## MONDAY MORNING

### 2 October 2017

| 07:00 – 08:30 | **Jhpiego Breakfast Session:** Optimizing Client Care Through System-Level Improvements in Low- and Middle-Income Countries  
4th Floor, Room: Westminster  
Chair: Jeffrey Smith; US |
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<td><strong>Speakers:</strong> Njide Ndili; NG, Shams Syed; WHO, Bulbul Sood; IN</td>
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<td>Join this breakfast session to explore current approaches in low- and middle-income settings to improve quality of care, add value, and optimize the client experience at all levels of the health system. Jhpiego’s Vice President for Technical Leadership, Dr. Jeffrey Smith, will moderate this dynamic and interactive “talk show” that includes speakers from PharmAccess (SafeCare), WHO, and Jhpiego, who will share their experiences promoting and developing patient-designed care, patient-reported outcomes, certification, coaching, public-private partnerships and national strategies in low- and middle-income countries. You will hear practical examples of how these approaches are being applied and scaled up, in addition to recommendations for future priorities for system-level improvements.</td>
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| 08:00 – 08:45 | **WELCOME COFFEE WITH THE TRADE EXHIBITORS** 3rd Floor |

| 08:45 – 10:00 | **OPENING PLENARY AND AWARD**  
3rd Floor, Room: Fleming and Whittle  
Chair: Jennifer Dixon; UK |
|---|---|
| **Official Conference Opening** *(15 minutes)*  
Cliff Hughes; President, ISQua, Jennifer Dixon; CEO, The Health Foundation  
**Making the Most of the Conference** *(5 mintues)*  
Peter Lachman; CEO, ISQua |
| **Morning Plenary** *(50 minutes)*  
Patient Voices: How Stories of Safety, Quality and Culture Form the DNA of Care  
Pip Hardy; UK  
The Benefits and Feasibility of Bringing Patient-Reported Outcomes into Cancer Clinical Care  
**Speaker:** Ethan Basch; US |
| John Ware and Alvin Tarlov Career Achievement *(5 minutes)* |
The global Healthcare Quality Improvement and Patient Safety Community is replete with wonderful and inspiring leaders. These leaders strive relentlessly for improvement to enhance the healthcare environment for patients and providers alike. Lived experiences from such leadership can provide essential lessons and remarkable insights, upon which future improvements may be built.

ISQua recognises that a key enabler for the future spread and sustainability of Healthcare Quality Improvement is that these lessons may be shared and celebrated as significant points of direction on the healthcare improvement map.

This session provides a fantastic opportunity to explore and engage healthcare improvement leaders in shared reflection of their improvement journey to date, the essential learning that they have gained along the way and an opportunity to impart some aspects of the human narrative in leading improvement. It is hoped that these reflections may help to inspire the next generation of improvement leaders as they embark on their own improvement adventure.

This session will be led by:
- **John Brennan**, General Practice, RCPI/ISQua Quality Improvement Scholar in Residence
- **Rory Conn**, Child and Adolescent Psychiatrist, Royal Devon and Exeter

The confirmed healthcare improvement leaders include:
- **Gail Nielsen** - Fellow & Faculty, Institute for Healthcare Improvement & RCPI
- **David Bates** - Chief of General Internal Medicine at Brigham and Women’s Hospital & Professor of Medicine, Harvard Medical School
- **Cliff Hughes** - ISQua President
- **Kevin Stewart** - Medical Director, Healthcare Safety Investigation Branch
- **Christina Krause** - Executive Director, BC Patient Safety & Quality Council
- **Pat O’Connor** - Faculty member of the Institute of Healthcare Improvement
- **Sibylle Erdmann** - Chair of the London Neonatal Parent Advisory Board
### A2 Understanding Systems for Safety – 90 minutes

**3rd Floor, Room: Whittle**  
**Chair:** Helen Crisp; UK

**Patient Safety, System Safety and Organisational Resilience**

**Speakers:** Charles Vincent; UK, Rebecca Lawton; UK, Christian von Plessen; DK, Jeffrey Braithwaite; AU

A chaired panel discussion between experts, enabling a ‘deep dive’ into the resilience and other approaches which stress a more proactive and positive approach to patient safety. We aim in particular to explore the practical implications of such ideas for leadership, culture, interventions to improve safety and regulation for safety. The session will allow the experts on the panel to explore these in detail and discuss theory, methods and practice, together with the opportunity for questions and discussion with the audience. The session will aim to provoke robust debate - so come and join the conversation!

### A3 Data to Drive Decision Making/Health Policy – 45 minutes each

**3rd Floor, Room: Fleming**  
**Chair:** Mike Durkin; UK

#### Session 1: Understanding Professional Misconduct: A Novel Method to Analyse Datasets to Understand the Individual, Social and Organisational Factors Where Professional Misconduct Occurs

**Speakers:** Rosalind Searle, Douglas Bilton; UK

This session explores the results of a pilot study using cluster analysis and case analysis to understand the relationships between individual, social and organisational factors in misconduct cases involving health and social care professionals. The study utilises data from the Professional Standards Authority (which holds data on the outcomes of fitness to practise cases against regulated health professionals), CQC reports, and NHS staff surveys. This pilot study was commissioned by the Professional Standards Authority for Health and Care, which oversees professional regulators. It was carried out by Professor Rosalind Searle, Centre for Trust, Peace and Social Relations, Coventry University, Professor Jeremy Dawson, Professor of Health Management, Sheffield University and Dr Charis Rice, an expert in qualitative coding. The project is introduced by staff of the Professional Standards Authority who explain the Authority’s interest in protecting the public through better understanding of how, when and why professionals do not follow their regulator’s code of conduct, and how regulators might use this insight to reduce prevalence in future. The session will include presentations from the Authority, the research team and conclude with an interactive discussion with the audience.

