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# GHP

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*Guild of  
Healthcare  
Pharmacists*



17<sup>th</sup> June 2008

Registration consultation  
Department of Health  
Quarry House  
Quarry Hill  
Leeds LS2 7UE

Dear Sir/Madam

**Consultation on the Framework for the Registration of Health and Adult Social Care Providers**  
**Response from the Guild of Healthcare Pharmacists**

Thank you for the opportunity to respond to this consultation. The Guild of Healthcare Pharmacists represents UK wide around 4,000 pharmacists including the majority of hospital pharmacists, pharmacists employed by Primary Care Trusts (PCTs) and pharmacists employed by other public bodies such as the Commission for Social Care Inspection and the Healthcare Commission. The Guild is part of the health sector of the union Unite-Amicus section.

We are limiting our comments to the broad principles set out in the document and some comments on proposals around medicines.

In general we broadly support the proposals in this document. However, we have serious concerns about the proposals for medicines in that they do not appear to help to address any further the high level of medication errors.

Medication errors are reported to be responsible for 10-20% of all NHS adverse events (1). The projected annual cost of hospital admissions due to adverse drug reactions is round £466 million per annum, utilising 4% of hospital bed capacity with overall mortality of 0.15% (2). If the NHS is to be “a safe NHS”, as set out in the Darzi review of the NHS, these figures must improve. Subsequent studies confirm these sorts of figures for adverse events. Although these sorts of figures have been around for

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some time there does not seem to be much public awareness of them. This gives time to address them before there is public “hype” over them.

Our responses to some of the questions are shown below: the numbers correspond to the numbers on pages 95/96 of the consultation document.

## **Chapter 2 – Registration requirements for essential safety and quality**

*2.1 We propose to introduce a generic set of registration requirements (set out in regulations) for all providers offering services that are within scope. These requirements will be supplemented by compliance criteria, to be developed by the Care Quality Commission, that are specific to the type of activity. These will be consulted on at a later date. Do you agree with this approach?*

We agree that there should be a generic set of registration requirements for safety and quality applicable to all providers, both NHS providers and independent and private and voluntary providers, as set out on page 23 of the consultation document. However the compliance criteria to be developed must be applicable to all providers large and small. Implementation should recognize the limitations of some small organizations in understanding what is required of them.

*2.2 Are the areas covered by the registration requirements (set out in Annex A) the right ones to provide the assurance of the essential levels of safety and quality that we are aiming for?*

We agree with the areas covered by the registration requirements set out in annex A and that, for example, the same standards should apply for the same function such as handling of medicines, personal dignity, proper food.

*2.3 Does the wording of the registration requirements in Annex A provide appropriate coverage of these areas?*

No. We have serious concerns about the limitations of the proposals for medicines in that they do not appear, as worded, to address all areas where safety could be improved. It should NOT exclude prescribing except in terms of which drugs are actually prescribed. The processes around the prescribing of medicines must be included, for example, are records updated, are blood monitoring tests organised where needed, are patients assessed properly before being prescribed a medicine, are full records available of a particular protocol eg chemotherapy before prescribing an oral anticancer drug? These examples are taken from National Patient Safety Agency Alerts or Rapid Response Reports either issued or about to be issued.

The proposals on medicines seem merely to bring forward the current standards. They do not appear to be updated for primary care situations. Prescribing is the most common healthcare intervention and more important in primary care. The proposals do not address the difficulties currently encountered in getting some medical staff to realize that they need to be more careful around prescribing systems both in primary and secondary care

For example in care homes the National Minimum Standards for Older People require that there is an audit trail from receipt of medicines to administration or disposal. However there is no requirement for an auditable record trail of what exactly was prescribed by the GP and whether the patient actually receives that. That means that a substantial part of the record of a drug does not need to be reconciled. Many errors happen in that record “journey” before the medicine is received into the home. As there will be one regulator for health and social care, and GP practices are likely to be registered, there would be a potential mechanism within the regulator to address such “cross organization” issues.

In secondary care there is a reluctance on the part of some members of the medical profession to engage with the safety agenda for medicines eg alerts from the NPSA. Including prescribing processes specifically should help address this attitude, although the Duthie Report (see below) does include prescribing.

