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Ref: LT0981

6 December 2017

Private and Confidential
Mrs Heidi Connor
Assistant Coroner
HM Coroner's Service
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[redacted]

Dear Mrs Connor

Thank you for your response to my last letter and for your patience. I have now completed my analysis of the internal review which took place of the concerns described in your Regulation 28 letter.

I have responded to each of your concerns below.

1. ***As matters stand, in a community pharmacy setting, there is no way of communicating clinical urgency between prescriber and pharmacy staff at the time the prescription is downloaded. A large number of prescriptions are downloaded every day by pharmacies. Urgent and non-urgent prescriptions look the same on the system. It is only at the labelling stage that any clinicians' comments can be seen.***
Currently there is no mention in the GMC's Good Practice in Prescribing and Managing Medicines and Devices on communicating clinical urgency. For most GP prescribers the normal way to communicate clinical urgency is to speak to the pharmacist, usually by phone, or directly and provide information about the patient; the medication/s that need to be dispensed; who will collect the medication, or whether it will need to be delivered and how they will receive the prescription (patient/carer, fax/post or collect from surgery). The GP may delegate this to a member of his staff. This communication is normally in response to the need for the delivery of medicines, but can also be in relation to early notice to order a special medicine as these can have a longer lead in time.
The EPS system was designed to transmit prescriptions electronically reducing the need for paper prescriptions. Pharmacies use their IT systems to request (pull) prescriptions from the NHS Spine which releases all the available prescriptions for that pharmacy and adds them to the existing prescription queue. All EPS prescriptions look the same on pharmacy screens and there is no means to currently distinguish urgent from routine. The prescription list can be sorted by time or surname. Well Pharmacy sort their prescriptions by surname to prevent the risk of missing multiple prescriptions for the same patient.
GP's also have access to an 'Additional Instructions' field which could be used to add a note for the dispenser to highlight urgency, but the presence of the note is not visible on the main list view and it is only visible on screen when the prescription is processed and additionally not all pharmacy systems conform to this requirement.

2. We were told that a different system (Vision) is used in scenarios where a pharmacy is run by a GP practice. This system is often used in rural settings. The Vision system allows for a prescription to be marked with a red exclamation mark at the point of downloading, where a prescription is urgent.

This functionality is only used by sixteen Dispensing Doctor practices in England who use the Vision clinical system in the consulting rooms and Cegedim Pharmacy Manager dispensing system in the dispensary. These two systems are owned by the same company Cegedim and they have functionality to highlight an urgent prescription to the dispenser. These practices are not using EPS and the NHS Spine but the practice local area network so the solution cannot be scaled to form a national solution.

3. Where prescriptions go via the NHS Spine, such a system is not currently possible.

EPS connects all prescribing and dispensing systems to the NHS Spine and an EPS prescription can flow from any prescribing site to any community pharmacy in England.
The current prescription message does not contain an urgency flag. Any solution that would allow transmission of a flag from prescriber to dispenser would require a change in the prescribing and dispensing systems, prescription message and the NHS Spine. NHS Digital is already exploring this option as part of the EPS enhancements for prescribers and dispensers.
To be fully operational, this would require changes to all prescribing and dispensing systems as well as the NHS Spine. NHS Digital would have to work collaboratively with prescribing and dispensing systems suppliers to implement this change and it could take up to 24 months for it to be developed and deployed due to the complexity of the primary care provider environment and the need to implement business change within the NHS.

4. We heard evidence about a recent survey conducted by NHS Digital, in which pharmacists made it clear that this was the change they most wanted to see.

The EPS Enhancements survey took place in August 2017 and a “High Priority Alert” was most desired enhancement for dispenser and the second most desired for prescribers. NHS Digital are undertaking further work with users to elaborate the requirements and explore how such an alert would work.
NHS Digital are also evaluating the introduction of an extra prompt in Urgent and Emergency Care for a prescriber to contact the pharmacy if required when an urgent prescription is issued.

5. It is clear that agreed guidelines will need to be considered, in line with any such change, to define what is meant by the term ‘urgent’.