**Objectives:**

1. Learning to identify the factors that may combine to make an unsafe system for patients.
2. Introduction to a model for analysing individual, social and organisational factors in wrongdoing.
Session 2: New Frontiers in Professional Regulation: Building Risk Based Approaches to Prevention of Patient Harm

Speakers: Martin Fletcher; AU, Anna van der Gaag; UK

Safe health care systems require both well designed systems of care and competent, well trained and safety aware clinical frontline staff. This workshop provides a unique opportunity to consider how risk based approaches to regulation of health professions create new opportunities to strengthen the contribution of regulation to system wide efforts to improve patient safety and reduce patient harm. This interface is vital if we are to improve our collective effort to ensure safer health care systems. Drawing on examples from research and experience in Australia and the UK, this workshop will explore the concept of ‘risk based regulation’ which is bringing a shift in focus from a predominantly reactive model to one based on harm reduction as the core business of practitioner regulation. It will illustrate examples of how regulators are learning from regulatory data to identify ‘hot spots’ which may cause harm. It will show how such learning is being used to build evidence and to apply different regulatory tools. It will also show how regulators are working much more closely with others to strengthen clinical governance systems and help to prevent harms arising in the first place.

Objectives:
1. Understand the concept of ‘risk based’ regulation and how it is being applied.
2. Learn from examples of how risk based approaches to data analysis are helping to identify patterns of risk and choice of regulatory interventions and tools.
3. Consider a future agenda to further strengthen the contribution of professional regulation to patient safety and move from a predominantly reactive to a more proactive regulatory stance.
## A4 Quality in the Community – 45 minutes each

4th Floor, Room: Westminster  
Chair: Christopher Cornue; US

### Session 1: Implementing Integrated Care: Key Lessons for Improving Quality and Outcomes for People and Communities

**Speaker:** Nick Goodwin; UK

This seminar examines the evidence related to the successful implementation of integrated care programmes in policy and practice around the world. It seeks to showcase how people-centred and integrated health services delivery can significantly promote value in health and care provision. Specifically, it examines the core design components when integrating care and sets out key strategies in how transformational change may be managed.

### Session 2: Developing and Improving a Systems Approach to Diagnostic Safety in Primary Care

**Speakers:** Sudeh Cheraghi-Sohi, Hardeep Singh, Ian Litchfield; UK

Both the US Institute of Medicine and World Health Organization have recently highlighted the problem of diagnostic error and the imperative to improve the diagnostic process. The session will cover recent advances in understanding diagnostic errors, their measurement and how electronic health records (EHRs) and their abundant data can be leveraged for diagnostic safety improvement.

We will

1. discuss definition(s), causes and measurement science around diagnostic errors;
2. use a case study to illustrate process breakdowns in test result communication and follow-up that lead to diagnostic errors and
3. discuss potential challenges and opportunities offered by EHRs in diagnostic error measurement and improvement.

This session will include practical takeaways, conceptual frameworks and potential areas for solutions for mitigating diagnostic safety risks.

**Objectives:**

1. Measurement of diagnostic errors: Understanding their causes and how they are measured.
2. Understanding key contributory factors to diagnostic error: a focus on diagnostic test-results communication and follow-up.
3. Understanding how Electronic Health Records and their data can be leveraged for diagnostic safety improvement and the challenges that need to be addressed to make this possible.
Session 1: Using Data Analysis to Guide Quality Improvement in Primary Care

Speakers: Sarah Deeny, Isaac Barker, Rebecca Rosen, Rebecca Fisher; UK

This session will give examples of innovative uses of data analytics in primary care to aid quality improvement, the profile of which has risen appreciably in recent years. In common with other countries, primary care in the UK is under significant pressure. Those attending primary care increasingly require treatment for multiple, chronic conditions, increasing the complexity of the patient need. Health systems are also trying to move the treatment of patients from secondary to primary care. With resources (both funding and workforce) remaining constrained, the pressures in the primary care system are clear.

We will present recent research on how data analysis in general practice can be used to guide quality improvement methods in a number of ways. These include identifying segments of the population who need alternative approaches to care, formatively evaluating local quality improvement initiatives, and by analysing data beyond single practice level to identify suitable targets for improvement, and monitor outcomes post intervention.

Objectives:

1. Knowledge of examples of using data analysis to guide quality improvement in primary care.
2. Knowledge of the challenges and benefits of using applied data analytics in primary care.
3. Discussions on how innovative applied data analytics could be used more widely in a range of settings.
Session 2: Improving Patient Safety, Using a Variety of Tools

Speakers: Louis P. Ter Meer; NL/CL, Ezequiel García-Elorrio; AR, Carol Wratten; US

Most of the time patients are ill prepared when undergoing treatment. Besides a wide range of general facts, such as a list of personal preferences and medical facts, which should be known to caregivers, patients and their families are mostly forgotten in the healthcare process and as a result, even the most basic documentation like medication lists, allergies, or ethical questions are seldom completed without error.