One potential difficulty is that there may not be one recognized document to cover best practice for primary care medicines activities, although there is enough published material to enable this to be pulled together relatively easily. For example the Duthie Report, “The Safe and Secure Handling of Medicines: a Team Approach”, Royal Pharmaceutical Society 2005, which is referenced for the core NHS standards, is secondary care based.

Unless the systems around prescribing are included medication error rates will not fall anywhere near as fast as is desirable /necessary to improve patient safety.

*2.4 Are there any overlaps, gaps or unintended consequences that will not be picked up by other parts of the system?*

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*2.5 What are your views on the transition arrangements for existing providers to enter the new registration system?*

These seem reasonable.

### **Chapter 3 – Scope – which health and adult social care services should be registered?**

*3.1 Do you agree with our proposed list of regulated activities in Annex B to be included within the scope of registration?*

*> Are there any high-risk services not covered?*

*> Have we proposed any inappropriate registration of lower-risk services?*

*> What are your views on the exclusion of non-urgent patient transport services under the ‘Emergency and urgent care’ activity topic?*

*> What are your views on the proposals for the registration of agencies who supply workers to other registered providers, under the ‘Personal care’ and ‘Nursing care’ activity topics?*

The proposals seem appropriate. We agree that for there to be a “level playing field” all services presenting a sufficiently high risk should be registered. We also agree with the approach that the service should be registered rather than the current system for the private and voluntary sector. With many services moving out of secondary care to primary care the division between the 2 sectors is becoming blurred: some traditional secondary care services are now provided in a community setting, so registration of services is a better method.

*3.2 Are the activities for registration described at the right level of detail, given that they will be underpinned by more specific and legally enforceable regulations?*

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*3.3 Is there a risk of inappropriately deregulating high-risk activities in this approach?*

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### *3.4 Have we determined the right situations in which to register a manager?*

The proposals are an improvement on the current situation where a manager has to be re-registered every time they move to another managerial post.

## **Chapter 4 – Registration of primary care**

*4.1 Does the list of activities in Annex B appropriately capture the services where people might be at risk of harm provided in primary care settings? In particular, do you agree with our proposal that ultimately all GP and primary dental services should be within the scope of registration?*

We agree with the list of activities which should be registered. As noted above, with many services moving out of secondary care to primary care the division between the 2 sectors is becoming blurred: some traditional secondary care services are now provided in a community setting.

We agree that ultimately all GP services especially should be registered, although this may have to be achieved over a significant period of time.

We also agree that primary dental services should be within the scope of registration although less of a priority than GP services.

For small practices, both GP and dental, where a recognized system of accreditation is in place which covers service safety and quality, including medicines systems, in an adequate manner (we understand this is being developed for GP practices) registration probably needs to be little more than the recognition of accreditation.

*4.2 Does the list of activities in Annex B inappropriately capture some services that are less likely to cause harm when provided in primary care settings?*

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*4.3 What information would you expect the new Commission to draw on when making decisions? How could it best do this?*

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*4.4 What is the scope for rationalising the existing requirements on primary care providers if a registration system is introduced?*

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*4.5 When should services provided in primary care settings be required to register? Should we phase in registration?*

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*4.6 If we do phase in registration, how should we determine the services to be captured?*

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4.7 Is our assessment of the costs and benefits in our accompanying impact assessment (available at [www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm](http://www.dh.gov.uk/en/Consultations/Liveconsultations/index.htm)) reasonable? Do you have any additional information on impact that we could use?

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We hope these comments are of assistance

Our reply may be made freely available.

Yours sincerely

*Jean Curtis*

Jean Curtis  
Professional Secretary

(1)“Adverse Events and the National Health Service: An Economic Perspective”, A Report to the National Patient Safety Agency, Health Economics Research Centre, Department of Public Health, University of Oxford 2003

(2) Pirmohamed, M., James, S., Meakin, S., Green, C., Scott, A. K., Walley, T. J., Farrar, K., Park, B. K., and Breckenridge, A. M. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. *BMJ* 3-7-2004; **329** 15-19.