

RISK

& Patient Safety 2012

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Thursday 2 February - Friday 3 February 2012 Cavendish Conference Centre, London

KEY BENEFITS OF ATTENDING

- Develop your knowledge of international, national and local developments in patient safety and risk management
- Learn from practical case studies of patient safety improvements at a local level
- Develop your patient safety skill set with in depth masterclasses facilitated by experts on key issues
- Understand how to set a local patient safety agenda that matters to your trust board
- Understand how to meaningfully involve patients in the patient safety agenda
- Develop your patient safety programme with measurable goals for improvement and QIPP

IN DEPTH MASTERCLASSES

- Advanced Incident Investigation
- Compliance
- Patient Safety Metrics
- Engaging Junior Doctors in Patient Safety
- Reducing Avoidable Mortality
- Root Cause Analysis
- Patient Safety, Clinical IT and Electronic Patient Records
- Patient Involvement in Patient Safety

KEYNOTE OPENING ADDRESS

Dr Carolyn M Clancy *Director*
Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services
Clinical Associate Professor
The George Washington University School of Medicine
and Senior Associate Editor
The Journal Health Services Research
(via Videolink)

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“This is a broad and complex agenda and a significant leadership challenge for us all. It requires us to keep a firm grip on delivery for today, facing up to issues such as the need to maintain patient safety during a period of organisational change....We must meet these challenges at a time when staff and leaders across the NHS face personal and professional uncertainty about their futures. I do not underestimate the scale of what lies ahead, but I have confidence, based on our track record of delivery, that we can succeed.” David Nicholson, Chief Executive, NHS; The Operating Framework for the NHS in England 2011/2012

Now in its twelfth year Risk and Patient Safety 2012 aims to bring together Clinical Risk Managers, Clinicians and Boards to share and learn from good practice and improve safety for patients. The plenary conference focuses on evaluating patient safety improvement, an update from the national programmes and practical case studies of patient safety initiatives that have led to improvement. The conference also focuses on how to set patient safety priorities at a local level and how to move from patient safety initiatives to patient safety transformation.

This year the conference also comprises of in depth masterclasses alongside the traditional conference programme allowing you to mix and match the sessions and to develop your skills in specific patient safety areas.

The Masterclasses focus on:

Advanced Incident Investigation
Patient Safety Metrics
Reducing Avoidable Mortality
Patient Safety, Clinical IT and Electronic Patient Records

Compliance
Engaging Junior Doctors in Patient Safety
Root Cause Analysis
Patient Involvement in Patient Safety

These masterclasses aim to accelerate the success of your patient safety and risk management initiatives learning from experts in patient safety, and networking with others to share best practice.

Aimed at Risk Managers, Clinicians, Boards, Health Managers and Patients this conference will enable you to develop your patient safety programme at clinical service or organisational level, network with fellow colleagues and take back new ideas to implement in your organisation.

Chair Jane Cummings *Chief Nurse and Deputy Chief Executive NHS North West*

10.00 Chair's introduction

10.15 Evaluating Patient Safety Improvement: Have we made a difference? World Health Organisation Patient Safety Programme Update

Dr Carolyn M. Clancy via Videolink

*Director, Agency for Healthcare Research and Quality (AHRQ)
U.S. Department of Health and Human Services
Clinical Associate Professor
The George Washington University School of Medicine
& Senior Associate Editor
The Journal Health Services Research*

- monitoring and evaluating patient safety improvement
- implementing change and improvement: what we have learnt
- tips for monitoring and evaluating the difference you have made in your practice or organisation

10.45 Safety Express: An update from the Clusters Implementing the QIPP Safe Care Workstream

Dr Maxine Power

*Safe Care Lead and Improvement Advisor
Safety Express
National Improvement Lead for Quality and Productivity
QIPP National Programme*

- moving towards a safer more reliable NHS with improved outcomes at significantly lower cost
- key interventions and improvement goals
- an update from the Clusters

