Niche Health and Social Care Consulting

Implementing the PSIRF – Investigating deaths. Ensuring learning.

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HEALTH & SOCIAL CARE CONSULTING

Introduction – Tom McCarthy

Session aims

The four key aims of the PSIRF are:

1. compassionate engagement and involvement of those affected;
2. a system-based approach to learning;
3. considered and proportionate responses;
4. supportive oversight focused on strengthening response systems and improvement.

This session will provide support for how you can achieve those objectives, particularly through the lens of 'learning from deaths.' After this session you will:

- understand why a focus upon deaths is important for learning
- know how to draw in dispersed learning from deaths to generate intelligence
- understand the relationship between deaths and the PSIRF
- understand the types of data that can support proper learning
- see an example of a helpful system-level implementation project
- understand how to bring bereaved families into the conversation
- understand the importance of assurance within the PSIRF cycle

Introduction

About Niche and our credentials

- Over 30 years delivering health and social care consultancy across investigations/reviews, governance, evaluations and analytics.

- The last decade has seen Niche become the most respected firm delivering the most complex investigations and reviews across health and social care systems and individual providers. Niche often deal with complex cases and our objective is to support organisations and families to *safely surface the truth*.

- Niche are a values-based firm and we ensure that kindness, respect and integrity run through everything we do. We are proud to be an Employee-Owned Trust and we are also working towards becoming a 'benefit corporation' or B-Corp.

- With 23 employed (and many dozen associates) we have a unique blend of clinical expertise, investigatory knowledge, working governance and assurance approaches together with complex analytical techniques. All of this combines to offer clients and families outstanding and reliable investigation and review services.

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To illustrate our depth of experience, over the last three years alone we have:

- ✓ Completed several hundred investigations nationally, which has given us an enormous bank of primary evidence and insights.
- ✓ 107 of these investigations and reviews have been directly in relation to a catastrophic incident or serious care failing which has resulted in a death.
- ✓ These 107 cases related to over 187 deaths, a high proportion being mental health related homicides (including multiple victim homicides), DHRs and inpatient suicides. We also look at many non-mental health incidents and neonatal deaths.
- ✓ Around a quarter of our work relates to multi-agency pathway reviews, complex complaints, assurance reviews, well-led governance reviews, whistle blowing investigations and individual care and treatment reviews.

The investigations and reviews that we do often involve:

- Complex multiagency stakeholders (Police, Coroner, Prisons, LA, housing etc.)
- Very traumatised families and very traumatised staff
- Increasing media profile and public interest making an inflammatory environment
- Relationships and trust which are completely broken (whistleblowing / complaints)

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- The Patient Safety Incident Response Framework (PSIRF) fundamentally shifts how the NHS responds to patient safety incidents for learning and improvement. *PSIRF is not an investigation framework that prescribes what to investigate.* Instead, PSIRF:
  - advocates a co-ordinated and data-driven approach to patient safety incident response, that prioritises compassionate engagement with those affected
  - embeds patient safety incident response within a wider system of improvement
  - prompts a significant cultural shift towards systematic patient safety management
  - and emphasises the importance of demonstrating learning.

- We know that it is not entirely clear to organisations how the above can be achieved, particularly when families are involved. How do we know if we are 'proportionate in our response'?

- Today we will also talk about our 'intelligent analytics' and how to deliver PSIRF's data-driven approaches.

PSIRF and Learning from Deaths – Mary Ann Bruce

The legislation underpinning reviews of death

Health and Social Care Act 2017
https://www.legislation.gov.uk/uksi/2017/744/pdfs/uksiem_20170744_en.pdf

- *.. learning from deaths is not being given enough consideration in the NHS and that opportunities to improve care for future patients are being missed. None of the Trusts that the CQC approached could demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented. The CQC also reported that Trusts need to do more to engage bereaved families and carers and to recognise their insights as a vital source of learning.*
- *.. require Trusts to provide a narrative description about what they have learnt from their case record reviews and investigations of deaths in the reporting period, a description of what actions they have taken in the reporting period and propose to take following that reporting period, and an assessment of the impact of actions that they have taken. The National Health Service (Quality Accounts) (Amendment) Regulations 2017*

- PSIRF provides an important framework to continue to meet legislative requirements on mandatory reporting on deaths and the learning arising from them.

How can deaths inform a patient safety incident profile?

- There are between 570-670,000 deaths annually in the UK; the majority are located in UK hospitals, followed by care homes. Over 22% of all deaths in the UK are considered to be avoidable. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2020

- Approx. 5.2% of cases in (2012) a retrospective case review were considered preventable deaths due to problems in care. https://qualitysafety.bmj.com/content/21/9/737

- In a study by the London School of Hygiene and Tropical Medicine (2015) 1 in 28 hospital deaths were considered avoidable (3.6%) https://www.lshtm.ac.uk/newsevents/news/2015/hospital_quality_measure.html

- This is a cohort of possible potential patient safety incidents that Trusts need to fully understand to inform a patient safety incident profile

- It is important to understand, in the focus on risk, that patient experience is not lost. A death may not have avoidable factors but the experience for the patient and family may have learning. Not listening to patients, families or parents is a patient safety risk.

Cont.

- Mandatory investigations are required for deaths (including suicide and homicide) whilst under Mental Health Act detention, and incidents which meet the criteria for Never Events.

- There is a wide range of other organisations that review deaths – does the Trust use these in its incident profiling for example, child deaths, maternal deaths, LeDeR? Add these to your incident profile.

- Under PSIRF only incidents posing the most significant of risks, incidents arising in particular defined areas, or exceptional cases with the most significant opportunity for learning, will be expected to have a formal investigation. All other incidents could instead be addressed with a range of different tools, such as informal reviews, structured judgement reviews, and debriefs. Due to the processes involved in deaths there is significant opportunity to use wider information to inform thematic reviews.

- Leaders are now being asked through the PSIRF to identify the review priorities within the areas where they want to see the most improvement. Review priorities are often derived from deaths, same causal factor serious incidents **and** near misses. The next slide shows us some examples of how to inform the thematic review process.

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"Organisations are required to develop a thorough understanding of their patient safety incident profile, ongoing safety actions (in response to recommendations from investigations) and established improvement programmes. To do so, information is collected and synthesised from a wide variety of sources, including wide stakeholder engagement". (PSIRF)

1. Deaths subject to mortality review: any inpatient death (or death within 30 days of leaving hospital), emergency department death, death whilst in receipt of community services. All Trusts to provide estimates of deaths which are an outcome of poor care. Using case note review, structured judgement review, trusts are able to establish awareness of care delivered to expected standards, or not. How does your Learning from Deaths Policy align with the principles of the PSIRF?