The Batz Patient Safety Foundation is working to disrupt this current paradigm by producing patient safety guides and health literacy resources in multiple languages in both printed and electronic versions. By offering learning materials, asking questions, and providing space for prompted conversation, the Batz Foundation aims to equip patients and their families with the tools they need to help contribute to optimal care while facilitating a more secure, less stressful environment for all involved.

During the session, the Batz Foundation team, their researchers, and app developers will provide insights on their model, use an application of their material, discuss future plans for including artificial intelligence, and demonstrate how hospitals, community partners and patients are utilizing these resources.

Session attendees will each leave with copies of the paediatric and adult Batz guides and models for how their healthcare setting can take advantage of these free resources.

Objective:

1. By attending this session, delegates will learn how to better include their patients in their own treatment, how to help patients best advocate for themselves, and how to help increase health literacy among patient populations.
Session 1: Enabling Clinician-Led Quality Improvement: Mixed-Methods Findings from the EPOCH Trial

**Speakers:** Carol Peden; US, Tim Stephens, Graham Martin; UK

The Enhanced Peri-Operative Care for High-risk Patients (EPOCH) trial is one of the largest quality improvement studies undertaken globally, involving 27,000 patients in 90 hospitals in the United Kingdom. The trial operated at 2 levels; a high-level data analysis of an intervention implemented as a stepped-wedged cluster randomised trial, and 90 separate hospital-level improvement projects. The overarching research question was, “Can a quality improvement programme enable the implementation of a care pathway to reduce mortality after emergency abdominal surgery?” This session will address both aspects of the study, combining the main quantitative trial results with ethnographic and process evaluation data to describe and analyse how the local clinician-led quality improvement developed iteratively across the 90 hospitals.

**Objectives:**

1. Delegates will hear practical wisdom generated from the experiences of clinicians delivering local improvement within EPOCH, including the key barriers and enablers to local improvement efforts and clinical pathway implementation, and consider how this could be applied in their own settings.

2. Delegates will learn the answer to the question, “Can a quality improvement programme to enable the implementation of a care pathway reduce mortality after emergency abdominal surgery?” and the robust research methods leading to this answer.

3. Delegates will have the opportunity to consider and discuss how research methods can and should be applied to manage the tension, present in real world improvement research, between robust trial methodology and on-the-ground implementation.

Session 2: Designing Improvement Evaluations to Maximize Learning: Salzburg Global Seminar – Session 565 Insights in Practice

**Speakers:** Rashad Massoud, Emily Evans, Gareth Parry; US

This session will present on the outcomes of applying lessons learned from the Salzburg Global Seminar – Session 565 “Better Health Care: How do we learn about improvement?” to the evaluation designs of improvement activities. Presenters will explain how evaluation is integrated into the design of improvement efforts in order to maximize attribution and generalizability as well as lessons learned from this change in evaluation and improvement design.

**Objectives:**

1. Learn from how the outcomes of the Salzburg Global Seminar is applied to improvement initiatives to better understand what worked, how it worked, what was generalizable and what was context specific in each initiative.

2. Learn which evaluation and research designs can be used to maximize learning, including mixed methods.
### A7  Education Through Learning and Sharing
- 15 minutes each
4th Floor, Room: Abbey  Chair: Bruno Lucet; FR

- **Effectiveness of an Education of Point-Of-Care Ultrasound Guideline in an Emergency Department** (Abstract no. 1734)
  - **Myunh Ah Lee**, H. Kwon; KR

- **Medical Student Perception of Academic Stress and Satisfaction with the Revised Curriculum Quality at IAU Saudi Arabia** (Abstract no. 2709)
  - **Somanath Mohapatra**, A.M. Sebiany, C.C. Jones Nazar; SA

- **A Conceptual Map for Patient-Centred Care Requirements: Enhancing the Approach of Systems to Achieving Patient-Centred Care** (Abstract no. 2215)
  - **Jenny Barr**, K. Ogden, D. Greenfield; AU

- **Training Healthcare Workers to Improve the Quality of Maternal, Newborn & Child Healthcare Services in Marginalized Settings** (Abstract no. 2981)
  - **Kamran Baig**, F. Shahid; PK

### A8  Sustainable Quality Improvement for LMIC
- 15 minutes each
2nd Floor, Room: Olivier  Chair: Teresa Tono; CO

- **Strengthening Quality Improvement Work in Hospitals by Using WhatsApp: Exploratory Qualitative Study from Indian Hospital** (Abstract no. 2417)
  - **Parika Pahwa**, S. Smith, N. Livesley; IN

- **Qualitative Evaluation of Low-Dose-High-Frequency Learning Experiences to Improve Newborn Outcomes and Quality of Care, Ghana** (Abstract no. 2824)
  - **Amos Asiedu**, A. Nelson, P. Gomez, F. Effah; GH

- **Remote Facilitation of Quality Improvement Plans Using WhatsApp Mobile Application in Kwara State, Nigeria** (Abstract no. 3268)
  - **Ibironke Dada**, O. Adebola, A. Shittu-Muideen; NG

- **Telemedicine in the Himalayas - Reaching the Unreached** (Abstract no. 2624)
  - **A. Sibal**, K. Ganapathy, V. Thaploo, S. Premanand; IN

