HSJ PATIENT SAFETY CONGRESS

15-16 September 2022 | Manchester Central, Manchester

Pushing boundaries. Changing practice. Saving lives

Day 1 – Thursday 15 September	
8:00	**Registration opens**
9.00	**Chair's welcome and opening remarks** • Set the scene for the Congress with an up-to-date overview of patient safety • Understand the major shifts in patient safety over the last year and what steps need to be taken to make further progress • Learn how you can make the most of the next two days to improve patient outcomes within your own organisation ***Shaun Lintern**, Chair, Patient Safety Congress and Health Editor, The Sunday Times*
9.20	**Keynote panel** **Why aren't we learning from past mistakes? Breaking the cycle of repeat errors to advance the safety agenda** • Identify long-standing barriers to change and discuss the underlying factors in healthcare that make it hard to implement key learnings and make real progress • Debate the effectiveness of national reports and enquiries • Re-thinking our approach to safety issues - focusing on really understanding the problem before coming up with solutions to ensure long-term sustainability and safety • Discuss practical ways you can break down barriers to improvement in your organisation ***Professor Mary Dixon-Woods**, Director and Professor of Healthcare Improvement Studies, THIS Institute and University of Cambridge* ***Professor Ted Baker**, Former Chief Inspector of Hospitals* ***Tom Bell**, Patient Representative, Author, Consultant and Founding Director, Humanity and Integrity in Public Sector Services* ***Professor Sir Robert Francis QC,** Chair, Healthwatch England*
10.05	**Keynote panel** **Putting an end to gender bias in healthcare: Re-setting the dial on women's health and safety** • Hear from a female patient about her experience with surgical mesh and the challenges faced as a woman navigating the health system • Consider the recurring theme from personal testimonials and healthcare scandals in recent years, that women's voices and patient safety concerns are being ignored or dismissed • Address the lack of transparency around the risks of medicines and medical devices • The need to discuss both benefits and risks of investigations and medication • Ending the culture of doctor knows best - Is there a clash of values between medical paternalism and patient autonomy?

	Yvette Greenway, *Patient Representative* ***Professor Matthew Cripps,*** *Director of Behaviour Change, NHS England and NHS Improvement* ***Professor Marian Knight,*** *Professor of Maternal and Child Population Health, University of Oxford*				
10.45	**Meet our Partners / Refreshment break** Explore the exhibition hall and be sure to catch up with our partners who have a variety of patient safety solutions to help you with your current challenges and priorities. Simply head over for a chat or connect with them via the event app to book a meeting Tea, coffee and refreshments available **Outpatients' Department** Head over to the exhibition hall to the 'Outpatient's Department' zone and catch up with speakers after sessions! This is an opportunity to meet the speakers one to one and ask your questions				
	Delegates can now break into the following 5 tracks and attend sessions which focus on hands-on learning and practical case-studies. Send your colleagues to different tracks to get the most out of the content				
	Track 1 **Building Restorative Organisations** *Chaired by* ***Professor Murray Anderson-Wallace,*** *Visiting Professor*, *Health Systems Innovation Lab London South Bank University* ***In association with Radar Healthcare***	**Track 2** **Human Factors** *Chaired by* ***Martin Bromiley OBE****, Founder, Clinical Human Factors Group and* ***Professor Chris Frerk****, Chair, Clinical Human Factors Group* ***In association with BD***	**Track 3** **Patient safety in non-acute settings** *Chaired by* ***Jyotika Singh,*** *Healthcare Consultant and Former Senior Pharmacist, Wilmington Healthcare*	**Track 4** **Patient and family engagement** *Chaired by* ***Rachel Power,*** *Chief Executive, The Patients Association*	**Track 5** **Supporting our workforce** *Chaired by* ***Annabelle Collins,*** *Senior Correspondent, HSJ*
11.30	**Panel** **Tackling bullying and harassment: What a restorative just culture looks like in practice** • Hear examples of how the lack of a just culture can lead to bullying, misperceptions, and	**Modelling what good looks like: An automation approach to addressing medication error** • Understand human factors that influence the collaboration	**Restart a Heart: Optimising survival rates through rapid response to out-of-hospital cardiac arrests** • Hear directly from doctor on how he and his team help save the life of an	**Humanising harm: Using a restorative approach to heal and learn from adverse events** • Explore how current investigative responses can increase harm for	**Looking behind the brave face: Getting in tune with your staff to achieve peak performance and embed psychological safety** • Address mental health and impact on staff from a