2. Deaths where there was clearly an unexpected outcome: perhaps a catastrophic incident or accident, or where care was not delivered, or not available. This usually requires an investigation or (now) grouped thematic review, as there are clear indications that these deaths might have avoidable aspects.

3. There will increasingly be a focus upon the latent factors associated with death, especially iatrogenic causes – particularly in mental healthcare.

How deaths inform a wider organisational incident profile

- An index case focusing on the emergency care in last days of life required a look back at the whole journey – the learning highlighted much earlier failings and process challenges. **… look at the whole pathway of care on a *small number of cases* per year.**
- A thematic review of deaths across a whole system – highlighted failings to handover diabetic care and weaknesses in glucose monitoring and insulin management in delayed care for the elderly. … **Consider *regular pathway reviews* of a cohort of patients across the system.**
- A complaint after the death of a child highlighted weaknesses in mortality review processes and child death overview. **Consider a review of the *functioning of processes* designed to highlight weaknesses/strengths in care to confirm they are robustly doing so.**
- The death of a mental health patient in the car park of an acute medical unit highlighted estates risks. **Venture into non-clinical areas and scope risks accordingly. How do these risks get reflected in your trust-wide risk profile?**
- A child death highlighted weaknesses in ventilation and building risk assessments. **Be prepared to seek super-specialist external expertise – including non-clinical expertise.**

Learning factors

What factors can we apply based on learning from previous investigations following death, actionable recommendations and impact to be able to determine learning potential at a local, system or national level?

Of our 187 independent investigations involving death we have observed:

- ✓ The benefit of independence in building trust
- ✓ The benefit of having insights and contributions from families
- ✓ The importance of a good recommendation
- ✓ The importance of robust assurance processes around implementation
- ✓ Having buy-in from stakeholders and the freedom to talk to people across a system
- ✓ The ability to make organisational, regional and national recommendations
- ✓ The development of learning lessons bulletins and our targeted learning quadrant
- ✓ The importance of trauma-informed interview approaches
- ✓ The value of analytics as an evidence base

Impactful analytics – Dr Paul Smith

Using data and analysis

At Niche we have developed sophisticated methods of using data and analysis to support investigations' key lines of enquiry. For example, we could look at incidents of restraint by area, by time and by individual staff – this can be juxtaposed with training rates and individual patient incident profiles. This is really impactful intelligence.

What does the PSIRF say about analytics?

- The thousands of SIF reports we have seen over the years have been largely 'data free zones' (internal and external investigations).
- PSIRF promises this will change with a 'data driven approaches'…. BUT
- The latest Patient Safety Incident Investigation (PSII) report template doesn't mention data (or how to utilise it) in its critical components that need completion.
- Also the plethora of guidance tools and template that are now available are data intelligence 'light'… and so organisations are required to think this through.
- What is intelligent analytics and how can you embrace this as part of the PSIRF revolution?

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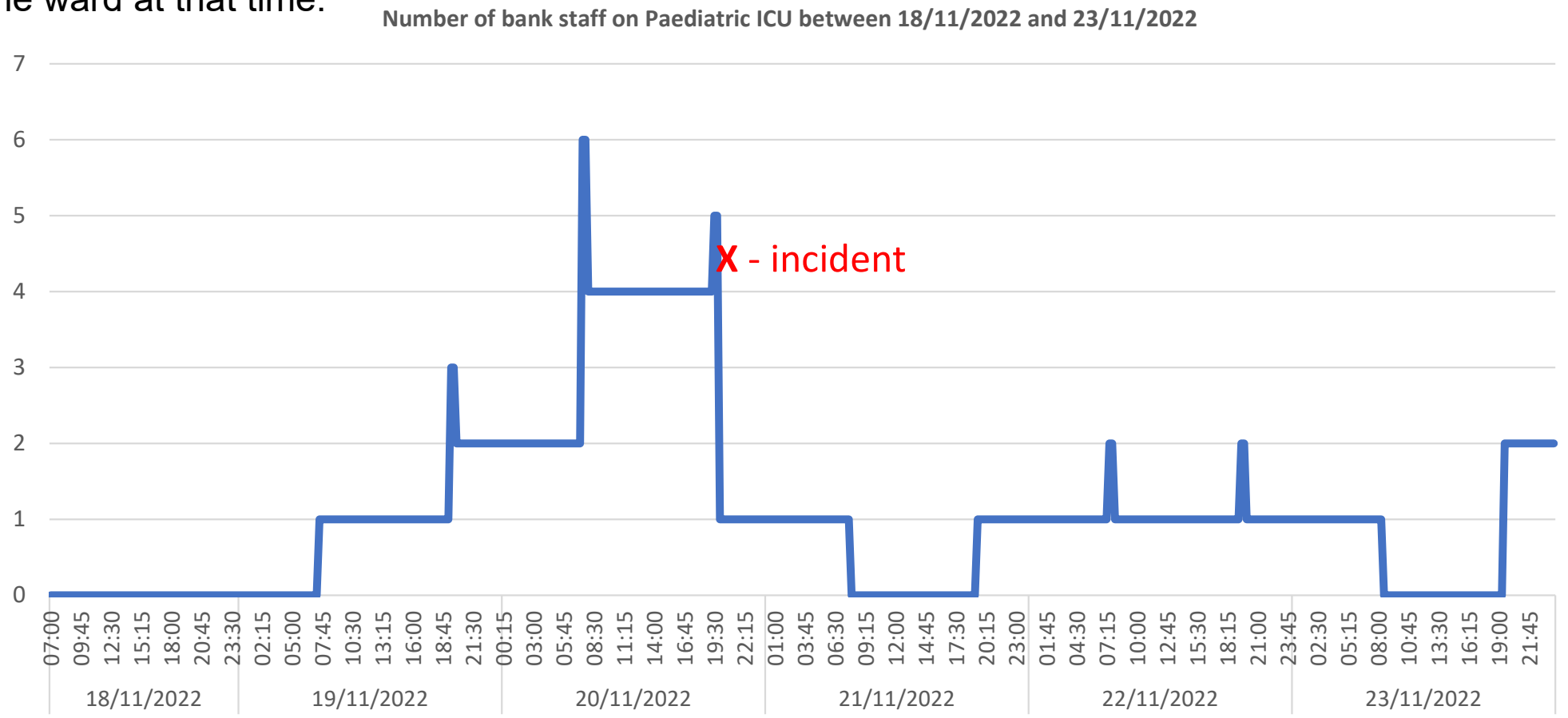
Intelligent analytics is about:

