

Report into the
Immediate
Review of Cancer
Services at
Colchester
Hospital
University NHS
Foundation Trust



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Executive Summary

In this report, NHS England has addressed the question “Are the cancer services in Colchester safe? “

The report summarises the findings of an immediate review into the quality and safety of cancer services at Colchester University Hospital NHS Foundation Trust (CHUFT / ‘the Trust’). This review was initiated by the Incident Management Team (IMT), led by NHS England, in response to a Care Quality Commission (CQC) inspection into cancer standards at the Trust, published on 5 November 2013. The CQC report identified a number of failings in cancer services at the Trust including unwarranted delays to diagnosis and treatment which may have caused harm to patients.

The IMT established a Clinical Oversight Group which together with the East of England Strategic Clinical Cancer Network organised and conducted clinically-led visits to each of the Cancer teams in the Trust. The purpose, summarised in this report was to determine if cancer services at the trust were safe.

At the end of the visits, verbal feedback on the findings and any immediate risks identified was given to the Trust. A report on the visit findings, immediate risks and overall assurance of each pathway was provided to the Clinical Oversight Group for analysis and summarised in this report. For each pathway, the Clinical Oversight Group has agreed with lead clinicians from the Trust, the steps to be taken to improve pathways.

Actions taken are summarised in sections 7.2 and 7.3. Some of the service improvements necessary will take several months, because of the scale or complexity of the changes to ensure that services are of the highest standard. The timelines are presented in detail in the report.

At this stage:

- The Trust is co-operating with the Monitor-led review of Trust governance and implementing its recommendations, including the completion of an action plan
- The Trust has re-established the Trust Cancer Board which, as a sub-group of the Trust Board, will work across the clinical directorates in the organisation to implement the findings of this report,
- Trust developments which were already at the planning stage have been accelerated,
- The commissioners of the cancer services (Clinical Commissioning Groups and for those services designated as specialist cancer services, NHS England) have via the Clinical Oversight Group assessed each clinical site visit report and have determined whether each cancer pathway is currently providing a safe service, and where not meeting standards, the IMT has

taken the appropriate action to ensure that pathways are adequate for the continued provision of cancer care at the Trust.

The 17 clinical visits took place between the 14th November to the 9th December 2013.

The specific immediate actions to address the immediate risks for the internal management of cancer services in the Trust are detailed in the general (Section 7.2) and specific tables for each individual cancer pathway (Section 7.3). All findings of this review will be incorporated into the Trust cancer action plan and be performance managed by the commissioners and regulators.

The NHS Intensive Support Team visit completed in December 2013 is included as an Annex to this report, and their main recommendations have also influenced the findings of this review.

Five of the pathways were particularly problematic. These were Urology, Cancer of Unknown Primary origin, Sarcoma, Brain & Central Nervous System and Skin cancers as detailed in Appendix 6 – Clinical site visit reports. Urology had to produce written up-to-date pathways in bladder cancer and prostate cancer. To operationalise the modern pathways investments had to be made in equipment and additional consultant, cancer nurse specialist, advanced nurse practitioners and managerial and administrative staff and extra clinics. In addition the trust had to produce a detailed capacity and activity plan and temporarily outsource some services as detailed in section 7.3.17 Urology. Until the cancer information and management system is fully established, dedicated staff are allocated by the Trust to receive and resolve all phone and fax enquiries along with back-up systems to cross check patients progress along pathways. More time has been allocated to local multi-disciplinary teams for discussion of cases in agreement with other networked hospitals.

For Cancer of Unknown Primary origin, there is guidance on how to set up services for patients who may present with illnesses suggestive of cancer or with secondary metastases where the primary is not yet known. The trust has taken advice from the visiting cancer experts and has produced pathways based on their experience, and is now recruiting to a multidisciplinary team. The Trust has also issued guidance on which specialties will manage people with different pathologies until the primary cancer is ascertained. In addition there are now systems in place to upgrade incidental findings in radiology to the lead clinicians.

Sarcoma is a rare condition where the histology goes to a specialist centre for confirmation of the diagnosis. The creation of a written pathway introduced clarity about how the Trust will track patients during the phases of their treatment which are at other specialist centres. The Trust has introduced a Contact Centre (for central logging) and electronically forwards the information to MDT co-ordinators.

For Brain and Central Nervous System cancers the Trust refreshed its internal protocols with staff on the on call arrangements with the neurosurgical centre in London and the provision over weekends for emergency MRI scanning for patients with spinal cord compression.

