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Your ref: 311497
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22 June 2020

Mr Jason Wells
H M Assistant Coroner
(South Manchester)
H M Coroner's Office
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Wells

Regulation 28 Report to Prevent Future Deaths
Sam Robson PRINGLE (Inquest date 6 December 2019)

We refer to your report dated 28 April 2020 in relation to the above case; we are sorry to learn of the circumstances surrounding the death of Mr Pringle, and would offer our collective condolences to his family.

Stockport CCG has worked together with Pennine Care NHS Foundation Trust (PCFT) and the Greater Manchester Medicines Management Group (GMMMG) in the review of this case and we respond jointly to you which we trust is acceptable.

The senior leadership across all 3 organisations have met to review this case and to consider the steps we can take across the system to reduce the likelihood of any other patients experiencing delays in the prescribing of Lithium and / or other medications governed by a Shared Care Protocol (SCP).

It should be said that shared care has been an ongoing and challenging GM work stream, as it was previously a known area of risk at the transfer of care. To that end GMMMG has a library of 58 current SCPs and an archive of almost 80 previous versions. The procedures in place to date have undoubtedly made transfers of care safer for countless patients, so when it does not go as planned we review and make improvements.

From 2018 GMMMG will only approve an SCP where assurance that robust commissioning and provisions arrangements are in place. This lithium SCP was approved prior to that procedure being in place.

The outputs from the multi organisation meeting on 1st June 2020 were taken to GMMMG on 11th June for consideration. The group reviewed an anonymous version of this unfortunate case and discussed wider lessons which can be learnt to prevent a similar occurrence.

It was concluded that there are specific learnings from the individual circumstances which the individuals and organisations involved have learned from. Given the wider system of shared care within which this occurred, lessons for the Greater Manchester health and social care system were discussed which it will learn from.

We shall detail these separately below:

Specifics of the case

It is apparent that in this case there was a communication breakdown between the psychiatrist and the GP, with the former expecting the patient to communicate the final decision around choice of treatment (lithium) to the GP. While it is recognised that lithium is a well-established treatment, with which many GPs will have experience, communication via the patient is not reliable nor acceptable. The consultant had informed the GP of the two options given to the patient and provided written advice to the GP around initiation in the discharge letter for both medicines based on the patients chosen treatment. This was to support the GP in prescribing the medicine of choice.

The procedure for sharing care across Greater Manchester has been in place for some time and clearly expects a specialist to make an initiation decision and request in writing that the GP takes on continuation of supply, which the GP must confirm is acceptable. Generic template letters and all shared care protocols approved by GMMMG to facilitate this process are available on the GMMMG website. This unfortunately did not occur this in this case as you highlighted.

Stockport CCG have a quality scheme in place, which facilitates shared care and Dr Woodworth has communicated to colleagues in General Practice to highlight this issue and ensure that any similar problems with a shared care process are highlighted to the CCG, such that there is oversight and an opportunity to ensure patients get their treatment safely and in a timely manner.

Pennine Care senior managers and clinicians have discussed the case with colleagues at the Drugs and Therapeutic Committee and reasserted the importance of communication for safe transfers of care.

These actions have already occurred.

Greater Manchester system learnings

These reviews highlighted that although there are SCPs and a process in place, in some cases there is referral within the published protocols to ‘local commissioning arrangements’ which may allow for unwarranted variation which appears to have contributed to a lack of clarity and delay in this case. this is the case with the lithium shared care guideline which identifies that where local commissioning arrangements allow the GP can be asked to initiate the lithium by the specialist. This is the case for GP practices usually covered by this consultant.

The issues highlighted have led to a wider review of all GM processes, inform the culture of continuous quality improvement and it is expected that learnings will have a positive impact for similar clinical situations across all of Greater Manchester.

As a result of this case it was agreed that:

- **A full review of the content of all Shared Care Protocols is required so as to ensure consistency, improve safety and prevent any delay for patients accessing their medications as occurred in Mr Pringle’s case.**
    - Agree a risk based prioritisation of SCP review
    - Agree timescale for review with GMMMG and GM Directors of Commissioning

- **Make recommendations for a unified GM position on implementation of SCPs.**
    - This will ideally be a de minimus, standardised GM process.
    - Where a GM standard is not adopted due to local commissioning considerations, clinicians must have access to an agreed local process, which is clearly documented and communicated.
    - GMMMG to assure implementation of standards.

- **Take account of necessary changes in practice as a result of Covid 19**
    - Impact on secondary care repeat prescribing systems.
    - Electronic shared patient records to ensure/ assist clear communication
    - Where best practice is identified it will inform GM standards
    - Engage with external stakeholders such as the Care Quality Commission (CQC) who inspect care establishments to encompass their shared care learnings in providers and GPs into this review.

- **Develop business cases for GM approval where additional funding and assurance is required,**
    - Consider approving of SCPs and related pathways as policy only when funding and assurance in place.
    - Consider reconciliation of local approval of GM standards to assure consistency for all GM residents.
    - Assurance required if local process deviates from the agreed position.

- **Ensure all independent sector providers comply with the same GM standards as NHS providers**

As you can see from the number of proposed actions this is a significant system wide piece of work. These actions will be prioritised by the Pathways and Guidelines Development subgroup of GMMMG at its July meeting and the subgroup's plan approved by the August GMMMG.

It is anticipated that it will take several months to fully review all SCPs and implement the systems proposed, further complicated by the Covid-19 recovery. We intend to continue this work as quickly as possible.

We hope the above is acceptable to you but if you have any questions in the meantime please do not hesitate to contact us via e mail at [redacted]@nhs.net , [redacted]@nhs.net or [redacted]@nhs.net

Yours sincerely

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Stockport CCG

Dr Henry Ticehurst
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Dr [redacted]
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