



# RISK & Patient Safety 2010

Thursday 25 and Friday 26 November Church House, London

Choose from a wide range of presentations which have been split into three streams, containing policy updates, practical case studies and interactive workshop sessions

## FEATURES THE FOLLOWING KEYNOTE PRESENTATIONS

- › Ensuring that patient safety is the NHS's top priority  
*New Government speaker*
- › Does improving patient safety save money?
- › Patient and clinician story  
*A surgeon and the patient that he harmed will share the story of the incident and its aftermath*
- › Implementing human factors to improve patient safety
- › Developing a regional approach the patient safety – The SW Quality and Patient Safety Improvement Programme
- › Update on the achievement of the UKs 4 National patient safety campaigns

The event also provides 31 information rich sessions across the 3 different streams over the 2 days:

## STREAM A

- › Reducing costs through patient safety
- › Indicators, metrics and information for assurance

## STREAM B

- › Patient Safety improvement stories
- › Learning from incidents and acting on information

## STREAM C

Patient safety essential workshops include:

- › Commissioning for patient safety
- › Delivering safety in primary care
- › The governance of safer care across organisations

## KEY SPEAKERS FOR 2010 INCLUDE

Maxine Power  
*National Improvement Adviser  
Department of Health*

Professor Paul Corrigan  
*Management Consultant and Former  
Director of Commissioning  
NHS London*

Dr John Ovreteit  
*Director of Research  
The Karolinska Institutet Sweden*

Dr Ken Catchpole  
*Senior Post-Doctoral Scientist –  
Quality Reliability Safety and  
Teamwork Unit  
University of Oxford*

Mike Durkin  
*Medical Director  
South West Strategic Health  
Authority*

Raj Jain  
*Chief Executive  
Liverpool Heart and Chest Hospital  
NHS Foundation Trust*

**“Quality and safety are at the heart of what we do, and it must be the responsibility of each and every board to assure itself that the services it provides are safe.”**

DAVID NICHOLSON NHS CHIEF EXECUTIVE THE OPERATING FRAMEWORK FOR THE NHS IN ENGLAND 2010/11



# RISK & Patient Safety 2010

**Thursday 25 and Friday 26 November Church House, London**

The eleventh annual Risk and Patient Safety conference offers delegates the opportunity to hear from some of the leading speakers in patient safety, risk management and improvement, and to learn directly from a range of successful safety initiatives being implemented across the UK.

**“We need a cultural shift in the NHS. From a culture responsive mainly to orders from the top-down, to one responsive to patients, in which patient safety is put first”**

ANDREW LANSLEY, HEALTH SECRETARY,  
8TH JUNE 2010

Patient safety has come a long way in recent years and advances have certainly been made through the use of coordinated safety campaigns. However, nationally and internationally there is still a significant threat to patients, and this represents an increasingly unaffordable cost to the NHS.

In an increasingly scarce financial climate, a key focus of Risk and Patient Safety 2010 is around reducing cost through the reduction of harm to patients. You'll hear the latest guidance designed to help you meet the quality and productivity challenge. Crucially you'll also share the experiences of Trusts that have delivered quantifiable savings through improvements in patient safety.

As well as the main plenary sessions you'll have the chance to learn through a selection of workshops, debates and case studies. Workshop sessions have been designed to enable delegates to enhance their knowledge in specific areas applicable to them and their job role. Delegates will be provided with an abundance of information across the three work streams running simultaneously on both days. Resulting in two days of inspiration and providing simple tools, methodologies and practical approaches to implement in their own organisations. There will also be ample opportunity in-between sessions to network with other delegates, sharing your experiences whilst enjoying a cup of tea/coffee and lunch.