For skin cancers extra photography arrangements were put in place to ensure that patients saw an expert clinician within two weeks of GP referral and histopathology cover will have to be arranged to cover absences of leave. The trust is recruiting an additional histopathologist.

The key recommendations of this review are:

i. The Trust must introduce organisational development for Cancer services.

Creating the environment in which clinical excellence can flourish is a prerequisite for safe services. As such the Trust needs to engage in a process of organisational development in which clinical governance and leadership is an essential feature. One practical application is to ensure that each cancer specialty has up to date, practical cancer pathways that are adequately resourced, and where the volume of work is matched with the supply of appropriately trained clinical staff who work in sustainable rotas.

ii. The Trust must ensure it has up to date pathways for all cancer teams.

Clinical leadership is vital, and it is important that the medical knowledge on service redesign is fully integrated with that of management and nursing colleagues. Cancer services are regulated and this is part of that regulation.

iii. The Trust must ensure milestones are agreed for all Cancer clinical pathways and establish mechanisms to monitor these.

iv. The Trust must improve failsafe handling of paper processes including referral, inter-MDT transfer, inter-hospital transfer, radiology 'urgent findings and upgrades' (incidental findings) and 'consultant upgrades'.

There are key stages in the cancer pathway which patients have to progress through and in this instance the administrative support had to be increased. Such improvements need to be maintained and monitored until electronic systems are implemented and thereafter. This includes referral, inter-multidisciplinary team transfer, inter-hospital transfer, radiology 'urgent findings and upgrades' (incidental findings), and 'consultant upgrades'. (i.e., when a consultant change a non cancer referral to a cancer diagnosis.)

v. The Trust needs to confirm the expectations regarding timeliness of data validation by MDT co-ordinators and agree on-going monitoring and escalation where appropriate.

vi. The commissioners need to continue to insist on audit of the Cancer Waiting Time Tool data for validation and review of amendments.

While some cases will be reviewed at the weekly Patient Tracking List (PTL) meeting with the Trust, the Trust needs to provide assurance that changes to the cancer waiting tool are legitimate. The new central office should prevent delays in the timeliness of tertiary referrals to the Trust and help in the agreement of milestones for inter-provider transfers.

vii. The Trust must invest in a cancer pathway management tool.

Informatics is central to the modern management of cancer pathways. The need for investment in modern communication systems which aid the progress of patients along the suspected cancer pathway is clear. In this situation, special measures had to be taken to make secure out-dated methods of transferring requests for tests or for entry into pathways, such as the use of faxes. The administration had to be enhanced to support these out-dated means of communication, until more modern communications are put in such as the Choose and Book system and a cancer pathway management tool. The management of patients along pathways needs to be consistently and reliably managed.

viii. The Trust must address all the concerns raised in the pathway reviews as presented in this report.

The Trust has already taken steps to deal with the processes for managing consultant upgrades. Similarly the Trust has begun to address the high priority areas cited in the Intensive Support Team report e.g. in upper GI, a cancer nurse specialist service workforce review. This should be part of normal continuous quality improvement in the Trust.

ix. The Trust should include consideration of cancer services as it updates its workforce plans.

Many cancer specialties had only part time support staff, associated with cancer specialties on different sites. Ultimately decisions have to be made on the centralisation of specialist procedures that should only be done in recognised centres where specialists, equipment and staffing comply with national standards. One practical application of workforce planning is to ensure that each cancer specialty has up to date, practical cancer pathways that are adequately resourced, and where the volume of work is matched with the supply of appropriately trained clinical staff who work in sustainable rotas. This requires agreement in job plans. Specific reference needs to be made to the numbers of cancer nurse specialists.

- x. **The Trust must ensure that the substantive post of a Consultant Oncologist is filled, and that there is sufficient capacity in the oncology team.**
- xi. **The Trust must review the Multidisciplinary Team Co-ordinator roles and workload, along with training and induction.**
- xii. **The Trust needs to be pro-active with the regulator Monitor in the review of its own governance systems.**

Clinical leadership is vital, and creating the environment in which clinical excellence can flourish is a prerequisite for safe services. As such the Trust needs to engage in a process of organisational development in which clinical governance and leadership is an essential feature. The Trust Executive lead for cancer is now the Trust Medical Director and a lead cancer nurse is being recruited.