As mentioned above there no existing guidance or definition of urgency in relation to prescriptions. User interviews and discussion on communicating clinical urgency have indicated that the spectrum of time can be anything from two hours up to and including the following or next working day as in your inquest.
As EPS extends in to new care settings such as Urgent Care, there may need to be different definitions of urgency dependent on the care setting.
NHS Digital continue to work with stakeholders and held a national risk workshop with health professionals and their professional bodies to explore this and more work needs to be done in this area including discussions with regulators where appropriate to agree any guidance on best practice. I personally favour a set time frame (4 hours) by which the medicine should be in the hands of the patient or representative so there is one standard, which aligns to the standard set by A&E waiting time, but this will need buy-in from the prescribing and dispensing professionals.

6. Prof Hodges' case makes the case for this change very clearly, and I consider there is a real risk of future deaths if this is not addressed.
NHS Digital are working with all stakeholders to mitigate the risks associated with communicating clinical urgency recognising that technology solutions are only one part of this multi-dimensional and complex system.

Conclusions
Following our review, I have come to the same conclusion as you in that I believe there is a strong case for a technical change to highlight an urgent prescription. This is a very significant undertaking impacting prescribing and dispensing systems as well as the NHS Spine. The urgency flag will currently impact patient care in GP, Out of Hours and NHS 111 settings.

For this to be implemented successfully such a change would require significant changes to professional practice and behaviours and would need the backing of the professional bodies. NHS Digital only has powers to direct GP IT system supplier and the Spine, whereas NHS England has power to influence other IT suppliers and professional groups. Such a major undertaking has considerable costs and business change requirements and will require a decision to be taken at the highest level.

I have formally written to [redacted], Chief Clinical Information Officer and Senior Responsible Owner for funding major IT programmes to seriously consider commissioning a programme of work to enable the technical flagging of urgent prescriptions and enable sound professional use and gain support from professional trade, professional standards and professional regulatory bodies and for this to be able to be implemented systemically within two years.

In the short term you would also expect actions to be taken to mitigate risk during this intermediate period, assuming there is a positive response to my request. I have divided the mitigating actions into two broad actions:

1. Mitigating actions in the roll out of EPS into urgent and emergency care settings:

    - When a prescriber sends an urgent prescription via EPS, the mitigating methodology is that the prescriber will not be able to send the prescription to the pharmacy until (s)he has made a declaration to confirm that (s)he understands there is a requirement for the pharmacy to be contacted for all urgent prescriptions.

    - The effect of the above process is that the prescriber will have notified the pharmacy of the fact of an urgent prescription at or before the point at which the prescription is downloaded by the pharmacy, which we respectfully suggest meets the concern you have raised within the Report. This has the same effect as the red exclamation mark system and is appropriate mitigation until a technological flag can be delivered, if that is the agreed strategic solution.

    The above system is the subject to a pilot scheme in respect of Urgent Care services (i.e. NHS 111 service and GP Out of Hours services) and is due to be implemented across a controlled geographical area, namely London Central West, with respect to

Urgent Care services within the next month. Upon further analysis of its performance it may then be subject to a wider geographical roll-out.

2. Mitigating actions in the prescribing of GPs

Your inquest demonstrated that there was not a standard practice amongst GPs. I have written a letter to go to all General Practices in England which draws attention to this case, points out normal practice and which highlights high risk cases when a phone call to the pharmacist should be made, namely those cases:

- When the prescriber views the prescription as urgent and
- When the patient relies on home delivery for the medication as this is outside the contractual obligations of a community pharmacist and/or
- When the prescription is issued within normal working hours as the urgent prescription will not be visible within the large numbers of repeat prescriptions and/or
- When there is any doubt about the prescription will be collected in the desired time frame by the patient or representative in the case of a vulnerable patient.

This letter is liable to be considered more seriously if it has the support of the RCGP, BMA and RPS so I have asked that it gains that support before it is sent.

Kind regards

[redacted]

cc [redacted]