Patient Safety Congress & Awards DAY 1 – 6th July 2015 Efficiency, effectiveness and experience: the business case for safety				
8.00	**Registration opens**			
9.25	**Welcome from conference chair** Dr Phil Hammond, GP and Broadcaster			
9.30	**Keynote: Innovation in the NHS** Bruce Keogh, Medical Director, NHS			
10.00	**Panel session: How we deliver whole system change** • How trusts create a foundation of excellence: holistic rather than prescriptive • The role of proactive management in driving improvement David Behan, Chief Executive, CQC Doug Bonacum, Vice President of Quality, Safety and Resource Management, Kaiser Permeate			
10.40	**Keynote: Collaborating for quality** Suzette Woodward, Director, Sign up for Safety Campaign			
11.00	**Morning break in the exhibition area**			
	Shared learning to improve outcomes	**Commissioning harm free care**	**Culture of personality: focus on leadership**	**Technology and system reconfiguration**
11.30-12.00	**Involving patients in pressure ulcer prevention** -New tools for assessing patients at risk of pressure ulcers -Working with service users to develop new pathways and share learning across sectors Susanne B Coleman, Programme Manager, Pressure Ulcer Programme, University of Leeds Service user Clinical lead	**Commissioning: are your providers safe?** -Monitoring safety across the whole health economy -Ensuring you have a good and transparent working relationship with your providers -The financial impact of monitoring your providers: short term investment for long term gain Dr Paul Bate Executive Director of Strategy & Intelligence, Care Quality Commission Bob Ricketts CBE Director of Commissioning Support Strategy & Market Development, NHS England	**Collaborative leadership for change: the new landscape of patient safety** -The progress of the Patient Safety Collaboratives: where are we now? -The developing role of NHS England's SAFE team -Who are our Safety Fellows, and how are they shaping the future of patient safety? Dr Chris Streather, Chief Executive, London South	**Developing safety plans to save lives and money** -Using thoroughly kept, robust data to drive improvement -How to build these structures from the ground up: the role of clinical leadership -What you need to know to build your business case
12.05-12.35	**Improving the flow of older people through emergency care** -Tackling the A&E crisis head on: developing ways in which capacity can be better matched to demand -How to increase rates of safe discharge with no increase in the re-admission rate Professor Tom Downes, Sheffield Teaching Hospitals	**What is a commissioner's role in patient safety?** -How to communicate the importance of patient safety to non-clinical team: the importance of a business case -The role of the CCG in unifying the healthcare economy -CQUINs: is providing financial incentive the way forward? Dr Howard State, Chairman, Bexley CCG	**From rhetoric to reality: the role of patient leadership** -Time is up for excuses: why you need strong patient leaders in your organistion -Using your experts by experience to improve patient safety	**Acute kidney injury** -Derby's innovation identified 4,500 undiagnosed cases in one year, creating a sustainable early diagnosis system to improve outcomes, patient experience and reduce cost
12.35-14.00	**Networking lunch break**			
14.00-14.30	**Co-designing solutions to improve outcomes** -Focus on co-designing solutions with elderly residents and their relatives to improve safety -Lessons from social care: why understanding shared risk is key to transforming your orgnisation	**How do I improve safety with less money?** -What does low cost, high quality integrated care look like? -Efficient programmes for quality improvement: it doesn't have to be expensive to be effective Doug Bonacum, Vice President of	**Leading the change: learning from industry** -Viewing patients as customers: a consumer approach to healthcare -Money talks: using a business case to drive change	**Case study: London's system wide reconfiguration of stroke services** -Not without our staff: the human factor in system wide reconfiguration -What does success look like? -Measuring patient experience across the pathway: data as your