11.15 Questions and answers, followed by coffee and exhibition at 11.25

Conference Splits: Choice of Main Stream or two Masterclasses

Practical case studies of Patient Safety Improvement

Chair Jane Cummings *Chief Nurse and Deputy Chief Executive NHS North West*

11.50 Proactively sustaining improvements in patient safety

David Dalton

*Chief Executive
Salford Royal NHS Foundation Trust*

- sustaining improvements in patient safety through challenging times
- maintaining momentum and motivation at all levels
- leading safety express locally
- learning from others through local, national and international networks

12.20 Proactive improvement of patient safety: peer assessment of patient safety across the organisation through Clinical Area Safety Assessment (CASA)

Dr Susan Robinson

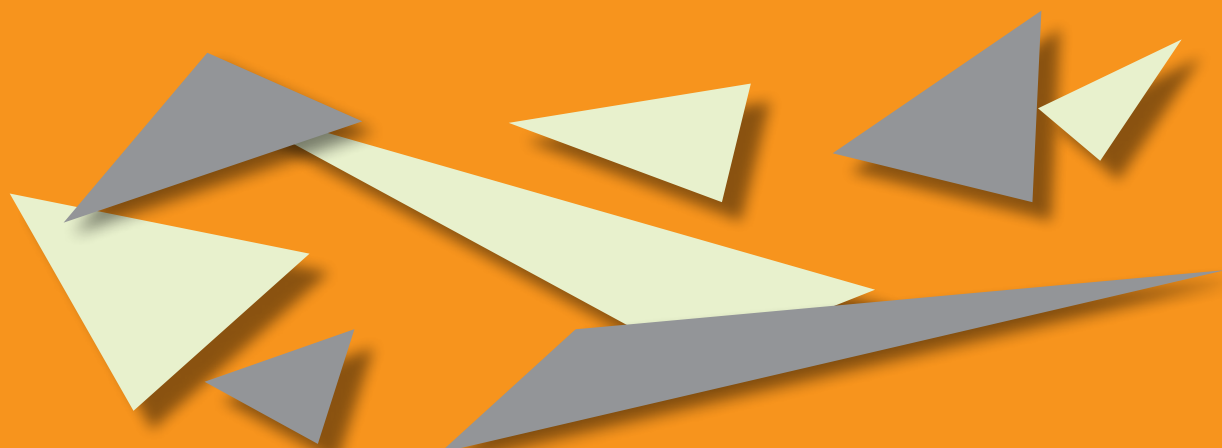
Consultant in Emergency Medicine & Deputy Medical Director

Carol Heesom-Duff

*Head of Patient Safety
Cambridge University Hospitals NHS Foundation Trust*

- moving to a more proactive approach which includes assurance
- the Clinical Safety Area Assessment (CASA) Programme: a proactive peer assessment of patient safety across the hospital
- the impact on the patient safety culture and sharing solutions to common problems: our experience in Cambridge

13.00 Questions and answers followed by lunch and exhibition at 13.15



14.00 Panel Session: Setting the Patient Safety Agenda: How do we set patient safety priorities locally?

Organisations face some challenging choices when it comes to patient safety, particularly in the prevailing economic climate. This session will start with a case study from Imperial College Healthcare on their process for establishing local trust priorities and then expands into a panel session on how you identify and justify which areas to focus on, including making decisions on the scale and number of initiatives; understanding need and assessing the evidence for interventions.

Setting the patient safety agenda: a case study of the development of a process for establishing local trust safety priorities based upon stakeholder require:

Anne Mottram *Director of Governance and Corporate Affairs*
The Centre for Patient Safety and Service Quality with

Danielle D’Lima

Joint-post Research Assistant
Imperial College Healthcare NHS Trust

Setting the Patient Safety Agenda Panel Members include:

Jo Bibby

Director of Improvement Programmes
The Health Foundation

Kate Beaumont

*Director Quality Governance Intelligence
& Nurse Director, The Learning Clinic*
Further Panel Members to be announced

