Derby and Derbyshire Integrated Care Board
Lincolnshire Integrated Care Board
Nottingham and Nottinghamshire Integrated Care Board

Sir John Robinson House
Sir John Robinson Way
Arnold
Nottingham
NG5 6DA

27 February 2026

Confidential

[redacted]

Dr Elizabeth Didcock, Assistant Coroner,
for the coroner area of Nottinghamshire

Dear Dr Didcock

Re: Regulation 28 Report regarding the case of Mr Jake Kieran Hartwright

I am writing on behalf of NHS Nottingham and Nottinghamshire Integrated Care Board (NNICB) regarding the recent inquest into the tragic death of Jake Kieran Hartwright, which concluded on 12 December 2025 with a Regulation 28 (Prevention of Future Deaths) report issued. On behalf of the Nottingham and Nottinghamshire Integrated Care Board (ICB), I wish to extend our sincere condolences to Mr Hartwright's family.

The ICB proactively ensures that learning stemming from operational challenges translates into system-wide improvement. This includes assuring that learning from incidents is systematically captured, analysed, and translated into coordinated actions across partners; that cross-organisational interfaces are governed robustly; and that progress against improvement actions is monitored, evidenced, and embedded into ongoing quality oversight. We will also continue to oversee the governance of cross-organisational interfaces and track the sustainability of improvement actions, in line with expectations for sharing learning from Regulation 28 reports.

Actions taken to coordinate system learning and improvement
Following receipt of the report, the ICB facilitated a system wide After-Action Review (AAR) to enable collaborative learning and improvement across relevant partners.

The AAR identified improvement priorities relevant to system safety and reliability at service interfaces, including:

- The UCCH pathway may not consistently meet the needs of patients with serious systemic illness where disposition is a Category 3 response.

- Risks in information transfer and visibility, including whether information transferred into EMAS systems is consistently available and acted upon at decision points.
- The importance of clear patient/family communication where an ambulance will not be sent, including what to do next.
- Clarity of roles, skills and governance at points where Category 3 calls are reviewed/handled and transferred between services.
- The need for agreed criteria for transfer between services (including how prior clinical validation affects subsequent decision-making).

NNICB will use these identified themes to structure oversight and ensure improvement actions are coherent and measurable. As an ICB we have met jointly with both EMAS and NEMS to ensure that their planned actions (as described in their responses to the Regulation 28 report) are clear, time specific and address the issues above.

We have ensured the manual push remains paused and there are no plans for reinstatement of this pathway at this point in time, as not all actions agreed have been completed. Several codes that were being automatically transferred to NEMS by EMAS have also ceased since December 2025 and we are in the process of reviewing these with other similar services across the East Midlands to assess whether they should be removed on a larger scale.

As the commissioner of the UCCH we have also reviewed and redefined the existing service specification that is included in the contract we have with NEMS, ensuring that all learning has been included.

Our analytics team have recently developed the ability to join up multiple data sets that will from March 2026 allow us to understand the patient journey and outcomes across this entire pathway. This will support us to review and refine the journey for our patients, enhancing our ability to evaluate and adjust accordingly the service offer.

Actions and assurance
NNICB's oversight actions are aimed at ensuring that provider actions are coherent, measurable, sustained, and transparently governed across the pathway. Maintenance of this oversight and assurance will continue following the recommendations of oversight framework designed to identify where support is needed, with a focus on improving patient safety, experience, and outcomes. This will include a comprehensive quarterly review process on progress towards these actions.

As per the ICB's statutory responsibilities for PFD learning and assurance actions from this report will be shared and embedded in:

- ICB Joint Quality and Service Improvement Committee
- Provider review processes
- ICS System Learning from Deaths Forum
- Regional Quality Committee

We have also offered and committed to joining the clinical governance meeting set up between NEMS and EMAS to support the continued work between the two organisations.

Yours sincerely

Chief Executive
NHS Derby and Derbyshire, Lincolnshire and Nottingham and Nottinghamshire ICBs