- Understanding and really interrogating ‘the numbers, themes and trends*, correlations between core bits of quantitative evidence ’ to add to the understanding of ‘what went wrong and why’.
- Testing hypotheses that we hear from interviews and assessing them against quantitative findings.
- Supporting the evidence base for KLOEs, as well as assessing emerging qualitative feedback e.g.
  - *‘staffing levels were well below safety levels’*
  - *‘the unit was never as busy as when the incident occurred’*
  - *‘our case mix and demographic profile benchmarks differently’.*
  - *‘acuity is rising!’*

- * Establishing themes and trends is core to the PSIRF but this is generally in relation to incidents which don’t fully meet the ‘test’ for full investigation. For example, *10 incidents identified poor observation on night shifts as factors.*
- Examples of how ‘intelligent analysis’ has been used in some of our work recently…

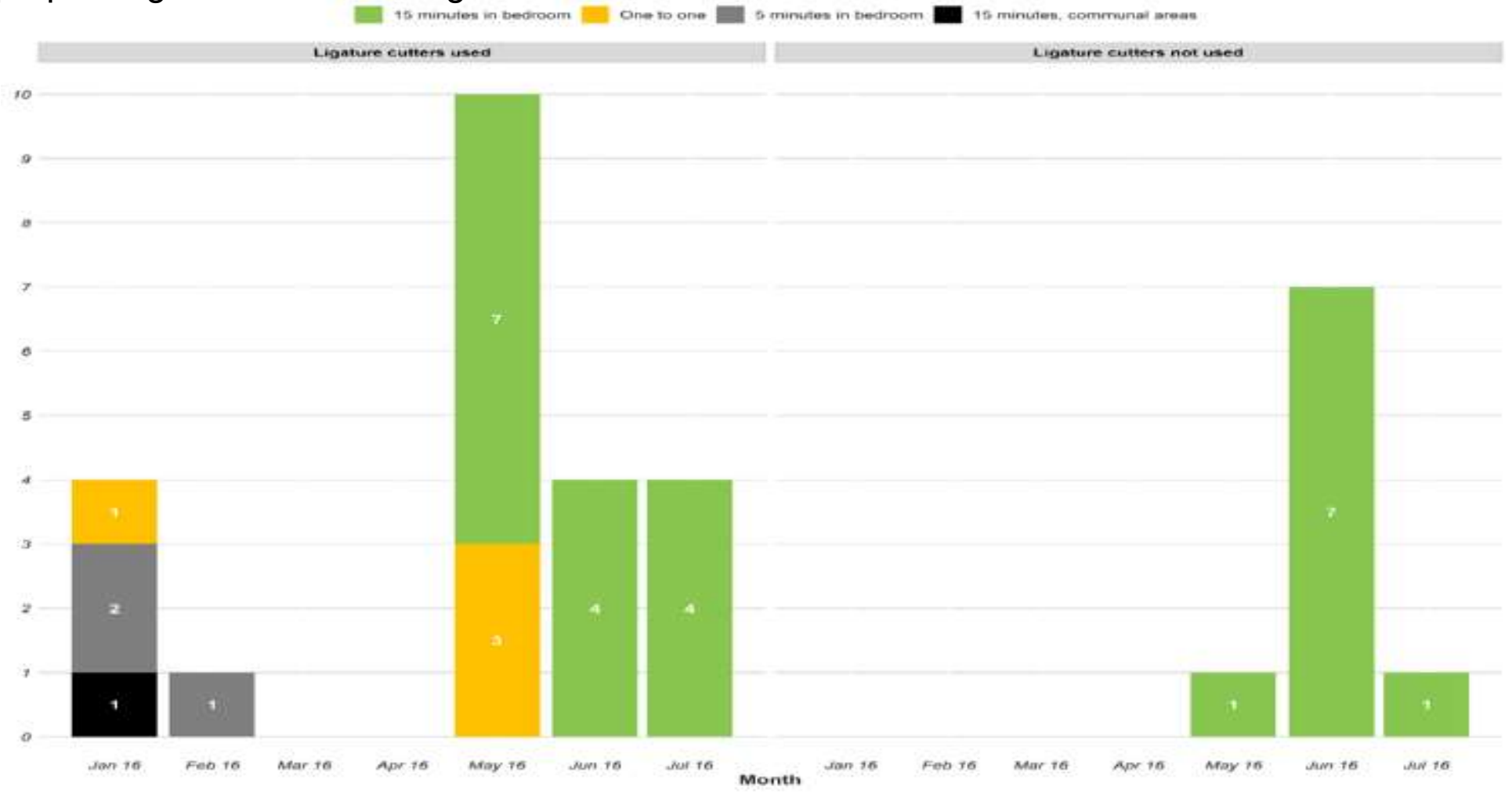
Use of bank staff (example)

The chart shows the number of bank/agency staff on a paediatric intensive care ward over the period during which a critical incident occurred. In this review, the parents of a child who died said that there appeared to be a lot of temporary staff on the ward for the whole of their six day stay. This diagram helped the Trust and the parents to better understand the actual numbers and the reality of staffing on the ward at that time.