## EVENING DRINKS RECEPTION

All delegates are invited to attend an evening drinks reception following the first day of the conference, kindly sponsored by



If you are interested in exhibiting at this event or for future events, please contact Carolyn on [carolyn@healthcare-events.co.uk](mailto:carolyn@healthcare-events.co.uk) or 020 8481 0354

**HEALTHCARE**events

Specialists in health & social care conferences

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 delegates may have

## POSTER DISPLAYS

- 1 Does Pleural Ultrasound in the Radiology Department Ensure Safe Insertion of Intercostal Chest Drains? Experience of a District General Hospital**  
The Royal Wolverhampton Hospitals NHS Trust  
Judith Brebner Respiratory ST3
- 2 Mortality reduction – targeting VTE**  
Royal Berkshire NHS Foundation Trust  
Hester Wain Head of Patient Safety
- 3 Current prescribing and documentation of PCA and Epidurals: an assessment on a surgical ward**  
North West London Hospitals NHS Trust  
Inderjit Sanghera Principal Pharmacist Clinical Service
- 4 An Audit of near misses in the Pharmacy Dispensary**  
North West London Hospitals NHS Trust  
Inderjit Sanghera Principal Pharmacist Clinical Service
- 5 The challenges of working with people who self harm: a forensic perspective**  
Broadmoor Hospital  
Taffy Gatawa Patient Safety Lead
- 6 Learning From Incidents – a Complete Audit Cycle**  
West London Mental Health Trust  
Dr Kaysi Thinn Honorary Specialist Registrar in Forensic Psychiatry
- 7 Managing Drug Prescribing Errors**  
Christie Hospital  
Dr Anna Britten Consultant
- 8 Prescribing standards for outpatient prescriptions: a re-audit**  
North West London Hospitals NHS Trust  
Ashita Tailor Senior Surgical Pharmacist Clinical Services
- 9 Measuring Safe Prescribing on Ward Rounds by use of a Pharmaceutical Checklist**  
Western Sussex Hospitals NHS Trust  
Naomi Burns Medication Safety Pharmacist
- 10 CNST requirements, are we meeting the standards?**  
University Hospitals Coventry and Warwickshire NHS Trust  
Dr Rajneesh Sachdeva Speciality Registrar Anaesthesia
- 11 An Audit of Pharmacist Interventions on Electronic Discharge Notifications**  
North West London Hospital NHS Trust  
Roshni Patel Pre-registration pharmacist
- 12 Reducing Medication Errors, Increasing Patient Safety**  
James Cook University Hospital Trust  
Ms Janette Keld Assistant Clinical Matron
- 13 Patient Safety First – Reducing risk in medicine management within critical care**  
Betsi Cadwaladr University Health Board  
Tracey Harris Practice Development Nurse
- 14 An audit of missed doses in a Community Rehabilitation Hospital**  
Central Middlesex Hospital  
Sangita Kapur Clinical Pharmacist Elderly Care and Rehabilitation Services
- 15 Reducing harm from deterioration the WEHCT model**  
Winchester and Eastleigh Healthcare NHS Trust  
Jo Murray Patient Safety Manager
- 16 Vital Radiology for Junior Doctors – learning from our mistakes**  
University Hospital Aintree  
Dr Rebecca Mullett Speciality Trainee in Radiology
- 17 Developing a paediatric risk managers forum**  
Great Ormond Street Hospital NHS Trust  
Salina Parkyn Head of Clinical Governance and Patient Safety
- 18 Improving and sustaining peripheral cannulation practice – the journey**  
South Tees Hospitals NHS Foundation Trust  
David Charlesworth Assistant Clinical Matron for Corporate Practice Development

## INFORMATION

### Venue

Church House, Deans Yard, Westminster, London SW1P 3NZ.

### Dates

Thursday 25 and Friday 26 November.

### 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.

### Cancellations/substitutions

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 time 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 details of accommodation options.

### Exhibition

If you are interested in exhibiting at this event, please contact Carolyn Goodbody on 020 8481 0354 or email [carolyn@healthcare-events.co.uk](mailto:carolyn@healthcare-events.co.uk)

### Accreditation

The conference has been accredited with 6 CPD credits for day one and 4 CPD credits for day two. The conference is also recognised by the IHM.

