HSJ PATIENT SAFETY CONGRESS

20-21 SEPTEMBER 2021

MANCHESTER CENTRAL

HSJ Patient Safety Congress

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	
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* ***Professor Andrew Goddard**, President, Royal College of Physicians*
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

	• 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 ***Derek Richford,*** *Patient Representative* ***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*** 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** *Chaired by* ***Dr Elaine Maxwell,*** *Scientific Advisor, National Institute for Health Research*
11.15	**Panel discussion** **Ending the blame game: Driving cultural change to empower staff**	**Work-as-done vs. work-as-imagined: Bridging the gap between reality**	**Shifting the dynamic: Enabling and equipping carers to identify**	**Making patient rights a reality through informed consent and**	**Panel discussion** **Priorities for resetting health and social care: A**

	• 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 ***Tom Bell**, Patient Representative and Founding Director, Honesty and Integrity in Public Sector Services*	**and expectation in an ICU** • 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	**patient deterioration in the community** • 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	**shared decision making** • 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*	**response from the frontline** • 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

		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*	support patient self-management 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**	**Adjusting behaviours after the surge to rebuild quality of care** • Understand how staff dealt with the reality that	**Casting the safety net across all care sectors: Why achieving true integration is essential** • Casting the safety net across	**Developing a Harmed Patients Pathway to prevent second harm** • Comprehend the impact of preventable	**<u>Panel discussion</u> Growing and retaining the workforce: Delivering the NHS People Plan**

	• Insight into the role and responsibilities of Patient Safety Specialists • How you can support Patient Safety Specialists to ensure the whole organisation is involved in the safety agenda	usual standards of care could not 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	all care sectors: Why achieving true integration is essential • Hear from advanced integrated care systems that have overcome siloed working to deliver better health outcomes • Gain insight into how covid-19 has tested and magnified interdependence between sectors. Learn how this has impacted patient safety and what gaps still remain • The role of leaders in creating a consistent culture and the right behaviours across the system to ensure high quality care • Find out how regulators are adapting and evolving to mirror these behaviours to support system working,	'second harm' on patients and families and the wider consequences on the system • Address issues around the way the system currently operates. What positive changes to patient safety would we see if we took a patient rather than system-centred approach? • Insight into the campaign to develop a Harmed Patients Pathway. Understand the impact this would have on promoting healing, learning and restorative culture • The need for a restorative approach after healthcare harm to support a just and caring response for all parties ***Joanne Hughes,*** *Co-Founder, Harmed Patients Alliance*	• How the NHS People Plan has been adapted in 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*

			collaboration and innovation • 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*	***Peter Walsh**, Chief Executive, Action Against Medical Accidents*	
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	**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	**Designing error out of the system: A practical, collaborative approach to improving the way we learn from adverse events** • Embedding a human factors and ergonomics approach at system level to reduce individual error • The importance of collaborations between clinicians, experts from high reliability	**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	**Achieving true co-production with patients from design to delivery** • Hear successful examples of co-production and what meaningful, collaborative input from patients looks like • Recognise the value of involving patients with lived experience in reviewing	**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

	• 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 Trust / Leeds GP Confederation*	organisations and human factors scientists in order to roll this out with success • Take back evidence-based, feedback driven training strategies to help equip your teams with the right skills to help avoid mistakes under pressure ***In association with Datix*** ***Tim Kane****, Consultant Orthopaedic Surgeon, Portsmouth Hospitals NHS Trust and Director, Practical Patient Safety Solutions*	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 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*	processes from the outset • How you can 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 Patient Experience Lead for the Integrated Personalised Care Team, NHS England and NHS Improvement*	• 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
14.50	Time to move between sessions				
14.55	**Attaching a patient safety lens to complaints to**	**Embedding ergonomics & human factors at**	**Closed-loop medication administration**	**Liaising with families through adversity: The**	**From warfare to healthcare: Valuable lessons**

	ensure a just culture for patients • Address the importance of moving away from complaints as negative and instead treating them as a vital resource for driving learning and improvement in practice • The significance of the patient/family experience and how this should be given equal weight in any investigation • Take back practical examples of trusts who have improved patient safety through learning from complaints to ensure a just culture for patients by balancing safety and accountability ***Rob Behrens,*** *Parliamentary and Health Service Ombudsman*	**the core of system re-design: A local project adopted at national level** • Hear about a local patient safety project which adopted an innovative approach to system re-design by incorporating ergonomics and human factors theory • The benefits of engaging and co-designing with parents and frontline staff to identify system gaps and ensure system design maximises clinical safety improvement • Positive results and learnings from the new system and its impact on patient safety and identifying deterioration • The impact of this project at national level and how it will affect your organisation in the near future	**Leveraging technology to elevate patient safety** • Recognise the risks and consequences of Medicines-Related Harm on both patients and the system • Hear from organisations who have implemented digital strategies to reduce medication error • Learn about the closed-loop medicines management system (CLMM) and its impact on reducing medication error, adverse drug event rates as well as optimising workflow and reducing costs • Understand the roles of Pharmacy, Nursing and Physicians within collaborative workflows to facilitate CLMM	**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 • 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	**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 • 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*

			• The long-term effects of technology-based interventions in reducing medication errors • Get an update on the national Medicines Safety Improvement Programme and plans to develop a framework to help you self-assess your current approach to medicines safety **In association with Cleveland Clinic London** ***Francine de Stoppelaar***, *Director of Pharmacy, Cleveland Clinic London*	***Dr Timothy Bonnici,*** *Intensive Care Consultant, University College London Hospitals NHS FT* ***Anna Petsas,*** *Intensive Care Consultant, University College London Hospitals NHS FT*	
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	**<u>The James Reason Lecture</u>** **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 • 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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Putting patient safety at the centre as health and social care resets

