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Clinical Commissioning Group

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2nd August 2019

Dear Ms Kearsley

Re: Ms Beverley Shaw

Further to your Regulation 28 report of 10th June 2019 following the inquest into the death of Ms Shaw, we can confirm that a full investigation into the matters raised regarding the care received by Ms Shaw has been undertaken and we are now in a position to respond to the concerns raised. The matters of concern raised and the actions we will take as a CCG to address these concerns are as follows:

1. **There was a lack of communication between Turning point and the GP Practice specifically in respect of Ms Shaw's use of butane gas.**

2. **There is no record of a response from the GP practice to Turning point following their letter dated the 15th May 2018.**

3. **A medication review took place in the GP Practice in August 2018…there is no evidence that there was a full review of all medications prescribed to Ms Shaw.**

4. **The Court heard evidence that following the transition from another provider to Turning Point, a decision was taken that all medical records do not need to be carried over to Turning Point…hence they do not have the full past medical history available.**

The review of the timeline of events with the practice has demonstrated where gaps in communication have had an impact. The practice acknowledges the fact that the reference to butane gas within the illicit drugs section of the letter may have been missed by doctors and Turning Point have also highlighted the need to be explicit about substance use in addition to prescribed medications, with both agencies acknowledging that this detail could be improved by both parties to ensure recognition of the impact on the individual concerned and therefore appropriate treatment and management from a prescribing perspective.

In respect of the butane gas use, the appropriate electronic code has been identified to flag misuse of butane on the EMIS system. This will be communicated to all practices as part of the lessons learned from this review to ensure that all Oldham GP practices are aware of this code.

The CCG is also keen to involve colleagues in our Local Authority Trading Standards department to look into the supply of the butane gas in this lady's local area. As we embrace a place based method of working it is vitally important that we are looking at all influencing factors and the potential sale of large quantities of gas needs further scrutiny.

The events surrounding Ms Shaw's death highlight the requirement for effective and up to date 'Did Not Attend' policies to be followed in Primary Care and to initiate discussion in practice meetings to ensure holistic information is shared and reviewed by the team in a manner which supports clinicians to make decisions based on the full facts and influencing factors. Such discussions can trigger communication back to secondary providers such as Turning Point to clarify and/or share information. The presence of Focussed Care within a number of Oldham practices has been seen to support such instances where substance use influences existing co-morbidities and as a CCG we are promoting wider uptake of this across the Oldham footprint. Practices that do not have a focussed Care worker directly linked to their practice do have access through the central office and this will be re-communicated as part of the lessons learned from this situation.

From a system perspective, there is clear learning in reviewing the medication and prescribing issues identified in Ms Shaw's situation. This has highlighted some locum GP competency issues within the practice that have been addressed through the appropriate channels. The learning that has arisen from reviewing this lady's care as a significant event has emphasised the importance of careful consideration of methadone use and subsequent or potential prescribed medication interactions. There is the facility for medications prescribed external to the practice (i.e. hospital or externally commissioned service such as Turning Point) to be entered into the EMIS system and therefore prompt alerts. This will also be highlighted to all practices and supported through the clinical pharmacy in-reach into all clusters.

Oldham CCG has a number of Clinical Pharmacists who work at Cluster level to support practices, carry out audit work and deliver CCG commissioned pieces of work. It is not within the current resource for these individuals to carry out reconciliations for every patient within every practice, therefore the role of the Clinical Pharmacist would not necessarily have picked this issue up. The CCG believes that the focus on entering externally prescribed medications onto the system as described in the paragraph above is a safer way of improving alerts & visibility of such interactions.

The CCG are co-ordinating a learning event with Hopwood House Medical Centre and the Oldham Turning Point team to facilitate a group reflection and agreed actions on how we can improve working relationships. The learning from this will also form the basis of a learning event that Turning Point are undertaking across the borough with those GP practices signed up to shared care arrangements.

We hope that this demonstrates that the CCG has robustly reviewed all aspects of the concerns raised within the Regulation 28 notice and provides assurances regarding the lessons learned and the actions taken to prevent reoccurrence in the future.

Please do not hesitate to contact either one of us should you wish to discuss and further concern.

Kind Regards

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