### Day 1 Programme: Tuesday 4 July 2017

08:00 - Registration opens

09:00 - Exchange Hall
  - Welcome from Congress Chairs
  - Shaun Lintern, Patient Safety Correspondent, HSJ and Jenni Middleton, Editor, Nursing Times

09:10 - A new approach to learning from error
  - Keith Conradi, Chief Investigator, Healthcare Safety Investigation Branch (HSIB)

09:40 - A paradigm shift in patient safety?
  - Professor René Amalberti, Patient Safety Advisor, Haute Autorité de Santé

10:10 - 10:40
  - Networking break
  - Exhibition

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<tbody>
<tr>
<td>Stream Chair:</td>
<td>Martin Bromley OBE, Chair, Clinical Human Factors Group</td>
<td>Stream Chair: Jenni Middleton, Editor, Nursing Times</td>
<td>Stream Chair: Mike Durkin, Former Director for Patient Safety, NHS Improvement</td>
<td>Stream Chair: Shaun Lintern, Patient Safety Correspondent, HSJ</td>
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<tr>
<td>10:40 - 11:20</td>
<td>Leadership and lasting cultural change</td>
<td>Perspectives from international best practice</td>
<td>Governance, risk and compliance</td>
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10:40 - 11:40
  - Engaging the board to support human factors training and initiatives
  - Persuasively making the case for cost-effective human factors initiatives at a time of budget limitations
  - Applying human factors training across a system to achieve the biggest impact on patient safety
  - Using time and resources effectively
  - Nick Marsden, Chair, Salisbury NHS Foundation Trust
  - Cassandra Cameron, Policy Advisor – Quality, NHS Providers

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<thead>
<tr>
<th>11:25 - 12:15</th>
<th>Exchange 9</th>
<th>Exchange 10</th>
<th>Exchange Auditorium</th>
<th>Exchange 11</th>
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<tr>
<td></td>
<td>Human factors</td>
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<tr>
<td>New perspectives: Lessons from the rail industry</td>
<td>The squeezed middle: Supporting managers in healthcare</td>
<td>Quick-fire learning from Ireland and Wales</td>
<td>Learning from errors: A system-wide approach</td>
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<tr>
<td>• The rail industry, like healthcare, is a safety critical sector experiencing an unprecedented increase in demand</td>
<td>• Effectively addressing the impact of stress and burn out</td>
<td>• Applying lessons learnt from serious incidents to maintain safety as care pathways are redesigned</td>
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<td>• Find out how the sector has designed-in safety and designed-out risk whilst reducing costs</td>
<td>• Supporting managers functionally and emotionally</td>
<td>• Effectively utilising data from reporting to implement whole system safety</td>
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<td>• Discover how this can be applied in everyday healthcare settings</td>
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<td>• Sharing learning and insight across health and social care systems to ensure consistent safety standards across patient pathways</td>
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<tr>
<td>The impact of human factors: How the system and frontline can inadvertently create harm</td>
<td>Working resiliently, collaboratively and effectively at times of high pressure and strain on the system</td>
<td>Patient safety in maternity care: Safety initiatives for baby and mother</td>
<td>Staying compliant as our healthcare system changes at pace and scale</td>
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13:15 - 14:00
  - Edward Baker, Deputy Chief Inspector of Hospitals, Care Quality Commission
  - Ciara Kirke, Programme Lead, Rapid Response to Acute Illness Learning Set (RRAILS)
  - James Titcombe, Director, Datix
  - Jonathan Hazan, Director, Datix
  - Jane Reid, Clinical Director, Wessex Patient Safety Collaborative
  - Chris Hancock, Programme Lead, Patient Safety in Maternity Care:
  - Paul Leach, Lead Human Factors Specialist, Rail Safety and Standards Board
  - Joselyn Cornwell, Chief Executive, NHS Improvement
Day 1 Programme: Tuesday 4 July 2017

14:00 - 14:05  Time to move between sessions

14:05 - 14:15  Exchange 9
**Human factors**
- Partnering with human factors experts to “enable” throughout a whole organisation
  Nicola Maran, Associate Medical Director for Patient Safety, NHS Lothian

