NHS
South Kent Coast
Clinical Commissioning Group

SOUTH KENT COAST CCG
Clinical Education Event

The Good, The Bad and (rarely) The Ugly of Clinical Events

Thursday, 24 January 2019 - Channel Suite, Leas Cliff Hall, The Leas,
Folkestone CT20 2DZ

AGENDA
Lunch will be available from 1.00pm | Event 2.00pm - 5.00pm

1.00 – 2.00 pm	**Lunch & Networking**
2.00 – 2.10 pm	**Welcome, Introductions and Updates** Dr Rakesh Koria
2.10 – 2.30 pm	**The Good, Bad and Ugly Incidents Practice** All Participants
2.30 – 3.00 pm	**Serious Incidents: What is the Point?** Tim Smith, Ruth Germaine, Sara Jane Kray
3.00 – 3.30 pm	**Case 1 Spinal Cord Compression** Dr Zaw Thike, Rosie Baur and All Participants
3.30 – 3.45 pm	**Refreshments**
3.45 – 4.15 pm	**Case 2 Sepsis, Meningitis and Delayed Diagnosis: Are we learning?** All Participants
4.15 – 4.50 pm	**Cases and Reflections across the SKC Practices** All Participants
4.50 – 5.00 pm	**Sharing SI: Better Care Quality, Safety and Less Stress & Burnout!**
5.00 – 5.10pm	**Close and Evaluation**

Educational Certificates for PDP will be provided

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Contributors: All Participants and facilitated by the Education and Quality Team
Target Audience: All Team Members in Primary and Community Care

Learning objectives and overview of session

Overall Aims:

- To jointly acknowledge that the majority of our clinical practice delivers optimal care and such best practice needs to be celebrated but sub optimal care outcomes and rarely serious incidents are inevitable given the complexity of health and social care in the current national context
- To optimise transparent, no-blame culture with reflective shared learning from all events to improve patient care outcomes and inter professional support
- To review challenges posed by Spinal Cord Compression, Unexpected Deteriorations, and Delayed Diagnosis
- To review Quality and Safety Processes and the value of Multi-professional Reflective Learning

Issues:

- What constitutes a significant incident (SI), both positive and negative?
- What factors, habits and behaviours contribute to SI and related improvements?
- What can we learn from national and local best practice to minimise SI?
- What tools, resources and wider processes are available locally and beyond for SI?
- How do you approach adverse events and what can we learn from each other's practice?
- What are the personal and professional repercussions when facing complaints and investigations?
- What can we learn from others such as the aviation industry?