ROYAL PHARMACEUTICAL SOCIETY

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Nicholas Moss
Cambridgeshire & Peterborough Coroner Service
Lawrence Court
Princes Street
Huntingdon
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1 July 2021

Dear Nicholas Moss,

RE: Samantha Jane Gould Deceased

Thank you for your letter dated 28th May 2021 following the recent inquest into the death of Samantha Jane Gould. We would like to express our sincere condolences to Samantha's family.

As you may know the Royal Pharmaceutical Society ('RPS') is the professional body for pharmacists and pharmacy in Great Britain, representing all sectors of pharmacy. Our role is to lead and support the development of the pharmacy profession.

We understand the matters of concern which you have raised and are keen to assist where we can. Our considerations on the concerns you have raised are as follows:

Communication to pharmacy teams about patient safety plans

The Regulation 28 report highlighted the lack of guidance/standards to ensure that the NHS and other providers of care inform community pharmacies of patient safety plans. We would very much welcome guidance/standards in this area.

This is an active area in which the RPS continues to campaign. We believe access and sharing of patient health records for community pharmacies is really important and recognising pharmacists have a legitimate need to access patient health records to improve patient outcomes for patients.

An electronic copy of our policy and position statement is available from our website.
https://www.rpharms.com/recognition/all-our-campaigns/policy-a-z/patient-health-records

We have also published guidance around keeping patients safe when they transfer between care providers. This is available on our website.
https://www.rpharms.com/resources/quick-reference-guides/keeping-patients-safe

Need for national protocols

We understand from your report that there has been implementation of a local protocol whereby the Cambridgeshire and Peterborough Foundation Trust's Child and Adolescent Mental Health Service ensures that any pharmacy used regularly by their patients aged 16-17 are (where appropriate) advised of relevant care plans. This sounds like an excellent initiative. We have also heard of other Child and Adolescent Mental Health Services (CAMHS) creating links with local community pharmacies.

We believe that there is a need for more system leadership in this area noting that pharmacies are often the recipients of information. This regulation 28 report has been addressed to pharmacy organisations, and there is parallel need for organisations representing the NHS and CAMMHS services to make changes to prevent deaths.

It would not be within the scope of our role to mandate local changes are adopted across the NHS and by other care providers, however we recognise the need for community pharmacies to be involved in the development of medication safety plans. If changes can be made by the relevant NHS organisations to ensure pharmacy teams are involved in this process, we will raise awareness of this amongst the pharmacy profession.

Further considerations

You may be aware of the Healthcare Safety Investigation Branch (HSIB). They are a government organisation that conducts independent investigations of patient safety concerns in NHS-funded care across England and are able to make safety recommendations to improve healthcare systems and processes in order to reduce risk and improve safety.

If you would like to make a referral, their contact details are: HSIB, A1, Cody Technology Park, Farnborough, GU14 0LX [redacted]. You may wish to contact them separately if you haven't already done so.

Thank you for bringing this to our attention and I hope our response has been helpful.

Yours sincerely

[redacted]
Professional Support Manager