NHS
England

Professor Sir Bruce Keogh
National Medical Director
Skipton House
80 London Road
SE1 6LH

Andrew Bridgman
Assistant Coroner for Manchester
South
Coroner Court
1 Mount Tabor Street
Stockport
SK1 3AG

5th September 2016

Dear Mr Bridgman,

RE: Fred Whittaker – NHS England Regulation 28 Report Response

Thank you for your letter dated 14 July 2016 regarding your Regulation 28 Report following your investigation and inquest into the death of Mr Fred Whittaker. On behalf of NHS England I would like to express our sympathy to Mr Whittaker's family.

NHS England is a single national organisation and [redacted], Medical Director for Greater Manchester is professionally accountable to me. This letter is NHS England's single response on behalf of both of us and [redacted] I trust you will find this acceptable.

You have raised the following concern for NHS England to respond to:

"NHS England should draw attention of all GP practices this potential for the inadvertent re-prescription of discontinued medications and to take steps to ensure the risks are reduced to its minimum or negated."

All GP practices in England have electronic clinical systems to support them in the delivery of their care of patients. Within the patient record there is the ability to record both acute (i.e. one off) and regular 'repeat' prescriptions. When a repeat prescription is generated, the reason or diagnosis for the medication should be recorded. Similarly, when a repeat medication is stopped, the reason for stopping the medication should be recorded in the clinical records.

In the guidance published by the Department of Health, Responsibility for prescribing between hospitals and GPs EL (91) 127, 1991 (enclosed) makes it clear that the legal responsibility for prescribing lies with the doctor who signs the prescription.
The issue of any prescription and the subsequent doctor's signature is to assure the dispensing pharmacist that the doctor considers the medication to be appropriate and necessary to treat that patient, giving due regard to dose,

strength, duration, formulation and interactions with other medication or with the patient's physiology.

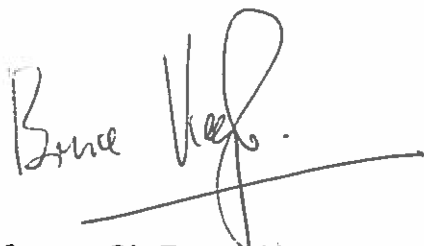
In this instance the prescribing GP should have been alerted to the fact the medication requested by the pharmacy had in fact been stopped by the patient's consultant. I have been assured by my colleague [redacted] Medical Director NHS England, that the practice and GPs involved have undertaken an appropriate review, are planning to undertake a thorough significant event analysis and have put into place appropriate measures to prevent a recurrence of a similar event.

[redacted] has informed me that he will raise this regulation 28 report and our response at the Quality Surveillance Group that has oversight of the quality of health and social care in Greater Manchester. He is writing to all GPs in Greater Manchester to share learning from this tragic event and to remind them of their responsibilities when prescribing for patients, especially when making changes, stopping and starting medicines. He is also writing to the medicine management teams of the Greater Manchester Clinical Commissioning Groups to ask them to provide relevant advice and support to practices.

Additionally, NHS England will share this learning and best practice further with GPs.

I trust this response addresses the concern as detailed in your report and thank you for bring this important matter to my attention.

Yours sincerely,



Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director
NHS England