Department of Health & Social Care

[redacted]
Parliamentary Under-Secretary of State for Health Innovation and Safety

39 Victoria Street
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[redacted]

HM Coroner James Thompson
Gateshead and South Tyneside

[redacted]

06 March 2026

Dear Mr Johnson,

Thank you for the Regulation 28 report of 06/05/2025 sent to the Department of Health and Social Care about the death of John James Johnson**.** I am replying as the Parliamentary Under-Secretary of State with responsibility for data and technology, and I apologise for the delay in doing so.

Firstly, I would like to say how saddened I was to read of the circumstances of John Johnson's death, and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter. Thank you for the additional time provided to the department to provide a response to the concerns raised in the report.

The report raises concerns over multiple IT systems being used not just in one, but many NHS Trusts which makes it a matter of concern on a national scale as significant patient information may be overlooked switching between different clinical systems as well as slowing down clinical decision making which makes it more difficult to follow a patient's overall care.

In preparing this response, my officials have made enquiries with NHS England and the Care Quality Commission (CQC) to ensure we adequately address your concerns.

<u>NHS England Response:</u>

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 6th May 2025 concerning the death of John James Johnson on 22nd November 2023.

In advance of responding to the specific concerns raised in your report, I would like to express my deep condolences to John James Johnson family and loved ones. NHS England are keen to assure the family and yourself that the concerns raised have been listened to and reflected upon. Your concerns are as follows:

1. The hospital trust operates a variety of IT systems to document a patient's stay whilst in hospital. There is not one system which contained all the information generated during a patient's stay. This requires clinical users to switch between systems to gather all the necessary information which raises the potential risk of significant findings being overlooked. This slows down clinical decision making and makes it more difficult to follow a patient's overall care.
2. The X Ray report was returned to a department not then involved in his care. The use of multiple systems can create a risk around safe transfers of care for discharge or handover.
3. This issue is not confined to one individual trust, and the use of multiple systems is widespread across the National Health Service. Their use is well known to the national NHS responsible bodies.
4. Your concerns are not confined to the operations of one NHS Trust, as this risk appears to present nationally.

Queen Elizabeth II Hospital is managed by Gateshead Health NHS Foundation Trust and uses System C Medway EPR system (System C Healthcare Ltd) which was first deployed in 2012 and was found to meet the core standards of the Frontline Digitisation (FD) Programme. Gateshead Health NHS Foundation Trust subsequently received further funding through the FD Programme to support greater optimisation of its Electronic Patient Record (EPR).

Queen Elizabeth II Gateshead have used Philips Picture Archiving and Communication System (PACS) a Radiology information system (RIS) since 2014 which is integrated into their EPR thus any flags/notes applied to abnormal result in RIS are visible across departments using RIS and the EPR.

The Frontline Digitisation (FD) Programme enables provider organisations to procure EPR systems and provides guidance on their implementation to enhance local digital capability and interoperability, including the ability of different digital systems to communicate more effectively. However, these systems are typically configured and managed locally, in line with agreements between provider organisations and their technology suppliers. As a result, interoperability often varies depending on local infrastructure and information governance arrangements.

Where multiple digital systems, including EPR systems and RIS system are in use across a provider organisation, policies and procedures should be in place to outline expectations, advice, clinical record management, and handover of abnormal results to relevant individuals. Responsibility and accountability for the sharing of information held within electronic records, including across different systems, rests with each organisation through its established digital governance processes.

NHS England (NHSE) recognises that delayed information-sharing within and between care settings can contribute to delays in discharge, incomplete handovers, and less effective continuity of care. NHSE has developed and led the Frontline Digitisation (FD) Programme, which has supported provider organisations to adopt Electronic Patient Record (EPR) systems which support increased consistency in digital maturity but also improve information sharing within and between organisations.

The FD Programme not only enables organisations to purchase EPRs but also advises on safe and effective deployment. However, whilst the FD Programme supports investment into local digital capabilities, interoperability i.e. how different digital systems communicate with one another, is typically configured and managed at a local level, based on local arrangements between provider organisations (although regional centres will be cognisant of the wider catchment area) and their technology suppliers. As such, interoperability may vary depending on local infrastructure and information governance arrangements. Access and information contained within the Gateshead Health NHS FT record is determined by local policy and procedures.

All trusts have to use multiple systems which follow agreed technology standards for timely management of patient data and have mechanisms to manage multiple systems. For example:

Unified Integration Engines - Rather than connecting every system individually, trusts use a Trust Integration Engine (TIE). This acts as a central hub that translates data between different technologies (like blood test results and patient records) using messaging protocols such as HL7 and FHIR.

