NHS
Trafford
Clinical Commissioning Group

Private & Confidential

F.A.O: Alison Mutch
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

1st Floor
Crossgate House
Cross Street
Sale
Manchester M33 7FT

Tel: 0161 873 9500
Fax: 0161 873 9501
E-mail:s[redacted]

12th March 2019

Dear Ms. Mutch,

Re: Jacqueline Elliot

I write in response to your letter dated 11th January 2019 received into the CCG on 17th January 2019 and respond accordingly to the matters raised. In compiling this response the CCGs Medicines Optimisation team have fully reviewed the patient's notes as well as liaising with [redacted] Medical Director, Trafford CCG.

You specifically asked us as a CCG to respond to paragraphs 1-5 Matters of Concern we would like to offer the following information and context and in chronological order.

With regards to first Matter of Concern:

It is good practice for GPs to put high risk medicines, newly prescribed medicines, or medicines that require review at every issue on an 'acute' prescription rather than a repeat. This should prompt the prescriber, every time the medication is requested, to review whether it is appropriate and safe to issue. Even medicines that are taken regularly long-term may not be appropriate to add to the repeat list. Medications are only added to the repeat list if it is safe to issue them a certain number of times without review. Although 'acute' medications are not on the 'repeat list' they are listed on the medication screen and it would be usual practice to review both 'acutes' and 'repeats' when undertaking a medication review.

The only time that an 'acute' would not be listed on the medication screen would be if the patient was not taking it regularly and the course had expired automatically as described below:

EMIS (the practice software system) expires acute medication courses using the following logic:

Last issue date + the course duration + 14 days.

For example, an acute medication has a last issue date of 10/11/16 with a course duration of 20 days. The course duration is added to the last issue date (making this 30/11/16) and then, after a further 14 days, the medication course will expire. Following this logic, the medication would expire on 14/12/16 (34 days after the last issue date).

There's a minimum of 28 days before a medication will expire. If a medication course has a course duration of less than 14 days, this medication will expire after 28 days and not follow the above logic.

If a medication had expired as above, it would not appear on the medication list and the person undertaking the medication review may not be aware that the patient is taking it. However, a check of past medications would show any medication that had been recently issued on acute.

The medicines that were issued on acute and were not on the patient's repeat list included:

1. Tramadol – this was appropriate to be on acute as was not being taken regularly (1 issue of 30 caps 28/12/17; 1 issue of 30 caps on 23/1/18; 1 issue of 30 caps on 28/3/18; 1 issue of 100 caps on 8/8/18. However, the patient was on co-codamol as well. This was identified at the medication review on 10/4/18 and the tramadol was stopped.
2. Co-codamol – this was started on 13/1/17 and issued as acute prescriptions each month since then. It was issued regularly and the acute courses did not expire so it would have been listed on the medication screen when medication reviews were undertaken. It would not be unusual for GPs to issue analgesics on acute prescriptions long term so that they can more closely monitor use.
3. Pregabalin – 25mg twice daily started on 26/3/18; reviewed 10.4.18 and increased to 50mg twice daily; then 28 day supply issued as an acute on 23/5/18; 29/6/18 and 24/7/18. Was on acute because the GP who increased the dose on 10.4.18 had advised follow-up in 3-4 weeks. There is no record that follow-up occurred and so it continued to be issued as an acute. However, it would have been listed on the patient's medication screen from 10/4/18 onwards so would be obvious to anyone reviewing the medication that the patent was taking this.
4. Sertraline – this was started on 9/1/17 and issued as acute prescriptions each month. It was issued regularly and the acute courses did not expire so it would have been listed on the medication screen when medication reviews were

undertaken. It would not be unusual for GPs to issue antidepressants on acute prescriptions long term so that they can more closely monitor use.

On checking the patient's record there was **no record that amitriptyline had ever been prescribed by the practice**. It was not on the repeat, acute or past drugs list (2 pharmacists have checked the records and confirmed this to be the case). There was also no mention of amitriptyline in the consultation records. The only possibility is that a handwritten prescription for amitriptyline was issued.