## Day 1 – Joint introductory plenary session

- 10.00 **Chairman's introduction**  
**Stephen Ramsden** *Independent Consultant and Former Chief Executive Luton and Dunstable Hospital NHS Foundation Trust and Chair Core Team Patient Safety First Campaign*
- 10.15 **Ensuring that patient safety is the NHS's top priority**  
**Government representative – speaker to be confirmed**
- balancing finance and safety – clarifying that quality and safety remain the NHS's top priority
  - acknowledging that our safety systems and processes are dependent on the culture and values of staff and that clinical teams are the front line of defence
  - the role of leadership at all levels in driving the development of safety culture
  - how appropriate is the continued use of self assessment?

## Conference splits

### Stream A: Reducing costs through patient safety

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

- 11.50 **Developing a set of safety interventions which help Trusts deliver the quality and productivity challenge**  
**Maxine Power** *National Improvement Adviser Department of Health*
- describing new relationships between reducing harm and reducing cost
  - identifying the characteristics of safe, cost effective healthcare systems
  - proving that you are being efficient and delivering improvement
- 12.15 **Cost saving patient safety case study 1: demonstrating a dramatic reduction in the rate of Urinary Tract Infections (UTIs) for patients in NHS provided care**  
**Radha Brown** *Assistant Clinical Matron for Corporate Practice Development South Tees Hospitals NHS Foundation Trust*
- delivering savings by improving safety
  - eliminating the average 6 day increase in length of stay caused by UTIs
  - saving an estimated cost to the NHS of £124 million a year or £1,122 per infected patient
- 12.40 **Cost saving patient safety case study 2: patient safety through evidence based clinical engagement**  
**Amanda Hastings** *Consultant CHKS*  
**Yvonne Peel** *Consultant CHKS (NHS speaker to be confirmed)*
- delivering savings by improving safety
  - establishing credibility of information
  - linking patient safety with clinical audit
  - improving efficiency through better patient management processes
- 13.00 Questions and answers, followed by lunch and exhibition at 13.05
- 14.00 **Panel debate: Is it really possible to reduce costs and improve patient safety at the same time?**  
**Panel members include:**
- Dr John Ovretveit** *Director of Research and Professor of Health Innovation Implementation and Evaluation The Karolinska Institutet Sweden*
  - Professor Paul Corrigan** *Management Consultant and Former Director of Commissioning NHS London*
- how drastic will NHS cuts need to be?
  - can cuts be made without putting patients at risk, what is the evidence?
  - should we set minimum staff to patient ratios to safeguard patients?
  - how have other industries approached this challenge?
- 15.00 **Cost saving patient safety case study 3: delivering savings through the elimination of central venous catheter bloodstream infections**  
**Jeanette Beer** *Project Lead – Matching Michigan National Reporting and Learning Service*
- delivering Matching Michigan in 97% of English acute trusts
  - developing an economic analysis of the impact of the Matching Michigan project
  - quantifying the savings available to the NHS
- 15.25 Questions and answers, followed by tea and exhibition at 15.30

### Stream B: Patient safety improvement

- 11.50 **Patient safety simulation to promote patient safety**  
**Dr Mark Piper** *Consultant Anaesthetist Northumbria Healthcare NHS Foundation Trust*
- 12.15 **Taking a walk on the wild side of patient safety**  
**Hester Wain** *Head of Patient Safety Royal Berkshire NHS Foundation Trust*
- 12.40 **Localising national and international patient safety**  
**Sharon Barnes** *Theatre Matron The Newcastle upon Tyne NHS Foundation Trust*
- 13.00 Questions and answers, followed by lunch
- 14.00 **Presenting a region wide programme to reduce venous thrombo-embolism (VTE)**  
**Julie Brantner** *Associate Director for Patient Safety*  
**Rob Bethune** *Clinical Advisor to the Regional Director of Public Health South West Strategic Health Authority*
- 14.30 **Safeguarding patients in acute hospitals**  
**Janet Emmerson** *Acute Liaison Nurse – Learning Disabilities South Tees Hospitals NHS Foundation Trust*
- 14.55 **Supporting residential and care home safety**  
**Speaker to be announced**
- 15.20 Questions and answers, followed by tea and exhibition at 15.30

