

A Practical Guide to Serious Incident Investigation & Learning

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Monday 29 April 2019 De Vere West One Conference Centre, London



Chair and Speakers Include:

Mr John Reynard
Consultant Urological Surgeon
Oxford University Hospitals
NHS Foundation Trust

Lorraine Schwanberg
*Head of Patient Safety and
Risk Management*
King's College Hospital
NHS Foundation Trust

Dr Martin Farrier
Clinical Director for Quality
Wrightington Wigan & Leigh
NHS Foundation Trust

Supporters Include:



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"We want the NHS to be the safest healthcare system in the world....We also propose a focus on three principles that should underpin implementation of the strategy: a just culture, openness and transparency and continuous improvement."
NHS Improvement December 2018

"We know there are problems, for example, with how incidents are investigated and learned from. In our recent engagement to find out how we can improve the Serious Incident framework, people told us they were concerned about: providers' lack of capability and capacity to carry out good quality investigations; the tendency to use investigation for the wrong purposes; the generally poor approach to patient and family involvement; and the fact that actions to reduce risks after the completion of an investigation are too often ineffective. We know from the Care Quality Commission's (CQC's) review of how the NHS responds to and learns from the care provided to patients who die that too often problems with care are not identified and the bereaved, who may have concerns, are not sufficiently supported." NHS Improvement December 2018

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 in Spring 2019, 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 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 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**

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 National Guidance
- Update your knowledge with national developments including forthcoming revised 2019 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 improvementDevelop your skills in Serious Incident Investigation: applying the serious incident framework and using skilled analysis to move the focus of investigation from acts or omissions of staff, to identifying the underlying causes of the incident
- Identify key strategies for improving investigation of serious incidents
- Gain cpd accreditation points contributing to professional development and revalidation evidence

10.00 Chairman's introduction

Mr John Reynard *Consultant Urological Surgeon Oxford University Hospitals NHS Foundation Trust
Honorary Senior Lecturer, University of Oxford & Human Factors Trainer*

10.10 Improving Patient Safety: Changing the Culture

Dr Umesh Prabhu
*Consultant Paediatrician
Medical Director for more than 15 years
Medical Adviser for International Recruitment*

- improving patient safety: changing the culture
- 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?

10.40 Working with and involving families when an incident occurs

Richard West
Richard West is the father of David West who died aged 28 years whilst a patient under Southern Health NHS Foundation Trust

- learning from the lived experience
- how can we put patients and carers at the heart of the process?
- involving patients and families in the investigation
- involvement in reviews and investigations: what does excellence look like?
- implementing the new national guidance in practice

11.10 Questions & answers, followed by coffee at 11.20

11.45 The decision to investigate: Prioritisation of incidents

Prof Helen Young
*Executive Director of Patient Care and Chief Nurse
South Central Ambulance NHS Foundation Trust
Formerly Chief Nurse of Birmingham Women and Children's NHS Trust*

- developing criteria for full investigation
- ensuring a proportionate response: methods for managing and learning from other types of incidents
- ensuring conclusions in investigations will lead to inform learning and change practice
- key steps within incident investigation

12.25 EXTENDED SESSION: Implementing the revised Serious Incident Framework in practice

Dr Hester Wain
*Deputy Director of Patient Safety and Risk
Royal Free London 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

13.10 Questions & answers, followed by lunch at 13.20

14.00 EXTENDED MASTERCLASS SESSION:

Serious Incident Investigation: using Root Cause Analysis to move from a focus on an individual's acts or omissions to identifying failing and missing systems

Jo Haswell
*Barrister & Trainer
InPractice Training*

- a step by step guide to the investigation of deaths
- implications of the new serious incident framework
- ensuring a well structured investigation methodology - the use of root cause analysis
- how do we move the focus to identifying contributory factors, failing and missing systems
- how technology can help
- writing the investigation report

15.00 EXTENDED SESSION: Mortality Governance and Meeting the new National Guidance on Learning from Deaths and the National Mortality Review Programme

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 casenote review
- using the new national dashboard for data publication
- implementing the learning to change practice
- 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

15.45 Questions and answers, followed by Tea and Exhibition at 15.55

16.00 How understanding human factors can help improve learning from serious incident investigation

Mr Tim Kane
*Consultant Orthopaedic Surgeon,
Portsmouth NHS Foundation Trust
& Human Factors Trainer Practical Patient Safety Solutions*

- using a human factors approach to improve learning from serious incident investigation
- understanding why things go wrong
- case study examples

16.30 Learning from serious incidents: Ensuring the learning is implemented and shared

Lorraine Schwanberg
*Head of Patient Safety and Risk Management
King's College 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

17.00 Questions and answers, followed by Close

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Serious Incidents Investigation and Learning

Monday 29th April 2019

De Vere West One Conference Centre, London

Download

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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 29 April 2019

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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**Group Rates

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Accommodation

On confirmation of your booking you will receive information for booking accommodation should you require it.

Confirmation of Booking

All bookings will be confirmed by email, unless stated otherwise. Please contact us if you have not received confirmation 7-10 days after submitting your booking.

Exhibition

If you are interested in exhibiting at this event, please contact Carolyn Goodbody on 01932 429933, or email carolyn@hc-uk.org.uk

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