HSJ PATIENT SAFETY CONGRESS

15-16 September 2022 | Manchester Central, Manchester

POSITIONING PATIENT SAFETY AT THE CORE OF SYSTEM RESET TO TRANSFORM STANDARDS OF CARE

Day 1 – Thursday 15 September	
8:00	**Registration opens**
9.10	**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*
9.20	**Keynote panel** **Why aren't we learning from past mistakes? Breaking the cycle of repeat errors to advance the safety agenda** • Identify long-standing barriers to change and discuss the underlying factors in healthcare that make it hard to implement key learnings and make real progress • Debate the effectiveness of national reports and enquiries • Re-thinking our approach to safety issues - focusing on really understanding the problem before coming up with solutions to ensure long-term sustainability and safety • Discuss practical ways you can break down barriers to improvement in your organisation ***Professor Mary Dixon-Woods**, Director and Professor of Healthcare Improvement Studies, THIS Institute and University of Cambridge* ***Professor Ted Baker**, Former Chief Inspector of Hospitals* ***Professor Sir Robert Francis QC,** Chair, Healthwatch England* ***Shaun Lintern**, Chair, Patient Safety Congress and Health Correspondent, The Independent*
10.05	**Keynote panel** **Putting an end to gender bias in medicine and research: Key considerations and developments in women's health** • Hear from a female patient on here experiences with surgical mesh and the challenges faced as a woman navigating the health system • Consider the recurring theme from personal testimonials and healthcare scandals in recent years, that women's voices and patient safety concerns are being ignored or dismissed • • Address the lack of transparency around the risks of medicines and medical devices • The need to discuss both benefits and risks of investigations and medication • Ending the culture of doctor knows best- Is there a clash of values between medical paternalism and patient autonomy?

	Professor Marian Knight, *Professor of Maternal and Child Population Health, University of Oxford* ***Shaun Lintern****, Chair, Patient Safety Congress and Health Correspondent, The Independent*				
10.45	**Meet our Partners / Refreshment break** Head over to the Exhibition Hall to catch up with our partners and find out what solutions they can offer to help meet your patient safety challenges. Tea, coffee and refreshments available. **Outpatients' department** This is an opportunity for you to meet the speakers and ask your questions				
	Building a safe culture *Chaired by* ***Professor Murray Anderson-Wallace,*** *Visiting Professor,* ***Health Systems Innovation Lab London South Bank University***	**Human factors** *Chaired by* ***Martin Bromiley OBE,*** *Founder, Clinical Human Factors Group and* ***Professor Chris Frerk,*** *Chair, Clinical Human Factors Group* ***In association with BD*** BD	**Patient safety in non-acute settings**	**Patient and family engagement** *Chaired by* ***Rachel Power,*** *Chef Executive, The Patients Association*	**Supporting our workforce** *Chaired by* ***Annabelle Collins,*** *Senior Correspondent, HSJ*
11.30	**Humanising harm: Using a restorative approach to heal and learn from adverse events** • Explore how current investigative responses can increase harm for all those affected, by neglecting to respond to the human impacts • Understand how the risk of harm can be reduced if investigations respond to the need for healing alongside system learning (with the former having	**Human factors challenges for the safe use of artificial intelligence in patient care** • Learn about the incorporation of AI-supported services in clinical practice and the benefits it has on patient care • Find out what human factors challenges are likely to emerge with the collaboration of humans and AI in clinical processes • Finding the right balance between humans and	**Restart a Heart: Optimising survival rates through rapid response to out-of-hospital cardiac arrests** • Hear directly from an athlete who suffered a cardiac arrest and how the immediate response from medical staff saved his life • Gain insight into the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) • Learn about a clinician-led	**Assessing quality of care in the home: Ensuring patients and families have the tools to safely self-manage** • How covid-19 has challenged perceptions around what patients can or should do – causing a major shift towards self-management at home • Assess the situational variables that could present risks to patients • Understand the type of training and resources	**Behind the brave face: Normalising human emotions at work and coping with the ups and downs** • Hear about research carried out on staff wellbeing and what the results show about staff experiencing conflicting emotions due to not being able to achieve consistently high standards of care • It's ok not to be ok: Creating an environment that reassures staff when feeling low or distressed

