Northamptonshire Safeguarding Adults Board

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SERIOUS INCIDENT/SAFEGUARDING PROCESS

2021-2022

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Northamptonshire Inter-Agency Procedures

Interface between Serious Incident reporting in health services and multi-agency safeguarding adults' procedures

1. Aims and Objectives

This procedure seeks to ensure an effective interface between safeguarding adult's procedures and procedures carried out through the Serious Incident investigation process for health services.

The coordination of investigations requires a mutual understanding of each organisation's statutory/legal responsibilities, effective communication, cooperation, transparency and learning across the multi-agency safeguarding adult's partnership.

2. Context

Serious Incidents (SI) requiring investigation were defined by the *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (NPSA 2010)* and subsequently revised and updated in the NHS England Serious Incident Framework, April 2015[1] In summary, the April 2015 definition describes a Serious Incident as:

> "An event in health care where the potential for learning is so great or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient's safety or an organisations ability to deliver ongoing healthcare".

The definition below sets out circumstances in which a Serious Incident must be declared. Every incident must be considered on a case-by-case basis using the description below. Inevitably, there will be borderline cases that rely on the judgement of the people involved.

Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
  - Unexpected or avoidable death of one or more people. This includes suicide/self-inflicted death and homicide by a person in receipt of mental health care within the recent past.
  - Unexpected or avoidable injury to one or more people that has resulted in serious harm.
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user or serious harm, or
  - Actual or alleged abuse including sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where healthcare did not take appropriate action/intervention to safeguard against such abuse occurring, or where abuse occurred during the provision of NHS-funded care; This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident. *Refer to NHS England Serious Incident Framework, April 2015 in 2. above.*
- A Never Event - all Never Events are defined as Serious Incidents although not all Never Events necessarily result in serious harm or death - see Never Events Policy and Framework January 2018.

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[1] As outlined in the NHS patient safety strategy NHSE are in the process of developing a new Patient Safety Incident Response Framework (PSIRF) to replace the current Serious Incident Framework in 2022.

- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
  - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
  - Property damage
  - Security breach/concern
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services)
  - Activation of Major Incident Plan (by provider, commissioner or relevant agency)
  - Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

3. Care Act Safeguarding Definition

The adult safeguarding duties under the Care Act 2014 apply to an adult, aged 18 or over, who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Care and support is the mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent, including older people, people with a disability or long-term illness, people with mental health problems, and carers. Care and support includes assessment of people's needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations.

Safeguarding adults at risk of abuse or neglect under Section 42 of the Act:

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

  (a) has needs for care and support (whether or not the authority is meeting any of those needs)
  (b) is experiencing, or is at risk of, abuse or neglect
  (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

(3) "Abuse" includes financial abuse; and for that purpose "financial abuse" includes:

  (a) having money or other property stolen
  (b) being defrauded
  (c) being put under pressure in relation to money or other property
  (d) having money or other property misused.

4. Process

Safeguarding is effectively protecting adults with care and support needs from abuse or neglect. All NHS commissioned services have a key role to play in safeguarding as this is a statutory requirement under the Care Act 2014.

Serious Incident investigations take a systematic approach that seeks to improve the way services are being provided and to minimise the risk that incidents of concern will reoccur through sharing lessons learned. Each NHS organisation will have a separate Serious Incident policy which is in conjunction with the overarching commissioning policy. The purpose of the safeguarding investigation is to establish whether abuse or neglect has occurred in order to inform the protection planning process.

As the focus of the investigations is different, the findings of one investigation do not in itself determine the conclusions of the other. The Safeguarding Serious Incident process supports decision making whilst undertaking an investigation where there are safeguarding concerns such as omissions in care.

A number of events that are reported as a serious incident are often safeguarding issues too e.g. neglect or poor care in a health setting. Whilst such incidents should always be reported as Serious Incidents they are also a safeguarding issue and a notification must also be raised in line with multi agency procedures.

Integrating the processes allows:

- Responses in line with requirements of the NHS England Serious Incident Framework 2015
- Effective communication and support to those patients and service users involved
- Transparent, coordinated and comprehensive investigation
- The bringing together of learning for continuous improvement
- The avoidance of duplication of effort from multiple investigations
- One investigation report to serve both purposes.