The last medication review undertaken on 10.4.18 was a face to face review with the patient. From the notes made during this consultation the notes indicate the GP was aware that the patient was taking pregabalin, tramadol and co-codamol. All of these were reviewed: the pregabalin dose was increased – this is in line with recommendations as it is usually started at a low dose and titrated up to an effective dose. The GP stopped the tramadol as the patient was also taking co-codamol. There was no mention of sertraline in this consultation but it would definitely have been on the medication screen so the GP should have been aware that the patient was taking it. All other medication was on the repeat list. At this review the GP noted that the patient was awaiting baseline blood tests and was due to have them that week. It is not clear which blood tests the GP was referring to.
For the medication that the patient was taking – routine blood tests would not usually have been done.

<u>Actions agreed with the CCG and in progress</u>

1. Make GPs and pharmacists aware of the need to review both acute and repeat medications when undertaking a medication review, and also to check past drugs for any recently issued acutes that the patient may still be taking. At this point the prescriber can assess whether appropriate to move acutes to repeat if the patient is stable. This will be done via newsletters but it has also been included in the Level Three GP safeguarding training from 7th March 2019,
2. If regular long-term medications are issued as acute – document the reason for this and the plan for review so that when they are issued other prescribers are aware of the plan. Otherwise there is a danger that acute items will be issued long-term without a review, with the person issuing assuming that because it is on acute someone else will review it next time.

When undertaking a medication review ensure patients are asked whether they are taking medication that has not been prescribed to them by the GP – including whether they are taking any hospital prescribed medication, a relative's medication or OTC medicines. It is not clear where this patient obtained amitriptyline from but if this question had been asked it may have been identified.

With regards to the second Matter of Concern:

There was some documented advice regarding medication – during the medication review on 10.4.18 the GP noted that the patient had been prescribed tramadol in addition to co-codamol and stopped the tramadol after advising patient she couldn't take both and discussed addictive potential.
The consultation on 26.3.18 documents that the patient was sometimes taking more than 8 co-codamol a day and patient advised must not take more than 8 a day due to paracetamol content.

Consultation 8.8.18 documents that switched from co-codamol to tramadol and paracetamol instead for acute flare only. The tramadol dose prescribed was 1 or 2 three times a day as required. There is no documented advice to the patient regarding this.

When pregabalin was initiated there was no documented advice regarding any plan for increasing the dose or when review was planned.

There was no documented advice regarding non-pharmacological management of pain.

Actions agreed with the CCG and in progress

1. When medication is started document the plan for follow-up/ review and any advice given relating to the dose to take.
2. When analgesia is prescribed also give, and document, advice on non-pharmacological treatments e.g. exercise.

The plan for both of these points will be to share the learning with all GPs via training events and newslettters.

With regards to the third Matter of Concern:

Medication reviews (during 2017/2018) were recorded as having taken place on:
10.4.18 – This was a face to face review and there was detail regarding review of tramadol, co-codamol and pregabalin. It was also noted that awaiting baseline bloods which were due that week. It is not clear which blood tests this refers to?. (Blood tests were requested in Feb-18 when the patient attended with leg cramps – presumably to see if there was any underlying cause. Note that the patient never attended to have these blood tests). There was nothing documented regarding review of any of the other patient's medication.
28.3.18 – Medication review of medical notes recorded and new review date was set for Sept-18. Nothing documented to state what had been reviewed.
26.9.17 – Medication review recorded and new review date set for 25.3.18. Nothing documented to state what had been reviewed.

10.3.17 – Medication review recorded and new review date set for June-17. Nothing documented to state what had been reviewed.
The medication review date is primarily set to ensure that repeat medication gets reviewed at regular intervals. As previously stated this should also include a review of any medication on the acute list. A medication review may be a review of the medical notes or a review with the patient in a telephone consultation or face to face.

