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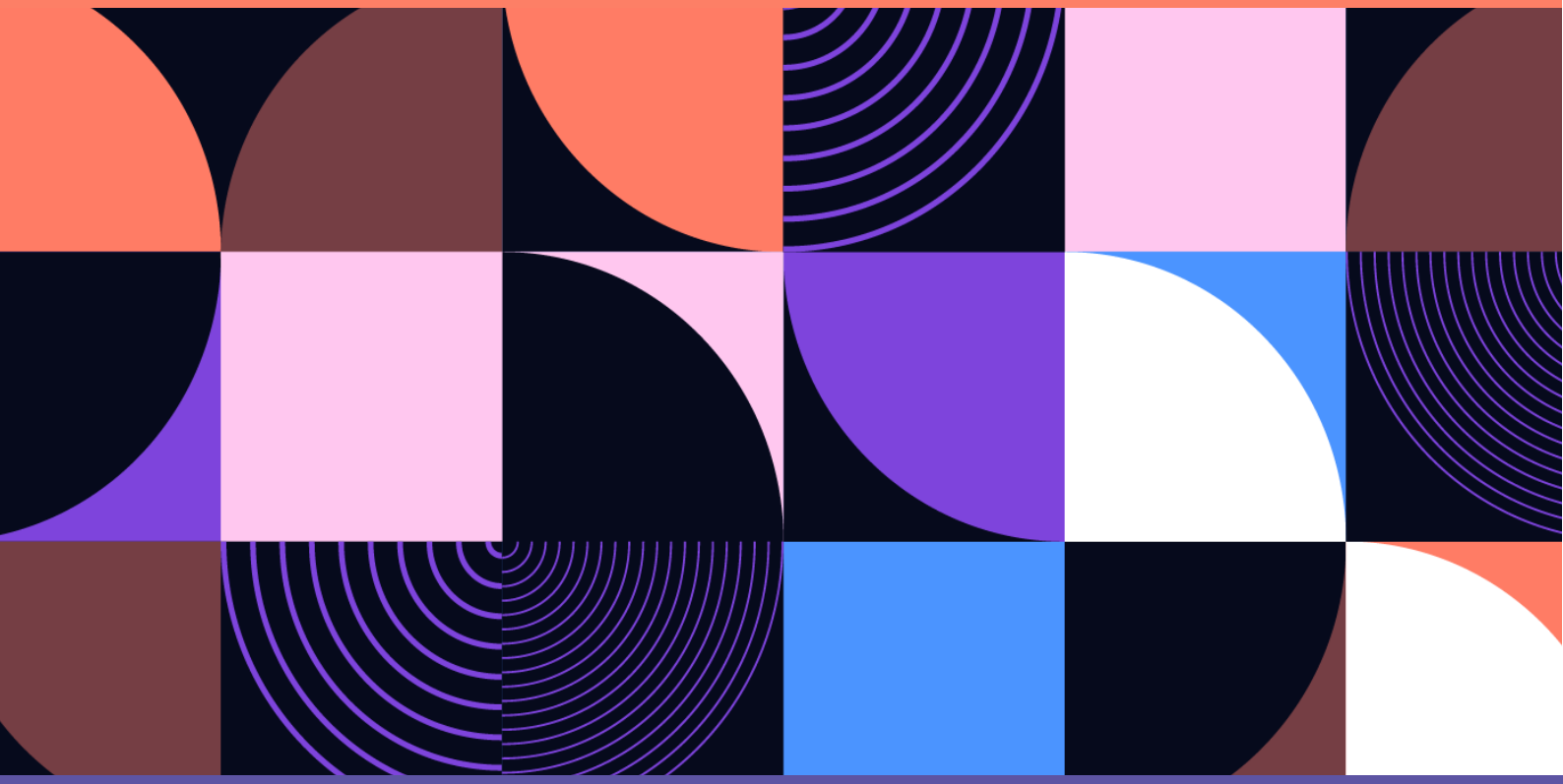
Improving the Learning from

Investigation of Deaths & Serious Incidents in Mental Health Services

Wednesday 26th January 2022 Virtual Conference



Chair and Speakers include:

Dr Panchu Xavier
Consultant Forensic Psychiatrist and College Tutor, Chair – Ethical Advisory Group, Deputy Medical Director – Quality and Patient Safety, Director of Patient Safety, Mersey Care NHS Foundation Trust

Elena Baker-Glenn
Liasion Psychiatrist Cambridgeshire and Peterborough NHS Foundation Trust
& Development Lead Care Review Tool The Royal College of Psychiatrists

Kate Eisenstein
Assistant Director of Insight and Public Affairs Parliamentary and Health Service Ombudsman

HEALTHCARE CONFERENCES UK

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Improving the Quality & Learning from

Investigation of Deaths & Serious Incidents in Mental Health Services

Wednesday 26th January 2022 **Virtual Online Conference**

"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

"Learning from the early adopters will inform the final version of the PSIRF which we anticipate will be published in Spring 2022. We anticipate that at that point, all other organisations will be encouraged to begin the transition to the PSIRF, with an expectation that all parts of the NHS in England will be using the new framework by Autumn 2022."
NHS England and NHS Improvement 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 from Deaths in Mental Health Services. The event will look at the development and implementation of the New Patient Safety Incident Response Framework (previously known as the Serious Incident Framework). The PSIRF now been published for the early adopter sites, the final version is due in Spring 2022, and is due to be fully introduced in all organisations during 2022, the conference will examine how the new framework will fit with the Royal College of Psychiatrists Care Review Tool for mortality review.

