

Child Action Northwest provide a number of services such as;

Fostering Services in line with National standards currently rated as Good in 2023. (commissioned by multiple Local Authorities as part of the North West and West Yorkshire Framework agreements and regulated by Ofsted in their three year inspection cycle.)
Emotional Health and Well-being support (commissioned by Local Authorities, Schools, ICB)
Criminal Justice (commissioned by Local Authorities and Police & Crime Commissioners)
Residential Care for Children (commissioned by Local Authorities as part of the North West Framework Agreement and regulated by Ofsted).
ProContact (commissioned by CAFCASS, BwD, Local Authorities, Private commissions)
Social Inclusion (commissioned by Shared Prosperity Funding, Lottery Funding, Youth Engagement Fund)

Patients/Service users are referred into the services by schools, health, self-referrals, courts, police or local authority.

Our services offer a range of support including but not limited to; therapeutic care, fostering and respite foster care, counselling on an individual group basis , appropriate adults services in custody, children's residential homes, supported family time in community settings and contact centers, volunteering and support opportunities for marginilised groups of young people and vulnerable adults including NEET.

3. Defining our patient safety incident profile

Child Action Northwest is committed to learning from patient safety incidents. The type of incidents we may face include but are not limited to; suicide ideation, suicide, self-harm or harm to others, injury to staff, safeguarding concerns, injuries, children and vulnerable adults at risk.

Incidents and service user feedback and complaints are reviewed regularly for any trends and themes and preventative measures where possible. Child Action Northwest will produce improvement plans with corrective actions which will be shared with staff.

4. Our patient safety incident response plan: National Requirements.

Reported incidents at Child Action Northwest are low and to date, we have not met the national criteria to undertake investigations. Child Action Northwest will however consider improvement plans as and when required as a risk or issue arises.

As stated in our Policy

This plan 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.

It is also important to note that this plan also aligns with our Safeguarding practice improvement plan and protocols in line with DFE Working Together principles Working together to safeguard children - GOV.UK and OFSTED Notification processes as required through our formal registration process.
Ofsted - GOV.UK

We will ensure that we strive to adhere to statutory reporting and learning review processes while being flexible in respect of the learning and needs of patients/service users impacted by any incident so that we don't overwhelm and duplicate reviews and learning processes.

Patient safety incident type	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	PSII	Would support larger organisations to develop local organisational actions.
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 organisations to create local organisational actions.
Deaths of patients detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies.	PSII	Would support larger organisations to create local organisational actions.
Mental health-related homicides	Referred to the NHS England Regional Independent Investigation Team (RIIT) for consideration for an independent PSII	As decided by the RIIT
Maternity and neonatal incidents meeting Healthcare Safety Investigation Branch (HSIB) criteria or Special Healthcare Authority (SpHA) criteria when in place.	Refer to HSIB or SpHA for independent PSII	Would support larger organisation to develop local organisational actions
Child deaths	Refer to Child Death Overview Panel review. PSII	As directed by the Child Death Overview Panel
Safeguarding incidents	Refer to local authority safeguarding lead.	Identify greatest potential for learning. Create local safety actions.
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	As directed by the DHR panel, meeting the obligations of The Domestic Violence, Crime and Victims Act 2004.

	and commissioners of health services in relation to DHRs	

5. Our patient safety incident response plan: local focus

PSIRF allows organisations to explore patient safety incidents relevant to their context and the populations served. From the patient incident identified in section 3. Child Action Northwest will respond accordingly when incidents occur ensuring that these incident are reported to relevant regulated authorities such as but not limited to, charity commissioners, LADO, Ofsted, HSE and local Safeguarding Children or Adult Boards as most appropriate.

Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Delay in referral into CANW Services	Action Review QAF Quality Assurance Framework CANW follow a structured approach for reflecting on the work of a group and identifying what went well, strengths, weaknesses and areas for improvement. This exercise will take place within discussions following an event.	Identify and share learning. Further training where required. Create local safety actions.
Information Governance Breach	Action Review QAF quality assurance framework This will take place a facilitated discussion in the event of a breach also in line with company policy on data breaches.	Identify and share learning. Further training where required. Create local safety actions
Safeguarding incidents / concerns	Refer to local authority safeguarding hub and follow internal safeguarding policy and framework for each service.	Identify and share learning. Further training where required. Create local safety actions

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