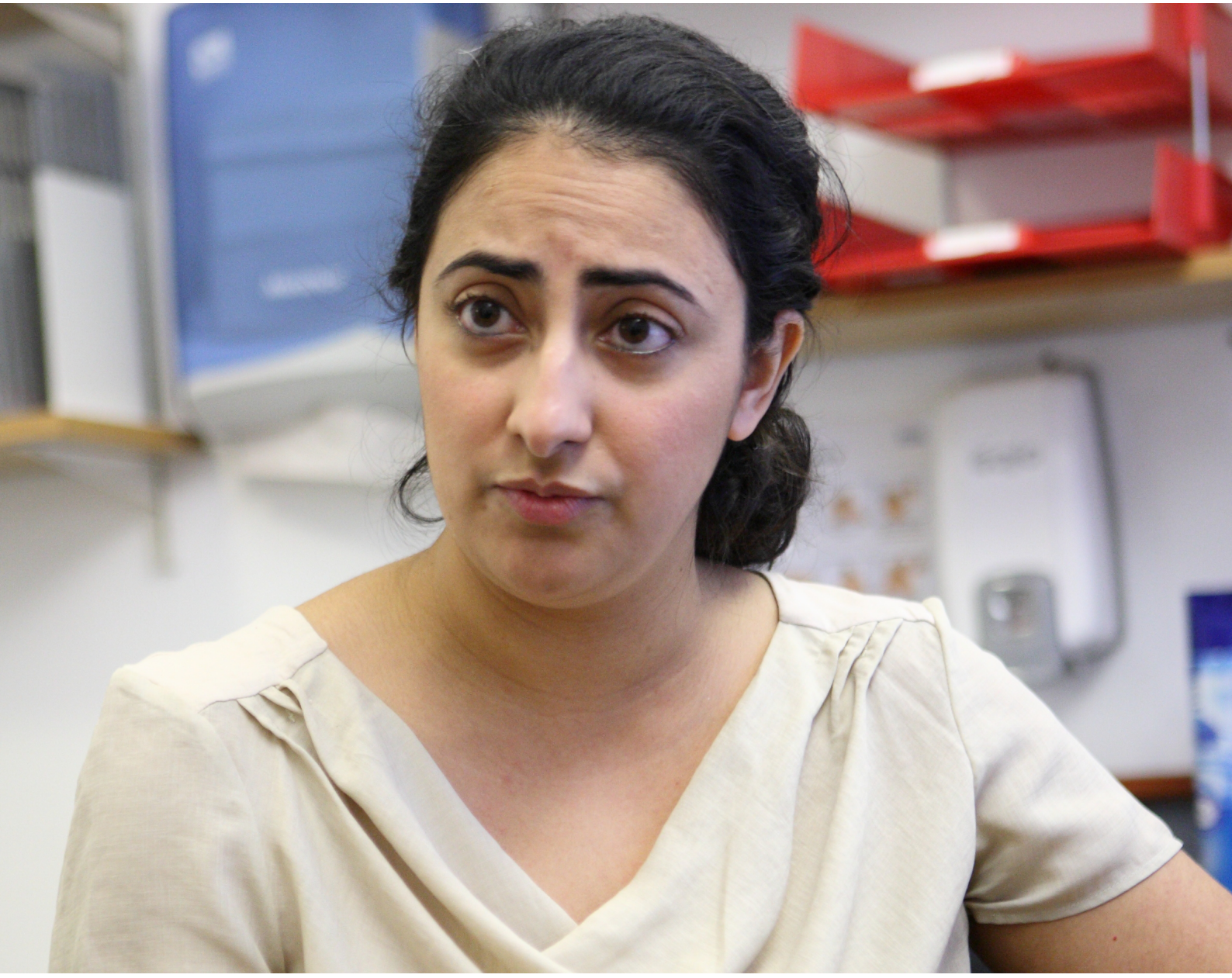
Caring, supportive, collaborative

a future vision for the NHS

BMA

Northern Ireland



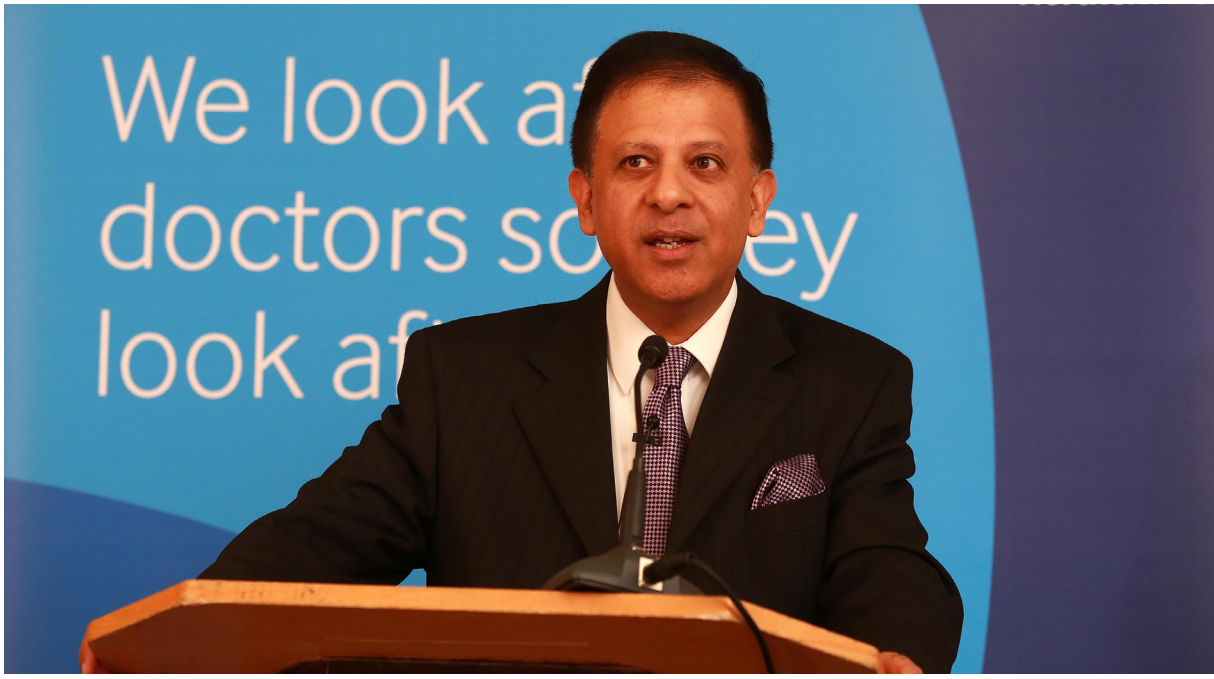
Better culture, better care

Creating trust, learning and accountability within health and social care

Conference report, December 4th 2019, Belfast

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

Introduction



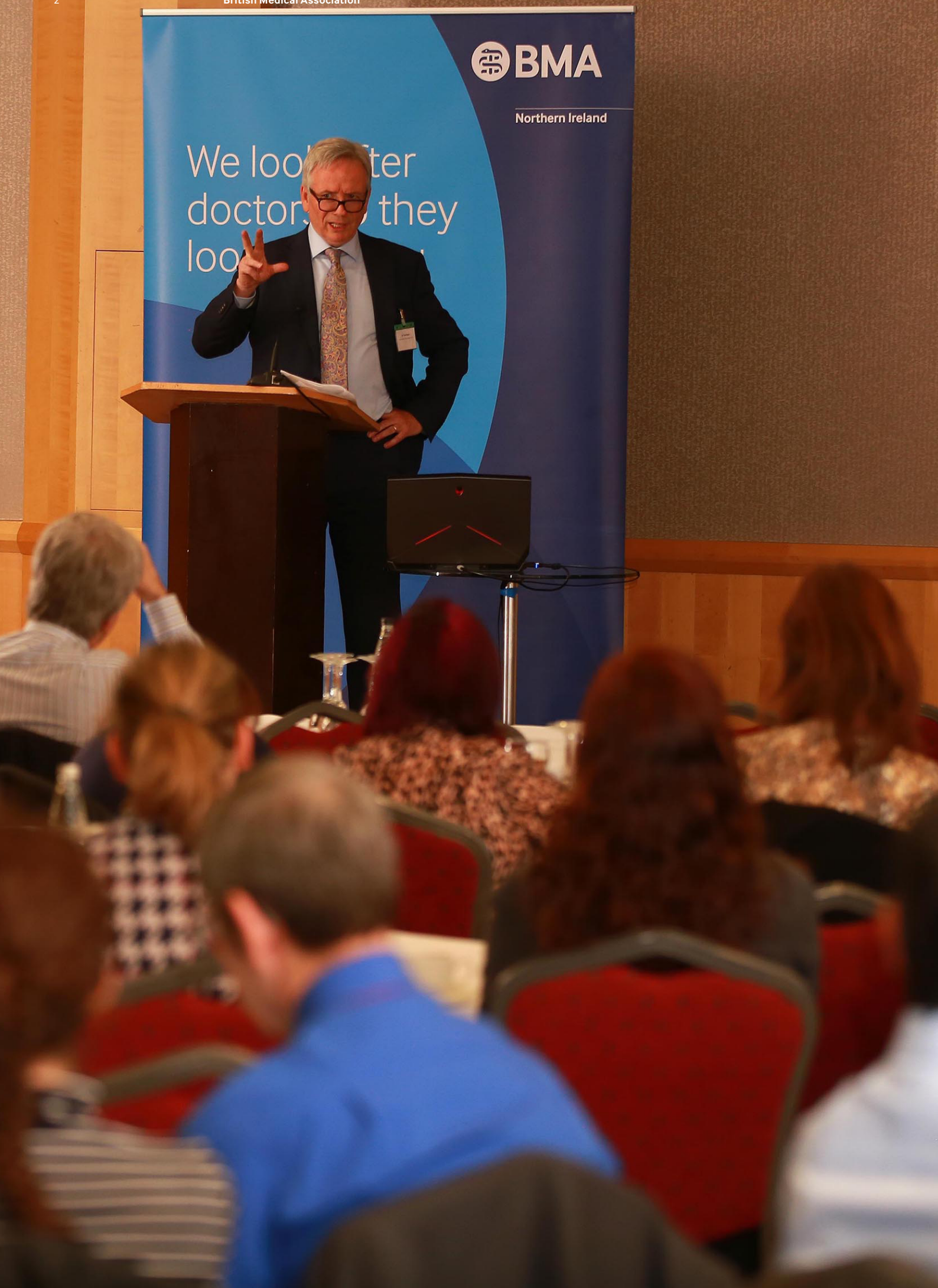
The **Caring, Supportive Collaborative** project was set up by the chair of BMA UK council in 2018 with the aim of establishing a vision for change in the NHS, informed by the views of doctors across the UK. Doctors have told us that radical change is needed if we are to build a health service that is truly caring, supportive and collaborative, where patient safety is prioritised, and doctors are valued.

Doctors want to see:

- an NHS that has a culture that is not rooted in blame, but supports and encourages learning and improvement, and equality of opportunity and reward, celebrating diversity so that everyone has the opportunity to succeed
- an NHS that values its workforce as its strongest asset and supports doctors to be able to work safely, with the right mix of skills to meet the changing needs of patients
- an NHS set up to encourage collaboration across traditional organisational divides, and where money is spent on delivering patient care – not on transaction costs, fragmentation and bureaucracy.

Doctors have suggested, for example, that the way patient safety incidents are investigated should be radically changed to ensure they are seen as opportunities to learn from and identify any systemic factors to improve future care rather than assigning blame.