15.25 Questions and answers followed by tea and exhibition at 15.35

DAY 1 - JOINT CLOSING SESSION

Chair Jane Cummings *Chief Nurse and Deputy Chief Executive NHS North West*

16.00 Patient Safety Transformation: achieving rapid improvement

Heather Caudle

Associate Director of Quality
Ashford and St Peter’s Hospital NHS Foundation Trust

- how ambitious should patient safety goals be? Our goal of a reduction of 50% in the number of harm events caused to our patients in the next year
- a transformational approach: translating the goals into rapid improvement
- accountability for delivery of patient safety improvement targets

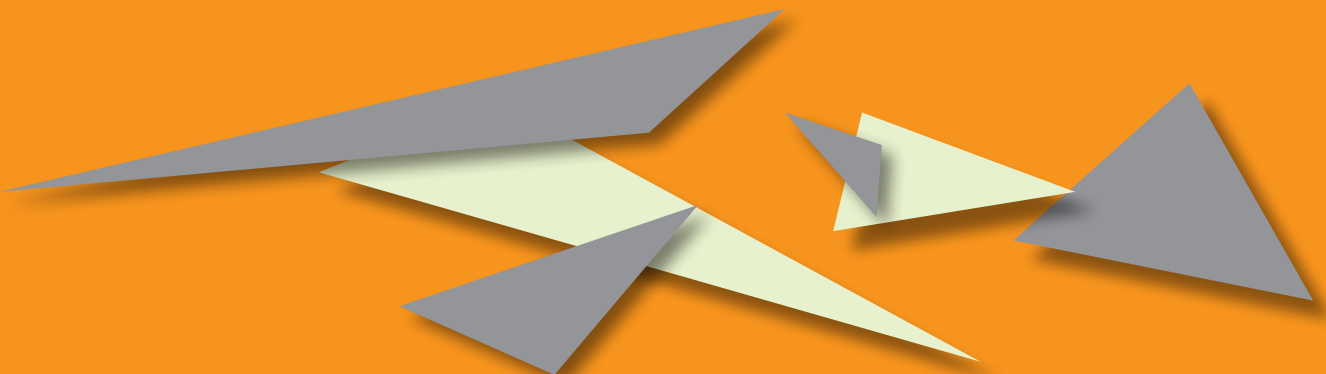
16.30 Ensuring Patient Safety Initiatives lead to outcomes improvement at a local level

Dr Marius Buiting

Director of the Department of Knowledge Management and Innovation
The Dutch Institute for Healthcare Improvement
and *Fellow*
The European Society for Quality in Healthcare (ESQH)

- delivering quality outcomes: making a real difference
- understanding quality variation and identifying priorities for improvement
- measuring and monitoring success
- what are you going to do that will make a difference after attending this conference?

17.00 Close



11.50 Masterclass 1

Advanced Incident Investigation

Facilitated by:

Kate Hill

Solicitor and Senior Trainer
RadcliffesLeBrassuer and InPractice Training

When faced with an incident many lack a methodology for analysing all the evidence and a structure for reporting on the incident. With potential disclosure issues it is vitally important that incident reports are thorough, well argued and objective.

This masterclass will equip delegates with a proven methodology and a highly-regarded report structure that will help with the analysis of an incident and the production of practical recommendations.

Objectives:

- Grading incidents and time management
- Dealing with external stakeholders and agencies; external notification requirements. Looking at your investigation in the wider context – complaints and formal legal proceedings
- The fundamentals of witness statement production; provision of witness statement format and checklist
- To know how statements might be used in the future against the mental health practitioner and to assist him/her
- Identifying gaps and ambiguities. Distinguishing between relevant and irrelevant facts

14.00 Masterclass 3

Patient Safety Metrics

Facilitated by:

John Madsen

Information Strategy Manager

Martin Orton

Head of Customer and Account Services

The NHS Information Centre for Health & Social Care

This masterclass will focus on developing patient safety metrics and indicators to measure and monitor patient safety within your clinical practice or organization. The masterclass will include presentations from expert speakers who have implemented patient safety metrics within their own practice.