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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

	• 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* ***Una Lane****, Director of Registration and Revalidation, General Medical Council* ***Kashmir Uppal****, Clinical Negligence Partner, Shoosmiths LLP* ***Matt James****, Chief Executive, Private Healthcare Information Network*				
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**	**Safety II in action: Spearheading a digital preventive approach to**	**Preparing for the rising tide: Revolutionising the delivery of mental**	**11:15 - Welcome and opening remarks**	**Rolling out the first ever patient safety syllabus for NHS staff**

	• Learn how partners in the healthcare system are breaking down 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* ***Chris Stirling,** Interim Director of Medical Technologies, Department of Health and Social Care*	**patient safety risks** • Find out what organisational culture is required to enable the shift from safety I to safety II as outlined in the NHS Patient Safety Strategy • Understand the role of technology in enabling staff to shift from a reactive to a proactive approach to deliver patient care • Examples from organisations who have adopted a digital approach to identifying risks. Find out how it has driven a culture of proactivity, joint learning and continuous improvement • Learn what steps you can take to make safety II a reality in your organisation in line with national plans	**health services to meet patient needs** • Gain insight into research commissioned by NHS England on 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	**11.25 - Using a theoretical framework of behaviour change to develop a complex implementation 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*	• Get an update on NHS plans to implement a universal patient safety syllabus and training 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

	***Graeme Tunbridge**, Director of Devices, Medicines & Healthcare products Regulatory Agency*	***In association with Radar Healthcare*** ***Paul Johnson**, Chief Executive, Radar Software*	programme in your own organisation to improve as experience for patients and families	*Nursing, City university of London* **11:40 - RRS/CCO Calls: Approaches to 'Not for Resuscitation': A 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 future death reports** • 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 •	**How the National Patient Safety Improvement Programmes are supporting safer care across the NHS** • An update on all 5 National Patient Safety Improvement Programmes and current priorities • Learn how the Programmes have been adapted to reflect new challenges presented by the pandemic • Find out what this means for your organisation and how you can help roll out the initiatives outlined in the Programmes ***In association with The National Patient Safety Collaboratives Programme***	**Protecting vulnerable patients from sexual abuse in mental health hospitals** • 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	**12.10 - The role of outreach in post-intensive care support and its impact on mortality/ morbidity: The REFLECT study** • 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*	**Mind the gap: Smart thinking to deliver safer care for a stretched workforce** • 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

	• Effective learning to take from this / useful intelligence to improve patient safety ***Prof Alison Leary**, Chair of Healthcare and Workforce Modelling, London South Bank University*		sexual safety that still remain	**12.25 - Being cared for by critical outreach teams: The patient experience as seen from the other side** **12.45 – Q&A**	
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	**What good really looks like: How to be a safe maternity unit** • 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	**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	**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,	**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

	play in patient pathways • Lessons learned from covid-19 and how these will be applied to 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*	***Mary Dixon-Woods,*** *Director, THIS Institute and Professor of Healthcare Improvement Studies, University of Cambridge*	• Debate the need to offer a holistic, integrated approach rather than symptom by symptom management • Recommendations and examples of how the current approach to long-covid can be improved to avoid patient harm and deterioration ***Monique Jackson,*** *Patient Speaker* ***Dr Elaine Maxwell,*** *Scientific Advisor, National Institute for Health Research* ***Dr Jo House,*** *Research Lead, Global Environmental Change theme, University of Bristol*	skills and behaviours ***Lesley Durham,*** *President Elect, International Society for Rapid Response Systems (iSRRS)* **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)**	challenges and threats • Hear from other nations and learn what strategies are in place to respond quickly and at greater scale to deal with future pandemics

				• Why we need wireless monitoring for reliable detection of deterioration • What's the state of the art? • 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	**Working collaboratively to improve safety, reduce harm and subsequent litigation claims** • What can be done at the local level to reduce clinical negligence claims and the cost of them • How health providers can	**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	**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	**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

	make improvements in response to harm for patients, families, carers and staff involved in adverse events • The importance of access to justice for patient safety as well as injured patients and their families • Closing the loop: Ensuring opportunities for learning from claims acted upon ***Peter Walsh**, Chief Executive, Action Against Medical Accidents* ***Dr Denise Chaffer,** Director of Safety and Learning, NHS Resolution*	• 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 • Take away strategies that can help minimise further risks to patients and allow for the safe restoration of elective services ***Dr Jugdeep Dhesi,** Deputy Director, Centre for Perioperative Care and Consultant Physician in Geriatrics and General Medicine, Guys and St Thomas' NHS FT*	• Find out how patient representatives are working to embed Seni's Law in mental health units across the UK • 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		• Find out what is being done nationally to drive forward mental health and wellbeing initiatives in the long-term • 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	**Reflections and realities of confronting the pandemic: A critical care perspective** - Gain insight into the pressures faced by staff in critical care units over the past year				

	- What have we learnt about the NHS? Discuss key takeaways and lessons for the wider system - Innovations in critical care that can be embedded across the entire system ***Nicki Credland**, Chair, British Association of Critical Care Nurses (BACCN)*
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 • Learn about the Nightingale Project and clinician-led innovations. What other future technological possibilities can we expect across healthcare? • To what extent can we trust technology to guarantee the safety of patients? – Debate the importance of humans influencing the creation of digital products and how we can determine 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 and gaps that still remain ***John Welch**, Nurse Consultant, University College London Hospitals FT* ***Dr Lauren Morgan,** Human Factors Lecturer, Quality, Reliability, Safety and Teamwork Unit, Patient Safety Academy, University of Oxford* ***Dr Mark-Alexander Sujan,** Managing Director, Human Factors Everywhere Ltd. and Trustee, Chartered Institute of Ergonomics and Human Factors*
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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