

Safe handover: safe patients

Guidance on clinical handover for
clinicians and managers



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Handover of care is one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients. This has always been so, but its importance is escalating with the requirement for shorter hours for

General Medical Council

Effective communication lies at the very heart of good patient care. The General Medical Council recognises this and in its publication *Good handover practice* makes clear the expectation that doctors will 'keep colleagues well informed when sharing the care of patients'. The changing face of medical practice – and particularly the introduction of shift working – makes that requirement more important than ever. The GMC welcomes this guidance from the BMA Junior Doctors Committee as a very helpful contribution to this fundamentally important subject.



Professor Peter Rubin

Chairman of Education Committee
General Medical Council



This document:

- provides guidance to doctors on best practice in handover
- provides examples of good models of handover that doctors and hospital managers can learn from
- aims to drive further developments in standardising handover arrangements in UK hospitals.

- Continuity of information is vital to the safety of our patients.
- With the move to shift patterns, which increase the number of individuals caring for patients, the need for comprehensive handover of clinical information is more important than ever.
- Good handover does not happen by chance. It requires work by all those involved, from organisations to the individuals involved:
 - shifts must coordinate
 - adequate time must be allowed
 - handover should have clear leadership
 - adequate information technology support must be provided.
- Sufficient and relevant information should be exchanged to ensure patient safety:
 - the clinically unstable patients are known to the senior and covering clinicians
 - junior members of the team are adequately briefed on concerns from previous shifts
 - tasks not yet completed are clearly understood by the incoming team.
- Lastly, handover is of little value unless action is taken as a result:
 - tasks should be prioritised
 - plans for further care are put into place
 - unstable patients are reviewed.

This guide contains practical advice, underlying principles and .028 TwA5op1me md.

The need for change

Changing patterns of work in the hospital setting have created a need for improved handover of clinical responsibility and information. There is a growing recognition that enhanced training and systems for effective and safe handover are essential to maintain high standards of clinical care.

Changing working patterns

The implementation of the New Deal and European Working Time Directive for doctors in training has acted as a driver for change in the way that the medical workforce is organised in the UK.

- Full shift rotas have become the norm in many acute care settings as all time spent in the place of work is now counted as working time. This effectively limits doctors to spending a maximum of 13 hours in the hospital each day or to be non-resident on call.
- Different teams will be looking after the same group of patients over the course of any given day.
- A doctor may have no day-to-day contact with the patients they are responsible for in the out-of-hours period.
- There will be greater cross-cover between some specialties, and an increasing multidisciplinary approach to care.
- Resident and non-resident staff must be part of handover.

As a consequence of these changes, robust handover mechanisms are now of the utmost importance for patient safety.¹

A whole systems approach will, therefore, be necessary to enable effective handover of all necessary information and responsibilities.

Good communication is essential between all doctors to protect the safety of patients when shifts are introduced.¹ In one study, junior doctors felt that existing handover arrangements were frequently not as good as they would have liked them



Doctors and patients perceive continuity of care differently. While overall personal continuity is valued by patients, it does not ensure quality of treatment. It may also legitimise the idea that there are patients for whom an individual is not responsible and this threatens organisational responsibility.^{6,7}

Developing system responsibility

It is essential that the necessary move away from personal continuity should result in system continuity. The patient's experience of this is consistency and accuracy of knowledge and information between all multidisciplinary team members. The team, rather than the individual should be seen as the care provider.

Achieving system continuity requires mechanisms to support the transfer of high quality clinical information across shift changes. These should include:

- time in rotas for members of the team to meet, share information, and clarify responsibility for ongoing care and outstanding tasks
- access to up-to-date summaries and management plans for all patients under a team's care
- robust means to identify and contact the doctor who is responsible for a patient at any given time.

To ensure effective continuity of information, the handover must achieve a balance between comprehensiveness and efficiency.

Improving handover will require major changes to the culture and organisation of doctors of all grades and disciplines, an understanding of the concept of both system and personal continuity, and should be supported by education and training.