- **Improving Efficiency in Haematology Laboratory** (Abstract no. 3166)
  - **Mashhooda Rasool Hashmi**, B. Moiz, S.A. Baloch, I.A. Ansari; PK
A9 The Patient’s Voice – 15 minutes each
4th Floor, Room: Rutherford and Moore  Chair: Carsten Engel; DK

Patient Advisors at the Bed Side for Hand Replantation Patients: What Added Value for Quality of Care? (Abstract no. 1828)
Marie-Pascale Pomey, O. Fortin, J. Arsenault, V. Lahaie, M-A. Danino; CA

Improving Pulmonary Rehabilitation: The Role of Patient Volunteers (Abstract no. 1369)
Sharon Williams, H. Beadle, A. Turner; UK

Patient and Public Involvement in Japanese Clinical Practice Guideline Development (Abstract no. 3274)
Akiko Okumura, T. Nakayama, H. Sugawara, N. Yamaguchi; JP

Co-Designing Patient-Centred Care Using Participatory Action Research [PAR] - the Epilepsy Partnership in Care [EPIC] Project (Abstract no. 2402)
Jarlath Varley, R. Power, J. Saris, M. Fitzsimons; IE

Consumer Involvement in the Quality Of HIV Care, The Namibian Experience (Abstract no. 1843)
Julie Taleni Neidel, A. Basenero, N. Hamunime, P. Luphahla; NA

A10 A Mile in my Shoes – 90 minutes
3rd Floor, Exhibition Area

An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else’s shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes.

The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories.

Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system.
Patient Safety And Cinema: A Training Opportunity for Developing Empathy in Healthcare Professionals

4th Floor, Room: St. James

Chair: Sara Albolino

Speakers: Riccardo Tartaglia, Stavros Prineas; IT, Jeffrey Braithwaite; AU
Melissa Redmond; IE

The Workshop will be aimed at promoting the use of movies in the training of health care professionals in order to diffuse a patient safety culture and the empathic approach towards patients and families. The workshop will investigate, through the projection and discussion of video clips, the role of movies and TV series in building a cultural stereotype of healthcare quality and safety issues in both public opinion and clinicians. Moreover, the discussion with participants will focus on understanding how movies not only reflect ‘reality’ but also how they manipulate it, and how this also reflects in medical error. What we think we see is often different to what’s really there.

Objectives:
1. Learn how to use movies as a strategic tool for training in patient safety.
2. Learn how cinema can affect patient safety culture and empathy.
12:45 – 13:30  “We Want to Work Out What Works, What Doesn’t, and Why” New Improvement Research Institute - ‘We Need to Improve Improvement’
4th Floor, Room: Westminster
Chair: Will Warburton, The Health Foundation, UK

**Speaker:** Mary Dixon-Woods; UK

The Health Foundation is investing around £40 million in the establishment of an improvement research institute. Based at the University of Cambridge, the institute will work closely with a wide range of partners including the health service, university and charity sectors and from other sectors across the UK. Led by Mary Dixon-Woods, RAND Professor of Health Services Research and Wellcome Trust Investigator at the University of Cambridge, the institute will produce practical, high quality learning about how to improve patient care and will grow capacity in research skills in the NHS, academia and beyond. The vision is bold and ambitious: the institute will create the enabling infrastructure for the NHS to become the producer of systematic learning about how to improve health care for patients. To do this, the institute will use innovative approaches ranging from citizen science through to large-scale research capacity building and will be working directly with patients themselves as partners.

The basic principle behind the institute is a simple but important one: the need to get better at getting better at delivering health care and one way to make that happen is by creating a better evidence-base for improvement.

**12:45 – 13:30**  Meet the World Health Organisation Experts
4th Floor, Room: Abbey

Open to all delegates, this is your chance to meet and network with WHO experts.
**12:40 – 13:30 E-POSTER PRESENTATIONS AP1 – AP5**

| AP1 | Generalisability of Improvement Outcomes  

*– 10 minutes each*

5th Floor, E- Poster, Area 1 | Chair: Alex Bottle; UK |

| | **Chair:** Alex Bottle; UK |

| **BBCN in Healthy China 2030: Innovative Development of Capacity of Quality Improvement with the Practice of PHS Win-Win (Abstract no. 2114)** |
|---|---|
| QianLi Jiang, W. Li, Y. Zhang, T.F. Liu; CN |

| **Monitor the Quality Indicators to Reduce Rate of Unplanned Return to the Operating Room of Inpatients (Abstract no. 2243)** |
|---|---|
| Wen-Hsin Chang, F.-C. Kao; TW |

| **Evaluating the Ten Year Impact of the Productive Ward in Clinical Microsystems in English Acute Hospitals: A National Study (Abstract no. 2425)** |
|---|---|
| Glenn Robert, S. Sarre, R. Chable, J. Maben; UK |

| **Enablers of and Barriers to Change in Primary Care: A Process Evaluation of an Adaptable Guideline Implementation Strategy (Abstract no. 1479)** |
|---|---|
| Rebecca Lawton, C. Hunter, V. Ward, T. Willis, L. Glidewell; UK |

| **Implementation of Recommendation to Avoid Low Value Clinical Practices in Catalonia. Essencial Project (Abstract no. 3257)** |
|---|---|
| Cari Almazán, J. Caro, M. Moharra, T. Paada; ES |
### AP2  Sustainable Quality Improvement for LMIC

