

## NHSLA circular re-issue on hold after protest

A revised version of the NHS Litigation Authority's (NHSLA's) circular on apologies and explanations has been put on hold following protest that it did not go far enough in fostering openness with patients and their families.

The revised NHSLA circular was to be issued in the autumn, and was to include for the first time the endorsement of professional medical and nursing organisations such as the British Medical Association and Royal College of Nursing.

However, at a meeting of the National Patient Safety Forum in October last year (details of which became available in December), chief executive of Action against Medical Accidents, Peter Walsh, objected to the wording of the circular as it was "inconsistent with the spirit of *Being open* and issuing it without some amendment would be very unhelpful". It was agreed at the meeting that the circular would not be re-issued until after further discussion.

Steve Walker, chief executive of the NHSLA, commented to HCR: "To no-one's surprise, AvMA said the circular didn't go far enough. We are optimistic that we should be able to come up with a compromise fairly quickly although there is a limit to how much we can tinker with words."

He said it was important to try and use healthcare professionals' own channels of communication to endorse the message about openness and honesty, as "clinicians don't see circulars that go to NHS chief executives". He added that

he wanted to ensure that the NHSLA was "eliminated from being an excuse not to do the decent thing".

The meeting also heard findings of a review of the National Patient Safety Agency's *Being open* guidance, by Professor Albert Wu from the USA's Johns Hopkins University. This made six recommendations, as follows:

1. NHS bodies should make patients aware of *Being open*;
2. trusts should appoint three clinicians to support other clinicians in being open about adverse incidents;
3. patient liaison services should provide "on the spot" help;
4. NHS boards of directors should ensure that *Being open* is supported by non-punitive local policy and by staff training;
5. the NHS Litigation Authority should review its communications to trusts and medical defence unions should review current practices; and
6. the National Patient Safety Agency should consider a relaunch of *Being open*.

At the meeting the NHS chief executive David Nicholson commented that there was a "strong case for each of the recommendations and he would be considering the best way of taking these forward".

A draft summary of the meeting can be found at [www.dh.gov.uk/en/PublicHealth/Patientsafety/DH\\_073927](http://www.dh.gov.uk/en/PublicHealth/Patientsafety/DH_073927).

- See feature p12.

## Winners celebrate award for safer cancer care

Salford Royal Foundation NHS Trust has won a patient safety award for reducing missed or delayed diagnoses of cancer.

The trust came first in the patient safety category of the *Health Service Journal's* awards, given out in December.

It developed a "safety net" system to ensure that every chest x-ray report where there was suspected early cancer would be seen by an appropriate clinician and receive effective follow-up. After 12 months, audit identified 21 patients whose diagnosis would have been missed or delayed had there not been a safety net.

NHS Tayside and NHS Forth Valley were highly commended for their joint work in patient safety in primary care, while the Skills for Health Workforce Projects Team were also highly commended for developing the Hospital at Night programme.

## "Measure to improve", says patient safety campaign

The Patient Safety First Campaign is encouraging trusts in England to sign up to a "measurement extranet" so they can monitor how well they are doing in trying to improve safety.

The campaign is also due to launch a guide on measurement for improvement, introducing the model for improvement that it promotes, and the process of collecting, analysing and reviewing data. The model for improvement has been developed by the Institute for Healthcare Improvement in the USA.

To find out more about the campaign in your country go to [www.patientsafetyfirst.nhs.uk](http://www.patientsafetyfirst.nhs.uk) (England), [www.wales.nhs.uk/sites3/home.cfm?orgid=781](http://www.wales.nhs.uk/sites3/home.cfm?orgid=781) (Wales) or [www.patientsafetyalliance.scot.nhs.uk](http://www.patientsafetyalliance.scot.nhs.uk) (Scotland).

- See feature p16.

## Employers encouraged to prevent needlestick injury

NHS organisations should be encouraged to adopt safety devices to prevent needlestick injuries in healthcare workers, and should ensure that appropriate occupational health systems are in place to deal with exposure to bloodborne viruses (BBVs), according to the Health Protection Agency.

In *Eye of the needle*, a biennial report on occupational exposure to BBVs in England, Wales and Northern Ireland published in November, the HPA says there were 914 incidents where healthcare workers were put at risk between 2006/07, with four workers acquiring hepatitis C as a result.

Dr Peter Carter, chief executive and general secretary of the Royal College of Nursing, commented: "Employers in the NHS need to take this issue seriously by investing in safer alternatives to traditional needles, so that these accidents don't happen the first place."

- A standards document outlining all NHS organisations' responsibilities regarding occupational health and safety is now available from the Partnership for Occupational Safety and Health in Healthcare, part of the NHS Staff Council. See p20 for details.