HSJ PATIENT SAFETY CONGRESS

20-21 SEPTEMBER 2021

MANCHESTER CENTRAL

HSJ Patient Safety Congress
Draft Programme

Positioning patient safety at the core of system reset to transform standards of health and social care

This programme is a living document which serves as an indication of the final programme content; therefore, details will change.

Day 1 – Monday 20 September

Time	Session
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 Correspondent, The Independent*
9.15	**Building back better: Capitalising on the increased awareness of the gaps in patient safety** • How covid-19 has forced the system to change long-standing ways of working • Innovative examples of positive service shifts rolled out at scale and pace, which would otherwise have taken years to achieve • Learn how you can ensure rapid innovation leads to sustainable change, through co-production with staff and patients • Creating an infrastructure that enables meaningful patient involvement • Maximise this time to make the service more resilient ***Aidan Fowler,** National Director of Patient Safety, NHS England & NHS Improvement*
10.00	**Actioning recommendations from the Ockenden Report** • Comprehend the impact of harm from pregnancy experiences ending with stillbirth, new-born brain damage or death by hearing directly from patient representatives • Understand the relevance of the Report to wider maternity safety issues, including lack of compassion, failure to listen to patients, inconsistent investigation processes and limited evidence of feedback to staff

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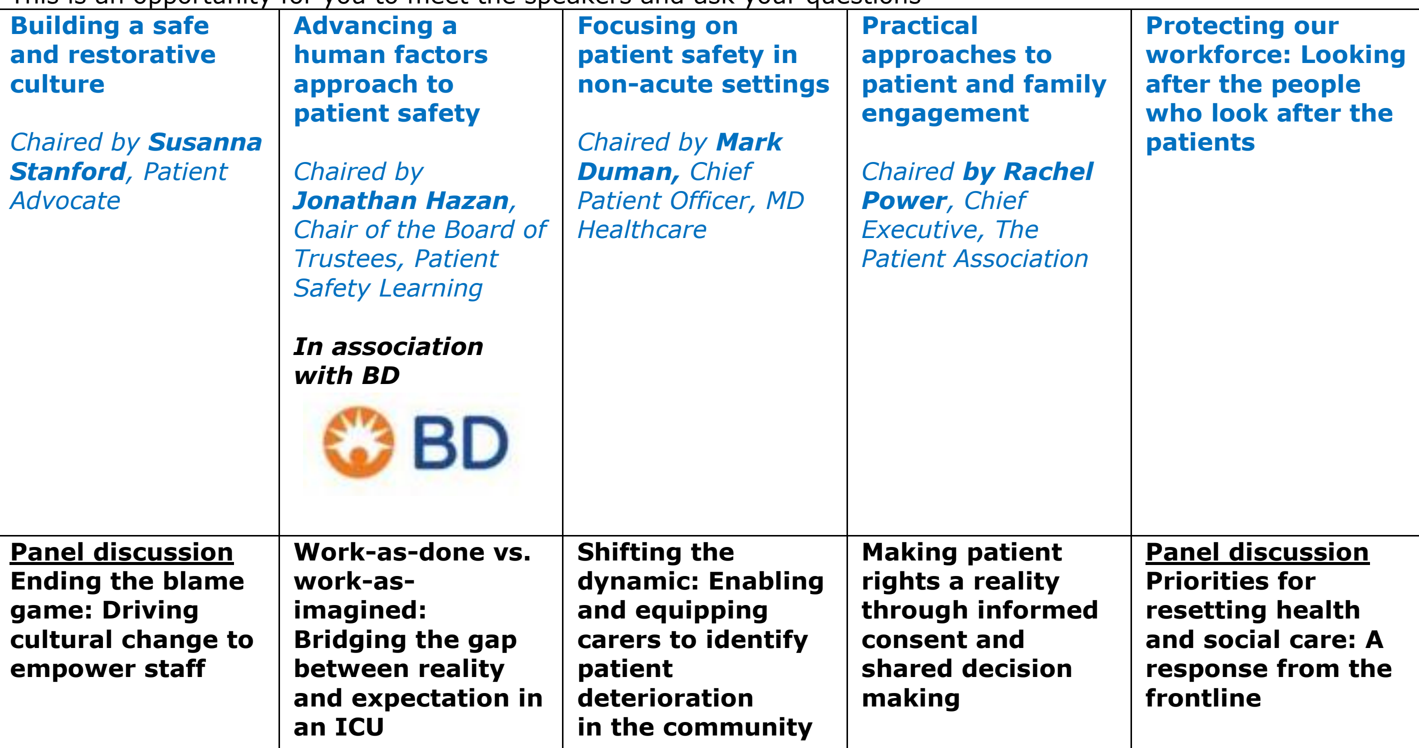
	• How to enable women to participate equally in all decision-making processes and make informed choices about their care when risks are probable • Find out how regulators and professional bodies are strengthening their efforts to work collaboratively with local networks to ensure the rapid implementation of recommendations from the Report • Establish what further actions must be taken to implement changes in practice and ensure they are translated into safer maternity care across England ***Donna Ockenden,*** *Chair, Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust* ***Sarah-Jane Marsh,*** *Chair, NHS England Maternity Transformation Programme and Chief Executive, Birmingham Women's and Children's NHS Foundation Trust*				
10.45	**Morning break in Exhibition Hall** **Outpatients department** This is an opportunity for you to meet the speakers and ask your questions				
	Building a safe and restorative culture *Chaired by* ***Susanna Stanford****, Patient Advocate*	**Advancing a human factors approach to patient safety** *Chaired by* ***Jonathan Hazan****, Chair of the Board of Trustees, Patient Safety Learning* ***In association with BD*** 	**Focusing on patient safety in non-acute settings** *Chaired by* ***Mark Duman,*** *Chief Patient Officer, MD Healthcare*	**Practical approaches to patient and family engagement** *Chaired* ***by Rachel Power****, Chief Executive, The Patient Association*	**Protecting our workforce: Looking after the people who look after the patients**
11.15	**<u>Panel discussion</u>** **Ending the blame game: Driving cultural change to empower staff**	**Work-as-done vs. work-as-imagined: Bridging the gap between reality and expectation in an ICU**	**Shifting the dynamic: Enabling and equipping carers to identify patient deterioration in the community**	**Making patient rights a reality through informed consent and shared decision making**	**<u>Panel discussion</u>** **Priorities for resetting health and social care: A response from the frontline**

