

Compass Safety Incident Response Plan

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Contents

Introduction2

Our Services2

Defining our safety incident profile3

Defining our safety improvement profile4

Our safety incident response plan5

Monitoring safety incident responses6

Introduction

This safety incident response plan sets out how Compassintends to respond to safety incidents over a period of 6 - 12 months. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which safety issues and incidents occur and the needs of those affected. This plan reflects the context of care and services provided by Compass setting out proportionate and purposeful response to support our continuous improvement in the delivery of early intervention, prevention and promotion services.

Our services

Compass provides early intervention and prevention services to children and young people (CYP) across a wide geography and multiple specialities including school health, substance use and risky behaviours, sexual health and emotional and mental health and wellbeing. In all services Compass has clear local pathways of care and partnerships which allow for timely onward referral to additional support or services where there is a known or suspected risk to safety. Providing early intervention prevention and health promotion activity naturally means that safety incidents are not common.

Defining our safety incident profile

Some types of patient safety incident need to be responded to in a particular way as set out in national policies or regulations. This may include review by or referral to another body or team, depending on the nature of the event. For Compass and our work with early intervention, prevention and promotion in the community many of these national priorities are not relevant to our scope of work.

Compass may work with children, young people or families who are impacted by incidents defined as a national priority, including:

Deaths thought more likely than not due to problems in care.

Child deaths.

Safeguarding incidents in which:

• Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence.

• Adults (over 18 years old) are in receipt of care and support needs from their Local Authority

• The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence.

Compass response to these national priorities are detailed here in the plan.

To ensure that we understood Compass local safety incident profile, and to identify our incident response priorities, we have reviewed data from April 2021 – December 2023 for all incidents and complaints reported to Clinical Governance Group (advisory group to the Compass Board of Directors). There have been very few safety incidents with no evidence of significant repeating themes or ongoing risk.

We have sought feedback from across the organisation including practitioners, managers, clinical leaders and members of the Board.

We have identified that 2 incidents over the review period included concern regarding the practice in clinical risk assessment and this is also included in our response plan below as a local priority.

## Defining our safety improvement profile

Safety Incident Investigations (SIIs) are Compass’s most in-depth investigation response for incidents. In addition to those that are mandated nationally, Compass will carry out SIIs for the priority area identified in this plan and any safety incident, event or series of events with the potential for learning and improvement, this may include a series of no harm incidents where closer scrutiny of patterns may reduce likelihood and improve safety.

Incidents meeting the Never Events criteria[[1]](#footnote-2) (2018) or its replacement, and deaths thought more likely than not to have been due to problems in care require a locally-led and coordinated response but are highly unlikely to be led by Compass due to the nature of the care and services provided. Compass staff will always work collaboratively with commissioners and system partners and contribute to such safety responses as required.

The national safety incident framework sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Instead, organisations are able to balance effort between learning through responding to incidents or exploring issues and improvement work.

# Our safety incident response plan.

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| **National Safety Incident Priority** | **Planned Response** |
| Safeguarding incidents in which:• Babies, child and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence. • Adults (over 18 years old) are in receipt of care and support needs from their Local Authority • The incident relates to FGM, Prevent (radicalisation to terrorism); modern slavery & human trafficking or domestic abuse / violence. | Refer to local authority safeguarding lead. Compass will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the Local Safeguarding Partnership (for children) and local Safeguarding Adults Boards. |
| Deaths thought more likely than not due to problems in care. Including all deaths by suicide of young people in the care of Compass. | Participation in system NHS/ICB led Patient Safety Incident Investigation (PSII) of Compass led Serious Incident Investigation SII. |
| Child Deaths | Refer for Child Death Overview Panel review. Compass led SII (or other response) may be required alongside the Panel review – Compass will liaise with the panel and contribute to multi agency panel and review. |
| **Local Safety Incident Priority** |  |
| Standards of Clinical Risk Assessment | Compass led SII. |

# Monitoring safety incident responses.

Compass has established clinical and quality assurance frameworks centred around specialist Clinical Working Groups (CWG) across each of the three directorates:

* Mental health and Emotional Wellbeing
* Risky Behaviours including Substance Misuse
* School Nursing

Each CWG brings together practitioners, clinical leaders and operational managers to analyse safety and quality themes, prepare responses and coordinate continued development of safe and effective practices. The CWGs work to a standard terms of reference and report to the Clinical Governance Group (CGG), an advisory group to the Compass Board who retain oversight of and accountability for the safety and effectiveness of services.

**Clinical Working Group Terms of Reference**

* Undertake tasks and activities arising from the CGG that require operational or clinical attention and those considered a priority.
* Review incidents, actions and lessons learnt identifying any common themes where action may be required.
* Review local identified risks, linked to the organisational clinical risk register ensuring actions are in place to minimise risk.
* Monitor and review findings from compliance and quality audits sharing good practice and identifying any areas requiring improvement, ensuring mitigations are in place to address these.
* Monitor and review of informal and formal complaints identifying lessons learnt and common themes occurring throughout to improve the quality of services and minimise any future risk of reoccurrence.
* Explore service improvement opportunities identified through reviewing the risk register, incidents, complaints, and findings from clinical audits to improve clinical pathways and early intervention.
* Ensure information is shared regarding updates/changes to organisational policies and information has been disseminated throughout the organisation in a timely manner.
* Review, monitor, and update embedded local working documents by regular review, testing and responding to feedback from staff, service users & stakeholders.
* Ensure that services are working to national standards, guidelines and evidence based best practice (NICE, D of H, UKHSA, NMC, OHID, BACP etc) and develop new local policies, procedures and documentation as required to support practice.
* Deal with issues arising from planned or completed CQC inspections. This includes sharing learning across the organisation as necessary.
* Encouraging clinical feedback via compliments received from service users and stakeholders across the directorate highlighting, sharing and celebrating good practice within the services.

The CWGs will maintain oversight of and accountability for the delivery of this safety incident response plan.

1. Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. [↑](#footnote-ref-2)