The National Clinical Assessment Service (NCAS) has been called upon to help the General Dental Council (GDC) tackle poor performance in dentistry.

NCAS will provide an assessment service for the GDC, as part of the council’s new procedures. The GDC has been given new powers (effective from July 2006) that will strengthen its procedures for deciding whether a registrant’s fitness to practise is impaired through misconduct or ill health, and to establish new procedures for considering poor performance.

NCAS assessments for the GDC will consist of a core standard clinical assessment, with additional behavioural assessment, occupational health assessment and simulation of clinical practice to be added on request.

The assessors will be drawn from NCAS’s experienced dental/medical and lay assessors.

Once an objective assessment has been carried out, NCAS will report their findings to the GDC. NCAS assessors may also be called upon to explain their findings at a GDC fitness to practise hearing.

The decision about a practitioner’s fitness to practise will, however, remain the responsibility of the GDC.

It is planned that the NCAS assessment service for the GDC will be available from August this year. The service will be distinct from the service NCAS currently provides to the NHS.

NCAS will continue to provide advice and support to NHS organisations when handling concerns about the performance of NHS dentists and, where necessary, undertake assessments to assist in resolving these concerns.

For more information on NCAS’s work go to: www.ncas.npsa.nhs.uk

New minister announced

Following the recent government reshuffle, the NPSA’s new minister is Andy Burnham MP, Minister of State for Delivery and Quality.

His portfolio includes patient safety, healthcare associated infections, private finance initiatives, and research and development. The minister, who is MP for Leigh, comes to the Department of Health from the Home Office, where he had responsibility for identity cards and refugee integration.
NHS alerted to continued risk with oral methotrexate

Guidelines aimed at reducing the risk of patient harm associated with the incorrect use of oral methotrexate have been reissued to the NHS.

The guidance emphasises the points made in the NPSA’s original alert on oral methotrexate, which was published in July 2004. The alert has now been reissued because a significant minority (18 per cent) of organisations have not yet implemented the actions set out in it.

Oral methotrexate is a safe and effective medication if taken at the right dose and with appropriate monitoring. However, very occasionally, problems with taking the medication can cause serious harm and even death.

Since July 2004 the NPSA has received, via its National Reporting and Learning System, 165 reports of patient safety incidents involving oral methotrexate.

The patient safety alert provides action points around purchasing, prescribing, dispensing and administering oral methotrexate.

An accompanying patient information leaflet has also been issued to ensure patients have comprehensive information about their treatment.

The NPSA’s Medical Director, Professor Sir John Lilleyman said: “Methotrexate is a well established and vital part of treatment for many conditions and incidents relating to it are very rare. As our reporting system shows, however, patients are still being harmed and in some cases this medication is still not being taken or monitored properly.

Risk assessing commissioning in primary care

New tools have been developed to help those responsible for commissioning in primary care to identify factors that could potentially contribute to patient harm.

The NPSA’s two new risk assessment tools, for out-of-hours services and practice-based commissioning, will support practices, clinicians, integrated locality commissioning groups and primary care organisations with commissioning for patient safety.

Based on the premise that risk assessment should be an integral part of the commissioning process, the tools will help with risk assessing systems, services and patient pathways.

Joanna Parker, Head of Safer Practice at the NPSA and involved in the development of the tools, said: “Practice-based commissioning will change the way care is commissioned and provided, and is a major opportunity to ensure that patient services and pathways are developed and implemented with patient safety in mind.

“Commissioning out-of-hours services also offers challenges to primary care staff and organisations about the way that services are developed and delivered.

“The NPSA’s risk assessment tools are one approach to help ensure that those services are as safe as possible and that patients are protected.”

The tools are available now on the NPSA website at [www.npsa.nhs.uk](http://www.npsa.nhs.uk) and at [www.saferhealthcare.org.uk](http://www.saferhealthcare.org.uk)

New NPSA website planned

Our corporate website ([www.npsa.nhs.uk](http://www.npsa.nhs.uk)) is being redesigned this summer.

The aim is to have a new site in place in September which better meets the needs of patient safety professionals throughout the UK. The main design goal is to make the site easier to use and the content easier to find.

We’d like to hear your suggestions and ideas – please send them to mike.guida@npsa.nhs.uk.
Expansion of hand hygiene campaign

Following a highly successful first year, the NPSA's hand hygiene campaign, clean your hands, is looking to increase its impact on patient safety by continuing to work to reduce hospital-acquired infections.

The key themes for year two are ‘the power of one’ and ‘the point of care’. The focus will be on the role of the individual and the critical issue of staff hand hygiene occurring next to the patient and before and after every contact.

New guidance and resources have been sent to all NHS organisations that have implemented the campaign, with the main resource being a maintenance handbook, Flowing with the go. The handbook provides campaign leads in each trust with advice on how to sustain and expand the campaign at a local level.

Other tools include clean your hands stickers to be placed at all points of care (pictured left) and a new range of posters developed by frontline staff as part of a competition held earlier in the year.

This year’s strategy follows a review of the campaign that assessed the effectiveness of the core toolkit, the needs of staff and the experience of patients.

The campaign has also been assessed for rollout beyond the acute sector and a number of options and recommendations have been evaluated. The non-acute sector is diverse and complex and the needs of each component in improving hand hygiene have been appraised.