In addition, in line with recent legislative developments in Scotland for safe staffing, new legislation is needed to create much clearer lines of accountability for safe staffing which promotes a safe environment for patients and staff.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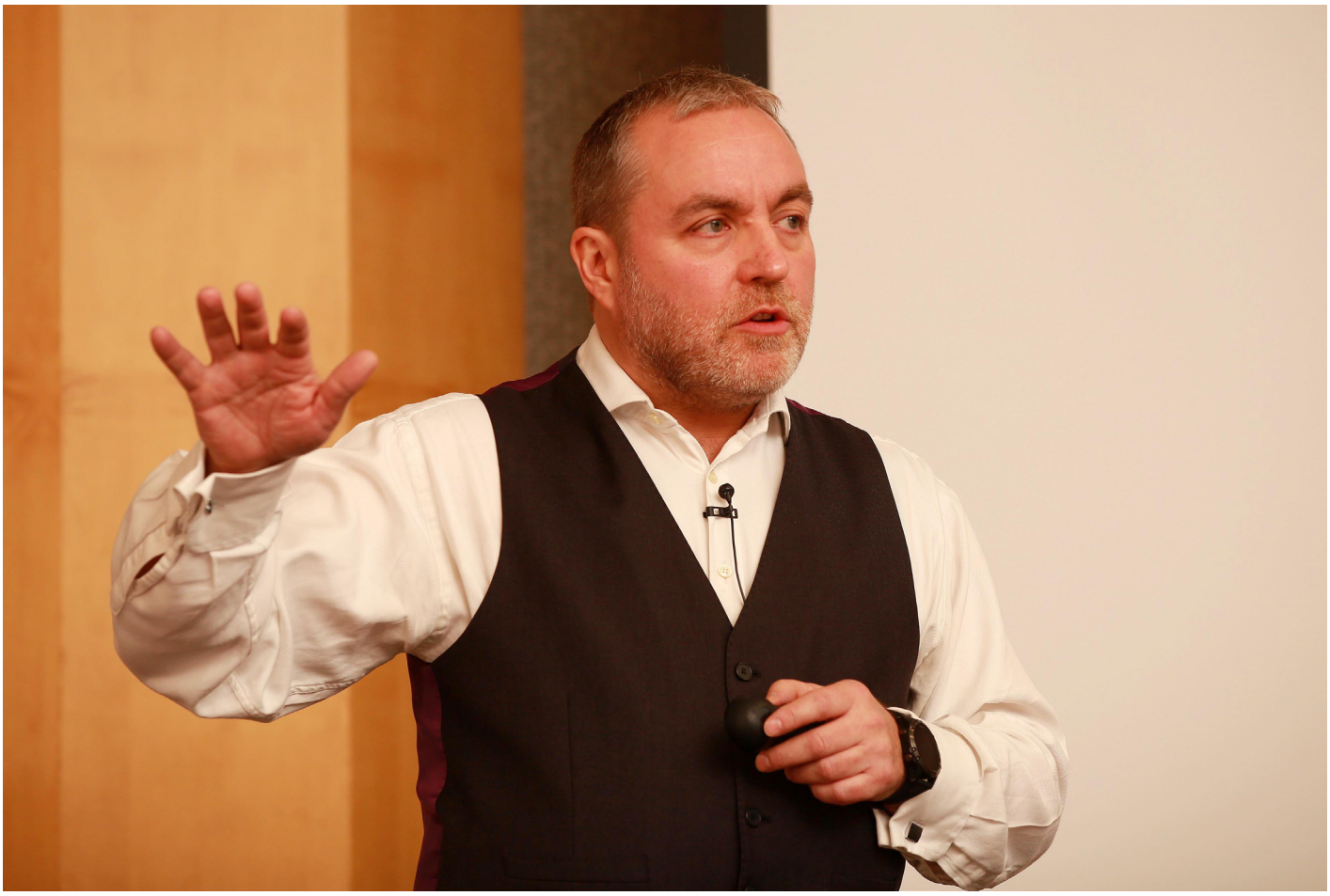
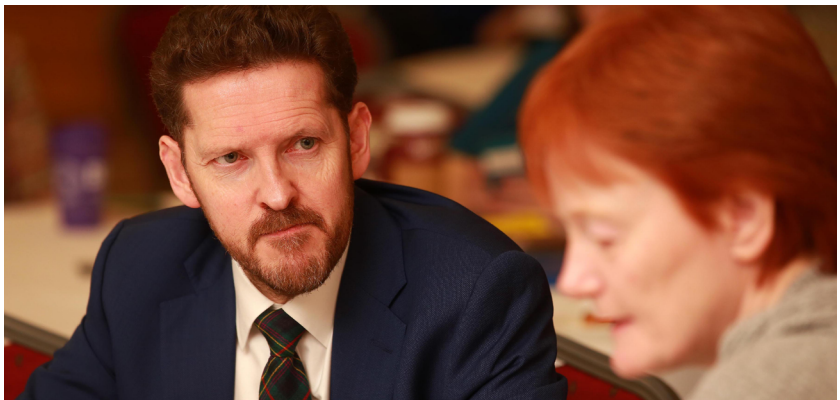


The aim of the conference *Better Culture, Better Care* was to position key patient safety debates within the themes of creating a better culture, to hear from experts on what a caring and trusting environment would look like for patients and doctors, and what needs to happen for this to become the norm.



Key conference themes

The conference heard from expert speakers, all of whom have experience in leading initiatives to improve culture and patient safety in health and social care.

Managing patient safety in an environment under pressure

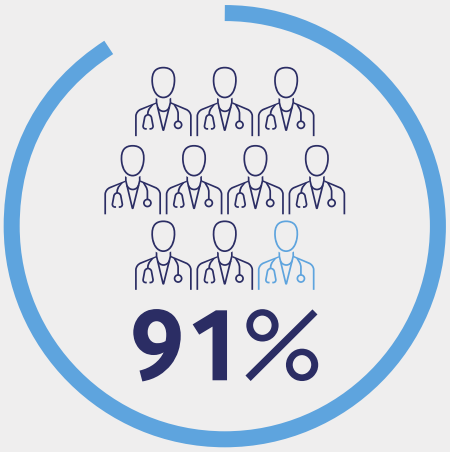
Patient safety defines the work of doctors as they strive to do no harm when treating patients. However, the system and context in which they work does not always allow for this. 53% of GPs and 68% of hospital doctors responding to the BMA Caring, Support Collaborative survey highlighted the lack of doctors, rota gaps and vacancies as a factor affecting their ability to deliver safe patient care.