14:15 - 14:25  Exchange 10
**Leadership and cultural change**
- An open culture and incident reporting
  Chris Lake, Professional Leadership Coach

14:25 - 14:35  Exchange Auditorium
**International best practice**
- Preparing national health systems for aging populations and complex healthcare needs
  Umesh Prabhuj, former Medical Director, Wigan & Leigh NHS Trust
- Patient Safety Alerts – a window into safety leadership?
  Jonathan Hazan, Director, Datix

14:35 - 14:45  Exchange 11
**Governance, risk and compliance**
- Don’t forget to download the app to create your own schedule of sessions

14:45 - 15:05  Networking break

15:05 - 15:15  Exhibition

Exchange 9: Human factors
- Why haven’t I achieved safer care yet?
  - What we’ve tried and how it went: a helicopter view
  - Why is it so hard?
  - A model for success in the current environment
  - What we may have missed: a possible game-changer
  Peter McCulloch, Professor of Surgical Science and Practice, University of Oxford

Exchange 10: Leadership and cultural change
- Co-producing safety: Learnings from a patient’s experience
  - Addressing the nature of the doctor-patient relationship in a complex healthcare environment
  - Communication as a clinical skill
  - Considering ethical and statutory thresholds for Duty of Candour
  Susanna Stanford, Patient Representative

Exchange Auditorium: International best practice
- Providing safe care across multiple settings in an ever-changing health care environment
  - Developing an adaptive and robust way to measure and mitigate safety risks
  - Reducing errors and avoidable harm across the ambulatory, hospital and home settings
  Paul Ridout, Partner, Ridouts Professional Services Plc

Exchange 11: Governance, risk and compliance
- Have we got the right approach to regulating safety in the NHS?
  - A model for success in the current environment
  Scott Morrish, Patient Representative

15:15 - 15:25  Networking break

**The Francis Inquiry: How far have we come?**
- Sir Robert Francis QC

**The right approach to regulating safety in the NHS?**
- Scott Morrish, Patient Representative

**Preparing national health systems for aging populations and complex healthcare needs**
- Professor René Weichselbraun, Vice President, The Swedish Association of Midwives
Elinore Macgillivray, National Programme Lead, OBS Cymru

15:55 - 16:05  Time to move between sessions

16:05 - 16:15  Exchange Auditorium: University of Oxford
**Don’t forget to download the app to create your own schedule of sessions**

**Human factors**
- What we may have missed: a possible game-changer
  Peter McCulloch, Professor of Surgical Science and Practice, University of Oxford

**Leadership and cultural change**
- Comparing approaches in countries with rapidly aging populations
  Professor René Weichselbraun, Vice President, The Swedish Association of Midwives

16:35 - 16:45  Exchange Auditorium: University of Oxford
**International best practice**
- Developing the patient’s insight story about experiencing harm and working with the practitioner involved
  Jonathan Hazan, Director, Datix

16:45 - 16:55  Exchange Auditorium: University of Oxford
**Governance, risk and compliance**
- Developing the ability to forgive as a way to learn from failing
  Kathryn Walton, Patient Representative

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## Day 2 Programme: Wednesday 5 July 2017

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>08:00</td>
<td>Registration opens</td>
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<tr>
<td>08:30 - 09:00</td>
<td>Exchange Hall Enabling our workforce: Safe staffing and multi-disciplinary working</td>
</tr>
<tr>
<td>09:00 - 10:45</td>
<td>Exchange 9 From safety initiatives to safety systems</td>
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<tr>
<td>09:45 - 11:00</td>
<td>Exchange 11 Finding efficiencies while enhancing safety</td>
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<td>10:00 - 11:45</td>
<td>Exchange 10 Clinical excellence and quality improvement</td>
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<tr>
<td>10:45 - 11:15</td>
<td>Stream Chair: Vikkie Nelson, Programme Director, Sutton Homes of Care Vanguard</td>
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<tr>
<td>11:15 - 12:00</td>
<td>Stream Chair: Peter Lachman, Chief Executive, ISQua, Haelo</td>
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### Implementing Safe Staffing Guidance