- 10 minutes each
- 5th Floor, E- Poster, Area 2  
  Chair: Andrew Likaka; MW

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<th>Session</th>
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<tr>
<td>Improving Quality of Care in Primary Healthcare Facilities in Rural Nigeria Using the Safecare Standards and Methodology (Abstract no. 1053)</td>
<td>N. Spieker, U. Okoli, <strong>Njide Ndili</strong>; NG</td>
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<td>Onsite Mentoring to Improve the Quality of Emergency Maternal and Neonatal Care in Nepal (Abstract no. 1789)</td>
<td>V. B. Alvarez, <strong>Tulasa Bharati</strong>, P. Silwal, B. Rajbhandari; NP</td>
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<td>Promoting Gender-Based Violence Services in Mozambique: Experience Using a Quality Improvement Approach (Abstract no. 2075)</td>
<td><strong>Edgar Necochea</strong>, A. Baptista, H. Muquingue, Al. Jaramillo; MZ</td>
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<td>A Model to Measure Healthcare Quality in Ethiopia (Abstract no. 3235)</td>
<td><strong>Berhanu Endeshaw Mohamed</strong>, T. Debebe; ET</td>
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<td>Impact of Continuous Quality Improvement on Infection Prevention &amp; Control in VMMC Services in Gauteng, South Africa (Abstract no. 2858)</td>
<td><strong>Hulisane Matakanye</strong>, J. Ndirangu, C. Visser, J. Littlefield; ZA</td>
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### AP3  Understanding Systems for Safety

- 10 minutes each
- 5th Floor, E- Poster, Area 3  
  Chair: Virginia Mumford; AU

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<tr>
<td>Nurses’ Experiences and Perceptions of Escalating Deterioration to Treating Teams Using Pre-Met Urgent Review Criteria (Abstract no. 1214)</td>
<td><strong>Gordon Bingham</strong>, M. Fossum, L. Hughes, T. Bucknall; AU</td>
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<td>Safety Attitude of Operating Room Teams Associated with Accurate Completion of Surgical Checklist (Abstract no. 2484)</td>
<td><strong>Florence Sens</strong>, A. Duclos, E. Herquelot, C. Colin; FR</td>
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<td>Missed Nursing Care: The Role of Personal and Ward Accountability in Improving Patient Safety and Quality of Care (Abstract no. 2382)</td>
<td><strong>Einav Srulovici</strong>, A. Drach-Zahavy; IL</td>
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<td>Improving Patient Safety by Reduction of Dispensing Near Miss Rate in the Inpatient Pharmacy of a Medical Center in Taiwan (Abstract no. 3129)</td>
<td><strong>Jui-Hu Shih</strong>, W.-T. Shao, C.-W. Huang, C.-C. Hsieh; TW</td>
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<td>Code H and its Impact on Reducing Catastrophic Adverse Events due to Bleeding Management Failure (Abstract no. 3261)</td>
<td><strong>Camila Oliveira</strong>, M. Jaures, R. Reis, J.C. Guerra; BR</td>
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### AP4 The Patient’s Voice – 10 minutes each
5th Floor, E- Poster, Area 4  
**Chair:** Jan Mackereth-Hill; UK

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<tr>
<td>Communicating Risk in Active Surveillance of Prostate Cancer – Hearing the Patients’ Voice (Abstract no. 2954)</td>
<td>Anne Hogden, K. Churruca, P. Shih, F. Rapport; AU</td>
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<td>Patients, Students and Professionals Learn Together in an Educational Program to Improve Patient-Centredness of Health Care (Abstract no. 2378)</td>
<td>Thomas W. Vijn, H. Wollersheim, J.A.M. Kremer, C.R.M.G. Fluit; NL</td>
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<td>Patients’ Self-Management of Breast Cancer Risk: Gaining Control in Clinical and Non-Clinical Contexts (Abstract no. 2245)</td>
<td>Patti Shih, A. Hogden, M. Bierbaum, F. Rapport; AU</td>
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<td>Pharmacist-Led Bedside Discharge Medication Counselling Service – A Patient-Centred Approach (Abstract no. 1955)</td>
<td>Hiu Wing Theola Lau, P.K. Yick; HK</td>
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### AP5 Data to Drive Decision Making/Policy – 10 minutes each
5th Floor, E- Poster, Area 5  
**Chair:** Carlos Goes De Souza; UK

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<tr>
<td>Embedding Quality Measurement in Health Services Accreditation: Stroke Distinction Program (Abstract no. 3283)</td>
<td>Louise Clémence, D. Dorschner, A. Gregus; CA</td>
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<td>Creating a System of Safety Through Governance &amp; Data Driven Decision Making (Abstract no. 3110)</td>
<td>P. Cruz, Elizabeth Joseph, J. Varghese; IN</td>
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<td>Implementation of a Standard Operating Procedure to Improve Viral Load Documentation Practices in Northern Namibia (Abstract no. 2450)</td>
<td>Pearl Kalimugogo, S. Geza, N. Hamunime, A. Zegeye; NA</td>
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<td>Big Data Exploration for Drugs and Cancer Risk: Online Tool for Massive Observational Studies with Controls (Abstract no. 3255)</td>
<td>Usman Iqbal, H.A. Ali Khan, W.S. Jian, Y.-C.(J) Li; TW</td>
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## MONDAY AFTERNOON
2 October 2017

