Royal College of General Practitioners

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12 MAY 2014

Professor Nigel Mathers FRCGP
Honorary Secretary

Ms Karen Henderson
Assistant Coroner, West Sussex
Coroner's Office
West Sussex Record Office
Orchard Street
Chichester
West Sussex
PO19 1DD

7 May 2014

Dear Ms Henderson

Inquest into the death of Lee Hollman – RCGP response

Thank you for your letter seeking comments from the Royal College of General Practitioners on factors relating to general practitioner care following the inquest you conducted into the death of Lee Hollman.

On behalf of the College, I set out below a brief description of the remit of the Royal College of General Practitioners. I also provide some detailed comment on the specific concerns you raise in your report with regard to systems within a general practice for managing and monitoring the practice's interface with external organisations, records management and communications with colleagues.

The role of the College

The Royal College of General Practitioners is a registered charity under Royal Charter and is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has approaching 50,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we also maintain close links with other professionals working in General Practice, such as practice managers, practice nurses and physician assistants.

As well as running the postgraduate Membership examination (MRCGP) which is now required for doctors to qualify as GPs, the College also provides continuing professional development (CPD) for its members, and these continuing programmes are also available to non-members of the College. However, not all GPs are members of the College, and older GPs may never have joined. The General Medical Council holds the register of all who are considered able to practise as GPs, and it is to the GMC that revalidated doctors will be notified..

Similarly, it is not for us to comment on the performance of any individual GP and the information set out below is solely to show you what we do in the context of training and advice to our Members.

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RCGP Education and Training

Currently all doctors wishing to follow a career in general practice in the UK are required to undergo a 3 year programme of vocational training for general practice, based on the College's GP Curriculum. (The curriculum forms the foundation for GP training and assessment across the UK, prior to taking the College's Membership Examination (MRCGP) and is relevant to GPs throughout their career, including preparation for revalidation) http://www.rcgp.org.uk/gp-training-and-exams/gp-curriculum-overview.aspx

The death of Lee Hollman raises issues about the need for strictly accurate medical record-keeping in GP practices, GP workload, the need for close working relationships between GPs and pharmacists and the duty of the doctor to conduct regular medication reviews with patients as part of a sound practice repeat prescribing system. Best practice calls for patients with long-term conditions to be given medication review appointments at regular six-monthly or yearly intervals.

Record-keeping

Addressing your concern about failures in maintaining accurate and updated medical records and, more specifically the failure to remove Trazodone from the repeat prescription record and the failure to delete the the 'old' dosage of Quetiapine from the record, the key importance of accurate record-keeping is stressed in the section of The Curriculum entitled "Being a General Practitioner"**:**

http://www.rcgp.org.uk/gp-training-and-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-1-Being-a-GP.ashx

"This means that as a GP you should:
1.1.3 Use an organised approach to the management of chronic conditions

1.5 Make available to your patients the appropriate services within the healthcare system
This means that as a GP you should:
1.5.2 Develop your organisational skills for record-keeping, information management, teamwork, running a practice and auditing the quality of care"

The importance of record-keeping in the practice is further developed in the section entitled "Patient safety and quality of care" where you will also see highlighted the importance of close collaboration with medical colleagues and other healthcare professionals

http://www.rcgp.org.uk/gp-training-and-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-2-02-Patient-Safety-and-Quality-Of-Care.ashx

I refer you to page 9 in particular:

"1.13 Demonstrate an understanding of the connection between good data entry and improved patient health outcomes
1.14 Demonstrate how to use information management and technology (IM&T) to share information and co-ordinate patient care with other health
professionals
1.15 Demonstrate an understanding of the need for information recorded in the practice clinical system to be fit for sharing with different health professionals in different organisations
1.23 Understand the concept of variation in clinical care, how it is determined and measured and what actions might need to be taken to address inappropriate variation, for example in referrals, prescribing, admissions
1. 30 Demonstrate an understanding of the principles of medicines management"

Pages 10 and 11 further develop this theme:

"This means that as a GP you should:
3.1 Compare the systems and processes in place in your practice to identify and manage risk in the primary care setting and compare these with other practices

3.3 Be aware of the limitations of your own skills in risk management and illustrate that you understand when the skills of colleagues trained more extensively in risk management should be called upon

4.2 Reflect on the risks to patient safety in a care pathway in which a variety of healthcare professionals are involved, looking at interface issues and be able to comment on the ways in which, as a GP, you can work to minimise these"

Other sections of The GP Curriculum of particular relevance in this case are given below:

"3.10 Care of people with mental health problems

http://www.rcgp.org.uk/gp-training-and-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-10-Mental-Health-Problems.ashx"

This section includes the need for the general practitioner to be able to assess and manage risk/suicidal ideation.

