Pharmacy2U

Lumina
Park Approach
Leeds
LS15 8GB

0113 265 0222

Pharmacy2U.co.uk

HM Assistant Coroner, Luisa Maria Nicholson
County Hall
Topsham Road
Exeter
Devon
EX2 4QD

10th February 2025

Dear HMC Nicholson,

Inquest into the death of Mr Billings (2024-0656) - Response to Prevention of Future Deaths (PFD) report

First and foremost, I would like to extend my deepest condolences to the family and friends of Mr Billings.

I note the following matters of concern raised in the PFD report:

(1) That a subsequent prescription was submitted in the knowledge that the first was cancelled or to be cancelled but that steps do not appear to have been taken or be able to be taken to ascertain the status of that prescription before the subsequent prescription was issued.

(2) That the swift dispatch of medication (whilst admittedly necessary in many circumstances) does not allow for mistakes to be noticed and/or remedied.

(3) That the onus was on Oliver to remedy the error when Pharmacy2U could not be contacted.

Response to concerns raised by HMC

The prescription was issued by the surgery directly to the NHS "spine" – the secure online database for electronic prescriptions - at 14:20 on 27 November 2023. We subsequently downloaded the prescription from the NHS spine at 14:21 on 27 November 2023.

It is pertinent to note that electronic NHS prescriptions do not pass from a surgery to a pharmacy directly – they are sent from the surgery to the spine, and then from the spine to the pharmacy (and then only when the pharmacy checks the spine for any prescriptions that may have been assigned to it).

The downloaded prescription was passed into our pharmacy system at 16:29, which allowed us to start our clinical processes (clinical check, labelling, assembly of the medicines, etc).

Following receipt of the PFD report, we have manually checked the tracking details of this prescription on the NHS spine. Pharmacies are not expected to do this at the time of dispensing a prescription, nor would it be practical to do so. We can now see that the surgery sent a cancellation message to the spine at 17:22, just over three hours after the prescription was originally issued.

Because we had already downloaded the prescription from the spine, the surgery's attempted cancellation of the prescription from the spine was ineffective, and the surgery's computer system would have indicated this to the surgery at the time, with a prompt to contact the pharmacy, which would have included our contact

details. In the absence of an attempt to contact us directly, we remained unaware of the surgery's attempt to cancel the prescription.

A pharmacy that has already downloaded a prescription from the spine does not receive an electronic or automatic notification of an attempted cancellation by the prescriber. This is how the software for the Electronic Prescription Service was designed by the former NHS Digital (now NHS England, "NHSE"). NHSE would be able to explain in more detail, but I believe that it was considered to be an unacceptable risk to patient safety if a prescriber was able to send a cancellation message directly to a pharmacy that relates to a prescription that has already been downloaded by that pharmacy, as to do so may give the prescriber a false sense of security that the cancellation would in all cases be effective; when the prescription could be at any stage of the dispensing process in the pharmacy and the medicines may have already been handed out or sent to the patient. The prescriber might then make further prescribing decisions based on the false assumption that the prescription has been cancelled, when it may not have been possible for the pharmacy to do so; and it would undoubtedly also place an unreasonable burden on pharmacy teams to constantly check for such cancellation messages, as well as placing the burden of responsibility on the pharmacy to carry out the cancellation of the dispensing process when in many cases this would not be possible.

The cancellation of an electronic NHS prescription by a prescriber after it has already been issued and downloaded by a pharmacy is an exceptional situation and, we consider, should be treated as such, and dealt with by way of a personal communication between the surgery and the pharmacy, so the prescriber can accurately establish the dispensing status of the prescription at the pharmacy immediately and use that information to guide their subsequent decisions.

This is our understanding of how NHSE has designed the system: upon receiving a notification from the spine that its attempt to cancel a prescription has been unsuccessful, a surgery should manually contact the relevant pharmacy to discuss the intended cancellation, and the pharmacy's contact details are displayed on the screen in the prescriber's clinical system to enable them to make such contact. The relevant guidance on cancelling electronic prescriptions is available at: https://digital.nhs.uk/services/electronic-prescription-service/cancelling-an-electronic-prescription

In the absence of direct contact, as described above, regrettably I consider that there are no reasonable steps which we could have taken to have established that the prescriber had attempted a cancellation of the prescription on the spine after we had downloaded it.

At 11:21 on 28 November 2023, we marked the prescription as "dispensed" on the spine, and the prescription was dispatched to the patient that day. The Royal Mail tracking information for the parcel is now unavailable due to lapse of time, but it was sent with a 48-hour service, so the earliest we expect it would have been delivered would have been 30 November 2023 (three days after it was prescribed). I understand the concern relating to the swiftness of the dispatch of the medicines, however I consider that our dispensing of the prescription was done with reasonable promptness and was no more swift than would have been anticipated from any other pharmacy.

The NHS Community Pharmacy Contractual Framework requires that NHS medicines and appliances are dispensed by registered pharmacies for patients on demand with "reasonable promptness" (Exhibit 1). I consider that it would be neither safe nor proportionate to introduce planned delays into pharmacy processes to allow a prescriber extra time to identify any post-prescribing concerns over and above those delays which are a natural part of a pharmacy's existing processes.

As I have shown with our timescales above, it took several hours for our clinical processes to be completed and for the medicine to be dispatched in this case. In addition, the dispensing pharmacy has a responsibility to conduct a clinical and professional check of prescriptions, an aim of which is to identify concerns and resolve

them with the patient and/or prescriber before dispensing. However, in this case, we could not reasonably have identified that the prescriber wished to cancel the prescription in the absence of direct contact from them.

I have no evidence of contact from the surgery or the patient in relation to this prescription. The PFD report states that a matter of concern is "*That the onus was on Oliver to remedy the error when Pharmacy2U could not be contacted".* I consider that it is incorrect to state that we "could not be contacted", as we at all times remained available to be contacted. As a matter of good business practice, we continually review our inbound contact capacity and performance to ensure that anyone who wants to contact us can do so quickly and easily, and we will always continue to monitor this.

The NHS Directory of Services (https://digital.nhs.uk/services/directory-of-services-dos) is also available for healthcare professionals to access contact details for healthcare providers, in addition to those which are available to the general public.

In terms of actions that could be taken to prevent a recurrence of this situation:

1. I consider that there may be a need for all prescribers to be reminded of the applicable guidance highlighted above and the importance of making direct contact with a pharmacy if they wish to cancel an electronic NHS prescription that has already been issued and downloaded by a pharmacy, and to follow the instructions in their clinical system when it alerts them that the electronic cancellation was ineffective. This may be a matter for the professional leadership body for GPs.

2. I will also ensure that we continue to monitor our inbound contact channels and performance to ensure that we remain available for prompt inbound contact by anyone who needs to get in touch with us urgently for any matters.

3. I have also discussed this case with our senior clinical management team as part of our clinical review process and we will continue to work internally and with our healthcare colleagues in other parts of the NHS, as well as with groups such as the Community Pharmacy Patient Safety Group, to continue to improve patient safety and share learnings across organisations.

I am very sorry to have had to write to you in these circumstances and I again reiterate my condolences to the family and friends of Mr Billings.

Yours sincerely,

[redacted]

[redacted]
Superintendent Pharmacist, Pharmacy2U