NHS England

Anita Bhardwaj
Liverpool and Wirra Coroner's Service
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Liverpool
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National Medical Director
NHS England
Wellington House
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[redacted] [redacted]

24 January 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Amirah Khalifa who died on 31 January 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 27 November 2023 concerning the death of Amirah Khalifa on 31 January 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Amirah's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Amirah's care have been listened to and reflected upon.

Your Report raises the concern that the current Summary Care Record (SCR) model does not appear to automatically flag drugs such as steroids which may have potentially fatal side effects when used long term. You also raised that the SCR does not have space for recording the clinical indication for initiation of certain drugs to aid future prescribers.

The National Care Records Service is the improved successor to the Summary Care Record application (SCRa). The NCRS has been developed gradually over the last 4-5 years, and as the NCRS product has matured, we have been migrating service users across from SCRa to NCRS throughout 2023.

NCRS provide a quick, secure way to access national patient information to improve clinical decision making and healthcare outcomes and it is free to use. It includes additional features and services beyond the legacy SCRa product. The service is a web-based application and can be accessed regardless of what IT system an organisation is using. NCRS provides access to an ever-increasing number of centrally provisioned national digital services that support the direct care of patients, including:

- Summary Care Records (SCR) - core and Additional Information
- National Record Locator Service (NRL) – pointers to and retrieval of data held in local provider systems.

Details of long-term conditions, significant medical history and the reason for any prescribed medication, should now be included by default for patients with an SCR, unless they have previously told the NHS that they did not want this information to be shared. For more information, and to illustrate the type of content included in an SCR, an example SCR is available here: Additional Information in the SCR.

It is also relevant to the circumstances of Amirah's care to note that NHS England has commissioned the Royal Pharmaceutical Society (RPS) and the Royal College of General Practitioners (RCGP) to develop tools and guidance to help primary care healthcare professionals to improve issues concerning repeat prescribing. This follows the publication in September 2021 of the Good for you, good for us, good for everybody plan to reduce overprescribing in England and to ensure that patients get the right treatment for their needs. The final toolkit is expected to be published in May 2024.

NHS England has also engaged with Cheshire and Merseyside Integrated Care Boad on the circumstances of Amirah's care raised in your Report and has been sighted on the Serious Incident Review undertaken by Liverpool University Hospitals NHS Foundation Trust ('the Trust'). As part of the review, the Trust has identified clear opportunities to prevent a similar incident occurring again and NHS England welcomes the actions outlined in the Trust's Improvement Plan. These include:

- Making the completion of the 'changes to Medication' part of Discharge Summary documentation compulsory.
- Ensuring that the indication for long-term steroid treatment is included in drug initiation, clerking documentation, discharge letters, medicines reconciliation and primary care records.
- Making the medicines section of clinical letters compulsory.

NHS England would refer you to the Trust for any further information on their review and action plan.

I would also 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,

[redacted]

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Medical Director for Professional Leadership and Clinical Effectiveness

NHS England