Further, modern medicine is complex and can transform the lives of patients, but this is not without risk. We do all we can to minimise these risks, but it will never be possible to eliminate them fully.

As most harm in healthcare results from problems within the systems and processes that determine how care is delivered, there is a need to identify the contributory factors that have led to harm or the potential for harm to patients.

It is also important for government to invest in a service with adequate numbers of staff and an infrastructure that allows doctors and healthcare professionals to provide patients with safe, timely and quality care.

Doctors across the UK are working in a health service that is underfunded, under-doctored and over-stretched. There are simply not enough doctors to look after patients safely – of the European OECD countries, only Poland and Slovenia have fewer doctors per head of population than the UK.



Nine in 10 respondents (**91%**) to a survey of BMA members confirmed this, telling us that current staffing levels are not adequate to deliver safe, high quality patient care.

More than seven in 10 say this has worsened in their main place of work over the **last 12 months**.

This means nine in every 10 respondents now work more hours each week than contracted and paid for. Even though so many doctors go the extra mile, nearly a third say their hospital or GP practice cannot usually provide cover for doctor absences or unfilled vacancies.

Creating a 'just and learning culture' within health and social care

There is a general recognition that culture in the health service affects the safety and quality of care that NHS staff are able to provide. There is an organisational responsibility to create an environment that promotes a caring, supportive culture and which facilitates learning.

A restorative 'just culture' is about repairing and building trust and relationships when things have not gone as planned. This includes a need to develop working practices that move people away from fear and blame, including tackling incivility and bullying, and addressing the health and wellbeing needs for staff to help them work safely. In such a culture staff should feel safe to be open so that there is learning from errors to prevent reoccurrence.

A duty of candour with a meaningful apology when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them. NHS organisations already have a statutory duty of candour in England, Scotland and Wales, and further all doctors have a personal professional duty of candour as part of their GMC registration.

To have sensitive, clear and candid conversations with patients, these need to be carried out in an environment where doctors and healthcare professionals are not fearful of being penalised or punished and lessons are learnt to continuously improve care.

However, the proposal in Northern Ireland to attach criminal sanctions to an individual for breaching their duty of candour goes against what is happening elsewhere as individuals and organisations strive to improve patient safety through better culture. Criminal sanctions run the risk of creating a fearful culture that could be counterproductive with people being more likely to seek to deflect blame onto others rather than learn and work collaboratively. This does not absolve individuals of accountability – those who cause harm due to neglect or willful misconduct should feel the full force of appropriate disciplinary action.

The importance of the concept of civility in health and social care

There is a need to recognise how negative or uncivil behaviour adversely impacts on the performance of individuals and the whole team and that managers and professionals working in the health system are in a position to improve this. The concept of 'civility' needs to be applied in all healthcare settings and which has been shown to improve patient care and outcomes.

The 'Better culture, better care' conference gave an overview of evidence based good practice from various areas where improving culture and patient safety have been viewed as priorities for change.

> 'There is an opportunity to pull together these initiatives into a model of cultural change for health and social care in Northern Ireland.'

Calls to action

- Development of a model of cultural change for Northern Ireland based on learning from best practice elsewhere including: the development of a fair and Just Culture, creation of safe and protected spaces for disclosure; development of a Civility Saves Lives implementation programme; and Freedom to Speak Up Guardians
- Genuine development of a learning culture in which staff are fully engaged and feel able to raise concerns without fear or blame, knowing that these will be promptly acted on to improve care and safety for patients
- Safe staffing mechanisms so that no one has to work in a consistently under-staffed and under-resourced health and social care environment and clinical teams being able to provide care within manageable workloads
- Effective accountability procedures and mechanisms in place to escalate concerns, with a genuine focus on improving patient care, not hitting financial or political targets
- A shift in culture to recognise that staff wellbeing is essential to good patient care and the development and implementation of a comprehensive occupational health and wellbeing service for doctors in Northern Ireland
- Creation of a compassionate working environment in which staff treat each other with civility, kindness and respect
- Development of an investigation process that is effective for patients, families and doctors with safe spaces for disclosure and implementation of improvement and learning from situations
- Having a fair and proportionate system of individual and service wide regulation that understands context and systemic pressures and is part of a culture of learning and improvement

Conference report

Dr Tom Black, chair of BMA Northern Ireland council opened the conference saying that we are at a time in Northern Ireland where the need for cultural change in the healthcare system has never been greater. **Modern medicine is complex and wonderful at the same time and can transform the lives of patients, but this is not without risk. We do all we can to minimise these risks, but it will never be possible to eliminate them fully.**

Dr Black spoke of the proposed duty of candour with criminal sanctions being considered in Northern Ireland and the considerable concern it is causing for doctors who fear it will reinforce a culture of blame and fear rather than openness and learning.

Welcoming the speakers to Belfast, Dr Black said they were there as experts in their particular fields, specifically invited so they could share their expertise, experience and insights on culture change, safety and what components need to be in place to create a 'just culture' in health and care,

> 'There is significant learning to be gained by hearing about policy, findings and initiatives on improving culture and our conference today creates a key opportunity for this. Doctors and medical students at any stage in their career should rightly expect to have a positive culture within their working environment which facilitates and supports them in providing the best possible care for patients.'

Dr Chaand Nagpaul, chair of BMA UK council said in his opening address that this was the year's most important event and the most important issue affecting our health service. **Patient safety defines us as doctors as we strive to do no harm when treating our patients, but the system and context in which we work does not allow for this.**

Dr Nagpaul referred to the shocking waiting list figures for Northern Ireland where at the time of the conference 120,201 patients are waiting over one year for planned care. In England and Wales, it is 1,154 and 4,176 respectively.

More worryingly, excluding Scotland, Northern Ireland comprises 3% of UK population but 96% of all UK patients waiting over one year for treatment. If we are serious about patient safety, these figures do not allow for this to happen. But when patient safety fails and mistakes are made, too often the focus is on the individual doctor and not the system.

