Somerset Council

Learning from serious incidents in Adult Social Care

Learning from Serious Incidents in Adult Social Care Policy

1. Purpose

This Policy sets out the approach that Somerset Council's Adult Social Care (ASC) service takes to reporting, reviewing, and learning from serious incidents.

The Care Act 2014 places a general duty on Local Authorities to promote the wellbeing of individuals. Specific duties are placed on the Local Authority to safeguard adults at risk of abuse or neglect, and on Safeguarding Adults Boards to carry out Safeguarding Adults Reviews where the criteria are met (Section 5).

Care Act Statutory Guidance (2016) establishes the role of the Principal Social Worker (PSW), and the associated responsibility to deliver excellent social work practice, encompassing quality assurance and improvement.

In meeting individuals' care and support needs as defined in the Act, the Local Authority commissions services which are regulated by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and require that 'organisations assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services)'.

This policy aims to support the delivery of these services and our own legal responsibilities through robust internal governance processes, and continuous learning and improvement. The policy also aims to support the delivery of other statutory and non-statutory review processes (Section 5) through the provision of high-quality information and effective partnership working.

2. Scope

This policy relates to the reporting, reviewing, and learning from incidents that meet the following criteria:

- Where an individual known to our adult social care service experiences severe harm[1], dies unexpectedly or dies in untoward circumstances.
- A "near miss" may also be considered a serious incident. Staff should use their professional judgement to consider the severity of the harm which may have occurred, and the likelihood of the incident occurring again if current systems and practices are not reviewed when deciding whether to report a near miss. If in doubt, it is better to report than not.

This policy does not cover health and safety incidents involving ASC staff. These should be reported using the Data Collection Form in accordance with the Council's Health and Safety Incidents policy. Additionally, any quality concerns regarding local care provider settings should be reported using the Service Quality Feedback (SQF) Form

[1] Severe harm may include serious physical injury, emotional harm, or sexual harm.

3. Reporting serious incidents

All incidents that meet the definition and criteria outlined in Section 2 of this policy should be considered and reported.

When people in receipt of care and support experience poor outcomes, we are committed to understanding how and why something happened to inform learning and changes that will reduce the risk of it happening again in the future.

The timely reporting of incidents enables ASC to coordinate its response to, and engagement with, other statutory reviews and learning activity, such as Safeguarding Adults Reviews (SARs) and/or investigations led by HM Coroner.

It also enables our teams to coordinate escalation to senior management teams, legal services, and corporate communications as appropriate.

Safety of the individual

In the event of a serious incident, priority must be given to ensuring the welfare and safety of those involved. Objective and contemporaneous details of the incident should be added to Eclipse as soon as practicably possible.

How to report

All Adult Social Care staff share responsibility for identifying incidents.

If an employee becomes aware of an incident which they believe may meet the criteria in Section 2, they should discuss it with an available Service/Locality Manager (G8 and above) as soon as possible. The operational manager should then review the circumstances against the criteria and agree whether a referral should be made.

Any member of staff can report an incident, with agreement from an operational manager, using the ASC Serious Incident Reporting Form. The form should be completed as soon as practicable after the management discussion and within 2 working days of becoming aware of the incident.

The case will be logged by the ASC Policy, Performance and Assurance Team, and the referrer will receive an automatic reply confirming receipt.

Media and press

In reporting an incident, staff should consider whether the incident is likely to also attract media coverage which could impact negatively on the Council's reputation and indicate this on the referral form.

Be aware that the Council's Press Office within the central Communications Team is responsible for responding to all media enquiries about Somerset County Council.

If a member of the media contacts a member of staff directly, please ensure you refer them to the Press Office on 01823 355020, even if they ask for information about a service or situation you are familiar with.

The ASC Policy, Performance and Assurance Team will escalate concerns to the Senior Management Team and Corporate Communications team as/where necessary.

Where staff become aware that ASC may be subject to such media coverage which is not related to a serious incident as defined in this policy, they should escalate this via usual line management processes.

Duty of candour

The Duty of Candour regulation places a legal duty on CQC registered health and social care providers to be open and transparent with service users and their families when things go wrong. It also requires services to acknowledge the harm a person or their family has suffered and is the first step to learning from what happened so that services can be improved for the future.

In ASC, the spirit of the legislation extends further, and a duty of candour therefore applies to all services provided or arranged by the service.

