PATIENT SAFETY CONGRESS

9-10 July 2018 | Manchester Central

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Patient Safety Congress 2018 Programme

Translating policy and theory into practice

9 - 10 July – Manchester Central, Manchester

Day 1 – Monday 9 July 2018

08:00	**Registration opens**				
09:00 – 09:10	**Welcome from conference Chairs** **Shaun Lintern**, Patient Safety Correspondent, **HSJ** and **Jenni Middleton**, Editor, **Nursing Times (TBC)**				
09:10 – 09:50	**Just Culture: Moving beyond blame in your organisation** **Professor Sidney Dekker,** Author of *Just Culture: Restoring Trust and Accountability in Your Organization*, **Griffith University** and **Joe Rafferty**, Chief Executive, **Mersey Care NHS Foundation Trust** • Hear the key principles of just culture from one of the leading thinkers in this area • Learn how Mersey Care Trust put the principles into action to drive a cultural shift • Understand and learn how to develop just culture practices				
09:50 – 10:10	**Joint plenary with Rapid Response Systems** **Driving change in safety critical industries** **Invited speaker: Professor Kevin Fong,** Consultant Anaesthetist, **University College London Hospitals FT** • Learn how human factors impact the work of NASA, and processes they use to reduce risk • Understand how safety critical industries implement effective safety systems • Make changes in your practice to improve safety in your organisation				
10:10 – 10:50	**Joint debate with Rapid Response Systems** **Safety in healthcare, who drives change?** **Chair: Shaun Lintern,** Patient Safety Correspondent, **HSJ** **Professor Ken Hillman,** Professor of Intensive Care**, University of New South Wales** **Julie Bailey CBE,** Founder, **Cure the NHS** **Peter Homa CBE,** Chair, **NHS Leadership Academy** **Invited speakers:** **Professor Kevin Fong,** Consultant Anaesthetist, **University College London Hospitals NHS Foundation Trust** **Dr Celia Ingham Clark,** Medical Director for Clinical Effectiveness, **NHS England** • Do the best patient safety improvements come from the top or the frontline? • What should policy makers, leaders and frontline staff be doing to make hospitals safer? • How can we work together to drive improvements?				
10:50 - 11:20	**Morning break in exhibition hall**				
	Human Factors: Beyond the theory **Chair: Martin Bromiley OBE,** Chairman, **Clinical Human Factors Group**	**Driving a culture of patient safety** **Chair: Shaun Lintern,** Patient Safety Correspondent, **HSJ**	**Improving patient safety through governance and compliance** **Chair: Jenni Middleton,** Editor, **Nursing Times (TBC)**	**Delivering quality improvement on the frontline** **Chair: Dr Mike Durkin,** Senior Advisor on Patient Safety, **Imperial College London**	**Joint stream with Rapid Response Systems** **Bridging the gap: policy and clinical practice**
11:20 - 12:00	**Creating a sustainable focus on human factors as part of a whole healthcare system** • Understand how Scotland has adopted and	**Why we need a relentless drive on sepsis** • Learn from an evidenced approach to reducing admission to ITU,	**The importance of listening to patients and relatives** • Understand the role of Duty of Candour in learning from accidents	**The impact of genuine partnerships between staff and patients** • Learn from the experience of the West London Collaborative,	**Making it easy to do the right thing** • Examine how approaches from behavioural science can be adopted into your work

