Patient Safety Congress Draft Programme
At a time of change, keep safety and quality a central focus
4 – 5 July – Manchester Central, Manchester

Day 1 – 4 July 2017				
08:00	Registration opens			
09:00	Welcome from conference 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	**Morning break in exhibition hall**			
	Stream 1: A how to guide: Applying human factors to everyday working **Martin Bromiley OBE**, Chair, **Clinical Human Factors Group**	**Stream 2: Leadership and lasting cultural change** **Jenni Middleton,** Editor, **Nursing Times**	**Stream 3: Perspectives from international best practice** **Mike Durkin,** Director for Patient Safety, **NHS Improvement**	**Stream 4: Governance, risk and compliance** **Shaun Lintern,** Patient Safety Senior Correspondent, **HSJ**
10:40-11:20	**Engaging the board to support human factors training and initiatives** **Learning outcomes:** • 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** **Jane Reid**, Clinical Lead, **Wessex Patient Safety Collaborative**	**Illustrating the characteristics of a learning organisation and how they can be embedded** **Learning outcomes:** • The key tenets of a learning organisation in healthcare • Hurdles overcome to achieve change in approach and behaviour • Practical examples to implement step changes across a system **George Findlay,** Medical Director, **Western Sussex Hospitals NHS Foundation Trust**	**How Denmark reduced avoidable harm to become a patient safety exemplar** **Learning outcomes:** • Danish best practice to reduce pressure ulcers, medication errors, falls and infections • Preventing harm in the community • Improvement methods and data collection **Tina Lynge Lyngbye**, Programme Director, **Danish Society for Patient Safety**	**The changing CQC inspection regime: what you will need to know** **Learning outcomes:** • Key findings on safety from the CQC's inspection programme • CQC's new approach to inspection and monitoring • how the changes relate to quality and safety **Edward Baker**, Deputy Chief Inspector of Hospitals, **Care Quality Commission**
11:25-12:15	**New perspectives: lessons from the rail industry** *The rail industry, like healthcare, is a safety critical sector experiencing an unprecedented increase in demand.*	**The squeezed middle: supporting managers in healthcare** • Effectively addressing the impact of stress and burn out	**Quick -fire learning from Ireland and Wales** *Medication safety* - **Ciara Kirke**, Clinical Lead, Medication Safety, **Health Service Executive Ireland**	**Learning from errors: a system-wide approach** • Applying lessons learnt from serious incidents to maintain safety as care pathways are redesigned

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	• Find out how the sector has designed-in safety and designed-out risk whilst reducing costs • Discover how this can be applied in healthcare settings **Paul Leach,** Lead Human Factors Specialist, **Rail Safety and Standards Board**	• Supporting managers functionally and emotionally **Jocelyn Cornwell,** Chief Executive, **Point of Care Foundation**	*Reducing Harm - Sepsis and AKI* - **Chris Hancock**, Programme Lead, **Rapid Response to Acute Illness Learning Set (RRAILS)**	• Effectively utilising data from reporting to implement whole system safety • Sharing learning and insight across health and social care systems to ensure consistent safety standards across patient pathways **Jonathan Hazan,** Director, **Datix** **James Titcombe,** Patient Safety Specialist, **Datix**
12:15-13:15	**Networking lunch break**			
13:15-14:00	**The impact of human factors: how the system and frontline can inadvertently create harm** • A patient's insightful story about experiencing harm and working with the practitioner involved • Considering what can be learnt from exploring perspectives from the system, the patient, and the practitioner • Developing the ability to forgive as a way to learn from failing **Kathryn Walton**	**Working resiliently, collaboratively and effectively at times of high pressure and strain on the system** • Keeping safety at the top of the agenda amid financial restrictions and stretching targets • Balancing competing priorities • Developing resilient teams to weather the storm **Chris Lake**	**Patient safety in maternity care: safety initiatives for baby and mother** • Hear how Sweden achieved a 50% reduction in avoidable serious birth injuries over the past 6-7 years • Learn how Wales are working with mothers to improve patient safety during pregnancy and birth **Marianne Weichselbraun** Vice President, **The Swedish Association of Midwives** **Elinore Macgillivray,** National Project Lead, **OBS Cymru**	**Staying compliant as our healthcare system changes at pace and scale** • Review your understanding of regulation, compliance and governance in the changing landscape **Paul Ridout**, Partner, **Ridouts Professional Services PLC**
14.05-14:45	**Partnering with human factors experts to "enable" throughout a whole organisation** **Nikki Maran,** Medical Director, Scottish Centre for Simulation & Clinical Human Factors, **NHS Forth Valley**	**An open culture and incident reporting** • Connecting the dots between culture and the effective use of incident reporting • Reporting with a focus on learning and the implementation of positive practice • Speaking openly about error to determine strategies for improvement	**Preparing national health systems for aging populations and complex healthcare needs** • How can healthcare systems adapt to deliver sustainable, high quality care to the widest range of patients? • Comparing approaches in countries with rapidly aging populations	**Patient Safety Alerts – a window into safety leadership?** • Is it harder to learn from death or harm that 'didn't happen here'? • Why do some organisations respond more effectively than others? • Can we apply error wisdom to the leadership of Alert implementation?

