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Ms Sarah Huntbach
HM Assistant Coroner for Derby and Derbyshire
Town Hall
Rose Hill
Chesterfield
S40 1LP

By email only to: [redacted]

27 August 2024

Dear Ma'am

Inquest touching upon the death of Debra Bates: Prevention of future death report

We are writing to provide our response to the Regulation 28 Report, received on 2 July 2024.

Background

At the time of her death, Ms Bates was prescribed 14 medications on repeat, which included three controlled drugs ([redacted], [redacted] and [redacted]). She was also prescribed [redacted] but this was never issued on a repeat basis and always had to be authorised by a GP.

In April 2023, during an admission to hospital following an overdose, Ms Bates was reviewed by a Consultant from the Liaison Psychiatry Team who suggested that her regular prescriptions be supplied in blisters on a 3 days followed by 4 days cycle.

This recommendation was discussed with Ms Bates' pharmacist, but they declined to issue her medication in blister packs because historically she had not used blister packs appropriately, and there were concerns about putting controlled drugs into blister packs. They also did not consider Ms Bates was a suitable candidate for medication delivery due to the risk of stockpiling medication. They suggested non-blister 3 and 4 day prescriptions would be more suitable. However, when this was discussed with the PCN Pharmacist, they were concerned that in this particular case (the addition of two sets of 14 medications, including controlled drugs) could cause confusion and a risk of prescribing errors. A decision was ultimately therefore taken to continue 7-day prescribing, in the absence of other safe solutions.

Matters of Concern

The main concerns in the Report to Prevent Future Deaths were expressed as follows:

> *"No further investigation or inquiries were made as to how other practices implemented this [3 and 4 day] prescribing approach in a case where there are multiple medications (including controlled drugs) or whether / what safety measures are available on the computer system, to prevent / minimise the risk of the wrong prescription being requested."*

Action Taken

We had an initial debrief at the Practice on 14 June 2024 to discuss the issues raised during the Inquest the previous day. We agreed that it should be possible to safely manage 3 and 4 day prescribing recommendations and that we would like to identify a solution / process to facilitate this. We agreed to hold a more formal meeting on 14 July 2024 to discuss matters in more detail and to develop a Standard Operating Policy (SOP) for patients requiring 3 and 4 day prescriptions.

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The meeting on 14 July 2024 was attended by all five GP Partners and our Practice Manager. We discussed the background as outlined above and agreed that we needed to develop an SOP to facilitate any future requests for 3 and 4 day prescribing.

It was noted that two patients are currently prescribed medications in this way. One patient was newly registered at Park Surgery in March 2024 and was already on a twice-weekly prescription regime, which has been continued. The second patient was requested to have twice weekly prescriptions on 14 June 2024 and this has been successfully implemented in collaboration with the duty GP and the PCN Pharmacist.

We discussed a way in which we could implement safe prescribing and issuing of 3 and 4-days prescriptions. A key point was having as few people as possible involved in the process to maintain continuity. Additionally, since each drug will appear twice on the repeat prescription list it must be clearly stated which day of the week each item should be issued on. Furthermore, avoiding prescriptions being issued on Mondays was considered important due to Bank Holidays and the potential confusion this might cause. We noted that ideally, prescriptions would be issued on Tuesdays and Fridays.

We agreed that administrative staff, who normally issue repeat prescriptions, should not be involved in issuing medications for patients on 3 and 4-day prescriptions. This is to reduce the risk of errors when issuing future-dated prescriptions for medications where each item appears twice on the repeat medication list. We noted that we would need to include a reminder in the home screen for any patients on twice-weekly prescriptions, to alert staff that the patient is on twice-weekly prescriptions, and that we would create a READ code 'Risk Reduction technique' for audit purposes.

We agreed the following actions:

i. Practice Manager to create a READ code
ii. Prescribing Lead GP to draft SOP and review with the PCN Pharmacist and GP Partners
iii. Contact prescribing lead GPs in other local PCN Practices to enquire about experience with (and policies for) managing twice weekly prescriptions.
iv. Contact the ICB prescribing team to see if there is any guidance on issuing prescriptions more frequently than weekly.
v. Contact the Community Mental Health Team (CMHT) to see if they have any policies regarding their processes for requesting 3 and 4-day prescriptions from GPs and also ensuring ongoing review of such patients, including whether there is a continuing need for twice-weekly prescriptions.
vi. Further Partners meeting to review progress arranged for 18th July 2024.

