



Ms Caroline Topping

HM Coroner's Court
Station Approach
Woking
GU22 7AP



National Medical Director

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG



14 June 2023

Dear Coroner

Re: Regulation 28 Report to Prevent Future Deaths – Amy Henderson who died on 21 March 2022.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 21 April 2023 concerning the death of Amy Henderson on 21 March 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Amy’s family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Amy’s care have been listened to and reflected upon.

In your report, you raised a concern that there was no quick method to obtain NHS records on admission to a private hospital. It is hoped that improvement will be made to issues such as this through the NHS England Shared Care Records programme, which seeks to bring together information from a range of healthcare providers in support of the provision of direct care. The focus is on the person receiving the care, rather than the provider and supports the safe and secure sharing of individuals’ health and care information. A shared care record joins up information based on the individual, from across different organisations. For patients, shared care records will include information such as care plans, previous appointments, inpatient stays, clinical contacts and medications, and is anticipated to bring:

- Safer, more coordinated services
- Reduction in time by avoiding the need to repeat medical or social care history
- Fewer repeats of tests, appointments and admissions
- Preferences and needs observed
- Improved experience and continuity of care
- Improved confidence in services

Implementation and operation of shared care records is the responsibility of Integrated Care Boards (ICBs). Initially, public sector connectivity is being prioritised but the forward programme plan for the Shared Care Record programme for 2023/25 acknowledges the important role that independent sector providers of care play. NHS England are aware that some ICBs are already engaging with Voluntary, Community and Social Enterprise organisations, recognising the important role that they play in the provision of care to their population. The Shared Care Record programme is also

prioritising national interoperability, pertinent to this case where there were two separate Care Record locations (South West London ICB, where Kingston Hospital is located, being part of the [London Care Record](#), and Surrey Heartlands ICB, where this site of the Priory is located, being covered by the [Surrey Care Record](#)). Further information on the Shared Care Record programme can be found [here](#).

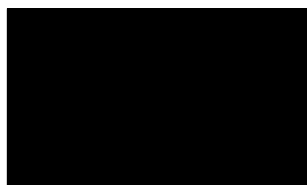
Regarding your second concern that at The Priory Woking there was a lack of clarity and confusion among clinicians as to who was responsible for ensuring that banned and restricted items are identified and removed from a patient at admission, this is outside of NHS England's remit and I note that you have also addressed your Report to Priory Group who are the appropriate organisation to respond to this concern.

NHS England has, however, been sighted on Priory Group's Serious Incident Report regarding this matter and the resulting Action Plan and recommendations. I would like to provide some additional assurance that national guidance around risk assessments is currently being reviewed. I have also asked my regional colleagues to confirm whether Priory Woking now has access to GP records. NHS England is happy to provide further updates to the coroner in due course.

I would also like to provide further assurances on national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director