Lister House Surgery
207 St Thomas Road
Pear Tree, Derby
DE23 8RJ
Tel: 01332 271212

Oakwood Medical Centre
Danebridge Crescent
Oakwood, Derby
DE21 2HT
Tel: 01332 271212

Lister House Surgery

Lister House Chellaston
Fellow Lands Way
Chellaston, Derby
DE73 6SW
Tel: 01332 271212

Lister House Coleman Street
Coleman Health Centre
Coleman Street, Allenton
DE24 8NH
Tel: 01332 271212

www.listerhousesurgery.co.uk

15 November 2023

Ms Susan Evans
Assistant Coroner for Derby and Derbyshire
Coroner's Office
St. Katherine's House, St. Mary's Wharf
Mansfield Road
Derby
DE1 3TQ

Dear Assistant Coroner,

Inquest Touching the Death of Melvyn Blount: Report to Prevent Future Deaths

Please find below our response to the request for Prevention of Future Deaths Report. We have reflected on your comments and met several times to consider our actions and learning following this Coroner's inquest.

Coroners Concerns

We note the Coroner's concerns expressed in the Report to Prevent Future Deaths. The main concerns were expressed as follows:

> *'…It was clear that if the GP had direct contact with the patient it would be their responsibility to digest the* [drug] *alert and inform the patient. What remains unclear is what should happen to ensure that an alert is digested and disseminated when it is the GP who receives the alert but is prescribing at the behest of a non-prescriber and so does not see the patient. The lack of a clear policy gives rise to the risk that drug alerts are not seen by non-prescribers and therefore not communicated or are being seen or known about but still not communicated. It also remained unclear from the evidence whether the GP prescribing the dug remains ultimately responsible for ensuring that patients are properly informed and if they do, how they can satisfy themselves that relevant information is passed to the patient without seeing them personally.'*

Summary

The Practice has reviewed the concerns of the Coroner. We have implemented a number of reviews and changes to prescribing practices and supervision at the practice, both in response to the event, and later following the Coroner's Report to Prevent Future Deaths. The practice has also considered other issues that arose as a result of the review of this event.

The main actions undertaken by the practice are as follows:

Prescribing Review and Changes

1. Introduction of improved clinical supervision and review of non-prescribers.
2. Clinical audit of mental health workers including prescribing.
3. Prescribing and drug safety review
4. Review of provision of drug safety information

Other Changes Regarding Mental Health Care

5. Clinical education and training on mental health

Details of each of the above actions are described below.

Clinical Supervision

In October 2023 the practice introduced a daily debrief with a General Practitioner for all mental health workers.

A debrief is a direct conversation that can be used for knowledge or skill attainment, or to answer questions to ensure patient safety and patient care, based on a recent consultation. Its goals are to discuss the actions and thought processes involved in a particular clinical situation, encourage reflection, and incorporate improvement into future performance.

At the daily clinical supervision recommended medications by mental health workers will be discussed. Prescriptions can be generated by the GP who will provide clinical advice and ensure appropriate indications. Any repeat medications that require authorisation will also be discussed with the GP to decide the suitability to prescribe.

Any urgent recommendations for medication arising during the day will be discussed with the duty doctor and the same supervision process and discussion will occur.

For hypnotics and benzodiazepines the GP will consider the need to review the patient with the mental health worker to ensure there is shared decision making around prescribing decisions.

The process for both daily debriefs and urgent medication requests includes ensuring that any drug safety alerts and side effects are discussed with the patient and documented in the records. This will be in accordance with GMC guidelines and good medical practice.

The new process commenced the week of 23rd October 2023. Please see the example rota provided at Appendix A.

Clinical Audit of Mental Health Workers

In October 2023, GP Partners [redacted] completed a clinical audit reviewing the mental health workers consultations focusing on any medications recommended as part of their assessment and treatment plan. A random sample from a 12-month clinical audit was independently reviewed by both GPs checking the appropriateness and clinical safety of prescriptions that were issued and signed by a GP on the recommendation of a mental health worker.

Conclusions and recommendations from the audit were as follows:

- Overall medicines recommended were clinically appropriate, with no allergies, very few contraindications and interactions, and there was evidence of good drug safety and monitoring, and record keeping around crisis plans, safety netting and follow-up.
- The importance of good safe documentation had been discussed already. In the consultations that were reviewed from recent months, it was evident that changes to provide clearer documentation had been made.
- Both GPs noted one mental health worker to have outstanding record keeping and this will be shared as best practice.
- [redacted] recommend as part of the audit that mental health workers consider documenting routinely the following in every consultation,
    - Important and rare risks of taking medication e.g. serotonin syndrome, increased suicidal ideation.
    - Safe storage of medication.
- Improvements were recommended for general record keeping for mental health consultations.
- An MDT session will be held to reiterate the use of the Psychological Ardens System template. This template covers all aspects of safety netting checks during the consultation. The session will be recorded and then shared to the team.
- An annual review of consultations and documentation of the mental health workers will be completed by [redacted] and feedback given to individuals and the whole team.

