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20 September 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Lee Dryden who died on 12 January 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2 August 2023 concerning the death of Lee Dryden on 12 January 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Lee's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Lee's care have been listened to and reflected upon.

In your Report you raised the concern that Royal College Guidance as to how external organisations should be reporting images to NHS Trusts was not understood or embedded by NHS Trusts. NHS England has undertaken or been involved in several initiatives and activities around imaging reports to improve processes across Trusts and stakeholder organisations. These include:

- Alerts and Notification of Imaging Reports Recommendations was published in October 2022 and was supported by a Royal College of Radiology (RCR) hosted webinar: https://www.rcr.ac.uk/publication/recommendations-alerts-and-notification-imaging-reports
- NHS England hosted a national webinar on 7th March 2023 with the inclusion of the above delivered by the RCR for NHS services. This guidance is also available on the NHS England Futures website, a virtual collaboration platform for NHS staff members to make change, improve and transform health and social care.
- The RCR have also indicated they will review the Standards for the Provision of Teleradiology within the United Kingdom Guidance which was first published in 2016. This will potentially take place next year.
- The Academy of Medical Royal Colleges (AoMRC) published a report on 'Alerts and notification of imaging reports – Recommendations' which include recommendations on fail-safe notification systems. This was highlighted by NHS England in the January 2023 national Patient Safety bulletin and followed a report from the Healthcare Safety Investigation Branch (HSIB): Failures in communication or follow-up of unexpected significant radiological findings.
- The NHS England National Imaging Board has developed new standards for imaging reporting turnaround times which was published on 9th August 2023.

This Radiology Reporting Turnaround Guidance cab be viewed here: . NHS England » Diagnostic imaging reporting turnaround times. To help embed this new guidance, a national webinar will be hosted by NHS England on Thursday 28 September and communications will be cascaded across the NHS as well as to Independent Sector Providers. This will include an update in the national Patient Safety bulletin.

- NHS England is also investing in digital infrastructure to support Imaging network development to enable radiology reporting infrastructure across constituent providers and the independent sector and should link into this infrastructure for any outsourced Radiology Reporting services.

I acknowledge that the above activities have occurred following Lee's death in January 2022, but I hope they provide assurances that actions have been taken or are underway to clarify guidance around imaging reports and how they should be shared between NHS Trusts and independent sector providers.

My North East & Yorkshire (NEY) regional colleagues have also advised that they have gone out to all NEY systems for assurance that national guidance is being followed around image reporting. Systems bring together Nhs organisations, local authorities and others to take collective responsibility for health and care planning services across geographical areas.

Your second concern focused on the delay in the Yorkshire Ambulance Service response time to the ambulance call made by Lee's mother, which was categorised as a Category 2 call.

NHS England recognises the significant pressure on ambulance services since the Covid-19 pandemic, which has seen longer response times across all categories than before the pandemic. That is why NHS England are focusing on improving ambulance performance for 2023/24, supported by the Delivery plan for recovering urgent and emergency care services, published in January 2023. The plan outlines the actions and steps that we are taking across England to recover and improve urgent and emergency care services, including improving ambulance response times for Category 2 incidents, increasing ambulance capacity through growing the workforce, speeding up discharges from hospitals, expanding new services in the community, and taking steps to tackle unwarranted variation in performance in the most challenged local systems.

In July 2023, we also published a letter to Integrated Care Boards, NHS Trusts and Primary Care Networks title Delivering operational resilience across the NHS this winter. This included focusing on improvements around Accident & Emergency handover and ambulance handover times.

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,

Professor Sir Stephen Powis
National Medical Director