In the case of an unexpected death or severe harm, the operational team reporting the serious incident, or directly involved, are responsible for ensuring that a letter of acknowledgement or condolence is sent to the affected person, their family or representative, as appropriate. In deciding who to send the letter to, the team should consider the individual's recorded expressed wishes. *Please refer to an example letter of condolence template in the 'supporting linked documents' section at the end of this policy.*

4. The Review Process

The review process at all stages should be guided by the following principles:

- **Positive**: All reviews should seek to identify good practice and should take a positive approach to identifying strengths in existing practice and systems, as well as areas where practice and systems could be improved.
- **Holistic**: Nationally, systems learning approaches are recognised as an effective method to identifying quality learning outcomes to support positive change. The systems approach recognises that people's behaviour is shaped by systemic

influences. It looks, therefore, at the interactions between people and factors in the workplace.

- **Reflective:** Reviews should reflect the professional responsibilities of ASC practitioners and a positive culture of continuous learning and improvement. They should embody critical reflection, considering what we already know from research, law, and the national body of learning.
- **Proportionate:** Reviews should be proportionate to the likely opportunities for learning and, to a lesser degree, the severity of the incident. They should be carried out in such a way that the timescale of completion does not inhibit improvement action.
- **Objective:** Reviews should be fair, balanced and evidence based. The process is not used to apportion blame. It should take account of what practitioners knew or could have been expected to have known at the time. Reviews are not disciplinary proceedings. If poor practice issues emerge that require capability/disciplinary procedures, these will be conducted by the relevant manager in liaison with HR and are separate from the review process
- **Confidential:** Those who are the subject of a review have a right to dignity and confidentiality, even if they have sadly passed away. In carrying out the activities outlined in this policy, staff are required to follow ASC policy and guidance in relation to the Data Protection Act 2018. Staff members involved in the case also have a right to confidentiality within the review process and written reports.

Triage of serious incident reports

The ASC Policy, Performance and Assurance Team will ensure the Principal Social Worker and Principal Occupational Therapist (in their roles as Chairs of the ASC Practice Quality Board) are made aware of any incidents reported and are kept up to date throughout the process.

- **Dynamic ('rapid') Review – Stage 1**

Once an incident has been identified and reported, the relevant operational team (the referrer and/or operational manager/Practice Development Advanced Practitioner[2]) must initially carry out a dynamic review within 15 working days / 3 weeks using the required template to capture key chronological information and identify initial learning/recommendations:

ASC Dynamic Rapid Review Template.docx

[2] *There may be reasons why the dynamic review needs to be allocated outside of the referring team, such as - level of concern regarding the severity of the incident and initial findings; significant issues of capacity in the referring operational team to undertake the work, as confirmed by a Service Manager; the necessity of an objective review of the circumstances.*

The dynamic review should also indicate whether the case is already, or is likely to be, subject to other parallel processes which are outlined in Section 5.

Formal interviews with staff are not carried out at this stage but the reviewer may wish to contact other staff to clarify information, for example, if a case note is unclear or if the reviewer is unfamiliar with a specific process.

The reviewer should summarise their findings on the Dynamic Review Recording Template and notify senior and departmental management of any relevant concerns (media, legal or complaints) as appropriate.

At the conclusion of the Dynamic Review, the completed template will be reviewed and if there is a clear indication of actions which can be taken at this stage, these will be disseminated to appropriate practice groups and Departmental Managers/ members of the Practice Quality Board.

A decision will be made as to whether the case should progress to an Enhanced Review (Stage 2). This decision will be taken by Principal Social Worker and/or Principal Occupational Therapist / via the Practice Quality Board.

Some incidents will close at this stage because there either is no specific learning or the learning identified can safely be progressed without further escalation, or it may be that the case will now be appropriately being investigated by other processes (Section 5).

- **Enhanced Review – Stage 2**

The decision to progress to an Enhanced Review is based on the following criteria:

- The Dynamic (Stage 1) Review indicates a likelihood of further learning which is not already well understood by the Service; *and/or*
- The incident is considered sensitive due to having attracted public or media attention, or concerns have been raised by family members or wider stakeholders, which require the Service to assure itself and others of any learning related to the case.

Following review of the Dynamic Stage 1 Review against these criteria, the Principal Social Worker and/or Principal Occupational Therapist, will take a decision as to whether the case should progress to an Enhanced Review.

