



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

Veronica Hamilton-Deeley, LL.B Senior Coroner for City of Brighton& Hove The Coroner's Office Woodvale Lewes Road Brighton BN2 3QB

2um November 2016

Your ref:

Dear Ms Hamilton-Deeley,

Thank you for your letter of 15<sup>th</sup> September 2016 and the report written under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (investigations) Regulations 2013, setting out the sad circumstances surrounding the death of Mr Breatnach.

I note there are nine express concerns set out by the Coroner in the Regulation 28 report which generally concern the prescribing of drugs on-line.

It may be helpful if I explain that NHS England is formally known as the NHS Commissioning Board in legislation (Section 9 Health & Social Care Act 2012 amending Sections 1G & 1H of the NHS Act 2006). The Board's functions and duties are set out in that legislation too and include a duty in respect of commissioning arrangements for NHS services. These include commissioning primary care services (including general practice and pharmacy), managing performer's lists and maintaining the pharmaceutical list. We also have responsibility for ensuring that primary care contractors work within the terms of their contract, or for pharmacies under their Terms of Service which are outlined in the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013) and can take action such as issuing breach notices and requiring action or withholding payments in certain circumstances.

As noted in my letter of 27th July 2016, NHS England has, what may be termed, a "systems oversight" role for the safe use of controlled drugs (including dihydrocodeine) under the Controlled Drugs (Supervision and Management of Use) Regulations 2013. We raised the issues arising from this case at the Care Quality Commission National Controlled Drugs Group on 14th June 2016 and hosted a multiagency meeting to discuss these issues further on 2nd November 2016. Representatives from the Police Force, Care Quality Commission, Department of Health, General Medical Council, General Pharmaceutical Council, Medicines and Healthcare products Regulatory Agency, NHS England, NHS Improvement and the British Medical Association General Practitioners

Committee attended (a full list of attendees is set out in Annex 1 and a brief explanation of the role of each of the organisation to assist the Coroner in understanding the nature and extent of various Regulatory bodies involved in this issue.

The group agreed to work together to assimilate current regulatory and professional guidance into one place so there is greater clarity regarding good practice in respect of online prescribing and supply of medicines giving particular guidance on medicines such as controlled drugs and antibiotics.

Agencies also shared intelligence on this case. Regulators agreed to work together further to look at protecting vulnerable patients in future.

NHS England will use this learning to inform its Digital Strategy. We will also include advice to General Practitioners about Special Patient Notes, which are used within the integrated urgent care software so alerts can be set up for NHS 111 call handlers and out of hours general practitioners when they access a particular patient record as part of the Pharmacy Urgent Medicines Supply service being introduced from 1st December 2016.

We will continue to discuss the Coroner's concerns and endeavour to develop strategies in partnership with other responsible agencies aimed at preventing future deaths.

Yours sincerely,

Professor Sir Bruce Keogh KBE, MD, DSc, FRCS, FRCP

**National Medical Director** 

**NHS England**