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	• Learn how to shift the focus from individual failings to the underlying systemic faults when errors occur • Identify steps leaders can take to build a psychologically safe environment that encourages transparency and honesty • Learn what more you can do to remove the fear of speaking up • Understand the impact this has on patient safety through the prevention of repeat errors	• Look into what actually happened vs. what should have happened in ICU units during the pandemic • Gain insight into findings of a study showing the severity of mental health disorders experienced by staff and implications on delivering high quality care, patient safety and workforce resilience • Address the wider lessons to be learned and steps you can take to react and do things differently ahead of winter 2021 • Strategies being developed nationally to protect the mental health and decrease the risk of functional impairment of ICU staff during	• How covid-19 has changed perceptions of patients monitoring their own health • Equipping patients and carers with the skills and confidence to recognise deterioration and communicate concerns to healthcare professionals • Hear how NHSE, AHSNs, experts by experience and carers have collaborated to develop the RESTORE2 online training programme to help carers spot signs of deterioration • Looking forward: Bringing about improved health outcomes, cost benefits and reduced system pressures though digital tools that support patient self-management	• Hear from Nadine Montgomery about her influence on patient autonomy and reshaping the law on informed consent • How to advise patients effectively to deliver genuine informed consent and the positive impact this has on wider safety issues • Finding the right balance between patient autonomy and medical paternalism • Preparing patients psychologically for risks in an ethical and responsible way and encouraging them to ask questions about their care ***Edward Morris MD PRCO****, President, Royal College of Obstetricians & Gynaecologists*	• Frontline staff share insights into their experiences, concerns, and current challenges • Discuss what effective leadership should look like during times of uncertainty • How to avoid a disconnect between senior leadership and the needs of frontline staff • How you can best support staff priorities as the NHS moves into recovery

