NHS
Bedfordshire Hospitals
NHS Foundation Trust

Mr Tom Osborne
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[redacted]

3rd September 2025

Dear Mr Osborne,

Re: Suzanne Edwards - Regulation 28 Report to Prevent Future Deaths

I am writing in response to your Regulation 28 Report to Prevent Future Deaths (hereafter "Report") issued on 1st August 2025 following the Inquest into the death of Suzanne Edwards held on 24th July 2025.

I would like to begin by extending my sincere condolences to the family of Mrs Edwards for their loss. I appreciate this will still be a very difficult time for the family.

In response to evidence heard at the Inquest you raised a concern in relation to Accident and Emergency Department clinicians not being able to access primary health care records, in this case GP records, upon a patient arriving at an Emergency Department. The Bedfordshire Hospitals NHS Foundation Trust (the Trust) would like to assure both you and the family that the concern raised in your report has been listened to and reflected upon.

This letter sets out the Trust's formal response.

Regulation 28 Concern

The matter of concern raised and responded to is as follows:

1. *Emergency Departments at hospitals in this and surrounding jurisdictions do not have reliable access to patients' primary care records, including recent GP consultations, investigations or concerns. This means that clinicians are frequently treating acutely unwell patients without full access to their recent medical history, which can delay or misdirect diagnosis and undermine patient safety and continuity of care and lead to avoidable deaths. Without access to a patients full records further lives may be put at risk.*

I understand that thankfully the care Mrs Edwards received at the Bedfordshire Hospitals NHS Foundation Trust was not affected by the concern you raise in the report. As a prompt diagnosis of a kidney stone was made and the clinical teams swiftly began treating the infection that had been caused by the obstructed kidney; including inserting a stent to relieve the blockage. Sadly, despite appropriate pre-operative care, surgery and optimal post-operative treatment in our Critical Care Complex, Mrs Edwards succumbed to septic shock.

I do of course recognise the risk you have identified that can result when primary and secondary healthcare providers cannot access each other's medical records. I welcome the opportunity to explain what access to Shared Care Records (including GP records) our A&E clinicians have at both the Bedford and Luton & Dunstable hospital sites. I hope this will assure you that Bedfordshire Hospitals NHS Foundation Trust clinicians do, as far as is possible, have access to primary care records to assist them in the diagnosis of conditions thus reducing the overall risk to patient safety and further mitigating the risk of future deaths.

Clinicians have access to three services:-

The Shared Care Record (ShCR)

The Shared Care Record (previously known as the Clinical Portal,) represents a collaborative effort between Bedfordshire Hospitals NHS Foundation Trust and the Bedfordshire, Luton and Milton Keynes Care Partnership (BLMK), originating in late 2019 and early 2020 in response to NHS England's mandate for regional Integrated Care Boards.

This platform facilitates the exchange of data among all BLMK health providers in a "read-only" capacity. The Shared Care Record consolidates healthcare information from various organisations into a unified, confidential electronic record. Only relevant and accessible healthcare data is shared on this platform for direct care purposes. Essentially, this provides a broader view of the patient's history to support joined up care.

It is important to note that patients can, through their GP practice opt out of data sharing which subsequently means that our clinicians will not be able to see their GP records. However, patients are automatically opted in unless they make the conscious decision to opt out.

GP Connect

This is a national NHS service that allows authorised clinicians to view the patient's primary care record so that they can review medications, allergies and any recent GP interactions. It also allows for the sending and receiving of data, for example, booking appointments or sharing information between services.

Our A and E clinicians have access to this part of the service via an internal hospital system called Viper and the Shared Care Record.

Summary Care Record (SCR)

This is a national NHS service which is automatically created from GP records. It contains key patient information such as medications, allergies and any previous adverse reactions a patient may have had. The SCR is primarily used in urgent or emergency care when GP records are not accessible. It is important to note that the patient has the option to opt out of their data being put on to the SCR.

These services have clear benefits for both the patients attending our hospital sites and the clinicians working within the Emergency Medicine setting.

Benefits of the three system to our patients include:-

- There are fewer steps for patients, this reduces the repetition of relaying information multiple times to different clinicians with the attached risk of missing something vital.

- Medication safety improvements; patients do not need to remember their full list of medication which may be extensive.
- Improved communication between referrers and service providers.
- Improved healthcare outcomes for patients, including patient experience.

Benefits to our Clinicians include:-

- Clinicians are able to make a better informed decision with more extensive information available at their fingertips.
- Increased productivity and efficiency as clinicians may not need to contact other sources, departments or services.
- An improved user experience and clinical satisfaction; our clinicians are able to do their job with the right information available to them resulting in positive interactions with patients.

It is not within the Trust's control to expand upon what patient information is shared on the services outlined above as the record is taken from the Summary Care Record and GP Connect. The extent of what is contained in the Summary Care Record is regulated by NHS Digital which forms part of NHS England.

There are unfortunately certain limitations to what can be accessed and shared without a single system for medical records which could be used nationally by all NHS Care providers; but we strive to ensure that what is available is easily accessible to our treating clinicians.

Thank you for bringing this important patient safety concern to my attention. As a Trust we are committed to working closely with our healthcare partners to ensure that data sharing happens, we all recognise the vital information sharing that is needed to effectively treat our patients.

Yours sincerely

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Chief Executive Officer