

A Practical Guide to Learning from Serious Incidents

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Monday 3 December 2018 De Vere West One Conference Centre, London



Chair and Speakers Include:

Dr Martin Farrier

*Clinical Director for Quality
& Consultant Paediatrician
Wrightington, Wigan and Leigh
NHS Foundation Trust*

Catherine Pelley

*Chief Nurse and Director of
Governance
Homerton University Hospital
NHS Foundation Trust*

Jo Habben

*Head of Patient Safety
Western Sussex Hospitals
NHS Trust*

Supporters Include:



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This national conference looks at the practicalities of Serious Incident Investigation and Learning. The event will look at the revised Serious Incident Framework which is currently post consultation and due for publication this year, and the implications for serious incident investigation. The conference will update delegates on the National Learning from Deaths guidance and implementation in practice. There will be a focus on learning from serious incidents, ensuring the investigation findings lead to change and improvement.

"The NHS conducts patient safety investigations after things go wrong in patient care to learn from these events and to inform changes to prevent them happening again. Compelling evidence from patients, families, carers and staff has revealed weaknesses in the way NHS organisations investigate, communicate and learn when things go wrong." NHS Improvement March 2018

"Many reports and reviews highlight that NHS organisations struggle to routinely underpin their investigations with these principles: investigations do not always appropriately involve and support patients, families, carers and staff; many are undertaken by staff without the necessary time and expertise; some focus too narrowly on care in specific settings and do not consider the care a patient received from several different organisations; too often they do not follow a systems-based methodology; and too many make weak recommendations that do not effectively address problems in care." NHS Improvement March 2018

Key factors contributing to poor investigations identified by NHS Improvement include

- Defensive cultures and lack of trust
- Inappropriate use of the Serious Incident process
- Misaligned oversight and assurance processes
- Lack of time and expertise
- Inconsistent use of evidence-based investigation methodology

The conference will also update delegates on effective involvement of families and carers in the investigations of serious incidents including the July 2018 Guidance for NHS trusts on working with bereaved families and carers.

"Under any circumstances, losing a loved one can be traumatic, and the level of support provided to families by the NHS at this time can make a considerable difference. However, there are families whose loved ones have died in untoward circumstances and whose subsequent experience has been deeply at odds with what we expect from our highly valued NHS... We urge you to embrace this guidance. It has the potential to produce the dramatic change the CQC proposed; reducing trauma to the bereaved; and giving real meaning to the term 'learning from deaths'." Families involved in the Learning from Deaths Steering Group July 2018

This conference will enable you to:

- Network with colleagues who are working to improve the investigation of serious incidents
- Learn from outstanding practice in the development of serious incident investigation and mortality review
- Reflect on the perspectives of bereaved families and carers and understand how you can engage them and recognise their insights as a vital source of learning in line with the 2018 National Guidance
- Update your knowledge with national developments including the revisions to the Serious Incident Framework
- Reflect on the development of mortality governance within your organization
- Understand how to work with staff to ensure a focus on learning and continuous improvement
- Identify key strategies for improving investigation of serious incidents
- Gain cpd accreditation points contributing to professional development and revalidation evidence

100% of delegates at the last conference on this subject would recommend the event to a colleague

Follow the conference on Twitter #NHSSeriousIncidents

10.00 Chairman's introduction

Dr Martin Farrier *Clinical Director for Quality & Consultant Paediatrician* Wrightington, Wigan and Leigh NHS Foundation Trust

10.10 The Revised Serious Incident Framework

Speaker to be advised

- building on the NHS Serious Incident framework
- the review of the Serious Incident Framework
- the five key factors contributing to poor investigation
- making recommendations following serious incident investigations
- implementing the revised serious incident framework in practice: what needs to change?

10.30 A personal journey: how organisations could improve the investigation process from a family perspective

Richard West

- a personal journey: how we could improve practice from a family perspective

10.50 Involvement of Families and Carers: Implementing the 2018 National Guidance

Rosie Reed

- families experiences
- involving families and carers in the investigation
- implementing the new national guidance in practice

11.20 Questions & answers, followed by coffee at 11.30

11.45 Learning from serious incidents: process for ensuring the learning is implemented and shared

Catherine Pelley

Chief Nurse and Director of Governance
Homerton University Hospital NHS Foundation Trust

- ensuring the learning from serious incident investigations is shared
- how we ensure learning from incidents is embedded into practice
- linking learning from deaths with learning from serious incidents
- using quality improvement science to implement change

12.25 EXTENDED SESSION: Implementing the revised Serious Incident Framework

Jo Habben

Head of Patient Safety
Western Sussex Hospitals NHS Trust

- ensuring adherence to the new framework
- developing the culture of the organization
- supporting staff when an incident occurs
- ensuring appropriate use of the serious incident investigation framework
- developing effective oversight and assurance

13.25 Questions & answers, followed by lunch at 12.50

14.15 Learning from Deaths: The National Mortality Review Programme

Speaker to be advised

- the national context - Learning From Deaths and the introduction of Medical Examiners
- developing Mortality Governance locally
- findings and learning from our regional mortality review programme
- implementing the CQC recommendations and new regulations on serious incident investigation at a local level – what we know so far
- sharing information about deaths between providers: challenges and information governance

14.45 EXTENDED SESSION: Mortality Governance and Meeting the new National Guidance on Learning from Deaths

Dr Martin Farrier

Clinical Director for Quality & Consultant Paediatrician
Wrightington, Wigan and Leigh NHS Foundation Trust

- implementing the national framework for Identifying, Reporting, Investigating and Learning from Deaths in Care
- developing mortality governance in your organisation
- Death Certification, Case Record Review and Investigation
- a step by step guide to mortality case note review
- using the new national dashboard for data publication
- implementing the learning to change practice
- interactive discussion

15.45 Questions & answers, followed by coffee

16.00 Case Study: A Serious Incident Investigation

Tracy Barfield

Lead for Quality Governance – Maternity & Integrated Care, with

Jane Bown

Head of Patient Safety
Chesterfield Royal Hospital NHS Foundation Trust

- a walk through the investigation process
- case study and implementing the learning
- our experience

16.30 EXTENDED MASTERCLASS SESSION: Serious Incident Investigation: using skilled analysis to move the focus of investigation from acts or omissions of staff, to identifying the underlying causes of the incident

Amelia Newbold

Solicitor
Browne Jacobson

- recap on immediate actions in the aftermath of an incident
- ensuring a well structured methodology and analysis leading to identification of key causal factors, and moving the focus to identifying the underlying causes
- interviewing staff involved in serious incidents - techniques and tips
- writing the investigation report - techniques and tips

17.15 Questions and answers, followed by close at 17.25

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Download

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Conference Documentation

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The PDF will be emailed out after the conference, please fill in the 'Your Details' section above, ensuring your email address is clear and the 'Payment' section..

For more information contact Healthcare Conferences UK on **01932 429933** or email **jayne@hc-uk.org.uk**

Venue

De Vere West One Conference Centre, 9-10 Portland Place, London, W1B 1PR. A map of the venue will be sent with confirmation of your booking.

Date Monday 3 December 2018

Conference Fee

- ☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
☐ £300 + VAT (£360.00) for voluntary sector / charities.
☐ £495 + VAT (£594.00) for commercial organisations.

The fee includes lunch, refreshments and a copy of the conference handbook. VAT at 20%.

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Confirmation of Booking

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