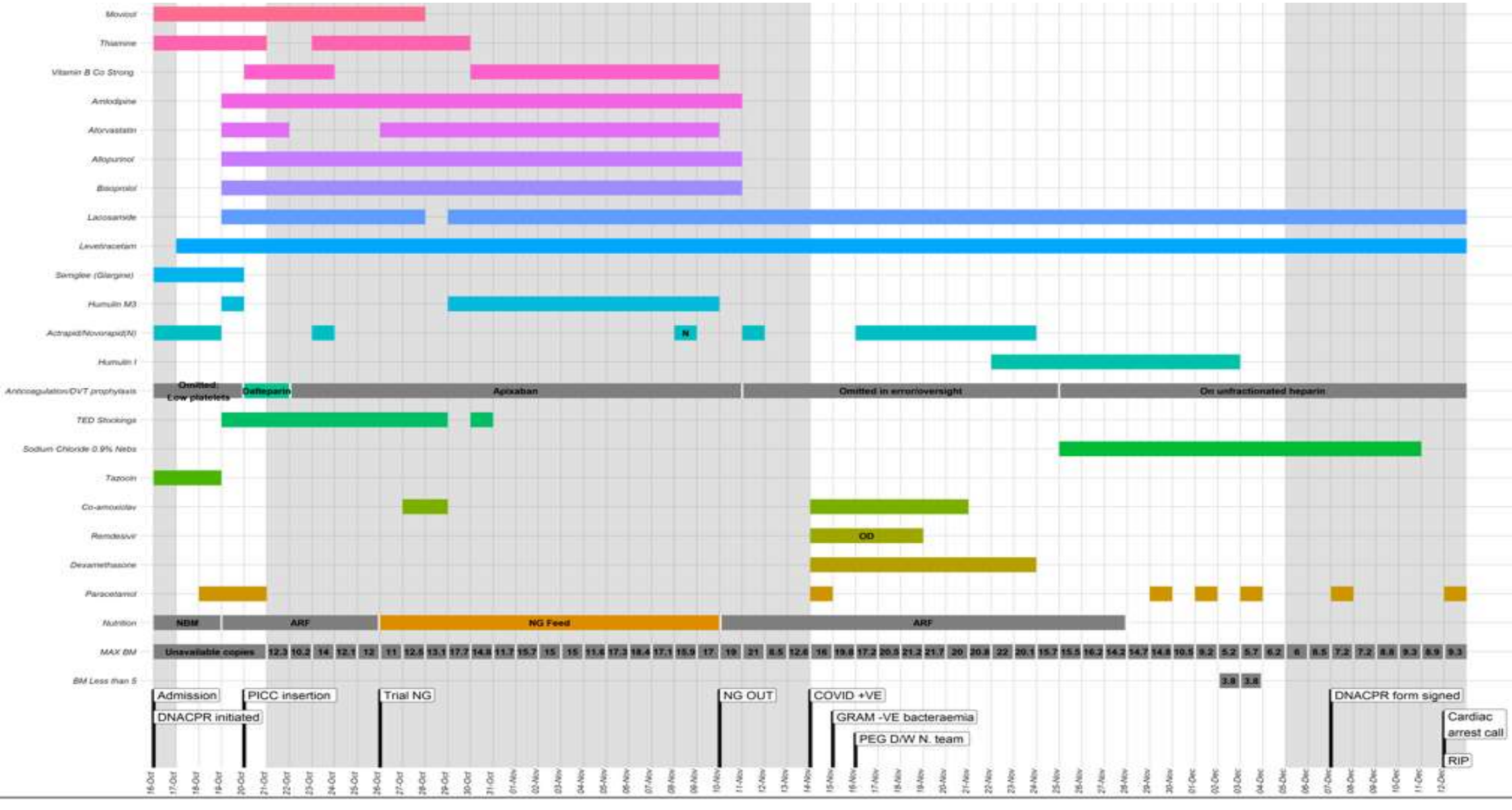
Observations

This chart shows the distribution of a patient's incidents of self-harm by level of observation. In this review, where a young girl died by suicide in July, we were able to see whether the increased incidents of self-harm were aligned to the risk assessments and onward actions by the ward, and whether these were appropriate given the escalating distress.



Drugs chart

This chart combines medications data, blood glucose results, feeding regimes, critical events and patient movements between wards to enable a better understanding of care continuity. This was a significant concern of the family as the patient was moved four times and medication was inadvertently stopped.

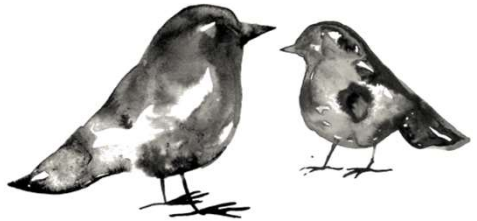


System-based learning example: ‘Reducing choking’ Nursing and Care home sector – Julie Kerry

A system approach to learning from Resident Safety Serious Incidents

Scotland QI Collaborative: Reducing Choking

Julie Kerry
Chief Nurse Director of Quality
May 2023



Context – What's the risk ?

Collaborative Design

- 55 Care Home Teams across Scotland
- Neutral environment at university base
- Time for social interactions
- 3 days QI facilitated learning (2 facilitators)
- Used organizational incident reports to generate ideas
- Culminated in one countrywide Test of Change (PDSA) designed together (tests prioritized by collaborative)
- Executive Sponsor and QI Lead for Scotland- working in Partnership across the System – CIS, SaLT

Aim

- To reduce death by choking in Scotland by 95% by Jan 2024

The Test of Change (PDSA 'Do')

Lunch service Mealtime Coordinator 7/7:

- Agree and standardize role and role definition
- Agree 'requirements' and responsibilities,
- All coordinators have F2F texture training – IDDIS
- Know all residents well
- Confident to coordinate meals
- Advise on positioning and second texture test

- Pre and post huddle
- Measure the process re-design and capture feedback

Early wins

Bringing a dispersed group of leaders (fractal organisation) together to learn

- Modelling cultural shift:
  - All teach, all learn (flatten hierarchies)
  - Psychological safety and personal accounts of choking

Understanding the system change and responsibilities for improvement

Standardise the supply and replacement of texture equipment

First Test of Change (PDSA) designed and implemented by ALL participants

All measures designed together to increase ownership

Early wins

Working on data quality – new codes designed for incident reporting to understand

- Importance of reporting (Nos of incidents increasing over time)
- Categorise cause of choking (foodstuffs)
- Clarify *'near miss'* and report for learning

Equipment used to texture food – immediate alert to equipment failure

Established LIFE QI as learning platform

Offered IHI OS to all leaders

Chef college – development days delivered

F2F texture training for 250 colleagues delivered by hospitality

Standardised Blenders

Replaced sausages with Skinless sausages

Hopes – To improve the safety of our residents

Colleagues

- develop understanding of QI and psychological safety (feedback has been good)
- improve ‘cross working and support’
- learn to ‘diagnose’ problems before attempting to solve them by enjoying their own data
- understand that the whole of their system is responsible for working together to solve this problem

Publish papers / research studies to build the evidence base in home care – working with Leeds University

Test of change introduces a better focused and coordinated mealtime service by an experienced colleague, all trained in serving texturing food.

To sharing learning internally and nationally to improve practice and reduce deaths