Some specific areas of heightened clinical risk are highlighted below. Trusts should ensure that the facilitation of high quality handover is seen as a clinical governance issue at all levels within the organisation.

Communications:

- laboratory staff, faced with a critical result, have difficulty contacting the doctor responsible for the patient, as they may be different from the doctor that requested the test
-

Handover omission endangers patient safety

Saturday morning handover 'Please take Mrs Smith's bloods, I think her kidney function may be deteriorating.'

Saturday day shift Mrs Smith's blood taken. Busy shift so results not checked.

Saturday night handover 'Please check Mrs Smith's results.'

Saturday night shift Results chased and found with some difficulty after the ward insisted they had not been taken. Results appear normal.

Sunday morning handover Handover interrupted by emergency call... Mrs Smith suffers cardiac arrest.

Critical incident review

1. Handover did not detail that there were two patients called Mrs Smith on the ward. Bloods were taken from the wrong Mrs Smith.
 2. The results of bloods taken from the incorrect patient were not chased by the team that knew the reason for the tests. They may have been cautious about a normal set of results from a patient known to have renal problems.
 3. The outgoing team did not fully hand over the reasons for investigation. The potassium kept rising over the weekend for the correct Mrs Smith affecting her safety. Later that weekend she suffered a hyperkalaemic cardiac arrest.
- A.** Why were her bloods not checked?
- B.** Where did the problem start?

Every hospital will need to develop its own handover policy. This will require a coordinated approach from managers, all grades of doctors and the rest of the multidisciplinary team.

- The handover leader (see below) should ensure the team are aware of any new or locum members of the team and that adequate arrangements are in place to familiarise them with local systems and hospital geography.

When should handover take place?

- Handover should be at a fixed time and of sufficient length.
- This period should be known to all staff and designated 'bleep-free' except for immediately life threatening emergencies.
- Shifts for all staff involved should be coordinated to allow them to attend in 'working time'. This is particularly important for the handover to, and from, the night team.
- Handovers will also be needed in the morning and at the change of other shifts (for example 5pm in some ward settings).

Where should handover take place?

- Handover should be at a fixed time and of sufficient length.
- Ideally this should be close to the most used areas of work (such as A&E or Admissions Unit).
- It should be large enough to comfortably allow everyone to attend.
- This should be free from distraction and not used by others

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How should handover happen?

The style of handover will vary depending on local need – whole hospital handovers to night teams, local handovers on specific units, community-based specialties or those covering several sites. However, all types need a predetermined format and structure to ensure adequate information exchange.

- Ad hoc handovers often miss out important aspects of care.
- Handover should be supervised by the most senior clinician present and must have clear leadership.
- Information presented should be succinct and relevant.
- Ideally, this can be supported by information systems identifying all relevant patients.¹

The Royal College of Physicians has published guidance on handover, relevant to general medical staff. Included in this document is an example of a handover sheet that can be used to facilitate effective information transfer between colleagues.⁹

There are many ways in which developments in information technology can assist with the handover process. An electronic information-sharing system that works effectively can be time neutral for junior doctors compared with traditional paper based or verbal handover.¹⁰ It may also contribute to safety, although this has not been demonstrated in any research to date.

- Regular review of the system, for example at clinical governance meetings, appraisal meetings and through monitoring incident reports, is advisable.
- The relevant senior consultant or the medical director, should have responsibility for ensuring handover happens as expected.

- publish a 'live' list on the hospital intranet of the name and contact details for doctors covering each consultant's or specialty's patients at any given time
- electronic patient lists could be provided in a secure password protected manner on the hospital intranet.
-

Real examples

Handover guidance

Models of good practice

District General Hospital handover

The paediatric unit of a district general hospital coordinates handover well. Each morning a multidisciplinary 9.00am handover is held, led by the senior nurse on duty and the consultant of the week. This handover takes place in a specific room, and is ring fenced to ensure that it is not disturbed except in unforeseen emergency situations. All of the outgoing night team, and incoming day team attend and all patients on the paediatric ward and neonatal unit are discussed. A consultant led ward round then takes place seven days a week, involving the night medical team and daytime oncoming team.