All correspondence to the Safeguarding Adult Teams should be sent to the secure inboxes at either:

West Northants Council - SafeguardingWest.NCC@WestNorthants.gov.uk

North Northants Council - SafeguardingNorth.NCC@NorthNorthants.gov.uk

5. Timescales

From the outset, a single timeframe (initially 60 working days – anything outside of this timeframe must be communicated to the respective Safeguarding Adults Team in North or West Northants Council) has been agreed for the completion of investigation reports. This allows providers and commissioners to monitor progress in consistent way. This also provides clarity for patients and families in relation to completion dates for investigations.

Please refer to the flowchart in Appendix I which sets out the process for managing incidents.

6. Multi-Agency Concerns

When an agency has commenced a Serious Incident investigation where multi-agency concerns have been identified as omissions, they should refer to the Northamptonshire SAR Protocol and discuss with their agency safeguarding lead to consider whether the criteria is met for a Safeguarding Adult Review (SAR) referral. Agencies should review their own internal processes to evidence that a SAR has been considered as part of the Serious Incident investigation, such as in the Terms of Reference for the SI. Once agreed, referrals should be sent to the Business Office at NSAB.NCC@WestNorthants.gov.uk.

7. Audit

Audit is an important assurance process for health organisations and the Safeguarding Adults Teams in North & West Northamptonshire Councils to check the quality of the safeguarding records, and that internal and multi-agency procedures have been followed. The Serious Incident & Safeguarding Protocol provides a framework for a joint audit process between health providers and the Local Authorities Safeguarding Adult Teams to ensure there is a shared understanding and consistant application of the process.

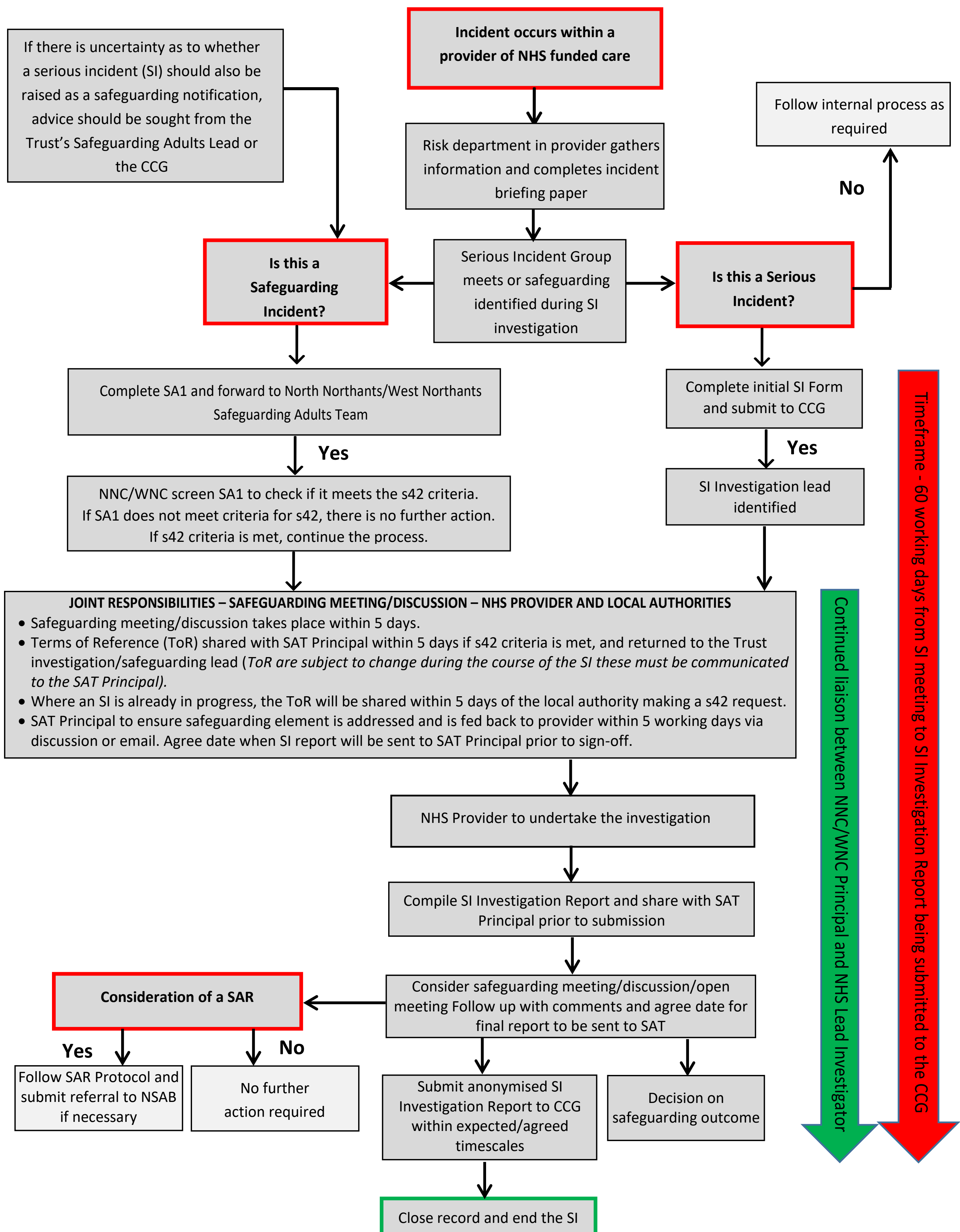
Each health organisation will examine five serious incidents/safeguarding adult investigations using the Serious Incident and Safeguarding Audit tool (please refer to Appendix II), as part of the Quality & Performance (Q&P) Sub Group's audit calendar.