Terms of Reference (TOR) will be drawn up to enable the identified lead reviewer[3] to build on the learning identified in the Dynamic Review, rather than beginning the reviewing and learning process again.

The lead reviewer should also consider the learning which has already been carried out across the Service, to ensure that learning which is well understood is not repeated. Conversely, there may be learning areas which are frequently identified, but which are not yet understood to the required degree to achieve effective improvement action planning.

Enhanced Reviews should be completed in timely way. The timescale must be scoped as part of the TOR based on the circumstances and complexities of the situation.

Methodology of the Enhanced (Stage 2) Review

Enhanced Reviews may encompass tools and methods, such as:

- Face to face interviews
- Virtual meetings with individuals or small groups
- Telephone interviews
- Reflective accounts
- Group/team reflective workshops.

These different methods are designed to support the delivery of a proportionate Enhanced Review and achieve the learning aims identified as part of the TOR.

Involvement of the individual and their family

The enhanced review should, as far as is possible, offer the opportunity for the individual affected (in the case of injury or harm) and/or family members of the individual, to contribute to the review and share their views and concerns. This should include a meeting if the family agree, either face to face or virtually, as appropriate.

Involvement of External Partners

Enhanced Reviews are an ASC process and typically are limited to reviewing internal departmental practice and systems. However, on occasion it may be that the case involved substantial joint working with a particular partner agency and that partner agency agrees to be invited to join the review. For example, they may join in a reflective workshop. In this case, the agreement of the TOR would be extended to include a nominated senior manager of that organisation.

[3] *The lead reviewer should not be someone directly involved in the case decision making to ensure impartiality; Principal Practice Leads will support with the identification of a suitable individual*

Completion and sign off of Enhanced Reviews

At the completion of the Enhanced Review, the report will be jointly signed off by the Principal Social Worker and/or Principal Occupational Therapist, and the relevant strategic operational or commissioning manager(s). If queries are raised regarding the findings which cannot be promptly resolved, a meeting will be convened with the report author to agree the outcome, to ensure timely dissemination of the learning and resulting action plan.

The report will be shared with the family. This can be done via a meeting (in person or virtually) if the family request it. A letter will also be sent outlining any learning to be taken forward, and an apology or acknowledgement of where things could have been done better, if appropriate, to meet the Service's Duty of Candour.

The report will also be shared with the operational team who made the referral in a manner agreed with the operational management team.

Learning will be disseminated via the Practice Quality Board, Practice Development Advanced Practitioners, relevant practice groups, departmental managers, and Learning and Development function to support strategic onward action planning.

5. Parallel Processes

Links with Safeguarding (S42) and Departmental Quality Assurance Processes

Where a case is subject to review under this policy, normal departmental processes and responsibilities should continue as appropriate. For example, where an individual has experienced serious harm or passed away when in receipt of a commissioned service, Quality Assurance and Contract Monitoring processes may need to continue to minimise the chances of others experiencing poor outcomes.

Unexpected deaths alone should not be investigated using safeguarding processes. However, if a person dies whilst they are subject to an open S42 safeguarding enquiry, that enquiry should be properly concluded.

Serious harm cases: If you suspect an injury may have been caused by abuse/neglect a safeguarding enquiry must be opened in accordance with our duties under S42 Care Act 2014, and the local Multi-Agency Safeguarding Policy and guidance.

Safeguarding Adults Reviews (SARs)

Under Section 44 of the Care Act 2014, the Somerset Safeguarding Adults Board (SSAB) must arrange for there to be a review of a case involving an adult in its area

with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a)there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b)condition 1 or 2 is met.

(2) Condition 1 is met if

(a)the adult has died, and

(b)the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)

(3) Condition 2 is met if—

(a)the adult is still alive, and

(b)the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to -

(a)identifying the lessons to be learnt from the adult's case, and

(b)applying those lessons to future cases.

A serious incident as defined in this policy, may also meet the criteria for a SAR.

If this is apparent at the point of reporting the incident, it should be highlighted on the referral form. The Principal Social Worker is responsible for making SAR referrals to the SSAB and ensuring that key officers are made aware of the referral. This includes, for example, the Service's representative on the SSAB SAR Subgroup.

Where a formal report is required to support a SAR, the report will require sign off by the Principal Social Worker.