The masterclass will cover:

- patient safety metrics explained
- the difference between a metric and an indicator
- how to prioritise metrics
- how to ensure the metric represents what you want to measure
- working through metrics and examples of metrics in practice

Case Study Preparation (30 mins)

Patient Safety Metrics: how we did it

Dr Chris Newson

Associate Medical Director

James Avery

Business Manager to the Medical Directorate

Walsall Healthcare NHS Trust

- key indicators to measuring and monitor the patient safety
- augmenting the national indicators with local measures and metrics
- emerging tools and techniques to improve the patient experience and patient safety
- integrating patient safety indicators within quality reporting

11.50 Masterclass 2

Compliance

Facilitated by:

Hilary Merrett

Editor
Clinical Risk

In its report on failure to implement safety alerts, AVMA (report ref) commented that “...a worrying number of NHS trusts are failing to implement patient safety alerts or to engage with the system.This represents a shameful failure to ensure that the NHS learns from past mistakes in order to protect patients. It is putting lives at unnecessary risk and adds insult to injury for those who have been harmed or lost loved ones as a result of lapses in safety.”

To a large extent, we know the interventions that improve patient safety. We have patient safety alerts, never events, safety express and guidance, care bundles, pathways, checklists, toolkits, evidence and all manner of tools to implement best patient safety practice. But why is it that compliance is frequently implicated when things go wrong? What does that tell us about our rules and the sustainability of our improvement programmes?

This masterclass will set out some key issues and latest thinking around compliance and challenge participants to consider how we can – from Board to the front line - improve our response to compliance issues and also understanding violations.

Prof Rory Shaw

Medical Director

North West London Hospitals NHS Trust

~Action against Medical Accidents, “Adding Insult to Injury” – NHS Failure to Implement Patient Safety Alerts, February 2010

14.00 Masterclass 4

Engaging Junior Doctors in Patient Safety

Facilitated by:

Sukhmeet Panesar

Special Advisor
National Patient Safety Agency

The masterclass will include:

- an update on Junior Doctor programmes and involvement in Safety Express
- practical tools for improving safety of Junior Doctor Practice and engaging Junior Doctors in Patient Safety

Short 15 minute presentations

Junior Doctors and Patient Safety: awareness, attitudes and perceptions of safety climate

Mr Piyush Durani

Clinical Leadership Fellow

NHS East Midlands & University Hospital of Leicester NHS Trust

An Electronic Clipboard for improved Patient Safety

Anthony Marino

Consultant Spinal Surgeon

Dr Hanne Johansen

FY1

Royal Wolverhampton Hospitals NHS Trust

Junior Doctors Quality Improvement Project: Patient Safety at Night

Dr Sean Chivers

Junior Doctor and Junior Doctor Colleagues

Bristol Royal Infirmary

Chair Stephen Ramsden *Independent Consultant and Former Chief Executive*
Luton and Dunstable Hospital NHS Foundation Trust & *Core Team Chair Patient Safety First Campaign*

10.00 Chair's introduction

10.05 Opening Address: The Patient Impact

Patients for Patient Safety UK Representative/s

- the power of patient stories and experience
- involving patients in improving patient safety
- an update from Patients for Patients Safety UK

10.30 UK Patient Safety Update

An update from the Patient Safety Campaigns across England, Northern Ireland, Scotland and Wales

HSC Safety Forum, Northern Ireland

Dr Gavin Lavery

Clinical Director
HSC Safety Forum

The 1000 Lives Campaign, Wales

Dr Alan Willson

Director
1000 Lives Plus Programme

The Scottish Patient Safety Programme

Ros Gray

National QIPP Safe Care Programme Director
Safety Express

Safety Express and QIPP Safe Care

Representative to be announced

11.30 Questions and answers, followed by coffee and exhibition at 11.40
Conference Splits: Choice of Main Stream or two Masterclasses

