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* ***Penny Pereira**, Q Initiative Director, The Health Foundation* ***Dr John Dean,** Clinical Director for Quality Improvement and Patient Safety, 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 • 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, 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 FT*				
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 Safety 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**	**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*
Room	**Charter 1**	**Exchange Auditorium**	**Charter 2**	**Exchange 9**	**Charter 3**
11.15	**Panel discussion** **Ending the blame game: Driving cultural change to empower staff** • Learn how to shift the focus from individual failings to the underlying systemic faults when errors occur	**Work-as-done vs. work-as-imagined: Bridging the gap between reality and expectation in an ICU** • Look into what actually happened vs. what should have happened in ICU units	**Shifting the dynamic: Enabling and equipping carers to identify patient deterioration in the community** • How covid-19 has changed perceptions of patients monitoring their own health	**Making patient rights a reality through informed consent and shared decision making** • How to advise patients effectively to deliver genuine informed consent and the positive impact	**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 moral

	• 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**, Author, Consultant, Whistleblower and Founding Director, Honesty and Integrity in Public Sector Services* ***Thea Stein,** Chief Executive, Leeds Community Healthcare NHS Trust* ***Dr Matt Hill**, Consultant Anaesthetist and Regional Patient Safety Lead, Plymouth Hospitals NHS Trust, South West Academic Health Science Network*	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 covid-19 and beyond ***Professor Kevin Fong OBE,** Consultant Anaesthetist, University College London Hospitals NHS FT and National Clinical Advisor in Emergency Preparedness,*	• 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 and detection of deterioration ***Andrew Bright,** Expert by Experience* ***Dr Alison Tavaré**, Regional Clinical Lead NHS England Southwest, Primary*	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 **In association with Eido Healthcare** ***Simon Parsons**, Consultant Surgeon, Nottingham University Hospitals NHS Trust, Honorary Associate Professor, Nottingham University and Clinical Director, EIDO Systems International Limited* ***Professor Vivienne Harpwood,** Emerita Professor of Law, Cardiff University and Chair, Welsh NHS Confederation* ***Edward Morris MD PRCOG**, President, Royal College of Obstetricians & Gynaecologists*	injury, increased stress, and trauma • 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 ***Dr Adrian Neal,** Consultant Clinical Psychologist / Head of Employee Wellbeing Service, Aneurin Bevan University Health Board* ***Maria Paviour**, Occupational Neuropsychologist, Cariwellbeing*

		Resilience and Response for the COVID-19 Incident, NHS England (speaking virtually) ***John Welch**, Nurse Consultant, University College London Hospitals FT*	*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 of Patient Safety Specialists • How you can support Patient Safety Specialists to ensure the whole organisation is involved in the safety agenda ***Joan Russell**, Head of Patient Safety, Policy and Partnerships, NHS*	**Adjusting behaviours after the surge to rebuild quality of care** • Understand how staff dealt with the reality that 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 and embed a strong culture across	**Casting the safety net across 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	**Developing a Harmed Patients Pathway to prevent second harm** • Comprehend the impact of preventable '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-	**A conversation with Professor Mark Radford - Harnessing opportunities for innovation to strengthen the health and social care workforce** • Hear from Professor Mark Radford on some of the biggest challenges covid has presented for the nursing workforce as well the impact on his role • Opportunities for innovation that can be embedded into long-term workforce strategies

	England and NHS Improvement ***Margaret Devaney,*** *Patient Safety Specialist for East and North Hertfordshire NHS Trust*	your organisation that will help rebuild higher standards of care as staff and the system recover ***Dr Julie Highfield****, National Project Director – Wellbeing, Intensive Care Society* ***Dr Suzanne Bench,*** *Associate Professor, London South Bank University and Deputy Director of Nursing, Royal National Orthopaedic Hospital*	• 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, 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* ***Elaine Clancy, Joint Chief Nurse,*** *Croydon Health Services NHS Trust and NHS Croydon CCG*	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* ***Peter Walsh****, Chief Executive, Action Against Medical Accidents* ***Rosi Reed****, Training Coordinator, Making Families Count*	• Examples of workforce interventions being rolled out that will retain and attract staff - evaluate their impact on patient care • Engage in this discussion and get a chance to ask your questions and raise your concerns ***Professor Mark Radford****, Chief Nurse, Health Education England and Deputy Chief Nursing Officer, NHS England and NHS Improvement*
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 • 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* ***Dr Chris Turner,*** *Founder, Civility Saves Lives and*	**Designing error out of the system: A collaborative, safety science, approach to learning from avoidable harm** • Embedding a human factors and ergonomics approach at system level to reduce individual error • The importance of psychological safety including compassion and empathy when dealing with events to inform the improvement journey • Collaboration: connecting the heart with the head and working in collaboration across multiple disciplines (clinicians, experts from high reliability organisations and human factors) to roll this out with success • Take back evidence-based, feedback driven training strategies to	**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 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 (speaking virtually)*	**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 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,	**Getting to grips with safe staffing to prevent work left undone in the community** • Gain insight into reports around work left undone due to increased workloads in district care nursing • Challenges around choosing what work to prioritise and deprioritise and the impact on patient safety • Hear directly from a district nurse about the pressures and demands encountered on a daily basis • Solving the staffing issue – address why staff are leaving and steps you can take to prevent this • Why safety is not just about numbers but frontline expertise and clinical confidence amongst staff • Getting returners back