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		covid-19 and beyond ***Kevin Fong,*** *consultant anaesthetist, University College London Hospitals NHS FT and National Clinical Advisor in Emergency Preparedness Resilience and Response for the COVID-19 Incident, NHS England*	and detection of deterioration ***Andrew Bright,*** *Expert by Experience* ***Dr Alison Tavaré****, Regional Clinical Lead NHSE SW, Primary Care Clinical Lead, West of England Academic Health Science Network* ***Dr Chris Subbe****, Consultant Physician, NHS Wales, Bangor University and Improvement Science Fellow, The Health Foundation* ***Louise George****, Senior Project Manager, West of England Academic Health Science Network*		
12.05	Time to move between sessions				
12.10	**Patient Safety Specialists: Leading the development of an ingrained safety culture across the system** • Insight into the role and responsibilities	**Adjusting behaviours after the surge to rebuild quality of care** • Understand how staff dealt with the reality that usual standards of care could not	**Casting the safety net across all care sectors: Why achieving true integration is essential** • Hear from advanced integrated care systems that	**Developing a Harmed Patients Pathway to prevent the lesser known 'second harm'** • Comprehend the impact of preventable 'second harm' on	**Panel discussion** **Growing and retaining the workforce: Delivering the NHS People Plan** • How the NHS People Plan has been adapted in

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	of Patient Safety Specialists • The power of an apology when things go wrong and the impact on litigation • How you can support Patient Safety Specialists to ensure the whole organisation is involved in the safety agenda ***In association with BD***	be achieved during surge times • Assess the long-term risks to patient safety of not changing attitudes and behaviours as pressures ease • Find out how you can reset behaviours to rebuild higher standards of care as the system recovers	have overcome siloed working to deliver better health outcomes • Gain insight into how covid-19 has tested and magnified interdependence between sectors • How to harness the benefits and close the gaps that still remain • Learn how you can ensure patient safety is maintained in your organisation's journey towards true integration ***Rosie Benneyworth,*** *Chief Inspector of General Practice and Integrated Care, Care Quality Commission*	patients and families and the wider consequences on the system • Address the ethical and moral responsibility of system leaders to recognise the scale and extent of unnecessary suffering caused by the way the system currently operates • Find out about the campaign to develop a Harmed Patients Pathway. Gain insight into how this would positively impact patient safety and build back trust after harm • Learn what is being done at national level to introduce this new pathway to ensure a just culture for both patients and staff involved in harmful events ***Joanne Hughes,*** *Patient Advocate*	response to new workforce challenges presented by covid-19 • Implications of the pandemic and Brexit on overseas recruitment and new measures in place to ethically boost numbers of overseas staff • Proactive approaches you can take to make your organisation more attractive to the next generation of health and care workers • Find out what really matters to staff in order to prevent high attrition rates as covid-19 pressures ease ***Mark Radford****, Chief Nurse, Health Education England and Deputy Chief Nursing Officer, NHS England & NHS Improvement*
13.00	**Lunch break in Exhibition Hall**				

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	Outpatients department This is an opportunity for you to meet the speakers and have your questions answered				
14.00	**Why civility is no longer enough: Fostering a kinder culture to enhance the patient experience** • The importance of kindness as the key to delivering effective care and not an 'optional extra' • Going beyond civility to strengthen trust and wellbeing between staff and patients • Retaining compassion and humanity under high-pressure and fast-paced environments • Hear real examples about how acts of kindness have directly impacted the patient experience ***John Walsh,*** *OD Lead / Freedom to Speak Up Guardian Leeds Community Healthcare NHS*	**Installing a safety science approach to avoidable harm: Improving the way we learn from adverse events** • Establish what factors a good patient safety investigation should include • How specialist 'air accident investigation' training can improve the way the health service learns from incidents • Spearheading a preventative approach to incidents to detect safety risks before they worsen • What is being done nationally to equip staff with the right skills and knowledge to effectively conduct an incident investigation	**Re-engineering the future of healthcare provision: Virtual care and remote monitoring opportunities for patient safety** • Outcomes from the national covid-19 oximetry implementation across the UK • How this 'bottom-up' revolution has transformed the delivery of primary and community care by detecting the early deterioration of patients with covid-19 • Lessons learnt so far and future plans to foster sustainable change that enables patient autonomy and self-management • Take back strategies to ensure patient safety is sustained in a	**Achieving true co-production with patients from design to delivery** • Hear successful examples of co-production and what meaningful input from patients looks like • Utilising patients with lived experience in reviewing processes from the outset • How to work towards effective co-production to improve clinical outcomes • Find out what is being done nationally to ensure the NHS is working in equal partnership with patients, families and carers ***Jono Broad,*** *Senior Manager for Co-Production and*	**Safety is not just about numbers: Retaining frontline expertise in district nursing care** • Hear from a district nurse about the pressures and challenges encountered on a daily basis • Focusing on expanding knowledge as well as increasing staff numbers to improve patient safety • Putting into practice the Queen Nursing Institutes' recommendations linking pressure on services and delayed patient care • Developing and delivering a coherent workforce plan for district nursing at national level