## Day 1 – Joint Closing Plenary Session

- 16.00 **Patient and clinician story**  
 A surgeon and the patient that he harmed will share the story of the incident, its aftermath and the learning that it generated. *(Details to be confirmed)*

- 16.30 **Implementing human factors to improve patient safety**  
**Dr Ken Catchpole** *Senior Post-Doctoral Scientist – Quality Reliability Safety and Teamwork Unit University of Oxford*

## 10.45 Does improving patient safety save money?

**Dr John Ovretveit** *Director of Research and Professor of Health Innovation Implementation and Evaluation*  
The Karolinska Institutet Sweden

- reviewing the evidence of which improvements to quality and safety can reduce costs
- analysing the costs of poor safety and low quality care
- understanding the true costs of safety interventions
- exploring the context factors which determine whether money will be saved through an intervention

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

## into 3 streams:

### Improvement stories

#### Human factors

- using real time simulation to provide training in human factors and non – technical skills
- delivering communication training (SBAR)
- evaluating the impact of the training on actual clinical behaviour

#### Patient safety

- developing patient safety walkarounds to provide direct assurance to the board
- the power of visible leadership in driving development of a safety culture
- empowering front-line staff and providing an integration of Board and front-line action

#### Local guidance

- adapting the WHO checklist for use in cardiac surgery
- identifying the challenges of implementation and exploring how they were overcome

and exhibition at 13.05

### How to reduce death and morbidity from

- setting ambitious local standards for VTE prevention
- establishing a Clinical Peer Review Team
- improving rates of risk assessment and prescribing
- becoming the first SHA to achieve exemplar status

#### Hospitals

- supporting patients with learning disabilities
- linking the adult safeguarding agenda and patient safety
- establishing the Acute Liaison Nurse role
- improving communication between primary, secondary and learning disability services

### Ways to deliver safer care

- understanding the definitions of safety incidents by social care providers
- identifying reporting approaches and improvement mechanisms in use
- how can levels of safety and dignity in care homes be further improved

and exhibition at 15.30

### How to improve patient safety

- understanding why healthcare staff make errors and which specific system factors put patients at risk
- developing safer clinical systems – Using a human factors approach to pro-active risk management to prevent patient safety incidents
- learning lessons from other high risk industries
- challenges for Implementation

OR

## Stream C: Patient safety essential workshops

### 11.50 Workshop 1: working with patients to reduce safety incidents

#### Facilitated by:

**Bev Hurst**  
*Patients for Patient Safety Champion*  
WHO Patient Safety  
**Sue Bothwell**  
*Assistant Director Patient Safety Improvement*  
NHS North West

#### This interactive workshop will include:

- exploring how working with patients can help improve patient safety issues
- how to engage patients with patient safety projects
- sharing and disseminating good practice

### 14.00 Workshop 2: making junior doctor in handover safer

#### Exploring a new tool to improve communication during junior doctor handover

**Dr Clare Rees**  
*Specialist Registrar in Paediatric Surgery*  
**Dr Chloe Macaulay**  
*Specialist Registrar in Paediatrics*

- raising the priority of patient safety at handover
- understanding the human factors at clinical handover
- how to use the THINK FIRST! Tool to improve outcomes

#### Demonstrating that electronic handover systems improve safety

**Dr Judith Brebner**  
*Respiratory ST3*  
The Royal Wolverhampton  
Hospitals NHS Trust

- exploring the evidence of retention rates for various mechanisms of recording and sharing information at handover
- using electronic handover tools to improve patient safety

### 15.00 Workshop 3: best practice in root cause analysis (RCA)

#### Facilitated by:

**Hilary Merrett**  
*Associate Director Quality and Safety Consulting*  
**Fiona Gale**  
*Principal Consultant Quality and Safety Services CHKS*

