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21 July 2025

Dear Mr Thompson,

Re: Regulation 28 Report to Prevent Future Deaths – Malcolm Morris who died on 5 January 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21 May 2025 concerning the death of Malcolm Morris on 5 January 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Malcolm's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Malcolm's care have been listened to and reflected upon.

Your report raises concerns around disjointed communication between hospital and community healthcare systems across different geographical areas and the impact this has on the efficiency of referrals to district nursing services.

My response has been informed by engagement with NHS England's North East and Yorkshire regional colleagues, NHS Pathways and National Patient Safety colleagues.

NHS England recognises that limited information sharing between care settings can contribute to delays in discharge, incomplete handovers and less effective continuity of care, particularly when patients receive support across organisational or geographical boundaries.

Over the past three years, NHS England has developed and led 'The Frontline Digitisation' (FLD) Programme, which has supported trusts in adopting electronic patient record (EPR) systems, and which nationally supports increased consistency in digital maturity and improves information sharing between and within organisations.

The FLD Programme not only enables organisations to purchase EPRs but also advises on safe and effective deployment. However, whilst FLD enhances local digital capabilities, interoperability (i.e. how different digital systems communicate with one another) is typically configured and managed at a local level, rather than being led nationally by NHS England. This will be based on local arrangements between provider organisations and regional centres, will be cognisant of the wider catchment area and will depend on the range of technology suppliers. As such, interoperability will vary depending on local infrastructure and information governance arrangements.

For safety reasons, the deployment of digital clinical systems, of which the EPR is one, requires health provider organisations to employ Clinical Safety Officers who undertake a full and detailed risk assessment regarding their deployment. Implementation plans should clearly state how certain circumstances, such as those described in this case, should be managed.

All healthcare provider organisations continue to have the need to be able to respond to all types of information flows (digital and paper) into and out of their organisation as they frequently work with, for example, smaller health and social care organisations, e.g. hospices who are yet be digitised. In other words, every digitised organisation needs to be able to receive and send care information in both digitised and non-digitised formats. Managing this is integral to the safe design of patient pathways and how a hospital discharges its care responsibilities, regardless of whether these care pathways are local, regional or national services.

For information, the Sunderland Royal Hospital, part of South Tyneside and Sunderland NHS Foundation Trust (STSFT), already has an EPR that meets the FLD Programme's core standards and has received funding as part of the FLD Programme to support optimisation of their EPR.

Northumbria Healthcare NHS Foundation Trust's (NHFT's) EPR had not met the FLD Programme's core standards and has therefore received funding as part of the Programme to extend functionality.

Both trusts are part of The Great North Care Record (GNCR), which shares healthcare data which should be available at the point of care. The type of information typically available on the GNCR includes - Clinical correspondence, Alerts, Appointments, Cellular pathology and Allergies.

To further support more consistent interoperability across the NHS, NHS England has developed the 'Booking and Referral Standard' (BaRS), which is a national framework designed to help digitise and standardise referrals and bookings across care settings, including urgent and emergency care (UEC), general practice, hospital, and community services.

BaRS is still in the very early stages of implementation, but it offers a significant opportunity to improve information flow, reduce missed handovers, and support timelier and coordinated discharges. Realising the full benefits of BaRS will require broad adoption across the health and care system, including provider engagement and supplier integration. This means that progress may be complex, slow, and shaped by wider policy, operational capacity, and investment considerations.

In the meantime, it remains essential that hospitals and local health systems have clear, clinically safe fallback processes for when digital interoperability is not yet in place, including robust discharge summaries and communication protocols to support safe, joined-up care.

Colleagues from our North East and Yorkshire regional team have been in touch with STSFT, who recognise that whilst your Report was issued to NHS England, there is still learning for the Trust in terms of improving discharge and referral processes for

outside of area patients. In response, their Incident Review Group recently commissioned a clinician review to look into the circumstances of Malcolm's hospital discharge and identify any necessary improvements. Once the learning has been established the report will be shared with North East and North Cumbria Integrated Care Board (ICB), with findings and/or any emerging actions to then be shared with NHS England.

NHFT acknowledges the challenges that the different digital infrastructures in place have on the quality of discharge arrangements, particularly when outside of their area. The Trust has commenced an audit of their Situation, Background, Assessment, Recommendation (SBAR) communication arrangements and has put in place a new hub model to better support clinical triage.

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 Malcolm, 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,

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Co-National Medical Director
(Secondary Care)