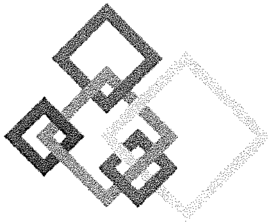

Commissioning Alliance
Brighton and Hove CCG
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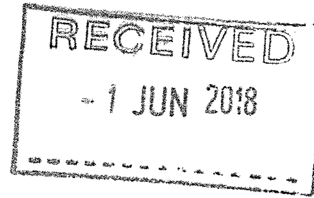

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Veronica Hamilton-Deeley DL, LL.B.
Her Majesty's Senior Coroner for the City of Brighton & Hove
The Coroner's Office
Woodvale Road
Brighton
BN2 3QB

Your Ref: VHD/TS/REEVES

01 June 2018

Dear Veronica Hamilton-Deeley,

The Late Mr Ross REEVES (RR)

Thank you for your recent letter enclosing a Regulation 28 report. I was sorry to hear of the death of Ross REEVES and I hope the following information is of help.

As outlined in your report, Brighton and Hove has a high rate of drug related deaths. Prescription medication has been noted as a factor in a significant number of cases, and it is clearly essential that all appropriate measures are in place to reduce the chances of future similar deaths.

In addition, many of the issues relating to prescribing safety following a change in registered Practice are equally relevant for other patient groups, perhaps especially the vulnerable elderly who are often very sensitive to medication side effects.

Locally and nationally, the vast majority of data transfer following a change in GP Practice is via the 'GP to GP' digital process. This should avoid the traditional delay, as was the case in the past, when paper records were transferred manually via a central administration hub

I have spoken with [redacted] and had sight of her report to you, RRs paper and electronic records, as well as the National Patient Safety Agency Investigation Report prepared by St. Peters.

Transfer of RR to new GP

On registration, St Peter's asked for a faxed summary (from RRs previous Practice) that arrived promptly, as did an electronic summary via the 'GP to GP' process. Unfortunately, St Peter's were unable to access details of correspondence via the electronic record; the digital explanation for this is unclear and requires urgent clarification, as full access was not possible until after RRs death.

No medication was issued prior to having sight of the faxed paper summary that confirmed RR's current medication regime.

The summary did include 'Drug Dependency' codes from 2016. On questioning by St. Peter's Practice, RR suggested [as was the case] that he had had treatment for 'spice' dependency. A summary code from March 2017 was somewhat ambiguous. ['Time spent obtaining drugs']

Furthermore, potentially useful information was available via free text entries in the electronic records from 2016/2017. These entries are interspersed with entries relating to coincidental medical conditions.

The paper records arrived on 12/12/2017 having been requested on 10/10/2017. The records were requested urgently; this delay is very concerning and warrants clarification as a priority.

Quantities of Medication Prescribed

The records confirm that prescribers at St Peter's were well informed as to important prescribing issues in this cohort of patients as frequent initial reviews were arranged, weekly scripts were suggested [although not insisted on], pharmacist input arranged and a urine sample was sent for drug testing. As noted, RR had been receiving monthly prescriptions via his previous GPs.

As recorded elsewhere, Zomorph, Gabapentin and Mirtazapine were prescribed via St Peter's. The doses of each [if taken correctly] were within recommended prescribing ranges. The benzodiazepines detected following death was not prescribed via St Peter's.

Recommendations

I have attached a copy of the St Peter's Investigation Report as this outlines several important steps already in hand at St Peter's. I am aware however that as a CCG we have a role in supporting implantation at St Peter's, discussing any additional learning and disseminating any changes in Practice throughout Brighton and Hove.

Initial steps [for action over the next 2 weeks]

1. Alert to local Primary Care, highlighting issues around safe transfer of data [paper and electronic] during patient transfer, robust coding and the importance of restricting quantities of medication in patients identified as high risk until relevant clinical notes are available, and a period of assessment has reassured the new practice that prescribed medicines are used according to directions . Practices will be advised to adopt a blanket policy thereby removing the need for negotiation with individual patients.

2. Clarification as to digital issues causing corruption of correspondence following GP to GP data transfer.

3. Clarification as to reasons for delay in paper records arriving in the context of contractual obligation of Primary Care Support England. Commissioning of this service is via NHSE.

4. If uncertainty remains, prescriber to consider direct [verbal] contact with clinician from previous surgery.

Medium term

The CCG will set up a 'Task and Finish' group with input from Primary Care prescribers as well as Practice Managers, CCG and Community Pharmacists, Pavilions substance misuse service, the CCG digital team, Public Health colleagues, the CCG Quality and Safety Team and representatives from the Community and Voluntary sector. In terms of Primary Care we will specifically ask for input from The Arch Healthcare as their team has expertise in managing this cohort of patients.

This Task and Finish group will aim to report over the next 6-8 weeks. In addition to covering the issues raised above, I envisage:

1. Learning from elsewhere in the UK

2. Guidance on appropriate coding that will serve as an immediate alert to a new GP surgery [and potentially to other providers such as BSUH via approved data sharing routes].

3. Guidance on appropriate route for urgent request of paper records and routes to escalate any digital issues with imported records.

4. Guidance on best practice for summarising records of high risk patients.

5. Guidance around quantities of high risk with consideration of a 'Citywide' approach.

6. Options for supporting Educational development in Primary Care around patients with drug dependency and chronic pain. To include prescribing issues and best use of urine drug screens.

7. As noted elsewhere, St Peter's do have regular structured discussions of challenging cases. This is not universal and is clearly good practice. Pressure on Primary Care time is a barrier and as a CCG we need to ensure maximal support for Primary Care to enable such discussions on a regular basis. Logistically it will not be possible for all high risk cases to be discussed and inevitably [as with RR] some cases may not be formally discussed.

8. As commissioners we need to ensure that adequate specialist support is available to Primary care.

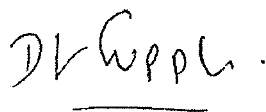
We would aim to disseminate learning throughout Primary Care via circulated guidance as well as interactive sessions.

In summary, the team at St Peters are experienced in the management of this cohort of patients. Despite this, a drug related death occurred for a registered patient. Several important learning points have been identified that need addressing, measures are being taken in house and I am confident that staff will welcome ongoing CCG input and support.

Additionally, I am confident that the learning from this case can and will be disseminated, some immediately and some when more information is to hand.

Please do not hesitate to contact me if any further information is helpful

Yours sincerely,



Clinical Chair
Brighton and Hove Clinical Commissioning Group