#### This interactive workshop will include:

- providing a greater understanding of the advantages of using a system based approach to investigating incidents
- increasing your understanding of the theory of root cause analysis
- an overview of root cause analysis tools
- undertaking RCA outside of acute hospitals
  - mental health
  - primary and community care

15.45 Questions and answers, followed by tea and exhibition at 15.50

### 16.00 Workshop 4: the governance of safer care across organisations

**Facilitated by: John Bullivant** *Director* The Good Governance Institute

#### This interactive workshop will include:

- why does safety often fall down at handover of care between organisations?
- working across boundaries to make patient transfers safer
- releasing the savings available from better alignment of the acute, community and social care systems?
- delivering truly integrated governance and maximising the advantage of organisational integration
- interventions to improve the safety of care

17.00 Evening Networking Drinks Reception

## Day 2 – Joint introductory plenary session

Chairman: Gren Kershaw *Independent Healthcare Consultant*

10.00	<b>Chairman's introduction</b>	
10.10	<b>Update on the achievement of the UK's national patient safety campaigns – What has been achieved in the last year?</b>	
	<p><b>Lessons from the Patient Safety First campaign</b>  <b>Dr Suzette Woodward</b>  <i>Director of Patient Safety</i>                      National Patient Safety Agency</p> <p><b>The Scottish Patient Safety Programme from the Scottish Patient Safety Alliance</b>  <b>Jane Murkin</b>  <i>National Coordinator</i>                      Scottish Patient Safety Programme</p>	<p><b>Assessing the impact of the Welsh 1000 lives campaign</b>  <b>Professor Jonathon Gray</b>  <i>Director of Healthcare Improvement</i>                      Public Health Wales</p> <p><b>The HSC Safety Forum, Northern Ireland</b>  <b>Janet Haines-Wood</b>  <i>Assistant Director</i>                      HSC Safety Forum</p>

## Conference splits

### Stream A: Indicators, metrics and information for assurance

Chairman: Gren Kershaw *Independent Healthcare Consultant*

11.50	<b>How effective is hospital standardised mortality ratio (HSMR) as a measure of patient safety?</b>	
	<p><b>Professor Richard Lilford</b>  <i>Professor of Clinical Epidemiology</i>                      Birmingham University</p> <ul style="list-style-type: none"> <li>is HSMR are an effective diagnostic test for quality and safety?</li> <li>agreeing a standardised methodology and approach to HSMR</li> <li>should HSMR be used as an early warning measure to target further investigations and inspection?</li> <li>if not HSMR then what? – overview of other potential indicators</li> </ul>	
12.20	<b>The development of nationally agreed indicators for patient safety</b>	
	<p><b>Speaker to be announced</b></p> <ul style="list-style-type: none"> <li>using the Indicators for Quality Improvement</li> <li>moving from process to outcome based measures</li> <li>updates on new and forthcoming safety indicators</li> </ul>	
12.50	Questions and answers, followed by lunch and exhibition at 13.00	
14.00	<b>Building a risk management dashboard to enable feedback trend analysis and action planning</b>	
	<p><b>Bob Hibberd</b>  <i>Head of Governance</i>                      University Hospital Birmingham                      NHS Foundations Trust</p> <ul style="list-style-type: none"> <li>providing clinical staff with access to incident data on a real time basis</li> <li>encouraging the identification and ownership of risk at a clinical level</li> <li>enabling staff to identify trends and formulate action plans to mitigate risk in their clinical area</li> </ul>	
14.25	<b>Developing safety dashboards for Non-Executive Directors</b>	
	<p><b>Andrew Corbett Nolan</b>  <i>Director</i>                      The Good Governance Institute and                      Fellow Open University Business School</p> <ul style="list-style-type: none"> <li>developing a tool to support Board accountability for risk and patient safety</li> <li>understanding the knowledge and information requirement of NEDs around risk and patient safety</li> <li>evaluating whether these needs can be met by putting together a dashboard</li> </ul>	
14.50	<b>Using information from patients to drive safety improvement</b>	
	<p><b>Sarah Puntoni</b>  <i>Project Support Officer</i>                      1000 Lives Campaign</p> <ul style="list-style-type: none"> <li>harnessing the power of patient stories</li> <li>using patient stories as an agent for change across all levels of the NHS in Wales</li> <li>helping Boards shift from a target focus to a patient focus</li> <li>stories as improvement tools</li> </ul>	
15.15	<b>Preventing harm, improving safety – a coordinated organisational safety campaign</b>	
	<p><b>Mandy Gibbs</b>  <i>Patient Safety Manager</i>                      The Royal Wolverhampton                      Hospital NHS Trust</p> <p><b>Rebecca Bartholomew</b>  <i>Associate – Safer Care</i>                      NHS Institute for Innovation and Improvement</p> <ul style="list-style-type: none"> <li>developing the Patient Safety Scorecard to provide the Board with an overview of patient safety information at a glance</li> <li>your hospital, your voice – designing and using a questionnaire to capture a snapshot of the organisations culture and measure the experiences of patients</li> <li>exploring the outcomes of the campaign</li> </ul>	
15.40	Questions and answers, followed by close at 15.45 (tea and coffee will be available)	