- xiii. **The Trust must ensure that vulnerable people are safeguarded and that there are systems in place for adult and childrens' safeguarding.**
- xiv. **NHS England with the Trust must conduct retrospective reviews.**

Tracking patients through their cancer pathways is a recognised priority now both for Colchester Hospital University NHS Foundation Trust and its' commissioners, including North East Essex CCG and NHS England. The findings from all three recent reviews at the Trust, including a lack of evidence of failsafe systems in place within the cancer pathways at Colchester Hospital University NHS Foundation Trust and examples where patients have stopped pathways without clinical sign-off or been lost to follow up, have prompted NHS England to decide that a retrospective review is required.

This review has a number of identified elements:

- Firstly, to look at a random sample of notes to define the accuracy of the recording of information on the historic Cancer Waiting Tool (CWT) and to look at the implications of any errors which may be identified.
- Secondly, to learn from the recent external clinical reviews, looking at those parts of cancer pathways where there was any pattern of loss to follow up or the stopping of pathways without clinician oversight.
- Thirdly, and important for public reassurance, is the continuation of the helpline for any patients or professionals who have concerns about how their care was managed.
- The review will also look at the numbers of patients with delays over 100 days and breaches

These reviews are technically audits and can be undertaken by those who have a legitimate clinical relationship with the patient. However given the amount of scrutiny that the Trust is under, the protocols for such reviews will be agreed with NHS England, who will also provide external assurance, validity and scrutiny of the process (including the checking of the accuracy of any reviews through the analysis of anonymised records, as appropriate).

19th December 2013

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1 Introduction

This report summarises the findings of an immediate review into the quality and safety of cancer services at Colchester Hospital University NHS Foundation Trust (the Trust). The immediate review was conducted as part of the work of an Incident Management Team (IMT), led by NHS England in response to a Care Quality Commission (CQC) inspection into cancer standards at the Trust, published on 5th November 2013. The CQC report identified a number of failings in cancer Services in the Trust including unwarranted delays to diagnosis and treatment which may have caused harm to patients.

This immediate review goes beyond the issues identified by the CQC and is a rapid but thorough review of current processes in the Trust's cancer services. This review has undertaken expert external assessment of the current safety of the Trust's cancer services and identified immediate remedial action to make the services safe, or indicated where services cannot be made safe immediately. The primary aim of the immediate review was to answer the question "Are the Cancer Services safe now"? These assessments are summarised on a service-by-service basis in section 7.3 Assessment of safety by cancer team. Summary of themes and issues identified

A number of serious failings in cancer services organisation, management and infrastructure have been identified during the immediate review. Analysis of the clinical site visits and the Key Line of Enquiry (KLOE) self-assessment proformas completed by the Trust identifies some common issues across cancer teams. These include failures of basic governance processes, unsafe information and records systems, poorly documented clinical pathways, a lack of training for key staff, inadequate or unsustainable levels of staffing in key services, poor handover of patients between cancer teams and with other hospitals. More worryingly the immediate review confirmed the CQC finding that some Trust staff had a lack of confidence that concerns would be listened to, borne out by experience of trying unsuccessfully to do so in the recent past.

At times the responsibility for a patient's care may be shared between more than one Trust, in common with all areas of England. These findings provide an opportunity for other hospitals to reflect on the organisation of their own services.

1.1 Governance of Cancer services

Clinical governance of cancer services was found to have a number of significant failings including the absence of clear, consistent clinical pathways (or parts thereof) and variable functioning of Multi-Disciplinary Teams (MDTs).

1.1.1 Clinical pathways

Poorly documented clinical pathways were found in two thirds of cancer teams (which describe the correct flow of patients through the complexity of diagnosis and treatment for each cancer). In some cancer teams there appeared to be no agreed pathway, including Sarcoma, Anal cancer, Brain and Skin.

In several clinical pathways this included lack of “milestones” which would allow the Trust to identify if patients treatment was becoming delayed, for example in Skin cancer, Haematology and Urology. There was also a lack of clarity regarding the pathway for diagnosing patients with cancer of Unknown Primary origin although this is an emerging area of good practice and is not standardised in many hospitals.

The detail is addressed within the assurance by Cancer team in section 5.

1.1.2 Multi-Disciplinary Teams

There were a number of problems identified with the processes, documentation, communication and attendance at Cancer Multi-disciplinary team meetings (MDTs).

MDTs are not always fully attended by all the relevant experts, including Colorectal, Breast and Skin. Some MDTs clashed with each other making attendance of key staff impossible. Some MDTs were not scheduled for long enough to complete their work, for example Skin. Some staff could not attend due to clashes in their work plan or lack of capacity in their professional group (some clinical nurse specialists). This sometimes led to delays in decision making.

Some MDTs operate in a way which could reduce their effectiveness, including hierarchical discussions and poor documentation.

