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A Practical Guide to Serious Incident Investigation

Responding to and learning from Patient Safety Incidents

Friday 28th January 2022 **Virtual Conference**

Chair & Speakers Include:

Mike O'Connell
Legal Services Practitioner and Interim Senior Inquests Manager
Calderdale and Huddersfield NHS Foundation Trust

Jo Mason-Higgins
Head of Claims, Complaints and Patient Safety, Investigations Lead for Duty of Candour
Gloucestershire Hospitals NHS Foundation Trust

Mr Gabriel Slayer
Associate Medical Director, Consultant General and Vascular Surgeon
Barking Havering & Redbridge University Hospitals NHS Trust

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Supporting Organisations:

patient safety learning

A Practical Guide to

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"The NHS has systems to support the reporting of safety incidents and from these reports it learns how to make healthcare safer. However, despite these efforts and the continuing advances in patient care, the inherent risks and complexity of healthcare mean an NHS entirely free of incidents is an unrealistic expectation. Identifying incidents, recognising the needs of those affected, examining what happened to understand the causes and responding with action to mitigate risks remain essential to improving the safety of healthcare. Creating systems that do this is a complex, challenging and continuous endeavour that requires the right skills, processes and – perhaps most importantly – behaviours. We know that organisations are struggling to deliver good quality investigations that consistently support the reduction of risk. As a result, opportunities to reduce patient safety incidents can be missed."
Patient Safety Incident Response Framework 2020 An introductory framework for implementation by nationally appointed early adopters
March 2020

"To support the NHS to further improve patient safety, we are preparing for the introduction of a new Patient Safety Incident Response Framework (PSIRF), outlining how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted."
NHS England 2020

"This introductory Patient Safety Incident Response Framework responds to calls for a new approach to incident management, one which facilitates inquisitive examination of a wider range of patient safety incidents "in the spirit of reflection and learning" rather than as part of a "framework of accountability". Informed by feedback and drawing on good practice from healthcare and other sectors, it supports a systematic, compassionate and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement."
Patient Safety Incident Response Framework 2020 An introductory framework for implementation by nationally appointed early adopters
March 2020

"Changing embedded incident management processes will take time, particularly as the NHS is in the midst of intense organisational and system-wide transformation."
Patient Safety Incident Response Framework 2020 An introductory framework for implementation by nationally appointed early adopters
March 2020

"We expect preparation for implementation to be a gradual process that will commence in Spring 2022"
NHS England 2021

"Local systems and organisations outside of the early adopter areas can use this version of the PSIRF to start to plan and prepare for PSIRF's full introduction in 2022."
NHS England and NHS Improvement 2021

This national conference looks at the practicalities of Serious Incident Investigation and Learning. The event will look at the development and implementation of the New Patient Safety Incident Response Framework (previously known as the Serious Incident Framework) a version of which has now been published and which is being tested in early adopter sites. NHS Improvement is working with these early adopters to test implementation, and analysis of this will inform the final version. Local systems and organisations outside of the early adopter areas are free to use the already published version of the PSIRF to start to plan and prepare for PSIRF's full introduction from Spring 2022. The conference will also update delegates on best current practice in serious incident investigation and learning, including mortality governance and learning from deaths. There will be an extended focus on ensuring serious investigation findings lead to change and improvement.

This conference will enable you to:

- Network with colleagues who are working to improve the investigation of serious incidents
- Ensure your approach to Serious Incident Investigation is in line with the NHS Patient Safety Strategy
- Update your knowledge with national developments including the New Patient Safety Incident Response Framework
- Understand developments in the PSIRF early adopter sites
- Reflect on the management and investigation of serious incidents involving Covid-19
- Learn from outstanding practice in the development of serious incident investigation and mortality review
- Reflect on the perspectives of a patient who has been involved in a serious incident
- Develop a risk based response to incident investigation
- Reflect on the development of mortality governance within your organization and understand the challenges of Covid-19
- Understand how to work with staff to ensure a focus on learning and continuous improvement
- Learn about the role of systems and data management in serious incident investigation, and the new the National NHS Learn from Patient Safety Events Service (LFPSE)
- Develop your skills in Serious Incident Investigation: applying the human factors to move the focus of investigation from acts or omissions of staff, to identifying systems improvement
- Identify key strategies for improving investigation of serious incidents
- Supports CPD professional development and acts as revalidation evidence. This course provides 5 Hrs training for CPD subject to peer group approval for revalidation purposes