	an increase in patient safety errors • Understand the difficulties of dealing with bullying from a leadership perspective • Find out what a restorative just culture actually means, how to implement it and what it should look like in practice • Share successful strategies from trusts on how to manage and prevent the disproportionate impact of bullying on minority groups ***Joe Rafferty**, Chief Executive, Mersey Care NHS Trust*	between humans and automation • Digital evolution and resistance to change: Understanding barriers to overcome, fully embrace and implement system automation • Learn how automation can support clinical practice and deliver improved medication management • Proof of concept - Hear examples from trusts that have adopted connected Medication Management and how this has helped reduce errors, waste and increased efficiencies ***In association with BD*** ***Francine de Stoppelaar** Director of Pharmacy, Cleveland Clinic* ***James Davis,** Chief Innovation Officer, Royal Free London NHS FT*	athlete who suffered a cardiac arrest • Gain insight into the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) • Learn about a clinician-led quality improvement initiative around prompt CPR to improve patient outcomes • Join a practical workshop on CPR training across the 2-day Congress to learn how to respond in life-threating situations ***Dr Jonathan Tobin,** GP and Club Doctor, Wigan Athletic Football Club* ***Dr Alison Tavaré,** Clinical Lead, NHS@Home SW and Primary Care Clinical Lead, West of England Academic Health Science Network* ***Marisa Mason**, Chief Executive, NCEPOD*	all those affected, by neglecting to respond to the human impacts • Understand how the risk of harm can be reduced if investigations respond to the need for healing alongside system learning (with the former having been consistently neglected) • Debate why incident responses should be conceived within a relational as well as regulatory framework and how this can radically shift the focus, conduct and outcomes of patient safety investigations • Identify the preconditions and mechanisms that enable the success of restorative approaches in global health systems ***Joanne Hughes**, Patient Advocate and Founder, Harmed Patients Alliance* ***Jo Wailling**, Registered Nurse, Research Fellow*	neuro-scientific perspective • Deep dive into the different levels of brave face syndrome or presenteeism and identify behaviours you will see and how this impact staff's ability to perform and do their job safely • Looking at 'why' not 'who' during investigations and identifying the real underlying cause when things go wrong. Are staff capable of providing safe care in the brain state and environment they're in? • Gain practical ideas from trusts that have approached mental health like a risk assessment and the impact it's had on teams so far • Take back strategies you can embed in your organisation to ensure staff are working in a positive brain state

		Nikki Smith, *Patient Safety Lead for Medicines, NHS Surrey Heartlands CCG*	***Professor Andrew Lockey,*** *President of Resuscitation Council UK*	*and Facilitator with the Diana Unwin Chair in Restorative Justice, Victoria University of Wellington, New Zealand (live stream)* ***Allison Kooijman,*** *Patient Advocate, School of Nursing, University of British Columbia (live stream)*	***Maria Paviour,*** *Occupational Neuropsychologist, Author and Founder of Wellbeing with Cari and the NeuChem Coaching Model*
12.20	**Time to move between sessions**				
	Track 1 **Building Restorative Organisations**	**Track 2** **Human Factors**	**Track 3** **Patient safety in non-acute settings**	**Track 4** **Patient and family engagement**	**Track 5** **Supporting our workforce**
12.25	**Driving a culture of learning from patient safety incidents: Making the switch from NRLS to LFPSE** • Hear about the transition from the current National Reporting and Learning System (NRLS) to Learn from Patient Safety Events (LFPSE) • When and why: Understand the reasons behind the change and how the new reporting system will benefit your teams and support national learning and improvement • Find out how the system will work in practice to speed up	**A human factor approach to examining errors that contribute to death or serious harm** • Hear about Beth's Story from Clare Bowen, mother of Bethany who died during routine surgery • How and why: Understand the multiple human factors and medical errors that lead to Bethany's death • Hear perspectives from a trust CEO on what the death of a patient taught him about human factors • How to change defensive	**Maintaining the safety of patients in digital or hybrid care settings** • Share learnings from the shift towards digital-first primary care and find out how engaging patients in their own care has improved safety outcomes • Assess the dynamic between secondary care leadership and primary care delivery and how this relationship can be fine-tuned to improve patient safety • Hear from digitally advanced organisations who have embedded cross-boundary	**What does true co-production look like? The impact of patient input and involvement on quality improvement** • Hear how the involvement of patients helped challenge trusts to think differently about safety initiatives based on their own experience using the health service • Discuss and share approaches you can take to attract patient partners, and understand what training, support and conditions are required to enable meaningful co-production	**Harnessing digital to join up systems and processes to facilitate real learning and improvement** • Discuss what good quality looks like and the challenges around ensuring organisations are getting the full picture of whether or not they are delivering good quality • How a siloed approach to learning from incidents and the use of multiple tools and systems makes its harder to identify trends and there for prevents learning • Find out what solutions are

