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NHS
Oldham Care Organisation
Northern Care Alliance NHS Group

[redacted]

[redacted]

Medical Director's Office
The Royal Oldham Hospital
Rochdale Road
Oldham
OL1 2JH

Reference: HMC4207

26 March 2021

Dear Mr Cox,

I write to you following the inquest of Mrs Monica McCormick which concluded on 27 January 2021. Following the inquest the Northern Care Alliance was issued with a Prevention of Future Death notification with a requirement to respond by 31 March 2021 including details of actions proposed or taken. At the outset please accept my sincere condolences to the family of Mrs McCormick.

Thank you for bringing your concerns to our attention. The Trust is dedicated to ensuring that patient safety is maintained throughout all services. I would like to take this opportunity to provide assurance to both you and the family that the Trust takes the concerns raised very seriously and have conducted a thorough review of this case, both before and after the inquest.

Response to the matters of concern has been led by the Divisional Clinical Director - Surgery, Dr [redacted] and can be found below.

Matters of Concern:

1. **Appropriate consideration was not given to the deceased's medical records at the time of her discharge from hospital.**

   Our investigation confirms that the pathology results confirming the positive cancer diagnosis were recorded on the pathology database on 15 October 2019, one day before discharge from hospital.

   [redacted] has discussed this case with [redacted], Clinical Director of General and Colorectal Surgery, who has confirmed that it is unusual for a histopathology diagnosis to be available at the time of discharge and that therefore this will have been the expectation of the team caring for the patient.

   We apologise that the team did not check whether there had been a histopathology diagnosis at the time of discharge. We will share this PFD response at the Divisional of Surgery Governance Meeting and discuss with team members the importance of checking medical records in full when completing the Handover of Care Communication. It is important to highlight that these documents are completed throughout the patient admission to ensure a timely discharge once the patient is considered medically fit or optimised. We

would also like to give assurance that the actions agreed in this letter described under the second matter of concern will ensure that any diagnosis of cancer will be communicated to the patient in a timely manner and have appropriate oversight by the cancer services team.

2. **The pathology report was not communicated to her general practitioner at the time she was discharged from hospital.**

[redacted] has reviewed the case and confirms that the pathology report was not communicated to Mrs McCormick's general practitioner (GP) at the time of discharge from hospital. However disclosure to GP at this time would not be standard practice. Any letter sent to the GP is also copied to the patient; this therefore would create the risk of a patient being made aware of a cancer diagnosis without appropriate support in place on receipt of the information.

It is best practice that when a cancer diagnosis is shared that this is undertaken in an out-patient environment to the patient and next-of-kin, by the responsible consultant supported by a cancer nurse specialist. The role of the cancer nurse specialist includes a holistic approach to supporting the patient.

However, [redacted] does recognise that in the case of Mrs McCormick the delay in informing the patient of the diagnosis led to an avoidable shortening of her life. On review of the case it is recognised that the patient's cancer was not upgraded onto the cancer pathway because the pathology specimen had arisen from Mrs McCormick's treatment and was a new and unsuspected cancer rather than as a consequence of a diagnostic investigation such as a biopsy. Upgrade onto the cancer pathway ensures that the patient is tracked on the cancer tracking database (Somerset) so that the cancer services team can track the appropriate and timely management of cancer treatment. We can confirm that following this incident cancer services have developed a standard operating procedure for New Unsuspected Cancer pathology, so that irrespective of whether cancers are found as a consequence of treatment or investigation the patient will be added to the cancer tracking database. By adding Mrs McCormick to the database the cancellation of outpatient appointments would have been visible and appropriate resolution sought regarding the disclosure and management of the cancer. This provides the 'safety net' required to ensure that such a situation will not happen again in the future.

3. **Appropriate consideration was not given to her records at the time that each outpatient appointment was cancelled.**

As per the concise investigation presented at inquest, Mrs McCormick was unfortunately cancelled from outpatient appointment five times by the service and once by the patient. As an organisation we recognise that this is not the service that we aspire to offer and for that I apologise. It was the continued cancellation of outpatient appointments that led to the delay in informing the patient of the diagnosis and progression of treatment. As per our response to the second matter of concern, we can confirm that cancers identified via treatment, such as Mrs McCormick's, are now added to the cancer tracking database. This means that

cancellation of outpatient appointments would only be made taking into account the patient's cancer diagnosis. [redacted] has also discussed outpatient appointment cancellations with the Directorate Manager for General Surgery, who has agreed the following actions to be completed by 31st March 2021, to support the reduction of cancellation of outpatient clinic appointments:

- Review of management of leave by clinical staff to ensure due process in terms of adequate notice (8 weeks as per policy).
- Review of the process for clinical and administrative oversight of outpatient cancellations within surgery. This will identify any further improvements to be made.
- Update of the risk assessment related to surgical outpatient waiting lists, including a review of controls in place, and any actions identified.

It is important to recognise the current challenge that the hospital faces with regard to waiting list management. The impact of COVID19 on already busy waiting lists has been significant and as an organisation we are unable to prevent the risk of outpatient cancellations fully in the future. We do however continue to take learning from incidents such as this one seriously. By introducing the use of cancer tracking for patients such as Mrs McCormick we feel assured that patients, who have a cancer diagnosis identified outside of a diagnostic pathway, will not be cancelled from outpatient waiting lists without clear recognition of the patient's diagnosis and impact upon treatment.

I hope that this response has provided you with assurance that we have taken on board the concerns identified during the inquest of Mrs McCormick. If you have any further questions please do not hesitate to contact me.

Yours Sincerely,

[redacted]

[redacted]

Medical Director

Oldham Care Organisation