13:45 – 15:15 **CONCURRENT SESSIONS A11 – A20**

| A11 | Masterclass: Lessons Learned in Leading for Quality  
– 90 minutes *(Follow on from morning session A1)*  
2nd Floor, Room: Gielgud |
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| A12 | The Patient’s Voice – 45 minutes each  
3rd Floor, Room: Fleming  
Chair: Susan Frampton; US |
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| Session 1: Lessons Learned About Primary Care from Listening to Children’s Voices  
– MOCHA Project |
| Speakers: Michael Rigby; UK, Vinita Mahtani; ES, Alexander Palant; DE, Manna Alma; UK |
| There are over 70 million children under 18 living in the EU with considerable variation between and within countries in how well they are being served by current primary care health systems. MOCHA (Models of Child Health Appraised) is a Horizon 2020 EU Commission funded project which is appraising the systems in 30 countries. In order to listen to children’s voices, the qualitative DIPEx research methodology about patient experiences is used. This workshop will highlight the importance of listening to children’s voices, how this has been done within the MOCHA project and what lessons have been learned from listening to children’s voices. |
| Objectives: |
| 1. To get insight in how to listen to children’s voices and the value of listening to these voices. |
| 2. To get insight in and to understand children’s experiences regarding primary care for children. |
| 3. To get insight in similarities and differences in children’s experiences with primary care across Europe. |
Session 2: Removing Barriers and Enhancing Facilitators for Patient-Safety Communication: Improving Care and Safety for Patients with Speech Impairments and their Supporters

Speakers: Bronwyn Hemsley; AU, Susan Hrisos, Richard Thomson; UK

Research shows that patients struggle to make their voices heard in interactions with hospital staff, impacting on their safety; and that engaging patients in interactions about their safety helps reduce risks for safety incidents. Staff interpersonal skills make an enormous difference to patients and contribute to safer healthcare. ThinkSAFE provides evidence and theory-based support to enable patients and staff to participate collaboratively in discussions about safety. However, patients with communication impairments encounter several barriers to effective communication that warrant additional strategies on the part of hospital staff. We will draw upon patient and carer stories of care and medical record documentation of incidents and patient communication, to examine patient-provider interactions for patients with communication difficulties. These incidents will be related to the Generic Model of Patient Safety [16]. Three case-based scenarios will be discussed in relation to strategies to improve interpersonal communication for all patients, including those who have difficulty communicating their patient safety needs.

Objectives:

Through the presentations and by interaction with the other delegates and presenters, delegates will:

1. Learn about a range of evidence-based strategies relating to patient-provider communication in hospital for patients, including both patients who are communicatively vulnerable (i.e., the vast majority of patients) and patients with more severe communication disability (i.e., the minority of patients, with little or no speech).

2. Hear about patient safety research from the perspectives of patients with little or no speech and their family carers/supporters in hospital.

3. Consider how to implement approaches to support collaborative interactions between staff and patients that promote improved quality and safety of healthcare.

4. Identify ways to detect common barriers and facilitators to patient-provider communication about safety, apply the generic model of patient safety to guide improvements, and consider directions for undertaking future research in their own settings.
A13 Regulations Influence on Governance
- 45 minutes each
6th Floor, Room: Mountbatten  Chair: David Greenfield; AU

**Session 1: Safety Standards for Digital Health Services – Learning from a Shared International Perspective**

**Speakers:** Meredith Makeham; AU, Hardeep Singh; US and Aziz Sheikh; UK

**Workshop Facilitators:** Meredith Makeham, Andy Carson-Stevens and David Greenfield; AU

The workshop aims to provide an international perspective on optimising healthcare safety while implementing digital health services and technologies. It will provide an opportunity to share knowledge on digital health safety standards - why they are needed, what is currently in use (noting generally the developmental stage of digital health safety standards), and additional work required to promote future safety standards development. This workshop will support international sharing and collaboration needed to make progress.

The session includes presentations from digital health safety thought leaders providing the evidence base and conceptual foundation to address emerging safety risks related to digital health. Participants will contribute to the key workshop outcome of identifying digital health safety gaps that would benefit from future standards development.

**Objectives:**

Through the presentations and by interaction with the other delegates and presenters, delegates will have:

1. An understanding of the current evidence on safety threats associated with the use of digital health technologies and services.

2. An understanding of standards to support the safe use of digital health technologies and services (technical and behavioural).

3. The opportunity to network with and plan for future collaborations in the field of digital health.
Session 2: Developing Metrics for the Complex Care Primary Care Interface for Children

Speakers: Maria Brenner; IE, Mitch Blair; UK

This session will focus on framing person-centric quality for complex care, reporting on the adaptation of standards from the US to explore the integration of care for children with complex care needs across the European Union (EU) and European Economic Area (EEA). This is part of a Horizon 2020 funded project Models of Child Health Appraised (MOCHA), running from 2015 to 2018. The session will present findings from 30 countries using three tracer conditions, in relation to quality and governance at the acute-community interface. Through mapping EU data to the US experience, we will present a potential way forward for enhancing quality care for children with complex care needs through our revised standards and proposed model of care.

Objectives
1. Explore contemporary needs of children with complex care needs in the community.
2. Critically reflect on the optimum facilitators of integration of care at the acute community interface.
3. Contribute to discussion on components of a model of care and proposed revised standards for this population.

