Mr James Bennet
The Birmingham and Solihull Coroner's Court
Steelhouse Lane
Birmingham
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[redacted]

National Medical Director
NHS England
Wellington House
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[redacted]

8 September 2023

Dear Mr Bennet,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Peter Fleming who died on 10 November 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 14 July 2023 concerning the death of Mr Peter Fleming on 10 November 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Peter's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Peter's care have been listened to and reflected upon.

This letter responds to the concerns raised in your report relevant to NHS England. It is not within NHS England's remit to respond to many of the concerns raised, particularly relating to Birmingham and Solihull Mental Health Trust (BSMHFT). NHS England has asked to be sighted on the responses from BSMHFT and Birmingham and Solihull Integrated Care Board (ICB) and will give due consideration to their responses.

Digital systems

In your Report you raised the concern that different health organisations use different digital systems that do not communicate with each other, and that GPs often do not get important patient updates from other primary care organisations.

Current GP systems are designed to be interoperable before being allowed to be used for patient care and as such are accredited under the Digital Care Services Catalogue which requires suppliers to meet relevant standards, including interoperability with other systems, which is a pre-requisite of being included on the catalogue. This has enabled almost all GPs (99%) to have the digital capability to share and receive medical information from a variety of care providers within the NHS. This quick and efficient way of relaying and transmitting information between clinicians should address the sharing of important clinical information. The NHS is working to further improve this capability to enable information to be automatically added into the GP Patient record as appropriate.

In addition, NHS England is also undertaking a programme of work that will enable the safe and secure sharing of an individual's health and care information as they move between different parts of the NHS and social care. A shared care record joins up

information based on an individual rather than an organisation, and is a safe and secure way of bringing an individual's separate records from different health and care organisations together. We are currently working on the interoperability of shared care records, to ensure that where systems are used, they can connect with each other.

GP checks on prescribed medication

You also raised a concern over the lack of resources at a national level for GPs to check that patients are collecting prescribed medication.

The dispensing notification used by pharmacies is for payment purposes and does not link back to the prescribing system. It is not used consistently by pharmacies as some use the notification system for when an item has been dispensed and is ready for collection, meaning the patient has not yet collected the medication and in fact may not collect it. Therefore, the system would not be a reliable way for the GP to check the patient's compliance with medication as there is no confirmation on the system that the patient is taking the medication as prescribed. Some prescribing systems may display compliance figures, but this is also dependent on accurately adding the medication to the patient record so that a daily dose can be calculated.

Resourcing

Your Report raised resourcing concerns, both at BSMHFT and of GP services. It is acknowledged that resourcing remains an issue across the NHS, with local services reporting over 112,000 vacancies.

In June this year, the NHS published its Long Term Workforce Plan, setting out how we will ensure that staffing is put on a sustainable footing over the next fifteen years to improve patient care. The plan sets out three core priorities; to improve training and education, ensure that we retain more staff, and to reform. The plan is underpinned by the biggest recruitment drive in NHS history.

Transformation of mental health services

In 2022, NHS England also established a new Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme. The programme's aim is to support cultural change and a reimagined model of care for the future across all NHS-funded mental health, learning disability and autism inpatient settings. It is underpinned by £36 million investment over three years and focuses on the following four themes:

1. Localising and realigning inpatient services, harnessing the potential of people and communities.
2. Improving culture and supporting staff
3. Supporting systems and providers facing immediate challenges
4. Making oversight and support arrangements fit for the sector.

I would like to provide further assurances on national NHS England 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,

National Medical Director