The landmark BMA all-member survey, *Caring, Supportive, Collaborative* (2018) revealed that:

- 97% of doctors reported that the current NHS resources are simply inadequate and affecting the quality and patient safety of patient care
- An overwhelming 95% of doctors say they are sometimes fearful of making a mistake
- For factors affecting a doctor's ability to deliver safe patient care:
- 68% reported feeling pressurised to attend to multiple tasks simultaneously
- 63% reported a lack of time to attend to patients
- 62% felt affected due to the lack of doctors, vacancies and rota gaps.

Dr Nagpaul also spoke of the how the culture of the NHS fails to support black and minority ethnic doctors, with many reporting they are fearful of being blamed, and figures show they are twice as likely to be bullied, harassed and undermined and twice as likely to be referred to the GMC by their employer.

Turning to culture, after the care failings at Mid-Staffordshire and the Francis Report, the Department of Health in England commissioned Don Berwick an international expert on patient safety to review patient safety in the NHS. He subsequently reported that NHS staff are not to blame and in the vast majority of cases, it is the systems, environment and constraints they face that lead to patient safety problems.

Looking to Norway, Dr Nagpaul outlined how 76% of health and education sector employees raise concerns, 83% had a positive reaction about raising concerns and 64% reported improvements after raising a concern. This was achieved in a 'no fault' system. Dr Nagpaul referred to the recommendation from the O'Hara Inquiry that proposes the introduction of an individual duty of candour with criminal sanctions in Northern Ireland, and how this was out of step with the rest of the UK and indeed the world and could have unintended consequences for patient safety. Quoting Sir Liam Donaldson in 2015 who stated that criminal liability could '*exacerbate a culture of fear... In a culture of fear people are more likely to seek to deflect blame onto others rather than learn and work collaboratively.*'

Dr Nagpaul concluded his opening address by stating that we need cultural change to enable safety – openness to identify and address systematic failings rather than targeting and unfair blame, learning from error to improve safety and at the same time not absolving individual accountability.

> 'If you take anything home from this conference today, is that we are all serious about patient safety... it is absolutely critical for us as doctors, it defines us as doctors... What is obvious and clear is that systematic factors and pressures are the major cause of errors and every individual works within such a system.'

Dr Chris Turner a consultant in emergency medicine outlined the concept of how *'civility saves lives'* and that healthcare is a *'team business.'*

In his presentation Dr Turner asked us to consider what makes a good team and how that team can perform better within the current system. He pointed out that a team can perform better if they know what they are about and what they are trying to achieve. He highlighted that the different measurements for the different professionals within a team can mean '*hitting a target but missing the point'*. Referencing Professor Michael West, Dr Turner argued that teams need common goals and measurements to perform as effective teams.

Turning specifically to civility, Dr Turner spoke of inappropriate behaviours, and how we treat each other is vitally important, but unfortunately this is not recognised as a key factor that impacts on performance. Being shouted at, dismissed or made to feel inadequate are common occurrences in highly stressful and complex situations. Breaking this down by those on the receiving end and those who are bystanders, he outlined research which showed that for the recipients of incivility, their cognitive ability is reduced by 61%. For bystanders there is a 20% decrease in cognitive performance and a 50% reduction in willingness to help.

Process is written on paper, but practice happens between people and in different environments. Early intervention is essential. Properly functioning, clear, safe and respected 'speaking up' mechanisms are central to improving culture. Ensuring there is 'psychological safety' and that leaders create a culture of being open about issues and problems with the aim of correcting these.

Dr Turner closed by saying there is a need to recognise how behaviour impacts on the performance of the whole team and that doctors working in the health system are in a position to do something positive about this.

Peter McBride, chair of the 'Being Open' subgroup within the Duty of Candour workstream under the Inquiry into Hyponatraemia Related Deaths (IHRD) in Northern Ireland began his talk by explaining that the aim of the work of this sub-group was to create a healthcare system that is open, honest and transparent.

Mr McBride pointed out that Justice O'Hara, when carrying out the inquiry, came across a repeated lack of openness, honesty and candour from medical staff, hence the focus on candour in his report. He outlined the recommendations from the IHRD report for an organisational and individual duty of candour with criminal sanctions attached to this duty.

Mr McBride acknowledged that the attachment of criminal sanctions to the duty of candour is the most provocative of the recommendations and goes further than anywhere else in the world. The Department of Health and IHRD workstreams are mindful of the unintended consequences that may result if this is enacted in Northern Ireland.

He was clear in his presentation that people change culture not legislation, and there is an organisational responsibility to create the environment that facilitates learning. Mr McBride acknowledged that fear was a common thread coming through in their work and this is not conducive to being open and honest. They have developed a multi-level model for this work.

Mr McBride outlined how each of these levels are expected to work in practice, from the daily routines of healthcare professionals to the responsibilities of organisations to ensure staff are engaged and the regulatory and inspection regimes work to facilitate the necessary environment. He ended by asking professionals to work with them as they take forwards the recommendations from the IHRD report.

Conference participants then heard from **Fiona Smith** an organisational effectiveness practitioner who outlined how **Merseycare NHS Trust** implemented a just and learning culture.

Describing their journey, Ms Smith highlighted how the psychological contract with staff had broken down, leading to '*a retributive emphasis in language with an emphasis on investigations, hearings, allegations, disciplinary action, tribunals and mistrust'.*

The Trust therefore set about creating a just and learning culture. Ms Smith acknowledged that this was not without its challenges, but what was important was **that they learnt from their mistakes along the way.** She mapped out their journey starting with **putting the 'human' back into human resources, by reducing suspensions and investigations.** By 2017 the emphasis was on supporting colleagues to enable learning and to raise concerns by sharing good practice and moving away from policies that punish, to policies that support. They continued by developing modules on civility and a standardised framework to support learning from incidents including supporting staff.

