Department of Health & Social Care

From Karin Smyth MP
Minister of State for Health

39 Victoria Street
London
SW1H 0EU

Our ref: [redacted]

HM Coroner Andrew Barkley
Coroners Chambers,
Town Hall, Kingsway,
Stoke-on-Trent,
Staffordshire ST4 1HH
By email: [redacted]

25 July 2024

Dear Andrew,

Thank you for the Regulation 28 report of 31 May 2024 sent to the Department of Health and Social Care about the death of Ms. Glennis Connolly. I am replying as the Minister with responsibility for data in the NHS, on behalf of the Secretary of State for Health and Social Care.

Firstly, I would like to say how saddened I was to read of the circumstances of Ms. Connolly's death. I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to the attention of myself and the Department.

The report raises concerns over the fact that the Queens Hospital Burton Upon Trent and the Royal Derby Hospital have different electronic patient record systems, although governed by the same hospital trust. Entries made by the renal team at the Royal Derby Hospital were not automatically visible to medical staff at the Queens Hospital, and information on allergies did not automatically cross populate despite entries being made on the Lorenzo system and the GP records being updated.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission (CQC).

As you may be aware, NHS England has been supporting NHS Trusts and Foundation Trusts in acquiring and developing the effectiveness of their electronic patient records, with funding and support available to bring trusts to an optimum level of digital maturity.

The Queens Hospital Burton Upon Trent and the Royal Derby Hospital had secured their own electronic patient records independently when they were governed by separate trusts. Following their organisational merger, University Hospitals of Derby and Burton NHS Foundation Trust undertook to connect data to ensure patients could be identified across the two systems and information appropriately shared to support effective care. The failure of information sharing in respect to Ms. Connelly's treatment was clearly in part due to the challenge of still having two systems. The action needed to address this, which I am assured is underway, is for the hospitals to move to convergence and the Trust to have a single

electronic patient record system within the next two years. A provider has already been identified. This is a clinically assured process, with NHS England clinicians scrutinising the plans and support provided, to ensure safe implementation, as required by the Information Standard DCB0160: *Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems* (*DCB0160: Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems - NHS England Digital*).

More widely within the NHS the One Digital Estate programme will deliver increasing electronic patient record convergence and connection between hospital provider systems, and its implementation will be subject to clinical quality assurance, both centrally, and in the local trusts which are required to have the appropriate leadership, governance and capacity to safely deliver.

Where there is any death or serious injury at a provider or service registered by the CQC, the CQC will consider this in line with their specific incident guidance to identify if a patient has suffered avoidable harm or they were placed at significant risk of avoidable harm. This includes when there are issues relating to digital systems, and a specific incident review would consider the role of the system, as well as the registered providers involved.

Since receiving this Regulation 28 Report, the CQC has followed its usual processes and has reached out to the Trust requesting information on this death, alongside any response the Trust issued to yourself as HM Coroner. This information will be used in the decision making when considering the matter as a specific incident and if any further actions need to be taken by the CQC. The CQC continue to monitor this Trust through its usual regulatory powers.

I understand that the University Hospitals of Derby and Burton NHS Foundation Trust will be separately responding to the report and commenting on specific local action in their response.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

[redacted]

KARIN SMYTH MP