

**National Medical Director** 

NHS England & NHS Improvement Skipton House 80 London Road London SE1 6LH

Miss E Serrano
Assistant Coroner for Derby and
Derbyshire Coroner's Area
St Katherine's House
St Mary's Wharf
Mansfield Road
Derby

8th February 2021

Dear Miss Serrano,

## Re: Regulation 28 Report following the Inquest touching upon the death of Maureen Brown

Thank you for your Prevention of Future Deaths Report (the "report") dated 4<sup>th</sup> February 2019 concerning the death of Maureen Brown. I am sorry for the significant delay in our response. Please share my deep condolences with Mrs Brown's family.

The regulation 28 report concludes Mrs Brown's death was a result of

1a Subdural haemorrhage due to; 1b Fall

Following the inquest you raised concerns in your Regulation 28 Report to NHS England relating to the Trust and national handover processes. I understand that the Trust has responded to address the specific learning with regard their own internal patient transfer processes.

In your report you express concern that "the national policy still states the only piece of information necessary for a transfer is the electronic transfer information". I am assured by my colleagues at NHSX that there is a national Minimum Dataset (MDS) for transfers of patients between hospitals; <a href="Inter-Provider Transfer Administrative Minimum Data Set">Inter-Provider Transfer Administrative Minimum Data Set</a>. This is overseen by NHS Digital. This does not relate to transfers of patients between wards within a single healthcare provider (a Trust in this case) and in such circumstances Trusts would be expected to have their own policies and protocols to govern the minimum data provided between departments to facilitate an effective transfer of patient information, following relevant clinical standards. On that basis, the actions taken by University Hospitals Of Derby And Burton NHS Foundation Trust would be relevant to your concerns.

There is no national policy for a Minimum Dataset for inter-hospital transfers, as was the case in Mrs Brown's care, and where these occur it would be incumbent on the Trust or provider to ensure they have robust handover and transfer of information procedures. My Regional Colleagues have had assurance from the Trust of the changes they have made and the response to learning that has been implemented.

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