Not all MDTs monitored the progress of patients through the clinical pathways and no routine root cause analysis (RCA) was done when patients were not treated within the national cancer standard times⁶¹.

Clinical audit in some MDTs was not planned in a standardised way and did not systematically review their effectiveness and safety, including Sarcoma, Gynaecology and Brain.

1.1.3 Handover between cancer teams or hospitals

Handover protocols between some MDTs and between the Trust and other hospitals were not standardised or documented, for example Haematology and Brain. This led to patients having delays in diagnosis or treatment which could be at either the referring or receiving hospital, for example Gynaecology, Brain, Colorectal and Urology. For some types of cancer there was poor communication with members of the MDT when particular rare types of cancer were suspected but tests needed to be done or samples sent to other hospitals, for example in Sarcoma.

The process for “consultant upgrade” is not well documented or standardised (where a patient is seen in a routine setting but the consultant suspects cancer and the patient is therefore added to the appropriate cancer pathway).

1.1.4 Corporate governance

Corporate governance had very serious failings including

- a lack of clarity within the cancer teams as to the Trust executive lead for cancer services
- there is no documented cancer strategy for the Trust
- there was no lead cancer nurse for the Trust, which should be standard practice
- the Trust Cancer committee, which should oversee the quality and performance of cancer services, did not meet for a significant period from the end of 2012 until June 2013
- internal audit within some cancer teams and of the cancer waiting time system was not done in a systematic way and did not detect these problems^{22,23,24,25}
- staff in two cancer teams indicated that they felt unable to raise concerns with management or that if they did so they would not be listened to. Some staff cited experience of trying to raise concerns and being unsuccessful, for example Haematology and Gynaecology
- staff in some Cancer teams felt inadequately supported following the CQC inspection and report which caused significant stress and anxiety for them

1.2 Information and record systems

Half of the Cancer teams visited cited issues with recording or tracking important data. The Trust has several separate systems for recording key information about patients referred with suspected cancer. The Trust had purchased, in 2010, a licence for the Somerset Cancer information system which would provide a single, industry standard record system and would have avoided many of the problems identified in this report. Unfortunately, this system has never been implemented in the Trust. This means that:

- Multiple separate data systems, including paper-based systems are in use and are not updated in real time'. This was cited by the following clinical site visits: Colorectal, Lung, Breast, Haematology', Radiology.
- Staff are required to enter data multiple times into different systems, leading to some errors. This was cited by the following clinical site visits: Head & Neck, Breast.
- Tracking of patients on pathways is subject to errors in recording and potential delays'. This was cited by the following clinical site visits: Sarcoma.
- Audit of cancer waiting times data and of changes made to the records is not routinely performed, so errors can remain undetected'.

For the majority of suspected cancer referrals the Trust is also reliant on faxed referrals from GP services and between hospitals. These are not all received in one office and there was evidence of some referrals going missing leading to delays in treatment. There were also delays in sending clinic letters back to GPs.

Some parts of the reporting system between diagnostic tests and cancer teams are paper based and at risk of information being lost in transit.

1.3 Staffing levels, workload, training and accommodation

Excessive or pressured workload was identified as an issue within two thirds of cancer teams. This related either to a generic issue for the team, or to specific individuals. Half of cancer teams had concerns regarding dependency on a single individual for some parts of the cancer pathway.

The Multi-Disciplinary Team co-ordinators and clinical nurse specialist teams in several cancer teams were found to be understaffed'. This led to these staff being unable to provide the best level of care to all patients and to be absent from important discussions such as the MDT meetings. These included Acute Oncology, Haematology', Skin', Colorectal, Paediatrics and Sarcoma. Of particular concern was the lack of any formal training or induction for the MDT co-ordinators.

Some cancer teams found overall workload to be excessive including Breast, Urology, and Paediatrics. There are particular concerns over the workload of the Oncology team with one specialist leading for at least five cancer teams including Gynaecology, Teenage & Young Adult cancer, Brain plus Head & Neck and Cancer of Unknown Primary origin.

One third of cancer teams had inadequate accommodation, including:

- disparate locations for team members, for example Skin
- lack of flexibility of clinic accommodation, for example Breast and Skin
- MDT meeting room size and facilities, for example Colorectal.

1.4 Specialist Cancer services arrangements

Issues were identified in Urology, where Colchester is one of two specialist cancer sites in Essex, the other being Southend. These included long-standing capacity issues in Urology cancer surgery at Colchester leading to patients' treatment being routinely delayed due to lack of operating list availability. In addition, the national Improving Outcomes Guidance for specialist cancer services suggests that there should only be one specialist site in Essex.

