Ms Emma Serrano
Acting Senior Coroner
Stoke-on-Trent and North Staffordshire
Coroner's Service
Stoke Town Hall
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ST4 1HH

[redacted]

National Medical Director
NHS England
Wellington House
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SE1 8UG

[redacted]

3 March 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Alix Elizabeth Knowles who died on 9 December 2023

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 October 2024 concerning the death of Alix on 9 December 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Alix's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Alix's care have been listened to and reflected upon.

The first concern raised in your Report was that bank staff are not able to access patient notes before assessments. Individual healthcare providers determine the access levels that different members of staff have to different parts of their electronic patient records systems. This decision will be in line with each Trust's access policy and risk assessment, and is determined solely by individual healthcare providers. I note that you have also addressed your Report to Derby and Burton Hospital (Royal Derby Hospital) and Royal Stoke University Hospital and refer you to their responses on this matter.

Your second concern raised that different NHS Trusts are unable to access patient notes because the different computer systems in use do not allow this.

NHS Trusts are at differing levels of digital maturity regarding their Electronic Patient Records (EPR) system capabilities, with some having legacy systems that are not able to transmit information between systems in line with today's standards and expectations.

As a response to this, NHS England set up the Frontline Digitisation Programme (FLD) in 2021 and has been supporting NHS and Foundation Trusts in acquiring modern EPR systems and helping them develop their system's effectiveness once deployed. The FLD programme comes with substantial financial and specialist IT support to bring all Trusts to an optimum level of digital maturity.

The next phase of optimising digitisation in England is for the FLD programme to support increased EPR convergence across Integrated Care Boards (ICBs).

Implementation of this will be subject to assurance by Trust Boards collectively, which are required to have the appropriate leadership, governance and capacity for their safe delivery.

For information, local healthcare providers make the decision on which Electronic Patient Records (EPR) system to procure and deploy, and their decision may apply to either a single NHS organisation or across multiple NHS organisations within a single Integrated Care System (ICS) where convergence of EPR systems across an ICB or ICS is seen as the most beneficial model. These decisions are based on many factors including the required functionality, a system's suitability for the service specialities on offer, user experience, cost, and ease of information sharing. Today, there are already many examples where EPR records are shared seamlessly between provider organisations to enhance care provision.

However, there remain multiple reasons as to why information may not be openly accessible or shared with other healthcare providers. For example, this could be due to incompatibility between the version of the systems being used thus not enabling full data sharing, permission not being granted between organisations to share data due to concerns about data security or sensitivity of the material or not having patient permission to share data.

Patient handover and referral are two processes that are central to care and are expected to be effective regardless of the availability of digital records.

I would also like to provide further assurances on the 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 events, such as the sad death of Alix, are shared across the NHS at both a national and regional level and helps us to 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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National Medical Director