3.14 Care of people who misuse drugs and alcohol

Section 3.14 of the GP Curriculum on the Care of people who misuse drugs and alcohol, whilst not directly relevant, highlights some interesting points about GP awareness of prescribing problems.

http://www.rcgp.org.uk/gp-training-and-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-3-14-Drug-and-Alcohol-Misuse.ashx"

In particular, the general practitioner should:

"3.1 Always be aware of possible drug- or alcohol-related problems with almost any presenting problem or prescribing issue
3.4 Be aware of common long-term effects of drug and alcohol misuse including reasons for drug-related deaths
3.6 Be aware of urgent and important issues of safety including risks to self or others and the need for urgent medical or psychiatric care"

Relationship between GPs and Pharmacists

The tragic death of Lee Hollman highlights the need for GPs and Pharmacists to work closely together.

At its meeting on 18 June 2011, the RCGP Council approved a joint statement drawn up by RCGP members and the members of the Royal Pharmaceutical Society setting out guidelines for good working relationships between GPs and pharmacists. A copy is attached to this letter as an appendix. You will see from the paper that one of the "building blocks for change" suggested is: "Better transfer and sharing of patient information facilitated by improved inter-professional IT links."

Repeat Prescribing

Guidance for doctors, including general practitioners, on repeat prescribing is set out in the GMC's document: "Good practice in prescribing and managing medicines and devices (2013)"

http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp

"Prescribing guidance: Repeat prescribing and prescribing with repeats"

http://www.gmc-uk.org/guidance/ethical_guidance/14325.asp

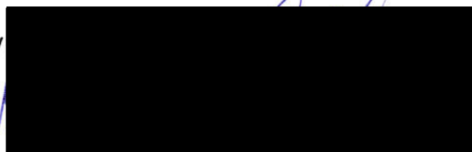
Relevant extracts are set out below:

"55. You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate. You should consider the benefits of prescribing with repeats to reduce the need for repeat prescribing.

56. As with any prescription, you should agree with the patient what medicines are appropriate and how their condition will be managed, including a date for review. You should make clear why regular reviews are important and explain to the patient what they should do if they:
a. suffer side effects or adverse reactions, or
b. stop taking the medicines before the agreed review date (or a set number of repeats have been issued).
You must make clear records of these discussions and your reasons for repeat prescribing.*
57. You must be satisfied that procedures for prescribing with repeats and for generating repeat prescriptions are secure and that:
a. the right patient is issued with the correct prescription
b. the correct dose is prescribed, particularly for patients whose dose varies during the course of treatment
c. the patient's condition is monitored, taking account of medicine usage and effects
d. only staff who are competent to do so prepare repeat prescriptions for authorisation
e. patients who need further examination or assessment are reviewed by an appropriate healthcare professional
f. any changes to the patient's medicines are critically reviewed and quickly incorporated into their record.
58. At each review, you should confirm that the patient is taking their medicines as directed, and check that the medicines are still needed, effective and tolerated. This may be particularly important following a hospital stay, or changes to medicines following a hospital or home visit. You should also consider whether requests for repeat prescriptions received earlier or later than expected may indicate poor adherence, leading to inadequate therapy or adverse effects.
59. When you issue repeat prescriptions or prescribe with repeats, you should make sure that procedures are in place to monitor whether the medicine is still safe and necessary for the patient. You should keep a record of dispensers who hold original repeat dispensing prescriptions so that you can contact them if necessary."

I hope you find these comments helpful.