	been consistently neglected) • Debate why incident responses should be conceived within a relational as well as regulatory framework and how this can radically shift the focus, conduct and outcomes of patient safety investigations • Identify the preconditions and mechanisms that enable the success of restorative approaches in global health systems	technology to avoid over-reliance on automation which can lead to errors ***In association with BD***	quality improvement initiative around prompt CPR to improve patient outcomes • Join a practical workshop on CPR training across the 2-day Congress to learn how to respond in life-threating situations ***Dr Alison Tavaré****, Clinical Lead, NHS@Home SW and Primary Care Clinical Lead, West of England Academic Health Science Network* ***Marisa Mason****, Chief Executive, NCEPOD* ***Professor Andy Lockey,*** *President of Resuscitation Council UK*	required for patients, families and clinicians to effectively identify and prevent potential risks in the home • Hear examples of tools and training available that enhance safety in the home ***Jono Broad,*** *Senior Manager for Co-Production and Patient Experience, Lead for the Integrated Personalised Care Team, South West Regional Team, NHS England and NHS Improvement*	• Practical advice and steps you can take related to psychological first aid to understand what's really going on under the 'brave face' • Current trends around wellbeing – what does the data show and where do we go from here? ***Maria Paviour****, Occupational Neuropsychologist, Author and Founder of Wellbeing with Cari and the NeuChem Coaching Model*
12.20	**Time to move between sessions**				
12.25	**Rooting out racism from organisational cultures to enable progress on healthcare staff inequities** *Discuss the findings of the study which conclude that tackling staff inequalities is marred by a culture of racism embedded in the NHS, which sustains such inequalities* • Address reasons why we have ended up with a culture of high	**Examining errors that contribute to death or serious harm: A human factors perspective** • Hear about Beth's Story from Clare Bowen, mother of Bethany who died during routine surgery • How and why: Understand the multiple human factors and medical errors that lead to Bethany's death	**Achieving true integration: Valuable lessons from mature integrated care systems outside England** • Take a closer look at the Scottish and Welsh integrated care models and explore specific lessons you can take away from their approaches to partnership working • How advanced levels of	**What does true co-production look like? The impact of patient input and involvement on quality improvement** • Hear how the involvement of patients helped challenge trusts to think differently about safety initiatives based on their own experience using the health service • Discuss and share approaches you	**Beds, backlog and bureaucracy: Aligning national strategies with local realities for a safe system reset** • Hear perspectives from frontline clinicians on how dealing with continued service disruption and uncertainty is impacting staff and patient safety • Discuss and share practical recommendations for making patient safety a priority as

	diversity but low inclusion for racial and ethnic minority healthcare staff • Identify ways to start breaking down racist structures in your organisation that are preventing change and progress • Take back recommendations and practical actions you can begin to implement to eliminate inequalities in the workplace	• Hear perspectives from a trust CEO on what the death of a patient taught him about human factors • How to change defensive organisational behaviours, with emphasis on learning rather than denial • Share strategies and examples to ensure complete transparency and candour when things go wrong to achieve true restorative justice for families involved • Take away strategies you can implement to reduce the incidence of similar errors ***Clare Bowen,*** *Patient Representative and Trustee, Clinical Human Factors Group* ***Professor Joe Harrison,*** *Chief Executive, Milton Keynes University Hospital NHS Foundation Trust*	integration significantly enhanced patient safety, especially against the backdrop of covid-19 • Find out what initial challenges these systems faced when starting their integration journey, as well as key elements required for ICSs to succeed	can take to attract patient partners, and understand what training, support and conditions are required to enable meaningful co-production • Hear successful examples from trusts that involved patient partners in QI projects and assess the positive impact on patient safety and staff experience • Key takeaways: Take back strategies to help you involve patients as partners in your work to help shape and influence improvements in your organisation ***Deborah Tighe,*** *Partner Manager, Leeds Teaching Hospitals NHS Trust* ***Dr Anna Winfield,*** *Patient Safety & Quality Manager and Specialty Doctor in Elderly Medicine, Leeds Teaching Hospitals NHS Trust*	the systems recovers • Share strategies and case studies on how patients and families can be involved in system redesign led by clinicians
13.15	**<u>Lunch break in Exhibition Hall</u>** **<u>Outpatients' department</u>** This is an opportunity for you to meet the speakers and ask your questions				

