



Interim report

Electronic referrals for ongoing care: risk of losing patient referrals

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Theme:

Access to care, Follow-up care, Continuity of care

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A note of acknowledgement

We would like to thank the many people who continue to contribute to this investigation. Staff across provider organisations, integrated care boards and national bodies have made themselves available to the investigation in support of the findings and learning.

About this report

This report is the second interim publication in HSSIB's investigation into [electronic patient record systems – electronic referrals for ongoing care](#). In response to patient safety concerns heard by HSSIB, this report focuses on the risk to patients when they 'disappear' from, or 'drop off', worklists held within the electronic referral service (e-RS).

The first interim publication was produced in August 2026. It considered [advice and guidance services and single point of access models](#). A final publication as part of HSSIB's investigation into electronic referrals for ongoing care is planned for 2027.

This report is intended for patient safety, digital and leadership teams in healthcare provider organisations that make or receive electronic referrals through e-RS, including general practice and secondary care organisations. It is also relevant to independent healthcare providers that use e-RS, and to those who commission and oversee services and care pathways at regional and national levels.

Technical language relating to referral processes and electronic systems is used within this report. Due to variation in the terminology used, a glossary of terms and their use in this report is provided in section 3.

Executive summary

This is the second interim report in HSSIB's investigation into [electronic patient record systems and electronic referrals for ongoing care](#). It has been published to highlight a risk to patient safety associated with the electronic referral service (e-RS), where referrals may be removed from healthcare provider organisation worklists without warning or recognition.

The e-RS system generates digital worklists, which are used by provider organisations to manage patient referral processes. Referrals are automatically removed from a provider's worklist within e-RS when a user performs an action, like accepting a referral or booking a patient appointment, or when 180 days pass with no action since the unique booking reference number (the patient referral) entered a worklist.

The 180-day function was designed into e-RS to reduce the risk of large worklists affecting the performance of the service. However, the investigation found that the function also creates a hazard to patients.

Findings

- Incidents were identified in which referrals disappeared from e-RS worklists without provider organisations' knowledge. These included referrals that disappeared for unknown reasons and those automatically removed after 180 days without action, before patients had been booked for appointments.
- There is an ongoing risk that patients may experience missed or delayed care as a result of the 180-day function. The level of risk is difficult to determine but has potentially increased in light of demands on outpatient services and longer waits for appointments.
- The 180-day function is not new, but recognition of it as a hazard to patient safety has not been formally documented. At the time of writing, available national digital clinical risk documentation for e-RS (in line with the DCB0129 digital clinical safety standard) did not refer to the function.
- e-RS was not designed to manage the current volume of referrals seen across the NHS, particularly since the COVID-19 pandemic. The 180-day function was heard to be necessary and the associated risk cannot currently be eliminated.
- Management of the risk created by the 180-day function has been delegated to provider organisations. The investigation identified gaps in organisational knowledge about the function and, as a result, gaps in how the risk is managed.
- Local management of the risk relies on administrative processes, which vary in their formality and effectiveness. Where processes have been weakened by reduced administrative capacity or unclear roles and responsibilities, repeat incidents have occurred.

- Providers deploying e-RS were unable to provide evidence that they had achieved compliance with required digital clinical safety standards (as set out in DCB0160). The deployment of e-RS into local pathways, and the risks associated with that deployment, had not been assessed.

HSSIB notes the following safety action

Safety action A/2026/003:

NHS England, as the supplier of the electronic referral service, is reviewing and updating the associated digital clinical risk management documentation (in line with the DCB0129 digital clinical safety standard) to recognise the hazard associated with the 180-day function. This will be made available to provider organisations to support local assessment and management of associated risks to patient safety.

Local-level learning

HSSIB investigations include local-level learning where this may help provider organisations respond to a patient safety issue at the local level. Informed by the findings in this report, the investigation shares the following prompts to help provider organisations manage risks, including those associated with the 180-day function.

- Does your organisation have a responsible clinical safety officer for the electronic referral service (e-RS)?
- How does your organisation support collaboration between digital, patient safety, patient experience and complaint teams to identify incidents where patient referrals may have been lost?
- Has your organisation formally assessed and documented the clinical risk of patients disappearing from e-RS worklists, including as a result of the 180-day function?
- Has your organisation developed and evaluated measures to reduce risks to patient safety created by the 180-day function in e-RS?
- Does your organisation meet the DCB0160 digital clinical safety standard requirements for e-RS deployment and ongoing use, including maintaining a local hazard log?
- What local processes has your organisation formally established to identify, validate and manage referrals that have dropped off e-RS worklists?

