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A Practical Guide to

Investigation & Learning from Deaths in NHS Trusts

Monday 1st October 2018 De Vere West One Conference Centre, London

Chair and Speakers include:

Dr Paul Johnston
Mortality Lead and Renal Consultant
Royal Cornwall Hospitals NHS Trust

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

Dr Alan Fletcher
Consultant in Acute and Emergency Medicine
Sheffield Teaching Hospitals NHS Foundation Trust *and Medical Examiner*
HM Coroner South Yorkshire (West)

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"Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more. A CQC review… 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England' found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care."
NHS Improvement 2018

"The requirement on organisations is clear. It is not simply to have a robust process for reviewing deaths in care, important though this is. Trusts need also to engage with and support bereaved families, to provide mechanisms for staff support and debriefing and to ensure active and robust board oversight. Perhaps most importantly learning needs to be translated into sustainable action to improve the way we look after the people in our care."
Kathy McLean Executive Medical Director, NHS Improvement 2017

"The NHS is the first healthcare system to commit to reporting and publishing information on the number of avoidable deaths in its hospitals and the work that is being done by individual NHS trusts to learn from those deaths. This new level of transparency will be central to improving care and ensuring the safety of the NHS services we all rely on…We will use this information alongside the findings of our inspections to identify where providers must make improvements and to share good practice where we find hospitals that are doing it well… the challenge now is to deliver the full vision of a safer learning culture that was laid out in 'Learning, Candour and Accountability so that learning from deaths becomes an accepted part of practice that provides answers for families and drives improvements in the quality and safety of care."
Prof Ted Baker, Chief Inspector of Hospitals, Care Quality Commission, December 2017

The NHS is the world's first health organisation to publish data on avoidable deaths. The National Guidance on Learning from Deaths has driven a strengthening of systems of mortality case review with emphasis on learning. By collecting the data and taking action in response to failings in care, trusts will be able to give an open and honest account of the circumstances leading to a death.

This National Conference focuses on improving the investigation and learning from deaths in NHS Trusts following the National CQC and NQB guidance, and Department of Health reporting requirements.

Attendance at this conference will support you to:

- Network with colleagues who are working to improve practice in the investigation and learning from deaths
- Understand national developments and national reporting requirements
- Learn from best practice in the investigation of deaths
- Improving your processes and skills in mortality review and mortality governance
- Reflect on how you improving involvement of families and carers
- Understand the decision to investigate, and the appropriate level of investigation
- Improving 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
- Learn from working examples of mortality governance and develop the role of mortality audits, internal nspection and mortality reviews to answer the question "did a problem in care contribute to the death?
- Implementing and integrating a Learning from Deaths dashboard
- Self assess your learning from deaths process and ensure investigations lead to change
- Gain CPD accreditation points contributing to professional development and revalidation evidence

10.00 Chair's Introduction
Implementing the national mortality case record review programme in practice

Dr Paul Johnston
Mortality Lead and Renal Consultant
Royal Cornwall Hospitals NHS Trust

- developing Mortality Governance locally
- findings and learning from the national mortality case record 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

10.30 Identification and reporting of deaths and the role of the Medical Examiner

Dr Alan Fletcher
Consultant in Acute and Emergency Medicine
Sheffield Teaching Hospitals NHS Foundation Trust
and Medical Examiner
HM Coroner South Yorkshire (West)

- implementing the CQC recommendations on identification and reporting of deaths
- understanding the root cause of avoidable deaths, ensuring independent review and correct referral to the coroner
- understanding which deaths are attributable to problems in care at a local level
- establishing cause of death and improving the system for death certification
- ensuring conclusions in investigations will lead to inform learning and change practice
- developing the role of the Medical Examiner

11.00 The decision to investigate

Dr Berenice Lopez
Associate Medical Director in Quality and Safety, and Consultant Chemical Pathologist Norfolk and Norwich University Hospital
Honorary Senior Lecturer Norwich Medical School

- deciding whether a review or an investigation is needed
- developing consistency in practice
- changing the culture: Making Mortality More Meaningful at Norfolk and Norwich

11.30 Question and answers, followed by tea & coffee at 11.35

11.50 Involvement of families and carers

Dr Josephine Ocloo *Family Representative*
and David Smith *Patient and Public Voice Partner*
Department of Health and Social Care's 'Learning from Deaths' Programme Board

- working with families when an incident occurs – what does poor practice look like?
- involvement of families in reviews and investigations: what does excellence look like?
- applying 'being open' principles
- lessons and experiences from the Learning from Deaths programme board

12.30 Case Study: Supporting families and developing the role of the Family Liaison Officer

Helen Ludford
Associate Director of Quality Governance
with **Elaine Ridley** *Family Liaison Officer*
Southern Health NHS Foundation Trust

- supporting families and carers
- the role of the Family Liaison Officer

13.00 Question and answers, followed by lunch at 13.10

14.00 EXTENDED MASTERCLASS SESSION
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

Mike O'Connell
Legal Services Practitioner

- a step by step guide review and investigation of deaths following the CQC recommendations
- ensuring a well structured methodology and analysis leading to identification of key causal factors
- how do we move the focus to identifying the underlying causes
- interviewing staff involved in serious incidents - techniques and tips
- writing the investigation report - techniques and tips

14.45 EXTENDED SESSION: Mortality Governance
Developing the role of mortality audits, internal inspection and mortality reviews to answer the question "Did a problem in care contribute to the death?

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

- what does Mortality Governance mean in practice?
- implementing a weekly mortality audit, and generating learning and systematic quality improvements from the problems identified
- identifying and focussing on priority areas for meaningful improvement
- using mortality review to engage clinicians in quality improvement
- a step by step guide to scoring phases of care
- making judgements on the level of care provided
- board assurance
- feeding back the results to clinicians to change practice

15.45 Question and answers, followed by tea & coffee at 15.50

16.00 Learning from Deaths: identifying learning points for change

Dr Jason Shannon
Consultant Pathologist, National Clinical Lead for Mortality Review in Wales, Senior Responsible Officer for Medical Examiner Implementation in Wales
Cwm Taf University Health Board

- the process for review of deaths: when a mortality alert is raised
- linking with quality improvement
- how we are involving relatives and carers
- ensuring lessons learned are used to target staff training

16.30 Implementing and integrating a Learning from Deaths dashboard

Dr Helena Jopling
Lead on Learning from Deaths
West Suffolk NHS Foundation Trust

- ensuring learning from the mortality review process, incidents and investigations leads to sustainable improvements in quality or safety
- our Learning from Deaths Dashboard
- changing the culture across the organisation

17.00 Question and answers, followed by close at 17.10

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Investigation & Learning from Deaths in NHS Trust

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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, 9-10 Portland Place, London, W1B 1PR. A map of the venue will be sent with confirmation of your booking.

Date Monday 1 October 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.

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