Thank You

Making families count – Rosi Reed

The impact of poor engagement, a Family's story

Rosi Reed

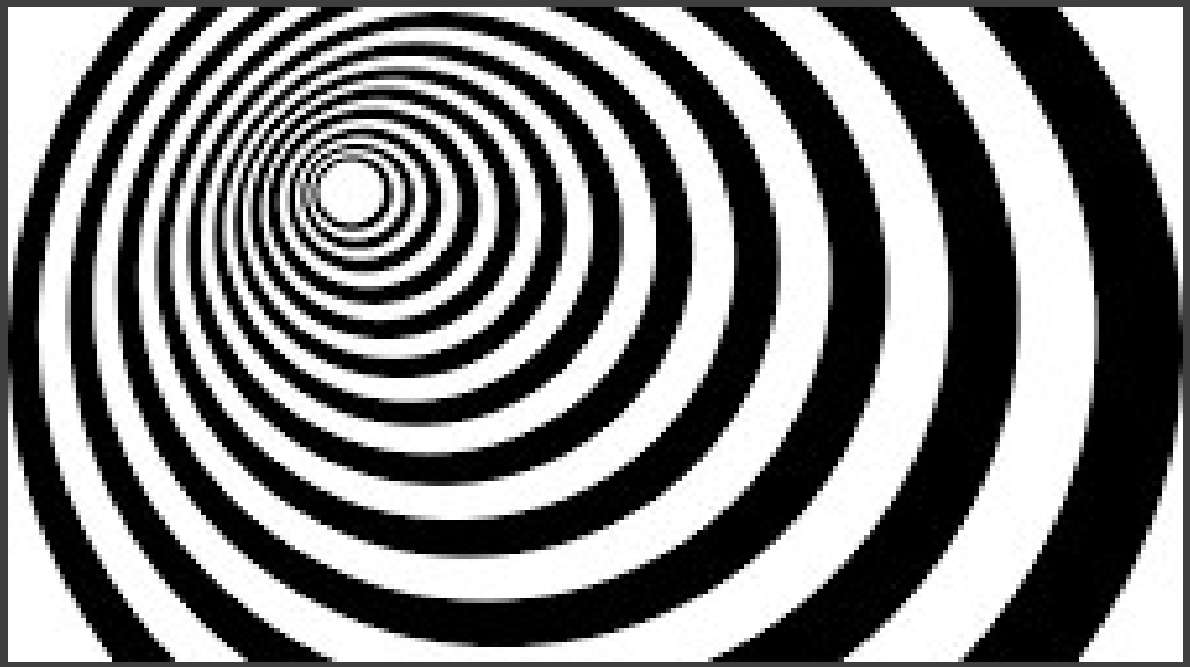
Making Families Count
Development and Training Coordinator

Impact on families

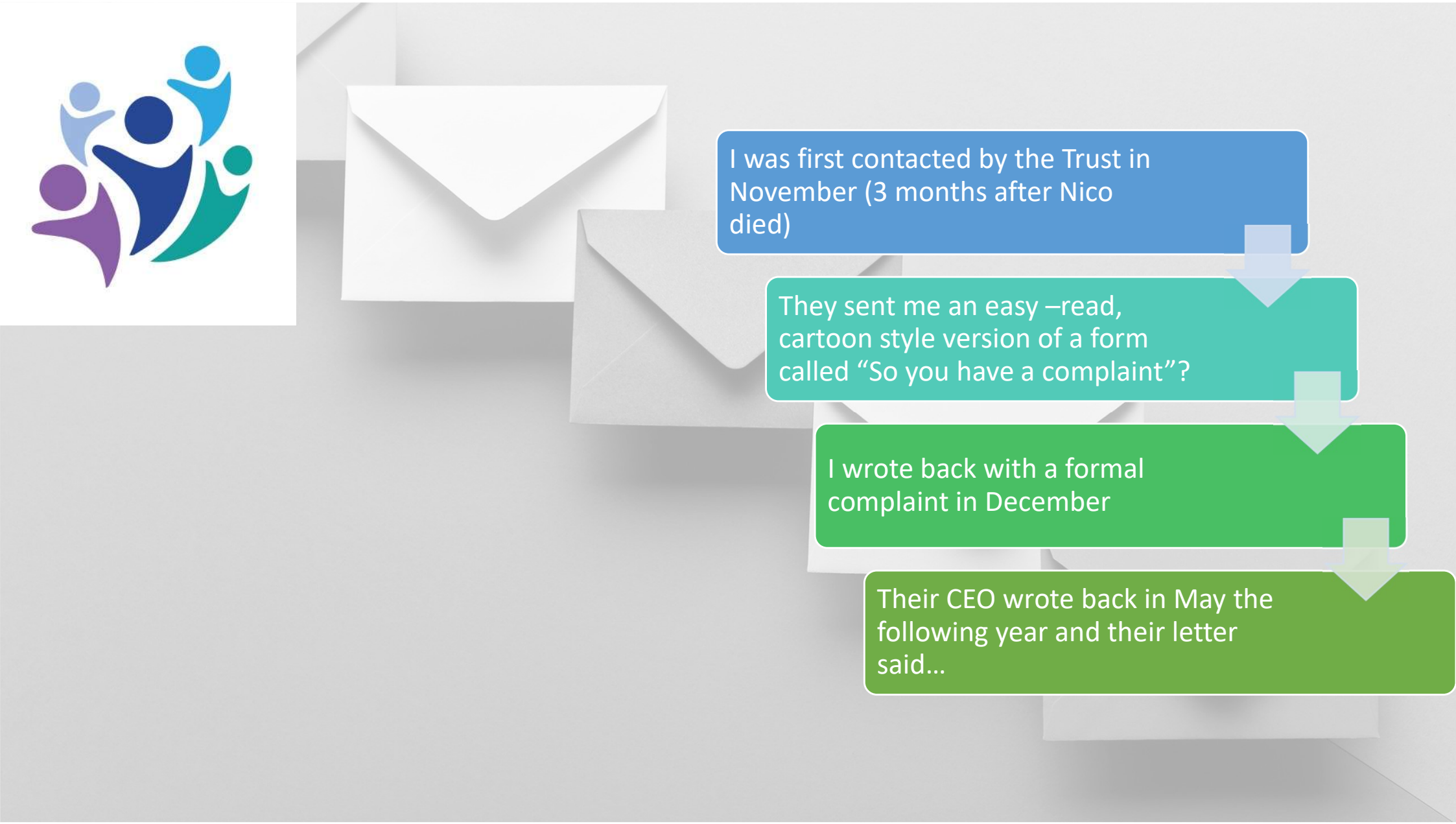
"It felt as if people in this trust had decided that our son's life was so unimportant and our son's death was so unimportant, and *we* were so unimportant, that we were just a bit of dust they swept into the corner"

Transparency

"The reason that transparency matters is because unless you know, you imagine and imagine and after a while you start to imagine that because they won't tell you, they must be concealing something dreadful."



"Your imagination goes into overdrive and you wonder what the hell they're concealing. It becomes a terrible spiral of deceit and grief, and anger that goes nowhere - because they won't even engage with you and it becomes like a poison."


I was first contacted by the Trust in November (3 months after Nico died)
They sent me an easy –read, cartoon style version of a form called “So you have a complaint”?
I wrote back with a formal complaint in December
Their CEO wrote back in May the following year and their letter said…


“Although a Root Cause Analysis has now been completed, we made the decision NOT to inform you that this had taken place, or share our findings, as we thought this would be too distressing for you”

Parity of Status ?

2 years later we had an Article 2 inquest

The coroner asked for an independent investigation to be commissioned

The investigation began 2 years later

The investigation took 2.5 years. Some Trust staff refused to take part

Parity of Status?

