NHS
The Shrewsbury and
Telford Hospital
NHS Trust

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Mr J P Ellery
Senior Coroner for Shropshire, Telford and Wrekin
The Shirehall
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Date: 30th March 2020

Dear Mr Ellery

Regulation 28 Report – Peter Smith (deceased)

I write in response to the Regulation 28 Report issued on 5 February 2020. For ease of reference, I will respond to the Coroner's concerns following the numbering pattern within the Regulation 28 Report.

1. There was a significant delay in the diagnosis and treatment of Mr Smith's adenocarcinoma which contributed to his death on the 4 March 2019.

The Trust and the teams involved recognise the delays in this case and have reviewed their pathways and processes. From November 2019, the Trust has updated their Standard Operating Procedure (SOP) which provides advice on the referral of patients for surgical resection of proven or suspected lung cancer to prevent delays. This covers the following areas:

- Stages of investigations in patients under consideration for surgery;
- Basic physiological assessment in all patients under consideration for surgery;
- Focused investigations for specific patient groups;
- Criteria for urgent cardiology opinion;
- Criteria for urgent vascular opinion;
- Lung Cancer Nurse Specialist patient assessment for all patients under consideration for surgery; and
- Single point of referral to thoracic surgeons.

This document is enclosed at Appendix 1 for ease of reference.

Please note that at present cancer and imaging pathways will be severely compromised because of the impact that public health priorities, namely corona virus, is having on the Trust.

2. Time was of the essence, but tests, reports, appointments and discussions took place consecutively to the extent that by the time a final date for surgery was fixed it was no longer possible.

3. Had tests been conducted expeditiously and concurrently with predictable tests organised in advance it is likely that the surgery would have been able to take place significantly earlier than it did.

Concerns 2 and 3 will both be addressed below.

From November 2019, the Trust has streamlined the diagnostic pathway (enclosed at Appendix 2) for patients being investigated for potential lung cancer which involved collaboration with Clinical Commissioning Group's regarding 'direct to CT' pathways and to the urgent 'hot-reporting' of chest x-rays where there is a suspicion of lung cancer.

Improvement work has been undertaken and evaluated with regards to developing diagnostic 'bundles' of tests to streamline investigations and agree which investigations are appropriate for specific patient groups, recognising that each investigation involves a potential delay, but that it is important to ensure that a patient is risk assessed appropriately prior to listing for surgical intervention.

These improvements have been ratified through the Trust's Governance processes and are approved by NHS England.

There have been additional actions prior to receipt of the Regulation 28 Report. There are as follows:-

- The Trust has formally discussed the SOP (referred to within section 1) at the Lung Cancer Multi-Disciplinary Team (MDT) bi-annual meeting in January 2020;
- This case was discussed at the Respiratory Governance Mortality and Morbidity Meeting on 11 July 2019 and the Unscheduled Care Group Mortality and Morbidity Meeting on 10 January 2020.
- Every chest x-ray with an abnormality which is concerning for a potential lung cancer is now flagged up to the Lung Cancer Team on a daily basis. Although, in the case of Mr Smith, his initial x-ray had been reported as normal as the changes were subtle.
- There is daily triage of CT scan results performed following receipt of an abnormal chest x-ray where the potential for lung cancer has been raised by the reporting radiologist. It has been established that had this been the case for Mr Smith, this may have reduced the timescale between radiology reporting and receipt of that report by the requesting clinician by six days. This would also trigger the Lung Cancer Team and alert the patient's Consultant.
- The request of additional tests can result in further delays; the Trust's new protocol has standardised the pre-operative assessment process to try and minimise clinically unnecessary tests, recognising that each additional test builds in a potential time delay.
- Patient's cases do not need to be discussed at an MDT meeting in order to facilitate the requesting of a PET scan, but only following receipt of the PET CT result.
- There has been an increase in surgical clinical capacity, preventing delays for clinic appointments.

4. Although separate Trusts they were effectively treating Mr Smith's adenocarcinoma as one.
The Lead Clinician for Lung Cancer, Lead Cancer Clinician, a Consultant Cardiologist and Consultant Vascular Surgeon met with thoracic surgeons at the University Hospital of North Midlands (UHNM), to formally discuss pre-operative patient work up on 12 September 2019.

The Shrewsbury and Telford Hospital NHS Trust and UHNM continue to maintain close links and working closely together in the diagnosis and treatment of lung cancer patients. UHNM cardiothoracic surgeons attend SaTH weekly to operate surgical outpatient clinics and to attend weekly MDT meetings in person.

All improvements have also supported the Trust in quality improvement to work towards compliance with the National Optimal Lung Cancer Pathway which is due to come into practice by April 2020.

I hope the above provides assurance that the Trust has taken action to implement the lessons learned from this sad case. If you require any further explanation please do let me know.

Yours sincerely

Louise Barnett
Chief Executive