	incident data capture • Understand how to triangulate LFPSE with CQC, NICE, policy, and audit to provide local assurance and continuous improvement • Take away strategies you can implement to achieve quality insight and improve safety and compliance culture ***In association with InPhase*** ***Marcos Faquer Manhaes**, Head of LFPSE and NRLS, Patient Safety, NHS England and NHS Improvement* ***Robert Hobbs,** Chief Executive Officer, InPhase* ***Warren Edge**, Senior Associate Director of Assurance & Compliance, County Durham and Darlington NHS FT*	organisational behaviours, with emphasis on learning rather than denial • Share strategies and examples to ensure complete transparency and candour when things go wrong to achieve true restorative justice for families involved • Take away strategies you can implement to reduce the incidence of similar errors ***Clare Bowen,** Patient Representative and Trustee, Clinical Human Factors Group* ***Professor Joe Harrison,** Chief Executive, Milton Keynes University Hospital NHS FT*	digital solutions with system oversight of primary and secondary care, ensuring efficient sharing of data and insights • Get a national update on the Digital Clinical Safety Strategy and plans to further integrate services with a digital approach ***Jyot Mehani,** Chief Executive, Health Care First Partnership* ***Dr Natasha Philips**, Chief Nursing Information Officer, NHSX* ***Sheinaz Stansfield,** Development Advisor, Primary Care Transformation Team, NHS England and NHS Improvement*	• Hear successful examples from trusts that involved patient partners in QI projects and assess the positive impact on patient safety and staff experience • Key takeaways: Take back strategies to help you involve patients as partners in your work to help shape and influence improvements in your organisation ***Charlotte McArdle,** Deputy Chief Nursing Officer for Patient Safety and Improvement, NHS England and NHS Improvement* ***Deborah Tighe**, Partner Manager, Leeds Teaching Hospitals NHS Trust* ***Dr Anna Winfield,** Patient Safety & Quality Manager and Specialty Doctor in Elderly Medicine, Leeds Teaching Hospitals NHS Trust*	available to help you join up different processes. Hear examples from a trust on how this has positively impacted safety outcomes in their organisation ***In association with Radar Healthcare*** ***Paul Cresswell** Associate Director of Quality Governance, North Bristol NHS Trust* ***Molly Kent**, Patient Safety Specialist, Radar Healthcare*
13.15	**Lunch break in the Exhibition Hall** **Meet our Partners**				

	Explore the exhibition hall and be sure to catch up with our partners who have a variety of patient safety solutions to help you with your current challenges and priorities. Simply head over for a chat or connect with them via the event app to book a meeting **<u>Outpatients' Department</u>** Head over to the exhibition hall to the 'Outpatient's Department' zone and catch up with speakers after sessions! This is an opportunity to meet the speakers one to one and ask your questions				
	Track 1 **Building Restorative Organisations**	**Track 2** **Human Factors**	**Track 3** **Patient safety in non-acute settings**	**Track 4** **Patient and family engagement**	**Track 5** **Supporting our workforce**
14.15	**Are we losing sight of what good looks like? Reversing the impact of normalised deviance on patient safety** • Explore the systematic conditions and flaws that set up good people to fail and the long-term effect this has on patient care when behaviours do not change • The importance of a top-down approach, ensuring good practice is carried out and followed through by leaders to embed a strong safety culture across the entire organisation • Discuss and share actions you can implement now to help identify and manage unsafe practices and behaviours before they become normalised and pose	**Challenges and possibilities of integrating human factors and ergonomics into healthcare** • Hear from experts on the current barriers and opportunities of bringing human factors into the health system • Discuss ways you can get past system and cultural issues to operationalise human factors thinking • Hear different perspectives on the system from each speaker, whilst also learning from their shared thinking to help you incorporate human factors in your organisation ***In association with NHS Supply Chain***	**Improving outcomes and experiences of patients discharged from mental health hospitals** • Hear from a mental health service user who experienced difficulties when discharged due to no plan being put in place • Gain insight into the factors and challenges that prevent mental health hospitals from providing a seamless discharge experience for patients • Find out about a research study led by a patient, working together with trusts to improve outcomes for patients being discharged from mental health hospitals	**Positive family engagement and involving families well: Impact on the system and patient safety** *The Making Families Count workshop will focus on the importance of positive family engagement including:* • Using positive family engagement after a patient safety incident • How to have difficult conversations with families and do this well • Using Confidentiality and Duty of Candour with families • What does a blame-free culture look like and how does it benefit families and staff?	**<u>Interactive Workshop</u>** **Tackling discrimination and inequality in healthcare** *We know that inclusive workplaces are crucial for both staff wellbeing and for patient safety. So why are so many still experiencing discrimination and what can we do to change it?* *In this interactive session we will:* • Reflect on the impact of discrimination in healthcare • Consider how cultures aid discrimination at work • Explore the work the GMC is doing to tackle inequality issues • Identify what you can do locally to create a more