Following the investigation the PHSO took up our case

They investigated the report for malpractice and maladministration over a year

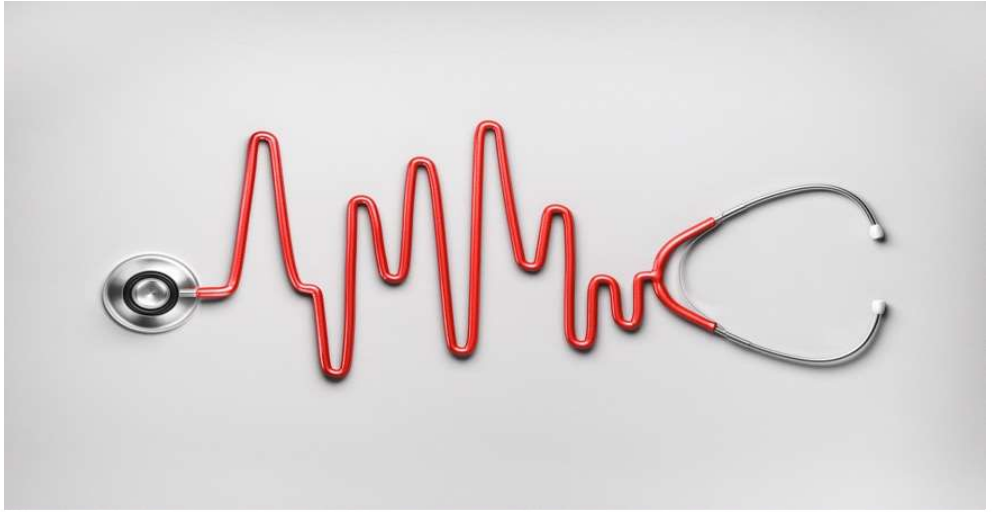
They ordered the Trust, the CCG and the investigators to apologise to us in writing

Impact on Families' Mental Health

It's very common for family members to develop PTSD

"I was in my bedroom when I saw in the mirror that a stranger had walked into the room. I whirled around to confront them, but there was no one there, and when I turned back, to my horror, they were there in the mirror. Then suddenly, the stranger turned into me. I was looking at my own reflection. I remember shaking all over, quite terrified and unable to understand what was happening."

Impact on Families' Physical Health



It's also very common for families to develop physical health problems

On of the causes of this is the enormous, continuing stress of long-drawn out, multiple investigations

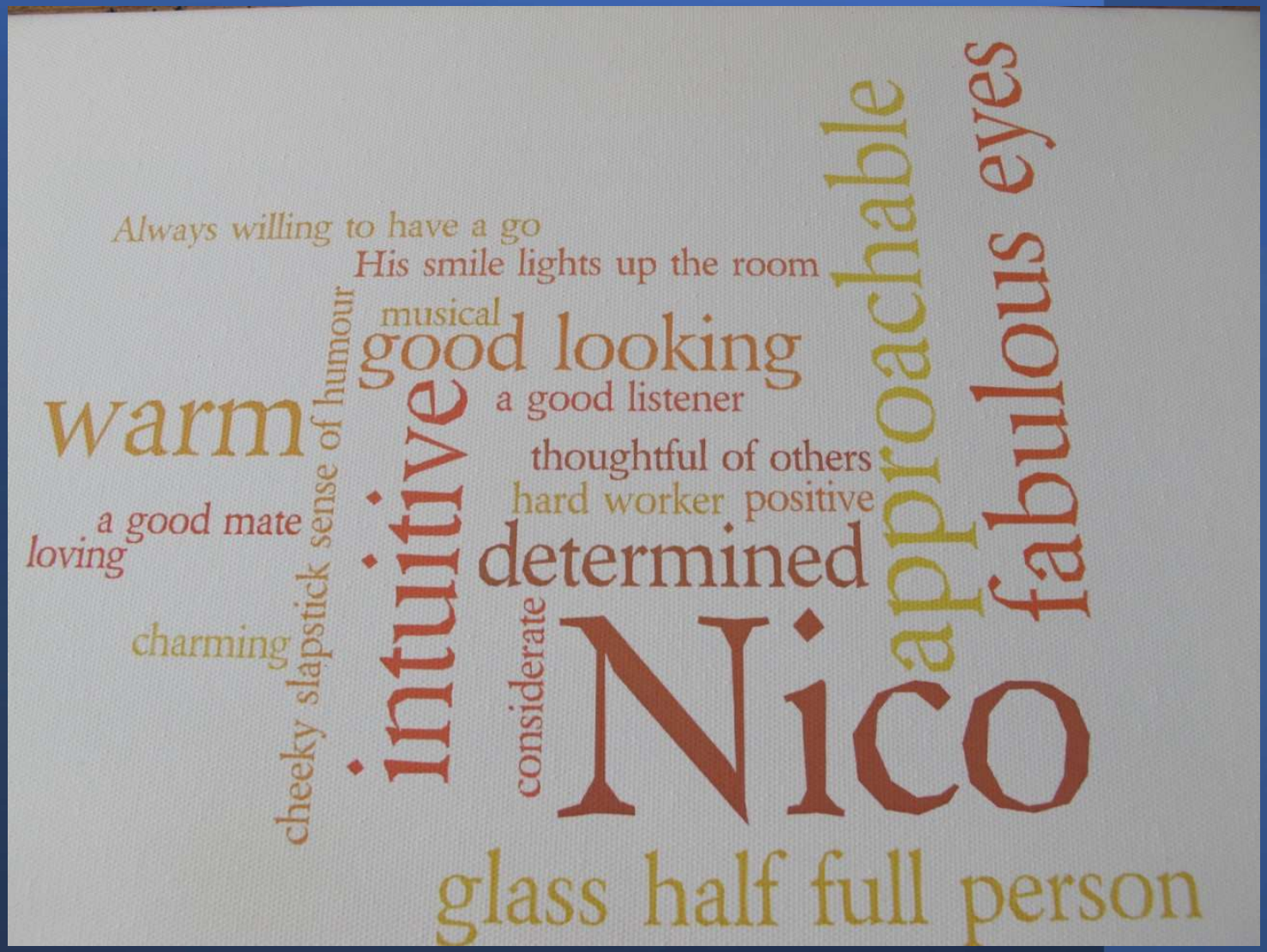
"*Multiple studies have shown that family members affected by long-term grief and stress are also far more likely to develop chronic and serious health conditions, such as heart disease, diabetes, lowered immune system and raised blood pressure*" Mental Health UK.

