NHS England

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National Medical Director
NHS England
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16 November 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Chantelle Reed who died on 29 October 2020.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 21 September 2023 concerning the death of Chantelle on 29 October 2020. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Chantelle's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Chantelle's care have been listened to and reflected upon.

In your Report, you raise the concern that there was a lack of awareness of aortic dissection amongst Urgent & Emergency Care (UEC) and acute medicine health professionals.

In recent years, significant work has been undertaken to raise awareness within acute care settings of the indicators of acute aortic dissection, following recommendations made by the Healthcare Safety Investigations Branch (HSIB) in January 2020 on the culmination of an investigation into delayed recognition of acute aortic dissection and an acknowledgement that there have been challenges in frontline staff diagnosis and treatment of acute aortic dissection. This included the Manchester Triage International Reference Group updating the Manchester Triage System (MTS) in 2020 to include 'aortic pain' as a discriminator for chest pain and to raise awareness of acute aortic dissection as a potential cause. The MTS is a clinical risk management tool commonly used in Emergency Departments to enable clinicians to safely manage patient flow, by assigning a clinical priority to patients based on presenting signs and symptoms to ensure life threatening injuries and illnesses are identified.

In November 2021, the Royal College of Radiologists and the Royal College of Emergency Medicine (RCEM) published their guidance on the diagnosis of thoracic aortic dissection within emergency departments on their respective websites: Diagnosis_of_Thoracic_Aortic_dissection.pdf (rcem.ac.uk). I realise that this guidance was published after Chantelle's death, but I hope this provides some assurance that that actions are being taken to address the issues raised in your Report. Awareness raising has also been undertaken via the Think Aorta campaign, a global campaign focused on misdiagnosis and delay in acute Aortic Dissection which provides accredited learning resources for first responders, emergency medicine and radiology teams.

NHS England's Getting It Right First Time (GIRFT) Programme also includes the possibility of aortic dissection in its chest pain pathway for acute settings: Chest-Pain-Pathway-FINAL-V2-July-2023.pdf (gettingitrightfirsttime.co.uk). GIRFT is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and wide-ranging data analysis and is part of an aligned set of programmes within NHS England input into by senior clinicians.

NHS England has been sighted on the response to you from the RCEM and the Royal College of Radiologists. NHS England notes their position that they do not believe there is sufficient evidence to support the suggestion that chest pain radiating to the neck or jaw should mandate the investigation for Thoracic Aortic Dissection or that Computed Tomography of the Aorta should be performed in all such cases.

NHS England's national Patient Safety Team are linked into the RCEM's Patient Safety Committee and so will be aware of any future work in this area. We will of course support wherever necessary.

Your Report also raises the concern that there is a national shortage of Radiologists and that this can lead to delays in reviewing x-rays, which, in this case, may have led to the timely diagnosis of acute aortic dissection in Chantelle.

NHS England published the Image report turnaround time guidance in August 2023, available here: NHS England » Diagnostic imaging reporting turnaround times. The guidance sets out the maximum turnaround times from acquisition to image reports, with a 4-hour maximum for acutely unwell patients in Accident & Emergency (A&E) during routine hours of working.

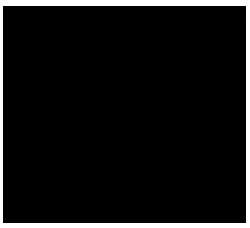
The guidance incudes caveats for sufficient availability of workforce as the numbers of reporting staff (radiologists and reporting radiographers) are not increasing in line with demand. We are supporting Trusts to increase reporting capacity by increasing the number of reporting radiographers and radiologist trainees per financial year, international recruitment initiatives and workforce demand and capacity planning tools.

In June 2023, NHS England also published the NHS Long Term Workforce Plan, in response to the current lack of sufficient workforce. The plan sets out how we will train, retain and reform healthcare staff across the NHS over the next fifteen years, and is underpinned by the biggest recruitment drive in NHS history.

I would also like to provide further assurances on 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 preventable deaths are shared across the NHS at both a national and regional level and helps us 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,



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National Medical Director