Tameside Metropolitan Borough

CHIEF EXECUTIVE

ASHTON-UNDER-LYNE · AUDENSHAW · DENTON · DROYLSDEN · DUKINFIELD · HYDE · LONGDENDALE · MOSSLEY · STALYBRIDGE

Strictly Private and Confidential

Alison Mutch OBE
HM Senior Coroner
Coroner's Court
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Stockport
SK1 3AG

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Date 15 June 2020

Dear Ms Mutch

Wendy Margaret Wilkes - Regulation 28 Report to Prevent Future Deaths

Further to your letter, dated 20 April 2020, regarding the tragic case of Wendy Margaret Wilkes please find my response outlined below.

The untimely death of a person is distressing for their family and any others affected by their death and loss, and all the more so if there is any belief that but for the actions of any organisation it could have been avoided.

I would like to record my sincere condolences to the family of Wendy Margaret Wilkes for their loss and I hope through this process they can obtain some closure.

Your report highlights concerns raised with the Regulation 28 Report to Prevent Future Deaths were as follows;

- No clear system of alert notes/follow up review appointments at her GP practice despite the extent of the prescribed medication; and

- The General Practitioners' Practice ("Practice") did not appear to have a system to ensure that prescribers were aware that her alcohol use was high and to assess the risk of mixing alcohol with the prescribed medication.

The Haughton Thornley Medical Centres have undertaken a Significant Event Analysis of the circumstances, which was subject to a Clinical Peer Group discussion of all General Practitioners Haughton Thornley Medical Centres at a GP meeting on 25 February 2020.

Significant Event Analyses are reflective tools that take place in all healthcare settings when there has been a significant event. They allow clinicians to review what has happened, understand what learning can be taken from the incident to prevent it happening in the future, sharing best practice and making sure that the recommended learning and the subsequent changes are put in place.

As a result of the findings of the Significant Event Analysis, the practice has put in place several safeguarding changes from 25 February 2020.

Alert Note/Review System effective from 25 February 2020
The practice has identified relevant existing patients by running reports for patients coded on the practice's clinical system as using neuropathic medication, cross referenced with patients coded with alcohol dependency who have had an intentional or accidental overdose. A "flag" is now placed on these patients' medical records and a medication review is undertaken. The patients are then contacted to discuss their medication and their alcohol consumption.

This process is managed by the Practice Manager who will run this report every three months to ensure it is constantly identifying the cohort of patients. The process will be reviewed at these three monthly intervals and will evolve from any learning taken from them.

The process for patients who may unfortunately suffer from an intentional/accidental overdose in the future when the practice has been made aware of an overdose, is that the patient will be seen and reviewed by the Practice. Subsequently, in order to minimize the risks of future overdoses, all such patients will be placed on weekly prescriptions. The practice will refer patients to mental health services, social prescribing and drug and alcohol service as appropriate.

To further support this process, non-clinical staff have been trained to ensure that information related to intentional or accidental overdoses are shared with the General Practitioners in the practice; so the process described above can be followed.

Tameside and Glossop Clinical Commissioning Group (CCG) actions
[redacted], Director of Commissioning, is accountable to ensure that in line with the Coroner's request, the following actions will be undertaken:

> The CCG has developed the enclosed guidance to all practices regarding the identification and management of patients prescribed neuropathic drugs and opioids that may also be dependent upon alcohol to ensure they are safely managed. This has been sent to all practices electronically to be shared internally at their clinical meetings and for them to save on their electronic systems (June 2020)

We shall keep these issues under review as part of the quality monitoring reported to the Strategic Commissioning Board, whose meetings are held in public. Minutes are available on the Tameside and Glossop CCG website (https://www.tamesideandglossopccg.org/corporate/strategic-commissioning-board).

The quality of care in primary care is also discussed and reviewed at the following monthly meetings: Primary Care Delivery and Improvement Group and Primary Care Committee.

I trust that our actions offer reassurance that the CCG and the Practice have reflected on the evidence and findings provided at Mrs Wilkes' Inquest. It is acknowledged that there has been a great deal of learning and reflection following the Inquest of Mrs Wilkes and we assure you that this learning has been shared and disseminated.

I hope this brings some reassurance that we are working to ensure another tragic loss of life doesn't occur in similar circumstances.

Please contact me if you require any further information or if I can assist further in any way.

Yours sincerely

Steven Pleasant MBE
Chief Executive, Tameside MBC/Accountable Officer, Tameside & Glossop CCG

Enc: General Practitioners Guidance document regarding patients taking opioids and neuropathic drugs with alcohol dependency (June 2020)