14.15	**Tackling discrimination and inequality in medicine** *We know that inclusive workplaces are crucial for both staff wellbeing and for patient safety. So why are so many still experiencing discrimination and what can we do to change it?* In this interactive session we will: • Reflect on the impact of discrimination in medicine • Consider how cultures aid discrimination at work • Explore the work the GMC is doing to tackle inequality issues • Identify what you can do locally to create a more inclusive culture, including resources and support available to you ***In association with the GMC***	**Challenges and possibilities of integrating human factors and ergonomics into healthcare** • Hear from experts on the current barriers and opportunities of bringing human factors into the health system • Discuss ways you can get past system and cultural issues to operationalise human factors thinking • Hear different perspectives on the system from each speaker, whilst also learning from their shared thinking to help you incorporate human factors in your organisation ***Dr Tracey Herlihey,*** *Head of Patient Safety Incident Response Policy, NHS England and NHS Improvement* ***Professor Chris Frerk,*** *Chair, Clinical Human Factors Group* ***Professor Paul Bowie,*** *Programme Director (Safety & Improvement), NHS Education for Scotland*	**<u>Debate</u>** **Rolling out virtual wards at scale: A risk to patient safety?** • Outcomes from the national covid-19 oximetry implementation across the UK so far and impact on staffing pressures and patient safety • Address lessons learnt so far and discuss patient safety concerns around plans to roll out virtual wards at scale and pace • Issues around workforce capacity and how this will impact the implementation of virtual wards as well as patient safety	**Positive family engagement and involving families well: Impact on the system and patient safety** • Families are often 'managed' rather than treated as central to the investigation process, despite holding key information • Helping you gain a better understanding of the outcomes which families feel are important after an incident involving serious harm or death • Improving your learning and your confidence around the delivery of the Duty of Candour with a greater understanding of how this affects families • The crucial involving of families in a compassionate manner in all care from first contact and as an essential part of the investigation process. • Giving you a more in-depth understanding of involving families positively achieves better care and	**Prioritising care in the face of service disruption: The impact on staff and patient safety** • Assess the psychological impact on staff who have to make ethically challenging decisions when prioritising care between patients, sometimes resulting in delayed treatment or avoidable harm • Address how departing from established care procedures during covid-19 has challenged professional values, knowing that usual standards of care cannot always be achieved • Practical steps leaders can take to ensure staff are able to make difficult decisions with consistency and clarity, keeping patient safety as the primary focus • Find out what is being done at national level to help staff get back to usual standards of care once pressures ease

				better investigations for everyone ***Rosi Reed**, Training Coordinator, Making Families Count* ***Frank Mullane MBE**, Member, Making Families Count* ***Stephen Habgood**, Director, Making Families Count*	
15.05	**Time to move between sessions**				
15.10	**<u>Panel discussion</u> Balancing no-blame with accountability: Playing your part by speaking up to create a health system that owns up to error** • Address issues around blame and defensiveness as key contributors to the lack of safety progression over the past decades • Debate why defensiveness remains a core issue within the system and understand what factors are preventing a shift in culture, at both national and local level • Practical, initial strategies for leaders to build a psychologically safe environment, that encourages transparency and	**Being proactive to uncover unknown risks and reduce never events** • Learn about a common never event involving a nasogastric tube and why it is also a national issue • Hear about the post-incident investigation process which resulted in no findings of care gaps or staff errors • The importance of being proactive and inquisitive and how this resulted in identifying previously unknown gaps • Learn how one trust is evaluating all PH strips on the market in order to adopt the best device and minimise error	**Improving outcomes and experiences of patients discharged from mental health hospitals** • Hear from a mental health service user who experienced difficulties when discharged due to no plan being put in place • Gain insight into the factors and challenges that prevent mental health hospitals from providing a seamless discharge experience for patients • Find out about a research study led by a patient, working together with trusts to improve outcomes for patients being discharged from mental health hospitals	**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 • 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	**Preparing for a digital future: Striking the balance between staff skills and technology** • Get an update on national plans to drive digital transformation across the NHS • Debate the importance of clinician involvement when integrating digital products to ensure the right balance between staff skills and technology to sustain patient safety • Hear from digitally advanced organisations on how to avoid over-reliance on automation and ensure staff are confident with rapidly changing ways of working