A14 Understanding Systems for Safety
- 45 minutes each
3rd Floor, Room: Whittle Chair: John Helfrick; US

Session 1: Designing and Implementing Deteriorating Patient Safety Net Systems at Scale – in Australia and Qatar

Speakers: Charles Pain, Cliff Hughes, Malcolm Green; AU, David Vaughan; IE

The background, theory of change, design principles, and lessons learned from implementation of deteriorating patient safety net systems in two different health systems (Australia and Qatar) will be described; and the implications for large scale, sustainable health systems improvement will be derived. Participants will then be guided through the practical design of a deteriorating patient safety net system for their own health system by applying the design principles.

Objectives:
1. Understand the benefits of deteriorating patient safety net systems.
2. Understand the theory of change and design principles of deteriorating patient safety net systems.
3. Understand the implications of these principles for the design of other large scale sustainable health systems improvement.
4. Apply the design principles to the design of their own deteriorating patient safety net system in their home jurisdiction.
Session 2: The St. Vincent’s Ethos Program is “Redefining Normal” with a Pragmatic Approach to Addressing Unprofessional Behaviour

Speakers: Victoria Atkinson, Catherine Jones; AU

Entrenched cultures and behaviours in the health sector are putting the safety of staff and patients at risk. Many health services are at a loss as to how to tackle the problem. This session will outline the St. Vincent’s Ethos program which provides a pragmatic approach to addressing unsafe behaviours including practical skills on how to speak up and how to provide feedback in an informal, respectful, non-punitive way. The St. Vincent’s Ethos program removes barriers to speaking up; responds quickly and equitably to unsafe behaviours and recognises staff who model positive behaviours.

The program includes:
- a validated, tiered accountability pathway and a peer driven early intervention process;
- a confidential reporting tool;
- capability building and skills training for staff; as well as development of a sector wide web of accountability.

Objectives:
1. Describe how the St. Vincent’s Ethos program will improve safety culture.
2. Demonstrate skills in how to speak up and how to provide feedback.

A15 Quality and Safety in Mental Health

- 45 minutes each

4th Floor, Room: Westminster

Chair: Sen-Tien Tsa; TW

Session 1: The Improvement and Development of Mental Health in Taiwan

Speakers: Shu-ling Lai, Joseph Jror-Serk Cheng; TW

Since 1950, in order to prevent social and living functions from withdrawal, the healthcare model for mental health provided worldwide has been gradually changed from traditional institutions to community- or home-based care, and the treatment for patients has been switched from institution to community. We will share the successful experience in improving and developing mental ill health and the coping measures in response to rapid population ageing, increased patients with chronic mental health and dementia prevalent in the elderly in Taiwan. The contents include: mental healthcare system, service network and resources in Taiwan; the improvement mechanisms for mental health in Taiwan (including accreditation); and the diversified community-based healthcare model to implement a patient-centred, community-oriented and rehabilitation-purposed service in order to facilitate the protection of rights and interests of patients with mental illness.

Objectives:
1. To continuously improve the quality of mental health.
2. To promote diversified community-based care models and solutions (including dementia).
Session 2: Safe and Healthy Working Environments: the ‘Enabling Environments’ Initiative

Speakers: Rex Haigh, Sarah Paget, Sarah Skett, Simon Coope; UK

The Enabling Environments Award is an evidence-based quality improvement project that invites applicants to consider whether they are achieving the ten core standards in their own organisation. Specific criteria give guidance on how to practically achieve them, and how to integrate them into the day-to-day life of the organisation. Achievement of the Award is a mark of quality providing recognition and external validation that the organisation is an “Enabling Environment”. It is valid for three years, subject to satisfactory interim reports.

The Francis report argues for changes in the culture of organisations. It supports more openness and transparency and a decrease in defensiveness to improve the organisation’s capacity to tolerate and learn from criticism. The Enabling Environment framework supports organisations to develop these qualities.

Objectives:
1. Appreciating the impact of psychosocial environment on outcomes.
2. Understanding a co-production methodology to improve psychosocial.

A16 Data to Drive Decision Making/Policy
- 15 minutes each
4th Floor, Room: Rutherford and Moore  Chair: Sarah Deeny; UK

The Association Between Hospital - Community Continuity of Care Patients with Chronic Disease and Clinical Outcomes (Abstract no. 3302)
Eyal Zimlichman, O. Sharlin, B. Oberman, S. Vinker; IL

Are Mortality Alerts Associated with Other Indicators of Hospital Quality in England? A National Cross-Sectional Study (Abstract no. 1767)
Elizabeth Cecil, A. Bottle, P. Aylin; UK

Comparison of Hospitalisation and Mortality for Patients with Heart Failure in England and Lombardy Region (Northern Italy) (Abstract no. 1421)
Alex Bottle, K. Dharmarajan, P. Aylin, A.M. Paganoni; UK

Developing the Digitally-Enabled Learning Health System For Improvement (DE-LHS) (Abstract no. 1040)
John Ovretveit; SE, L. Savitz; US
A17  
Understanding Systems for Safety  
- 15 minutes each  
4th Floor, Room: St. James  
Chair: Yu-Chuan (Jack) Li; TW

How to C a Difference: A Multidisciplinary Approach to C. Difficile  
(Abstract no. 2869)  
Vicki LoPachin, B. Koll, G. Patel, R. Anderson; US

The Voice Study: Embedding the Patient Voice of Older Adults in the Exploration of Their Experiences During Care Transitions  
(Abstract no. 1430)  
Chantal Backman, M. Crick; CA