The principles of the Royal College of Psychiatrists mortality review process are:
- All deaths are appropriately reviewed to assess if there is potential for organisational learning.
- The deaths selected for further review have a structured judgement review completed.
- The review of deaths is undertaken in a spirit of openness and transparency, and organisational learning, rather than blame.
- The review of deaths will involve families and those close to the deceased, where possible.

This conference will enable you to:
- Network with colleagues who are working to improve the investigation of serious incidents and deaths in mental health services
- Ensure your approach to Serious Incident Investigation is in line with the NHS Patient Safety Strategy
- Learn from outstanding practice in implementing the Royal College of Psychiatrists Mortality Care Review Tool
- Reflect on the lived experience of a bereaved relative
- Improve the way you involve and engage families and carers in the investigation process
- Develop your skills in incident investigation and mortality review
- Understand how you can improve serious incident investigation and understand the recent developments including the New Patient Safety Incident Response Framework
- Identify key strategies for undertaking a self assessment, and continuous review of deaths and investigation practice in your organisation
- Understand how human factors can help improve learning from serious incident investigation
- Ensure you are up to date with the role of the coroner
- Understand how you can better support staff when a serious incident occurs
- Self assess and reflect on your own practice
- Gain CPD accreditation points contributing to professional development and revalidation evidence

10.00 Chair's Welcome & Introduction

Dr Panchu Xavier *Consultant Forensic Psychiatrist and College Tutor, Chair – Ethical Advisory Group, Deputy Medical Director – Quality and Patient Safety, Director of Patient Safety,* Mersey Care NHS Foundation Trust

10.10 Improving Standards of Serious Incident Reviews through Accreditation, and Using the National Mortality Review Tool

Dr Elena Baker-Glenn
Liaison Psychiatrist
Northamptonshire Healthcare NHS Foundation Trust
Chair of SIRAN Accreditation Panel, Royal College of Psychiatrists

- the Care Review Tool for mortality reviews in Mental Health Trusts
- 'red flag' scenarios which should prompt further investigation
- development of Principles and Standards for serious incident reviews
- experience of the Serious Incident Review Accreditation Network to improve the investigation process and learning

10.40 Looking at deaths & serious incidents from a user/family perspective

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

- a personal journey: how organisations could improve the investigation process from a family perspective
- how can we better involve relatives and carers?
- moving from reactive to proactive services

11.20 Comfort Break and Virtual Networking

11.40 EXTENDED SESSION: Effective patient safety investigations Principles and practice & looking forward to the new National Patient Safety Incident Response Framework

Mike O'Connell
Legal Services Practitioner

- which deaths to report and investigate
- a step by step guide to effective investigation of a death in a mental health or learning disabilities setting
- systems for information gathering
- interviewing staff - techniques and tips
- writing the investigation report - techniques and tips
- the New Patient Safety Incident Response Framework: and overview, application in mental health and what has changed?

12.25 The role of the coroner

Andrew Harris
Senior Coroner Lead
London Borough of Southwark

- what deaths should the Coroner investigate?
- what sort of questions will the Coroner be likely to ask?
- what sort of questions will the family be likely to ask?
- the giving of evidence at an inquest
- regulation 28 reports

13.20 Lunch Break and Virtual Networking

FOCUS: Case studies in practice

13.50 Learning from complaints about serious incidents in mental health services

Kate Eisenstein
Assistant Director of Insight and Public Affairs
Parliamentary and Health Service Ombudsman

- learning from complaints we have received in mental health
- developing a culture of learning from mistakes
- PHSO's role in driving improvement in complaints (including new NHS Complaints Standards)

14.20 Involving families in investigations

Jan Fowler
Director
Making Families Count

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

14.50 Small Breakout Groups: Involving Families

15.05 Implementing the new Patient Safety Incident Response Framework

Speaker to be announced

- moving to the PSIRF Framework: practicalities
- challenges and advantages of the new system
- our experience
- case studies

15.40 Comfort Break and Virtual Networking

16.00 Supporting Staff when an Incident occurs

Speaker to be announced

- how can we better support staff when an incident occurs
- working with staff when investigating incidents
- supporting staff through inquests
- learning from personal experience

16.30 Learning from serious incidents and mortality review to deliver change

Dr Panchu Xavier
Consultant Forensic Psychiatrist and College Tutor
Chair Ethical Advisory Group
Deputy Medical Director Quality and Patient Safety
Director of Patient Safety Mersey Care NHS Foundation Trust

- how do you assess whether a death is clinically unavoidable?
- assessing the appropriateness of investigations
- ensuring continuous review, leadership and board oversight of deaths
- identifying themes, patterns or issues that may need further investigation
- undertaking a self assessment of practice in your service
- our experience

16.30 Question and Answers, followed by Close

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Investigation of Deaths & Serious Incidents in Mental Health Services

Wednesday 26th January 2022

Virtual Online Conference

Conference Registration

Download

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8 Wilson Drive, Ottershaw, Surrey, KT16 0NT

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Surname

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Organisation

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Please write your address clearly as confirmation will be sent by email, if you prefer confirmation by post please tick this box, ☐
Please also ensure you complete your full postal address details for our records.

Please specify any special dietary or access requirements

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Venue
This virtual conference will include a live stream on Zoom, interactive breakout sessions and a dedicated secure landing page with resources available for three months.

Date
Wednesday 26th January 2022

Conference Fee
- ☐ £295 + VAT (£354.00) for NHS, Social care, private healthcare organisations and universities.
- ☐ £250 + VAT (£300.00) for voluntary sector / charities.
- ☐ £495 + VAT (£594.00) for commercial organisations.

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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
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