- Does your organisation routinely review the EBSX12 weekly worklist drop-off extract and act on the findings?
- How does your organisation assess whether administrative processes for managing referrals, reviewing worklists and validating dropped-off referrals remain effective, including during periods of staffing change or service pressure?
- How does your organisation learn from incidents where patients are lost within referral processes, including where referrals have dropped off worklists, to strengthen the resilience of referral management?

1. Background

This section provides the background for this interim report and the rationale for why it was published.

1.1 Focus of this report

1.1.1 During evidence gathering for HSSIB's investigation into [electronic patient record systems – electronic referrals for ongoing care](#), the investigation identified patient safety incidents where patients had disappeared from or 'dropped off' worklists in the electronic referral service (e-RS). This delayed care because it was not identified until later that the patients were no longer visible on those lists.

1.1.2 NHS England told the investigation that e-RS functionality automatically removed patients from worklists under certain circumstances (see 1.2.6), and that provider organisations were required to manage any risk locally.

1.1.3 This interim report has been published because the investigation identified limited evidence that all provider organisations using e-RS were aware of this functionality, and because evidence indicated that the risk was not always being managed.

1.2 Referrals for specialist care

1.2.1 The General Medical Council (2024) defines a 'referral' as 'when you [a healthcare professional] arrange for another medical, health, or social care professional or a service to take over part or all of the care of a patient'. HSSIB's investigation into [electronic patient record systems – electronic referrals for ongoing care](#) has predominantly focused on referrals from general practice to NHS acute outpatient services.

1.2.2 Referring patients from general practice to specialist care is a common process, with around 400,000 referrals made each week in England (NHS England, 2026a). The number of patients who require specialist assessment has been increasing, which in turn impacts on the length of time it takes for patients to see a specialist (Nuffield Trust, 2026).

1.2.3 Referral processes have the potential to cause harm when patients miss out on, or experience delays to, the care they require. Research by Healthwatch (2025), for example, found that one in seven people ended up in a 'referral black hole' – where a referral was delayed, lost, rejected or not sent – with three in four reporting a negative impact on their health and wellbeing. These situations may have a disproportionate impact on some people, particularly those who face challenges advocating for themselves or navigating the healthcare system (Dehn Lunn et al, 2026).

Electronic referral service (e-RS)

1.2.4 In England, e-RS is widely used to refer patients to specialist providers; it is used across different parts of the NHS and by independent providers. It is a web-based digital platform supplied by NHS England (2026a) that provides functionality for creating referrals, holding advice and guidance conversations, and reporting on referral processes. The NHS Standard Contract (2026) includes a requirement for e-RS to be used for all general practice referrals to NHS acute outpatient services.

1.2.5 e-RS generates 'worklists' to help users to manage patient referral processes. Different types of worklist are available and are accessible to users depending on their association with a service. For example, the 'appointment slot issue' (ASI) worklist contains referrals where there are no slots available for booking at the time of the appointment search.

1.2.6 NHS England (2025b) expects all referrals on e-RS worklists to be managed efficiently, added to a provider's waiting list or patient tracking list, and clinically triaged. Referrals remain on a provider's worklist in e-RS until one of these events occurs:

- an appropriate action is recorded on e-RS to manage the referral
- an appointment date passes (specific to the 'referrals for review' worklist)
- 180 days pass with no action since the unique booking reference number (the patient referral) last entered the worklist (NHS England, 2025b).

Digital clinical risk management

1.2.7 The NHS England (2018a; 2018b) digital clinical safety standards (DCB0129 and DCB0160) provide frameworks for identifying, assessing and managing clinical risks associated with health IT systems. Compliance with these standards is mandated under the Health and Social Care Act 2012. The standards were under review at the time of this investigation.

1.2.8 The standards require suppliers and organisations to have a suitably qualified clinical safety officer and to maintain a clinical risk management file for a health IT system, such as e-RS. This file must include a risk management plan, hazard log and clinical safety case. A clinical safety case presents evidence that a system is safe for a given application, in a given environment, at a defined point in its lifecycle (NHS England, 2025a).