Prescribing and Drug Safety Review

The practice prescribing lead Partner [redacted], in conjunction with our practice and PCN pharmacy team, reviewed our prescribing practices when non prescribing clinicians are consulting patients. We have a number of non-prescribers including mental health workers, nurses, physician associate and clinical pharmacists. This project started in July 2023. Following consultation with the nurse lead, clinical pharmacist lead, and practice manager, a PDSA (Plan, Do, Study, Act) quality improvement project was commenced. The project aimed to ensure the processes around non-prescribers and recommending medications are robust with clear accountability and clinical governance processes. We have reviewed our prior method whereby a prescription is prepared by the non-prescriber and a red flag on the electronic prescription alerted the prescriber to check the prescription before signing. Whilst this is a method used by most other GP Practices we wanted to go up and above this safety check by introducing a debrief and supervision allowing the prescriber to discuss and check that all relevant alerts, risks, side effects and drug safety (interactions, contraindications, allergies, and drug monitoring) are discussed with the patient and documented as appropriate.

We have, therefore, changed our process for prescribing where the recommendation for prescription is from a non-prescribing clinician. From the start of July 2023, we have a separate list of patients requiring a prescribing decision allocated each session to a GP partner with protected time. This started with our non-prescriber nurses (that is those nurses that do not have a non-medical prescribing, NMP, qualification). These nurses are however trained and very experienced in managing and recommending the appropriate treatment for our Long-Term

Conditions. They follow the appropriate NICE guidelines. This GP partner will still review records and discuss case histories with the nurse as necessary.

There is a daily debrief for our physician associate like we do for the mental health worker since July 2023. The GP will discuss all prescriptions with the physician associate before any prescriptions are issued and the GP has responsibility for ensuring all drug safety, alerts and risks are conveyed to the patient. Similarly clinical pharmacists that do not have NMP have all their structure medication reviews (SMRs) and recommended prescriptions debrief by a GP and have done so since July 2023.

During the debrief and review the prescriber that prescribes a medication will review any alerts that pop up and check that there are no contraindications, interactions or allergies, and check for any drug safety issues such as renal function, before prescribing. The prescriber will be responsible for checking that appropriate drug monitoring follow up and that side effects have been discussed and recorded in the patient's medical records accordingly. Any alerts will be passed onto the non-prescriber to discuss with the patient as needed.

The prescriber ultimately takes responsibility for the prescription and any information to be passed onto the patient. The GP can contact the patient if felt necessary after a clinical review and assessment to discuss further.

Our aim is to have one debriefing GP everyday who supports all our non-prescribers in the practice. We will start this non-prescriber supervision method with one GP per session from 4th December 2023 (only delayed due to appointments already being booked with GPs). This will include all the clinical supervision for all non-prescriber as outlined above to streamline debriefing and supervision for ease with rota planning and coordination.

Provision of Drug Health Safety Information

MHRA (Medicines and Healthcare products Regulatory Agency) drug safety alerts are circulated by the prescribing lead [redacted] via email to all clinicians, including mental health workers. They are also circulated by the data team on 'SystmOne' to all clinicians (regardless if prescriber or not).

MHRA and prescribing updates are a regular agenda item on the monthly whole practice clinical meeting led by the pharmacy team. A new module called 'TeamNet' will be expanded for use by all staff and MHRA alerts will be circulated on TeamNet for review. A record of this will be kept and updated to ensure all clinicians have read and understood the update.

Important drug safety alerts and common side effects are discussed with the patient and documented as part of good clinical practice in the medical records.

The practice has also discussed how we can safely convey drug safety information and all recognised side effects in a drug information leaflet to patients. This includes the challenges around patient confidentiality and consent to share this beyond the patient consulting. The practice is trialling sending to some patients, based on clinical judgement, an AccuRx message with an NHS link to the medication patient information leaflet. A demonstration of this has been shared to the whole practice at the clinical meeting on 12th October 2023, alongside a recorded video demonstration which will be sent in our next weekly update.

Clinical Education and Training on Mental Health

The clinical team, both GPs and mental health workers attended a mandatory education event on 25th October 2023 with [redacted], a local Consultant Psychiatrist, covering mental health disorders on the topics of acute psychosis and depression, suicide and prescribing. A recording has been shared with all clinicians to watch and a register of attendees has been taken.

Learning from this educational event included,

- Recognising the diagnosis of psychotic depression and how this typically presents and evolves over a few weeks.
- The differential diagnosis and consideration of other causes of presentation of delusional thoughts, and hallucinations touching on schizo-affective disorders and acute psychosis.
- This case was discussed as part of the educational event and [redacted] described that this was likely to be psychotic depression based on age and presentation, and he went on to describe how he would usually manage this. He explained the importance that the appearance of delusions would immediately reach threshold of psychotic depression and that he would have a low threshold for prescribing antidepressant but a high threshold for starting antipsychotic due to risks of initiating such medications.
- He explained the local referral routes for crisis, and the early intervention team. He explained that early intervention team would usually assess within 2 weeks.

The practice engages in an annual mandatory suicide awareness and prevention training and the next update will be for all staff (clinical and non-clinical) on 17th April 2024. A register of attendance will be taken. Our previous training on suicide and prevention was at our staff wellbeing and resilience whole practice event on 19th April 2023.

We have provided a table at Appendix B showing timeline of event and actions undertaken by the practice since Mr Blount's tragic death on 14 January 2023.

We would once again like to offer our sincere condolences to the family. We trust this report confirms that we have taken necessary action to address the concerns raised by the Coroner. We would be happy to provide further information to assist the Coroner if required.

Yours sincerely,

[redacted] (Senior Partner)

Appendices:

A. Mental Health Worker Rota example with clinical supervision

B. Timeline of Events and Actions