Ms Alison Mutch
HM Senior Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

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

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24/07/2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – George Barry Broadhurst who died on 10 October 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 29 May 2024 concerning the death of George Barry Broadhurst on 10 October 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to George's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about George's care have been listened to and reflected upon.

Your Report raised concerns over a national shortage of radiologists and trained reporting radiographers, and the consequential risk of Emergency Department (ED) doctors interpreting X-rays without specialist input and discharging patients with more subtle fractures, as well as the impact delayed reporting of X-ray results has on ED consultant resource.

Following additional investment through spending review settlements in 2021/22 and 2022/23, the NHS has observed a significant and sustained expansion in recruitment to specialty training places. Clinical Radiology recruitment increased from an average of 234 trainees per year (between 2016 and 2020), to an average of 328 (between 2021 and 2022), meaning an expansion of around 100 specialty trainee places per year.

The current spending review settlement has enabled continued expansion of Clinical Radiology training places at similar levels, with planned expansion of places totalling 110 in 2022/23, 100 in 2023/24, and 75 in 2024/25. Continued expansion, through 2025 and beyond, will form part of Long Term Workforce Plan and spending review discussions.

A programme of international recruitment also ran in 2023/24 to enable Community Diagnostic Centres (CDCs) to deliver diagnostics and achieve the benefits in access, recovery and transformation of care. During 2023/24, 21 Radiologists were appointed through the programme. Further international recruitment is planned for 2024/25, with demand planning currently underway.

NHS England is also working at a national level to deliver the Long-Term Workforce Plan. This is a robust and effective strategy to ensure we have the right number of

people, with the right skills and support in place, to be able to deliver the kind of care people need. It heralds the start of the biggest recruitment drive in health service history, but also of an ongoing programme of strategic workforce planning. It includes ambitious commitments to grow the workforce by significantly expanding domestic education, training and recruitment, as well as actions aimed at improving culture, leadership and wellbeing so that more staff are retained in NHS employment over the next 15 years. These actions will aim to close anticipated staffing shortfalls in the NHS in the long term, however NHS Trusts have a responsibility to ensure safe staffing levels in the current day to day operation of their hospitals. This is in line with CQC Regulation 18, which states that providers must deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements.

Accident & Emergency (A&E) departments are required to have local procedures in place to ensure that they follow up X-ray reports, based on the formal report being finalised, as pathologies can be missed via A&E routes and imaging services do not support/deliver 24/7 reporting services for general X-rays.

On behalf of the Royal College of Radiologists, the Academy of Medical Royal Colleges (AMRoC) published 'Alerts and notification of imaging reports' in October 2022, which makes clear that the referrer is required to act on the report issued by imaging, and that it is the responsibility of the requesting doctor and/or their clinical team to read and act upon the report findings and fail-safe alerts as quickly and efficiently as possible. This extends to ensuring robust mechanisms are in place and that there are suitable resources to cover leave within clinical teams or practices.

Your Report also raised concerns over community / primary care teams recognising red flag / deterioration symptoms and pain within the context of a fracture, and the importance of training for this. NHS England's Primary Care colleagues have reviewed your Report and have advised that there is existing National Institute for Health and Care Excellence (NICE) guidance for primary care healthcare professionals on the assessment and management of back pain. This includes guidance on asking about red flag symptoms and the list of red flag symptoms.

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 preventable deaths 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.

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