Yours sincerely



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Appendix 1

Joint Statement by The Royal Pharmaceutical Society with the Royal College of General Practitioners: **Breaking down the barriers – how community pharmacists and GPs can work together to improve patient care**

Introduction

1. This joint statement sets out the background, summarises the evidence and makes recommendations for the benefits to patients of improved liaison between community pharmacists and general practitioners. Over the last 20 years successive policy changes have moved the pharmacist's role from primarily one of dispenser towards a generic health care provider advising patients on their use of prescribed medicines, self care and lifestyle as well as other innovative services. However these changes often seem to have been introduced in isolation from other primary care services, especially general practice, thereby minimising opportunities for enhanced patient benefit. General Practitioners are similarly taking on a broader role, particularly in England, to commission services as part of the recent White Paper thinking "Equity and Excellence: Liberating the NHS". GPs are also working with a range of primary care practitioners to deliver services to their local communities and recognising the skills and experience of the full range of healthcare professionals is key to the thinking in this statement.
2. Patients may be surprised when they discover that their community pharmacist and their GP do not share the same clinical record and that the community pharmacist is not always an integral part of the primary care team. Pharmacists play a key role in the long-term management of patients with chronic disease and can see the patient as often as the general practitioner. Many members of the public and patients see the pharmacist as a first port of call for advice, not just on their medicines but also on their underlying health problems. This is particularly true for men seeking advice on health issues.
3. Whilst many GPs do work closely with their local pharmacist, a culture change is recommended between GPs, pharmacists and the public to allow the collaborative partnership between general practice and community pharmacy to deliver its potential.

Building Blocks for Change

4. Some key building blocks need to be agreed to underpin new working relationships. These should include:
   - Better transfer and sharing of patient information facilitated by improved inter-professional IT links.
   - Shared standards and ways of working to ensure consistency of services and information to the public (for example in areas such as screening and diagnosis and pharmacy-led treatments and advice).
   - Joint education and training at undergraduate and postgraduate level could facilitate greater trust and understanding of the professions' respective and complementary skills and expertise.
   - Standard setting/clinical guidance on the provision of over-the-counter medicines where these medicines have doubtful value.

5. There are a number of key areas where joint working between community pharmacists and GPs will produce better and safer patient care.
   For example:
   - End of Life Care
   - Care of patients with long term conditions

- Care of complex "poly-pharmacy" patients
- Care of patients with substance misuse
- Care of patients with life-style related ill health
- Supporting patient self-care.

How working together can improve patient care and safety

6. The benefits to patients and practitioners of joint working in these and other key areas are summarised here. A separate paper sets out the evidence underpinning our recommendations.

7. Better use of Medication Use Reviews (MURs)[1] by pharmacists can reduce duplication of effort by the primary care team as well as improve patient care through reducing errors and improving adherence to treatment.

8. Pharmacist prescribers working closely with GPs and practice nurses, can similarly contribute to better patient management and can also help improve the quality and outcome of patient management in a range of long term conditions[2].

   By working together more closely, GPs and pharmacists will be able to deliver better healthcare to vulnerable groups such as those in care homes or elderly patients taking anti-psychotic medicine.

9. Community pharmacists working with general practices and specialist palliative care teams can ensure reliable and prompt medicine supply, and supportive advice (especially about analgesia) for patients, lay carers and other members of health care team.

10. Pharmacists with the appropriate expertise, working with drug misusers, can increase retention within treatment by a structured supportive approach, and those with prescribing and drug misuse qualifications can contribute to community detoxification by adjusting doses.

11. GPs and pharmacists can support life-style change and self care.

Recommendations

12. Our recommendations to deliver this broad and important agenda for service redesign at the general practice – community pharmacy interface follows:

Managing long term conditions

13. Patients can already benefit from being able to receive timely and accessible help from pharmacies in understanding and using medicines . Access to this should be promoted and resource more effectively targeted to patient need. An example of how this can work is the New Medicine Service being introduced in England.

14. Improvements should be made to improve the sharing of information between the pharmacist and the GP/practice.

15. Patients should have a choice where medicine reviews[3] take place, with consultation between the professions and communications systems in place to support this process.

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[1] A Medicines Use Review of a patient's medicines including items that are regularly prescribed, used only when necessary and those obtained for the purpose of self care. Its aim is to improve understanding of how, why and when medicines should be taken.

