NHS England

Ms Linda Lee
Assistant Coroner for Coventry and Warwickshire
Warwickshire Justice Centre
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National Medical Director
NHS England
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7 January 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – John Frederick Doyle who died on 30 December 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 12 November 2024 concerning the death of John Frederick Doyle on 30 December 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to John's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about John's care have been listened to and reflected upon.

Your report raises concerns about a lack of understanding and awareness from non-specialist medical staff as to when and how to contact specialist renal hospitals. You have also raised concerns around coordination and consistency of care provided to patients as they are transferred from non-specialist hospitals to renal hospitals, as well as the information which is being provided to patients about their care and the options available.

Renal services are covered by NHS specialised commissioning services. A specialist Clinical Reference Group have developed service specifications that clearly define the standards of care expected from organisations providing specialist care for patients who undergo kidney transplantation, as well as patients with acute kidney injuries or those undergoing dialysis. Further information can be found here: NHS commissioning » Renal services.

Renal medicine is a specialist service that is delegated to individual Integrated Care Boards. My regional colleagues in the Midlands have been sighted on your Report, and have shared it with Coventry and Warwickshire ICB, for the appropriate oversight.

Getting It Right First Time (GIRFT) is a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. The Renal Medicine GIRFT also highlights the importance of having clear pathways in place: https://gettingitrightfirsttime.co.uk/wp-content/uploads/2021/09/Renal-Medicine-Sept21k.pdf

I note that your Report has also been sent to University Hospitals Coventry and Warwickshire NHS Trust (UHCW) and George Eliot Hospital NHS Trust (GEH). It is appropriate that the providers involved in John's care respond to the Coroner regarding the concerns raised which relate to local arrangements and process. NHS England has asked to be sighted on their responses and will consider these in due course and whether any further actions are required from our Specialised Commissioning Teams.

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 John, 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,

National Medical Director