For Anal cancer, a rarer condition, there is no specialist cancer centre identified in Essex leading to unstandardized treatments potentially involving multiple hospitals⁶. Improving Outcomes Guidance suggests that there should be a designated team.

There is further work needed with the East of England Strategic Clinical Cancer Network and the Essex Local Cancer Forum, which the Essex working group supported by the Network, particularly to agree standardised arrangements for the speedy transfer of patients from one hospital to another.

The Incident Management Team continues to review the services in Colchester hospital, in partnership with Monitor and other local agencies. In addition to this report the planned further retrospective review of cancer services and waiting times has started in December and is planned to conclude in February. The retrospective

review is not the focus of this report and details of that review will be published separately.

A Glossary of Terms can be found in Appendix 1 – Glossary of Terms.

1.5 The structure of Cancer services in England

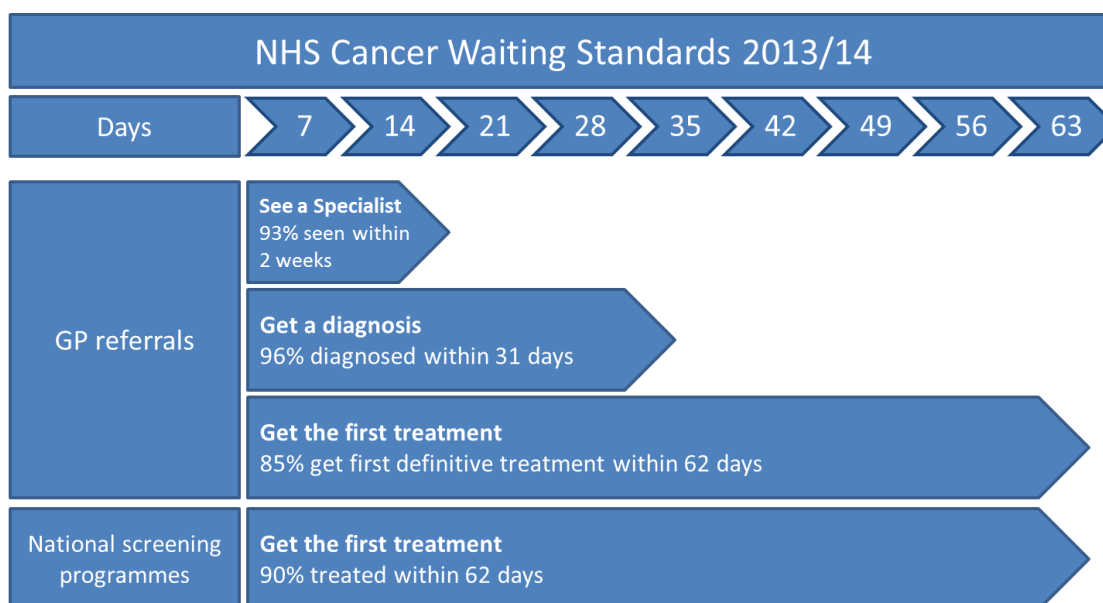
Cancer services in England are highly regulated in recognition that to deliver high quality care to a population requires a clear structure and standardised processes. Prior to April 2013 cancer networks oversaw cancer services, working with providers and service commissioners to redesign and assure cancer pathways. The cancer networks were disbanded in March 2013 and some of their roles continued by the East of England Strategic Clinical Network (SCN) part of NHS England. The cancer team within the SCN work across the East of England and work with clinical expert groups to review and advise on cancer services. Many cancer services are now commissioned by NHS England but services for common cancers remain locally commissioned by Clinical Commissioning Groups.

The processes have evolved over 25 years and reflect clinical expert opinion and patient priorities. All cancer patient care is now overseen by a multi-disciplinary team, depending on how rare the cancer type. These teams are located only in cancer centres, which recognise that bringing together expertise from a range of disciplines is essential to high quality care.

Cancer management is underpinned by guidelines that reflect national and international best practice, these are agreed and revised regularly by a group of regional clinical experts in their field. All cancer patients have access to a key worker to co-ordinate and explain their investigation and treatment, this is essential as high quality cancer care is complex and often involves several investigations and visiting several different hospitals.

Finally, prompt investigation and treatment is essential to the successful diagnosis and treatment of cancer, to that end there are a number of standards for the timings of the investigation and treatment of cancer. These standards represent the expected speed of first consultant review, diagnosis and first treatment for patients with “straightforward” cancer diagnosis. For some people their cancer can be hard to diagnose or complex to treat and therefore not every patient is required to be seen in these timescales; the requirement for hospitals is to achieve a high percentage of patients’ care within the standards.