Mersey Care is an NHS organisation that has realised learning cannot happen from mistakes if employees are too afraid to report those mistakes. Its work to embrace 'a Just and Learning Culture' has centred on the desire to create an environment where staff feel supported and empowered to learn when things do not go as expected, rather than feeling blamed. In the case of an adverse event, it instinctively asks 'what was responsible, not who is responsible'. It is not finger-pointing and not blame-seeking. But it is also not an uncritically tolerant culture where anything goes. It says that would be as inexcusable as a blame culture.

Ms Smith was clear this remains a journey for the organisation, but statistics from 2016-18 show a 54% reduction in disciplinary investigations and **£1.7m** saved in clinical suspensions in two years. But the real dividend is safer patients and staff.

Dr Denise Chaffer, director of safety and learning at **NHS resolution** highlighted how being fair supports a just and learning culture for staff and patients following an incident and feeds into their ambition to *'take every opportunity to learn'.*

Dr Chaffer outlined that patients and staff want similar outcomes from incidents as outlined in the table below:

What do patients and families want?	What do staff want?
An apology	Help to say sorry
To prevent it happening to someone else	To prevent it happening to someone else
To understand what went wrong	To understand what went wrong
To have answers and be heard	To have answers and be heard
Compassion, understanding and support	Compassion, understanding and support
Sign posting to support where appropriate	Sign posting to support where appropriate

Dr Chaffer then described reports by NHS Resolution that highlighted the impact on patients, staff and the costs to employers. ***Behavioural Insights*** examined those who made claims for medical negligence and found that NHS staff reactions were generally considered inadequate, and that the majority were not satisfied with the NHS complaints handling process, leading them to take further action. Dr Chaffer said by getting the environment right, the negative impact on patients and their families can be reduced.

NHS Resolution's publication, *Saying Sorry,* outlined how a meaningful apology when things go wrong is vital for everyone involved in an incident, including the patient, their family, carers, and the staff that care for them. Dr Chaffer spoke about *Being Fair* which was co-designed to develop solutions for supporting a just and learning culture for staff and patients following incidents in the NHS.

Dr Chaffer then moved the discussion to look at how **a restorative just culture is about repairing and building trust and relationships when things have not gone as planned. This includes a need to develop working practices that move people away from fear and blame, including tackling incivility and bullying, and addressing the health and wellbeing needs for staff to help them work safely.**

Concluding her presentation, Dr Chaffer outlined how the concept of being fair links in with the recently published *NHS Patient Safety Strategy* in England and provides the case for a just and learning culture for all: staff, patients and organisations and importantly about how we treat each other, every day.

The conference heard from **Professor Colin Melville**, medical director and director of education and standards at the General Medical Council who spoke about the role of the regulator in supporting doctors working in a system under pressure.

Professor Melville outlined how the publication, ***Caring for Doctors, Caring for Patients***, by Professor Michael West and Dame Denise Coia, is one of three major reports commissioned by the GMC to look at how doctors can be better supported in delivering patient care in the UK's pressured health systems – Leslie Hamilton's independent review of gross negligence manslaughter and culpable homicide in medicine and Dr Doyin Atewologun and Roger Kline's, ***Fair to Refer***.

All three reports make recommendations about the need for improvements to healthcare environments relating to leadership, culture and support for doctors that will require more fundamental culture change.

In their research, Professor Michael West and Dame Denise Coia found that **creating supportive, safe and inclusive working environments was key, and that doctors** – in common with all workers – have an 'ABC of core needs' if they are to remain well and stay motivated while at work.

- Autonomy/control – the need to have control over our work lives, and to act consistently with our work and life values.
- Belonging – the need to be connected to, cared for, and caring of others around us in the workplace and to feel valued, respected and supported.
- Competence – the need to experience effectiveness and deliver valued outcomes, such as high-quality care.

Professor Melville went on to outline the tension between what Robert Francis QC called for in terms of cultural change and for a solution of more inspection, regulation and sanctions, and Don Berwick's solution of low blame, high learning and transparency.

Citing the work of James Reason, Professor Melville described what a 'just culture' is:

> 'an atmosphere of trust in which people are encouraged, even rewarded, for providing essential safety-related information, but in which they are also clear about where the line must be drawn between unacceptable behaviour and blameless unsafe acts.'

He reinforced that the GMC shares this ambition to reduce harm and use learnings from mistakes and how this is the foundation of where we want to be as doctors. Concluding, Professor Melville outlined how the principles of a just culture in practice will continue to evolve in what is a live area of both academic and practical debate – we need a shared understanding of how we can operationalise a just culture.

On 2 May 2019, the Scottish Parliament passed the Health and Care (Staffing) (Scotland) Bill, which places a legal requirement on NHS boards and care services in Scotland 'to ensure appropriate numbers of suitably trained staff are in place, irrespective of where care is received'.

The legislation includes the inclusion of a clear requirement for a system of escalation of concern for any member of staff who is working in what they believe are unsafe levels of staffing; and risk monitoring. The Act includes a duty for boards to have real-time staffing assessment in place, and a duty to have risk escalation processes in place.

Dr Kevin Stewart, medical director of the Health Safety Investigation Branch for England (HSIB) outlined the role of 'safe spaces' for staff when an incident occurs. **He said that the main the role of investigations is for improvement and the need to learn from failure.** The role of the HSIB is to provide an independent investigatory role for the NHS to improve patient safety through effective and independent investigations and importantly they do not apportion blame or liability.

Dr Stewart argued there is much the NHS can gain from approaches in other safety-critical industries, such as the petro-chemical and the aviation industries. Industries have moved from culpability to responsibility and have seen safety levels improve. However, he was clear that healthcare organisations are widely recognised as among the most complex of working environments with multiple factors contributing to safety critical situations.

He highlighted two types of investigation – those focused on safety and those focused on accountability and the importance of separating these**. As most harm in healthcare results from problems within the systems and processes that determine how care is delivered, there is a need to identify the contributory factors that have led to harm or the potential for harm to patients.**

Recognising the wider debates within healthcare, Dr Stewart acknowledged the culture shift from fear and blame when things go wrong, to transparency for learning and improvement, and this is a journey that the HSIB can be a part of within the wider safety system. He was also clear that independent safety investigations are only one part of a wider approach to patient safety that encompasses the whole healthcare system, where all organisations and individuals recognise they have responsibility for supporting improvement.