	risks to patient safety, quality care, and employee morale ***Professor Rebecca Lawton**, Professor in Psychology of Healthcare, University of Leeds and Director, NIHR Yorkshire and Humber Patient Safety Translational Research Centre* ***Professor Matthew Cripps,** Director of Behaviour Change, NHS England and NHS Improvement*	***Dr Tracey Herlihey**, Head of Patient Safety Incident Response Policy, NHS England and NHS Improvement* ***Professor Chris Frerk,** Chair, Clinical Human Factors Group* ***Professor Paul Bowie,** Programme Director (Safety & Improvement), NHS Education for Scotland* ***Colette Longstaffe,** Product Assurance Specialist-Clinical and Product Assurance (CaPA), NHS Supply Chain*	• Hear how they have co-produced a new support package and toolkit for discharge which can be applied and adapted to the discharge process and understand how this will positively impact patient safety and the patient experience ***Sarah Rae**, Patient Representative* ***Dr Jon Wilson,** Consultant Psychiatrist, Norfolk and Suffolk NHS FT* ***Professor John Clarkson**, Professor of Engineering Design, University of Cambridge and Professor of Healthcare Systems, Delft University of Technology*	***Rosi Reed**, Training Coordinator, Making Families Count* ***Frank Mullane MBE**, Member, Making Families Count* ***Stephen Habgood**, Director, Making Families Count*	inclusive culture, including resources and support available to you ***In association with the GMC*** ***Chris Lawlor**, Senior Regional Liaison Advisor, Outreach Development Support Unit, General Medical Council*
15.05	**Time to move between sessions**				
	Track 1 **Building Restorative Organisations**	**Track 2** **Human Factors**	**Track 3** **Patient safety in non-acute settings**	**Track 4** **Patient and family engagement**	**Track 5** **Supporting our workforce**
15.10	**Panel** **Balancing no-blame with accountability: Playing your part by speaking up to create a health system that owns up to error**	**Being proactive to uncover unknown risks and reduce never events** • Learn about a common never event involving a nasogastric tube	**Panel** **Achieving true integration: Valuable lessons from mature integrated care systems outside England**	**Assessing quality of care in the home: Ensuring patients and families have the tools to safely self-manage** • How covid-19 has challenged percep tions around what	**Navigating the dual challenge of prioritising quality initiatives with an already-stretched workforce** • Understand the difficulties systems

	• Address issues around blame and defensiveness as key contributors to the lack of safety progression over the past decades • Debate why defensiveness remains a core issue within the system and understand what factors are preventing a shift in culture, at both national and local level • Practical, initial strategies for leaders to build a psychologically safe environment, that encourages transparency and honesty amongst staff • Responding to error: Learn how you can create a just culture where you ensure staff are speaking up when things go wrong without blame or fear of reprisal • Understand the impact this will have on patient safety through the prevention of repeat errors ***Jasvinder Sohal***	and why it is also a national issue • Hear about the post-incident investigation process which resulted in no findings of care gaps or staff errors • The importance of being proactive and inquisitive and how this resulted in identifying previously unknown gaps • Learn how one trust is evaluating all PH strips on the market in order to adopt the best device and minimise error • How this work has resulted in new guidelines that openly acknowledge the gaps in the system with the aim of preventing incidents ***Karl Emms,*** *Lead Nurse for Patient Safety, Birmingham Women's and Children's NHS FT* ***Fiona Terry,*** *Neonatal Matron, Joint Project Lead, Birmingham Women's and*	• The key challenges faced in the establishment of systems-level care through the lenses of finance, workforce and operational delivery • Take a closer look at the Scottish and Welsh integrated care models and explore specific lessons you can take away from their approaches to partnership working • How advanced levels of integration significantly enhanced patient safety, especially against the backdrop of covid-19 • Find out what initial challenges these systems faced when starting their integration journey, as well as key elements required for ICSs to succeed • How to best measure and assure patient safety when designing,	patients can or should do – causing a major shift towards self-management at home • Assess the situational variables that could present risks to patients • Understand the type of training and resources required for patients, families and clinicians to effectively identify and prevent potential risks in the home • Hear examples of tools and training available that enhance safety in the home ***Jono Broad,*** *Senior Manager Personalised Care, NHS England SW*	have in trying to drive evidence-based practice initiatives whilst coping with the service disruption and low staffing levels • How covid-19 further adds to this challenge, resulting in a 'start and stop' approach to QI, impacting staff's commitment and engagement with improvement programs • Hear best practice examples on how you can prevent staff burnout, to ensure your workforce have the capacity and energy required to engage with these programme • Take back strategies and tips on how you can prepare your teams to reposition QI and accelerate innovation to improve patient outcomes ***In association with Wolters Kluwer***