1. The following needs to be highlighted to GPs and Pharmacists who undertake medication reviews: If a medication review is recorded it should document which medications have been reviewed and what the review included. If not all medications were reviewed e.g if a patient is on a large number of medicines and it is not possible to review everything in the time available the patient should be given another appointment date (face to face or telephone if appropriate) so that the review can be completed. This should be clearly documented and a new medication review date set to coincide with the patient's appointment. The new medication review date should be set to the date that a review is next needed. For individual medicines that require an earlier review prescribers should be made aware of the facility to set a review date for that individual medicine (rather than authorisations which are less specific and can be overridden)

2. In the EMIS system a medication review is usually recorded by clicking on the medication review date at the bottom of the medication screen. This only allows recording of the read code for medication review and has no facility for recording the details of the review. The only way to record details of the review is to open

3. The CCG needs to liaise with EMIS to request that when a medication review is recorded via the medication screen there is a facility for recording details of the review and ideally prompts to ensure the appropriate information is considered and recorded. We will be looking at using current functionality within the EMIS system to make this easier to identify and record.

4. When undertaking a review – if blood tests have been requested but the patient had not yet attended, the medication review date should be re-set for a short period so that if the patent does not attend for blood tests this is followed up.

With regards to the fourth Matter of Concern:

There were 3 consultation records that noted deliberate self-overmedication of painkillers:

1. 26.3.18 – The GP noted that the patient was taking more than 8 co-codamol on some days and advised her not to take more than 8 per day due to the paracetamol content.

2. 5.4.18 – the receptionist recorded that the patient had run out of pregabalin because she was taking double the amount she had initially been supplied. The patient was asked to see the GP for review.
3. 10.4.18 – The GP reviewed the patient and noted that she was taking pregabalin three times a day instead of twice a day. Note that it is usual to start on a low dose of pregabalin and titrate up to a higher dose after 3-7 days if necessary. The patient was started on a lower dose than the usual starting dose and it is possible that the GP initially advised that she could increase the dose – this is sometimes done by increasing to three times a day. This was not documented so there is no way of knowing.

As a CCG we will offer advice to all GPs and Non-Medical Prescribers around these actions, this will be in the role of an enabler by providing appropriate tools and information/education. Our Medicines Optimisations team will continue to support practices to achieve and maintain the changes through an ongoing system of audit, against the Gold Standard Repeat Prescribing guidelines and medication review.

The pattern of prescription issues did not indicate that there was any overuse of medication and there was nothing flagged in the patient's notes that would immediately highlight to the prescriber concerns regarding medication overuse. It is possible that the GP who prescribed the tramadol on 8/8/18 would not have seen the consultation notes detailing overuse of co-codamol. If the GP had seen the notes regarding pregabalin this may not have raised concerns as it is quite usual for GPs to prescribe low dose pregabalin and advise patients to increase it after a few days.

Actions agreed with the CCG and in progress

1. If there is concern about overuse of painkillers (or any other medicines) this should be added as a patient alert so that it flags as a pop-up when the record is opened and when medication is added or issued.

With regards to the fifth Matter of concern:

In the year prior to August 2018 the patient had 8 consultations recorded: 3 with 3 different locum GPs; 2 with the same locum GP, 2 with the practice clinical pharmacist and 1 with the Nurse Practitioner.
No discussion of non-pharmacological pain management methods was documented and there were no documented referrals to physiotherapy or pain management services.

Actions agreed with the CCG and in progress

Increase awareness of and consider running GP, nurse and pharmacist education sessions regarding non-pharmacological management of pain and criteria for referral to MSK service.

The learning that the CCG has gained in working with Delamere practice on their improvement plan will be shared with all practices across Trafford to highlight the risks that have been identified in this case. This should also improve the quality of prescribing and repeat prescribing across all Trafford GP practices. Currently we are not aware of any other GP practices with the same level of risk. However to mitigate any potential risk we have now include the risks of repeat prescribing within our level three safeguarding training this commenced on 7th March 2019.

The CCG is working very closely with the practice including;

1. A review of the clinical staffing numbers and clinical sessions offered to support consistency for patients and support for existing clinical staff;
2. Review of prescribing and other quality markers to identify if there are areas that the practice can improve upon;
3. A comprehensive safeguarding training programme for all staff employed at the practice;
4. Summary of all medication related incidents reported, with actions for the practice to follow up and report on to the CCG;
5. Regular clinical meetings with the practice to ensure a full action plan is in place and being acted upon;
6. Review of the CCG process and governance for identifying where practices may be experiencing issues with provision of a robust clinical service to patients, to ensure the CCG can support the practice to make any improvements necessary, ensuring safety for patients and staff.