	implemented a human factors approach • Find out how human factors thinking has been moved from individual projects to large scale application • Reduce the impact of the human condition affecting patients by creating a long-term, consistent approach **Confirmed speakers:** **Professor George Youngson CBE,** Emeritus Professor of Paediatric Surgery, **University of Aberdeen** **Simon Paterson-Brown,** Consultant General Surgeon, **Royal Infirmary of Edinburgh** **Paul Bowie,** Programme Director - Patient Safety & Quality Improvement, **NHS Education Scotland** **Dr Shelly Jeffcott, NHS Education** **Invited speaker:** **Nikki Maran,** Consultant Anaesthetist, **Royal Infirmary of Edinburgh**	length of stay, readmission and mortality from sepsis • Improve sepsis outcomes by simplifying processes and empowering staff • Hear Melissa Mead's story – her son William died of sepsis at 12 months old. His death spurred her to lead a campaign to save lives **Confirmed speakers:** **Melissa Mead**, National Project Coordinator, **The UK Sepsis Trust** **Joan Pons Laplana,** Transformation Nurse, **James Paget University Hospitals NHS Foundation Trust** **Dr Matt Inada Kim, National Clinical Advisor for Sepsis**	• Learn from Susanna Stanford's fight to ensure that what happened to her doesn't happen again • Understand how healthcare professionals, government, lawyers and patients can work together to improve safety and justice **Confirmed speakers:** **Peter Walsh,** Chief Executive, **Action Against Medical Accidents** **Susanna Stanford, Patient Speaker**	which is working with service users from West London Mental Health Trust • Improve experience of care by finding out what really matters to service users and co-producing 'Always Events' • Learn about the national resources available to support co-production, and input ideas for future resources **Proposed speakers:** **Jane McGrath,** Chief Executive, **West London Collaborative** **Helen Lee,** Head of Quality Improvement and Experience, **Lancashire Care NHS Foundation Trust and IHI Faculty** **David McNally,** Head of Experience of Care, **NHS England**	• Use nudge theory and 'doing the right thing' to encourage consistent, good practice • Learn techniques to implement interventions to improve patient outcomes **Confirmed speakers:** **Stephen Bolsin,** Adjunct Professor & Staff Specialist, **Geelong Hospital** **Hannah Burd,** Senior Advisor, **Behavioural Insights Team** **Siri Steinmo,** Patient Safety Programme Lead, **Royal Free London NHS Foundation Trust** *(Stephen and Hannah are speaking again at 12:05 in the 'Human Factors' stream)*
12:00 – 12:05	**Time to move between sessions**				
12:05 - 12:45	**Behavioural insights: using the power of nudge theory**	**How better use of complaints can drive learning and accountability**	**Effective governance in a multi-agency environment**	**Improving the care and outcomes of vulnerable patients**	**End of life care in an acute setting** • "Talking DNACPR" - how

	• Examine how approaches from behavioural science can be adopted into your work • Use nudge theory and 'doing the right thing' to improve patient outcomes • Learn from real-world evidence to understand what is possible **Confirmed speakers: Stephen Bolsin,** Adjunct Professor & Staff Specialist, **Geelong Hospital** **Hannah Burd,** Senior Advisor, **Behavioural Insights Team** *(speakers also speaking at 11:20 in the 'Bridging the Gap' stream)*	• How to embed an open, transparent complaints culture, to ensure learning from mistakes • Understand what is working well in NHS complaint handling in England and what isn't • Hear from the new Ombudsman on his vision for complaint handling in the NHS **Confirmed speakers: Rob Behrens CBE, Parliamentary and Health Service Ombudsman** **Scott Morrish, Patient speaker**	• Hear about effective partnership working in a community setting • Understand how collaboration achieves effective governance • Adopt partnership working in your area to improve patient journey and outcomes	• Meet the needs of vulnerable patients, in the community, primary and acute settings • Work in partnership with other organisations to improve the care of vulnerable patients • Improve outcomes for vulnerable patients in your care	to have difficult conversations with patients • Have effective conversations in an emergency - the national Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) **Confirmed speakers: Dr Caroline Stirling,** Clinical Director, End of Life Care, **NHS England** **Jillian Hartin,** Senior Sister, Critical Care, **University College London Hospitals NHS Foundation Trust**
12:45 - 13:45	**Networking lunch break**				
13:45 - 14:25	**The reality gap: The difference between actual and perceived performance** • Close the gap between the best efforts of your staff and full clinical effectiveness • Learn from pioneering case studies • Use the evidence base to assess how best practice can be adopted	**Learning from incidents and investigations to prevent harm** • How to prevent repeat incidents by learning from mistakes • Empower junior doctors to engage with senior management to improve safety • Improve safety in the operating theatre and during the peri-operative period	**Safety culture in a primary care setting** • Hear from effective collaborations between primary, ambulance and acute trusts • Improve the safety of patients who first present in a primary setting • Ensure that important information is not lost on transfer	**Fighting the risk of infection: collaborating to improve methods** • Understand research into infection control in high-risk situations • Prevent surgical site, catheter-associated and other infections to improve outcomes and cut costs • Implement improvements in your organisation **Confirmed speakers:**	**Identifying and escalating the deteriorating patient** • How to use vital signs to identify deteriorating patients quickly and improve outcomes • Using the National Early Warning Score 2 to identify acutely ill patients **Confirmed speakers: Dr John Kellett,** Nenagh General Hospital**, Ireland;**

