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Managing & Supporting

Clinicians & Health Professionals

involved in a

Patient Safety Incident Complaint or Claim

Monday 11 March 2019 De Vere West One Conference Centre, London

Chair and Speakers Include:

Professor Colin Melville
Medical Director and Director, Education and Standards
General Medical Council

Jo Mason-Higgins
Head of Claims, Complaints and Patient Safety Investigations
Gloucestershire Hospitals NHS Foundation Trust

Dr Umesh Prabhu
Consultant Paediatrician & Former Medical Director

Supporters Include:

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"Healthcare professionals go to work to alleviate suffering not to add to it. They work in complex, high-risk environments, invariably as part of a team, and when things go wrong it is rarely the result of one individual's error. When a patient dies due to one or more errors, it has a profound effect on that healthcare professional and the entire team, both psychologically and in terms of their confidence. Such effects can then be compounded by an investigation which may seek to blame, rather than to understand the factors that have led to the tragedy so that lessons can be learnt to prevent future incidents. At all stages of any investigation the stress levels for those involved, including the professionals, can be overwhelming. For the healthcare professionals a sense of fear pervades and patient safety is jeopardised as they become cautious about being open and transparent, impeding the opportunity for lessons to be learnt."
Professor Sir Norman Williams to Jeremy Hunt, Secretary of State for Health and Social Care June 2018

"We know that any doctor, no matter how experienced, can make a mistake, particularly when working under pressure."
Dr Colin Melville Director of Education and Standards GMC, addressing some of the concerns raised following the ruling in the Dr Bawa-Garba case, January 2018

"The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated." **NHS Improvement 2018**

"When a doctor makes a mistake, they can find themselves in the loneliest place. For all the sympathy of friends and colleagues, they're on their own. There will only be one person's face on the front of the newspapers, or in the dock. The causes of that mistake may well have been systemic - but all too often the consequences are borne by individuals – the patient suffering an adverse outcome, and the doctor facing the consequences of the GMC, the courts and the media."
Helena McKeown Deputy Chair BMA Representative Body March 2018

"Doctors with recent/current complaints have significant risks of moderate/severe depression, anxiety and suicidal ideation."
The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey BMJ

This conference focuses on supporting staff who have been involved in patient safety incidents, or are the subject of complaints or claims. Involvement in an incident, complaint or claim can have severe consequences on staff who may experience a range of reactions including stress, depression, shame and guilt. Recent developments including the High Court judgement against Dr Bawa-Garba have brought into focus the impact mistakes can have on staff and the lack of support they often receive.

This conference will enable you to:

- Network with colleagues who are working to support staff following incidents, complaints or claims
- Deliver a just culture that supports consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents
- Reflect on national developments and learning
- Improve immediate support and debriefing when an incident occurs
- Develop your skills in providing the staff member involved in a patient safety incident specific individual support or intervention to work safely
- Understand how you can improve processes for ensuring candour and supporting staff
- Identify key strategies for interviewing staff and taking statements
- Ensure you are up to date with the latest developments in psychological support for staff including building resilience
- Self assess and reflect on your own practice
- Gain cpd accreditation points contributing to professional development and revalidation evidence

10.00 Chairman's Introduction: Accountability: Delivering a Just Culture
Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

Professor Colin Melville
Medical Director and Director, Education and Standards
General Medical Council

- understanding when an individual needs support or intervention to work safely
- recognizing unconscious bias
- the Just Culture Guide: Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

10.30 Fitness to Practise: Supporting local resolution

Paul Johnson
Assistant Director of Adjudications
Nursing and Midwifery Council

- dealing with complaints about nurses and midwives: a new approach to fitness to practice
- helping employers to deal with complaints
- supporting local resolution
- giving nurses and midwives the opportunity to remediate
- improving support and taking circumstances into account