Practical case studies of Patient Safety Improvement

12.00 Patient Safety from the ward to the board: ensuring visible leadership for patient safety and quality

Brigid Stacey

Director of Nursing with

Cathy Bratt

Deputy Director of Nursing
Derby Hospitals Foundation Trust

- the visible leadership programme: Back to the floor Friday, Clinical Quality Coordinators and our Quality Audit Programme
- assurance of quality and patient care
- ensuring frontline staff feel supported and empowered in decision making around patient safety and quality

12.30 Patient safety and Safeguarding

Case study: Pressure Ulcer Management and Reporting Grade 3 and 4

Margaret Greer

Named Nurse Adult Safeguarding
University Hospital of Coventry and Warwickshire NHS Trust

- when do patient safety issues become safeguarding issues?
- using risk management tools within safeguarding
- what clinical risks leads should be aware of
- case study: pressure ulcers as a safeguarding and patient safety issue

12.50 Questions and answers followed by lunch and exhibition

14.00 Learning from a systematic independent review of in hospital deaths

Celia Ingham Clark

Medical Director
Whittington Hospitals NHS Trust

- a review of the medical records of 220 patients who died in one acute hospital in one year
- short loop feedback to individual teams and generic anonymised feedback to all clinicians in the trust
- the impact: a range of quality improvement actions that had not previously been identified by existing clinical governance mechanisms
- key patient safety issues identified

14.30 Using simulation exercises and scenario debriefing to identify weaknesses in processes and improve staff training

Dr Ami Parikh

Consultant in General Paediatrics and Paediatric Emergency
Barts and the London Children's Hospital

- using simulation to identify and observe weaknesses in processes, variance from protocols, operational or equipment issues and improve staff training and leadership
- setting up simulation exercises in practice for common clinical conditions and emergencies
- tools and techniques to learn from simulation to improve patient safety

15.00 Outcomes: demonstrating an improving patient safety culture

Jo Murray

Patient Safety Manager with

Julia Parfitt

Associate Medical Director for Patient Safety
Winchester and Eastleigh Healthcare NHS Trust

- demonstrating an improving patient safety culture through patient safety metrics and outcomes
- the patient safety culture measurement tools available
- how can we demonstrate improvement?

15.30 Tea and Close

11.50 Masterclass 5

Reducing Avoidable Mortality

Facilitated by:

Arun Bhoopl

*Statistician, Quality Framework
Department of Health*

This Masterclass will give an update on reducing avoidable mortality including the new National Summary Hospital-Level Mortality Indicator (SHMI).

Short Presentations (15 minutes)

SHMI in practice

Dr David Rosser

*Medical Director
University Hospitals Birmingham NHS Foundation Trust & Steering Group
Member, The National Review of Hospital Standardised Mortality Ratio (HMSR)*

Beyond Mortality: minimising morbidity risk in cardiac surgery

Mr David McCormack & Henrietta Wilson

*Specialist Registrars in Cardiothoracic Surgery
The London Chest Hospital*

11.50 Masterclass 7

Patient Safety, Clinical IT and Electronic Patient Records

Facilitated by:

Sean Brennan

*Independent Consultant in Healthcare Informatics
Clinical Matrix*

Electronic Patient Records and Clinical Information Systems have potential to improve patient safety particular in areas including Electronic Prescribing and Clinical Decision Support however a new spectrum of patient safety risks can emerge – this session focuses on mitigating these risks through learning from the most experienced organisations in implementing Electronic Patient Records and Clinical Information Systems in Practice

Case Studies:

Electronic Patient Records and Patient Safety

Dr Charles Gutteridge

*National Clinical Director for Informatics
Department of Health &
Former Medical Director
Barts and The London NHS Foundation Trust*

Electronic Prescribing: Patient Safety Improvements and New Risk Areas

Chris Fokke

*Programme Manager
Basingstoke and North Hampshire NHS Foundation Trust*

11.50 Masterclass 6

Root Cause Analysis

Facilitated by:

Hilary Merrett

*Editor
Clinical Risk and*

Sally Adams

This masterclass will review lessons learned from practical experience of systems analysis, both in terms of applying the approach to investigation and also how to improve staff confidence and skills in systems analysis.