Patients suspected of cancer must ideally be seen by the relevant specialist within two weeks (93% to be seen this quickly). Patients referred with the suspicion of cancer must start their treatment within sixty two days (85% or 90% if detected through national screening programmes) with any patient found to have a cancer starting treatment within 31 days of their being informed of the diagnosis (94% or 98% if only needing chemotherapy).



Based on NHS standard contract 2013/14, Schedule 4 Quality Requirements

To assure services and reinforce good practice, cancer teams are regularly reviewed by their peers. When a service is visited by peer review a report is produced for the team and it is available to everyone.

If there are problems identified with a service the peer review team will make a judgement as to whether it represents an immediate risk to patient safety or a serious concern. Any immediate risk is highlighted to the hospital immediately with the expectation that there will be immediate action to mitigate the risk. Serious concerns and less serious concerns are again highlighted to the trust with the expectation that there will be a detailed action plan produced, which has to be agreed by the peer review team, which will correct the problem identified. The timetable for these plans will depend on the nature of the problem and how serious it is.

1.5.1 Peer review levels of assurance

The immediate review of cancer services at the Trust has used the National Cancer Peer Review categories¹ for indicating the findings of the review process for each cancer team. The decision as to assurance was taken by the Clinical Oversight Group using the advice of the clinical site visit teams.

National Cancer Peer Review Handbook, March 2011:

Reviewing cancer teams/services either during self-assessment and validation or as part of external verification or a planned visit may identify concerns. There will be occasions when these concerns are more serious and pose an immediate risk to patient safety or clinical outcome. The following guidelines provide a framework for organisations involved in validating self-assessments and for members of review visit teams to identify and manage the different levels of concern.

Within the peer review process there are three categories of concern, all require action to be taken, however timescales and management will vary.

Immediate Risk

An “Immediate Risk” is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.

Serious Concern

A “Serious Concern” is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care, and therefore requires urgent action to resolve.

Concern

A Concern is an issue that is affecting the delivery or quality of the service that does not require immediate action but can be addressed through the work programmes of the teams/services.

1.6 Cancer services in Colchester hospital

Colchester Hospital University NHS Foundation Trust serves a local catchment population of approximately 370,000 patients². The Trust offers a full range of routine cancer services and is a Specialist Cancer Centre for Urology cancers (kidney, bladder, testicle, prostate and penis). Radiotherapy services are provided to the 700,000 people of Mid Essex and North East Essex CCGs combined. Radiotherapy and chemotherapy services are commissioned by NHS England Specialist Commissioning; other services are commissioned by local CCGs.

The North East Essex population is significantly older than average with 20.4% over 65 years old, compared to an East of England average of 17.2%³.

1.6.1 Networked Cancer services

Colchester hospital is part of a wider network of cancer services including other providers in Essex, Suffolk, Cambridge and London. The following table outlines the relationship for some cancer services between the Trust and other hospitals.

Cancer Tumour Group	Incoming Inter-Trust referrals	Outgoing Inter-Trust Referrals	Further information / Improving Outcomes Guidance (IOG) Centres
	Hospitals CHUFT receives referrals from other hospitals for investigations and/or treatment	Hospitals CHUFT refers to other hospitals for investigations and/or treatment	
Acute Oncology	Provided solely by Colchester Hospital		
Brain & Central Nervous System	The Trust do not receive any incoming referrals for this specialist area	Queen's Hospital, Romford	Queen's Hospital is the recognised IOG Centre for the treatment of these types of cancers. Queen's Hospital is one of 7 Specialist Neuroscience Centres in London.
Breast	Provided solely by Colchester Hospital		
Colorectal (Lower Gastro-intestinal)		Southend Hospital (Anal)	Southend Hospital has been designated the Specialist IOG Centre for Anal cancers.
Cancer of Unknown Primary	Provided solely by Colchester Hospital		
Gynaecology		Ipswich Hospital	Ipswich Hospital is the designated Specialist IOG Centre for Gynaecological cancers covering Mid Essex, North East Essex and Suffolk.
Haematology and Lymphoma		St Bart's Hospital, London and University College London Hospital (UCLH)	St. Bartholomew's Hospital and UCLH are the designated IOG Centres for complex Haematological cancers.
Head and Neck		Broomfield Hospital, Chelmsford	Broomfield Hospital is the designated IOG Centre for Head & Neck, and Thyroid cancers, covering Mid Essex and North East Essex.
Lung		Basildon Hospital and Royal Brompton	We have close links with the Essex Cardiothoracic

