ADULTS AND HEALTH SCRUTINY COMMITTEE	AGENDA ITEM No. 6
19 SEPTEMBER 2023	PUBLIC REPORT

Report of: Assurance on cancer pathway harm review process due to delayed treatment, along with its subsequent impact on mortality.	North West Anglia NHS Foundation Trust

CANCER PATHWAY, DELAYED TREATMENT AND IMPACT ON MORTALITY

RECOMMENDATIONS
The report gives an update that Trust (North West Anglia NHS Foundation Trust) has established a robust 104-day clinical harm review process, supported by a governance framework for monitoring and escalation. The Committee members are requested to take note of this report and to raise if any further assurance is required.

1. ORIGIN OF REPORT

1.1 The trust has been formally requested by this Committee to provide an update on cancer waiting time standards and consequential harm resulting from treatment delays, along with its subsequent impact on mortality.

This report summarises the steps taken towards oversight and assurance with regards to Cancer waiting times and Harm Reviews. The Trust's Hospital Cancer Board (HCB) is set up and reports to the Board and various subcommittees. The HCB receives regular highlight reports on Harm Reviews and this paper summarises the action of each tumour site leads, and governance arrangements towards managing waiting times and monitoring/ reducing risk of harm.

2. PURPOSE AND REASON FOR REPORT

2.1 Situation/Background

- The growing demand on cancer services has unfortunately resulted in patients waiting for longer than the expected timeframes and the number of patients on a cancer waiting times pathway has also grown since the beginning of the pandemic.
- The wait for an assessment or intervention/treatment can in some cases potentially cause the condition of the patient to worsen, which differs from the unintentional harm that can potentially occur over the course of an assessment or treatment.
- 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.
- This is mandated by NHS England and is standard practice in all Trusts.

2.2 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, and to establish where potential harm has occurred, following which Trusts 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, and the case considered as a potential Serious Incident (SI).

2.3 The cancer waiting time standards:

The NHS has set maximum waiting time standards for access to healthcare. In England, the cancer waiting time standard 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, stabilises their symptoms from cancer or stabilises their health so cancer treatment can commence.

Cancer waiting times are key performance measures and aspects of the cancer pathway are currently covered by 11 different national standards set out in the NHS constitution of which there are eight main operational standards for cancer waiting times and three key timeframes in which patients should be seen or treated:

- two weeks
- one month (31days)
- two months (62 days)

The trust is mandated to report on all above statutory standards, as such, it undergoes internal monitoring.

Following the consultation and recent announcement, the number of these waiting time standards are expected to be reduced in England. These changes are set to be in place from October 2023. Three targets are set to be kept:

- diagnosis of cancer within 28 days of referral (Faster Diagnostics Standard)
- starting treatment within two months of an urgent referral
- starting treatment one month after a decision to treat.

