Paul Rogers
Westminster Coroner's Court
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SW1P 2ED

National Medical Director
NHS England
Wellington House
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[redacted] [redacted]

25 January 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Kai Takagi who died on 14 June 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 27 October 2023 concerning the death of Kai Takagi on 14 June 2021. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Kai's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Kai's care have been listened to and reflected upon.

In your Report you raised the concern that patients that leave Accident and Emergency (A&E) departments with outstanding diagnostic test results are not followed up and tracked. Both NHS England and the Royal Colleges have published national guidance and standards for following up on test results following discharge from hospital, please see below:

- NHS England, supported by the Academy of Medical Royal Colleges (AoMRC) published the Standards for the communication of patient diagnostic test results on discharge from hospital in March 2016. One of the guiding principles is that the clinician who orders the test is responsible for reviewing, acting and communicating the result and necessary actions to the patient and their GP, even if the patient has been discharged.
- The Royal College of Pathologists (RCPath) published The communication of critical and unexpected pathology results in October 2017 which states that for 'significant positive blood cultures for patients discharged from emergency departments, the principle of the result being the responsibility of the requester still holds'.
- The Royal College of Emergency Medicine (RCEM) published Management of Investigation Results in the Emergency Department in May 2020. This clearly states that 'All Emergency Departments should have a 'Standard Operating Procedure' for the handling of investigation results (radiological and non-radiological) that covers….those patients under the care of the Emergency Department, or discharged from the Emergency Department'.

Your Report also raises that there is a risk posed to patients and call-backs, given the reliance on A&E Departments for routine out of hours health care. It is recognised that services across the NHS are currently facing significant pressures. NHS England is

committed to improving patient experience within hospitals and in January 2023 we published a two-year Delivery plan for recovering urgent and emergency care services. The plan aims to relieve pressures on emergency departments by:

- Growing the workforce available for 111 online and urgent call services to offer support, advice, diagnosis and referral.
- Expanding services within the community to prevent avoidable A&E admission. This will include more joined-up urgent care within the community and use of virtual wards.
- Helping people access the right care first time, ensuring that 111 is the first port of call and reducing the need for people needing to go to A&E.
- Growing capacity and number of beds within hospitals to relieve pressures on A&E Departments.

It is the responsibility of Trusts to ensure that they have the necessary procedures and arrangements in place to follow national guidance. It will also be for the Trust to comment on your concerns surrounding their handover arrangements and the clinician led review into abnormal blood results. NHS England notes that you have also addressed your Report to Chelsea and Westminster Hospital. We will carefully consider their response to you which we have asked to be sighted on.

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,

[redacted]

Medical Director for Professional Leadership and Clinical Effectiveness

NHS England