		Hospital, London	Centre at Basildon for specialist diagnostic procedures and/or treatments. Patients are referred to the Royal Brompton under patient choice
Paediatrics		Addenbrookes Hospital, Cambridge	Addenbrookes Hospital is the designated IOG Centre for the treatment of Children's cancers.
Radiotherapy	Broomfield Hospital, Chelmsford		CHUFT is a designated Radiotherapy Centre covering the populations of Mid Essex and North East Essex.
Sarcoma		Royal Marsden, London University College and London Hospital (UCLH) (soft tissue) Royal National Orthopaedic Hospital (RNOH) (bone)	Royal Marsden and UCLH are designated Centres for the diagnosis and treatment of Soft Tissue Sarcoma. RNOH is the designated Centre for the diagnosis and treatment of Bone Sarcoma.
Skin		Broomfield Hospital, Chelmsford and St Thomas' Hospital, London	Sentinel Lymph Node Biopsy (SLNB) and Malignant melanomas are carried out at Broomfield Hospital. Mohs surgery is undertaken at St Thomas'
Teenage & Young Adults		University College London Hospital (UCLH)	UCLH is the designated IOG Centre for the treatment of cancer in teenage and young adults (from 16 to 24 years).
Upper GI		Broomfield Hospital, Chelmsford (Oesophageal/gastric) Royal London Hospital (Hepato-biliary/ pancreatic)	Broomfield Hospital is the designated IOG Centre for Oesophageal/gastric cancers Royal London Hospital is the designated IOG Centre for Hepato-biliary and pancreatic cancer
Urology	Broomfield Hospital, Chelmsford	Southend Hospital, Bart's Health, London and the Norfolk and Norwich Hospital	Broomfield Hospital refers to Southend Hospital for Brachytherapy (a treatment for Prostate cancer); St. Bartholomew's Hospital (London) which is the

			Regional Centre for the specialist MDT and treatment of testicular cancer; Norfolk & Norwich Hospital which is the Regional Centre for the specialist MDT and treatment of penile cancer)
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1.6.2 Activity volumes

Cancer services are organised by speciality and tumour sites. Over 12 months from April 2012 to March 2013 over 9900 patients were referred to the Trust by GPs to be investigated for suspected cancer. The table below details the number referred by cancer.

Cancer Type	Total Patients referred as 2 week wait 2012/13 (Does not include consultant upgrades)	% of all 2 week wait referrals
Suspected skin cancers	2664	26.7%
Suspected lower gastrointestinal cancers	2011	20.1%
Suspected breast cancer	1257	12.6%
Suspected urological cancers (excluding testicular)	1068	10.7%
Suspected upper gastrointestinal cancers	889	8.9%
Suspected head and neck cancers	775	7.8%
Suspected gynaecological cancers	786	7.9%
Suspected lung cancer	436	4.4%
Suspected haematological malignancies or Lymphoma	46	0.5%
Suspected testicular cancer	27	0.3%
Other suspected cancer	13	0.1%
Exhibited (non-cancer) breast symptoms	7	0.1%
Suspected sarcomas*	3	0.0%
Grand Total	9982	100%

*any 2ww referrals are forwarded to the IOG diagnostic centre

2 The Care Quality Commission Report 5th November 2013

On Tuesday 5th November 2013, the Care Quality Commission (CQC) published a report of its inspection of Colchester Hospital conducted during August and September this year. The inspection was undertaken in response to concerns raised

to the CQC about cancer waiting times at the Trust. The report identified a number of problems with cancer services at the Trust including not having “adequate systems to maintain the safety and welfare of people receiving treatment on the Cancer pathway” and that “the Trust did not have sufficient arrangements to promote effective performance of the cancer service”. The report also stated that ‘the inspectors’ were provided with examples by three members of staff where they told us that they felt they had been pressured, bullied or harassed to change the data on the cancer pathways to prevent a breach of the pathway.”

As a result of the inspection, the CQC found the Trust to be non-compliant with three regulations of the Care Quality Commission Regulations 2009. The CQC as the regulator of health and adult social care in England ensure through inspection of services that the care people receive meets essential standards of quality and safety. The CQC identified that action was needed to improve the following standards:

- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Records - Outcome 21 (Regulation 20)

The findings of the inspection were passed to Monitor, the regulator of Foundation Trusts (such as Colchester Hospital) and to the Police, in view of the serious nature of the allegations.