An identical handover takes place at 4.45pm, where the day teams handover to the evening team – this is, again, consultant and senior nurse led. All patients are discussed and their management plans reviewed by the consultant of the week. Using a 'consultant of the week' model enhances continuity of care for patients throughout the seven-day period.

A further handover takes place at 9.30pm which is attended by the evening and night medical staff and is followed up by a discussion with the consultant on call for the night.

Patient safety is paramount by ensuring that each patient is properly handed over, and the most senior member of the medical staff available is present together with nursing staff involvement. Impromptu educational questions can be raised, and direction can be given by consultants for further management of patients.

Burnley General Hospital

Hospital at Night

The Hospital at Night model is one of the most complete ways to achieve compliance with the European Working Time Directive. It is a competency-based approach to clinical care and out-of-hours medical provision. Doctors, nurses and other healthcare workers work in teams that are not demarcated by traditional boundaries and work is allocated on the basis of skills and competencies. This approach to working relies on cooperation at all levels of the clinical team. Doctors working in shifts alongside senior nurses provide out-of-hours cover.

One of the major recommendations to come out of the pilot projects was that handover was an integral part of successful implementation of such an approach. Successful implementation relied

on medical and nursing teams communicating effectively and efficiently both within their teams and also with other teams and shifts.

The Hospital at Night pilot projects have all taken different approaches to handover but the overall focus has been that handover was a fundamental part of a safe working clinical team.

A hospital-wide approach to handover

All specialties including general surgery, orthopaedics, anaesthetics and general medicine are involved in a handover to the night team. The hospital 'stops' at 9pm so all teams handover together. Everyone is made aware of the sick patients in the hospital and the tasks that are to be completed during the shift. The advantage of a hospital wide approach is that everyone is aware of what is going on and there is a true team approach.

The Homerton Hospital, London

Doctors have found that handover can be a useful experience that gives them the opportunity to involve appropriate specialties early, for example intensive care.

There is ability to discuss cases with other specialties in an open environment.

Intranet-based patient lists

One trust is using an online, live patient list, which is accessible in a secure manner to all members of the team from any computer in the hospital. As well as giving details of the location and consultant team responsible for the patient, it gives summary of current problems, and the outstanding management issues.

This is particularly useful for the continuity of information and tasks across large numbers of patients, where it would be otherwise impractical to discuss them all on an individual basis. It also gives more robust confidentiality and data protection than lists printed from individuals' PCs or disks.

Kings' College Hospital, London

A specialty specific approach to handover.

The medical and surgical specialties have separate handovers. There is a designated handover area, which is the 'control centre' for the out-of-hours team. Nurses and doctors take part in the handover together. Clinical priorities are identified and tasks allocated to the most appropriate professional to carry it out.

The Royal Liverpool University Hospital

The multidisciplinary approach to handover is fundamental to the successful flow of information and its link to continuity of care.

A message to junior doctors



We all hand over information about patients every working day. Many of us would accept that our present mechanisms for doing so are far from ideal. A scrap of paper left in the mess together with a rushed telephone call represents a real risk to our patients' quality of care.

This document sets out to change that. We will become increasingly reliant on high quality information to be able to look after our patients and it is imperative that the systems in place around us facilitate this:

- good IT
- time to handover
- a quiet place to do so
- coordinated shifts.

In turn, this will allow us to offer our patients even better care and improve the quality of our working lives.

Talking to fellow junior doctors in hospitals with really excellent handover arrangements in place, they all state that they cannot now imagine working in a system without them. All have seen good, comprehensive handover as being of enormous benefit to themselves as well as to their patients.

We have to get this right and the BMA is delighted to work with the National Patient Safety Agency and Modernisation Agency in taking a lead on improving handover and making hospitals and community care safer.


A handwritten signature in black ink, appearing to read 'Simon Eccles', with a large, stylized flourish at the end.