	Chief People Officer, Bath & North East Somerset, Swindon and Wiltshire ICS and Former Chief People Officer, Solent NHS Trust ***John Walsh**, OD Lead / Freedom To Speak Up Guardian, Leeds Community Healthcare NHS Trust* ***Tom Bell,** Author, Consultant and Founding Director, Humanity and Integrity in Public Sector Services*	*Children's NHS FT* ***Jennifer Abbott**, Clinical Educator, Birmingham Women's and Children's NHS FT* ***Michelle Moseley,** Senior Specialist Nurse, Birmingham Women's and Children's NHS FT*	implementing and refining acre pathways at systems level ***In association with RLDatix*** ***Dr Chris Grant,** Executive Medical Director, North West Ambulance Service NHS Trust* ***Darren Kilroy**, Medical Director, International, RLDatix*		***Rachel Dicker**, Product Management Associate Director, Wolters Kluwer, Health, Learning, Research and Practice*
16.00	**Meet our Partners / Refreshment break** Explore the exhibition hall and be sure to catch up with our partners who have a variety of patient safety solutions to help you with your current challenges and priorities. Simply head over for a chat or connect with them via the event app to book a meeting Tea, coffee and refreshments available **Outpatients' Department** Head over to the exhibition hall to the 'Outpatient's Department' zone and catch up with speakers after sessions! This is an opportunity to meet the speakers one to one and ask your questions				
	Regroup with all attendees for the closing keynotes followed by the networking reception				
16.30 - 16.50 **17.20**	**The James Reason Lecture** **Planning for the unthinkable: Responding to catastrophe in a healthcare setting** • Hear from Professor Lucy Easthope, the UK's leading authority on disaster management and recovery • Get a look behind the scenes at some of Lucy's work on major disasters, including 9/11, the 7/7 bombings, the Indian Ocean tsunami and covid-19 • Find out how healthcare systems should plan for disasters and the aftermath, prioritising emergency planning, compassion and putting those affected at the heart of arrangements • Assess why and how things go wrong in disaster management and what you can do to prevent repeat errors • Key considerations and takeaways: Short-term and long-term actions you can implement at local level ***Professor Lucy Easthope**, UK Leading's Authority on Recovering from Disaster, Professor in Practice of Risk and Hazard, University of Durham and Fellow in Mass Fatalities and Pandemics at the Centre for Death and Society, University of Bath*				

17.15 - 18.00	**End of day 1 - Networking drinks reception in the Exhibition Hall** After full day of discussions, debates, and learning, end your day by having a drink with colleagues and new acquaintances and get ready for the Awards celebration later in the evening! **Please take time to give your feedback via the app**

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Day 2 – Friday 16 September					
8.45	**Chair's welcome and opening remarks** • Reflect on the key learning points from yesterday's sessions • Look ahead to today's topics • Find out the winner of the Patient Safety Congress Poster Competition ***Shaun Lintern**, Chair, Patient Safety Congress and Health Editor, The Sunday Times*				
9:00	**Keynote** **Investing in the future: Challenges, opportunities and hope – A three year forward view of the health system** *Join Health Foundation Chief Executive, Dr Jennifer Dixon, as she shares her expertise and insights into what will help guide the health system towards its next stage of progress* • Analyse the current trends in health, including health inequalities, demand for care, funding, digital and workforce capacity • Get an update on system reforms and performance • Find out what this means for safety as the NHS evolves • What you can do to play a part in helping create an environment that drives innovation and improvements in care ***Jennifer Dixon,** Chief Executive, The Health Foundation*				
	Delegates can now break into the following 5 tracks and attend sessions which focus on hands-on learning and practical case-studies. Send your colleagues to different tracks to get the most out of the content				
	Track 1 **Governance and regulation** *Chaired by **Rosi Reed,** Training Coordinator, Making Families Count*	**Track 2** **Clinician-led innovation** *Chaired by **Rachel Power,** Chief Executive, The Patients Association*	**Track 3** **Safety for vulnerable people** *Chaired by **Annabelle Collins,** Senior Correspondent, HSJ*	**Track 4** **The deteriorating patient** *Chaired by **Lesley Durham,** President, International Society for Rapid Response Systems (iSRRS)*	**Track 5** **Women's healthcare** *Chaired by **Susanna Stanford**, Patient Safety Advocate*
9.35	**Patient Safety Incident Response Framework: What good looks like when learning and responding to patient safety incidents** • Learn about the new Patient Safety	**Unleashing local innovation: Transforming emergency care delivery through collaboration between services** • Address the issues around managing	**Managing the effects of Long-covid on staff to prevent human error** • Hear from frontline staff affected by Long-covid and get an understanding of	**Listening to families' Call 4 Concern to prevent patient deterioration and avoidable deaths** • Hear from patient representatives whose concerns were ignored,	**Tackling Gaps in Patient Safety in Maternity: Embedding a Learning Culture** • Are we training the frontline in themes that relate to avoidable harm?

