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Investigation of Deaths & Serious Incidents in Mental Health Services

Implementing the Patient Safety Incident Response Framework (PSIRF) in Mental Health

Wednesday 26th April 2023 **Virtual Conference**

Speakers include:

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

Lisa Falconer
Head of Clinical Quality and Patient Safety
NHS Derby and Derbyshire CCG

Nadia Persaud
Area Coroner
East London

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patient safety learning

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"Organisations are expected to transition to PSIRF within 12 months of its publication, and transition should be completed by Autumn 2023."
NHS England August 2022

"PSIRF fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement"
Healthcare Safety Investigation Branch Sept 2022

"The framework represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS."
NHS England August 2022

"PSIRF fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement"
Healthcare Safety Investi gati on Branch Sept 2022

"We welcome the publication of NHS England's new Patient Safety Incident Response Framework (PSIRF) and the focus it places on effective learning and compassionate, meaningful engagement with those affected when incidents occur. Through our monitoring and inspection we have seen how the existence of a strong organisational safety culture, where the views of staff and patients are listened to and acted on, and learning is prioritised is essential to good practice in responding when things go wrong."
Dr Sean O'Kelly, Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services, Care Quality Commission, August 2022

This national conference looks at the practicalities of Serious Incident Investigation and Learning from Deaths in Mental Health Services and implementation of the New Patient Safety Incident Response Framework (PSIRF previously known as the Serious Incident Framework). The Patient Safety Incident Response Framework (PSIRF) was published on 16th August 2022 and replaces the Serious incident Framework. 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, and updates from PSIRF early adopter sites in mental health. The conference will also examine how the new framework will fit with the Royal College of Psychiatrists Care Review Tool for mortality review.

The conference is particularly timely considering the current Essex Mental Health Independent Inquiry and the recent investigation onto concerns regarding CAMHS provision at Tees Esk and Wear Valleys NHS Trust both of which have National Implications:

"The Inquiry was established to examine deaths which have taken place in mental health inpatient settings within NHS Trusts in Essex. The Inquiry will look at the key factors which led to the deaths of individual patients, as well as cultural and governance issues which may have inhibited the Trusts' ability to learn and take action following breaches of safety. The Inquiry will also assess the quality of previous investigations and reviews. The Inquiry aims to make actionable recommendations to improve health care not only within Essex, but across the NHS and the wider system."
Essex Mental Health Inquiry 2022

"The Trust's governance framework placed disproportionate emphasis on operational performance rather than quality and safety."
A system-wide independent investigation into concerns and issues raised relating to the safety and quality of CAMHS provision at West Lane Hospital, Tees, Esk and Wear Valleys NHS Foundation Trust, March 2023

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 Patient Safety Incident Response Framework (PSIRF)
- 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 learn from Mental Health early adopters of 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
- 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 Putting people at the heart of Patient Safety Investigation

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

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

Dr Elena Baker-Glenn
Clinical Director and Consultant Psychiatrist
East London Foundation Trust
Chair of the SIRAN Accreditation Committee
RCPsych

Jemini Jethwa
Programme Manager at the College Centre for Quality Improvement
RCPsych

- 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

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 and Interim Senior Inquests Manager
Calderdale and Huddersfield NHS Foundation Trust

- 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 Learning from complaints about serious incidents in mental health services

Kate Eisenstein
Assistant Director
Parliamentary & Health Service Ombudsman

- developing a culture of learning from mistakes
- PHSO's role in driving improvement in complaints (including new NHS Complaints Standards)
- moving towards a Human Factors approach

13.10 Lunch Break and Virtual Networking

13.40 Implementing the new Patient Safety Incident Response Framework

Lisa Falconer
Head of Clinical Quality and Patient Safety
NHS Derby and Derbyshire CCG

- moving to the PSIRF Framework: practicalities
- challenges and advantages of the new system
- how can we better support staff when an incident occurs?

14.25 EXTENDED SESSION: The role of the coroner

Nadia Persaud
Area Coroner
East London

- what deaths need reporting?
- mental health death investigations and what does the coroner investigate?
- what evidence will the Coroner require?
- the giving of evidence at an inquest
- what conclusions can the coroner reach?
- how does the serious investigation report assist the inquest?
- regulation 28 reports

15.00 Comfort Break and Virtual Networking

15.15 Involving families in investigations

Julian Hendy
Co-Founder & Member
Hundred Families, 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

15.45 Small Breakout Groups: Involving Families

16.00 Learning from serious incidents and mortality review to deliver change

Dr Panchu Xavier
Consultant Forensic Psychiatrist and College Tutor, Deputy Medical Director – Quality and Patient Safety
Mersey Care NHS Trust

- moving towards a systematic, compassionate, and proficient response to patient safety incidents
- assessing the appropriateness of investigations: quality not quantity
- ensuring continuous review, leadership and board oversight of deaths
- identifying themes, patterns or issues that may need further investigation
- delivering change as a results of Patient Safety Investigation and Mortality Review
- our experience

16.45 Question and Answers, followed by Close

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Virtual Online Conference

Conference Registration

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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 April 2023

Conference Fee

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