NHS England

Dr Karen Henderson
Record Office
Orchard Street
Chichester
PO19 1DD

[redacted]

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

[redacted]

4th March 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – David Bryan Moore who died on 14 June 2021.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 8 January 2024 concerning the death of David Bryan Moore 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 David's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about David's care have been listened to and reflected upon.

In your Report you raised the matter of concern over a lack of guidelines for the anaesthetic or intensive care management of a flanged tracheostomy tube.

Your Report was addressed to the Chief Executive of Health Education England (HEE). On 3 April 2023 Health Education England and NHS England legally merged to create a new single organisation. Following this transfer, NHS England assumed responsibility for the activities previously undertaken by HEE, including planning and recruitment for the workforce and ensuring that it has the right values, behaviours and skills to support delivery of healthcare to patients and the public. Many of these responsibilities now sit with NHS England's Workforce, Training and Education (WTE) Directorate.

NHS England notes that you have also addressed your concerns to the Association of Anaesthetists Great Britain and Ireland and the Royal College of Anaesthetists. These organisations are better placed to respond to your concerns over national guidance for flanged tracheostomy tubes.

The National Tracheostomy Safety Project (NTSP) exists to provide a wide range of resources, materials and e-learning to support healthcare professionals with responsibility for providing care for patients with tracheostomies, for both general and emergency care. The website includes guidance on the different types and features of tracheostomy tubes, including flange tubes (NTSP Manual 2013 (tracheostomy.org.uk), red flags for tracheostomy emergencies, which includes displacement, as well as day-to-day management and checks.

The NTSP, together with the Faculty of Intensive Care Medicine and the Intensive Care Society have also published national guidance for Tracheostomy Care which outline key standards to improve the quality of care for all patients requiring a

tracheostomy. The document includes the following statement that the “position and orientation of the tracheostomy tube must be checked and documented, with the patient in the position that they will be nursed in (rather than the insertion position). This should include the distance from the carina, which is especially important for adjustable flanged tubes. A tube that is considered inadequately positioned must be changed whilst the team and airway equipment are all available.” You may wish to refer to the NTSP and the other organisations involved in the development of this guidance.

You may also wish to engage with the National Institute for Health and Care Excellence (NICE) who are responsible for producing a wide range of guidelines and guidance for health and social care professionals. Their existing guidance for evidence-based recommendations on translaryngeal tracheostomy can be found here: Overview | Translaryngeal tracheostomy | Guidance | NICE.

Commissioners and providers have a responsibility to ensure local policies and guidance are appropriately developed and implemented within their local context and regarding national guidance/guidelines. NHS England has engaged with Queen Victoria Hospital NHS Foundation Trust on the concerns from your Report and understand that a new local protocol they have developed has also been shared with the coroner.

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]

[redacted]
National Medical Director