Dr Stewart concluded by outlining the changes recommended by the Parliamentary Select Committee on a draft Health Service Safety Investigations Body (HSSIB) Bill, that would establish a new, fully independent body to investigate healthcare safety incidents in the NHS in England and that will set out the provisions for protected disclosure, commonly known as *'safe space'.*

BMA's head of wellbeing support services, **Tom Rapanakis** concluded the conference by outlining the support that BMA offers all doctors in the UK – '*there is always someone to talk to.'* BMA's wellbeing support services are open to all doctors and medical students, confidential and free of charge. He also outlined how any doctor can ask for support if they are subject to a complaint made to the GMC until the outcome of the case.

Many doctors will find this an extremely stressful process and the stigma associated with a GMC investigation cannot be underestimated. Many doctors may also be unable to talk with family or colleagues and find this service a lifeline as an investigation not only effects their professional lives but also their personal lives.

Closing remarks

Closing the conference, Dr Tom Black, reflected on the day and outlined how he was struck with the variety of different approaches that have come together to improve patient safety and culture across the UK:

'Dr Nagpaul set the scene for the need for cultural change and what doctors have told us about their current experiences. Dr Chris Turner outlined the role of civility in saving lives.

'Putting Northern Ireland circumstances forward, we heard Peter McBride advocate for cultural change and how it is people not legislation that will change culture. We heard from Fiona Smith about the importance of developing a just and learning culture, and importantly how this is applied in the day to day working environment and processes.

'Dr Denise Chaffer spoke about the importance of a meaningful apology when things go wrong and the need to develop working practices that move people from fear and blame. Professor Colin Melville talked about the role of the regulator in supporting doctors in pressurised environments and Dr Kevin Stewart outlined the importance of safe spaces in investigations. Finally, Tom Rapanakis gave an overview of the role of the BMA in supporting all doctors in the UK.'

Dr Black highlighted the work the BMA Northern Ireland office has been doing since the publication of the O'Hara Report and acknowledged that patients or their loved ones who have experienced trauma or injury as a result of a mistake, simply want answers. They want someone to take responsibility for what has happened to them or to their loved ones and to ensure that where possible, no other family has to experience what they are going through.

'As doctors, we go to work to do our best for our patients in a system that is in need of transformation, is underfunded and under resourced with too few staff. As a result of years of underinvestment, patient care has undoubtedly been compromised.

'We have heard here today some of the initiatives being developed and implemented across the UK and Northern Ireland must learn from these. **However the proposal to attach criminal sanctions to an individual duty of candor to individual health professionals goes against what is happening elsewhere, and in essence fails to understand the complexity of the healthcare working environment with multiple factors at play for every patient and interaction across our healthcare system every minute, every hour of every day.**

'Let me be clear, those who cause harm due to neglect or willful misconduct should feel the full force of the law. But, if we are to have sensitive, clear and candid conversations with patients, these need to be carried out in an environment where doctors and healthcare professionals are not fearful of being penalised or punished and lessons are learnt.'

Finally, Dr Black referred to the concerns raised with him, particularly by younger doctors about their fear of working in a blame culture in an increasing pressurised environment coupled with the potential introduction of an individual statutory duty of candour with criminal sanctions,

'It is crucial that Northern Ireland learns from developments and progress made elsewhere and puts in place mechanisms here to improve both culture and patient safety.'

Speaker Biographies

Dr Chaand Nagpaul

Dr Chaand Nagpaul is a GP and senior partner in his practice in Stanmore, North London where he has practised for 28 years. He was elected as Chair of the British Medical Association Council in July 2017 and has been a BMA Council member since 2008. He is past chair of the British Medical Association GPs committee (GPC) from 2013–2017, having been a member of the GPC since 1996, and was a GPC negotiator between 2007 and 2013. He has been a Local Medical Committee (LMC) member for over 20 years and vice-chair for the past 14. He is a Fellow of the Royal College of General Practitioners. Chaand was awarded a CBE in 2015 for his services to primary care.

Dr Tom Black

Dr Tom Black is a GP and has worked at his practice in the Bogside in Derry for the last 30 years. He was elected as chair of Northern Ireland Council in September 2018 and he was chair of NIGPC from 2011-2018. He has been a member of his LMC for the last 28 years and served as the LMC secretary for 17 years. He worked as a GP trainer for 20 years and achieved FBA fellowship of the RCGP in 1997. He is a strong advocate for a second medical school in Northern Ireland.

Dr Chris Turner

Consultant in emergency medicine Chris Turner trained in Edinburgh, graduating in 1992. He took a circuitous route to his chosen specialty of Emergency Medicine, including 2 years as a psychiatric trainee and 3 years in North Queensland. Eventually he found himself in the West Midlands where he became embroiled in the Mid Staffs Scandal, an experience that both made and broke him. He has been a governance lead for 10 years and is a passionate believer in evidence-based improvements and trusting in professionalism. He founded Civility Saves Lives with Joe Farmer and Penny Hurst, and they have been amazed at how well received the message has been.

Peter McBride

Chair of the Being Open sub-group; Duty of Candour Workstream, Peter McBride worked for 20 years as CEO of Inspire, an all island mental health and learning disability charity. Upon leaving this role in May, Peter has taken up position as Chair of the Being Open subgroup of the Duty of Candour Workstream in the implementation programme arising from the Investigation into Hyponatraemia Related Deaths (IHRD). He is also Chair of the Interdepartmental Working Group on Mother and Baby Homes, Magdalene Laundries and Historical Clerical Abuse. Peter also serves as Chair of the Northern Ireland Council for Voluntary Action (NICVA), is a board member of The Wheel, NICVA's sister organisation in the Republic of Ireland. Having served on the Board of BBC Children in Need for 11 years, Peter is now an ambassador, sitting on the board in his role as Chair of the BBC Children in Need Grant Making Committee, and Chair of Million and Me. Peter is a specialist in Post-Conflict Mental Health, working with organisations such as The Auschwitz Institute in the US and European Mental Health Organisations. Peter also provides coaching and mentoring support to senior executives within the private, public and voluntary sectors, and is a well-known international conference speaker.