	honesty amongst staff • Responding to error: Learn how you can ensure staff are held responsible for mistakes without blame or fear of reprisal • Understand the impact this will have on patient safety through the prevention of repeat errors ***Jasvinder Sohal*** *Chief People Officer, Solent NHS Trust* ***John Walsh,*** *OD Lead / Freedom To Speak Up Guardian, Leeds Community Healthcare NHS Trust* ***Tom Bell,** Author, Consultant and Founding Director, Humanity and Integrity in Public Sector Services*	• How this work has resulted in new guidelines that openly acknowledge the gaps in the system with the aim of preventing incidents ***Karl Emms,*** *Lead Nurse for Patient Safety, Birmingham Women's and Children's NHS FT*	• Hear how they have co-produced a new support package and toolkit for discharge which can be applied and adapted to the discharge process and understand how this will positively impact patient safety and the patient experience ***Sarah Rae**, Patient Representative* ***Dr Jon Wilson,*** *Consultant Psychiatrist, Norfolk and Suffolk NHS Foundation Trust* ***Professor John Clarkson**, Professor of Engineering Design, University of Cambridge and Professor of Healthcare Systems, Delft University of Technology*	enhance the patient and family experience	
16.00	**<u>Meet our Partners / Refreshment break</u>** Head over to the Exhibition Hall to catch up with our partners and find out what solutions they can offer to help meet your patient safety challenges. Tea, coffee and refreshments available. **<u>Outpatients' department</u>** This is an opportunity for you to meet the speakers and ask your questions				
16.30	**<u>The James Reason Lecture</u>** **Planning for the unthinkable: Responding to catastrophe in a healthcare setting** • Hear from Professor Lucy Easthope, the UK's leading authority on disaster management and recovery • Get a look behind the scenes at some of Lucy's work on major disasters, including 9/11, the 7/7 bombings, the Indian Ocean tsunami and covid-19				

	• Find out how healthcare systems should plan for disasters and the aftermath, prioritising emergency planning, compassion and putting those affected at the heart of arrangements • Assess why and how things go wrong in disaster management and what you can do to prevent repeat errors • Key considerations and takeaways: Short-term and long-term actions you can implement at local level ***Professor Lucy Easthope**, UK Leading's Authority on Recovering from Disaster, Professor in Practice of Risk and Hazard, University of Durham and Fellow in Mass Fatalities and Pandemics at the Centre for Death and Society, University of Bath*
17.10 - 18.00	**End of day 1 - Networking drinks reception in Exhibition Hall**

Day 2 – Friday 16 September					
8.45	**Chair's welcome and opening remarks** • Reflect on the key learning points from yesterday's sessions • Look ahead to today's topics • Find out the winner of the Patient Safety Congress Poster Competition ***Shaun Lintern,*** *Health Correspondent, The Independent, and Patient Safety Congress Chair*				
9:00	**Keynote panel** **Are we losing sight of what good looks like? Reversing the impact of normalised deviance on patient safety** • Explore the systematic conditions and flaws that set up good people to fail and the long-term effect this has on patient care when behaviours do not change • The importance of a top-down approach, ensuring good practice is carried out and followed through by leaders to embed a strong safety culture across the entire organisation • Discuss and share actions you can implement now to help identify and manage unsafe practices and behaviours before they become normalised and pose risks to patient safety, quality care, and employee morale ***Professor Rebecca Lawton,*** *Professor in Psychology of Healthcare, University of Leeds and Director, NIHR Yorkshire and Humber Patient Safety Translational Research Centre*				
9.45	**Keynote** **Faster improvement of care: What can we learn from high performing NHS organisations?** • Asses the key features of high performing NHS organisations that offer good quality care • Discuss how these features can be developed and what timeframe is realistic to carry out these improvements • Find out what your organisation can learn in practice and what resources are available to support you ***Jennifer Dixon,*** *Chief Executive, The Health Foundation*				
10.15	**Meet our Partners / Refreshment break** Head over to the Exhibition Hall to catch up with our partners and find out what solutions they can offer to help meet your patient safety challenges. Tea, coffee and refreshments available. **Outpatients' department** This is an opportunity for you to meet the speakers and ask your questions				
	Governance and regulation *Chaired by* ***Rosi Reed,*** *Training Coordinator, Making Families Count*	**Clinician-led innovation**	**Safety for vulnerable people** *Chaired by* ***Annabelle Colling,*** *Senior Correspondent, HSJ*	**The deteriorating patient** *Chaired by* ***Lesley Durham,*** *President, International Society for Rapid Response Systems (iSRRS)*	**Women's healthcare** *Chaired by* ***Susanna Stanford****, Patient Advocate*