<u>HM Coroner's Inquests</u>

In the case of an unexpected death, the case may also have been referred to HM Coroner. HM Coroner may carry out an investigation which may include an Inquest. HM Coroner has a statutory right to request information which supports their investigation into the circumstances surrounding a person's death.

Statements completed by ASC staff require sign off by the Principal Social Worker ahead of submission to the HM Coroner. Where HM Coroner requests information regarding a case which has already been reported and reviewed under this Policy, the review documentation can be used to support the production of the statement for HM Coroner.

Where the HM Coroner requests information about a case which has not been reported and reviewed under this Policy, the Practice Quality Board/Chairs will consider whether it should have been, and whether doing so retrospectively is now appropriate.

The team can liaise with the HM Coroner regarding the cause of death. This may be known or may remain under investigation by HM Coroner. Knowing the cause of death can be useful to the ASC internal review process. However, the completion of the review process takes priority, and waiting for the cause of death to be known should not inhibit the progress of reporting, reviewing, learning, and improving, where possible.

Other Statutory and Non-Statutory Reviews

Some cases considered for review may overlap with other review processes including:

- Domestic Homicide Reviews (DHRs): DHRs are carried out under the Domestic Violence, Crime and Victims Act 2004. Responsibility for the commissioning of a DHR rests with Somerset's Community Safety Partnership
- Multi-Agency Public Protection Arrangements Serious Case Reviews (MAPPA SCRs): MAPPA SCRs are carried out within provision made by the Criminal Justice Act 2003. Responsibility for the commissioning of a MAPPA SCR rests with the relevant MAPPA Strategic Management Board.
- Child Safeguarding Practice Reviews (CSPRs): CSPRs are carried out under the Children Act 2004. Responsibility for the commissioning of a CSPR rests with the Local Safeguarding Children Partnership (locally) and the Child Safeguarding Practice Review Panel (nationally).

- Mental Health Homicide Reviews: Mental Health Homicide Reviews are carried out under the NHS Serious Incident Framework. Responsibility for the commissioning of a Mental Health Homicide Review rests with NHS England.

- LeDeR (Learning from lives and deaths – People with a learning disability and autistic people) Reviews: The LeDeR programme is included in the NHS Long Term Plan 2019 and the expectations for delivery are set out by NHS England. Responsibility for the commissioning of LeDeR Reviews rests with the Integrated Care System (ICS).

- Ombudsman Investigations: Ombudsman Investigations are carried out under The Local Government Act 1974, which places on the Local Government and Social Care Ombudsman the statutory duty to investigate complaints against councils.

- The Patient Safety Incident Response Framework (PSIRF): The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. The PSIRF replaces the Serious Incident Framework (SIF) (2015) and makes no distinction between 'patient safety incidents' and 'Serious Incidents'. As such it removes the 'Serious Incidents' classification and the threshold for it. Instead, the PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

The interface between these processes and ASC's own reviewing activity will be coordinated to minimise duplication, ensure high quality engagement and effective partnership working, and to seek to prevent members of staff involved in a case being interviewed more than once, wherever possible.

6. Learning from incidents and dissemination

ASC is committed to learning from all review activity referenced in this policy, to improve practice, departmental performance and outcomes for the people that use services.

The ASC Practice Quality Board will:

- Oversee learning reviews (statutory and local).
- Oversee the Practice Quality Framework QA/audit programme.

- Identify practice priorities.
- Agree action plans to address themes/learning.
- Monitor action plans and seek assurance that learning has been embedded into practice.
- Inform the Learning and Development Strategy and commissioning of training/CPD.
- Celebrate good practice.

7. Implementation plan

This policy was agreed and ratified by: The Practice Quality Board (Feb 2024)

The implementation plan will include bespoke commissioned training initially targeted at ASC Practice Development Advanced Practitioners and key strategic practice / assurance leads with an associated workbook to support effective practice.

Policy Effective date: March 2024
Summary: This policy sets out the Adult Social Care Service's procedural approach for reporting, responding to, investigating, and learning from serious incidents.
Issued by: ASC Practice Quality Board

Supporting linked documents

- Learning from serious incidents in ASC Flowchart DRAFT.docx
- ASC Dynamic _ Rapid Review Template.docx
- Incident Review Training Workbook v2 Dec 2023.docx
- Letter of Condolence Template Example.docx