

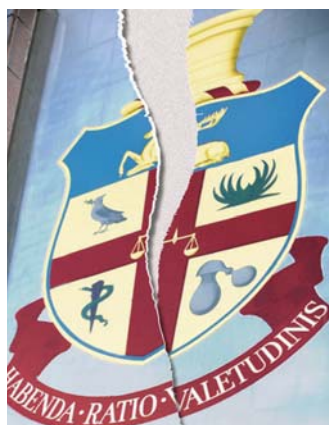
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# Mixed responses to splitting Royal Pharmaceutical Society

News that the Royal Pharmaceutical Society is to lose its regulatory function and that a royal-college type body is to be formed to take on the leadership of the profession has been greeted with mixed responses.

The Guild of Healthcare Pharmacists is broadly supportive of the direction that the proposals set out in the White Paper are taking the profession. Anthony Oxley, president of the guild said: "We welcome the formation of a General Pharmaceutical Council to regulate pharmacists and pharmacy technicians and pharmacy premises, as a separate regulatory body." He added that it is inevitable, in the current climate, that regulatory functions must be seen to be independent of any vested interests of pharmacists.

The guild supports the formation of a royal college-type organisation to carry on the representation function of the Society. "Critical to the success of such a college is that all areas of practice are effectively represented, something that the guild considers that the Royal Pharmaceutical Society has not been able to achieve... If a prime function of the royal college is to carry out revalidation of pharmacists and pharmacy technicians, it should be structured to accommodate the clinical roles of pharmacists now and in the future, when we expect to see far less emphasis on



"hospital" or "community" pharmacy work, and much more focus on developing clinical roles in a multidisciplinary environment". The royal college-type body should start with a "clean sheet," the guild said.

Sounding a more cautious note, Colin Ranshaw, principal pharmacist for quality assurance and control at Cardiff and Vale NHS Trust and member of the Society's Council, stressed that the profession must build upon, but not lose, what is good about the present system. "The RPSGB is an effective umbrella organisation bringing together pharmacists from all areas of the profession. RPSGB regulates and sets standards for pharmacists, premises, medicines and education and has been doing this very effectively." He added: "The professional body that is left when regulation is removed must offer equal professional leadership to the

majority (community-based pharmacists) and the minority (hospital-, industry- and academia-based pharmacists) because this is [the Society's] strength."

The detailed structure of the royal college-type body is not yet known. Duncan McRobbie, chairman of the United Kingdom Clinical Pharmacy Association, said he would like to see pharmacists who work at a specialist level recognised by the royal-college type organisation and he emphasised the importance of ensuring that it reflects the interests of smaller specialities. He added that the value of having a royal college would be that it would speak with one voice. "At the moment, the number of organisations with different agendas results in no cohesive voice for the profession."

One potential area of conflict looks set to be whether pharmacists will need to undergo an accreditation process before becoming eligible for membership of the royal college-type body. At a recent Department of Health stakeholder meeting, Bill Scott, Chief Pharmaceutical Officer for Scotland, said that the royal college-type body would not be "elitist" and pointed out that there is stringent accreditation already in place for pharmacists, namely a pharmacy degree and the preregistration training year. However, Celia Feetam, president of the College of Mental Health Pharmacists, said she is concerned that a royal college that does not have a strict accreditation process would dilute processes already in place for some specialist pharmacy groups.

Plans to split the Society were set out last month. "Trust, assurance and safety, the regulation of health professionals in the 21st century" is available from the DoH website ([www.dh.gov.uk](http://www.dh.gov.uk)) and via *PJ Online* ([www.pjonline.com.links/hp](http://www.pjonline.com.links/hp)).

## brief

■ **Guidance supporting the use of barcoding and other auto-identification techniques has been published by the Department of Health. One of the recommendations is that both the NHS and pharmaceutical industry adopt the "GS1" system of coding standards. Available via *PJ Online* ([www.pjonline.com.links/hp](http://www.pjonline.com.links/hp)).**

■ The 2007 edition of "Rules and Guidance for Pharmaceutical Manufacturers and Distributors" (the "Orange Guide") was published last month by The Pharmaceutical Press. Updates include details of the revised code for Qualified Persons.

■ **Last month saw the publication of the electronic prescribing functional specification (version 1.0) for systems to be used within hospitals in England. Available via *PJ Online* ([www.pjonline.com.links/hp](http://www.pjonline.com.links/hp)).**

■ **New advice on improving the care received by people with both a mental health and a substance misuse problem has been published by the Department of Health. Available via *PJ Online* ([www.pjonline.com.links/hp](http://www.pjonline.com.links/hp)).**

■ **The Scottish Executive Health Department have issued guidance on managing Controlled Drugs, which specifies how NHS Scotland will respond to the requirements of the Health Act 2006 and subsequent Controlled Drugs regulations. Available via *PJ Online* ([www.pjonline.com.links/hp](http://www.pjonline.com.links/hp)).**

■ In its response to the Shipman Inquiry's fifth report, the Government recommends that health care organisations should maintain files on the quality of care provided by all professional employees. Available via *PJ Online* ([www.pjonline.com.links/hp](http://www.pjonline.com.links/hp)).

