CORRESPONDENCE

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The NHS Patient Safety Strategy has a hole in it

In August 2018, I expressed my concern that the NHS was losing its patient safety memory and not addressing many important risks effectively ('A failure to learn from our mistakes puts patients at risk'. *Clin Pharm* 2018;10(8):226-227)

Other reports have also identified shortcomings in how patient safety was being managed in the NHS in England.

NHS Improvement published a new 'NHS Patient Safety Strategy for England' on 2 July 2019. There are some proposals that I can support (for example, broadening the ways to acquire, exchange and analyse patient safety data, and developing a universal safety curriculum for all NHS staff). But, just like in James Reason's 'Swiss cheese model' (used to illustrate the flaws in barriers to prevent errors), there is a hole in the new strategy that will leave patients at risk.

The strategy says that the existing reporting system and a new national reporting system will be analysed by NHS Improvement for risks to patient safety, and patient safety alerts will be issued to assist the NHS in addressing these risks.

The document also states that patient safety alerts are not an appropriate response for known risks. This raises uncertainty over previous alerts published by the National Patient Safety Agency and NHS England; for example, those concerning strong potassium infusions, methotrexate, wrong-route errors and omitted medicine doses.

Although there is evidence that implementation of patient safety guidance published in previous alerts has been poor in the NHS, where is the evidence that the guidance in previously published alerts was not effective if implemented as intended? What are these well-known risks? They would be better known if there was greater transparency by NHS Improvement of the 2 million patient safety incidents reported to the National Reporting and Learning System each year. What are the most frequently reported risks and most severe harms in each category? What safeguards are in place?

Most of these risks are not addressed by the National Patient Safety Improvement Programme. How will the NHS respond to patients harmed by these risks in the future? NHS Improvement needs to provide guidance on how risks outside the National Improvement Programme should be managed.

David Cousins, consultant in safe medication practice

A spokesperson for the NHS said: "The NHS is a world leader in patient safety, having published the strategy to improve safety, including embracing new technology with a more transparent patient safety reporting system, a medication safety programme to provide focused and long-term support, and the introduction of patient safety specialists to work alongside medication safety officers, all of which will empower front line staff to make decisions about how to improve safety rather than relying on top-down instructions."

Low rates for locum pharmacists are unfair

I happened to be in Barnet, North London, recently, and I popped into the local pharmacy. To my delight, the locum pharmacist on duty was a student of mine a few years ago at the University College London School of Pharmacy. We had a chat and he said he had plenty of work, but the rates of pay were disappointing, at £17–£19 per hour.

More than 20 years ago, I was paying £25–£27 per hour in my Essex pharmacies and, when I owned the pharmacy in Aldeburgh, Suffolk, I often paid £30 per hour for weekend work. I thought those rates were good value for a person who had spent five years acquiring skills and knowledge and, in addition, someone whom I could leave in full charge of the pharmacy.

Thank goodness there are opportunities for pharmacists to work in GP surgeries. This gives pharmacists the opportunity to use their qualification to its full extent and removes some of the pool of excess pharmacists that the universities are insisting on producing. Hopefully, as the supply reduces, the demand and salaries for locums will increase.

Barry Shooter, retired pharmacist, Hertfordshire

Corrections

'The big debate: is online dispensing a threat?' (*Pharm J* 2019;303(7927):28–29) was amended on 29 July 2019 to clarify that the Care Quality Commission – rather than the General Pharmaceutical Council – suspended one company and issued warnings to three others in 2017.

An introductory paragraph was added to Duncan Craig's letter 'Pharmacy Schools Council on the GPhC's conclusions to the pharmacy education consultation' (*Pharm J* 2019;303(7927):37) prior to publication for background information. This was not included in the original letter.