Point (i) above was actioned on 16 July 2024 and the new READ code and home screen alert – "THIS PATIENT IS ON 3/4 DAY SCRIPT REGIME. ISSUES OR ADJUSTMENTS SHOULD ONLY BE MADE BY A CLINICAL PRESCRIBER" – were added to the notes for the two patients already receiving twice-weekly prescriptions.

Point (iii) was actioned on 17 July 2024 with responses from four local practices. Two Practices stated that they have no patients on twice weekly prescriptions. One Practice stated they have two patients on twice weekly prescriptions that have been stable for a long time and the reception team manage these prescriptions. One Practice advised they had several patients on 3 and 4-day prescriptions, and they kindly emailed an outline of their process to us. There were some valuable points in this, particularly around the patient's stock of medications prior to commencing 3 and 4-day prescriptions and dealing with patient holidays, which were incorporated into the Park Surgery SOP.

Information was also received from the ICB (point iv) regarding prescribing intervals. Prescribing in Primary Care Guidelines.pdf (derbyshiremedicinesmanagement.nhs.uk) This was taken into consideration when writing the SOP, though there is no information specifically around prescription intervals of less than 7 days.

A draft SOP was prepared and discussed with the PCN Pharmacist on 18 July 2024. Amendments were made to remove any direct role for the PCN Pharmacists as they did not feel there was sufficient capacity within their team to respond in a timely manner to urgent requests. The SOP was reviewed and agreed at the Partners meeting the same day. The Lead GP for Mental

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Health also confirm that they had had a preliminary response from the CMHT, who confirmed that they would look to provide more information in due course.

On 22 July 2024, the Practice Manager met with the Reception Manager to explain the SOP regarding 3 and 4-day prescriptions – in particular that reception do not issue repeat prescriptions for patients on a 3/4 day script regime and any requests/queries about repeat issues or adjustments should be referred to a GP. Pop-up alerts will be added for any patients on a 3/4 day script regime.

We enclose a copy of the new SOP, which has been circulated to all staff. The new process, in summary, is as below:

- Any requests for twice-weekly prescriptions are passed to the Duty GP, who discusses the request with the requesting clinician if necessary and then speaks to the patient to explain the planned change and how it will work – that the GP will send prescriptions to the pharmacy for collection twice a week, usually on a Tuesday and Friday, with exceptions to 2 and 5 day prescriptions for longer bank holiday periods if necessary. Prior approval from the secondary care clinician would be needed in advance for longer issues (i.e. to cover holidays abroad).

- The Duty GP then sets up the 3 and 4 day prescriptions, noting which day of the week the 3-day supply should be issued (Tuesday) and the 4-day supply should be issued (Friday). The prescriptions are then sent to the patient's nominated pharmacy using post-dated electronic prescriptions. A maximum of four weeks of post-dated prescriptions can be issued, to ensure regular reviews by a clinician.

- The Duty GP also adds READ code to the patient's notes and the reminder to the home screen.

- Any queries or issues with prescriptions must be passed to the Duty GP.

Next steps and ongoing work

1. The next half-day education and training (QUEST) session at Park Surgery is on 18 September 2024, during which there will be an opportunity to reflect again on the SOP, answer any questions from the team and provide updates on any further information/advice from the CMHT.

2. We are also planning to undertake some quality improvement work in relation to opioid prescribing. We have already undertaken a review to identify any patients receiving high-dose opiates for non-cancer pain. There are 3 patients meeting this criterion and these patients will be reviewed with a view to reducing risk and opioid doses wherever possible. From August 2024, one of our GPs and a GP Registrar will undertake a wider review of opioid prescribing at Park Surgery. This is likely to include evaluation of data, education for the clinical team, de-prescribing, discussion around resources for patients etc. Although this work is likely to be ongoing, the time frame for the initial work is 12 months.

3. The SOP will be reviewed in July 2025.

Conclusion

We would like to again express our sincere condolences to Debra's family and friends for their loss.

We hope this letter demonstrates and provides the necessary assurance that we have taken the concerns raised very seriously and taken prompt and comprehensive action to ensure we have clear and robust processes in place to safely manage similar prescribing requests/recommendations in the future. As noted, this case has also prompted some wider quality improvement work around long-term opiate treatment, which we see as important work to better understand our prescribing and to facilitate opioid reduction where possible.

[redacted]

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We would be grateful if you could kindly confirm receipt of this letter and please do not hesitate to contact me if you require any further information.

Yours sincerely

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