Mr Simon Eccles

Chairman

United Kingdom Junior Doctors Committee

British Medical Association



Consultants rightly place themselves at the centre of maintaining excellence of care for patients. Through leadership, motivation and continued modernisation, consultants press forward positive change for patients. The long-term commitment consultants have to their organisations, often reaching 20-30 years, gives them vital insight into what works best for patients. There must be robust consultant support for the handover process and encouragement to multidisciplinary teams to become involved, in order to maximize the benefits for the teams, but most of all for patients.

Consultants need to ensure that they handover information about their most critically ill patients

A message to medical managers



Communicating what we do, what we have done and what we plan to do for our patients lies at the very heart of clinical care. We have evolved traditions of communication within the profession – which now must be changed and adapted, given the changes in the ways we must all work in the future to comply with the European Working Time Directive.

Fundamentally, what matters is the safety and wellbeing of patients in our care. As we move from the individual doctor-based approach to a team-based culture, from on-call to full shift working, so must the systems and processes of information exchange become considerably more sophisticated and precise.

For medical managers this means, firstly, providing support for whatever system of handover is in place in the trust. However, as a major component of the organisation's risk strategy and clinical governance, it also means that medical managers will need to develop mechanisms to be able to satisfy themselves that handover arrangements are in place, that they are robust, that they are adhered to – and most importantly – that they are working.

A rigorous approach to handover of vital patient care information, however, should not take the form of a stand-alone initiative, the sole province of the doctor in training. It should form part of an overarching, trust-wide policy of teamworking, based on appropriate and effective sharing and use of patient care information. The medical manager has a key role to play in ensuring that the underlying structures and processes are in place and that doctors and other clinical staff are totally supported in achieving effective handover, whatever their specialty or location.

Professor Jenny Simpson OBE
Chief Executive
British Association of Medical Managers

A message to postgraduate deans and clinical tutors

An essential aspect of postgraduate medical education is learning from working with patients. The European Working Time Directive, Changing the Workforce initiative and Modernising Medical Careers will impact on the way that patient care is delivered and will present new opportunities to make learning for doctors in training more effective. As training becomes more concentrated those with responsibility for medical education must learn new skills to magnify every learning opportunity.

Handover without senior input is a lost opportunity and can encourage confidence without corresponding increase in competence. The 'post-take' ward round has always been an effective way of reviewing clinical decisions and encouraging learning. New ways of working will require new ways of learning. Consultants and specialist registrars will need to learn how to use formal handover, often away from the bedside for effective use of time, to stimulate learning and encourage self-reflection at the same time as ensuring transfer of essential information.

This guide challenges the medical profession to think carefully about the clinical governance issues involved in handover and to consider how technology and effective communication can be used to ensure patient safety. The challenge for postgraduate deaneries, and those with responsibility for medical education in the trusts, is to develop skills in consultants and specialist registrars to use formal handover sessions as learning opportunities. Postgraduate deans and medical royal colleges will also need to consider how existing quality assurance processes can be used to encourage trusts to embrace these important changes.



Professor Jacky Hayden

Dean of Postgraduate Medical Studies
University of Manchester



A message to medical students and medical schools



We have paid a great deal of attention in recent years to modernising the undergraduate medical curriculum. Most of the effort has gone into changes in curriculum structure and delivery. Some effort has gone into making sure that the knowledge base that we are teaching is up to date. I have the impression that rather less effort has been directed to ensuring that our graduates are equipped to deal with the organisational aspects of healthcare delivery that they are going to meet from their first day as PRHOs. Important areas such as patient safety are just beginning to find their way into the formal curriculum.

The European Working Time Directive has already had a major impact on junior doctors' working patterns. It is impossible for there to be individual continuity of care by juniors when the working week is limited to 48 hours. This problem is likely to be exacerbated with the introduction of the more structured training programmes envisaged in Modernising Medical Careers. Properly structured and managed handovers will be essential for patient safety and optimal care.