We hope our response is satisfactory for the issues raised, please do not hesitate to contact us should you require further clarification;

Yours Sincerely,

[redacted]

Clinical Chair,
Trafford Clinical Commissioning Group.

Department of Health & Social Care

Caroline Dinenage
Minister of State for Care

39 Victoria Street London
SW1H 0EU

020 7210 4850

Your ref: 10960/CH

Alison Mutch OBE
Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

3rd April 2019

Dear Alison,

Thank you for your correspondence of 11 January 2019 to Matt Hancock about the death of Mrs Jacqueline Marie Elliott. I have been asked to reply and I am grateful for the additional time in which to do so.

Firstly, I would like to say how sorry I was to read of the circumstances of Mrs Elliott's death. If you have the opportunity to do so, please extend my sincerest condolences to her family.

It is essential that we look to make improvements where we can to ensure the safety of healthcare and prevent future deaths and I am grateful to you for bringing these matters to my attention.

Your report raises several matters of concern around the monitoring of medication in the primary care setting.

I hope you will appreciate that it is not possible for me to comment on the particular circumstances of Mrs Elliott's case. I expect the GP practice and the Trafford Clinical Commission Group (CCG) to look carefully at the matters of concern you have raised and to take firm action to respond to any learning that may be necessary to ensure the safety of local healthcare services.

However, my officials have considered the matters of concern raised from a national perspective and have sought advice from NHS England and NHS Digital.

I am advised that on the matter of the GP practice computer system and the recording of prescriptions, it could be that certain medications were not added to the repeat list to avoid them being issued without review. For example, if a medication is on the acute medication list then an active decision has to be made to re-issue the prescription. This would require a doctor to look at when the medication was last issued, and to review the indication for the drug to ensure the need for it was still evident.

NHS Digital understands that the GP practice computer system used by the GP practice involved is EMIS Web. I am advised that the EMIS Web GP practice computer system has the functionality to support comprehensive medication review. NHS Digital advises that the EMIS Web system provides a clear distinction between acute and repeat medication, as well as detailed information to support comprehensive medication reviews covering summary information, problem lists, current acute, repeat and all past medication, as well as information to support clinical evaluation of non-compliance and self-overmedication. EMIS Web records all drugs issued and can provide warnings (configurable at GP practice level) if a repeat drug is reissued too early.

It is important to note that full and accurate record keeping is the responsibility of the clinician. A lack of detailed records of consultations is related to the quality of record keeping by individual GPs and not to the GP clinical computer system capability.

Turning to the concern about a lack of continuity in care and GP capacity, we recognise growing the GP workforce has been, and continues to be, challenging but we remain committed to this.

NHS England and Health Education England are working with the Royal College of GPs and the British Medical Association to increase the GP workforce in England. This includes measures to boost recruitment, address the reasons why GPs are leaving the profession, and encourage GPs to return to practice.

The recently published NHS Long Term Plan made a clear commitment to the future of general practice, with primary and community care set to receive at least £4.5 billion more in real terms a year by 2023-24, meaning spend on these services will grow faster than the rising NHS budget.

Since the launch of the Long Term Plan, NHS England and the British Medical Association's General Practitioners Committee have agreed a five-year GP (General Medical Services) contract framework from 2019-20. The new, five-year, GP contract framework, published in January 2019 will see billions of pounds of extra investment for improved access to family doctors, expanded services at local practices and longer appointments for patients who need them.

Through the new contract, NHS England has committed to further expanding community based multi-disciplinary teams and will provide funding towards up to 20,000 other staff in primary care networks by 2023-24. This builds on the non-GP clinical staff already working in general practice, and will mean bigger teams of staff, providing a wider range of care options for patients and freeing up more time for GPs to focus on those with more complex needs.

I hope this information is helpful.

Yours

CAROLINE DINENAGE MP