Following a review of lessons from training by the facilitators, participants will hear an example of lessons learned from investigation of serious incidents.

Case Study Presentation

Frances Wood

University Hospitals of Leicester

14.00 Masterclass 8

Patient Involvement in Patient Safety

Facilitated by:

Patients for Patient Safety

Short 15 minute presentations

Risk and responsibility: involving patients in planning for safety

Dr Dinesh Sinha

*Consultant Psychiatrist in Psychotherapy
Cambridge and Peterborough NHS Foundation Trust*

A Patient and Public Led development of a medication passport

Kandarp Thakkar

Lead Pharmacist, Admissions with

Dr. Edward Dickinson

*Project Clinical Lead
Imperial College Healthcare NHS Trust*



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POSTER DISPLAYS

Poster Displays will take place in all breaks, lunches and during the evening reception throughout the conference. Poster presenters will be available to talk about their displays and answer questions the delegates may have.

Doing the essentials brilliantly

Lorraine Hopes *Ward Sister* University Hospital Bristol

Tara Shine *Ward Sister* University Hospitals Bristol

How do we improve communication of lessons learned from serious untoward incidents

Nick Shaughnessy *Hospital Manager* Partnerships in Care

Guidelines on the Management of Drug Misusers in Glasgow and Clyde Acute Hospitals

Dr Grace Campbell *Glasgow Addiction Services*

Developing positive teams using the CAIRO self assessment tool

Peter Bates *Head of Community Inclusion National Development Team for Inclusion*

Does the wearing of tabards during drug rounds reduce the number of interruptions

Morag Mitchell *Team Leader* NHS Grampian

Improving post-fall management using an action document

Dr Katherine Walsh *SpR Care of the Elderly* North Bristol NHS Trust

How do we weigh up? Routine patient weighting to aid safe prescribing

Dr Daniel Higbee *Foundation Doctor* Royal United Hospital Bath NHS Trust

Non medical prescribing in the community: limiting the risks

Jacqui Laycock *Practice Educator* City Health Care Partnership CIC

Improving pre-operative diabetic control to reduce operative risk in elective cardiac surgery

Henrietta Wilson *SpR in Cardiothoracic Surgery* The London Chest Hospital

Reducing risk of cardiovascular events through ensuring maintenance of perioperative beta blockade

Dr Emma Bellchambers *Core Trainee Year 2 Anaesthesia* Royal United Hospital Bath

Improving patient care following an early warning trigger

Alan Howe *Resuscitation Lead* North Bristol NHS Trust

Improving women's birth experience through effective communication

Brenda Kelly *Lead Midwife* Southern Health and Social Care Trust

Are Paediatric patients arriving by Ambulance being seen promptly?

Dr Salwa Malik *Foundation Year 2 Trainee* West Suffolk Hospital

Tests on day of discharge: are patients being discharged with actionable results outstanding?

Dr Aisha Egala *F2 Doctor* North Bristol NHS Trust

Cultural Characteristics of a Middle Eastern multicultural healthcare institution and how it facilitates mechanisms to enhance patient safety

Helena Tuite *PhD Student* University of Ulster

An audit of recording of patients weight

Dr Jamie Willson *Foundation Year 1 Doctor* Gloucester Royal NHS Trust
with Dr Sebastian Thomas, *F2*, Royal United Bath Hospitals

Prevalence and causes of prescribing error in general practice

Dr Maisoon Ghaleb *Lecturer in Pharmacy Practice* University of Hertfordshire

The Value of Simulation in Healthcare

Carey Edwards *Managing Director* LMQ Ltd

Exhibition

If you are interested in exhibiting at this event, please contact **Carolyn Goodbody** on **01932 429933** or email **carolyn@healthcareconferencesuk.co.uk**

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Download

> How to book

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> Your Details

(please complete a new form for each delegate. Photocopies are acceptable)

Dr Mr Mrs Ms (Please Circle)

First Name

Surname

Job Title

Department

Organisation

Address

Postcode

Telephone

Fax

Email

Please write your address clearly as confirmation will be sent by email, if you prefer confirmation by post please tick this box,
Please also ensure you complete your full postal address details for our records.