	Consultant in Emergency Medicine, University Hospitals Coventry and Warwickshire NHS Trust	help equip your teams with the right skills to help avoid mistakes under pressure ***In association with RLDatix*** ***Tim Kane**, Consultant Orthopaedic Surgeon, Portsmouth Hospitals NHS Trust and Director, Practical Patient Safety Solutions* ***Philip Taylor,** Chief Product Officer, RLDatix*	***John Welch**, Nurse Consultant, University College London Hospitals FT*	families and carers ***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* ***Joan Russell**, Head of Patient Safety, Policy and Partnerships, NHS England and NHS Improvement* ***Lindsay Farthing,** Programme Lead for UGI and LGI, RM Partners*	to work with increased flexible working ***Professor Alison Leary**, Chair of Healthcare and Workforce Modelling, London South Bank University*
14.50	Time to move between sessions				
14.55	**Attaching a patient safety lens to complaints to ensure a just culture for patients and staff** • Moving away from complaints as negative and instead treating them as a vital resource for driving learning and	**Embedding ergonomics & human factors at 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	**Closed-loop medication administration: 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	**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-	

	improvement in practice • Taking responsibility and accountability when complaints are submitted and acting on lessons learned from patient safety incidents when things go wrong • The significance of the patient/family experience and how this should be given equal weight in any investigation • Explore how you can and should use complaints as an opportunity to learn and improve the patient experience whilst also building a just culture for patients ***Derek Richford,*** *Patient Representative* ***Rob Behrens,*** *Parliamentary and Health Service Ombudsman*	incorporating ergonomics and human factors theory • The value of engaging and co-designing with parents and frontline staff to identify system gaps and ensure system design maximises clinical safety improvement • Learn how the trust used Ergonomics and Human Factors theory to guide the design of the system and policy. Find out how you can take a similar approach in your clinical safety projects and get results • Positive results and learnings from the new system and its impact on patient safety and identifying deterioration • The local impact of this project and how it will be used to influence national work ***Karl Emms****, Lead Nurse for Patient*	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 • 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*	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 ***Dr Timothy Bonnici,*** *Intensive Care Consultant, University College London Hospitals NHS FT*	