10.00 Chair's Introduction & Welcome

Mike O'Connell *Legal Services Practitioner and Interim Senior Inquests Manager* Calderdale and Huddersfield NHS Foundation Trust

10.10 Patient Experience at the Heart of Serious Incident Management

Dorit Braun
Retired Charity Chief Exec with personal experience of avoidable harm in the NHS and of working to try to support the NHS to learn from that harm and Lived Experience Speaker Making Families Count

- learning from the lived experience
- how can we put patients and their families at the heart of the process?
- how excellent engagement can produce better results for patients and Trust during serious incident investigations
- family and patient involvement in reviews and investigations

10.40 The Patient Safety Incident Response Framework

Professor Helen Young
Executive Director of Patient Care & Service Transformation
South Central Ambulance NHS Foundation Trust

- PSIRF: Introductory guidance
- working with the early adopters
- key differences between the PSIRF and the Serious Incident Framework
- moving forward: a timeline for implementation

11.10 Early Adopters of the PSIRF – Experience and Learning

Saranna Burgess
Director of Patient Safety and Quality, and Patient Safety Specialist
Norfolk and Suffolk NHS Foundation Trust

- leading the way on the PSIRF and how the Trust has implemented the pilot scheme
- challenges and barriers to change
- winning hearts and minds

11.40 Small Breakout Groups

12:00 Coffee Break & Virtual Networking

12.10 EXTENDED SESSION: Mortality Governance & Learning from Deaths

Mr Gabriel Sayer
Associate Medical Director, Consultant General and Vascular Surgeon
Barking Havering & Redbridge University Hospitals NHS Trust

- implementing the national framework for Identifying, Reporting, Investigating and Learning from Deaths
- the national context - Learning From Deaths and the introduction of Medical Examiners
- developing Mortality Governance locally
- serious incidents, learning from deaths, and Covid-19
- sharing information about deaths between providers: challenges and information governance

12.50 The decision to Investigate: a Risk Based Response

Jo Mason-Higgins
Head of Claims, Complaints and
Patient Safety Investigations Lead for Duty of Candour
Gloucestershire Hospitals NHS Foundation Trust

- the decision to investigate: developing a range of proportionate and effective learning responses to incidents
- 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
- our approach to serious incident investigation and cases involving Covid-19

13.20 Lunch Break & Virtual Networking

14.00 Serious Incidents and Human Factors

Dr Claudia Ganado
Neonatal Consultant and Neonatal Lead for Quality Governance
Human Factors and Team Effectiveness
Bedfordshire Hospitals NHS Foundation Trust

- how an understanding of human factors can support you to improve and change practice
- how a human factors approach can be embedded into serious incident investigation
- enabling a person centred approach

14.30 Learning from Serious Incidents: Looking ahead to the Patient Safety Incident Response Framework

Lucy Winstanley
Head of Patient Safety & Quality with

- improving the response to and investigation of incidents
- how we ensure learning from incidents is embedded into practice
- patient safety and continuous quality improvement: using quality improvement science to implement change

15.00 Coffee Break & Virtual Networking

15.30 EXTENDED SESSION: Serious Incident Investigation: towards systems-based patient safety investigation

Mike O'Connell
Legal Services Practitioner
and Interim Senior Inquests Manager Calderdale and Huddersfield NHS Foundation Trust

- a step by step guide to the investigation of deaths
- implications of the new serious incident framework
- changing the way we approach Root Cause Analysis to focus on systems
- writing the investigation report

16.30 Involving Families in Investigations

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

- how can we engage, support and involve families following a death?
- ensuring adherence to the Duty of Candour
- working with families to understand the full circumstances and answer questions

17.00 Chair's Closing Remarks, followed by Close

There will be time after each speaker session for Questions and Answers

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Venue
This virtual conference is run using a live stream on Zoom, interactive breakout rooms, and resources on a secure landing page available for three months after the event.

Date
Friday 28th January 2022

Conference Fee

- ☐ £295 + VAT (£354.00) for NHS, Social care, private healthcare organisations and universities.
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- ☐ £495 + VAT (£594.00) for commercial organisations.

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