Impact on this Trust

- Negative and widespread national media coverage and continuing negative media interest
- Several high-profile investigations (Mazars Report, Learning, Candour and Accountability and Learning from Deaths guidance) and substantial fines
- Reputational damage to organisation. Loss of staff, poor staff morale, poor staff confidence
- Difficulties in recruiting and retaining staff

Nico Reed

“A golden boy, a shining child”


Always willing to have a go
His smile lights up the room
musical
good looking
warm
a good listener
thoughtful of others
hard worker
positive
a good mate
loving
determined
charming
cheeky
slapstick
sense of humour
intuitive
considerate
Nico
approachable
fabulous eyes
glass half full person

Assurance – James Fitton

The steps to building a culture of assurance

1. What assurance is expected by national guidance?
2. The two key assurance questions
3. What is “assurance” anyway?
4. Assurance reviews
5. Pathway reviews
6. A learning quadrant
7. Top tips and questions to achieve effective assurance

Assurance: expectations of national guidance

Two key overall assurance questions:

1. Have we done what we said we would do?
2. Did it work? Are patients receiving safer, better care and treatment than they used to?

Under the SIF: *"There must be clear mechanisms to ensure that actions from action plans are monitored until implemented, and there is evidence of whether or not the action plan has resulted in the practice / system improvement anticipated. This should include oversight of implementation by system leaders."*

Under the PSIRF, less detail (and less direct mention of assurance), but there is a clear expectation that *"the **implementation** and **efficacy** of all safety actions are monitored, and a named individual identified with responsibility for this."*

"Organisations are required to develop a patient safety incident response plan in line with the national template. An organisation's plan represents a proposal for how the organisation intends to respond to patient safety incidents over a period of 12-18 months. They should:

- *Review their data to determine their patient safety incident profile*
- *Describe the issues the data demonstrates*
- *Identify improvement work underway*
- *Agree response methods"*

*"Continue being curious: inquire about how things are working and monitor that safety actions put in place remain impactful and are sustainable."(*Safety action development guide: NHSE 2022)

What is “assurance” anyway?

The concept of “assurance” is drawn from financial audit and safeguarding. Here, there are considered to be four “lines of defence.” As an example, consider a Trust wanting to ensure carers are fully consulted about the management of risks presented by and to service users:

Line of defence	Practice example
Day-to-day management of risks during normal activity	Care coordinator ensuring carers are consulted, their views and concerns are recorded, and they influence MDT care planning
Broader control framework	Team leaders and practice supervisors check that carers are being consulted, review case records, and discuss the impact on care planning
Internal, independent perspective	Data are gathered and sample practice audits undertaken, and reviewed by internal clinical governance structures and processes
External, independent assurance	The topic is considered a priority for external review; external independent practitioners review data, practice and processes against an agreed practice framework

All four lines should be considered in planning approaches to assurance. Effective assurance must be **comprehensive**, **objective**, **timely** and **based on accurate evidence**.

Have we done what we said we would do?
An example approach – the Niche Independent Assurance Framework (NIAF)

Assessments are meant to be useful and evaluative. We use a numerical grading system to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. 3 is regarded as a good score as it reflects action completion. Scores of '4' and '5' are harder to achieve due to the cycle of testing that is required to demonstrate sustained improvements being achieved (for at least 12 months).

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action completed, tested, but not yet embedded
5	Can demonstrate a sustained improvement

For each action, we consider:

1. New policies and procedures
2. Minutes of meetings
3. Email and letter correspondence
4. Memoranda of understanding
5. Audit templates
6. Local audit findings
7. Evidence of changes in all of these over time

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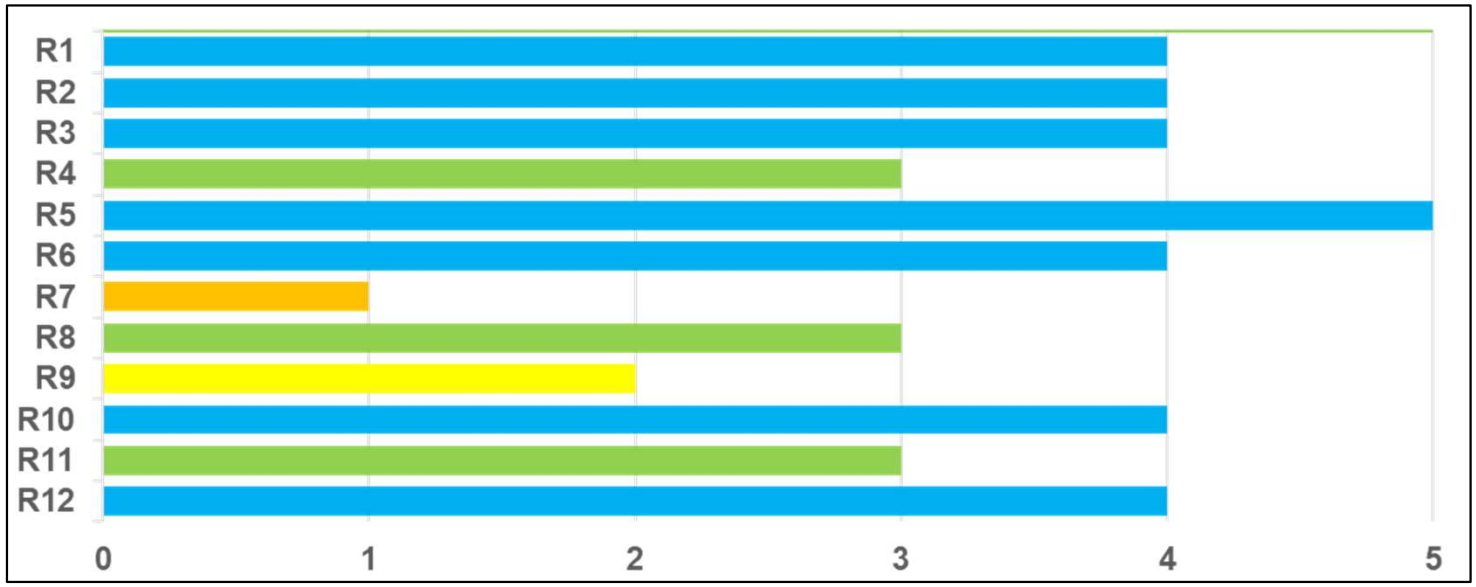

Simple visual presentations can draw attention both to areas of success and progress, and areas where more work is needed.

Review reports will typically include residual recommendations – those actions which are still required to ensure the incident response can be fully closed off.

Topic assurance may, however, still be required beyond closure of an incident response, or actions following a death. The four lines of defence for good, safe practice need to be maintained beyond these steps.

Did it work? Are patients receiving safer, better care and treatment than they used to?

- Pathway reviews

"If a service user accessed services today with a similar history/problem – what would change / be different"?

Steps required:

- Identify the issues arising from the index cases and carry out a review of the current pathway with reference to these issues.
- Review and assess compliance with local policies, national guidance, and statutory obligations in so far as these policies and guidance are relevant to the specific issues arising from these two cases.
- Via the review, identify areas of good practice, opportunities for learning and areas where improvements to service may be required.