[2] Evaluation of supplementary prescribing in nursing and pharmacy. Bissell et al 2008; Evaluation of nurse and pharmacist independent prescribing. Latter et al 2010 (forthcoming)

[3] Medicine reviews are: 'a structured critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication-related problems.' Room for Review. A guide to medication review; the agenda for patients, practitioners and managers.

16. GPs and pharmacists when working together should be able to map their work against agreed national standards according to local circumstances driven by patient needs.

17. Locally agreed protocols relating to medicine reviews should reflect agreed standards. From the patient perspective, care should be delivered to the same standard by whoever is undertaking the task.

18. The same quality standards should be used for GPs and pharmacists when undertaking medication reviews.

19. There should be better use of 'repeat dispensing'[4] to increase efficiency, reduce practice workload and increase patient convenience as well as increased value for money.

20. Working with patients, GPs and carers can benefit their patients with long-term conditions and complex medication regimes by utilising the pharmacist independent prescriber[5] jointly working with the GP and patient working in collaboration.

21. Pharmacists should be able to refer to services commissioned by the GP consortia using the same demand management criteria and guidelines as GPs and within agreed care pathways.

22. Pharmacists to be able to refer patients to local GPs and pharmacists with special interest services and to agreed parts of the care pathway. Pharmacists referring across to the patient's GP in accordance with agreed local care pathways/protocols.

23. National arrangements for patients and carers to be able to access a supply of their regular medicine/s in an emergency[6].

Care for the frail elderly

24. Improved joint working between GPs and pharmacists for patients who reside in care homes, for example, pharmacists to attend care-homes alongside GPs to undertake joint medication review, pharmacists to review medication being prescribed to patients who reside in care homes.

25. Pharmacists to participate in medication reviews for house-bound patients.

End of life care

26. Patients and their carers to have better access to medicines required for palliative care. This includes working with out-of-hours providers to ensure access across the whole 24 hours.

27. Pharmacists to form part of the out-of-hours team for palliative care, with a pharmacy on-call rota.

28. Improve the sharing of information between GP, palliative care service and community pharmacist throughout end-of-life care.

Care for drug misusers

29. Drug misusers to continue to have convenient access to supervised administration of substitution treatments and to be encouraged to make greater use of these interactions for other health interventions.

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[4] Part of the Community Pharmacy Contractual Framework in England & Wales, and of the Chronic Medication Service in Scotland

[5] Pharmacists who have completed the appropriate training and can prescribe any licensed medicine for any medical condition within their competence.

[6] Scotland already has a national scheme for patients to obtain an emergency supply of NHS medicines

30. Pharmacists with the appropriate expertise to contribute more to care planning and review of treatment objectives building on the knowledge of the drug misuser acquired through daily contact.

31. Pharmacist prescribers working within a locally agreed shared care protocol may be used to titrate doses, including during dose induction and detoxification.

32. Pharmacists to use the opportunities afforded by supervised administration to promote other health interventions, including blood-borne virus testing and immunization[7]; flu vaccination, in addition to appropriate counseling.

Preventing ill health

33. GPs and pharmacists to collaborate in providing cardiovascular risk assessment, including on-site cholesterol monitoring.

34. Pharmacists to ensure convenient public access to evidence-based preventive interventions including, for example 'Stop Smoking' services, emergency hormonal contraception, Chlamydia testing & treatment[8], and vaccinations. All delivered to the same quality standards.

35. Pharmacists with appropriate expertise to become providers of travel vaccinations and malaria prevention treatments and make recommendations as to what travel vaccinations are required/recommended. Furthermore, pharmacists could provide advice on ailments contracted abroad, including traveler diarrhoea and sexually transmitted disease. This service must be supported by suitable communications between pharmacists and GPs to ensure that patient records are updated accordingly.

36. Better publicity for the public on how to access services (e.g. emergency hormonal contraception)

Supporting self care

37. Patients to be able to conveniently access advice and or treatment for common minor illnesses including outside opening times of general practices.