		Quality, Safety and Resource Management, Kaiser Permanente		building blocks Dr Charlie Davy, Director, AHSN at UCLPartners
14.35-15.05	**Quickfire learning** -6 presentations from international innovators in patient safety -Dynamic, fast paced learning, looking at implementable examples of best practice	**How sharing data saves money and lives** -Creating a common vision for the healthcare economy: developing a joined-up approach -Reducing the impact of bed blocking through sharing data across providers Amir Mehrkar, CCIO, National Clinical Lead, Hampshire Health Record, E-Referral Service John Richards, Chief Officer, Southampton City CCG	**Value based leadership** -How value based leadership saved this organization £6m and hundreds of lives -Identifying enablers and blockers of effective value based leadership	**Using data intelligently to manage risk** -How CCIO's can collaborate with clinicians to invest in fit for purpose systems -Workshop challenge: using the data to provide solutions without spending money Dr Frances Healy, Senior head of patient safety intelligence, NHS England *War room style tackling a hypothetical issue based on data*
15.05-16.35	**Patient safety partnerships: WHO and the Ebola crisis** -Joint working across a global patient safety community -Universal issues in patient safety, and how to share learning and best practice Julie Storr, Member, WHO Ebola HQ, Director, WHO African Partnership Programme Africa partner speaker: Julie to advise	**Safe staffing in your organisation** - The use of evidence based tools to understand the your staffing needs - How to ensure your nursing staffing levels and skill mix meet the need of your patients - Reducing your reliance on temporary staff to save money long term Prof Gillian Leng, Deputy Chief Executive, NICE	**The role of leadership in primary and community care** -Where are the gaps? Identifying the need for improvement in your practice and deciding your agenda -Creating a positive culture of personality: encouraging GPs to step up to the challenge Dr Maureen Baker, Chair, RCGP Professor Trish Greenhalgh, Professor of Primary Health Care and Dean for Research Impact, Barts and the London School of Medicine and Dentistry **South Tyneside NHS FT: Electronic referral and caseload scheduling for district nursing: 42% reduction in medication errors** **CSH Surrey: integrating mental health with community matron services to improve patient safety**	**Short term investment for long term outcomes: improving safety with mobile health** -Identifying which systems are right for your organization -Improving outcomes and reducing avoidable harm Caron Swinscoe, Chief Nurse – Health Informatics, Nottingham University Hospital Nervecentre Software Ltd
16.35-17.05	**Make your idea count: the impact of frontline innovation** -How to effectively share best practice, and access resources most relevant to you -Applying for funding, what are the resources? Learning from those who have been successful -Breathing life back into established patient safety networks: accessing the Safety Fellows Peter Young	**Safety beyond a single setting: whole system care** Dr James Mountford, Director of Clinical Quality and Value, UCLPartners	**Building a culture of candour: what we've learnt so far** -What duty of candour has meant for us in practice -Encouraging candour and dissipating blame culture -The financial impact of a transparent culture: does it increase litigation? Peter Walsh, Chief Executive, AvMA Sir David Dalton, Chief Executive, Salford Royal NHS Foundation Trust	**Deteriorating patient and sepsis** -Why is sepsis still such a huge problem? Identifying the challenges in your organisation -Using patient methodology to identify patients at risk of sepsis and the use of intentional rounding -Understanding the limits of automated devices Matt Inada Kim, Consultant Physician, Hampshire Hospitals Foundation Trust
17.10	**James Reason Annual Lecture** Sir Ian Kennedy – Bristol Inquiry			

18.00	**End of day 1** Awards

Patient Safety Congress & Awards DAY 2 – 7th July 2015 Efficiency, effectiveness and experience: the business case for safety				
8.00	**Registration**			
9.00	**Keynote/panel: The business case for safety** Alastair McLellan, Editor, HSJ			
9.30-10.00	**How good people do bad things: the power of culture** "What happens when good people are put into an evil place? Do they triumph or does the situation dominate their past history and morality?"			
10.00-10.30	**Collaborative leadership for change: the new landscape of patient safety** -The progress of the Patient Safety Collaboratives: where are we now? -The developing role of NHS England's SAFE team -Who are our Safety Fellows, and how are they shaping the future of patient safety?			
11.00-11.30	**My Story: a patient's journey**			
11.30-12.00	Morning Break			
12.00-12.30	**Poster Awards**			
12.35-14.00	**Networking lunch break**			
	Human factors **Professor Jane Reid,** Researcher, Queen Mary, University of London	**Staff engagement & culture**	**Working across care pathways**	**Medicines management and optomisation**
14.00-14.30	**A vision for change: Health Education England** -The vision for human factor education for NHS and social care -Feedback from the frontline: the greatest untapped resource in care Professor Wendy Reid, Director of Education and Quality, Health Education England	**Ensuring your staff stay safe** -Changing the conversation from patient safety to safety for all in a healthcare environment -The impact of engaging staff in safety agenda for themselves as well as their patients -Case study: reducing physical assaults by 58% Ken Catchpole, Director, Surgical Safety and Human Factors, Cedars-Sinai Medical Centre, Los Angeles	**Improving emergency care handover** -Effective use of emergency care summaries to improve outcomes -Learning from Scotland: 99% of a population with ECS Jonathan Cameron, ECS programme manager at NHS National Services Scotland	**A new error for mankind: introducing e prescribing to staff and patients** -What do eprescribing systems cost and how can they be utilized efficiently? -Ensuring your staff are keeping up with your technology: getting to most out of your investment
14.35-15.05	**Increasing compliance by influencing behaviour** -Spending on new systems and procedures is wasteful if you don't focus on strengthening the link	**Improving safety for young people with long term conditions** -How co-production with patients and service users can reduce safety risks	**Safe discharge to reduce readmissions** - Patient safety is essential to reducing readmission rates: how to make your case	