### Stream B: Learning from incidents

Chairman: Harvey Marcovitch *Editor in Chief*

11.50	<b>Chairman's introduction</b>	
12.00	<b>Exploring the new National Framework for Serious Incidents Requiring Investigation</b>	
	<b>Speaker to be announced</b>	
12.25	<b>Using the Learning from Defects (LFD) approach</b>	
	<p><b>Raj Jain</b>  <i>Chief Executive</i>                      Liverpool Heart and Chest Hospital                      NHS Foundation Trust</p>	
12.50	Questions and answers, followed by lunch and exhibition at 13.00	
14.00	<b>Panel debate: we're reporting but aren't we learning?</b>	
	<p><b>Panel members include:</b>  <b>Dr Paresh Dawda</b>  <i>GP Principal</i> South Street Surgery and                      Associate Safer Care NHS Institute                      for Innovation and Improvement</p> <p><b>Jane Jones</b>  <i>Associate – Safer Systems</i>                      The Health Foundation</p> <p><b>Dr Maxine Power</b>  <i>National Improvement Adviser</i>                      Department of Health</p>	
14.50	<b>Using incident data to improve safety</b>	
	<p><b>Dr Naonori Kodate</b>  <i>Research Associate</i>                      NIHR Kings Patient Safety and Service                      Quality Research Centre</p>	
15.15	<b>Examining the documents and circumstances of a medical examiner</b>	
	<p><b>Dr Alan Fletcher</b>  <i>Consultant in Acute and Emergency Medicine</i>                      Sheffield Teaching Hospitals NHS                      Foundation Trust and                      Medical Examiner HM Coroner South                      Yorkshire (West)</p>	
15.40	Questions and answers, followed by close at 15.45 (tea and coffee will be available)	

10.50 **Developing a regional approach the patient safety –  
The SW Quality and Patient Safety Improvement Programme**

- Mike Durkin**  
*Medical Director*  
South West Strategic Health Authority
- Rob Bethune**  
*Clinical Advisor*  
South West Strategic Health Authority
- demonstrating that it is possible to deliver a patient safety improvement programme across an entire region
  - working in partnership with the Institute for Healthcare Improvement
  - striving for 95% reliability of all care processes

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

## into 3 streams:

### Stream A: Identifying and acting on information

*in Chief Clinical Risk*

#### Work for Reporting and Learning from Incident

- providing a nationally consistent definition of a serious incident that requires investigation
- developing an overarching framework to support good practice
- signposting to tools and resources
- update on the development of the National Serious Incident Management System (SIMS)

#### FD) tool

- describing the process used to identify and eliminate system defects
- exploring the evidence base for the John's Hopkins Learning from Defects tool
- adapting the tool for use in a specialist setting

and exhibition at 13.00

#### Are we really learning?

- is reporting drowning out learning?
- how can we best bring together the risk management and improvement communities?
- do we have a duty to patients to investigate and learn from every single incident?
- why, when we have good evidence about what improves safety, is it not more widely implemented?