### Government plans for the GPC and the royal college-type body

#### General Pharmaceutical Council

- Will be responsible for the regulation of pharmacists, pharmacy technicians and for the registration of pharmacy premises
- Will have at least as many lay members as professional members
- Members will be appointed, not elected

#### Royal college-type body

- Will have a significantly enhanced leadership function
- Should have an important role in revalidation arrangements and contribute expertise to the new GPC
- Will be a learned organisation, supporting professionalism, excellence and innovation in the science and practice of pharmacy
- Some lay involvement is likely, but details are not yet known

## Trusts should use more than one method to detect adverse events

Trusts should introduce more than one method of adverse event detection. This is the conclusion of a recent report in *Quality and Safety in Health Care* (2007;16:40–4).

Researchers reviewed the numbers and types of adverse incidents identified by three different methods — routine incident reporting to a hospital's confidential system; routine surveillance of inpatient prescriptions and medicines administration by pharmacists during a patient's stay; and clinician review of medical records 10 days after discharge.

In the study group of 288 patients admitted to a district general hospital, pharmacist surveillance detected 30 medicines-related potential adverse events and clinician review detected 14, with three of these reports overlapping. Pharmacist surveillance mainly detected failures to prescribe



Review of records can identify adverse events that might otherwise be missed

regular or indicated medicines (15/30) and failures to prescribe correct doses (9/30), while clinician review mainly detected failures to monitor the effects of medicines adequately (5/14, with pharmacist surveillance detecting less than half of these) and polypharmacy leading to side effects in elderly patients (4/14). No medicine-related events were detected using incident reporting.

A total of 66 adverse events of any nature (ie, including those that were not medicines-related) were detected by clinician review and 11 by incident reporting.

The authors conclude that incident reporting alone is not enough to gain a comprehensive picture of the areas of risk in clinical care and that a portfolio of systems should be used in an integrated and systematic way.

## Doctors need training in drug dose calculations

Training given during medical school to perform drug dose calculations should be reinforced during doctors' first year of practice, according to a report published last month in the *International Journal of Clinical Practice* (2007;61:189).

Researchers analysed the results of nearly 3,000 doctors who participated in an online test involving drug solution calculations expressed as percentages, ratios and mass concentrations. They found that, among doctors working in hospitals, there was a significant relationship between number of years of experience and test scores.

Doctors were more likely to make mistakes when the concentrations of drug solutions were expressed as ratios and percentages.

## Value-based prices for drugs needed, says OFT

Prices paid for branded drugs should reflect the therapeutic value that they bring to patients, according to a recent report from the Office of Fair Trading.

The OFT report recommends that value-based approaches to medicines pricing should replace the current Pharmaceutical Price Regulation Scheme. This would give pharmaceutical companies stronger incentives to invest in drugs for those medical conditions where there is greatest need, the report says. Also, reduced spending on poor value drugs could potentially mean more resources are available for other high cost, valuable medicines.

Under the proposed scheme, manufacturers would submit a suggested price, along with evidence of cost-effectiveness,

which would differ across indications. An analysis of prices reflecting value would then be carried out in a co-ordinated way by the National Institute for Health and Clinical Excellence, the Scottish Medicines Consortium and the All Wales Medicines Strategy Group. If these organisations considered that, at the given price, the drug would fall within the cost-effectiveness threshold in all indications, the drug would be recommended for use in the NHS. Recommendations would take the form of guidance similar to that issued through NICE's single technology appraisal process or by the SMC.

In the long term, the OFT suggests that a commission on the value of medicines be created.

## Discharge drug lists are inaccurate, study says

Discharge medication lists often contain inaccuracies, according to recent research published in *Quality and Safety in Health Care* (2007;16:34–9).

Researchers interviewed 200 patients within a week of their discharge from surgical or medical wards at a university hospital in Denmark. They found that 66 of the 80 patients (55 surgical and 11 medical) who had no drugs mentioned in their discharge letter were actually taking medicines at home.

Where medicines were included in the discharge lists, there were several discrepancies between the regimen prescribed in hospital and that which was being taken at home (affecting 34 patients) — 11 drugs included in discharge lists were not being used by patients at

home, 12 drugs that had been discontinued during a patient's hospital stay were still being used by him or her and 40 drugs were being used in doses or regimens other than those indicated in the discharge list or hospital file. Most discrepancies were likely only to have minor clinical implications, the researchers say, but nine of the 12 medicines that patients were still taking despite them being "discontinued" could have potentially harmful consequences due to use of unnecessary and unmonitored treatment.

The authors suggest that it is important to improve communication between primary and secondary care in order to prevent inappropriate use of medicines and adverse drug errors.