	Lucy Watson, *Chair, The Patients Association*	*Safety, Birmingham Women's and Children's NHS FT* ***Mary Salama,*** *Consultant Pediatrician, Co Project Lead, Birmingham Women's and Children's NHS FT* ***Jane Higgs,*** *Ergonomist, Birmingham Women's and Children's NHS FT* ***Alice Hemesley,*** *Senior Staff Nurse, Birmingham Women's and Children's NHS FT*	*Pharmacy, Cleveland Clinic London* ***Nicolas Houghton,*** *Director of Nursing - Critical Care, Cleveland Clinic London* ***Tony Jamieson,*** *Clinical Improvement Lead, Medicines Safety Improvement Programme, NHS England and NHS Improvement*		
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	**Implementing the NHS medical examiner system – Where are we now?** • Revisit the objectives of the NHS medical examiner system and gain insight into developments so far • Hear from National Medical Examiner, Dr Alan Fletcher and find out the new system will make a difference to patient safety • Understand the opportunities the medical examiner system will create for patients and trusts • Learn how covid-19 has changed the work of medical examiners ***Dr Alan Fletcher****, National Medical Examiner, NHS England and NHS Improvement* ***Shaun Lintern,*** *Health Correspondent, The Independent and Patient Safety Congress Chair*				
16.45	**<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 ***Professor Rhona Flin,*** *Emeritus Professor of Applied Psychology, University of Aberdeen*
17.25 **18.00**	**End of day 1 - Networking drinks 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: Playing your part to eliminate racial discrimination to enhance patient care** • 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* ***Moi Ali,*** *Board Member, Professional Standards Authority and Chair and Trustee, Action Against Medical Accidents*
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 Paterson 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 Paterson'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* ***Kashmir Uppal****, Clinical Negligence Partner, Shoosmiths LLP* ***Shaun Gallagher****, Director of Strategy and Policy, General Medical Council* ***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 *Chaired by* ***Lawrence Dunhill****, Bureau Chief, HSJ*	**Delivering quality improvement on the frontline** *Chaired by* ***Helen Hughes,*** *Chief Executive, Patient Safety Learning* ***In association with Radar Healthcare***	**Re-examining safety for vulnerable people** *Chaired by* ***Lucy Watson,*** *Chair, The Patients Association*	**Recognising and responding to the deteriorating patient** *Chaired by* ***Lesley Durham,*** *President, 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** *Chaired by* ***Ian Lindsley****, Secretary, Safer Healthcare and Biosafety Network*
Room	**Charter 1**	**Exchange Hall**	**Charter 2**	**Exchange 9**	**Charter 3**
11.15	**Developing a system response to supply disruption to maintain patient safety** • Learn how partners in the	**Safety II in action: Spearheading a digital preventive approach to patient safety risks** • Find out what organisational	**Preparing for the rising tide: Revolutionising the delivery of mental health services to meet patient needs**	**11:15 - Welcome and opening remarks** **11.25 - Using a theoretical framework of behaviour change to develop a**	**Rolling out the first ever patient safety syllabus for NHS staff** Get an update on plans to roll out the NHS patient safety syllabus and training

	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* ***Janine Jolly**, Group Manager - Devices Safety and Surveillance, Medicines &*	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 ***In association with Radar Healthcare*** ***Paul Johnson**, Chief Executive, Radar Software*	• 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 programme in	**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 Nursing, City university of London* **11:40 - RRS/CCO Calls: Approaches to 'Not for Resuscitation': A perspective from the US**	programme for the entire workforce Find out how training will be quickly and effectively implemented across the workforce Learn how the syllabus will improve the transferability of skills across the NHS What it means for you and how it will help you identify the right approaches to reduce risk and protect patients ***Christian Brailsford**, Regional Head of Nursing and Midwifery and Senior Responsible Officer for Patient Safety, Health Education England* ***Matt Fogarty**, Deputy Director of Patient Safety (Policy and Strategy), NHS England and NHS Improvement*

	Healthcare Products Regulatory Agency ***Zoe Packman**, Head of Nursing, NHS England and NHS Improvement*	***Laura Walker**, Head of Patient Safety and Learning, Somerset NHS FT* ***Paula Wiggins**, Systems Manager, Safety Alerts Lead, Somerset NHS FT*	your own organisation to improve as experience for patients and families ***Andy Bell,** Deputy Chief Executive, Centre for Mental Health (speaking virtually)* ***Adam Drage,** Clinical Service Lead, Mersey Care NHS FT* ***Zoe Prince**, Associate Director of Nursing and Patient Experience, Mersey Care NHS FT* ***Christine Edwards,** Operational Manager, Integrated Response Hub, Northamptonshire, Northamptonshire Healthcare FT*	**(pre-recorded)** • 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**	**How the National Patient Safety Improvement Programmes are supporting safer care across the NHS**	**Protecting vulnerable patients from sexual abuse in mental health hospitals**	**12.10 - The role of outreach in post-intensive care support and its impact on mortality/ morbidity: The**	**<u>Workshop</u> Reforming regulation: developing new professional standards to deliver safe,**