Planning for this expansion of the campaign is underway and the results of the analysis and a strategy will shortly be published.

For further information and details on clean your hands, go to www.npsa.nhs.uk/cleanyourhands

COREC plan unveiled

A plan detailing ways to improve the operation of NHS research ethics committees (RECs) is now complete.

The Central Office for Research Ethics Committees’ (COREC) implementation plan proposes a Research Ethics Service with RECs operating in structured networks, where decisions are made by reviewing the proportionate level of risk provided by each proposed study.

The plan includes establishing a new independent group of National Research Ethics Advisers, working in small executive sub-committees. They will ensure the RECs only have to consider appropriate proposals for studies. They will also be able to take some straightforward decisions on behalf of RECs.

A screening function, designed to identify those studies that are not appropriate, poorly presented or require more detailed review at an early stage, is proposed. This will save time for applicants.

The plan was developed in partnership with a wide range of research ethics stakeholders, including patient organisations, academics, pharmaceutical companies and members of RECs. The plan follows publication in June last year of a Department of Health report on NHS RECs, which made nine recommendations to refine and enhance the service offered to researchers and participants.

Following an extensive consultation earlier this year, the NPSA Board has agreed the plan and, subject to Ministerial agreement, COREC will put it into action later this summer.

For further information on the consultation, see the Spring issue of Safety Matters at www.npsa.nhs.uk or go to www.corec.org.uk

Lead for children and young people

The NPSA has appointed a lead for children and young people who will work to investigate the safety issues relating to this group of patients.

Jayne Wheway has joined the NPSA’s Safer Practice team and will be looking at patient safety in relation to children and young people across all sectors, including acute, community, mental health and learning disabilities.

Jayne’s priorities are to make contact with colleagues from partner agencies, build the NPSA’s children and young people network and scope the relevant safety issues.

If you have an interest in, or knowledge of, patient safety issues for children and young people, or know of others nationally or locally who have, Jayne would be very pleased to hear from you. Please contact Jayne on 020 7927 9514 or email jayne.wheway@npsa.nhs.uk
A series of reports of deaths and harm to patients due to the use of high strength opiates has prompted advice to be issued to the NHS on how to avoid potentially fatal mistakes.

The NPSA Safer Practice Notice was issued following reports of seven deaths due to high doses (30mg or greater) of morphine and diamorphine in cases where the patients had not previously been given a lower dose.

The seven case reports were published between 2000 and 2005. Additionally, between January and October 2005, the NPSA received 16 reports of similar patient safety incidents, two of which were fatal.

Many of these incidents involved 30mg ampoules of morphine and diamorphine being selected in error, instead of lower strength ampoules, and resulted in overdoses being administered. Others involved high doses being given to patients who had not previously received a lower dose and who had therefore not built up a tolerance to the medication.

Overdoses of these opiates can lead to respiratory depression, loss of consciousness and death.

More than 75,000 ampoules of morphine and diamorphine are given to patients every year and they are safe and effective if prescribed, prepared and administered in accordance with professional guidelines.

The NPSA safer practice notice advises the NHS in England and Wales to review and improve measures for prescribing, storing, administering and identifying these high dose opiate injections.

The major risks involving morphine and diamorphine are: packaging of different strengths of the drugs looking the same; higher strengths (30mg for example) being stored alongside lower strength products (10mg for example); and insufficient training and understanding on the part of healthcare staff of the risks and precautions when prescribing, dispensing and administering higher dose injections.

To help ensure safer practice with these opiates, the NPSA is advising NHS organisations to: risk assess and put in places procedures for the use of morphine and diamorphine injections; review guidelines for their use; update information on how to use them safely; and ensure that naloxone injection, an antidote to opiate-induced respiratory depression, is available.

Morphine and diamorphine are vital elements of treatment for many conditions and incidents relating to the use of these drugs are very rare. However, patients can be harmed by mistakes that are easily avoidable and the NPSA is urging organisations to implement the recommendations set out in the safer practice notice.

For more information on the NHS go to www.npsa.nhs.uk/advice

Patient Safety 2006 DVD

The NPSA’s second major event, Patient Safety 2006, took place in February and saw experts sharing their knowledge of how healthcare can be made safer for patients.

A DVD featuring key presentations from the event is now available.

To order a copy please call 0870 555 455 or email npsa@prolog.uk.com, quoting 0393JUN06.

The DVD features key presentations

Safer Patients Initiative

Hospitals are being invited to apply to take part in the second phase of an initiative to make hospitals safer for patients.

In 2004, four hospitals were chosen to work with the Health Foundation on a pilot as part of the Safer Patients Initiative; a £4.3 million patient safety improvement programme.

The patient safety performance of all four hospitals improved measurably and, following this successful pilot, up to 16 more hospitals will be chosen to take part in the second phase of the initiative.

Selected hospitals will work with the four pilot sites and the Institute for Healthcare Improvement to improve patient safety by taking on the successful procedures developed in the first phase and developing these further.

Applications are being sought from hospitals across the UK. More information is available on the Health Foundation website at www.health.org.uk

The deadline for applications is 31 July 2006 and the selected hospitals will be announced in November 2006.