**Designing and implementing whole system safety**
- An evident based approach to safe staffing
- Embedding systems and processes to determine what is safe, effective and sustainable staffing
- Developing whole system approaches to patient safety
- Exploring how the STP process will impact the safety culture in the NHS

**Achieving zero:**
- A holistic approach to tackle pressure ulcers
  - Errors and discrepancies in intravenous infusion practices: results from the first UK wide study
  - The differences in work-as-imagined and work-as-done
  - To DERS or not to DERS: that is the question

**Stream Chair**: Vikkie Nelson, Programme Director, Sutton Homes of Care Vanguard

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<td>10:20 - 11:00</td>
<td>Exchange Hall Enabling our workforce: Safe staffing</td>
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<tr>
<td>11:00 - 11:30</td>
<td>Stream Chair: Josie Rudman, Director of Nursing, Papworth Hospital NHS Foundation Trust</td>
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<tr>
<td>11:30 - 12:00</td>
<td>Stream Chair: Hein Le Roux, Deputy Chair, Gloucestershire CCG and Primary Care Patient Safety Lead, West of England AHSN</td>
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### Safe, kinder – improving end of life care by all staff for all patients

- Transforming practice and supporting multi-disciplinary teams with the with the knowledge, skills and, most importantly, the confidence to tackle the sensitive topic of end of life care

**Clinic**: Vickie Nelson, Programme Director, Sutton Homes of Care Vanguard

### Best practice case study: Utilising multi-disciplinary working to achieve a step reduction in Cardiac Arrest calls

- Managing the impact of overcrowding and delays in care on patient safety throughout the hospital
- Ensuring basic care is delivered well in time of crisis
- Balancing capacity and competing demand for beds

**Clinic**: Vickie Nelson, Programme Director, Sutton Homes of Care Vanguard

### A whole hospital approach to safety

- Managing the impact of overcrowding and delays in care on patient safety throughout the hospital
- Ensuring basic care is delivered well in time of crisis
- Balancing capacity and competing demand for beds

**Clinic**: Vickie Nelson, Programme Director, Sutton Homes of Care Vanguard

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### Stream: Mark Radford, Director of Nursing – Improvement, NHS Improvement

- Improving the flow and enhancing patient outcomes in ED
- Exploring new solutions in technology and information sharing to support ED staff to deliver safe care

### Stream: Vickie Nelson, Programme Director, Sutton Homes of Care Vanguard

- **Best practice case study:** Reducing omissions, errors and delays in medication administration
  - Increasing the number of in-patients who receive medication on time by 30%

### Stream: Peter Lachman, Chief Executive, ISQua

- **Improving the flow and enhancing patient outcomes in ED**
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<td>11:30</td>
<td><strong>Ministerial Address</strong></td>
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<td>11:30</td>
<td><strong>Rt Hon Jeremy Hunt MP, Secretary of State for Health</strong></td>
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<td>12:15</td>
<td>Whole system safety at a time of change</td>
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<td>12:15</td>
<td><strong>Jim Mackey, Chief Executive, NHS Improvement</strong></td>
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<td>12:15</td>
<td><strong>Sir David Behan, Chief Executive, CQC</strong></td>
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<td>Networking lunch break</td>
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<td>Exhibition</td>
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<td>14:00</td>
<td><strong>Exchange Hall</strong></td>
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<td>14:00</td>
<td>James Reason Annual Lecture</td>
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<td>14:00</td>
<td><strong>Sir Liam Donaldson, Envoy for Patient Safety, World Health Organisation (WHO)</strong></td>
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<tr>
<td>15:00</td>
<td>Poster competition: Overall winner announced</td>
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<td>15:15</td>
<td><strong>Jenni Middleton, Editor, Nursing Times</strong></td>
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<td>15:15</td>
<td>Closing remarks from Chairs</td>
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<td>15:15</td>
<td><strong>Shaun Lintern, Patient Safety Correspondent, HSJ and Jenni Middleton, Editor, Nursing Times</strong></td>
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