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	Trust / Leeds GP Confederation		virtual setting and symptoms are not overlooked ***Dr Matt Inada-Kim,*** *Acute Physician, Royal Hampshire County Hospital and National Clinical Director- Infection, AMR, Deterioration NHS England and NHS Improvement* ***John Welch****, Nurse Consultant, University College London Hospitals FT*	*Patient Experience Lead for the Integrated Personalised Care Team, NHS England and NHS Improvement*	
14.50	Time to move between sessions				
14.55	**Attaching a patient safety lens to complaints to ensure a just culture for patients** • Address the need to disassociate the word 'complaints' with negative connotations, criticism or objection • Should patient complaints be regarded as 'hard' evidence - equally reliable as statistics and data and when	**Coping with post-covid-19 fatigue to avoid human error** • The impact of fatigue and emotional distress on staff performance • Address the responsibility of system leaders to protect the workforce and what is being done to prioritise wellbeing? • Practical strategies to combat post-viral fatigue and ensure your	**Reducing medicines-related harm in the elderly, post-hospital discharge** • Understand the financial costs and risks of Medicines-Related Harm (MRH) on the NHS, patients and acute sector • Hear from organisations who have implemented strategies to reduce MRH	**Tearing down the wall between patient feedback and the patient experience** • Gain insight into the findings of Healthwatch England report on issues around transparency and responding to concerns raised by patients and families • Hear about a study carried out by the National	**From warfare to healthcare: Valuable lessons from the British Army** • Gain an in-depth understanding on how the Army handles contingency planning and mentally prepares troops for combat • Draw similarities between the psychological challenges healthcare staff are facing from covid-19 to experiences of military troops

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	should they be treated as adverse events? • Determine the potential problems around using complaints for quality improvement and how to tackle them • Examples of learning through complaints to ensure a just culture for patients by balancing safety and accountability	teams are fully protected in the longer-term	• Gain insight into the progress of the national Medicines Safety Programme and its role in the Patient Safety Strategy	Institute for Health Research on the widespread collection of patient feedback that should be used to improve patient safety • Address the need for more managerial focus on positive feedback as well as complaints to drive improvement in practice • Find out what is being done at a national level to ensure patient feedback is analysed to improve the patient experience	• How the Army deals with high-stress situations characterised by exposure to traumatic events and moral dilemma • Gain practical advice on how to support staff suffering from moral injury and post-traumatic stress disorder ***Maj (Retd) Cormac Doyle,*** *Registered Mental Health Nurse, Retired Senior Army Officer, Chief Executive, The Bridge Charity*
15.45	**Afternoon break in Exhibition Hall** **Outpatients department** This is an opportunity for you to meet the speakers and have your questions answered				
16.15	**The James Reason Lecture** **Human and organisational factors in a blowout: Key learnings for patient safety** • Hear about the Deepwater Horizon oil spill, an industrial disaster that led to multiple deaths and severe injuries amongst workers				

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	• Gain insight into the human and organisational factors that contributed to the accident, including safety culture, communication, underlying assumptions and non-technical skills • Learn about a research study on mindfulness training and offshore safety • Review key learnings from the accident which are relevant for improving patient safety ***Rhona Flin,*** *Emeritus Professor of Applied Psychology, University of Aberdeen*
17.00	**End of day 1 - Networking reception in exhibition hall**

