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

	Exchange 9	Exchange 10	Exchange Auditorium	Exchange 11
	A how to guide: Applying human factors to everyday working	**Leadership and lasting cultural change**	**Perspectives from international best practice**	**Governance, risk and compliance**
10:40 - 11:20	Stream Chair: **Martin Bromiley OBE,** Chair, **Clinical Human Factors Group**	Stream Chair: **Jenni Middleton,** Editor, **Nursing Times**	Stream Chair: **Mike Durkin,** Former Director for Patient Safety, **NHS Improvement**	Stream Chair: **Shaun Lintern,** Patient Safety Correspondent, **HSJ**
	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**	**Illustrating the characteristics of a learning organisation and how they can be embedded** • 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,** Executive Medical Director and Deputy Chief Executive, **Western Sussex Hospitals NHS Foundation Trust**	**How Denmark reduced avoidable harm to become a patient safety exemplar** • 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** • 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**

10:40 - 11:20 Continued **Jane Reid,** Clinical Director, **Wessex Patient Safety Collaborative**

11:20 - 11:25 Time to move between sessions

	Exchange 9	Exchange 10	Exchange Auditorium	Exchange 11
	Human factors	**Leadership and cultural change**	**International best practice**	**Governance, risk and compliance**
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 • 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**	**The squeezed middle: Supporting managers in healthcare** • Effectively addressing the impact of stress and burn out • Supporting managers functionally and emotionally **Jocelyn Cornwell,** Chief Executive, **The Point of Care Foundation**	**Quick-fire learning from Ireland and Wales** **Medication safety** **Ciara Kirke,** Clinical Lead, Medication Safety, **Health Service Executive, Ireland** **Sepsis and AKI** **Chris Hancock,** Programme Lead, **Rapid Response to Acute Illness Learning Set (RRAILS)**	**Learning from errors: A system-wide approach** • Applying lessons learnt from serious incidents to maintain safety as care pathways are redesigned • 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
Exhibition

13:15 - 14:00	**The impact of human factors: How the system and frontline can inadvertently create harm**	**Working resiliently, collaboratively and effectively at times of high pressure and strain on the system**	**Patient safety in maternity care: Safety initiatives for baby and mother**	**Staying compliant as our healthcare system changes at pace and scale**

13:15 - 14:00 Continued	• 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,** Patient Representative	• 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,** Professional Leadership Coach	• 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 Programme Lead, **OBS Cymru**	• Review your understanding of regulation, compliance and governance in the changing landscape **Errol Archer,** Senior Associate Solicitor, **Ridouts Professional Services Plc**
14:00 - 14:05	Time to move between sessions			
	Exchange 9 **Human factors**	**Exchange 10** **Leadership and cultural change**	**Exchange Auditorium** **International best practice**	**Exchange 11** **Governance, risk and compliance**
14:05 - 14:45	**Partnering with human factors experts to "enable" throughout a whole organisation** **Nicola Maran,** Associate Medical Director for Patient Safety, **NHS Lothian**	**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 **Umesh Prabhu,** former Medical Director, **Wigan & Leigh NHS Trust** **Jonathan Hazan,** Director, **Datix**	**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 **Professor René Amalberti,** Patient Safety Advisor, **Haute Autorité de Santé**	**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? **Frances Healey,** Deputy Director of Patient Safety, **NHS Improvement**

14:45 - 15:15	Networking break Exhibition			
	Exchange 9 **Human factors**	**Exchange 10** **Leadership and cultural change**	**Exchange Auditorium** **International best practice**	**Exchange 11** **Governance, risk and compliance**
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 McCulloch,** 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,** Patient Representative **David McNally,** Head of Experience of Care, **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 settings **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
15:55 - 16:05	Time to move between sessions			
16:05 - 16:50	**Exchange Auditorium** **The Francis Inquiry: How far have we come?** **Sir Robert Francis QC**			
17:00	Networking reception Exhibition			

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08:00 Registration opens

	Exchange Hall **Enabling our workforce: Safe staffing and multi-disciplinary working**	Exchange 9 **From safety initiatives to safety systems**	Exchange 11 **Finding efficiencies while enhancing safety**	Exchange 10 **Clinical excellence and quality improvement**
	Stream Chair: **Shaun Lintern,** Patient Safety Correspondent, **HSJ**	Stream Chair: **Katharine Goldthorpe,** Associate Director, **Haelo**	Stream Chair: **Jenni Middleton,** Editor, **Nursing Times**	Stream Chair: **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 Vanguard**	**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** **Richard Shorney,** Managing Director, **Real Healthcare Solutions**
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	**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	**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	**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%

	Exchange Hall **Enabling our workforce: Safe staffing**	Exchange 9 **Safety systems**	Exchange 11 **Efficiencies and safety**	Exchange 10 **Quality improvement**
09:35 - 10:15 Continued	• Rostering and real time monitoring of staffing levels **Josie Rudman,** Director of Nursing, **Papworth Hospital NHS Foundation Trust** **Ann-Marie Riley,** Deputy Chief Nurse, **Nottingham University Hospital NHS Trust** **Janet Davies,** Chief Executive, **Royal College of Nursing**	**Kay Haughton,** Deputy Director of Nursing (Clinical Development), **NHS Gloucestershire CCG** **Hein Le Roux,** Deputy Chair, **Gloucestershire CCG** and Primary Care Patient Safety Lead, **West of England AHSN**	• Simultaneously maximising capacity, efficiency and safety in ED • Improving flow and pathway management at times of overcrowding **Ben Teasdale,** Consultant in Emergency Medicine, **University Hospitals of Leicester NHS Trust**	• Delivering sustained improvements by engaging the hearts and minds of front line staff **Caroline Maries-Tillott,** Quality Improvement Lead, **Walsall Healthcare NHS Trust**
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** **Angela Windle,** Critical Care Outreach Sister, **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,** Clinical lead for Acute Medicine, **Dorset County Hospital NHS Foundation Trust**

Day 2 Programme: Wednesday 5 July 2017

11:00 - 11:30	Networking break Exhibition
11:30 - 12:15	**Exchange Hall** **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** **Sir David Behan,** Chief Executive, **CQC**
13:00 - 14:00	Networking lunch break Exhibition
14:00 - 15:00	**Exchange Hall** **James Reason Annual Lecture** **Sir Liam Donaldson,** Envoy for Patient Safety, **World Health Organisation (WHO)**
15:00 - 15:15	**Poster competition: Overall winner announced** **Jenni Middleton,** Editor, **Nursing Times**
15:15	**Closing remarks from Chairs** **Shaun Lintern,** Patient Safety Correspondent, **HSJ** and **Jenni Middleton,** Editor, **Nursing Times**

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PATIENT SAFETY CONGRESS

SAVE THE DATE

We hope to see you next year

9-10 July 2018
Manchester Central