11.00 Supporting and managing clinicians when an incident occurs

Dr Umesh Prabhu
Consultant Paediatrician,
Medical Director for more than 15 years.
Medical Adviser for International Recruitment

- how it feels to be involved in a patient safety incident
- supporting people to be open and honest about mistakes
- understanding when an individual needs support or intervention to work safely
- implications of the The Bawa-Garba ruling for clinicians in everyday practice
- improving support in practice

11.30 Questions & answers, followed by coffee at 11.40

12.00 Developing/adopting an effective process for ensuring candour and supporting staff

Jo Mason-Higgins
Head of Claims, Complaints and Patient Safety Investigations
with Cathy Schorah
Senior Patient Safety Investigation Manager
Gloucestershire Hospitals NHS Foundation Trust

- improving your incident reporting process and ensuring incident reporting forms support the recording of a duty of candour notification
- what level of harm should be trigger what level of response? triggers and thresholds
- the role of the Duty of Candour Facilitator

12.30 EXTENDED SESSION
Providing the clinician involved in a patient safety incident specific individual support or intervention to work safely

Dr Andrew Long
Consultant Paediatrician & Associate Medical Director
Great Ormond Street NHS Foundation Trust

- providing the clinician involved in a patient safety incident specific individual support or intervention to work safely
- enabling and supporting staff to overcome performance issues and concerns through resolution, remedial and developmental action
- assessing readiness and competence to work safety
- case studies in practice
- interactive discussion

13.10 Questions & answers, followed by lunch at 13.20

14.00 EXTENDED SESSION Interviewing staff and taking statements

Mike O'Connell
Legal Services Practitioner

- a step by step guide to interviewing and taking statements as part of the serious incident investigation process
- ensuring a well structured methodology and analysis leading to identification of key causal factors, and moving the focus to identifying the underlying causes
- supporting staff through the process
- writing the investigation report - techniques and tips

14.45 Supporting clinical staff who are the subject of complaints and claims

Richard Walter
Co-ordinator
NHS Complaints Personnel Association Scotland

- Understanding the impact of a complaint or claim on individual staff
- Human factors involved in complaints and claims
- Managing complaints involving individual staff
- Supporting staff involved in complaints and claims

15.15 Questions & answers, followed by coffee at 15.25

15.50 Immediate support and effective debriefing when an incident occurs

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

- immediate support following an incident
- immediate debriefing, post incident debriefing and group debriefing
- how can we better support staff who are involved in complaints, claims or coroners inquests?

16.20 Managing and supporting health professionals with health issues, and developing preventative approaches through resilience, time to think and mindfulness techniques

Jane Marshall
Consultant Psychiatrist South London and Maudsley NHS Foundation Trust
Clinician NHS Practitioner Programme

- managing and supporting health professionals who are suffering from psychological distress following an incident, complaint or claim
- preventative approaches including building resilience, time to think, and mindfulness techniques
- outcomes in terms of return to work, abstinence and patient experience

16.50 Questions and answers, followed by close at 17.00

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Supporting Clinicians involved in a Patient Safety Incident, Complaint or Claim

Monday 11 March 2019

De Vere West One Conference Centre, London

Conference Registration

Download

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Department

Organisation

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Postcode

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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

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)

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Signature

Date

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Conference Documentation

☐ I cannot attend the conference but would like to receive a PDF containing the conference handbook material, which includes speaker slides, at £49 each.

The PDF will be emailed out after the conference, please fill in the 'Your Details' section above, ensuring your email address is clear and the 'Payment' section..

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

Venue
De Vere West One Conference Centre, 9-10 Portland Place, London, W1B 1PR. A map of the venue will be sent with confirmation of your booking.

Date Monday 11th March 2019

Conference Fee
- ☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
- ☐ £300 + VAT (£360.00) for voluntary sector / charities.
- ☐ £495 + VAT (£594.00) for commercial organisations.

The fee includes lunch, refreshments and a copy of the conference handbook. VAT at 20%.

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