	Confirmed speakers: Professor Bryn Baxendale, Director, Trent Simulation & Clinical Skills Centre, **Nottingham University Hospitals NHS Trust** **Abbey Coutts,** Nurse and Patient Representative	**Confirmed speaker: James Titcombe OBE, Patient Safety Learning** **Invited speakers: Dr William Lea,** Clinical Fellow in Patient Safety, **York Teaching Hospital** **Professor Iain Moppett**, Professor of Anaesthesia and Perioperative Medicine, **Nottingham University School of Medicine**		**Jacqui Prieto,** Nurse Specialist in Infection Prevention, **University of Southampton** **Professor Jennie Wilson,** Richard Wells Research Centre, **University of West London** **Invited speaker: Philip Howard,** Consultant Pharmacist in Antimicrobials, **Leeds Teaching Hospitals NHS Trust**	**John Welch,** President, **International Society for Rapid Response Systems** **Invited speaker: Professor Bryan Williams,** Consultant Physician, **University College London Hospitals**
14:25 - 14:30	**Time to move between sessions**				
14:30 - 15:10	**How to reconcile learning and accountability. What are the limitations of human factors and just culture?** • How to have moral and ethical conversations about failure to ensure learning from mistakes • Foster a culture of openness and transparency to ensure learning from failure • Prevent repeat incidents through a culture of open conversation and learning **Confirmed speakers: Steve Shorrock, Human Factors Specialist and Work Psychologist** **Kathryn Walton, Patient Speaker**	**How the new national medical examiners service will save lives** • Learn about the April 2019 rollout of the national network of medical examiners • Hear about medical examiner pilots and how they have challenged systemic errors and changed practice • How your trust can adopt the medical examiner approach **Confirmed speakers: Dr Alan Fletcher, first Medical Examiner (of documents and cause of death) in England and Wales** **Professor Peter Furness,** Consultant Histopathologist and Honorary Professor of Renal Pathology,	**Addressing wrongdoing: raising concerns safely and effectively** • The legal bit: what you can and can't do when whistleblowing • How to raise concerns to keep patient safety foremost • How can Freedom to Speak Up Guardians improve safety in your organisation **Confirmed speakers: Dr Kim Holt,** Consultant Community Paediatrician, **Whittington Health NHS Trust** **Dr Henrietta Hughes,** National Guardian for the NHS **Francesca West**, Chief Executive, **Public Concern at Work**	**Thinking kidneys in patient safety: a community approach** • A new approach to acute kidney injury to improve treatment and outcomes • How rapid patient deterioration can be avoided by implementing basic checks in primary and secondary care • Prevent avoidable deaths from AKI **Confirmed speaker: Fiona Loud**, Policy Director, **Kidney Care UK** **Invited speakers: Dr Thomas Blakeman,** GP Clinical-Academic Lead, **Greater Manchester Kidney Health Programme** **Dr Nick Selby,** Associate Professor of Nephrology, **Derby Teaching Hospitals NHS foundation Trust** **Proposed speaker:**	**Examining the evolution of human factors and the prospects for a national safety plan** • Put your organisation on the front foot: understand where human factors is heading next • Pinpoint the five key turning points in human factors and establish what still needs to be done • Consider how a coordinated national plan could focus efforts to embed safety and human factors • 20 years of human factors in healthcare in context **Proposed speakers: Dr Suzette**

