TheUplands
MEDICAL PRACTICE
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Bury New Road,
Whitefield,
M45 8GH
[redacted]

Date: 3rd August 2021

IN THE CORONER AREA OF MANCHESTER NORTH

THE INQUEST TOUCHING UPON THE DEATH OF BRUCE LEE HOUGHTON

WITNESS STATEMENT OF DR [redacted]

I, Dr [redacted] of The Uplands Medical Practice, Whitefield Health Centre, Bury New Road, Whitefield, Manchester, M45 8GH make this statement in response to a Regulation 28 Report to Prevent Future Deaths made by Ms Joanne Kearsley Senior Coroner for the Coroner area of Manchester North in relation to the inquest of Bruce Lee Houghton:

1 I am a GP Partner at The Uplands Medical Practice ('the Practice') and I have been a GP at the Practice for 4 years. I am providing this response on behalf of the Practice. I am also now the Mental Health and Safeguarding Lead for the Practice.

2 Ms Kearsley specified in the Regulation 28 report that her concern related to the fact that the Court heard that the deceased had not had his annual medication review and that the Court heard evidence that at these reviews the patients were not asked about any over the counter medication they may purchase in addition to their prescribed medication.

3 The findings of the inquest highlighted the importance of information sharing between social care and health care providers. Since Mr. Houghton's sad death significant progress has been made in embedding and referring to integrated teams, and the Practice participates in monthly multidisciplinary team meetings which includes mental health teams, social care, and other providers. The members of the Practice team are encouraged to refer any individuals where this input would be of benefit, and referrals can also be made by social care partners. A network pharmacist attends these meetings and will complete medication reviews as required for any individuals of concern. He works across 4 practices in the Whitefield and District Unsworth Primary care network and neighbourhood.

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4 A change that has already been implemented at the Practice is that patients who are seen as vulnerable will be seen by more permanent senior GPs and clinicians rather than locum GPs whenever possible to preserve continuity of care in patients that need it the most.

5 Another change that has already been implemented at the Practice since Mr. Houghton's death is that clinical staff can place restrictions on prescriptions using the current IT system to prevent patients from over ordering medication. This update was covered in a clinical meeting in February 2021 and included in the prescribing policy which is shared with new clinicians on induction and available on the Practice shared portal.

6 The Practice is in the process of creating a standardised medication review template based on good medical practice which will include a prompt to routinely trigger an enquiry as to if the patient is taking any over the counter medication, or supplements at the point of prescribing and at annual reviews. The clinical staff at the practice will all be made aware that they are to complete this questionnaire when prescribing new medication to a patient or when they are conducting a medication review.

7 This questionnaire will be shared with the 3 other GP practices that are involved in the multidisciplinary team and will also be shared with Manchester Health and Social care Partnership for their views to see if it can be improved in any way and to promote good practice. I have already liaised with Manchester Health and Social Care Partnership to ask for their support and [redacted], Senior Primary care Manager for Quality Improvement across Greater Manchester has informed me she will investigate how they can assist. Once this feedback has been received the Practice will look to embed the questionnaire within the current clinical system (Vision) although due to its limitations this may not be possible until the Practice moves to a new clinical system. A date for sharing this has not yet been scheduled, but a slot on the next neighbourhood team meeting in September 2021 will be requested subject to other items on the agenda.

8 The Practice along with all the practices in Bury is in the process of moving to a new clinical IT system and it is our understanding that this has integrated prompts to improve the prescribing safety. This should assist staff who are prescribing in when it is appropriate to conduct a medication review and provide visual reminders. The Practice is due to have the new system in place by March 2022.

9 The Practice has already employed a permanent salaried GP who has been in post since May 2021 and has 3 more permanent salaried GPs set to join the practice in August 2021.

10 The medication review questionnaire and when it should be used will be included in the Practice's prescribing policy and in-house Practice training on conducting a good medication review will be set up which I will lead. I will be assisted by the Practice manager. The first training on this will occur once the new GPs are in post. The training will also be provided for all new staff as part of their induction, and they will be asked to review the Practice's prescribing policy. The practice aims to share this fully for feedback at the next practice meeting in August 2021 (17th August 2021) with a view to implementing it thereafter.

11 The Practice has employed a permanent pharmacist who is set to join in October 2021, after a thorough competency-based interview which specifically included questions about competency in conducting medication reviews and if they were routinely enquiring about over the counter medications as part of these. This was important to the Practice to ensure the pharmacist understands the goals of the Practice. The permanent pharmacist will then have an influence on the prescribing policy and the medication

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review questionnaire which can be updated and improved whenever necessary. This will also improve continuity of care.

12 If the Practice receives information regarding a patient from other organisations or staff members that cause concern, then that patient will be invited for a review by a doctor. As the mental health lead, I regularly attend the Neighborhood MDT meetings which allows for those patients with serious mental health conditions or flagged as vulnerable to be reviewed at the Practice by me as part of the actions with input from the network pharmacist allowing for a more detailed (structured) medication review. Staff at the Practice are aware of the importance of flagging any patients that may be causing concern, and these are flagged to me or the on-call GP in my absence. The Practice has since May 2021 started daily informal clinical huddles and this has been working well in sharing information about patients that may require review or further input. This has helped improve communication internally in sharing information and follow up of patients that may need more urgent input.

13 As part of the Covid recovery the Practice is in the process of sending out invites as part of the recall system. The Practice will prioritise the completion of a detailed structured medication review for all patients with serious mental health conditions as defined in the Quality Outcomes Framework (QOF). Mr. Houghton would have been included in this group of patients. As the Mental Health Lead for the Practice, I will have oversight of this process. A dedicated member of staff will manage this, and the Practice is looking to train up a mental health champion to support this. We expect to have this in place by the end of August 2021.

14 The higher risk mental health patients will be invited for a health check first and then subsequently all patients with known mental health conditions will be invited for a medication review. The Practice will aim to complete medication reviews of the higher risk patients with serious mental health conditions by the end of December 2021 with all patients having completed this by March 2022. An electronic document will be created as a safety net to priortise these patients and reviewed monthly with the support of a mental health champion to ensure the patient has a health check followed by a medication review with a GP or pharmacist. This document will be completed by the end of August 2021, and a traffic light system will be used to identify patients needing urgent, medium, and less urgent reviews in order of priority. A dedicated member of the administration team will support the review and booking of these patients and follow up when the patient does not engage. Any individuals causing concern will then be flagged to the neighbourhood team meeting. The Practice pharmacist will be an excellent resource for this

15 The Practice is engaging the practice development support of the Royal College of GPs to review the Practice processes currently in place and the plans shared above, for feedback and review. I would be happy to provide a further update to the coroner regarding the progress in November 2021 if that is acceptable.

16 I will encourage the new clinicians to complete continued professional development focusing on specific areas so that the practice has a broad range of specialist knowledge, and this will assist in treating more vulnerable patients and patients with long term health issues.

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I believe that the facts stated in this witness statement are true.

Signed: DR [redacted]

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