NHS
Commissioning Alliance

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27 July 2018

Dear Veronica Hamilton-Deeley,

The Late Mr Darren James CARRINGTON

Thank you for your recent letter enclosing a Regulation 28 request following the death of Darren James Carrington. I was very sorry to hear of his death and I hope the following information helps somewhat.

In preparing my request, I have spoken with [redacted], the CCG Medication Management and Quality and Safety colleagues, as well as clinical and senior admin colleagues from a linked GP Practice - who have provided support and advice to [redacted] and his team.

I have been encouraged by [redacted] open and constructive response to events, and his offer to participate in the CCGs Task and Finish Group (as proposed in previous correspondence) is welcome and I am confident will be of benefit to all of primary care.

Brighton and Hove has above average numbers of deaths relating to misuse of prescribed medication. Alcohol and recreational drug misuse are often factors. As you have outlined, the Primary Care workforce has changed, with more salaried, locum and less than full-time posts. Those signing prescriptions are less likely to have personal knowledge of patients and it is essential to have robust processes in place to ensure patient safety.

When Practices acquire new IT systems or upgrades, initial training is often limited. It is important that staff have access to ongoing structured training around optimal use of the system, as in-house digital knowledge can be variable.

Patients are increasingly obtaining medication directly via the Internet. My understanding is that this was the case with DC. Questioning if patients are obtaining medication via this route needs to become a standard part of the consultation.

I can confirm that the following changes have been implemented at North Laine Surgery via a Practice Meeting attended by all staff: -

- All reports of patient self-harm are now circulated to clinical staff.
- Review of best practice for coding self-harm.
- Increased awareness of potential significance of frequent requests for apparently small quantities of medication.
- All patients receiving Zopiclone have had their records audited. No evidence has been found of other patients over ordering. Quantities of medication have been reviewed as appropriate.
- Records of all patients receiving weekly prescriptions have been reviewed and access to on-line requests have been removed.
- Records of all patients receiving prescriptions for CDs or drugs of potential abuse or dependency, have been reviewed and access to online requests removed.
- Arrangements have been made to ensure administrative and clinical staff have adequate, protected time to manage prescription requests.
- Ongoing discussions with linked Practice around sharing high risk medication review protocol.
- Computer settings changed with a view to lower thresholds for flagging up early ordering of scripts and increased awareness around the potential significance of these and other alerts.
- The importance of appropriate 'maximum number 'of repeats authorised with a view to triggering a clinical review of cases.

Our Medication Management team are providing ongoing support. In particular, around embedding The High Risk Drug review protocol mentioned above, as well as ensuring that the new Practice Repeat Prescribing Policy covers current best practice.

I am confident that the measures outlined will significantly reduce the chance of future related patient harm at North Laine Surgery. It is however, essential that the learning is shared across the city. The Task and Finish Group's membership will include Community Pharmacy Representatives, CCG digital staff, Practice Managers as well as Primary care Clinicians with a view to ensuring maximal learning from this case is embedded across the city.

You raise the important issue to what extent Community Pharmacists provide an additional level of safety. Representatives of the Local Pharmaceutical Committee have agreed to attend the Task and Finish Group during which we will highlight this role and the importance of a joint approach.

Finally, the Practice are in the process of completing a serious incident investigation report that will be submitted to NHSE. Any further learning from this will be disseminated locally via the Task and Finish Group.

Please do not hesitate to contact me if you require any further assistance.

Kind regards,

[redacted]

[redacted]

Clinical Chair

Brighton and Hove Clinical Commissioning Group