Managing and Supporting

Clinicians/Healthcare Professionals

involved in a

Patient Safety Incident, Complaint or Claim

Wednesday 7th July 2021 Virtual Conference



Chair & Speakers Include:

Dr Caroline WalkerFounder of The Joyful Doctor
Psychiatrist and Specialist in Doctors' Wellbeing

Mike O'Connell
Legal Services Practitioner

















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"Organisations must "never lose sight of the staff at the sharp end of the error" and plan accordingly. The establishment of a just culture ensures staff are treated fairly and appropriately following patient safety incidents. For staff to be appropriately supported, all organisations must have systems and structures that ensure managers and wider staff:

- are confident about which incidents are being investigated and why
- understand the potential impact of patient safety incidents on staff
- can recognise and help to manage the signs and symptoms of stress (including those associated with post-traumatic stress disorder) in themselves and colleagues
 - have access to support following patient safety incidents.

"Staff should never be left feeling isolated and uninformed about what will happen following a patient safety incident... Organisations must establish procedures to identify all staff who may have been affected by a patient safety incident and to provide access to the support they need."

Patient Safety Incident Response Framework 2020

"It is vital that NHS staff are fully supported throughout the complaints process so that it doesn't damage their confidence, trigger mental health problems, or result in the over-management of patients."

Dr Clare Gerada, Chief Executive, NHS Practitioner Health

"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

"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

"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.

This conference will enable you to:

- Network with colleagues who are working to support staff following incidents, complaints or claims
- Understand national developments including the requirements in the 2020 Patient Safety Incident Response Framework
- Reflect on how we can better support staff experiencing these issues through Covid-19
- Deliver a just culture that supports consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents
- Reflect on a healthcare's professionals personal experience of being the subject of an incident investigation
- 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
- Understand how you can improve processes for ensuring candour and supporting staff
- Identify key strategies for interviewing staff and taking statements and preparing staff for Coroner's Inquests
- 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 Chair's Welcome & Introduction

Dr Caroline Walker Founder of The Joyful Doctor; Psychiatrist and Specialist in Doctors' Wellbeing

10.10 Accountability: Delivering a Just Culture

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

Ellen Nicholson

Safety and Learning Lead (General Practice)
NHS Resolution

- · how do you ensure early identification of concerns
- doctors in difficulty and difficult doctors: what's the difference?
- how to diagnose the nature of the issue
- ensuring open and honest communication
- behavior and conduct: setting the ground rules
- confronting inappropriate or disruptive behavior
- · understanding the root cause of the problem and tackling concerns
- · developing an approach based on values based leadership

10.40 Bringing joy back into work: supporting health professionals with mental health concerns

Dr Caroline Walker

Founder of The Joyful Doctor

Psychiatrist and Specialist in Doctors' Wellbeing

- finding joy at work in challenging times
- supporting health professionals with mental health concerns
- the additional pressure of Covid-19 and how we can support each other
- simple things we can all do to keep well and support each other

11.10 Small Breakout Groups

11.30 Questions & Answers, followed by Comfort Break and Virtual Networking

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

Jo Mason-Higgins

Head of Claims, Complaints and Patient Safety Investigations Gloucestershire Hospital NHS Foundation Trust

- how it feels to be involved in a patient safety incident
- 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 and ensuring adherence to the Patient Safety Incident Response Framework

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

Dr Andrew Long

Consultant Paediatrician and Former Associate Medical Director Great Ormond Street Hospital 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

This session includes interactive discussion in small breakout groups

13.00 Questions & Answers, followed by Lunch Break

13.45 EXTENDED SESSION: Interviewing staff and taking statements and supporting staff through Coroner's Inquests

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
- supporting staff through Coroner's Inquests practical advice

14.30 Small Breakout Groups

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

Ben Wesson

Head of Customer Enquiries and Complaints, People and Organisational Effectiveness NMC

- promoting a person-centred approach to resolving concerns
- \bullet dealing with complaints about nurses and midwives: a new approach to fitness to practice
- helping employers to deal with complaints
- supporting local resolution
- understanding the impact of a complaint or claim on individual staff members
- managing complaints about staff, attitudes and communication
- engaging frontline clinicians in complaints and learning from complaints
- how can we better support staff who are the subject of complaints and claims?

15.15 Questions & Answers, followed by Comfort Break

15.45 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
- briefing staff involved in accordance with the 2020 Patient Safety Incident Response Framework
- immediate debriefing, post incident debriefing and group debriefing
- how can we better support staff who are involved in complaints, claims or coroners inquests?

16.15 Supporting and managing clinicians when an incident occurs

Perbinder Grewal

General & Vascular Surgeon and Human Factors Trainer

- supporting people to be open and honest about mistakes
- immediate management of the incident and staff involved
- \bullet managing staff working under pressure in the current pandemic
- understanding when an individual needs support or intervention to work safely
- improving support in practice

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