	Incident Response Framework (PSIRF) • Understand the importance of overseeing system structures and processes to drive the right behaviours • Hear from early adopters of PSIRF and gain insight specific learnings from the pilot • Get advice from early adopters on how best to prepare for the implementation of PSIRF in your organisation ***Dr Lauren Morgan,*** *Human Factors Lecturer, Quality, Reliability, Safety and Teamwork Unit, Patient Safety Academy, University of Oxford* ***Donna Forsyth,*** *Director, Patient Safety Science* ***Tracey Herlihey,*** *Head of Patient Safety Incident Response Policy, NHS England and NHS Improvement*	ambulance delays and patient access to emergency care, resulting in harm or death • Learn about the award-winning Remote Emergency Access Co-ordination Hub (REACH) and its innovative approach to delivering emergency care using virtual consulting rooms • Hear from a patient representative on their previous care experience versus their experience using REACH • Look at what the data shows and the impact the new model has had on patient experience and safety by reducing the number of ambulances conveyed to hospitals and patient walk-ins • Learn how this work in being rolled at scale and pace and share strategies	how it is impacting their ability to carry out daily roles safely • Share practical steps managers can take to effectively support staff experiencing symptoms of Long-covid • Recommendations and examples of how the current approach to long-covid can be improved to avoid harm and deterioration ***Professor Amitava Banerjee,*** *Professor of Clinical Data Science and Honorary Consultant Cardiologist Institute of Health Informatics, University College London*	leading to rapid deterioration and suicide • Taking family concerns more seriously as those who know the patient best • Learn how the Call 4 Concern initiative provides patients and families with more choice about who to consult about their care and facilitates the early recognition of patient deterioration ***Dr Chris Subbe,*** *Consultant Physician working in Acute Medicine, Betsi Cadwaladr University Health Board* ***Lisa Cornell,*** *Senior Critical Care Outreach Practitioner, Kettering General Hospital NHS FT*	• Overcoming barriers to a learning culture: a frontline perspective • Listening to families effectively ***In association with NHS Resolution*** ***Dr Denise Chaffer,*** *Director of Safety and Learning, NHS Resolution*

		of how you can implement similar solutions ***Joanna Moore,*** *Senior Improvement Advisor, Barts Health NHS Trust* ***Tony Joy****, Lead Consultant for REACH and the Physician Response Unit, Barts Health NHS Trust* ***Tiffany Wishart****, Senior Sector Clinical Lead, London Ambulance Service*			
10.25	**Meet our Partners / Refreshment break** Explore the exhibition hall and be sure to catch up with our partners who have a variety of patient safety solutions to help you with your current challenges and priorities. Simply head over for a chat or connect with them via the event app to book a meeting Tea, coffee and refreshments available **Outpatients' Department** Head over to the exhibition hall to the 'Outpatient's Department' zone and catch up with speakers after sessions! This is an opportunity to meet the speakers one to one and ask your questions				
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11.15	**Is anybody 'Learning from Deaths'? – Implementing safety improvements based on a review of the national LFD Programme** • Analysis of national statutory reporting within the NHS in England 2017-2020 • Understanding what 'Learning' and	**Panel** **The creation of the Patient Safety Managers Network: Set up by staff, for staff to help spread safety innovation** • Learn about the fast-growing Patient Safety Managers Network, set up by staff, and the	**Reducing health inequalities for people with learning disabilities: Looking beyond the disability to improve safety** • Recognise the dangers of diagnostic overshadowing with LD patients and hear examples of avoidable	**Dying with dignity: Innovative end of life care models** • Understand the challenges practitioners face in ensuring a good death for dementia patients • Learn about innovative heuristics approaches which	**The systematic dismissal of women's safety concerns and its contribution to avoidable harm** • Hear from patients who were not informed of the risks of taking sodium valproate and the harm it has caused to them and their families

	'Actions' have occurred • A review of how trusts have assessed the impact of their actions • Hear examples of how trusts are engaging with and involving families in their LfDs work • Recommendations for how the LfDs programme can be developed and implemented further and what this means for your organisation ***Dr Zoe Brummell**, Anaesthetic and Intensive Care Medicine Specialist, University College London Hospitals NHS FT* ***Dorit Braun**, Patient Representative* ***Dr Emma Rowland,** A&E Consultant, Homerton University Hospital NHS FT*	motivation behind it • Understand how members of the network are working to break down barriers to improvement by sharing best practice between trusts • Discuss the impact of communicating with peers in similar roles regarding patient safety challenges and innovation • Find out what the network has achieved so far and how it supports the implementation of best practice across 82 different trusts • Assess the impact of the network on patient safety so far and future plans to continue sharing learning ***Claire Cox**, Patient Safety Lead, King's College Hospital NHS FT* ***Jordan Nicholls**, Serious Incident, Governance and*	patient harm caused as a result • Find out what you can do to prevent diagnostic overshadowing – hear about the RCP Acute Care toolkit for people with learning disabilities • Take back practical, reasonable adjustments you can make in your organisation to enhance safety for patients • Learn about how addressing inequalities can be embedded as a golden thread to help drive improvement" ***Scott Riley**, South West Inclusion Health Lead, NHS England and NHS Improvement (South West)* ***Hilary Gardener**, Strategic Liaison Nurse for Adults with Learning Disabilities - Primary Health, Hertfordshire County Council* ***Gavin Howcraft**, Expert by experience*	aim to better equip and train clinical staff on palliation and end of life care for patients • Discover how these approaches can be applied and evaluated in other areas of end-of-life care for people living with other critical conditions	• Ending the culture of doctor knows best - Discuss why concerns raised by female patients are still being dismissed as 'women's problems', leading to avoidable harm • Find out what changes are taking place at national level to strengthen regulation around sodium valproate and ensure risks are communicated properly • Learn from successful case studies on how to ensure full transparency when preparing women and girls of potential risks in an ethical and responsible way ***Emma Murphy.** Founder, Independent Fetal Anti-Convulsant Trust (IN-FACT)* ***Janet Williams,** Founder, Independent Fetal Anti-Convulsant Trust (IN-FACT)*