1.2.9 DCB0129 applies to health IT system manufacturers and suppliers. It requires them to design and develop systems in a way that anticipates and mitigates potential safety hazards (NHS England, 2018a). DCB0160 applies to organisations deploying and using health IT systems. It requires them to ensure that a system is safe in the context of local workflows, configuration and use in practice (NHS England, 2018b). DCB0129 requires the manufacturer or supplier to make each clinical safety case, including the hazard log, available to organisations to support local risk analysis.

2. Analysis and findings

This section describes the investigation's findings from examining the risk associated with electronic referral service (e-RS) functionality that automatically removes patient referrals from worklists. The terms used align with the terminology in NHS England's (2018b) digital clinical safety standard.

2.1 The hazard

2.1.1 A hazard is a potential source of harm to a patient (NHS England, 2018b). In relation to e-RS, the hazard of focus in this report is the '180-day function'.

2.1.2 The hazard is that referrals are automatically removed from e-RS worklists when 180 days have passed without action against the entry. This has the potential to cause harm to patients if a referral is removed without knowledge before plans have been put in place to manage the patient's referral.

2.1.3 The 180-day function has existed since 2004 and was part of the original Choose and Book platform before it was replaced by e-RS in 2015. NHS England told the investigation that the 180-day function was included to manage the risk of degraded performance of the service from large worklists containing unprocessed referrals. Requests had been received to extend the function but this was heard to not be feasible for service performance reasons.

2.2 The clinical risk

2.2.1 A clinical risk is a combination of the severity of harm to a patient and the likelihood of that harm occurring (NHS England, 2018b). For the hazard above, this means harm to patients resulting from a missed referral if it is no longer visible on an e-RS worklist, and the likelihood this could occur.

2.2.2 The investigation looked to understand the risk associated with the 180-day function by examining incident reports and engaging with national stakeholders, provider organisations and clinical safety officers (CSOs). A small number of related incidents were identified since 2018, including:

- Seventy-two referrals on an appointment slot issue (ASI) worklist ‘disappeared from booking teams’ view’ (reported 2018).
- More than 1,000 patients had ‘potentially dropped off the e-RS ASI worklist’ (reported 2019).
- Around 1,000 patients needed to be added back onto a worklist after ‘dropping off’ after a 6-month period, having not been booked into an appointment because of clinic capacity constraints (reported 2023/24).

2.2.3 During review of incidents, the investigation noted repeated reports by the same organisation where initial learning had not prevented recurrence. Incidents were commonly recognised only after general practice raised concerns that patients had not heard from the provider about their referrals, or where the patient had made a complaint.

2.2.4 Across the incidents, no harm, or no known harm was reported. However, during engagement with providers, concerns were shared that harm may be under-recognised – such as where a patient’s symptoms had been prolonged or where more invasive treatment may have been avoided if a patient had been seen earlier. The investigation also heard evidence of psychological harm to patients, and fear among staff that they may “lose” patients from lists.

2.2.5 The investigation also identified incidents in which patient referrals were no longer visible in e-RS for unknown reasons. Some were attributed to referrals being inadvertently removed or required actions not being completed, while the causes of others could not be identified. These incidents will be considered further as part of HSSIB’s wider investigation into [electronic referrals for ongoing care](#).

Determining the level of clinical risk

2.2.6 The investigation identified that the hazard presents a risk to patient safety. While reported incidents did not describe evidence of actual harm, the investigation heard about the potential for harm to occur from missed or delayed care, and that harm may be underestimated. The incidents also affected a large number of patients.

2.2.7 The investigation noted several challenges with reported incident data that made it difficult to identify whether other incidents and harm had occurred across England. Those challenges included:

- that the free-text nature of incident reports resulted in variation in data quality and completeness. This affected the extent to which hazards could be identified through searches in the Learn from Patient Safety Events service (NHS England, 2026b). The same issue was identified when searching for incidents relating to [advice and guidance](#).
- the investigation found examples where CSOs in organisations that used e-RS to manage referrals were not aware of the hazard. Incidents therefore may not be recognised, and may have been “hidden” and not reported.

Changing level of risk

2.2.8 The investigation heard from CSOs that the risk created by the 180-day function had potentially increased in recent years because of growing demand for, and capacity issues within, outpatient services. CSOs reflected that, in previous years, there were limited delays in allocating patients to clinic appointments. However, clinic capacity challenges were now common.