		Umesh Prabhu, former Medical Director, **Wigan & Leigh NHS Trust**	**Professor René Amalberti**, Patient Safety Advisor, **Haute Autorité de Santé**	**Frances Healey**, Deputy Director of Patient Safety, **NHS Improvement**
14:45-15:15	**Afternoon break**			
15:15-15:55	**Why we haven't 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 McCullouch,** Professor of Surgical Science and Practice, **University of Oxford**	**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** **Neil Churchill,** Director of patient experience, **NHS England**	**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 setting **Ailish Wilkie,** Director of Patient Safety and Risk Management, **Atrius Health/ Harvard Vanguard Medical Associates**	**Have we got the right approach to regulating safety in the NHS?** **Paul Ridout**, Partner, **Ridouts Professional Services PLC** **Julie Smith,** Head of Compliance, **James Paget NHS Trust** **Scott Morrish,** Patient Representative
16:05-16.50	**The Francis Inquiry: how far have we come?** Robert Francis QC			
17:00	**Networking reception in exhibition hall**			

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Day 2 – 5 July 2017				
08:00	Registration opens			
	Stream 1: Enabling our workforce: safe staffing and multi-disciplinary working **Janet Davies**, Chief Executive, **Royal College of Nursing**	**Stream 2: From safety initiatives to safety systems** **Katharine Goldthorpe,** Associate Director, **Haelo**	**Stream 3: Finding efficiencies while enhancing safety** **Jenni Middleton,** Editor, **Nursing Times**	**Stream 4: Clinical excellence and quality improvement** **Peter Lachman**, Chief Executive, **ISQua** ***Clinical leader of the year HSJ Awards 2016***
08:50-09:30	**Implementing Safe Staffing Guidance** • An evidence based approach to safe staffing • Embedding systems and processes to determine what is safe, effective and sustainable staffing **Mark Radford**, Director of Nursing – Improvement, **NHS Improvement**	**Designing and implementing whole system safety** • Maintaining a clear focus on safety at a time of change • Closing quality and safety gaps across health and social care services by developing whole system approaches to patient safety • Exploring how the STP process will impact the safety culture in the NHS **Viccie Nelson,** Programme Director, **Sutton Homes of Care**	**Is there a business case for smart technology?** • 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 **Ann Blandford,** Director, **Institute of Digital Health, UCL**	**Achieving zero: a holistic approach to tackle pressure ulcers** • Identifying pressure ulcers earlier to deliver better care and improve the productivity of multi-disciplinary teams • Securing buy-in and participation from board to ward • Describing positive outcomes in clinical practice, financial management and productivity **Glenn Smith,** Patient Safety Lead, **Isle of Wight NHS Trust**
09:35-10:15	**Safe staffing: best practice and perspectives from healthcare leaders** • Applying safe staffing guidance to real-life scenarios • Recruitment, retention and incentivising staff • Rostering and real time monitoring of staffing levels	**An integrated approach to tackling sepsis** • A multi-disciplinary, integrated approach to the prevention, early identification and treatment of Sepsis in the community and hospital settings **Kay Haughton,** Deputy Director of Nursing (Clinical Development), **NHS Gloucestershire CCG** **Hein le Roux,** Deputy Chair, **Gloucestershire CCG** and	**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 • Simultaneously maximising capacity, efficiency and safety in ED • Improving flow and pathway management at times of overcrowding	**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% • Delivering sustained improvements by engaging the hearts and minds of front line staff **Caroline Maries-Tillott,** Patient Safety Advisor, **Heart of England NHS Trust**

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		Primary Care Patient Safety Lead, **West of England AHSN**		
10:20 - 11:00	**Safer, 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 **Elin Roddy,** End of Life Care Lead Clinician, **Shrewsbury and Telford NHS Trust** **Kate Masters,** Patient Representative	**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 **Emma Redfern**, Consultant in Emergency Medicine & Associate Medical Director for Patient Safety, **University Hospitals Bristol NHS Foundation Trust**	**Best practice case study: Utilising multi- disciplinary working to achieve a step reduction in Cardiac Arrest calls** • Designing and implementing quality improvement interventions • Improving communication and decision making • Achieving a rate of arrests per 1000 admissions 33% lower than the national average **Anna Winfield,** Patient Safety and Quality Lead, **Leeds Teaching Hospitals NHS Trust**	**Innovating to improve clinical efficiency and outcomes** • Two Trusts share how they adapted to new ways of working and incorporated technology to: • Improve the clinical decision-making process to reduce the rate of cardiac arrests • Enhance the safety of the medical take during handovers and transfers of care **Katherine Murray,** ITU and Anaesthetic Consultant and Chair, Urgent Care Board **East Sussex Healthcare NHS Trust** **Toby Graves** Consultant Acute Physician and Clinical lead for Acute Medicine **Dorset County Hospital NHS Foundation Trust**
11:00 – 11.30	**Morning break in exhibition hall**			
11:30-12.15	**Ministerial Address** **Rt Hon Jeremy Hunt MP,** Secretary of State for Health			
12.15-13.00	**Whole system safety at a time of change** **Jim Mackey,** Chief Executive**, NHS Improvement** **David Behan,** Chief Executive, **CQC**			
13:00-14:00	**Networking lunch break**			
14:00-15:00	**James Reason Annual Lecture** **Sir Liam Donaldson,** Envoy for Patient Safety, **World Health Organisation (WHO)**			
15:00-15:15	**Poster competition – winners announced**			
15:15	**Closing remarks from Chairs** **Shaun Lintern**, Patient Safety Senior Correspondent, **HSJ** and **Jenni Middleton**, Editor, **Nursing Times**			