	• 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 ***Professor Alison Leary,*** *Chair of Healthcare and Workforce Modelling*	• 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*** ***Phil Duncan,*** *Head of Patient Safety Improvement Programmes, NHS England and NHS Improvement* ***Cheryl Crocker,*** *Patient Safety Director, AHSN Network* ***Heather Pritchard,*** *Senior Programmes Lead (Improvement), NHS*	• 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 directly from patients and find out what they think needs to change in order to protect patients against sexual abuse in wards • Explore mechanisms and structures that have been put in place to enhance sexual safety in mental health wards and the impact this had on patients, families and the organisation as a whole.	**REFLECT study** *Chaired by* ***Professor Natalie Pattison,*** *Florence Nightingale Foundation Clinical Professor of Nursing University of Hertfordshire and East & North Herts NHS Trust, and* ***Lindsay Garcia,*** *Nurse Consultant Critical Care and iSRRS representative* • 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 – <u>Panel discussion</u>**	**compassionate care** • Join this GMC-led interactive workshop interactive workshop, to contribute to the flagship programme of work, reviewing Good medical practice • Explore themes such as: ○ Discrimination and health inequalities ○ Attitudes and skills required by medical professionals working in multidisciplinary environments ○ Challenges for professionals and patients arising from new technologies • Have your say and feedback on key changes that could be made to the professional standards ahead of public consultation in 2022

	, London South Bank University ***Professor Iain Moppett,*** *Professor of Anaesthesia & Perioperative Medicine, Honorary Consultant Anaesthetist, University of Nottingham* ***Amelia Newbold,*** *Risk Management Lead, Browne Jacobson*	*England and NHS Improvement*	Examine the wider challenges of sexual safety that still remain ***Tom Bell****, Author, Consultant and Founding Director, Honesty and Integrity in Public Sector Services* ***Dr Julie McGarry,*** *Lead for Domestic Abuse and Sexual Safety, Nottinghamshire Healthcare NHS FT (speaking virtually)* ***Emma Furlong****, Sexual Safety Lead in Forensics and Independent Sexual Violence Advisor, East London NHS FT*	**Being cared for by critical outreach teams: The patient experience as seen from the other side** ***Alison Phillips,*** *Patient Representative* ***Mandy Odell,*** *Nurse Consultant for Critical Care, Royal Berkshire NHS FT* ***Dr Chris Subbe****, Consultant Physician, NHS Wales, Bangor University and Improvement Science Fellow, The Health Foundation* ***John Welch****, Nurse Consultant, University College London Hospitals FT* ***Dr Isabel Gonzalez****, Chair, The National Outreach Forum* **12.45 – Q&A**	***In association with General Medical Council*** ***Tista Chakravarty-Gannon****, Head of operation in Outreach Development and Support Operations, General Medical Council*
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	**What good really looks like: How to be a safe maternity unit** • Identify the behaviours and practices that are features of safe care in	**Debate – Exploring the most effective approach to protecting patients' living with covid-19** • Gain insight into the second	**14.00 - The Critical Care Outreach Practitioner National Credential & Competency Framework**	**Sustaining the digital revolution to build a smarter, safer NHS** • Gain insight into the benefits of re-designing organisational structures to

	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 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*	hospital-based maternity units and how you can make these features a reality • Hear examples from organisations that have enhanced maternity care over the last year and the impact this has had on mothers and babies • The future direction of safety in maternity care as the system recovers and continues to transform ***Roxanne Burrows,*** *Patient Representative* ***Professor Mary Dixon-Woods,*** *Director, THIS Institute and Professor of Healthcare Improvement Studies, University of Cambridge* ***Joselle Wright,*** *Consultant Midwife, University Hospitals Birmingham NHS FT*	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 how the current approach to long-covid can be improved to avoid patient harm and deterioration ***Monique Jackson,*** *Patient Representative (speaking virtually)* ***Dr Elaine Maxwell,*** *Scientific*	• 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, International Society for Rapid Response Systems (iSRRS)* *Chaired by* ***Professor Tracey Moore****, Dean of the Health Sciences School and Faculty Director of Engagement and Development, University of Sheffield and* ***Emma Lynch****, Critical Care Outreach Advanced Practitioner University Hospitals Birmingham and NOrF Board member* **14:15 - Frequency of Observations (FOBS) NIHR Project**	integrate digital and transform care delivery vs. making small improvements to existing ways of working • Share learnings from the move to digital-first primary care and find out what impact this had on both staff and patient safety • Address the remaining barriers of integrating technology across the system • Striking the right balance between humans and technology to avoid over-reliance on automation • Learn what steps you can take to ensure patient safety is sustained through virtual or hybrid models of care ***Dr Minal Bakhai,*** *GP and Clinical Director of Digital First Primary Care NHS England and NHS Improvement*