4. Standard Operating Procedure

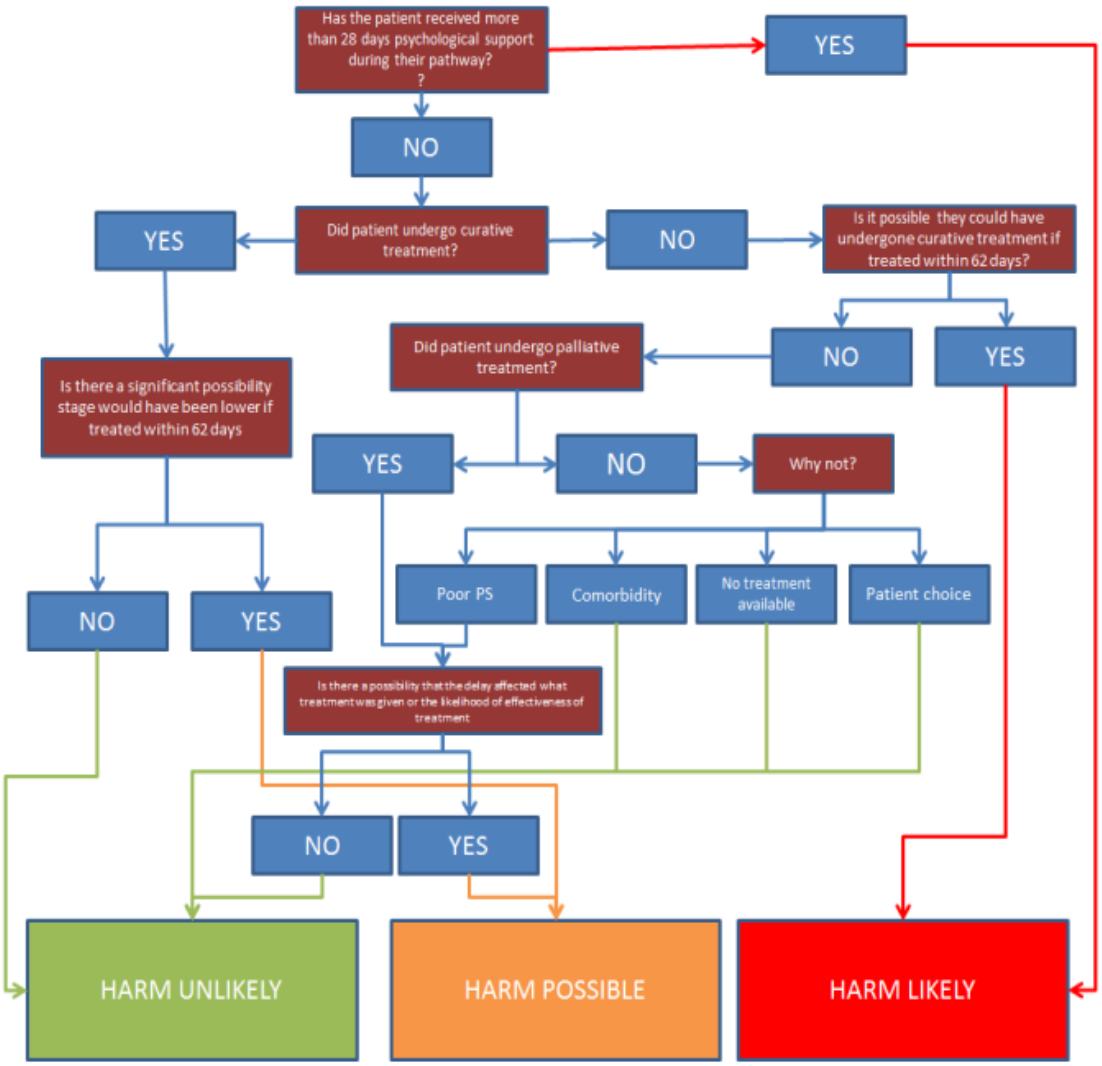
4.1 *Harm review process*

There is a robust process for the clinical harm 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. 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.

- All harm reviews are aligned to individual tumour sites.
- Where an individual patient with a confirmed cancer diagnosis has waited over 104 days for treatment, there should be a clear, transparent process in place to identify if the extended delay has caused harm to the patient (NHSE, 2018).
- Where a patient has chosen to wait, chosen not to have treatment or there is no risk of harm identified, there must be clear evidence in the patient notes and on Somerset database that the patient is aware of the risk of waiting for treatment or declining it.
- Where there was a medical reason for the patient to wait for cancer treatment then there should be clear evidence that the patient pathway has been reviewed monthly.
- If a risk of harm has been identified, a harm review checklist assessing level of harm will be completed by the patient's consultant (Cancer 104 Day Wait Harm Review assessment).

- It is the responsibility of the patient's Consultant to Datix that harm has been identified and the findings and the patient should be informed of the risk of harm if above level has been identified, as soon as possible.
- Where there is evidence of harm, as per the assessment process, either due to a single delay or a sequence of delays shown to have resulted in a serious harm event for the patient concerned, each case is then considered as a possible Serious Incident (SI).

Cancer 104 Day Wait Harm Review assessment



Consultant assesses harm at point of contact. Consultant completes harm review section of RCA. If harm is identified then a Datix under category C14 is completed.

5. Governance Structure

Progress reports on the Cancer waiting time as well as clinical harm is monitored as follows:

- NWAFT Hospital Cancer Board chaired by Chief Medical Officer– monthly review of detailed operational level plans including update on harm review
- NWAFT Improvement Board – monthly review of progress against objectives and exceptions
- NWAFT Hospital Management Committee – monthly review of progress against objectives

- NWAFT Performance and Estates Committee – monthly review of progress against objectives
- NWAFT Trust Board (Public/Private) – monthly review of board level summary
- NHSE/NWAFT/ICB Performance Meetings – monthly review of progress against objectives

5.1 *Cancer 104 Day Breaches and Harm Reviews*

Over the last 18 months 484 patients. Monthly average 26 patients were therefore subject to an assessment of clinical harm, but we have discovered no evidence of harm resulting from treatment delays, along with no subsequent impact on mortality.

6. Summary & Recommendation

The report gives an update that Trust has established a robust 104-day clinical harm review process, supported by a governance framework for monitoring and escalation.
The Committee members are requested to take note of this report and to raise any additional queries or request for further assurance as necessary.