Fiona Smith

Strategic Organisational Effectiveness Practitioner Mersey Care NHS Foundation Trust Fiona has more than 25 years' experience of facilitating and executive coaching. She has been involved in significant organisation development and transformation programmes in both private and public sector organisations. She has developed cultures that support sustainable growth and high performing teams which have enabled delivery of the organisation's strategy. Fiona has held director level posts in the manufacturing sector and was a non-executive director in the NHS for seven years. Her passion for getting the best from everyone permeates all that Fiona does. This led to her being nominated and coming second in the Midlands Businesswoman of the Year Award. Fiona took early retirement from the manufacturing sector and has now found her perfect role combining her passion for people and her love of the NHS in a trust which was this year rated as 'outstanding' by the Care Quality Commission in their domain of 'well led'.

Dr Denise Chaffer
Director of Safety and Learning for the NHS Litigation Authority Denise Chaffer is a Registered Nurse and Midwife and currently holds the post of Director of Safety and Learning for the NHS Litigation Authority. She holds a Master's degree in Management and Social Care, plus a Higher Education Teaching qualification and a PhD in health care leadership. She is a professional Clinical Nursing leader with over 15 years' experience, has been an Executive Director of Nursing in two Acute Trusts, as well as a Director in a PCT commissioning organisation. She was Director of Nursing for North West London Area Team at NHS England as well as being lead for patient safety across the London Region. She has significant experience of working at international, national and regional level within acute and community settings, nursing, midwifery, education, and on major change and reconfiguration initiatives. She has recently published a book; 'Effective Leadership, A Cure for the NHS?' which draws on the personal experiences of a range senior health care leaders.

Professor Colin Melville
Director of Education and Standards, GMC Professor Colin Melville's work in medical education and leadership goes back to 1997, and has included roles such as Clinical Director, Medical Director and Director of Medical Education. In 2012 Colin took up a full time clinical academic post as Head of MBChB and then Head of Medical Education at Warwick Medical School and in 2015 was appointed as Head of the Medical School at Lancaster University. Colin took up his role as Director of Education and Standards in January 2017 at the GMC and has already made significant contributions to the work of the GMC; overseeing the launch of several key documents in support of postgraduate medical education and more recently in the review of Outcomes for Graduates. In June 2018, Colin was appointed Honorary Professor of Medical Education at the University of Manchester.

Dr Kevin Stewart
Kevin Stewart is Medical Director of the Healthcare Safety Investigation Branch (HSIB), an autonomous body within the English NHS. He trained in geriatric medicine, which he still practices part time in Winchester, Hampshire. He has been Medical Director of the acute Trust in Winchester and a 2009/10 Health Foundation QI Fellow at the Institute for Healthcare Improvement in Boston, where he completed a Masters in Public Health at Harvard. He worked for the Royal College of Physicians in London leading their programmes on quality and patient safety before taking up his current role. The aim of the HSIB is to undertake professional patient safety investigations that do not attribute blame or liability, based on investigation principles adapted from aviation and other safety critical industries. A particular focus for HSIB involves adopting 'Just Culture' principles to patient safety investigations including legal protections for statements made by clinicians and other staff to investigators.

Tom Rapanakis Head of BMA Wellbeing Support Services
Tom is responsible for the BMA's provision of Wellbeing support services to doctors and medical students across the UK. This includes 24/7 counselling and peer support, available regardless of BMA membership. He sits on the board for DocHealth, an independent psychotherapy service for doctors. Tom is part of the organising committee for the International Conference on Physician Health, and a member of the steering group for the England-wide rollout of PHP

Useful resources

BMA NI briefing paper on the duty of candour: **bma.org.uk/-/media/files/pdfs/collective%20voice/influence/uk%20governments/northern%20ireland%20assembly/bma-ni-duty-of-candour-briefing-paper-aug-2019.pdf?la=en**
GMC: **www.gmc-uk.org**
The IHRD Programme: **www.ihrdni.org**
The HSIB: **www.hsib.org.uk**
NHS resolution: **resolution.nhs.uk**
Mersey Care NHS Foundation Trust: **www.merseycare.nhs.uk**

The BMA's vision for change

A supportive culture, where doctors work in an environment that supports their wellbeing, promotes learning and encourages the development of systems which improve safety and quality of care – and where diversity is celebrated and there is equality of opportunity and reward.

This means:
- a shift in culture to recognise that staff wellbeing is essential to good patient care
- a learning culture in which staff are genuinely engaged and feel able to raise concerns without fear or blame, knowing that these will be acted on to improve care and safety
- a compassionate working environment in which staff treat each other with respect
- a fair and proportionate system of regulation that understands context and is part of a culture of learning and improvement
- a focus on improving patient care, not hitting financial or political targets.

A valued workforce, where everyone who works in the NHS feels part of a properly resourced team working in harmony and with the right mix of skills to do the job.

This means:
- no one should have to work in a consistently under-staffed and under-resourced environment
- clinical teams providing care within manageable workloads
- protected time for professional development, innovation and research
- the right IT, equipment and facilities to provide the best care for patients
- doctors' skills being used in the most effective way, as part of multi-disciplinary teams
- doctors feeling valued, supported and fairly rewarded throughout their working lives.

A collaborative structure, where doctors and all NHS staff are empowered to work together across traditional organisational divides, so that patients receive seamless care.

This means:
- systems that encourage services to work together to achieve shared goals and outcomes, and funding flows that encourage collaboration
- compatible IT systems that support safe sharing of patient data to improve care
- care pathways designed around patients, not organisational boundaries
- full involvement of both those who work in the NHS and the public in decisions about how it is run
- service planning informed by population and patient need, free from the restrictions of competition legislation
- a focus on ensuring patients are cared for in a setting appropriate to their needs.
  All underpinned by sufficient funding and resources to do the job, in line with the growing needs of patients.

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