	Invited speaker: Dr Suzanne Shale, Ethics Consultant in Healthcare, **Clearer Thinking Consultancy**	**University Hospitals of Leicester NHS Trust Professor Jo Martin,** President**, The Royal College of Pathologists**		**Professor Nicola Thomas,** Professor of Kidney Care**, London South Bank University**	**Woodward,** Campaign Director**, Sign up to Safety; Professor Charles Vincent,** Emeritus Professor of Clinical Safety Research**, Imperial College London; Professor Sir Bruce Keogh,** Chair, **Birmingham Women's and Children's NHS Foundation Trust Dr Hazel Courteney,** Chief Executive, **State Safety Global** *(This session is repeated in the 'Human Factors' stream at 15:40)*
15:10 - 15:40	**Afternoon break**				
15:40 - 16:20	**Examining the evolution of human factors and patient safety and the prospects for a national safety plan** • 20 years of human factors in healthcare in context • Pinpoint the five key turning points in human factors and establish what still needs to be done • Put your organisation on the front foot: understand where human factors is heading next • Consider how a coordinated national plan could focus	**Recognition and escalation of the deteriorating patient in the community** • Measures to improve the recognition of the deteriorating patient in the community • The role of community nursing, pharmacists and general practice in recognising and escalating patients • Improve patient outcomes through communication and collaboration	**Reducing the risk of admission due to medication complication** • Understand the new national initiative on medication safety • Learn about what the evidence shows about the admission of those on multiple medications • Improve admission rates through knowing what this means in practice	**Improving safe care for mental health patients** • Hear the latest evidence and debate on constraint and least restricted practice • The key elements of best practice in improving the care and safety of mental health patients from evidenced case studies • Avoid harm and minimise instances of self-harm and self-injury with the right structures and practices	**Incident investigation: learning from errors** • Prevent repeat incidents by learning from mistakes • Hear how others have implemented processes to learn from incidents **Confirmed speakers: Dr Helen Hogan,** Associate Professor, Department of Health Services Research and Policy**, London School of Hygiene and Tropical Medicine** and Health Foundation Improvement Science Fellow **Proposed speakers: Dr Andy Haynes,** Executive Medical

	efforts to embed safety and human factors **Confirmed speaker: Dr Suzette Woodward,** Campaign Director, **Sign up to Safety** **Invited speakers: Professor Charles Vincent,** Emeritus Professor of Clinical Safety Research, **Imperial College London** **Proposed speakers: Professor Sir Bruce Keogh,** Chair, **Birmingham Women's and Children's NHS Foundation Trust** **Dr Hazel Courteney,** Chief Executive, **State Safety Global** *(This session is also on at 14:30 in the 'Bridging the Gap' stream)*				Director, **Sherwood Forest Hospitals NHS Foundation Trust**

16:20 – 16:25	**Time to move between sessions**
16:25 - 17:00	**James Reason Lecture: Hope is not a plan: what can healthcare learn from safety critical industries?** **Confirmed speaker: Professor Alison Leary,** Chair of Healthcare & Workforce Modelling, **London South Bank University** • Professor Alison Leary's insights from her Winston Churchill Fellowship visiting organisations such as NASA to investigate approaches to safety cultures and systems • Understand what these high reliability organisations do to handle risk, encourage safety cultures, utilise data and workforce • Learn what approaches your organisation could adopt to improve patient safety and workforce issues across the board
17:00	**Networking reception in exhibition hall**

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Day 2 – Tuesday 10 July 2018