The Incidence, Nature and Trends of Adverse Health Events at a Regional Hospital Between April 2011 to April 2014  
(Abstract no. 2942)  
Ozayr Haroon Mahomed, D. Kalonji; ZA

Clean Hands Save Lives: Using a Data-Driven Approach to Improve and Sustain Hand Hygiene Compliance  
(Abstract no. 1836)  
Rebecca Anderson, S. Garg, J. Mari, V. LoPachin; US

Prevention of Wrong Medication Through Enhanced Clarification by Pharmacist on Questionable Prescription  
(Abstract no. 1596)  
Shin Ushiro, M. Sakaguchi, H. Sakai, J. Inoue; JP

A18  
Quality and Safety in Crisis  
- See timings below  
2nd Floor, Room: Olivier  
Chair: Camila Lajolo; WHO

WHO Emergency Medical Teams Initiative: Shaping The Future Of Emergency Response - (30 minutes)  
Speaker: Camila Lajolo; WHO

Disasters and disease outbreaks can occur at any given moment and in any place in the world—often wreaking havoc and seriously disrupting and threatening lives of communities, and imposing an excess burden on health systems. Good intentions are not enough when responding to such events; ensuring appropriate quality of care and coordination is paramount. The WHO Emergency Medical Teams initiative established in 2015 works to help improve the timeliness and quality of care provided by national and international teams that deploy in response to emergencies. This session will present an overview of WHO Emergency Medical Teams initiative and how it is shaping the future of response to emergencies, like natural disasters and outbreaks. Case examples from recent emergencies, like the Nepal earthquake will be used to illustrate the benefits of this initiative.
<table>
<thead>
<tr>
<th>Title</th>
<th>Abstract No.</th>
<th>Duration</th>
<th>Authors/Institutions</th>
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<tbody>
<tr>
<td>Reduce Dengue Fever Effect of Soda Ash on Vector Control</td>
<td>1080</td>
<td>15 minutes</td>
<td>Chen Kun Chih, W. Yu-Lung, T. Yu-Hui, W. Guo-Ming; TW</td>
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<td>Improving Care in Complex Humanitarian Crises: A Process Evaluation of Médecins Sans Frontières’ Approach to Quality</td>
<td>3337</td>
<td>15 minutes</td>
<td>Anna Freeman, N. Hurtado, J. Ousley, S. Leatherman; US</td>
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<tr>
<td>Using Clinical Pathway to Manage Dengue Fever</td>
<td>1024</td>
<td>15 minutes</td>
<td>Abdul Aziz Abdul Rahman; MY</td>
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### A19 Disruptive Improvement and Adaptive Change

- **Implementation of a Standardized Delirium Management Program to Prevent, Detect and Treat Delirium in Surgical Patients** (Abstract no. 3024)
  - Maria Schubert, E. Lanz, G. Clémençon, D.L. Leuenberger; CH

- **The Development of a Tariff Model: Pay for Performance** (Abstract no. 2294)
  - Hansang Kim, S. Chung, E. Jeong; KR

- **Collective Leadership and Safety Cultures: Developing an Alternative Model of Leadership for Healthcare Teams** (Abstract no. 2839)
  - Eilish McAuliffe, M. Ward, A. DeBrun, U. Cunningham; IE

- **Health System Transformation in The UK: Making it Happen** (Abstract no. 2500)
  - David Hunter, G. Maniatopoulos; UK

- **Multidisciplinary Embedded Research to Identify Solutions to Emergency Department Overcrowding** (Abstract no. 2693)
  - Cecilia Vindrola-Padros, S. Crowe, L. Grieco, S. Elkhodair; UK

### A20 A Mile in my Shoes

- **A Mile in My Shoes** - 90 minutes
  - 3rd Floor, Exhibition Area

An interactive shoe shop, A Mile in My Shoes, invites you to (literally) step into someone else’s shoes and embark on a mile-long physical, emotional and imaginative journey to see the world through their eyes.

The Empathy Museum has teamed up with the Health Foundation to develop a collection of stories from people working within health and social care. The result is a giant shoebox, a display of shoes, and a series of unique audio stories.

Through sharing the experiences of different people, A Mile in My Shoes hopes to show the remarkable contribution and challenges faced by those working in, and using, our health and social care system.
15:45 – 16:50  AFTERNOON PLENARY

PLENARY
3rd Floor, Room: Fleming and Whittle  Chair: David Bates; ISQua

Afternoon Plenary: Quality and Safety in a Crisis Situation
Panel: Jorge Hermida; URC, Sidney Wong; MSF, Rashad Massoud; Harvard, John Gaffney; Save the Children International

A key challenge for healthcare is to maintain high levels of quality and safety in periods of great stress, be it an epidemic, a natural disaster, war or a terrorist attack. The question is “how do we stay safe, effective and person centred in all situations.”

The Panel includes members from Harvard Global Health Institute, Medicins sans Frontieres, URC/ASSIST and Save the Children International. Using examples from their organisations, they will discuss:

- The importance of quality improvement in humanitarian crises.
- What we mean by quality in these contexts.
- Challenges that everyone faces across different crisis situations.
- How we monitor quality improvement and how much resources should we expend on such monitoring.
- Innovative ways to accelerate the quality improvement process.

17:00 – 18:00  ISQua AGM
4th Floor, Room: St. James

19:00  Networking Reception
Venue: London Transport Museum
Tickets can be purchased from the registration area
NOTES: