Mrs Lydia Brown
Acting Senior Coroner
West London Coroner's Service
25 Bagleys Lane
Fulham
London
SW6 2QA

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

[redacted] [redacted]

6 October 2022

Dear Mrs Brown

Re: Regulation 28 Report to Prevent Future Deaths – Angela Maguire who died on 8 April 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 1 June 2022 concerning the death of Angela Maguire on 8 April 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Angela's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Angela's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise to the family for the delay, as I appreciate this will have been an incredibly difficult time for them.

Following the inquest, you raised concerns in your Report regarding there being no system for sharing radiology across the Region, meaning that the previous images taken at Queen Mary's Hospital, London, could not be accessed across a common link by Kingston Hospital, Surrey. It was noted that there are many shared systems in place in the NHS for cross-site sharing of images and reports, and it was not clear why similar systems are not currently in place for this Region and are not anticipated for "several more years". Whilst this issue did not impact on the outcome in this case, it could have very significant consequences and lead to missed diagnoses and potentially fatal outcomes of untreated disease processes. In Angela's case, the opportunity to offer palliative care and advise her relatives of end of life treatment was lost.

The NHS Long Term Plan committed to establishing Imaging Networks across England by 2023. Currently, the 22 Imaging Networks across England are being supported to increase their maturity, with a specific focus on the sharing of imaging history, reports and the images themselves.

The National Imaging Strategy, published here in November 2019, outlined how the formation of Networks would improve access to specialist opinion and introduce

technologies to allow all digital images acquired within the Network to be managed by a single shared worklist, allowing them to be shared and reported by any organisation within the Network or beyond. This would ultimately result in better access for patients to imaging services, and would allow greater collaboration with clinical pathways so that patients can engage with treatment earlier.

Each Imaging Network is responsible for assessing their own maturity against a maturity matrix, with the aim of having **70% at a "Maturing" level by the end of the financial year 2024/5.** By reaching a "Maturing" level, this means that the Networks will be "jointly working across the Network with the implementation of a network level plan underway".

At maturing level, Networks will enable Trusts to:

- Search and view a patient's imaging history and reports from all main local NHS imaging service providers
- Access all results and history held by the Imaging Network for authorised clinicians in other care settings (e.g. community care)
- Access all results held by the Network for the patient
- Routinely report at any site through the use of a single "global" worklist
- Work on solutions to unify workflow and have adopted common coding

In the interim, Trusts are able to use the Image Exchange Portal which has been the system to share images for ten years

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 Angela, 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.

We have not had sight of a response from the Kingston Hospital NHS Trust, but if one is received then this will be considered further by the Regulation 28 Working Group, to better understand any particular challenges faced by the Region and so that NHS England can support any action being taking to prevent future deaths.

Thank you for bringing this 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