AGENDA ITEM
7.5

QUALITY & SAFETY COMMITTEE

SUMMARY OF IMPLEMENTATION OF CANCER HARM REVIEWS

Date of meeting	(18/01/2022)
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Dawn Casey - Macmillan lead nurse for cancer services
Presented by	Dom Hurford, Medical Director
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
BCUHB	Betsi Cadwaladr University Health Board
ILG	Integrated Locality Group
SOP	Standard Operating Procedure
MC	Merthyr Cynon ILG
RTE	Rhondda Taf Ely ILG

SCP	Suspected Cancer Pathway

1. SITUATION/BACKGROUND

1.1 Cancer harm reviews were introduced by NHS England in 2015. A decision was made in quarter 4 of 2019 to commence this process within Cwm Taf Morgannwg University Health Board (CTMUHB) as a pilot. As part of the Welsh Government governance process across Wales, cancer harm reviews were trialled in 2021. This was as a result of the work that CTMUHB and Betsi Cadwaladr University Health Board (BCUHB) had undertaken.

1.2 A harm review is undertaken when a patient with a confirmed cancer diagnosis receives their first definitive treatment after 104 days from referral. It ensures there is a pathway review in accordance with the cancer standards relevant to their cancer pathway. CTMUHB's current Standard Operating Procedure (SOP) can be found in appendix 1 (available upon request).

1.3 **Aims**

The aims for the cancer harm review process are:

- To identify any avoidable harm and mitigate this going forwards;
- To provide assurance that all avoidable patient pathway delays are reviewed and actions implemented to reduce the risk to future patients;
- To provide oversight and management of the process for undertaking a root cause analysis and cancer Clinical Harm Review. These should be for any case where harm has been identified and should utilise the nationally reportable incident toolkit;
- To ensure that when a case of clinical harm is found to have occurred, the clinically responsible clinician will follow the Putting Things Right Policy.

1.4 The cancer waiting time target is for all patients presenting with a suspicion of cancer to start treatment within 62 days of the point of suspicion, regardless of their referral route. It is used where the first definitive treatment is any initial treatment that treats the patient's cancer, stabilizes their symptoms from cancer or stabilizes their health so cancer treatment can commence.

1.5 The current target is for 75% of patients to receive treatment within 62 days.

1.6 **Local implementation**

All harm reviews are aligned to the Integrated Locality Group (ILG) which hosts the service. This means that for some services, such as Urology, they are all discussed in one panel. For others, such as lung, they are discussed at their respective ILG panel. The SOP was written to allow flexibility of implementation between the ILGs, to reflect the differences between them. The first ILG to implement the process was Bridgend, followed by Rhondda Taff Ely. Merthyr Cynon have not implemented the full harm review process as yet, they have their first panel booked for January 2022.

There is a robust process for the clinical review. The patient's clinician reviews the pathway and assesses any potential harm caused by the delay. This is then quality assured by either the Multi-Disciplinary Team or the harm review panel, depending on the ILG. The learning from the review is consolidated at the panel, who also ensure that any resulting actions are undertaken. The panel also acts as a safety net, by confirming that the correct 'putting things right' process is followed where harm is suspected.

As all the harm reviews are added to Datix, there is a record of the review and its outcome on this system. Consequently should there be a complaint by the individual this review can be included in the investigation.

The harm may not occur immediately so there will be a process to review the cases after one year. As a consequence of the large numbers involved this will require significant administrative support initially.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 There have been 466 harm reviews since the process began, there is a summary of these included in appendix 3. Please note the MC reviews have not been quality assured as a panel as yet (first panel to be held in January 2022).

2.2 The summary in appendix 3 also demonstrates the services with the longest waits and most challenges regarding delivery of the suspected cancer pathway (SCP). It can be seen that Urology have particular challenges, these predate the pandemic. However, the issues for the colorectal service are related to the changes in the pathway brought about by Covid restrictions.

2.3 Due to the time taken to implement the harm review process and also the number of reviews, there is a backlog awaiting clinician review in both RTE and MC ILGs. The longest waiting review is a year old.

2.4 One harm review identified serious harm. Following a full investigation it was concluded that there was no learning for CTMUHB. The delay was caused by changes required nationally for Covid. There have also been four moderate harm review outcomes, no further action required for two, one under investigation, one required redress (currently being agreed).

2.5 Whilst clinicians may instigate the 'putting things right' process themselves, this pathway acts as a safety net, ensuring that any harm caused by unnecessary delay is investigated appropriately.

2.6 Central collation of the causes of pathway delays provides an overview of the wider challenges experienced along the cancer pathway, which might be impacting on more than one cancer site or ILG.

2.7 There has also been considerable learning around the cause of delays on the pathway and this process highlights those, allowing the relevant clinical service group, ILG or CTMUHB to develop actions to improve these.

2.8 The process also highlights the occasional difference in practice. There were a number of reviews relating to a single specialist using different triaging criteria to colleagues. This process brought that to the attention of the service and allowed the criteria to be standardised, preventing further delays for patients. Without this process it is unlikely the service would have been aware of this difference.

2.9 Although the reasons for delay are varied, there are a number that are more frequently occurring; Complex diagnostic pathway, complex individual/comorbidities, delays in diagnostic (undertaking the procedure and reporting), outpatient capacity and delays with the tertiary provider. These allow services to understand where the main bottlenecks for service delivery lay.

2.10 A recent Welsh government meeting reviewed the progress of the Wales wide pilot. The only Health Boards who have commenced the full process is BCUHB and ourselves. The other Health Boards have undertaken some reviews, but not commenced their panels. Across all of Wales there has only been two identified serious harm. This has led Welsh Government to suggest extending the period from 104

days to 146 and ultimately removing the process as it is clear there are very few significant harms identified. This mirrors experience in England.

2.11 This has been a challenging process for the ILGs to implement. However, having implemented the process, both Bridgend and RTE ILG wish to continue, because they have found the pathway learning valuable.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

The key risks which will be of interest to committee members are as follows:

3.1 There are a high number of reviews awaiting clinical in RTE and MC ILGs. The Medical Director has highlighted this to the ILG teams for them to address and report on progress.

3.2 The one year review of cases will require additional administrative resource to implement, whilst numbers remain high;

3.3 This is a secondary care pathway review, it covers referral into secondary care but not process before. Further work would be needed to incorporate Primary Care.

Managing and reducing these risks will be an area of focus for the Cancer Business Unit working with colleagues in ILGs as appropriate.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
Related Health and Care standard(s)	Timely Care
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	Yes If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. Appendix 2 (available upon request) If no, please provide reasons why an EIA was not considered to be required in the box below.

Legal implications / impact	Yes (Include further detail below)
	If a delay is found to cause harm the 'putting things right' process is followed and may result in legal action
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	If a delay is found to cause harm the 'putting things right' process is followed and may result in redress
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

Committee members are asked to **NOTE** the successful implementation of a Cancer Harm Review process and the value this has added to the pathway.