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NPSA set to overhaul its National Reporting and Learning System

Redesigning the National Patient Safety Agency's National Reporting and Learning System (NRLS) is one of the recommendations of "Safety first: a report for patients, clinicians and health care managers," published last month by the Department of Health.

The report is the result of a review commissioned by the Chief Medical Officer for England to address issues raised in the National Audit Office report "A safer place for patients: learning to improve patient safety." The report looks more widely at the approach to patient safety in the NHS.

Despite the large number of incident reports received, the review found little evidence that the NRLS is producing a complete and accurate picture of the major safety problems faced by the NHS. Reasons for



An overhaul of NRLS is included in the DoH's "safety first" report

this include an awareness that many incident reports contain inaccurate or incomplete information about patient harm and there is insufficient involvement of local NHS organisations in reviewing and acting upon analysis of their own incident reports.

Recommendations for improvement include suggestions that reports should be simplified and a new category of "incidents that could happen" should be added.

□ In a separate development, further inadequacies in the data feeding into the NRLS have been highlighted. Research published by *BMJ Online First* (www.bmj.com) on 15 December suggests that hospital reporting systems may be significantly under-reporting the scale and severity of incidents.

In the study, the number and type of incidents in a random sample of 1,006 admissions in a large NHS hospital in England, identified by reviewing medical notes, were compared with data extracted from the trust's routine reporting system. Of the 324 incidents that occurred, case review identified 303 incidents, while just 54 were recorded in the reporting system, which also missed 71 drug-related problems.

"The results do not mean that the early themes emerging from the analysis of the national reporting system are not useful", the authors state, "but estimates of the type and severity of incidents are likely to be biased."

Other recommendations in the DoH report

- All incidents should be considered locally within 24 hours of being reported and the NPSA should be notified within 36 hours of events that involve serious patient harm
- The NPSA should work in partnership with agencies that gather data, such as complaints, claims and coroners reports, to ensure that all incidents associated with death and serious harm are identified

DoH plan predicts excess NHS jobs

By 2010 there will be more health professionals than the NHS can afford to employ. This is according to a draft of the NHS pay and workforce strategy for 2008-11 that was reported in the *Health Service Journal* earlier this month. The document predicts that by 2010/11 there will be excess of 16,200 allied health professionals, health care scientists and technicians. However, it is unclear how many, if any, of these are pharmacists.

Anthony Oxley, president of the Guild of Healthcare Pharmacists, commented: "The

Royal Pharmaceutical Society's analysis has shown that there is likely to be a shortage of pharmacists in the future rather than a surplus. We cannot draw any conclusions from the broad approach used in the Department of Health draft document, where pharmacists are grouped together with so many other professions, but would need to see more detail of the breakdown of these figures."

David Miller, chairman of the guild's terms and conditions committee, added: "Workforce predictions are notoriously

inaccurate and DoH data normally only deal with numbers in the managed sector rather than the commercial sector where most of the profession practise. The increasing numbers of pharmacists employed by the managed sector over the past 10 years shows members' versatility and the value they add to the safe effective and economic management of medicines. This will continue over the next five years."

□ Potential job cuts and service rearrangements are discussed in this month's Comment (p2).

brief

■ Soraya Dhillon, chair of Luton and Dunstable Hospital NHS Foundation Trust and head of the University of Hertfordshire's school of pharmacy, was made MBE in the New Year's honours list.

■ Among those designated as fellows of the Royal Pharmaceutical Society last month are Stephen Bazire, pharmacy services director for Norfolk and Waveney Mental Health Partnership NHS Trust, Ray Fitzpatrick, clinical director of pharmacy at the Royal Wolverhampton Hospitals NHS Trust, and John Timmins, clinical director of pharmacy and medicines management for Sheffield Children's NHS Foundation Trust.

■ Two new online databases were launched last month by the National Institute for Health and Clinical Excellence, to support the implementation of its guidance. They are accessible via *PJ Online* (www.pjonline.com/links/hp).

■ Guidance on covert medication — the practice of hiding patients' medicines in food or drink — was published last month by the Mental Welfare Commission for Scotland. The guidance, mainly aimed at care homes, states that a pharmacist's advice must be sought on crushing tablets or combining medicines with food or drink. It can be accessed via www.mwscot.org.uk

■ Payment by Results guidance for 2007/08 was published by the Department of Health last month. In addition, an Audit Commission report outlines pilot results from testing aspects of the proposed assurance framework for England. Both documents can be accessed via *PJ Online* (www.pjonline.com/links/hp).

Section 60 Order now published as law

The Pharmacists and Pharmacy Technicians Order 2007 has finally been published as a draft Statutory Instrument. Following debates on the Order in both houses of parliament, the Order is expected to be made at a Privy Council meeting on 7 February.

Made under Section 60 of the Health Act 1999, the Order repeals the Pharmacy Act 1954 and brings in a new regulatory regime for pharmacists. Pharmacy technicians working in England and Wales also become part of a regulated profession.

Not all parts of the Order will come into effect at once — the process of bringing the various sections into effect will be linked to the making of rules by the Society's Council.

Some of the changes requested by the Society's

Council are included in the draft. These include that the definition of pharmacy or pharmacy technician practice will now include working in or giving advice relating to the practice of pharmacy. Another is that pharmacists registered in Great Britain who work overseas will be able to be on the non-practising part of the Society's register.

The Council has been partially successful in its request that the chairman of the new Disciplinary Committee be appointed by the Privy Council, as has been the case for the Statutory Committee. The final draft provides for the appointment to be made by the Privy Council, but allows the Privy Council to seek assistance from the Government's Appointments Commission.

Extent of drug errors in mental health unknown

The scale, cause and outcome of medication errors in mental health care is not really known, according to recent research published in *Quality and Safety in Health Care* (2006;15:409–13).

The authors screened 153 potentially relevant studies and carried out what they believe to be the first systematic review of the nine studies that met their inclusion criteria.

Error rates reported included 0.022 and 0.024 errors per prescribed item and 2.67 and 5.5 errors per month. Most of the errors identified related to the prescribing or administration of medicines, with far fewer relating to dispensing. Only those studies (four) carried out by pharmacists detected errors in clinical decision-making.

All nine of the studies reviewed were carried out in

psychiatric hospitals, with six focusing only on inpatients, so the authors conclude that the extent of errors in other settings is unknown.

Moreover, none of the studies looked at the cause of errors, or were outcome-based. Most studies were prospective, rather than retrospective.

The authors point out that some mental health services have limited pharmacy support, and so the ability of pharmacists to detect and prevent prescribing errors on a daily basis is hampered.

Correction

Implementation of the Supply Chain Excellence Programme is ongoing, and not at the dates specified in last month's *Hospital Pharmacist* special feature (p398, Panel 2)