The BMA guidance document [Handover of patient care](#) is a timely reminder of the importance of this area within the curriculum. Part of our instruction in communication skills must focus on communication between professionals. Good handover procedures must form part of this.

A handwritten signature in black ink, appearing to read 'Sam Leinster'.

Professor Sam Leinster

Dean
School of Health Policy and Practice
University of East Anglia

Conclusion

- Good doctor to doctor handover is vital to protect patient safety
- Multi-disciplinary handover is important to ensure all groups of staff are updated with current patient information
- With the increase in shift pattern working, the importance of good handover has never been so high
- Systems need to be put in place to enable and facilitate handover. These systems, although based on a generic model, must be adapted to local needs
- Continuity of care is paramount to protect patient safety; continuity of care is underpinned by continuity of information
- Safe handover = safe patients

- 1 Junior Doctors Committee (2003) Making IT work for hospital Juniors: Supporting Working Practices and Training with the New Contract and the EWTD. London: British Medical Association.
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- 3 National Patient Safety Agency (2004) *Handover: A Patient Safety Alert*. London: National Patient Safety Agency.
- 4 Department of Health Expert Group (2000) *Handover: A Patient Safety Alert*. London: Department of Health.
- 5 Cook RI, Render M & Woods DD (2000) Gaps in continuity of care and patient safety. *Journal of Clinical Pharmacy and Therapeutics* **30**: 791-94.
- 6 Veenstra M, Pettersen KI & Sjetne IS (2000) *Handover: A Patient Safety Alert*. Oslo: HELIEF Foundation for Health Services Research.
- 7 Krogstad U, Hotoss D & Hjortdahl P (2002) Continuity of hospital care: beyond the question of personal contact. *Journal of Clinical Pharmacy and Therapeutics* **32**: 36-8.
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Appendix I – New Deal & EWTD

The New Deal

The implementation of the New Deal for doctors in training has acted as a driver for change in the way that the medical workforce is organised in the UK.

In recent years, more doctors have moved away from the traditional on-call model to patterns of work more appropriate to their workload intensity. Full shift rotas have become the norm in many acute care settings. This will often mean different teams looking after the same group of patients in the course of any given day. As a consequence, robust handover mechanisms are of the utmost importance.

New Deal rest requirements

Rota type	Minimum time between duties (h)	Minimum Time off duty (h)	Rest
On call	12	48 + 62 every 28 days	OOH incl. 5 hours continuous at night
24-hour partial shift	8	48 + 62 every 21 days	6 hours incl. 4 hours continuous at night
Partial shift	8	48 + 62 every 21 days	OOH period
Full shift	8	48 + 62 every 21 days	Natural breaks only

- OOH (out-of-hours) – all time outside normal working day Mon-Fri.
- All working patterns are entitled to natural breaks – 30 minutes continuous break after approximately four hours of duty.

The European Working Time Directive

Doctors in training will benefit from a phased introduction of the EWTD. All other staff groups – and most other employees – are already protected by this legislation. The EWTD is essential health and safety legislation designed to protect the individual from the potentially damaging effects of working excessive hours and to ensure that they are adequately rested. Enforcement of the legislation is the responsibility of the Health and Safety Executive. The limits for working hours under the EWTD are summarised in the boxes below. These limits are in addition to those already provided by the New Deal, which continues to apply.

Average working hours per week for doctors in training

August 2004	58 hours
August 2007	56 hours
August 2009*	48 hours

* In exceptional circumstances a country may apply for an extended deadline up to 2012 with a 52-hour interim limit

Rest provisions from August 2004

11 hours continuous rest in every 24-hour period
Minimum 20 minute break when shift exceeds 6 hours
Minimum 24-hour rest in every 7 days **or**
Minimum 48-hour rest in every 14 days
Minimum 4 weeks annual leave
Maximum 8 hours work in 24 for night workers (if applicable)

Further details are contained in www.bma.org.uk/ewtd which can be accessed at www.bma.org.uk/ewtd