- Case-note audit requires agreement of:

1. Relevant **time period** (the more recent, the better)
2. **Service user** characteristics – inclusion and exclusion criteria
3. **Service use** characteristics – inclusion and exclusion criteria
4. **Factors** which should reasonably be expected to be visible in case records, and which are relevant to the issues arising in the index cases
5. What would be considered **"good" evidence** of adherence to expected practice? And what would be considered **"acceptable" evidence**?

- The method design should be expected to be iterative. It needs to produce a sample large enough to produce statistically meaningful findings, but small enough to be feasible within available time and resources. The sample needs to be recognisably recent enough, and similar enough to the index cases to permit a fair answer to the review question.

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Audit question	N/A	Good	Acceptable	No	Total (applicable)	Total
There is evidence that staff have checked whether: (a) A carer's assessment has been completed in the last year OR (b) There is evidence of family members/carers being made aware they are entitled to a carer's assessment.	7	74	10	9	93	100
There is clear evidence of the nature of any concerns that family members/carers have raised.	7	65	14	14	93	100
There is evidence of family/carer concerns being taken into consideration in managing risk.	7	42	20	31	93	100

Sample data only – original data redacted

Audit findings are then completed by preparation of an action plan, setting out:

- Observations on the audit findings
- Actions planned in response
- Responsible individual(s)
- Planned completion dates

Audit work can (and often should) be supplemented by direct qualitative engagement with service user / patient groups. To be most useful, this needs similarly to be based on agreed criteria as to personal characteristics and service use – not simply engaging with people who first put themselves forward.

Assurance – top tips and questions

1. Remember the four lines of defence. Assurance of good practice starts with practitioners' routines and line management / supervision. Internal and external audit supplement these, and are necessary but not sufficient in achieving safe and effective practice.
2. In incident response work, or in actions following a death, think assurance throughout. How will you ensure action plans are implemented and effective? Are your actions clear and focussed enough to be checked for implementation and effect? Will review plans be comprehensive, objective, timely and based on accurate evidence?
3. When reviewing progress, do you clearly identify residual requirements? Updated actions required to ensure the plan's expectations were met?
4. Are there implications and learning beyond your organisation? Don't avoid feeding upwards lessons and potential learning for other parts of the NHS?
5. Will your plans and responses provide assurance to families affected? How will you ensure this?
6. It's sometimes essential to look beyond the index cases. What is happening with similar cases now? How do you know?
7. When direct responses are closed off, is everyone clear how normal practice routines will sustain good practice?

PSIRF learning quadrant

The PSIRF and deaths learning quadrant

Learning Potential

- Are we using our mortality case reviews to inform thematic analysis?
- Are our case reviews considering patient experience learning and not just focussing on avoidability?
- Are we collating information from a variety of learning from deaths sources to inform our PSIIs?
- How do we gather back learning from outside review processes e.g. CDOP, MMBRACE, LeDeR?
- Do themes from these inform our organisational patient safety profile?
- Can we be confident that our organisational patient safety profile optimises learning from investigations when deaths occur?

Key inputs and drivers

- Are families always involved in investigations/reviews?
- How do we capture family insights?
- How are we building trust with families that we are listening?
- Are we thinking about reducing conflict or lack of trust with families?

Data

- When have we got it right and is there wider application?
- How do we use available data from a wide variety of sources to triangulate and inform our organisation safety profile?
- When we investigate, do we think about how analytics or quantitative analysis can help us analyse?
- How can analytics help us present complex conclusions?

System and wider involvement/ learning

- Can we demonstrate that, when we scope our work, we are thinking widely about system connections?
- Are we prepared to move into system-wide investigations?
- Do we have the buy-in from other providers that enables us to work with them?
- Have we let other organisations know we are open and willing to work with them to improve patient safety?
- Do we have the data sharing processes in place to facilitate system learning?
- Do we have the confidence to make regional and national recommendations?
- Do we have the escalation routes for regional and national recommendations that will share learning across the NHS?

Assurance and quality improvement

- Are we scoping our work with the intention of being able to assure ourselves that we have made a difference?
- Do we ask ourselves if the work delivered its intention?
- Are we building excellence in assurance or are we focussed on reassurance?
- Have we got really robust systems to track actions and the evidence of change?
- Are we seeking external assurance when appropriate?
- Do we plan to formally evaluate change and its impact?
- ICBs are key to supporting organisations with sharing learning. How is my ICB facilitating the sharing of learning with other ICBs?

The presenting organisations

About the presenting organisations

Niche Health & Social Care Consulting Limited www.nicheconsult.co.uk

Niche are one of the leading suppliers of independent health and social care investigations, healthcare analytics and assurance-based projects. We are a trusted advisor providing expert advice at the time that you need this the most.

Our team are amongst the best subject matter expert (SME) specialists in the country and at Niche we work hard to ensure that our clients have the best advice and support available. By becoming a Niche client, you are joining one of the key healthcare quality insight networks in the UK. We keep our clients up to date with regular briefings, thought leadership and knowledge gained from our primary research bank.

We have worked in most parts of the UK, as well as engagements in other countries and we can regularly draw upon this huge base of benchmark data, knowledge and experience to support our clients with their daily challenges. We have also developed unique models to ensure that governance, patient safety and quality improvement are central to the productivity and efficiency agenda in support of the notion that ‘good care costs less’.

Making Families Count www.makingfamiliescount.org.uk

Making Families Count aims to improve outcomes for families affected by serious harm and traumatic bereavements in health and social care services.

Our vision is that the NHS, social care and other public bodies will make families count by ensuring that families are integral to health and social care investigations, leading to better investigations, better learning, safer services and the right support for families.

Making Families Count is made up of people who are recognised experts in their respective fields. Some have suffered the loss of a family member through traumatic and complex bereavement. Others are highly experienced, senior NHS investigators.

Our combined experience gives us a unique perspective and understanding of the transformative power of positive family engagement.

HC-One www.hc-one.co.uk

We offer professional residential, nursing and specialist dementia care for older people. We aim to be the first choice care home in each community for Residents and colleagues; we will achieve this mission through providing the kindest possible care to Residents in c.300 care homes across the United Kingdom.

With c.300 care homes, we're proud to provide positive, personalised care and support to more than fourteen thousand Residents who live in our homes, encompassing dementia care, nursing, residential and specialist care. At HC-One, we're pleased to work with, train and develop more than twenty thousand caring Colleagues who deliver round-the-clock care and support.

We do this by fostering a culture that actively encourages simple kindness. 'Kindness' isn't just a warm and fuzzy feeling – it's an incredibly powerful force for good, making our Residents and Colleagues feel good about themselves and fostering many positive outcomes.