		Quality Improvement Lead, Central and North West London NHS FT ***Jayne Addison,*** *Deputy Head of Quality Governance, Patient Safety and Risk, Manchester University NHS FT* *Chaired by* ***Helen Hughes,*** *Chief Executive, Patient Safety Learning*	*Chaired by* ***Dr Alison Tavaré****, Clinical Lead, NHS@Home SW and Primary Care Clinical Lead, West of England Academic Health Science Network*		
12.05	**Lunch break in the Exhibition Hall** **Meet our Partners** Explore the exhibition hall and be sure to catch up with our partners who have a variety of patient safety solutions to help you with your current challenges and priorities. Simply head over for a chat or connect with them via the event app to book a meeting **Outpatients' Department** Head over to the exhibition hall to the 'Outpatient's Department' zone and catch up with speakers after sessions! This is an opportunity to meet the speakers one to one and ask your questions				
13.00	**Keynote** **The road to zero: Eliminating unnecessary deaths in a post-pandemic NHS** • Hear from The Rt Hon Jeremy Hunt MP on how the NHS can reduce the number of avoidable deaths to zero, saving money, reducing backlogs and improving work conditions in the process • What is being done at national level to help make the switch from a culture of blame to a culture of learning in order to meet this goal • Key considerations and takeaways to help you deliver the safest, highest quality care post-pandemic to achieve our own 1948 moment • Take this opportunity to ask questions and challenge our speakers via the event app ***The Rt Hon Jeremy Hunt MP****, Chair, Health and Social Care Committee and Former Health Secretary*				
13.30	**Time to move between sessions**				
	Track 1	**Track 2**	**Track 3**	**Track 4**	**Track 5** **Women's healthcare**

	Governance and regulation	Clinician-led innovation	Safety for vulnerable people	The deteriorating patient	
13.40	**Minimising the risks of extravasation** • Understand the volume of claims submitted relating to extravasation injury and the cost this has on patients and the system • Hear from a trust that has implemented innovate ways to reduce the risk of extravasation injury • Get an update on national guidance and recommendations ***Andrew Barton**, Nurse Consultant, Vascular Access & IV Therapy, Frimley Health NHS FT and Chair, National Infusion and Vascular Access Society (NIVAS)* ***Samantha Thomas**, Associate Safety and Learning Lead, NHS Resolution* *Chaired by **Helen Hughes,** Chief Executive, Patient Safety Learning*	<u>Panel</u> **Taking the next step in your improvement journey: Learning from organisations that 'require improvement'** • Hear from trusts in different stages of their quality improvement journey and find out which areas they are prioritising to raise quality standards • Hear examples of inspirational projects from trusts that helped bridge the gap from 'requires improvement' to 'good' • Take back practical and relatable advice to help you in your own improvement journey ***Hayley Flavell,** Director of Nursing, Shrewsbury and Telford Hospital NHS Trust* ***Dr Ruth O'Dowd**, Consultant Anaesthetist and Associate Medical Director Patient*	**Thinking pragmatically about capacity: Innovative approaches to improving hospital flow for urgent care** • Address the need to change and expand the general thinking around emergency patient flow • Explore the barriers and enablers to flow improvement • Consider the links between system safety, quality and hospital flow • Get involved in design thinking and find out about innovative approaches to flow improvement • Take back practical tools for a fresh look at flow within your own setting ***Phil Wilson**, Head of Nursing, Birmingham Women's and Children's NHS FT*	**Equipping staff with the skills to detect the seriously ill and deteriorating woman** • Address the challenges of recognising impending maternal collapse, especially with little or no warning signs of severe maternal illness • Learn about the Maternity Early Obstetric Warning Scoring System (MEOWS), designed to help critical care staff identify early warning signs for maternal collapse • Hear about the impact of these guidelines in practice, leading to appropriate escalation and intervention, improving women's safety outcomes • Share and take away maternity enhanced care competencies which provide you with skills to effectively assess	**The first Women's Health Strategy: Redesigning the system to prioritise care on clinical need, not gender** • Learn about the government-led Women's Health Strategy in England as part of plans to level up health care • Get an update on key issues raised in response to a call for evidence to inform the government's approach to tackling gender health inequality • Find out how these insights will inform the upcoming Women's Health Strategy to create a healthcare system that prioritises care on the basis of clinical need, not gender ***Professor Matthew Cripps,** Director of Behaviour Change, NHS England and NHS Improvement*

