NHS England

Ms Elizabeth Gray
HM Area Coroner
Cambridgeshire & Peterborough Coroner's Service
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

22 January 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Patricia Curtis who died on 2 April 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 4 December 2024 concerning the death of Patricia Curtis on 2 April 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Patricia's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Patricia's care have been listened to and reflected upon.

Your Report raises the concern that hospital discharge notes are not uniform across hospital Trusts. This carries the risk of essential patient information not being available to treating clinicians when a patient is received into a new clinical setting, leading to a potential delay in providing life-saving care and treatment.

Individual Trusts are responsible for their own discharge policies. However, the Hospital Discharge Service guidance and operating model, published by the Department of Health and Social Care (DHSC) in August 2020 and last updated in January 2024, details the national discharge requirements for all NHS Trusts, community interest companies, private care providers of acute care, community beds and community health services and social care staff in England. The guidance, which is based on successful discharge to assess principles, aims to ensure that all individuals are discharged from hospital in a safe, appropriate and timely way.

A set of role-based hospital discharge actions cards are also available, which summarise the responsibilities for key roles and staff members within the hospital discharge process.

NHS England has engaged with the Royal Papworth Hospital NHS Foundation Trust regarding your Report. We note that, in response to your concerns, their Discharge Planning Group have taken steps to improve their processes for ensuring that next of kin are updated on patient transfers. They advise that there were no concerns regarding the quality or format of their discharge summaries.

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 Patricia, 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]

National Medical Director