

Learning from Adverse Events in Maternity Services

Improving the way healthcare organisations respond to and learn from adverse events in maternity services.



Thursday 27th & Friday 28th February, 2020
7 Bedford Row, London, WC1R 4BS

Wednesday 17th & Thursday 18th June, Slater and Gordon, 58
Mosley St, Manchester M2 3HZ

Wednesday 30th September & Thursday 1st October, Birmingham
Wednesday 18th & Thursday 19th November, South East

For all members of the maternity team including midwives, obstetricians, risk managers, maternity safety champions, bereavement support staff and all staff involved in quality/safety improvement.

12 hours relevant for CPD

All Places Subsidised
at **£240**

Price includes lunch and refreshments

Student Discount Available!
See Website for Details

Course Content

- An overview of the national requirements, including reporting, notifications and internal / external processes.
- Practical training on how to support a 'just culture' and treating staff fairly.
- How to sensitively and compassionately engage with families throughout investigation processes (in line with best practice models).
- Key principles of adverse event investigation, including Human Factors and System thinking.
- Hearing directly from an NHS organisation about their improvement journey, how progress was achieved and the barriers and challenges.
- A practical workshop based on an anonymised real-life scenario so that delegates can practice and use the skills and knowledge gained during the course in practice.

Aims of the Course

To give attendees the knowledge and skills they need in order to:

- Understand all current national notification and reporting requirements and external processes.
- To understand the principles of good incident investigation, including methodology and tools.
- Be confident and skilled in how to engage and support families throughout investigative processes.
- To understand the principles of a 'just culture'.
- To write good, clear and effective investigation reports.
- To develop effective and evidenced based improvement actions.

Course Directors

Dr Michael Magro – Locum Consultant Obstetrician & Gynaecologist, Barking, Havering & Redbridge University Hospitals NHS Trust; Previous Darzi 8 Fellow at NHS Resolution (2016-17). Resolution (NHSR).

James Titcombe, OBE – Ambassador, Baby Lifeline and author of 'Joshua's Story'.

Emeritus Professor James Walker – Clinical Director of Maternity Investigations, Healthcare Safety Investigation Branch (HSIB).

Sascha Wells-Munro, OBE – Maternity Improvement Advisor, NHS Improvement.

The Need for Training

The way in which NHS organisations investigate and learn following adverse events had been highlighted as a cause for concern repeatedly in numerous recent reports and inquiries.

This course has been developed with leading experts from relevant organisations including NHS Improvement (NHSI) and NHS Resolution (NHSR) to provide delegates with crucial training in areas where a need for improvement has been repeatedly identified, including investigation methodology and approach, family engagement, treating staff fairly in line with 'just culture' principles, report writing and developing effective improvement actions.