38. GPs, nurses and pharmacists working together as part of a coordinated team across practices.

39. A pharmacy NHS Minor Ailments Service[9] to support GPs in urgent care and out-of-hours provision.

40. Pharmacists should also be supported to participate in the provision of out-of-hours services

41. More effective promotion to the public and others who can encourage use of pharmacies for minor ailments and encourage self-care.

42. **Levers and incentives**
    Levers and incentives should be considered in order to expedite the changes described above. These should be applied at various levels namely: individual pharmacy and practice level, at local professional group level, and at national level.

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[7] Immunisations are already provided by pharmacies in some areas (eg Isle of Wight 'Pharmacy Fix' service) with underpinning training and arrangements for dealing with anaphylaxis

[8] Supply of emergency hormonal contraception and provision of Chlamydia testing are part of the Public Health component of the pharmacy contract in Scotland and provided by all pharmacies.

[9] A national Minor Ailments Service has been in place in Scotland since 2006. Currently 60% of PCTs in England commission this.

National level

43. It is essential for patient safety that relevant patient information can flow both ways between general practices and pharmacies and IT systems in England and Wales need to enable this[10].

44. Ethical issues in sharing patient information need to be identified and resolved with input from patients and service users. A joint code of ethics addressing issues such as consent and confidentiality will be agreed by both professional bodies to facilitate this.

45. Joint national guidance should be produced with input from patients and the public on evidence based recommendations for non-prescription (OTC) medicines by all health professionals.

46. Identify outcomes for pharmacy contribution to patient care methods of measurement.

47. Explore new models of commissioning pharmacy input which requires joint working with general practice e.g. the Chronic Medication Service in Scotland.

48. Consult stakeholders on how best to achieve continuity of pharmacy care, including patient registration at pharmacies; shared records.

Local level

49. Wider commissioning of the Healthy Living Pharmacy[11] model or its equivalent

50. Share and disseminate examples and models of shared practice

Communication at local and national levels

51. Explore better ways of communicating between GPs and pharmacists. For example:
    - Meetings between Local Pharmaceutical Committee (LPC), Local Medical Committee (LMC)
    - RCGP faculties / RPS local practice fora should be encouraged to discuss health needs and how joint working can improve the provision of healthcare and encourage better self-care.
    - Both organizations consider it essential for the individual and specific needs of the public and patients in Scotland, Wales and Northern Ireland to be recognized and addressed by practitioners in everything they do at national and local levels.
    - Shared learning events for the primary health care team, including pharmacists
    - Shared Critical Event analysis
    - Periodic joint practice level meetings where this is feasible

52. Professional bodies for general practice and pharmacy to meet regularly and provide leadership on joint working for members.

Sharing information

53. Consultation process on the following areas:

54. Pharmacists to have access, with consent, to the patient's medical record.

55. Consider the issues around pharmacist access to the Summary Care Record [12]
56. Identify mechanism for the pharmacist being able to record clinically significant Over The Counter sales and NHS Minor Ailment scheme consultations and, with the patient's consent, sharing with the practice. This should also include other public health priorities such as immunization.

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[10] The Chronic Medication Service in Scotland includes electronic communication between the patient's nominated pharmacy and their GP practice
[11] The 'Healthy Living Pharmacy' model has been successfully piloted in Portsmouth City. The contract has three levels requiring which require increasing clinical input from the pharmacist.
[12] Emergency Care Summary in Scotland

Shared standards and ways of working

57. Pharmacies and GP practices to work to common quality standards for screening and diagnostic testing

58. Joint development of shared formularies for prescribing and supply for common conditions

59. Systematic use of patient feedback to assure adequacy of privacy and facilities in pharmacy consultation areas

Education and training

60. Both bodies recognize and are committed to how GPs and pharmacists can learn with and from each other starting at undergraduate level and continuing throughout their professional careers. Both bodies will work together to explore continued opportunities for joint learning

Moving forward

61. Action is now needed from individual clinicians, local professional groups, NHS organisations, national bodies and patients to shape how local care develops. The Royal College of General Practitioners and the Royal Pharmaceutical Society will start this process by:
    a. Bringing together an invited multi-stakeholder group to explore the recommendations in this paper and identify actions needed.
    b. Setting up a joint working group including patients and service users to take an agreed work programme forward.