08:00	Registration opens				
09:00 - 09:35	**Identifying the underlying causes of systemic failure to determine how to avoid future tragedies** **Confirmed speaker: Dr Bill Kirkup CBE,** Former Chair, **Morecambe Bay Investigation,** Member, **Gosport Independent Panel** • Dr Bill Kirkup's analysis of the Morecambe Bay, Jimmy Saville and Hillsborough investigations: the underlying causes that lead environments to fail • Identify the warning signs to take action in your own organisation and nip problems in the bud • Prevent problems escalating to crisis point with effective solutions				
09:35 – 09:50	**Poster competition: winner announced** **Shaun Lintern**, Patient Safety Correspondent, **HSJ** and **Jenni Middleton**, Editor, **Nursing Times (TBC)** • Find out the winner of the Patient Safety Congress poster competition • Finalists were chosen by our panel of expert judges, with the overall winner being decided by peers at the Congress • Find out more about the entries on the Congress app and in the Exhibition Hall				
09:50 – 10:25	**One year on: what can be learnt from HSIB investigations so far?** **Confirmed speaker: Keith Conradi,** Chief investigator, **Healthcare Safety Investigations Branch (HSIB)** • A year after HSIB was established, Keith Conradi will share key learning points from its first investigations • Learn from where harm has happened and the systemic causes • How to use HIB safety recommendations to raise standards in your organisation				
	Workforce: the crucial ingredient for safety **Chair: Shaun Lintern,** Patient Safety Correspondent, **HSJ**	**Collaborating to achieve patient safety (TBC)** **In association with the Patient Safety Collaborative**	**Delivering Improvement on the frontline (Day 2)** **Chair: Dr Mike Durkin,** Senior Advisor on Patient Safety, **Institute of Global Health Innovation, Imperial College London**	**Using research to solve the big challenges** **Chair: Jenni Middleton,** Editor, **Nursing Times (TBC)**	**Joint stream with Rapid Response Systems** **Bridging the gap: policy and clinical practice (Day 2)**
10:30 - 11:10	**Safe staffing: translating evidence and policy into practice** • Hear the most recent evidence and policy on safe staffing • See how this is being translated into effective practice by Hull and East Yorkshire Trust • Translate best practice to your own situation to		**Can quality improvement be improved?** • Discuss the findings of Professor Dixon-Woods' research into whether quality improvement actually improves quality • Explore the challenges that impede QI, including scale, variability of input	**Leading from the top: new research on trust level leadership** • How acute hospital boards have responded to the recommendations in the Francis report • The changes to leadership culture in the NHS, and the remaining challenges **Confirmed speakers: Professor Naomi Chambers,** Professor of	**The use of technology to identify the deteriorating patient** • Understand the application of technology in identifying and escalating the deteriorating patient • How to couple recent technologies with the knowledge and intuition of your staff to enhance patient

	prevent avoidable harm **Confirmed speakers: Professor Peter Griffiths** Chair of Health Services Research **University of Southampton; Professor Mark Radford,** Director of Nursing Improvement **NHS Improvement; Mike Wright,** Executive Chief Nurse, **Hull and East Yorkshire NHS Trust**		and lack of evaluation • Learn how you can counteract these challenges to improve the efficacy of your own QI projects **Confirmed speakers: Professor Mary Dixon-Woods,** THIS Institute (The Healthcare Improvement Studies Institute), **University of Cambridge; Dr John Dean,** Clinical Director for Quality Improvement and Patient Safety, **Royal College of Physicians Jonathan Broad, Patient Leader**	Healthcare Management, Alliance Manchester Business School, **University of Manchester Professor Judith Smith,** Director of the Health Services Management Centre (HSMC) and Professor of Health Policy and Management, **University of Birmingham Julie Bailey CBE, Cure the NHS, Patient Speaker**	safety and experience
11:10 – 11:40	**Morning break in exhibition hall**				
11:40 - 12:20	**Recruitment and retention: recommendations and solutions** • Hear the latest recommendations to make sure you have a safe level of staffing • Explore the work of trusts who improved their retention rates • Translate best practice to improve your own retention rates **Confirmed speaker: Ruth May,** Executive Director of Nursing, **NHS Improvement Dean Royles,** Director of Human Resources and Organisational Development**, The Leeds Teaching Hospitals NHS Trust**		**How to reduce falls to improve care and save costs** • Learn from projects that have reduced inpatient falls • Understand how to reduce the impact of falls in the community • Explore how you could implement similar measures in your setting to improve patient care in a low cost, high impact way **Invited speaker: Mark Renshaw,** Deputy Chief of Safety, **Brighton & Sussex University Hospitals NHS Trust Frances Healey – current leaders in this area**	**Using technology to support safety** • How intuition can help avoid errors caused by technology – ensure technology supports, not impedes • How your organisation's culture must support staff in using their own intuition when something doesn't feel right • How to couple recent technologies with the knowledge and intuition of your staff to enhance patient safety and experience	**What's happening with sepsis and how we can do better** • Understand what the data tells us nationally and Trust by Trust, to benchmark and improve your performance • Collaborate to improve hospital wide responses to the deteriorating patient • Hear the impact of sepsis from the patient perspective, and how Katie Dutton is using her experience to train others **Confirmed speakers: Dr Matt Inada Kim,** Acute Physician**, Hampshire Hospitals**