Adoption of Interoperability Standards - To ensure systems from different vendors can "speak the same language," the NHS mandates specific standards i.e.
Data Standards: Use SNOMED CT for clinical terminology and NHS Numbers as the universal patient identifier.

Communication Protocols: Rely on APIs (Application Programming Interfaces) to allow real-time data sharing between separate platforms.

Interoperability Toolkit (ITK): Are a set of national frameworks that provide developers with common specifications for system interaction.

The newly published Fit for the future: 10 Year Plan for England, sets out the government's plan for healthcare in England over the next 10 years, which includes a commitment to give patients 'a single patient record (SPR) – to enable more coordinated, personalised and predictive care.' However rather than build a SPR record from scratch, a likely solution may include even better interoperability between the many systems in operation as NHS England is aware of the challenge in sharing medical records and results within and between all organisations (including social care and commissioned organisations) that use different technologies.

CQC Response:

The Trust submitted Mr Johnson's death at the time as an incident in StEIS. Unfortunately, due to organisational and personnel changes CQC are unable to confirm whether it was discussed at the time with the Trust.

In relation to the matters of concern:

- The Trust was using a variety of IT systems to document a patient's stay in hospital. It required clinical users to switch between systems to gather all the necessary information.

CQC also understand that the use of multiple systems impacting safe transfers of care is a national issue.

- Mr Johnson's X-Ray was returned to a department not then involved in his care.

Following a fall, Mr Johnson presented to A&E in April 2022. The ED clinician requested a chest X-ray, where a suspicious mass in the lung was identified. This finding was flagged in the report comments, and with a red alert marker. The report was returned to the ED clinician; however Mr Johnson was by then under the care of the orthopaedic team. The ED clinician assumed the red alert was related to a fracture, and not suspected cancer. The orthopaedic department were not informed of the results, and Mr Johnson was not alerted or placed into the lung cancer pathway. The IT system did not allow the test result to be shared with multiple clinicians or different departments at the same time.

The Trust identified the failure to follow up the X-ray outcome with Mr Johnson and his family as a significant incident and subsequently followed the patient safety incident review process.

The Trust has undertaken work to make the multiple systems it uses as safe and effective as possible.

As part of a QI rapid process improvement group, the Trust developed a Standard Operating Procedure (SOP) which specifies how clinicians should handle results, for example, they should not be filed without recommended actions being completed. Additionally, the picture archiving and communication system has been upgraded, removing previous risks to the system. The Trust also conducted wider digital and quality improvements between 2022 and 2023.

CQC will continue to monitor the Trust's arrangements for ensuring diagnostic test results are shared with the right departments, and to prevent red flag warnings being missed in future. CQC will also share the learning internally with our National Professional Advisors for Urgent and Emergency Care to ensure that the UEC inspection methodology includes these arrangements.'

Department of Health and Social Care:

I agree that ensuring health and care professionals have access to a single source of digital information about the patients they are treating and caring for is vitally important to delivering the best care possible. The Department of Health and Social Care, and NHS England have programmes of work underway which should assist in preventing future deaths connected to this issue.

The Single Patient Record (SPR) will unify patient data from multiple sources into one easy-to-access platform for patients and clinicians. The SPR will bring together fragmented pieces of information, creating a single source of truth which improves care quality, reduces administrative burden, empowers patients and enables more effective use of health data for both care delivery and research. A single source of patient information will ensure that clinicians are able to view a patient's test results and diagnostic activity among other patient alerts, which will prevent important patient information from being missed by clinicians.

The SPR is designed to harmonise with existing data systems being used by healthcare professionals which will allow them to access the SPR through their existing clinical systems. Seamless data sharing through the SPR will significantly reduce administrative burden for clinicians. The Government's 10 Year Health Plan specifically commits to saving NHS staff an estimated 140,000 hours annually. This will free up valuable clinical time for clinicians to focus on direct patient care.

In addition to the SPR being a source for clinicians to access a patient's medical information in one place, the Data (Use and Access) Act 2025 builds upon the changes made in the Health and Social Care Act 2022 to enable improved integration between different IT systems across the NHS. The interoperability enabled by the changes in the Act would make it easier for all healthcare professionals delivering care to access accurate and complete information when they need it. These information standards will help ensure that patient data recorded across multiple IT systems are easy to read for clinicians and that no vital patient information is missed.

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

Yours sincerely,

Parliamentary Under-Secretary of State
for Health Innovation and Safety