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Day 2	
9.00	**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,*** *Health Correspondent, The Independent, and Patient Safety Congress Chair*
9:15	**Racism - The other pandemic: Melting the snowy white peaks of the NHS to protect patients and staff** • Join this open and honest exchange about the experience of BAME staff in the healthcare system today • What research shows about systemic racism as a root cause of health inequalities and its correlation with a poor staff and patient experience • Recognising systemic racism as a governance issue and what leaders are doing to dismantle it with clear vison and accountability • Take away real, actionable steps and evidenced-based interventions to help change daily behaviours and drive the cultural shift needed in your organisation to ensure a fair, safe environment for staff and patients ***Roger Kline,*** *Research Fellow, Middlesex University Business School* ***Dr Habib Naqvi MBE****, Director, NHS Race and Health Observatory*
10.00	**Dismantling a culture of avoidance and denial to prevent medical malpractice: Lessons from the Ian Paterson Inquiry** • Comprehend the scale of long-term, avoidable harm experienced by patients who underwent unnecessary treatment from Patterson and what it will take to rebuild their trust in the system • How checks and balances designed to ensure safety were inadequate or not followed, and how failure to monitor this enabled criminal practice to continue • How a culture of fear and avoiding problems favoured Patterson's behaviour and psychologically impacted the clinicians who worked with him

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	• Steps leaders can take to facilitate staff speaking up, ensure concerns are investigated and effective checks and balances are in place • Learn what is being done about the reformation of clinical governance procedures to ensure medical professionals are monitored and fit to work and how the NHS and independent sector will share this information more effectively ***Sarah-Jane Downing,*** *Patient Advocate*				
10.45	**Morning break in Exhibition Hall** **Outpatients department** This is an opportunity for you to meet the speakers and have your questions answered				
	Improving governance and regulation to achieve consistent quality of care	**Delivering quality improvement on the frontline** ***In association with Radar Healthcare*** 	**Re-examining safety for vulnerable people**	**Recognising and responding to the deteriorating patient** *Chaired by* ***Lesley Durham,*** *President Elect, International Society for Rapid Response Systems (iSRRS)* ***Dr Isabel Gonzalez,*** *Chair, the National Outreach Forum* 	**Protecting our workforce: Looking after the people who look after the people**
11.15	**Developing a system response to the Cumberlege Review – one year on** • Learn how partners in the healthcare system are breaking down	**Connecting the dots of patient safety: a digital approach** • Learn about Radar Healthcare's incident and risk management software which	**Preparing for the rising tide: Revolutionising the delivery of mental health services to meet patient needs** • Gain insight into research commissioned by NHS England on	**11:15 - Welcome and opening remarks** **11.25 - Using a theoretical framework of behaviour change to develop a complex implementation**	**Rolling out the first ever patient safety syllabus for NHS staff** • Get an update on NHS plans to implement a universal patient safety syllabus and training

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	siloes to develop cross functional ways of working • The impact of patient contribution on the safety of medical devices • Find out how the system will function differently to ensure safety on a number of levels • Learn about how future plans for safety will continue to evolve ***In association with NHS Supply Chain*** ***Jo Gander****, Director of Clinical and Product Assurance, NHS Supply Chain*	enables staff to shift from a reactive to a proactive approach to deliver patient care • Hear examples from organisations who use this software. Find out how it has driven a culture of proactivity, joint learning and continuous improvement • Find out how you can integrate this software to future proof your organisation and improve patient safety ***In association with Radar Healthcare***	the forecasted demand for mental health services nationwide • Hear from trusts who have successfully innovated services during covid-19 and find out what lessons they can share to help inform future plans • Re-thinking our approach to digital pathways to ensure inclusion and a blended care approach where required to sustain safety during surges in demand • Hear about developments in the national Mental Health Safety Improvement Programme and find out how you can build on the success of the programme in your own organisation to improve as experience for patients and families	**intervention to improve responses to deteriorating patients** • Using the systematic application of theory to change the behaviour of healthcare staff • Learn how a theory-based behaviour change intervention was developed to improve responses to deteriorating patients • Find out how TDF domains were mapped to behaviour change techniques to inform how techniques could be operationalised in an acute ward setting ***Duncan Smith****, Lecturer in Adult Nursing, City university of London* **11:40 - RRS/CCO Calls: Approaches to 'Not for Resuscitation': A**	programme for the entire workforce • Find out how training will be quickly but effectively implemented across the workforce • Learn how the syllabus will improve the transferability of skills across the NHS • Have your say in influencing the new syllabus in this interactive session

