MILLS & REEVE

Incident investigations 2019 – Getting them right

A one day training session for senior staff charged with conducting investigations and root cause analysis.

Engaging! Stimulating! Essential issues…

How your organisation handles an investigation will have a huge impact on patients, families, staff and your organisation. It will affect how commissioners, regulators, coroners and the media respond…

Why getting it right is so important

- Reducing risks to patients – putting patient safety first
- Prevention of future deaths
- Presenting you as a responsible, professional, well-run organisation
- Responding to the regulatory burden and demands
    - NHS England Serious Incident Framework
    - NHS Improvement: Guidance "Learning from Deaths in the NHS" (March 2017)
    - CQC
    - Police
    - HSE
    - Professional regulators
- Demonstrating your ability to learn
- Showing how you put changes into practice
- Reducing the impact and costs to your organisation
- Protecting your reputation & handling disclosure

What will we do?

- Help you get it right first time
- Help you appreciate the regulatory landscape – how your report will be used
- Get to grips with what 'root cause analysis' means
- Develop an evidence based approach to investigations
- Consider a firm but fair approach to investigations
- Provide the basic tools to convert analysis into impressive reports

The programme is a mixture of presentations and sessions where you will be working on a scenario drawn from a real serious incident. Please feel free to ask questions at any point! These sessions work best when delegates contribute with their own experience. There are often differing views as to how to approach an issue, and no single right answer. The more discussion we can generate, the more useful you are likely to find the day.

Programme for the day

(Suggested – the running order will be open and flexible)

09.30 Registration

10.00 Introduction and videos

Do the test – videos to test your observation and evidence planning skills. How well do you think you could do?

The context of an investigation within the wider regulatory framework

- Setting the scene – what's it all about?
- The changing framework for care organisations
- Do issues of candour, openness and transparency apply?
- CQC reporting requirements
- Other regulators, including the police and HSE
- Data protection
- Scrutiny of the report
- Communication with relations and families

Planning the investigation. Evidence and evidence gathering

- Roles and responsibilities of the investigating officer
- Time management
- Types of evidence
- Interviewing
- Statement writing
- The purpose of the statement & disclosure

11.15 (say) Break

- Practical Exercise 1
- Planning the investigation
- Discussion
- Feedback from practical exercise
- Questions
- Analysing your findings
- Root cause analysis tools
- Applying the principles applicable to public authorities?

13.00 (say) Lunch

13.45 (say) Practical Exercise 2

Analysis of the issues.

Report writing

- Terms of reference
- Factual conclusions
- Recommendations
- Follow up – auditing implementation
- Disclosure

Practical exercise 3

- Making recommendations and drawing up an action plan

Learning the lessons

- Corporate and public assurance
- Debrief with staff

Questions and discussion

Finish (say) 16.30

Get in touch

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Key experience

- Advising on inquiries/inquests since 1988
- Former Assistant Coroner
- Former BBC journalist

Stuart is our most experienced patient incidents lawyer. He began assisting health and care originations with inquiries and inquests in 1988 when he was part of the team advising the West Midlands Regional Health Authority panel of inquiry following the death of Alma Simpson at the hands of another patient at St Edwards Hospital, Cheddleton.

As a former BBC journalist, an Assistant Coroner and regulatory lawyer, Stuart is uniquely placed to help our clients through the difficult processes following a death or patient safety incident. And beyond the immediate legal processes, he will liaise with stakeholders, advise you on risks and help you manage your reputation, potential claims and the media implications.

Read more here.

Who we work with

With particular specialism in acute & mental health, prison deaths and Human Rights Act issues, we work with:

- Acute providers
- Ambulance trusts
- Out of hours providers
- Mental health providers with low and medium secure units
- High secure hospitals
- Independent sector providers
- Government bodies and regulators
- Charities
- CCG's
- NHS England

Some feedback on our team…

“I’m most grateful for your support... It was outstanding. ”

Peter Wright Executive Director Forensic Services, Nottinghamshire Healthcare NHS Foundation Trust

“I feel genuinely privileged to know that you are on our team and offer my heartfelt thanks”

Dr Stephen Merron, Consultant Anaesthetist, University Hospital North Midlands NHS Trust

“A powerful message in the right tone. Brought into sharp focus many of the issues… although quite uncomfortable in many respects. The impact was profound.”

Feedback on our risk management and harm reduction workshop

“Thank you again for everything you’ve done. I hope to apply all I’ve learned in delivering safer services. You are clearly master of your craft.”

Phil Griffiths, Head of Healthcare – HMP (Notts)

“Your support was invaluable and much appreciated by the witnesses … minimising the stress for witnesses, [who] felt that you were in their corner throughout”

Director, client