			Advisor, National Institute for Health Research ***Dr Jo House,*** *Research Lead, Global Environmental Change Theme, University of Bristol* ***Lt Col Mark Cranley,*** *Consultant in Rehabilitation Medicine, Defence Medical Rehabilitation Centre* *Chaired by* ***Claire Hastie,*** *Patient Advocate*	• 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? • Clinician and patient perspectives • Wireless monitoring at scale	***Kelsey Flott****, Deputy Director of Patient Safety, NHSX* ***Michael Smith,*** *Chief Officer, Bolton GP Federation*

				***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 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	**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 what is being done to ensure that patient safety considerations are at the heart of this process • National plans to approach the backlog efficiently and systematically, risk stratifying by clinical need and planning for increased demand in specific areas • Hear examples of how patients are engaged in	**Reducing restrictive interventions and human rights breaches for vulnerable people** • Reducing restrictive interventions and human rights breaches for vulnerable people • Examples from trusts who have implemented strategies to reduce physical restraint and the impact this has had on the patient experience • How the national Mental Health Safety Improvement Programme is working to reduce the incidence of restrictive practice in	**15:20 - The best of the abstracts: Presentations by members of iSRRS & NOrF** *Chaired by **Lesley Durham,** President Elect, International Society for Rapid Response Systems (iSRRS) and **Professor Natalie Pattison**, Chair, the National Outreach Forum* **15:20 - Presentation 1: Supporting domiciliary carers to identify deterioration using a softer signs tool** ***Sarah Fiori**, Head of Quality Improvement & Research, Vale of York* **15:30 - Presentation 2: Is NEWS2 old news? A review of physiological deterioration prior**	**Innovation in safety: Launching the first NHS Digital Clinical Safety Strategy** • Gain insight into the priorities of the first Digital Clinical Safety Strategy • Find out how it will drive forward digital safety by ensuring the right strictures and processes are embedded across the system • How the Strategy will gather the best intelligence about digital safety and create feedback loops for continuous learning • Enhancing training for digital clinical safety and ensuring digital inclusion for staff and patients • Explore new opportunities for

	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*	the process of prioritisation. What more needs to be done to mitigate the risks to patients with longer waits for care and treatment? • Understand how the approach to tackling the backlog is being coordinated at a national level to ensure policy and delivery alignment. Is the right information being made available about patient treatment and categorisation in priority decisions being taken? • Take away strategies that can help minimise further risks to patients and allow for the safe restoration of elective services ***In association with BD*** ***Dr Jugdeep Dhesi,** Deputy Director, Centre for Perioperative Care and Consultant Physician in Geriatrics and General Medicine,*	inpatient mental health and learning disability services • Understand how this will impact your organisation and what changes you can make to improve safety across mental health and learning disability inpatient services ***Dr Jennifer Kilcoyne,** Clinical Director and Deputy Chief Clinical Information Officer, Mersey Care NHS FT* ***Dr Helen Smith,** Consultant Forensic Psychiatrist and National Clinical Advisor to the Mental Health Safety Improvement Programme* ***Kevin Hunter,** Associate Director for Patient Safety, West of England Academic Health Science Network*	**to adult cardiac arrest at an acute NHS Trust in Essex** ***Matthew Ibrahim**, Lead Resuscitation Practitioner, The Princess Alexandra Hospital NHS Trust* **15:40 - Presentation 3 - A multi-disciplinary quality improvement project to improve the recognition and escalation of patients with Acute Kidney Injury (AKI) spanning primary, community, acute hospital, and end of life care** ***Sharon Harrison**, Practice Development Team Lead, Northumbria Healthcare NHS Foundation Trust* **15:50 - Presentation 4 - (Pre-recorded) The workload involved in patient monitoring & responding to deteriorating patients: An experience from New Zealand** ***Ehsan Ullah,** School of Public*	digital to improve patient safety issues and find out what this means for your organisation ***Kelsey Flott**, Deputy Director of Patient Safety, NHSX*

		Guys and St Thomas' NHS FT (speaking virtually) ***Kamal Mahawar,*** *Consultant General/ Bariatric Surgeon and NatSSIP Lead, South Tyneside and Sunderland NHS FT and Visiting Professor, University of Sunderland* ***Annie Hunningher,*** *Consultant in Anaesthesia at Barts Health NHS Trust*		*Health & Interdisciplinary Studies, Faculty of Health, Auckland University of Technology* **16.00 - Q&A and Certificates**	
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* ***Alison Phillips****, Patient Representative* ***Dr Lauren Morgan,*** *Human Factors Lecturer, Quality, Reliability, Safety and Teamwork Unit, Patient Safety Academy, University of Oxford*				

	Dr Mark 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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