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				perspective from the US • Discuss if there is a role for Rapid Response for patients who are not for resuscitation • Offer tips for rapid decision making during a crisis • Recognise common errors in speaking with patients who are not for resuscitation in crisis and their families • Recognise the "4 Conversations" in provider patient communication ***Dr Michael DeVita****, Director of Palliative Care Services and Professor of Medicines, Harlem Hospital Medical Centre and Columbia University Vagelos College of Physicians and Surgeons* **11.55 – Q&A**	
12.05	Time to move between sessions				
12.10	**Putting into practice lessons from prevention of**	**What good really looks like: How to**	**Protecting vulnerable patients from sexual abuse**	**12.10 - The role of outreach in post-intensive care**	**Mind the gap: Smart thinking to deliver safer care**

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	future death reports	**be a safe maternity unit**	**in mental health hospitals**	**support and its impact on mortality/ morbidity: The REFLECT study**	**for a stretched workforce**
	• Learn about the findings of an analysis into four years of coroner reports • Missed opportunities to prevent deaths • Underinvestment in the workforce and under-resourcing of the service • Reoccurring themes such as deficits in knowledge, lack of resources and uncoordinated care • The need for more systemic and national analysis of coroner's findings to allow the NHS to sport wider system issues • • Effective learning to take from this / useful intelligence to improve patient safety ***Prof Alison Leary,***	• Identify the behaviours and practices that are features of safe care in hospital-based maternity units • Hear how organisations can take practical steps to make these features reality • The future direction of safety in maternity care as the system recovers and continues to transform ***Mary Dixon-Woods,*** *Director, THIS Institute and Professor of Healthcare Improvement Studies, University of Cambridge*	• Dismantling the culture that enables sexual abuse to occur and restricts patients and staff from speaking up • Does the NHS have a bias when it comes to psychiatric patients raising issues? Discuss how we can tackle this bias • Hear examples of wards that have moved to an environment that privileges sexual safety • Explore mechanisms and structures that have been put in place to enhance sexual safety in mental health wards and examine the wider challenges of sexual safety that still remain	• Why discharge from intensive care is only the first step to recovering from critical illness • Challenges of post-ICU ward care identified by patients and staff • Find out how the REFLECT study uses mixed methods to examine post-ICU ward care and investigate how to improve both safety and quality of care delivery to this group of patients ***Dr Sarah Vollam,*** *Nurse Researcher, University of Oxford* **12.25 - Being cared for by critical outreach teams: The patient experience as seen from the other side** **12.45 – Q&A**	• Explore ways to best make use of technology to improve efficiency and alleviate heavy workload pressures • Hear successful case studies from organisations who have implemented strategic solutions to counteract the workforce deficit • Learn how you can redesign your workforce and harness technology to mitigate the impact of staff shortages on patient safety

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	Chair of Healthcare and Workforce Modelling, London South Bank University				
13.00	**Lunch break in exhibition hall** **Outpatients department** This is an opportunity for you to meet the speakers and have your questions answered				
14.00	**Smarter regulation for a safer system: Meeting the needs of a changing health and care sector** • Find out how the CQC are adapting regulatory processes to be more flexible and dynamic to manage risk and uncertainty • A system-based approach to assessing quality – find out how the role of private and voluntary sector partners will be assessed given the role they play in patient pathways • Lessons learned from covid-19 and how these will be applied to	**Tackling the backlog safely: Prioritising and optimising access to elective care services** • Address the challenges services face to prioritise patient access to elective care and streamline patient flow • Find out how the NHS plans to approach the backlog efficiently and systematically, risk stratifying by clinical need and planning for increased demand in specific areas • Gain insight into The Royal College of Surgeons' clinical guidance on surgical prioritisation post-covid	**Debate – Exploring the most effective approach to protecting patients' living with covid-19** • Gain insight into the second themed review into Long Covid by the NIHR and find out what the data shows • Hear about the Defence Medical Rehabilitation Centre (DMRC) Covid-19 Recovery Service and debate whether this model is a more effective way of managing long-covid • Debate the need to offer a holistic, integrated approach rather than symptom by symptom management • Recommendations and examples of	**14.00 - The Critical Care Outreach Practitioner National Credential & Competency Framework** • The development of a nationally recognised system of credentialing for Critical Care Outreach Practitioners • Improving patient safety by introducing a national standard of competence, skills and behaviours ***Lesley Durham,*** *President Elect, International Society for Rapid Response Systems (iSRRS)*	**Safeguarding the system against future health threats: Lessons from the UK and abroad** • Gain insight into the role of the UK Health Security Agency • Address and debate key lessons from the national covid-19 response and systemic emergency preparedness • Find out what is being done to enhance planning and response capacity for future health challenges and threats • Hear from other nations and learn what strategies are in place to respond quickly and at greater