		Safety and Quality Improvement, North Cumbria Integrated Care NHS FT ***Michael Wright,*** *Programme Director, Maternity Assurance, Shrewsbury and Telford Hospital NHS Trust* *Chaired by* ***Dr Lauren Morgan,*** *Human Factors Lecturer, Quality, Reliability, Safety and Teamwork Unit, Patient Safety Academy, University of Oxford*		and manage pregnant and postnatal women ***Eddie Morris,*** *President, Royal College of Obstetricians and Gynaecologists* ***Justin Chu****, Consultant Obstetrician and Gynaecologist Sub-specialist in Reproductive Medicine and Surgery, Birmingham Women's And Children's NHS FT*	
14.30	**Time to move between sessions**				
	Track 1 **Governance and regulation**	**Track 2** **Clinician-led innovation**	**Track 3** **Safety for vulnerable people**	**Track 4** **The deteriorating patient**	**Track 5** **Women's healthcare**
14.35	<u>Interactive session</u> **HSIB's Investigation Education Programme: A systems approach to local safety investigations** • Learn about HSIB's Investigation Education Programme and get a snapshot of the type of training and modules you can benefit from • Hear about the transition and future directions of the new HSSIB as it transitions into a	<u>Panel</u> **An update from Patient Safety Specialists: Assessing the current barriers and drivers to an ingrained safety culture** • Get an update from Patient Safety Specialists on the impact of this new role so far on safety, culture and quality • Find out how the aim of creating an ingrained safety culture across each	**Powering traceability and transparency in a clinical setting: Using digital to get at the forefront of patient and product management** • Find out how the adoption of GS1 standards is improving efficiencies and preventing unnecessary patient harm across the NHS • Learn about a pioneering digital project, Scan4Safety which	**Improving the early recognition of sepsis in primary care** • Listen to first-hand examples of how the failure to detect sepsis amongst GP's lead to avoidable deaths • Hear from organisations who have successfully used NEWS2 to support the early recognition of sepsis and improve communication at the interface of	**Tackling racial disparities in women's health** • Get a thorough understanding of the health disparities faced by Black, Asian, and minority ethnic women, including receiving poor quality of care and health outcomes, with higher rates of morbidity and mortality • Explore what is being done on the ground to narrow the inequalities gap

	statutory body in 2023 • Take back a practical overview of the importance of human factors and systems thinking in investigations • Next steps for you and your teams to get involved and benefit from this free training opportunity ***Professor Paul Bowie,*** *Senior Investigation Science Educator, Healthcare Safety Investigation Branch (HSIB)* ***Dr Laura Pickup****, Senior Investigation Science Educator, Healthcare Safety Investigation Branch (HSIB)* ***Andrew Murphy Pittock****, Head of Investigation Education, Healthcare Safety Investigation Branch (HSIB)*	organisation has varied across different trusts and the barriers/enablers behind this • Learn how you can support Patient Safety Specialists to ensure the whole organisation is involved in the safety agenda ***Elizabeth Klein****, Patient Safety Specialist and Head of Nursing Patient Safety and Clinical Quality, North Cumbria Integrated Care NHS FT* ***Linnie Pontin****, Patient Safety Specialist and Head of Quality and Patient Safety, Homerton Healthcare NHS FT*	uses barcode technology to enable effective patient and product management • Hear examples from trusts that are using Scan4Safety and find out the impact on patients and staff so far • Discover how you can get started on your own GS1 standards adoption journey and engage with those leading the charge in implementing Scan4Safety	care, from primary to ambulance or acute settings • Find out how you can adopt a primary care sepsis strategy to help assess patient deterioration rapidly	and improve diagnosis, early interventions, and treatment for women • Look at learning from successful case studies and how these can be applied across different care pathways ***Dr Karen Joash****, Consultant in Obstetrics and Gynaecology, Imperial College Healthcare NHS Trust and Head of School for Obstetrics and Gynaecology, Health Education England*	
15.20	Regroup with all attendees for the closing Q&A plenary session					
15.30	**<u>Q&A Panel</u>** **Patient Safety Question Time** Don't miss out on the closing Q&A quickfire discussion with some of the most leading figures in healthcare! This is an opportunity for you to quiz and challenge our panel of patient safety experts. Send in your questions and comments live via the event app and find out the most common concerns amongst our audience - all to be addressed! ***Charlotte McArdle,*** *Deputy Chief Nursing Officer for Patient Safety and Improvement, NHS England and NHS Improvement*					

	***Dr Habib Naqvi MBE**, Director, NHS Race and Health Observatory* ***Professor Alison Leary,** Chair of Healthcare & Workforce Modelling, London South Bank University* ***Rob Behrens**, Parliamentary and Health Service Ombudsman* ***Jono Broad,** Senior Manager for Co-Production and Patient Experience, Lead for the Integrated Personalised Care Team, South West Regional Team, NHS England and NHS Improvement*
16.15	**Chair's closing remarks** ***Shaun Lintern, Chair,** Patient Safety Congress and Health Editor, The Sunday Times* ***Please take time to give your feedback via the app***

To find out more about the Patient Safety Congress
click here.

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