10% card payments discount*
15% group booking discount**

Investigation and Learning from Deaths in NHS Trusts

Monitoring & Improving Hospital Mortality during Covid-19

Tuesday 22nd June 2021 **Virtual Conference**

Chair & Speakers include:

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

Dr Emma Redfern
Consultant in Emergency Medicine
Deputy Medical Director
University Hospitals Bristol NHS Foundation Trust

HEALTHCARE CONFERENCES UK

Investigation and Learning from Deaths in NHS Trusts

Monitoring & Improving Hospital Mortality during Covid-19

10% card payments discount*
15% group booking discount**

Tuesday 22nd June 2021 Virtual Conference

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 and will reflect on learning from deaths involving Covid-19 and how mortality investigation should be managed in these cases.

The conference, chaired by Dr Martin Farrier, Clinical Directors for Quality & Consultant Paediatrician, Wrightington, Wigan and Leigh NHS Foundation Trust, will discuss the role of Medical Examiners in learning from deaths.

"The objective is for medical examiners to independently scrutinise all non-coronial deaths across England and Wales"
NHS England 2020

"Care Quality Commission (CQC) inspections have shown good progress is being made by some NHS hospital trusts to implement national guidance on learning from deaths. However, failure to fully embrace an open, learning culture may be holding organisations back from making the required changes at the pace needed… the amount of progress made to date varies between trusts and CQC analysis suggests that some organisations have found it harder than others to make the changes needed."
Care Quality Commission

"Through our well led inspections we have seen trusts that have made positive changes to ensure that learning from deaths is given the priority it deserves…However, the speed of progress varies, and our review indicates that problems with the culture of some organisations is preventing sufficient progress. Cultural change is not easy and will take time, but we cannot lose momentum and the current pace of change is not fast enough... We will continue to assess the progress trusts are making through our inspection and monitoring and to hold trusts to account when we find improvements are required."
Professor Ted Baker, CQC's Chief Inspector of Hospitals

Attendance at this conference will support you to:

- Network with colleagues who are working to improve practice in the investigation and learning from deaths
- Learning from the National Mortality Case Review Programme
- Reflect on the lived experience of a carer
- Learning from deaths involving Covid-19
- Learn from working examples of mortality governance and develop the role of mortality audits, internal inspection and mortality reviews to answer the question "did a problem in care contribute to the death?
- Understand national developments and national reporting requirements
- Learn from best practice in the investigation of deaths
- Identification and reporting of deaths and the role of the Medical Examiner
- 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
- 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

100% of delegates who attended the last learning from deaths virtual conference said attending the event would ultimately have a positive impact on patient experience and outcomes

10.00 Chair's Welcome & Introduction

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

10.10 Learning from deaths through the national mortality case record review programme

Dr Emma Redfern
Consultant in Emergency Medicine & Deputy Medical Director
University Hospitals Bristol NHS Foundation Trust

- learning from deaths
- ensuring learning from the mortality review process, incidents and investigations leads to sustainable improvements in quality or safety
- implications of Covid-19
- our experience

10.40 Evaluating the implementation of the Learning from Deaths Programme

Dr Zoe Brummell
Anaesthetic and Intensive Care Trainee
University College London NHS Foundation Trust

- reviewing how organisations are using the LfDs programme to learn from and prevent, potentially preventable deaths
- themes and lessons from the findings

11.00 Working with and involving families when an death occurs

Tony Bonser
Member, NHS Patient Experience Workstream
Volunteer, Hospice UK
Member, NHS EoLC Programme Management Board
Vice-Chair, Trustees, St Catherine's Hospice Preston

- learning from the lived experience
- how can we put patients and carers at the heart of the process?
- how excellent family engagement can produce better results for family and Trust during serious incident investigations
- involvement in reviews and investigations: what does excellence look like?
- implementing the new national guidance in practice

11.30 Comfort Break & Virtual Networking

11.50 EXTENDED SESSION: Working with the Coroner: death notifications, coronial investigation, inquest & Preventing Future Deaths

Andrew Harris
Senior Coroner, London Inner South
Professor of Coronial Law
William Harvey Research Institute, Queen Mary's University London

- notification of deaths to Coroner, MCDs and Working with the medical examiner
- the coroner's investigation
- what is an unnatural death and opening an inquest
- Professional Witnesses, Interested Persons and the Inquest
- learning from deaths: Preventing Future Death Reports

This session includes breakout groups

12.50 Lunch Break & Virtual Networking

13.20 Supporting families and developing the role of the Family Liaison Officer

Michelle Barber
Patient & Family Liaison Officer
Cambridge & Peterborough NHS Foundation Trust
Founder, Family Liaison Officers Forum