2.2.9 NHS England described how COVID-19 had impacted on outpatient services. Before the pandemic, provider organisations had been better able to manage referrals promptly meaning that referrals were not held on e-RS worklists for prolonged periods. Between 2019 and 2025, e-RS has seen around a 40% increase in referrals compared to the 2019 baseline, and around a 60% increase in referrals on ASI worklists (NHS England, 2026a).

2.2.10 NHS England provided data on the number of e-RS entries automatically removed from worklists after 180 days. Between February and July 2026, 12.4 million referrals and requests for specialist advice were submitted through e-RS. Of these, more than 1.3 million entries were removed from worklists.

2.2.11 NHS England clarified that approximately 10% of the 1.3 million entries removed between February and July 2026 (127,450 entries) were from ‘inbound’ worklists containing new referrals received by provider organisations. These included advice and guidance requests, referrals for review and ASIs. The national data did not show whether these referrals had undergone local review or processing before they were removed. The remaining 90% of entries were removed from other worklists. NHS England described that referrals on these other worklists were likely to have undergone some form of local review or processing.

2.3 Clinical risk control

2.3.1 Clinical risk controls are the measures used to reduce clinical risks to, or maintain them within, specified levels (NHS England, 2018b). The 180-day function was designed as a control to the hazard of e-RS service disruption, as described in 2.1.3. NHS England told the investigation that it was the responsibility of provider organisations that deploy and use e-RS to undertake clinical risk management in line with DCB0160 (see 1.2.7) and manage any risk created by the 180-day function through local controls.

2.3.2 In support of managing the risk, national stakeholders highlighted the importance of provider organisations managing referrals efficiently to ensure they are moved from worklists and allocated to patient tracking lists and triaged; this includes minimising ASIs (see NHS England, 2025c). The investigation saw this being managed in different ways, including through the use of various 'workarounds' that will be considered in HSSIB's wider focus on [electronic referrals for ongoing care](#).

2.3.3 NHS England (2025b) further describes that providers 'should utilise the weekly worklist drop-off (EBSX12) extract to ensure all referrals are being managed'. EBSX12 is an extract from e-RS that includes all referrals from the previous reporting week that have 'dropped off' any provider worklist after 180 days of no activity since arriving on the worklist. The extract was introduced (June 2020) in response to the changing circumstances created by COVID-19 (see 2.2.9). The EBSX12 extract was confirmed to not be monitored at a national level as the ability to manage the risk was held at a provider level. The investigation saw examples where providers were reviewing this extract and validating whether patients required any further actions – some of the examples involved formalised processes and regular reporting.

National clinical risk management

2.3.4 At a national level, the investigation heard that the 180-day function was itself a control intended to reduce the risk of e-RS service disruption. NHS England further confirmed that it was not technically feasible to extend the 180-day timeframe because e-RS was not designed to manage the backlog of referrals currently being seen in the NHS.

2.3.5 NHS England confirmed that the 180-day function was communicated to provider organisations through the e-RS onboarding process, along with information about the function and the EBSX12 extract on NHS England's (2025b) website. It was recognised that an onboarding for some organisations may have taken place many years ago and memory of the function may have been lost.

2.3.6 Copies of onboarding materials and clinical safety documentation for e-RS, as required under DCB0129, were shared with the investigation. The onboarding materials noted that worklists should be monitored and that referrals would be removed after 180 days if no action was taken.

2.3.7 The investigation reviewed the national e-RS hazard log (version 1.3, January 2024). No reference to the 180-day function was identified. NHS England confirmed that the live version of the hazard log did not contain a reference to the function; the investigation was unable to fully ascertain why this was the case, but heard concerns about previous governance arrangements.

2.3.8 The investigation received confirmation from NHS England that the hazard log for e-RS was being rewritten, and was currently in draft form pending publication. In the draft version, the 180-day function was seen to be included in relation to reducing the risk of e-RS service disruption due to worklist size.

2.3.9 NHS England told the investigation that it plans to develop e-RS over the coming years into a single national referral and appointment service across all care settings. Greater interoperability between e-RS and providers' EPR systems was expected to reduce the risks associated with the 180-day function. Connecting the systems would support secure information exchange and allow providers to manage worklists within their EPR systems, rather than across multiple systems. NHS England is supporting this work through guidance and funding, including capital funding for 20 integrations in 2026/27.