#### Incident

- analysing how two Trusts used incident data to improve patient
- exploring how incident data can be used as a means of risk management
- clarifying the aims of incident review meetings and embedding more systems thinking in discussions

#### Circumstances of death: the role of the

- ensuring timely and appropriate referral to the coroner
- update on the proposed implementation of the Medical Examiner system in England and Wales (Coroners and Justice Act 2009)
- what the new role means for clinical governance and patient safety

at 15.45 (tea and coffee will be available)

### Stream C: Patient safety essential workshops

11.50 **Workshop 5: delivering safety in primary care**

- Facilitated by:**
- Dr Robert Varnam**  
*Associate – Safe Care Priority Programme*  
NHS Institute for Innovation and Improvement
- setting priorities for safety improvement
  - measuring harm with the Primary Care Trigger Tool
  - designing new solutions to safety problems
  - achieving sustainable change using Improvement methods

14.00 **Workshop 6: what do we need to understand about hospital patient safety indicators?**

- Facilitated by:**
- Greg Stevens**  
*Special Projects Director*  
CHKS
- which indicators really matter?
  - asking the right questions about data quality
  - involving clinicians in decisions based on indicators
  - demonstrating our patient safety initiatives work

14.45 **Workshop 7: commissioning for patient safety**

- Facilitated by:**
- Andrew Corbett Nolan**  
*Director*  
The Good Governance Institute and Fellow Open University Business School
- Sarah Andrews**  
*Director of Nursing and Acting Deputy Chief Executive*  
NHS Eastern and Coastal Kent
- using CQINs to drive safety improvement
  - using commissioning and contracting to improve safety and outcomes
  - implementing the Never Events framework
  - commissioning for improvement
  - case studies

15.45 Close (tea and coffee will be available)

► **How to book**

Fax the booking form to  
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Through our website at:  
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**Please tick the package you would like to book**

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 £300 + VAT (£352.50) for voluntary sector/charities  
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- Two days  £545 + VAT (£640.38) for NHS and private healthcare organisations  
 £465 + VAT (£546.38) for voluntary sector/charities  
 £750 + VAT (£881.25) for commercial organisations  
 £465 + VAT (£546.38) for IHM members

Please tick which day you would like to attend  Thursday 25 November  Friday 26 November  Both days

**Session choices** Please indicate which stream or workshops you are most likely to attend:

Day 1, 25 November

- Stream A:** Reducing costs through patient safety  
 **Stream B:** Patient safety improvement stories

**Stream C: Patient safety essential workshops**

- Workshop 1:** working with patients to reduce safety incidents  
 **Workshop 2:** making junior doctor in handover safer  
 **Workshop 3:** best practice in route cause analysis (RCA)  
 **Workshop 4:** the governance of safer care across organisations

Day 2, 26 November

- Stream A:** Indicators, metrics and information for assurance  
 **Stream B:** Learning from incidents and acting on information

**Stream C: Patient safety essential workshops**

- Workshop 5:** delivering safety in primary care  
 **Workshop 6:** what do we need to understand about patient safety indicators?  
 **Workshop 7:** commissioning for patient safety

Please tick if you would like to attend the evening drinks reception on Thursday 25 November 2010

► **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

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Please write your address clearly as confirmation will be sent by e-mail.  
 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

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**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)

Card security code \_\_\_\_\_ (This is the last three digits of the number printed on the back of your card)

Signature

Card billing address

For office use only

**Conference documentation**

I cannot attend the conference but would like to receive a CD containing the conference handbook material, which includes speaker slides, at £90 each.

The CD will be sent out after the conference, please fill in the 'Your Details' section above for delivery, and the 'Payment' section.

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