Appendix III – Royal College of Physicians Good Practice



Royal College of Physicians

Standards of good practice to improve continuity of care

1. A patient should know the name of the medical team responsible for his or her care.
2. A medical team should know the name and location of every patient under its care.
3. Medical teams should not routinely have patients outlying from their home wards.
4. A single medical team should be responsible for a patient's care at any one time.
5. Doctors should have sufficient protected time for patient handover.
6. On transfer of care, a patient's new team should have immediate access to all necessary clinical information.
7. Out of hours (evenings, nights, and weekends), doctors should be aware of the patients under their care who are particularly unwell.
8. Each clinical action and annotation in patient notes should be traceable to the doctor concerned.
9. A patient's resuscitation status must be stored sensitively, but also accessible immediately.
10. Doctors should know the outcome of their decisions.
11. When designing junior doctors' medical rota, the first priority should be daytime continuity of care on the wards.
12. A discharge letter, summary or report should leave the hospital within 24 hours of a patient's discharge.

Appendix IV – Common Pitfalls During Handover

Common pitfalls during handover

The Human Factors and Arterial Switch Operation study collected data on operations performed by 21 UK cardiac surgeons in 16 centres over eighteen months. During the study, researchers were present at operating theatre to ICU handovers.^{12,13}

- Healthcare professionals sometimes try to give verbal handovers at the same time as the team taking over the patient's care are setting up vital life support and monitoring equipment. Unless both teams are able to concentrate on the handover of a sick patient, valuable information will be lost. The importance of written handover information must be stressed.
- Roles and responsibilities are not always clear during handover and this can lead to omissions, for example, if one staff member assumes that another will verbally update the team taking over the care of a patient.
- Checklists and written updates are important and often under-utilised. They provide important sources of information for the team who has taken over care of the patient during the following shift. When such information is incomplete or omitted it has a knock on effect of increasing the workload of the staff who have taken over the patient's care because they have to spend a significant proportion of time chasing information.
- It is important that nursing staff are made aware of critical features in the medical management of a patient that will affect care during the next shift. Similarly, medical staff must be aware of specific nursing issues that may affect care. Multidisciplinary team handover helps minimise these omissions.
- Fragmentation of information at the point of handover is a major problem. It is important to avoid multiple concurrent conversations between individuals and let one person (a nominated lead) speak at a time to everyone. This reduces the opportunities for conflicting information to be given.
- Handover is a two way process. Good handover practice is characterised by the team who are taking over the patient's care asking questions and having the opportunity to clarify points they are uncertain of. They should not be passive recipients of information.

Appendix V – Safe Handover: Safe Patients – One day event summary

Background

Effective handover is of vital importance to the safety of patients. The British Medical Association's Junior Doctors Committee has been working closely with the National Patient Safety Agency (NPSA) and NHS Modernisation Agency to produce this crucial guidance on clinical handover.

It is important that this guidance is widely used and accepted throughout the United Kingdom. In order to facilitate this process a one-day handover event was held at the NPSA in London on Wednesday 21 July 2004.

Clinicians and managers attended the event as well as representatives from the NPSA, NHS Modernisation Agency, Department of Health, Nursing and Midwifery Council, postgraduate deaneries, NHS Litigation Authority and the BMA. The delegates at this conference ratified the contents of this booklet and produced a list of priorities and actions for the future.

These action points are detailed below, and the BMA will ensure that the external bodies listed continue to develop their work on good handover. Patient safety is paramount in all of our healthcare institutions and it is vital that the recommendations below are put into practice.