The audited cases should be communicated to the local authorities' North & West Safeguarding Adult Teams respectively, to ensure that the audit review includes appropriate aspects from both local authorities. The results of the audit will be discussed at the Q&P Sub Group for confirm and challenge.

Completed audits should be sent to the NSAB Business Office at NSAB.NCC@WestNorthants.gov.uk who will collate the information in preparation for review by the Q&P Sub Group. The results of the audits will be shared with NSAB to ensure that the expected standards have been achieved.

Appendix I

Northamptonshire Serious Incident and Safeguarding Procedure – June 2021



Appendix II

Audit Deadline	
Name of Auditor in the health provider	
Agency completing the audit	
Case Audit ID	

Serious Incident Safeguarding Adult Investigation Audit Tool

Question	Y/N	Answer
Number of adult safeguarding concerns that resulted in a decision to undertake a Serious Incident investigation.		Number of SIs within the reporting period that were also adult safeguarding concerns.
Was the SA referral made at the outset of the investigation process?	Y/ N	If no, was a SA concern raised during the SI process? Also provide justification for the delay.
Was a Safeguarding Adults Team (SAT) case lead (Principal) identified?	Y/N	At what point was the SAT Principal identified? If the case lead was not identified, please provide justification.
Did a multi-agency safeguarding discussion/meeting take place?	Y/N	At what point/s did the discussion/meeting take place? If there was a delay or didn't occur please provide justification.
Were the Terms of Reference shared with SAT within 5 days of the local authority notifying the provider of the s42?	Y/N	If a delay or ToR were not shared, please provide justification.
Where an SI is already in progress, were the ToR shared within 5 days of the local authority making a s42 request?	Y/N	If the ToR were not returned within timeframe, please provide justification
Were the Terms of Reference (ToR) returned by SAT within 5 working days?	Y/N	If ToR were not returned within timeframe, please provide justification.
Is there evidence of good communication from/to provider/ SAT lead during investigation?	Y/N	If there is no or little evidence of communication, what is the explanation and justification?
Was a safeguarding meeting/case discussion convened by SAT?	Y/N	If the meeting/case discussion was not required, please provide justification
Was a protection plan discussed, agreed and documented within the process?	Y/N	If the protection plan was not required, please explain and provide justification.
Did the SI meet the referral criteria for a SAR? If yes, was appropriate consideration given to the potential need for a SAR and can this be evidenced?	Y/N	If a SAR referral should have been considered but no referral was made, provide justification for why a referral didn't take place.
Was the SI report shared with SAT and the safeguarding elements agreed by the SAT Principal prior to submission, and was feedback provided to the provider SI lead?	Y/N	If the SI report was not shared/agreed by the SAT case lead, please provide an explanation.
Was an SA2 completed and returned to SAT?	Y/N	If the SA2 was not completed, please explain.
Was the alleged victim/family kept informed during the SI investigation and were they offered support during the process?	Y/N	If the victim/family were not involved, please explain the reason why.
Has the report been shared with the adult concerned or others as appropriate?	Y/N	If the report has not been shared, please explain the decision not to do so.
Can you evidence that Duty of Candour has been applied to the investigation including an apology if appropriate?	Y/N	If not, please explain the reasons why.

Now complete the NSAB Serious Incident & Safeguarding Excel spreadsheet with the detailed information for each case

Please forward your completed audit to: NSAB.NCC@WestNorthants.gov.uk