11.00	**What does a good patient safety investigation look like?** • Learn about the new Patient Safety Incident Response Framework (PSIRF) • Understand the importance of overseeing system structures and processes to drive the right behaviours • Hear from early adopters of PSIRF and gain insight specific learnings from the pilot • Get advice from early adopters on how best to prepare for the implementation of PSIRF in your organisation ***Dr Lauren Morgan,*** *Human Factors Lecturer, Quality, Reliability, Safety and Teamwork Unit, Patient Safety Academy, University of Oxford* ***Donna Forsyth,*** *Director, Patient Safety Science*	**Unleashing local innovation: Fine-tuning the efficiency of systems and services by giving clinicians freedom to innovate** • The value of listening to the experiences of frontline staff who and using this to inform the re-design of services and changes in policies to improve patient care • Hear about innovative initiatives led by healthcare professionals and assess the impact this had on patient safety • Address the need to encourage staff to take positive risks, with patient safety at front of mind, and debate how this could transform the delivery of care	**Revolutionising the delivery of mental 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	**Listening to families' Call 4 Concern to prevent patient deterioration and avoidable deaths** • Hear from patient representatives whose concerns were ignored, leading to rapid deterioration and suicide • Taking family concerns more seriously as those who know the patient best • Learn how the Call 4 Concern initiative provides patients and families with more choice about who to consult about their care and facilitates the early recognition of patient deterioration	**Tackling Gaps in Patient Safety in Maternity: Embedding a Learning Culture** • Are we training the frontline in themes that relate to avoidable harm? • Overcoming barriers to a learning culture: a frontline perspective • Listening to families effectively
11.50	**Time to move between sessions**				
11.55	**Is anybody 'Learning from Deaths'? – Implementing safety improvements based**	**The creation of the Patient Safety Managers Network: Set up by staff, for**	**Reducing health inequalities for people with learning disabilities: Looking**	**Dying with dignity: Innovative end of life care models**	**The systematic dismissal of women's safety concerns and it's**

	on a review of the national LFD Programme • Analysis of national statutory reporting within the NHS in England 2017-2020 • Understanding what 'Learning' and 'Actions' have occurred • A review of how trusts have assessed the impact of their actions • Hear examples of how trusts are engaging with and involving families in their LfDs work • Recommendations for how the LfDs programme can be developed and implemented further and what this means for your organisation ***Dr Zoe Brummell**, Anaesthetic and Intensive Care Medicine Specialist, University College London Hospitals NHS Foundation Trust* ***Dorit Braun**, Patient Representative* ***Dr Emma Rowland,** A&E Consultant, Homerton University*	**staff to help spread safety innovation** • Learn about the fast-growing Patient Safety Managers Network, set up by staff, and the motivation behind it • Understand how members of the network are working to break down barriers to improvement by sharing best practice between trusts • Discuss the impact of communicating with peers in similar roles regarding patient safety challenges and innovation • Find out what the network has achieved so far and how it supports the implementation of best practice across 82 different trusts • Assess the impact of the network on patient safety so far and future plans to continue sharing learning ***Claire Cox**, Patient Safety Lead, King's College Hospital NHS Foundation Trust*	**beyond the disability to improve safety** • Recognise the dangers of diagnostic overshadowing with LD patients and hear examples of avoidable patient harm caused as a result • Find out what you can do to prevent diagnostic overshadowing – hear about the RCP Acute Care toolkit for people with learning disabilities • Take back practical, reasonable adjustments you can make in your organisation to enhance safety for patients • Learn about how addressing inequalities can be embedded as a golden thread to help drive improvement" ***Scott Riley**, South West Inclusion Health Lead, NHS England and NHS Improvement (South West)* ***Hilary Gardener**, Strategic Liaison Nurse for Adults with*	• Understand the challenges practitioners face in ensuring a good death for dementia patients • Learn about innovative heuristics approaches which aim to better equip and train clinical staff on palliation and end of life care for patients • Discover how these approaches can be applied and evaluated in other areas of end-of-life care for people living with other critical conditions	**contribution to avoidable harm** • Hear from patients who were not informed of the risks of taking sodium valproate and the harm this caused to them and their families • Ending the culture of doctor knows best: Is there a clash of values between medical paternalism and patient autonomy? • Discuss why concerns raised by female patients are still being dismissed as 'women's problems', leading to avoidable harm • Learn from successful case studies on how to ensure full transparency when preparing women and girls of potential risks in an ethical and responsible way • Find out what is being done at national level to ensure the system listens and responds to concerns raised by female patients, putting patient voice at the centre of patient safety

