Patient Safety Collaborative Third Annual Conference
'From assurance to inquiry: conversations about safety'

Conference Report

Overview

The one day conference was organised by the Patient Safety team of the Oxford AHSN, and held on 25 May 2017, at Milton Hall Hotel, Abingdon.

It was attended by professionals from the patient safety community, comprising 79 delegates plus speakers, and staff from the Oxford AHSN.

Conference Aims

1. To bring together and develop a community for people involved in patient safety and quality improvement work across the region
2. To explore the role of conversation and inquiry in safety
3. To learn from the experience of improving safety in other industries

Structure of the day

All sessions were plenary, and the day facilitated throughout by Sarah Garrett [Consultant in Improvement & Innovation].

The conference opened with an overview of the conference theme from Professor Charles Vincent, Professor of Psychology, University of Oxford & Patient Safety Lead, Oxford AHSN, entitled '**From Assurance to Inquiry'**, followed by guest speakers Dr Suzette Woodward, Director, Sign up to Safety Campaign, and James Titcombe OBE, Patient Safety Specialist, Datix Limited, speaking on '**Assurance is never enough'.**

The conference then broke for lunch and networking.

The afternoon session started with a further invited speaker, Keith Conradi, Chief Investigator, who spoke about the vision of the **Healthcare Safety Investigation Branch** (HSIB).

This was followed by a presentation by Dr Suzette Woodward entitled '**Conversations about safety: what does inquiry mean for us?**

The final keynote presentation, entitled '**Protecting our customers'** was delivered by Allan Spence, Head of Corporate Passenger & Public Safety, Network Rail. Q&A sessions were lively and the atmosphere was energised.

Professor Charles Vincent gave some reflections on the day and closed the conference.

Conference evaluation

Delegates were requested to fill in an evaluation form before leaving the venue; 44 responses were received and evaluated, 56% response rate.

Results of the evaluation were universally positive, one delegate commenting 'assurance is never enough, every incident has lessons to be heard and protecting our customers - brilliant'. The

'interesting variety of speakers' was acknowledged and delegates were appreciative of the personal stories described by Suzette and James, which inspired the comment 'I feel more empowered to include patients in my safety work'.

Another delegate commented that, 'all of the talks were thought provoking, not just rhetoric' and that 'they worked really well as a set' and 'combined towards a common goal'.

Responding to the question 'which talks did you enjoy most and find helpful/useful?', several delegates felt that they all linked together to make one cohesive event. While many delegates acknowledged that they enjoyed all the presentations, some presentations resonated more deeply. Presentations by Suzette and James were particularly powerful, described by a delegate as 'human and insightful' and 'honest and clear' and inspired one delegate to 'think of patient safety in a different way'.

There was general appreciation of the value of 'the through line' as described by Suzette and that the balance between emotion and objectivity in the first half of the conference felt right.

Keith Conradi's talk on HSIB generated differing opinions, many delegates valuing his presentation and 'pleased to hear more about HSIB' but some frustrations around the uncertainties and unanswered questions. One delegate felt that 'some of this information may be easier to take in a written format'.

Allan Spence's talk was well received, 'clear and thought provoking' as the delegates drew parallels from a different industry with healthcare and appreciated the focus on the 'customer' and the importance of 'supporting staff'. While described as 'important and helpful' a couple of delegates felt it was too long and that the time available for reflection afterwards was insufficient.

Delegates were asked to comment on 'which talks were the least helpful and why?' The feedback reflects almost universal acknowledgement that all the talks were interesting and useful.

Asked to comment on 'What learning will you take from this event and seek to implement in your own organisation?', the delegates highlighted:

- 'having conversations about safety and building relationships with staff and patients and across organisations '.
- 'Reframing the conversations, I have with my team in relation to incident reporting'.
- 'Role modelling approaches and behaviours, a focus on listening, including patients in safety work, be kind and caring and an emphasis on learning with teams and helping staff to improve'.
- 'Seeing things from others perspectives, the attitude of the investigator, be more honest in identifying safety issues and processes needed and the importance of inquiry rather than blame was highlighted in the comments'.
- 'Patients pay the price for failed conversations'.

Comments and Learning points:

- Two observations that group work could have been more structured, one delegate requested more group work while another felt that some people dominate it.
- Comment on the length of presentation by Allan Spence, felt to be too long
- Suggestion that we invite Roy Lilley (Health Policy analysist and blogger on NHS issues)
- The 'entrance interview' and 'Gratix' were popular ideas.

Copies of the presentations from the day are now available from the PSC Website