- supporting and working with families
- what type of cases should be referred to the FLO and when the FLO can't assist
- how we have been supporting people through Covid-19

13.50 EXTENDED SESSION: Mortality Governance & Monitoring during Covid-19 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?
- mortality monitoring and Covid-19
- 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

14.40 Small Breakout Groups

14.55 Learning from Deaths: identifying learning points for change

Dr Michelle Webb
Lead Medical Examiner Renal Consultant, Freedom to Speak Up Guardian
East Kent Hospitals NHS Foundation Trust

- 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

15.25 Comfort Break & Virtual Networking

15.40 Supporting staff when a death occurs

Prof Helen Young
Executive Director of Patient Care and Services
South Central Ambulance NHS Foundation Trust

- understanding the impact a serious incident can have on frontline staff
- supporting staff when a death occurs
- how we have improved support and wellbeing for staff during Covid-19
- supporting staff through inquests

16.10 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, and moving the focus of investigation, from acts or omissions of staff, to identifying the underlying causes
- interviewing staff involved in serious incidents - techniques and tips
- writing the investigation report - techniques and tips

17.00 Question and Answers, followed by Close

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

10% card payments discount*

15% group booking discount**

Conference Registration

Investigation and Learning from Deaths in NHS Trusts
Tuesday 22nd June 2021
Virtual Conference

Download

> How to book

Book online via credit card and receive a 10% discount*

www.healthcareconferencesuk.co.uk

Post this form to Healthcare Conferences UK
8 Wilson Drive, Ottershaw, Surrey, KT16 0NT

> Your Details (please complete a new form for each delegate. Photocopies are acceptable)

Dr Mr Mrs Ms (Please Circle)

First Name

Surname

Job Title

Department

Organisation

Address

Postcode

Telephone

Fax

Email

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.

This form must be signed by the delegate or an authorised person before we can accept the booking
(By signing this form you are accepting the terms and conditions below)

Name

Signature

Date

> Payment

☐ **By Cheque** A cheque for _____ is enclosed

Please make Cheques Payable to: Healthcare Conferences UK Ltd.

☐ **By Invoice** Please send an invoice to

Name

Organisation

Address

Postcode

PURCHASE ORDER NUMBER
(If Applicable)

Please note if you are requesting an invoice many NHS organisations now require a Purchase Order Number to be provided. If you do not provide this number this may slow down the processing of this delegate place.

☐ **By B A C S**

For Payments in £: Sort Code 40-46-22 Account No. 21553690

- Please send your BACS remittance form as confirmation of payment
- Your BACS Reference

☐ **By credit card** Please debit my Visa/Mastercard/Switch

All sections must be completed

Cardholder's Name

Card No. | | | | | | | | | | | | | | | |

Valid From | Expiry Date

Issue No. (switch only)

You will be contacted during the processing of your booking to confirm the payment card security code. (this is the last three digits of the number printed on the back of your card)

Signature

Card billing address

Promotional Code

For more information contact Healthcare Conferences UK on **01932 429933** or email **jayne@hc-uk.org.uk**

Virtual Portal
This is a virtual conference on Zoom with interactive breakouts and a dedicated landing page with resources available for three months after the conference.

Date
Tuesday 22nd June 2021

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.

***Credit Card Discount**
10% discount when you book via credit or debit card. This offer is exclusive to card bookings and cannot be used in conjunction with any other Healthcare Conferences UK offer.

****Group Rates**
A discount of 15% is available to all but the first delegate from the same organisation, booked at the same time, for the same conference.

Terms & Conditions
A refund, less a 20% administration fee, will be made if cancellations are received, in writing, at least 4 weeks before the conference. We regret that any cancellation after this cannot be refunded, and that refunds for failure to attend the conference cannot be made, but substitute delegates are welcome at any time.

Confirmation of Booking
All bookings will be confirmed by email, unless stated otherwise. Please contact us if you have not received confirmation 10 days after submitting your booking. The access code for the virtual portal will be sent in the week before the conference.

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

Credits
CPD Certified.
Conference Producer is a member of the British Association for Professional Conference Organisers.

The information provided will be held on the Healthcare Conference UK's database and may be used to update you with details of other events that we organise. If you DO NOT wish to receive this information, please tick this box ☐

We occasionally release your details to companies sponsoring or exhibiting at our events. If you DO NOT wish to receive information from these companies, please tick this box ☐

Healthcare Conferences UK reserve the right to make changes to speakers and programmes without prior notice.

ABPCO FULL PCO MEMBER 2021