	Invited speaker: **NHS Employers**		**Care Homes**		**NHS Foundation Trust;** National Clinical Advisor for Sepsis **Professor Mervyn Singer,** Professor of Intensive Care Medicine, **University College London Hospitals NHS Foundation Trust** **Katie Dutton, Nursing Student and Patient Speaker**
12:20 – 12:25	**Time to move between sessions**				
12:25 – 13:05	**Maternity safety: instilling a culture of teamwork to save lives** • Prevent avoidable harm in your maternity service by hearing the latest thinking from leading experts • Get the latest information and evidence from the Each Baby Counts initiative to improve maternity and neonatal safety • Real life case studies on why a culture of collaboration, openness and transparency is essential for a successful maternity service **Confirmed speakers:** **Edward Morris,** Vice President, **Royal College of Obstetricians and Gynaecologists** **Andy Heeps,** Associate Medical Director for Quality Improvement,			**Improving end of life care** • Explore the approaches to end of life care across the UK • Take steps to improve the care of patients with dementia – in community and acute settings • "Talking DNACPR" - how to have difficult conversations with patients **Confirmed speaker: Dr Katherine E Sleeman,** NIHR Clinician Scientist and Honorary Consultant in palliative medicine, **King's College London** **Invited speaker:** **Michael Hurt,** Head of Older People and Dementia, **NHS Walsall Clinical Commissioning Group** **Proposed speaker:** **Jillian Hartin,** Senior Sister, Critical Care, **University College London Hospitals NHS Foundation Trust**	**Selling Rapid Response Systems to the board and policy-makers** • How to make the quality and business case for critical outreach and rapid response systems • Effect of a national standard for deteriorating patients on outcomes **Confirmed speakers:** **Dr Francesca Rubulotta,** Consultant in Critical Care, **Imperial College Healthcare NHS Trust** **Associate Professor Daryl Jones,** Associate Professor, Critical Care, **The University of Melbourne**

	Barking, Havering and Redbridge University Hospitals Trust **Leigh Kendall, Writer, Coach and Patient Leader** **Invited speakers: Professor Jacqueline Dunkley-Bent,** Head of Maternity, Children and Young People, **NHS England**				
13:05 – 14:05	**Networking lunch break**				
14:40 - 15:15	**Keynote address: The next steps for patient safety** **Confirmed speaker: The Rt Hon Jeremy Hunt MP, Secretary of State for Health and Social Care** • The longest serving health secretary outlines his vision for driving up safety and quality in the NHS • Hear about the current and future policy landscape and use this knowledge to build on your patient safety work • Place your work in a national context, and understand the impact on frontline work				
15:15 - 15:45	**Afternoon break**				
15:45 – 16:45	**Panel: How did they do it? Hear from national leaders who overcame safety challenges** **Confirmed speakers: Sir David Dalton,** Chief Executive, **Salford Royal Foundation Trust and Pennine Acute Hospitals Trust; Jackie Daniel,** Former Chief Executive, **University Hospitals of Morecambe Bay Foundation Trust; Kevin McGee,** Chief Executive, **East Lancashire Hospitals Trust** **Proposed speaker: Nicola Ranger,** Director of Nursing and Patient Safety, **Western Sussex Hospitals NHS Foundation Trust** • Three chief executives share how they turned their trusts around following safety controversies • Hear what steps they took to improve patient safety and care • Apply their learning to your own organisation – overcome existing concerns and avoid problems happening				
16:45 – 17:00	**Closing remarks from Chairs** **Shaun Lintern**, Patient Safety Senior Correspondent, **HSJ** and **Jenni Middleton**, Editor, **Nursing Times**				

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