2.3.10 NHS England also told the investigation that, currently, where interoperability between e-RS and an EPR system was not available, provider organisations must have local processes in place to ensure that referrals and requests for specialist advice submitted through e-RS are managed in a timely way.

Local clinical risk management

2.3.11 At a local-level, the investigation found that none of the provider organisations it engaged with could provide evidence that digital clinical safety standard requirements under DCB0160 had been met for e-RS. Some did not have a CSO responsible for e-RS as it was considered a national product.

2.3.12 The reasons for the limited evidence of clinical risk management of e-RS were explored in HSSIB's report on [advice and guidance](#). Limited evidence meant the assessment and management of the risk associated with the 180-day function had not been formally documented. Several CSOs also said that they had not seen a copy of the national DCB0129 documentation – as described in 2.3.7, the function was not included in the available national hazard log.

2.3.13 In the absence of digital safety documentation for e-RS in providers, the investigation sought evidence that provider organisations using e-RS to manage referrals were aware of the hazard, understood the potential risk to patient safety, and had processes in place to manage that risk. Several organisations recognised the risk and had documented administrative procedures to identify referrals that had dropped off worklists and validate whether further action was required to manage patients' care. These organisations also highlighted that e-RS does not alert users when entries drop-off worklists, so entries "just disappear". The investigation also found that some organisations were unaware of the hazard and/or were unclear whether they were effectively managing the risk, or reviewing the EBSX12 extract.

2.3.14 The investigation also noted repeat incidents in some provider organisations, suggesting that local administrative processes that had been developed to control the risk had not been effective in preventing recurrence. Examples included where reduced administrative capacity, and unclear roles and responsibilities for managing dropped-off entries, had contributed to patients being 'lost'. The investigation also heard concerns from providers that reductions in administrative staffing levels (see HSJ, 2026) had the potential to impact on risk controls such as those required for the 180-day function.

2.4 Summary and learning

2.4.1 The investigation found that the 180-day function in e-RS created a risk to patient safety with the potential to contribute to missed or delayed care. The likelihood associated with that risk has potentially increased because of the growing number of referrals and challenges to outpatient capacity. The investigation also noted other examples of where referrals had become no longer visible in e-RS worklists but for unknown reasons.

2.4.2 The 180-day function is a control to reduce the risk of e-RS service disruption but, within the context of high demand for healthcare services, is also itself a hazard. Ideally, risk management activities would look to eliminate risk by removing the potential for referrals to be automatically removed from e-RS worklists. However, the investigation heard that e-RS in its current form would not be able to sustain the volume of entries it contains without this function.

2.4.3 Management of the risk created by the 180-day function requires provider organisations to identify the risk and ensure controls are in place. However, the investigation found limited evidence that all provider organisations were aware of the existence of the hazard, had assessed the risk, and/or had controls in place. Gaps in communication of the hazard to organisations were noted, including the lack of any reference to it in the national e-RS hazard log.

HSSIB notes the following safety action

Safety action A/2026/003:

NHS England, as the supplier of the electronic referral service, is reviewing and updating the associated digital clinical risk management documentation (in line with the DCB0129 digital clinical safety standard) to recognise the hazard associated with the 180-day function. This will be made available to provider organisations to support local assessment and management of associated risks to patient safety.

2.4.4 The investigation also found gaps in local digital clinical risk management processes in line with the digital clinical safety standards (under DCB0160); this has also been described by other HSSIB investigations, including around [advice and guidance](#). These gaps meant hazards and risks to patient safety associated with e-RS had not been formally assessed within provider organisations, and controls had not been formally documented.

2.4.5 The investigation recognises that administrative processes are relatively weak clinical risk controls because they may not operate consistently, as demonstrated by the repeated incidents identified. However, they are currently the only controls available to provider organisations for managing the risks associated with the 180-day function. Provider organisations must therefore formalise and monitor these processes.

Local-level learning

2.4.6 HSSIB investigations include local-level learning where this may help provider organisations respond to a patient safety issue at the local level. Informed by the findings in this report, the investigation shares the following prompts to help provider organisations manage risks, including those associated with the 180-day function.

- Does your organisation have a responsible clinical safety officer for the electronic referral service (e-RS)?
- How does your organisation support collaboration between digital, patient safety, patient experience and complaint teams to identify incidents where patient referrals may have been lost?
- Has your organisation formally assessed and documented the clinical risk of patients disappearing from e-RS worklists, including as a result of the 180-day function?
- Has your organisation developed and evaluated measures to reduce risks to patient safety created by the 180-day function in e-RS?

