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

[redacted]

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

[redacted]

3 May 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths - Sandra Adina Lomax who died on 25th June 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 10 February 2023 concerning the death of Sandra Lomax on 25th June 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deepest condolences to Sandra's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Sandra's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused to Sandra's family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones and appreciate this will have been an incredibly difficult time for them.

National guidance for the use of stenting in cases of oesophageal/gastro-oesophageal cancers

The National Institute for Health and Care Excellence (NICE), who develop national guidance on referral from NHS England, the Department of Health and Social Care and the Department of Education, do cover the principles of stenting in its guidance on Oesophago-gastric cancer in adults: Oesophago-gastric cancer: assessment and management in adults (NG83) (nice.org.uk). This guidance references the use of stenting in oesophageal/gastro-oesophageal cancers in cases where the cancer is not suitable for surgery, or where there is a need to relieve the symptoms of dysphagia.

NHS England does not provide guidance covering every aspect of care. This is particularly pertinent for management of complex cases and cancers, such as Sandra's, which require management on an individual basis with input from a multi-disciplinary team (MDT) within the relevant Trust and NICE does make clear that that MDT decision-making is important in these complex cases.

NICE are currently consulting on a partial update to their guidance on Oesophago-gastric cancer, with publication expected on/or around 4 July 2023. This includes consideration of treatments offered to patients who have had stents inserted. In response to your Report and the concerns raised, NHS England plans to discuss your Report and the NICE guidance with the Cancer Clinical Advisory Group, in advance of the publication of updated NICE guidance relating to oesophago-gastric cancer, to consider whether any further immediate actions need to be taken. NHS England would be happy to write to the the Coroner again in due course to provide an update if she so wishes.

In addition, the national Regulation 28 Working Group will ensure that your Report and the concerns raised are shared with System Quality Groups for onward sharing to relevant Trusts and clinicians across NHS England, so that they may take learnings from this case.

Commissioning arrangements and requirements for complex cancer cases and stenting

Due to its complexity, the management of oesophageal cancer falls under the remit of NHS England's Specialised Commissioning function. Commissioned providers are required, under the NHS Standard Contract, to comply with national service specifications and have regard to guidance published by NICE.

I am able to confirm that the relevant service specification is due to be updated in the next 12 months, which will provide an opportunity to incorporate any specific recommendations from the updated NICE oesophago-gastric cancer guidance about stenting and chemo-radiotherapy. Importantly, the current published service specification does set out that chemo-radiotherapy is the responsibility of the specialist MDT.

NHS England's Regional Specialised Commissioning Team for the North West will review and consider any proposal from The Christie to support the delivery of the service specification requirements relating to chemo-radiotherapy and stenting.

In addition, the national Regulation 28 Working Group will ensure that your Report and the concerns raised are shared with System Quality Groups for onward sharing to relevant Trusts and clinicians across NHS England, so that they may take learnings from this case, to include the importance of holding effective and frequent MDT meetings for complex cancer cases.

GM are the appropriate organisation to respond to your concerns around GM staffing issues and ineffective communication between the MDT. I have been sighted on their response and welcome the Greater Manchester Cancer Alliance improvement programme for MDT reform. I also note that they will be sharing learning from Sandra's death across the Greater Manchester System.

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,

Signed:

Medical Director for Professional Leadership and Clinical Effectiveness
NHS England