Please specify any special dietary or access requirements

This form must be signed by the delegate or an authorised person before we can accept the booking

(By signing this form you are accepting the terms and conditions below)

Name

Signature

Date

> Payment

By Cheque A cheque for is enclosed

Please make Cheques Payable to: Healthcare Conferences UK Ltd.

By Invoice Please send an invoice to

Name

Organisation

Address

Postcode

PURCHASE ORDER NUMBER
(If Applicable)

Please note if you are requesting an invoice many NHS organisations now require a Purchase Order Number to be provided. If you do not provide this number this may slow down the processing of this delegate place.

By BACS

For Payments in £: Sort Code 40-46-22 Account No. 21553690

Please send your BACS remittance form as confirmation of payment

Your BACS Reference

By credit card Please debit my Visa/Mastercard/Switch **All sections must be completed**

Cardholder's Name

Card No.

Valid From

Expiry Date

Issue No. (switch only)

You will be contacted during the processing of your booking to confirm the payment card security code. (this is the last three digits of the number printed on the back of your card)

Signature

Card billing address

Promotional Code

Conference Documentation

I cannot attend the conference but would like to receive a PDF containing the conference handbook material, which includes speaker slides, at £49 each.

The PDF will be emailed out after the conference, please fill in the 'Your Details' section above, ensuring your email address is clear and the 'Payment' section..

IHM Members

I am an IHM Member

IHM Membership number

To find out more about becoming an IHM member, please visit www.ihm.org.uk

Venue

Cavendish Conference Centre, 22 Duchess Mews, London, W1G 9DT. A map of the venue will be sent with confirmation of your booking.

Date

Wednesday 2nd & 3rd February 2012

Masterclasses

Which Masterclasses would you like to attend?

1. Advanced Incident Investigation
 2. Compliance
 3. Patient Safety Metrics
 4. Engaging Junior Doctors in Patient Safety
 5. Reducing Avoidable Mortality
 6. Root Cause Analysis
 7. Patient Safety, Clinical IT and Electronic Patient Records
 8. Patient Involvement in Patient Safety

Note you can attend the main stream and not attend masterclasses

Conference Fee

TWO DAYS

- £495 + VAT (594.00) for NHS, Social care, private healthcare organisations and Universities.
 £465 + VAT (£558.00) for voluntary sector / charities.
 £695 + VAT (£894.00) for commercial organisations.
 £465 + VAT (£360.00) for IHM members.

ONE DAY

- £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and Universities.
 £300 + VAT (£360.00) for voluntary sector / charities.
 £495 + VAT (£594.00) for commercial organisations.
 £300 + VAT (£360.00) for IHM members.

The fee includes lunch, refreshments and a copy of the conference handbook. VAT at 20%.

*Credit Card Payment discount

10% discount when you book via credit card.

**Group Rates

A discount of 15% is available to all but the first delegate from the same organisation, booked at the same time, for the same conference.

Terms & Conditions

A refund, less a 20% administration fee, will be made if cancellations are received, in writing, at least 4 weeks before the conference. We regret that any cancellation after this cannot be refunded, and that refunds for failure to attend the conference cannot be made, but substitute delegates are welcome at any time.

Accommodation

On confirmation of your booking you will receive information for booking accommodation should you require it.

Confirmation of Booking

All bookings will be confirmed by email, unless stated otherwise. Please contact us if you have not received confirmation 7-10 days after submitting your booking.

For more information contact Healthcare Conferences UK on **01932 429933** or email **info@healthcareconferencesuk.co.uk**

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