Priorities for action

1. The Healthcare Commission should ensure, by regular inspections, that handover mechanisms in each organisation provide safe continuity of information in order to maximise patient protection and patient safety.
2. Postgraduate deans and the medical royal colleges should include effective handover practice as an essential criterion for granting educational approval of a training grade post.
3. Training Institutions, in conjunction with the General Medical Council, should develop and implement undergraduate handover training modules for every medical school, and handover training modules should also be included in every postgraduate curriculum in the UK.
4. Competency in handover, and in medical record writing, should feature as an aspect of all training or continuing professional development appraisals and assessments throughout the medical career structure, from medical schools onwards.
5. Each trust, NHS region, medical royal college, statutory body and other organisation connected with patient safety, or the education, training or representation of doctors, must identify and appoint a responsible handover champion.
6. The Department of Health and National Patient Safety Agency should develop and publish a standardised handover protocol and model handover documentation in conjunction with the British Medical Association.
7. The Department of Health should mandate each trust to have an effective handover policy as well as ensure that appropriate handover is built into each and every rota.
8. Trusts should ensure that information systems are in place to support handover processes.
9. The Healthcare Commission should include inspections of handover mechanisms and procedures in their measure of the performance of NHS trusts.
10. The National Patient Safety Agency and Department of Health should begin work on the standardisation of the format of medical records and ensure that attention is given to ensuring the patient record is optimal, in order to facilitate effective handover of information to protect the safety of each patient within the host institution.
11. The National Patient Safety Agency and Department of Health should develop generic medical handover guidelines to aid trusts in producing specific speciality and hospital based handover protocols.

Delegates

The following delegates attended the one-day handover event and contributed to the discussions and creation of the priority outcome above:

Name	Position & organisation
Dr Janet Anderson	Consultant Paediatrician & Tutor Support, Royal College of Paediatrics & Child Health, London
Ms June Andrews	Director, Centre for Change & Innovation, Scottish Executive Health Department, Edinburgh
Dr Robin Arnold	Chairman, Central Consultants Specialists Committee Psychiatry Subcommittee, British Medical Association, London
Dr Dan Ash	President, Royal College of Radiologists, London
Dr Simon Calvert	Chair, Junior Doctors Committee IT Working Group, British Medical Association, London
Dr Geoff Copland	Director of Clinical Training, Gold Coast Hospital, Southport, Australia
Ms Alison Dalby	Human Resources Advisor, University College London Hospitals NHS Trust, London
Dr John Dyet	Clinical Specialty Advisor for Radiology, National Patient Safety Agency, London
Mr Simon Eccles	Chairman, Junior Doctors Committee, British Medical Association, London
Dr Peter Ehrhardt	Consultant Paediatrician & Medical Director, East Lancashire Hospitals Trust, Burnley
Ms Georgina Fletcher	Human Factors Specialist, National Patient Safety Agency, London
Dr Rajat Gupta	Member, Junior Doctors Committee, British Medical Association, London
Professor Jacky Hayden	Dean of Postgraduate Medical Studies, North Western Deanery, Manchester
Mr Keith Haynes	Head of MPS Risk Consulting, Medical Protection Society, Leeds
Dr Paul Helliwell	Clinical Specialty Advisor for Dental Services, National Patient Safety Agency, London
Dr Sara Hunt	Specialist Registrar in Anaesthetics, Association of Anaesthetists of Great Britain & Ireland, London
Ms Candace Imison	Project Lead, Hospital at Night, Department of Health, London
Dr Geoffrey Lewis	Member, Junior Doctors Committee, British Medical Association, London
Professor Sir John Lilleyman	Medical Director, National Patient Safety Agency, London
Dr Andrew Long	Chairman, National Association of Clinical Tutors, London
Dr David Macklin	Deputy Chairman, Junior Doctors Committee, British Medical Association, London

Appendix VI – Contributors

British Medical Association Junior Doctors Committee

Miss Emma Bywaters

Dr Simon Calvert

Mr Simon Eccles

Dr Graeme Eunson

Dr David Macklin

Dr Chris McCullough

Dr Andrew Rowland

Dr Andrew Thomson

British Medical Association Central Consultants and Specialists Committee

Dr Paul Miller

University of Manchester

Professor Jacky Hayden

University of East Anglia

Professor Sam Leinster

General Medical Council

Professor Peter Rubin

British Association of Medical Managers

Professor Jenny Simpson

National Patient Safety Agency

Professor Sir John Lilleyman

Ms Joan Russell

Ms Elaine Stevenson