	Hospital NHS Foundation Trust	***Jordan Nicholls**, Serious Incident, Governance and Quality Improvement Lead, Central and North West London NHS Foundation Trust* ***Jayne Addison,** Patient Safety and Risk Lead, The Christie NHS Foundation Trust* *Chaired by **Helen Hughes,** Chief Executive, Patient Safety Learning*	*Learning Disabilities - Primary Health, Hertfordshire County Council* ***Gavin Howcraft**, Expert by experience* *Chaired by **Dr Alison Tavaré**, Clinical Lead, NHS@Home SW and Primary Care Clinical Lead, West of England Academic Health Science Network*		***Emma Murphy.** Founder, Independent Fetal Anti Convulsant Trust (IN-FACT)* ***Janet Williams,** Founder, Independent Fetal Anti Convulsant Trust (IN-FACT)*
12.45	**Lunch break in Exhibition Hall** **Outpatients' department** This is an opportunity for you to meet the speakers and ask your questions				
13.30	**Keynote** **The road to zero: Eliminating unnecessary deaths in a post-pandemic NHS** • Hear from The Rt Hon Jeremy Hunt MP on how the NHS can reduce the number of avoidable deaths to zero, saving money, reducing backlogs and improving work conditions in the process • What is being done at national level to help make the switch from a culture of blame to a culture of learning in order to meet this goal • • Key considerations and takeaways to help you deliver the safest, highest quality care post-pandemic to achieve our own 1948 moment • Take this opportunity to ask questions and challenge our speakers via the event app ***The Rt Hon Jeremy Hunt MP**, Chair, Health and Social Care Committee and Former Health Secretary* ***Shaun Lintern**, Health Correspondent, The Independent, and Patient Safety Congress Chair*				
14.00	**Minimising the risks of extravasation** • Understand the volume of claims submitted relating to extravasation injury and the cost this has on patients and the system	**Advancing from 'requires improvement' to 'good' – Taking the next step in your improvement journey** • Hear from trusts who have gone from 'requires improvement' to 'good' by the CQC and find out what which areas they	**Managing the effects of Long-covid on staff to prevent human error** • Hear from frontline staff affected by Long-covid and get an understanding of how it is impacting their ability to carry	**Dying with dignity: Innovative end of life care models to ensure patients die well and safely** • Understand the challenges practitioners face in ensuring high quality end of life care for patients and support for families	**The first Women's Health Strategy: Redesigning the system to prioritise care on clinical need, not gender** • Learn about the government-led Women's Health Strategy in England as part of plans to level up health care

	• Hear from a trust that has implemented innovate ways to reduce the risk of extravasation injury • Get an update on national guidance and new recommendations	focused on to raise quality standards • Hear examples of inspirational projects from trusts that helped bridge the gap from 'requires improvement' to 'good' • Take back practical and relatable advice to help you in your own improvement journey ***Hayley Flavell,*** *Director of Nursing, The Shrewsbury and Telford Hospital NHS Trust* ***Dr Ruth O'Dowd****, Consultant Anaesthetist and Associate Medical Director Patient Safety and Quality Improvement, North Cumbria Integrated Care NHS Foundation Trust* *Chaired by* ***Dr Lauren Morgan,*** *Human Factors Lecturer, Quality, Reliability, Safety and Teamwork Unit, Patient Safety Academy, University of Oxford*	out daily roles safely • Share practical steps managers can take to effectively support staff experiencing symptoms of Long-covid • Recommendations and examples of how the current approach to long-covid can be improved to avoid harm and deterioration	• Hear about best practice studies and innovative approaches to end-of-life care which have ensuring high quality of care for patients and support for families • Take back practical advice and support to enable you to transform end of life care in different settings • Gain insight into the national framework for end-of-life care and how this can be translated into local action	• Get an update on key issues raised in response to a call for evidence to inform the government's approach to tackling gender health inequality • Find out how these insights will inform the upcoming Women's Health Strategy to create a healthcare system that prioritises care on the basis of clinical need, not gender
14.50	**Time to move between sessions**				
14.55	**Patient Safety Question Time** Join us for the closing keynote Q&A discussion and have your chance to ask questions to the panel of leading healthcare figures and patient safety experts. ***Dr Habib Naqvi MBE****, Director, NHS Race and Health Observatory*				

	***Rob Behrens**, Parliamentary and Health Service Ombudsman* ***Shaun Lintern**, Health Correspondent, The Independent, and Patient Safety Congress Chair*
16.00	**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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