	compliance, assurance and improvement -Moving beyond the checklist – how to engage staff in self-reflection and with 'the critical friend' Raj Bhangoo, Consultant Neurosurgeon, King's College Hospital	-Establishing safe care in young people: key to long term improvement of outcomes and increasing savings Emma Walker, Program me Lead, Shared Decision Making, AQuA Patient	-Care pathway development across providers: ensuring effective communication with patients -Transfer of care for people with dementia Eileen Burns, Consultant Physician, Leeds Teaching Hospital	
15.10	10 minutes in between stream sessions during which time refreshments will be available in the corridors			
15.40-16.10	**Human factors in simulation** *-Bullets in development* Ken Catchpole, Director, Surgical Safety and Human Factors, Cedars-Sinai Medical Centre, Los Angeles	**A positive safety culture: an achievable dream** -The role of positive evaluation and staff morale in patient safety - Empowering staff to innovate and find safety solutions -Whole team approach: integrating cleaning staff and healthcare assistants into the safety culture Karen Dunderdale, Deputy Chief Executive, North Lincolnshire and Goole Hospitals NHS Foundation Trust	**Improving patient safety, assurance, clinical risk management in telehealth across care pathways** -What incident types support better clinical risk management in telehealthcare? -How to develop quality standards, accountability and assurance -Measuring the patient experience of telehealth and enabling self care	**Efficient commissioning: using e-prescribing as a commissioning tool** -Interrogating and segmenting data to determine patients with the highest need and likely hospital admittance -Coordinating specialised care for patients at risk -Working with GPs to analyze patient centered needs assessment Anne Marie Olphet, Chief Nurse, NHS Erewash CCG
16.10-16.40	**What the NHS can learn from military theatre** Lieutenant Colonel Tania Cubison, experiences in the field -	**Accountability in Primary and Community Care** -Introducing the never events culture to primary care -Do we apply the lessons of the Mid Staffordshire NHS scandal to every sector as we do with acute care?	**Improving effective clinical handover for deteriorating patients** - Identifying and escalating the care of deteriorating hospital patients -Innovative tools and techniques for ways of working -Improving outcomes of patients and reducing the impact of cost by early intervention	**Listen to your patient: polypharmacy for older people** -Using shared data to identify patients most at risk of harm from polypharmacy -Developing an understanding in how to communicate risk with patients and carers -De-prescribing: how understanding your patient's priorities impacts polypharmacy David Branford, Chair, Hospital Sector, Royal Pharmaceutical Society

16.40-17.10	**Human factors in surgical crises** -Identifying barriers to safe practice in the operating room -Understanding what makes an effective operating team **Professor Jane Reid,** Researcher, Queen Mary, University of London	**Implementing a patient measure of safety in partnership** -Joint working between patients and staff with safety as a feature of the wider patient experience agenda -Embedding patient voice beyond complaint handling -Setting out a proactive agenda for integrating patient feedback Luke O'Shea, Director of patient participation, NHS England	**Supporting safe self-care** -Working across providers to form thorough care plans for patients with long term conditions -Ensuring robust mechanisms for communication to place the patients at the centre of care -Supporting high quality safe self-care to save money long term	**Improving medicines reconciliation at discharge: closing the loop** -Improvement in discharge information about medication changes has improved safety -Savings of £600,000 as a result of the programme
	CLOSE OF CONGRESS			