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Geoffrey Sullivan, Senior Coroner
Hertfordshire Coroner Service
The Old Courthouse
St Albans Road East
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30th June 2020

Dear Mr Sullivan,

Re: Regulation 28 Report to Prevent Future Deaths – Peter Cole 14 August 2019

Thank you for your Regulation 28 Report dated 28 February 2020 concerning the death of Peter Cole on 14 August 2019. Firstly, I would like to express my deep condolences to the Cole family.

The regulation 28 Report concludes Peter Cole's death was a result of drug overdose and Ischemic Heart Disease.

Following the inquest, you raised concerns in your Regulation 28 Report to NHS England and Improvement regarding:

- repeat prescriptions not being adequately monitored, leading to many patients building up dangerous quantities of prescribed medication; and
- that as a result the inadequate supervision of repeat prescriptions is so widespread that the consequent waste of resources has an adverse impact on the overall provision of healthcare.

Thank you for raising these important points. Patient safety is the key responsibility of all who work for the NHS and is at the heart of NHS system and process, with NICE, the Care Quality Commission and the professional regulators and others, providing supporting mechanisms. Delivering patient safety is complex as it relates to all patient interactions and so ensuring effective delivery is on-going with learning from experience and research informing progress.

Regarding the monitoring of repeat prescribing this is covered in the implementation of the Long Term Plan[1] which identifies better use of NHS resources as a priority area. Work is ongoing to reduce the use of ineffective medicines as well as other programmes relevant to medicines waste which NHS England and Improvement

[1] https://www.longtermplan.nhs.uk/

has responsibility for. Several workstreams are currently in place to optimise prescribing and reduce medicines waste, these include:

- Carrying out Structured Medication Reviews: As part of the five year GP contract Primary Care Networks (PCNS) are able to recruit additional staff to work in primary care teams, this includes including clinical pharmacists. Clinical pharmacists are increasingly working as part of general practice teams. They are highly qualified experts in medicines and can help people in a range of ways. This includes carrying out structured medication reviews for patients with ongoing health problems and improving patient safety, outcomes and value through a person-centred approach. They will support GP practices in prioritising patients who would benefit from a structured medication review. This will include patients in care homes; with complex and problematic polypharmacy; on medicines commonly associated with medication errors: and, with severe frailty, who are particularly isolated or housebound. They will also work with community pharmacies to connect patients appropriately to the New Medicines Service which supports adherence to newly prescribed medicines.
- Supporting medicines optimisation through the Medicines Value Programme[2] to improve health outcomes from medicines through supporting people to take medicines as intended and, decreasing or stopping the use of medicines which are neither clinically - or cost-effective;
- Undertaking a review of over-prescribing in the NHS which is due to report in Spring 2020. The review covers: the role of digital technologies; research; culture change and social prescribing; repeat prescribing; and transfer of care. The report will provide recommendations to reduce overprescribing which will help to reduce medicines wastage;
- Encouraging Shared Decision Making where a clinician supports a patient to reach a decision about their treatment by a conversation that brings together
- the clinician's expertise: such as treatment options, evidence, risks and benefits; with what the patient knows best: their preferences, personal circumstances, goals, values and beliefs.
- The Medicines Safety Improvement Programme (MSIP) aims to reduce medication related harm in the NHS, focusing on high risk drugs, situations and vulnerable patients. The programme will contribute to the WHO Challenge target to reduce severe avoidable medication-related harm globally by 50% over five years.

In addition, to support improvement in dementia diagnosis and personalised care for people with dementia, NHS England published The Dementia Care Pathway: Full Implementation guidance . This resource sets out recommendations for reviewing and managing medication needs and provides examples of step-by-step best practice that includes monitoring and reviewing medication in the Appendices and Helpful Resources section of the guide.

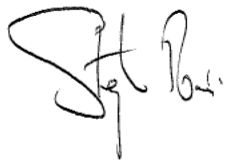
NHS England and Improvement also recently refreshed the Dementia: Good Personalised Care and Support Planning guide to help further enhance the provision of personalised post diagnostic support. The guide emphasises the need to include medication reviews to help to reduce poly pharmacy, minimise use of

[2] https://www.england.nhs.uk/medicines/medicinesoptimisation/

drugs which impair cognition, to ensure that appropriate post diagnostic medication/ services are highlighted and accessed or stopped, as appropriate, at the right time to improve outcomes for patients.

Thank you for bringing these important patient safety issues to my attention. I hope the extensive work I have outlined reassures you that we are actively addressing the points you raise. Please do not hesitate to contact me should you need any further information.

Yours sincerely,



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