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	new regulatory approaches • Find out how this will impact your organisation and how you can prepare for upcoming changes ***Ted Baker,** Chief Inspector of Hospitals, Care Quality Commission*	• Take away strategies that can help minimise further risks to patients and allow for the safe restoration of elective services	how the current approach to long-covid can be improved to avoid patient harm and deterioration ***Dr Elaine Maxwell,** Scientific Advisor, National Institute for Health Research*	**14:15 - Frequency of Observations (FOBS) NIHR Project** • Safer and more efficient vital signs monitoring to identify the deteriorating patient: An observational study towards deriving evidence-based protocols for patient surveillance on the general ***Professor Jim Briggs**, Director of the Centre for Healthcare Modelling and Informatics, University of Portsmouth* **14.25 - Remote wireless patient monitoring: Challenges, Experiences, What's Next? (The Nightingale H2020 project)** • Why we need wireless monitoring for reliable detection of deterioration • What's the state of the art?	scale to deal with future pandemics

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				• Clinician and patient perspectives • Wireless monitoring at scale ***John Welch**, Nurse Consultant, University College London Hospitals FT* **14.35 – Q&A**	
14.50	**Afternoon break in exhibition hall** **Outpatients department** This is an opportunity for you to meet the speakers and have your questions answered				
15.20	**Implementing a system-wide approach to patient safety** • The new working dynamic between the NHS and independent sector • Hear about the move towards making patient safety and data transparency a whole systems approach to better align both sectors • Learn about the development of an online data sharing system	**Liaising with families through adversity: The value of communication to achieve high quality care** • Learn how ICU units adapted in order to maintain high quality, family-centred care during the crisis • Hear from family liaison teams that were developed to improve communication between ICU patients and their families	**Reviewing restrictive interventions and human rights breaches for vulnerable people** • Gain insight into the aims of Seni’s Law which seeks to end the inappropriate use of physical force against mental health patients • Find out how patient representatives are working to embed Seni's Law in mental health units across the UK	**15:20 Presentations by members of iSRRS & NOrF**	**Caring for our caregivers: Rolling out an effective wellbeing plan to support long-term staff needs** • Address the unique challenges covid-19 has presented for NHS staff including morale injury, increased stress, and trauma • Find out what is being done nationally to drive forward mental health and wellbeing initiatives in the long-term

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	– a key step towards the seamless flow of data along the patient journey • Explore the benefits of this full visibility across providers including enabling patients to make informed choices about their care • How both sectors plan to further leverage this partnership in 2021 and beyond	• Address the impacts virtual communication had on alleviating family concerns and improving quality of care • Find out how this can be further leveraged across wider teams to enhance the patient and family experience	• How the national Mental Health Safety Improvement Programme is working to reduce the incidence of restrictive practice in inpatient mental health and learning disability services • Understand how this law will impact your organisation and what changes you can make to improve experiences for patients and families		• Hear successful examples from organisations that have created a safe working environment where staff feel valued
16.10	Time to move between sessions				
16.15	**If you could re-design the healthcare system, what would it look like?** • We ask a panel of patients, NHS and social care staff on the key changes they would make to care delivery based on their experiences • Understand the art of the possible and what can be done at every level to turn the rhetoric into reality for patients • What action you can take in your organisation to drive the fundamental cultural shift required to support the translation of the patient voice to improved services				
16.45	**Human vs. Machine: The future of patient safety** • Hear from senior leaders on professional knowledge and human skill vs. the use of algorithms and care protocols like NEWS2 and EOBS • To what extent can we trust technology to guarantee the safety of patients? - Determining the right balance between humans and technology to avoid over-reliance on automation • Listen to patient perspectives on the benefits of the growing use of technology in their care				

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	***John Welch**, Nurse Consultant, University College London Hospitals FT*
17.30	**Chair's closing remarks** ***Shaun Lintern**, Health Correspondent, The Independent, and Patient Safety Congress Chair*

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

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