Kate Bisset
Area Coroner for
Lancashire and Blackburn with Darwen
Coroner's Court
2 Faraday Court
Faraday Drive
Preston
Lancashire
PR2 9NB

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

17th February 2026

[redacted]

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – John Graham Alston who died on 8th November 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5th December 2025 concerning the death of John Graham Alston (better known as Graham Alston) on 8th November 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Graham's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about the circumstances relevant to Graham's death have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Graham's family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raises concerns with the following:

1. Difficulties in sharing information for discharge processes between Integrated Care Boards (ICBs) when a person has moved to a new area. Inaccurate or unknown information about which commissioning service is responsible for a patient or care home resident can result in delays to accessing increased funding for support, services and more suitable placements.
2. The determination of the responsible funding ICB arises on a reactive basis when additional care or changes are required, rather than there being a proactive determination.

Determining the ICB with commissioning responsibility

NHS Greater Manchester (GM) ICB's Head Nurse for Quality and Personalised Care has reviewed your Report and provided NHS England with further information around this case. NHS Funded Nursing Care (FNC) is the funding provided by the NHS to care homes to support the provision of nursing care by a Registered Nurse for those

assessed as eligible (with reference to the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care 2022).

As per NHS England's 'Who Pays' guidance, when an individual is eligible for FNC but has moved out of the area, the FNC is transferred to the receiving out of area ICB that the patient resides in and has a registered GP in. Exceptions apply where the individual is in receipt of Continuing Healthcare (CHC) or where they have been detained under the Mental Health Act. In this case, the FNC was transferred from GM ICB to Lancashire and South Cumbria (LSC) ICB and accepted. LSC ICB was responsible for the care home resident, Mr Wright, from 17 April 2022.

As confirmed by GM ICB's Head Nurse, the social care aspect of an individual's care is commissioned by either the individual patient (dependent on financial assessment, determined by the Local Authority) or contributed to by the Local Authority. It is the Local Authority that typically commissions the majority of the placement (depending on an individual's health and social care needs and the type of funding in place) and sets up the contract with the provider.

In Mr Wright's case, it is understood that he remained an ordinary resident of Bolton despite being moved to Preston with health funding in place, which may have contributed to the confusion around the responsible commissioner when Mr Wright was discharged from hospital to Care Home Two.

Appendix 1 of the 'Who Pays' guidance sets out the principles where there is any disagreement about commissioning responsibility between ICBs and the formal dispute resolution process that should be followed where this cannot be resolved locally. This includes escalating disagreements to NHS England's regional or national teams.

Ultimately, the 'Who Pays' guidance is an essential document for ICBs in setting out the framework for establishing which NHS commissioner has responsibility for an individual's NHS care and should be referred to by ICB's at the earliest opportunity.

Information sharing between ICBs

The concerns raised in your Report around the difficulties in information sharing and the delays in identifying the responsible ICB would be best addressed by the ICBs involved, rather than NHS England. In particular, it would be for the ICBs to comment upon how they could implement a clearer system to appropriately communicate the position around commissioning responsibility to care homes, where a new resident has moved areas.

GM ICB's Head Nurse has advised that they have been unable to locate any correspondence on their system regarding Mr Wright from the period relevant to this case.

NHS England's North West regional colleagues have also contacted LSC ICB who outlined the learning that has taken place as a result of this case. This included

commissioning and publishing a Safeguarding Adults Review (SAR) by the Lancashire Safeguarding Adults Board (LSAB).

To drive forward learning, a task and finish group was convened, and a multi-agency action plan was put in place. LSC ICB took the opportunity for wider learning in respect of this case by reviewing the processes both for receiving and transferring residents in/out of area. As a result, LSC ICB have changed and refined processes to ensure that all relevant information is shared with the receiving ICB when transferring a Lancashire patient's funding.

LSC ICB is committed to working with receiving ICBs to ensure that the package is stable and meets the needs of the patient before transfer. As part of this review process LSC ICB now make clear to the Regulated Care Provider when responsibility has transferred to them in order to eliminate confusion on the commissioner of the package of care. The All Age Continuing Care teams will meet with transferring ICBs as required. Weekly case progression meetings are held internally to allow progress updates for all cases being transferred and follow up of outstanding actions. LSC ICB continues to identify patients who are transferred to Lancashire providers with unstable packages of care.

An assurance audit of the SAR actions is to be undertaken by the Quality Performance subgroup of the LSAB. Work is scheduled for the coming quarter and Quarter 1 2026/27.

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 Graham, 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
NHS England