

**Review of patients who were referred with suspected cancer**

**A briefing for patients and local people**

**What has happened?**

The Trust has been investigating its referral and care pathways for patients with suspected cancer, and has contacted 810 people this week to let them know their care has been reviewed. Of these, 686 have been told that we have no clinical concerns about the care they received and this number is expected to increase over the next few weeks.

**What has been reviewed?**

The review was launched in late November 2013 after the Trust’s new management team found that the administrative process for monitoring patients referred with suspected cancer (by their GP or dentist) was not always followed in line with NHS guidelines. This related specifically to patients who had missed their initial outpatient appointment (known as a DNA (did not attend)).

The review, which covers people who were initially referred for urgent appointments between January 2010 and November 2013, showed that the Trust had discharged some patients following a single DNA. This contravenes NHS rules as they should have been offered a second appointment.

In addition, the Trust has reviewed all complaints, serious incidents and legal claims which relate to its cancer services to assure itself that there wasn’t a wider problem.

**How many patients are affected?**

Of the 810 people, 686 have been told that we have no clinical concerns about the care they received in relation to this review. They have been written to because we want to be open about the administrative error and to let them know that we have proactively reviewed their patient record to ensure they have received the care they need. We feel it is important to let patients know, and we have offered our apologies for any anxiety and distress this may cause.

121 people have been told that their case is still being reviewed. Much of this work is being undertaken in partnership with their GP or dentist. We expect to complete this shortly and we will contact them as soon as we know the outcome.

We have apologised to these patients for not being able to offer further clarity at this stage and for any anxiety this may cause. We have committed significant resource to the review, but due to its complexity it is taking us time to complete correctly.

In addition, we have met one person whose diagnosis was delayed because of the proper process not being followed, however, their cancer was still found at the earliest stage. We have apologised for the delay and for the distress that this matter will undoubtedly cause them and their family. We have offered them any support they need.

We have also met the family of a patient who has since died. Our clinical view is that a delay in seeing the patient (in line with the NHS guidelines) may have contributed to their death, but it is not certain.

We are also in the process of contacting the family of another patient who has since died. Sadly, this patient was already at an advanced stage of their illness when the initial referral was made.

We have offered our sincerest apologies to both of these families and will provide the support they need over the coming weeks and months.

**Should other patients be concerned?**

We have written to all patients affected by this review. Therefore, people who have not been contacted have no reason to be concerned. However, we are advising people who do have concerns to make an appointment to see their GP. Alternatively, they can contact our dedicated information line supported by doctors and nurses on **01923 217 100** (open seven days a week from 8am to 8pm). This is open to anyone with concerns including the people we have contacted.

**What has been done to help prevent it happening again?**

The problem was identified by the new management team as part of a major project to improve the way the Trust manages all patient appointments and bookings and a significant number of measures are now in place to help prevent it happening again. This includes:

* The implementation of a new IT system to track each patient’s appointment, missed appointments and cancellations;
* Weekly meetings to proactively review the overall management of all referrals and appointments;
* Retraining and better supervision of staff;
* Daily review of all patients who miss (DNA) a booked cancer appointment to ensure they receive a new appointment within the appropriate timeframe.

**Who else is involved in the review?**

A number of NHS colleagues have worked with us on this review, including NHS England, Herts Valley Clinical Commissioning Group and the NHS Trust Development Authority. We have also been supported by a number of patient groups, who have offered advice on how to contact and support patients. This includes Hertfordshire Healthwatch, Macmillan Cancer Support and the Trust’s Patients’ Panel.

**Will there be an external independent review?**

An external independent investigation has been launched and is being led by a former NHS Chief Executive who specialises in patient safety. We are also auditing other areas of our cancer care to ensure they are in line with best practice.

**For more information**

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