- Does your organisation meet the DCB0160 digital clinical safety standard requirements for e-RS deployment and ongoing use, including maintaining a local hazard log?
- What local processes has your organisation formally established to identify, validate and manage referrals that have dropped off e-RS worklists?
- Does your organisation routinely review the EBSX12 weekly worklist drop-off extract and act on the findings?
- How does your organisation assess whether administrative processes for managing referrals, reviewing worklists and validating dropped-off referrals remain effective, including during periods of staffing change or service pressure?
- How does your organisation learn from incidents where patients are lost within referral processes, including where referrals have dropped off worklists, to strengthen the resilience of referral management?

3. Glossary

Advice and guidance (A&G)	A&G services enable clinicians in general practice to seek specialist advice about a patient's care, either before or instead of referring them to hospital.
Clinical safety case	A structured argument which is supported by a body of relevant evidence that provides a compelling, comprehensible, and valid case that a health IT system is safe for release (NHS England, 2025a).
Controls	Measures used to reduce clinical risks to, or maintain them within, specified levels (NHS England, 2018b).
Digital clinical safety/ risk management	The identification, assessment and management of risks to patients from the development, deployment and use of health IT systems (NHS England, 2018a; 2018b).
Digital healthcare	Use of IT systems, data and digital tools to support the delivery of healthcare and high-quality patient outcomes.
Electronic patient record (EPR)	Software for collecting, storing and managing data about individual patients.
Electronic referral service (e-RS)	A web-based digital platform for referring patients to specialist providers. It is supplied by NHS England (2025b). e-RS provides functionality for creating referrals, having A&G conversations and creating reports for oversight.
Functionality	

	The features of an IT system, such as EPR software, and its ability to enable users to achieve their goal.
Hazard	A potential source of harm to a patient (NHS England, 2018b).
Health IT system	Technology used in a healthcare organisation to collect, store, use and share patient and organisational data. The term includes software, hardware and networks, to support clinical, administrative, and operational functions.
Learn from Patient Safety Events (LFPSE) service	A national NHS system for recording and analysing patient safety events that occur in healthcare.
Provider organisations	Used in this report to specifically refer to organisations that provide patient-facing healthcare, such as general practices and hospitals.
Referral	When arrangements are made for another medical, health, or social care professional or a service to take over part or all of the care of a patient (General Medical Council, 2024).
Risk	A combination of the severity of harm to a patient and the likelihood of that harm occurring (NHS England, 2018b).
Software	Components of IT systems including programs, procedures and routines that instruct hardware on how to run tasks.
Stakeholders	Individuals, groups and organisations that contributed to the investigation.
Worklists	Digital lists generated within e-RS to support referral management. Multiple worklists are available and are accessible to users depending on their association with a service.

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5. Appendix

Investigation approach

HSSIB's investigation into [electronic patient record systems – electronic referrals for ongoing care](#) was launched in January 2026. The evidence sources used were described in the [appendix](#) of the first interim report of this investigation.

The specific data searches for this interim report are described in table A.

The investigation also engaged with NHS England throughout.

Table A Evidence gathering and engagement

Evidence source	Details
Strategic Executive Information System – serious incidents	Incident date: 2018 – 2026. Search date: 28 August 2026. Description: Structured searches to identify incidents including free-text descriptions of referrals using key words including: 'drop off', 'lost', 'disappear', 'electronic referral service' (e-RS/eRS), and '180'. Findings: 4 reports clearly associated with investigation focus: 2018 (n=1), 2019 (n=2) and 2023 (n=1).
Learn from Patient Safety Events service	Incident date: February 2026 – August 2026. Search date: 28 August 2026, updated 2 October 2026. Description: Structured searches to identify incidents including free-text descriptions of referrals using key words including: 'drop off', 'lost', 'disappear', 'electronic referral service' (e-RS/eRS), and '180'. Findings: No further incidents related to 180-day function identified. 2 incidents identified where referrals were not visible for other/unknown reasons.
Reports to prevent future deaths (PFD)	Incident date: not applicable. Search date: 30 September 2026. Keywords: electronic referral service (e-RS), 180, drop off, referral lost. Findings: no reports clearly related to the investigation focus.