3 Risk Summits

In response to the CQC inspection, NHS England convened a series of multi-agency risk summits to review the issues identified and co-ordinate the response. Risk Summits took place during October 2013 and it was agreed that when the CQC inspection report was available the management of the cancer services issues would be transferred to a multi-agency Incident Management Team as the most suitable way to manage these complex issues.

4 Incident Management Team

An Incident Management Team (IMT), led by NHS England was convened on 8th November 2013 in response to the publication of the CQC inspection report. It is chaired by Andrew Pike, Director NHS England Essex Area Team. Its purposes are:

1. Provide strategic leadership and accountability to resolve any concerns, identifying all strategic and operational objectives to manage the incident and maintaining a comprehensive action plan.
2. To ensure clinical quality and patient safety of cancer services at Colchester Hospital and to provide public reassurance, including:-

- Determining the actions necessary to secure and assure the safe and effective management of the current cancer services.
- Determining the actions necessary to carry out any necessary retrospective reviews of cancer services management.

The Terms of Reference for the IMT can be found in Appendix 2 – Terms of Reference for the Incident Management Team.

The IMT has established a Clinical Oversight Group (COG), chaired by Dr Christine Macleod – Medical Director NHS England Essex Area Team. This group has overseen the immediate review of cancer services at Colchester Hospital. This comprised two key review processes:

1. An assessment of the quality and safety of cancer services at the Trust, including current practice, cancer diagnosis / treatment pathways and governance. This was conducted during November by the national Intensive Support Team for Cancer (IST), part of the NHS Interim Management and Support service.
2. Clinical site visits to each of the cancer teams at the Trust to review the safety of the services and to pursue the Key Lines of Enquiry identified by the CQC inspection report, the Intensive Support Team review and other issues identified by the IMT. These were conducted during November with the support of the East of England Strategic Clinical Cancer Network.

4.1 The national Intensive Support Team review

Since April 2009, the NHS Interim Management and Support service has incorporated the Intensive Support Teams (ISTs) who specialise in Urgent and Emergency Care, Elective Care and Cancer, focusing on improving performance, quality assurance and programme enhancement. Assignments typically include working with local health communities jointly to diagnose areas for performance improvement; supporting implementation planning and delivery; and transferring knowledge to produce sustainable and resilient solutions.

The Cancer team initially reviewed key governance documents and reports including previous Cancer peer reviews. This was followed by three visits to the Trust to interview all of the Cancer teams. The initial findings of this review were made available to the clinical site visit teams. The full report of the Intensive Support Team can be found in Appendix 3 - Report of the Intensive Support Team review.

4.2 The clinical site visits

At the request of the IMT and under the direction of the Clinical Oversight Group, the East of England Strategic Cancer Network organised and conducted clinically-led visits to each of the cancer teams in the Trust. These visits took place over a two week period in November 2013.

Terms of Reference for these visits can be found in Appendix 4 – Terms of Reference & methodology of clinical site visits.

Each clinical site visit was led by a cancer specialist (a consultant physician or surgeon) who is an expert in the type of cancer treated by the cancer team under review; all of these were from other hospitals unconnected with cancer services in Colchester*. They were supported by a local GP, an expert cancer manager from the Specialist Clinical Cancer Network and a member of the NHS England Essex Area Team. In advance of the visits each visiting team was provided with key documents including peer review documents, cancer pathway documents, any complaints and Serious Incidents relating to that cancer team. Any additional concerns raised by local GPs were also made available.

Each visiting team was provided with Key Lines of Enquiry to pursue as they spoke to staff and reviewed the physical environment in the Trust. These were drawn from issues identified in the CQC inspection report, the national Intensive Support Team review and other issues identified by the IMT during its initial work.

At the end of the visits, verbal feedback on the findings and any immediate risks identified was given to the Trust. A report on the visit findings, immediate risks and overall assurance of each service was provided to the Trust and the Clinical Oversight Group for analysis and summary in this report.

5 Actions taken concurrent to the immediate review of cancer services

Whilst this report examines the safety of current cancer services at the Trust a separate Retrospective Review of cancer services is being undertaken. In addition a number of actions were taken concurrent to the immediate review of cancer services by other agencies, in co-ordination with the Risk Summit and subsequently the Incident Management Team.

5.1 Colchester Hospital University NHS Foundation Trust

Following feedback from the CQC inspection the Trust has reviewed the care of approximately 910 patients to ensure that their treatment has been completed correctly or is progressing appropriately. This internal review included the 30 patients identified by the CQC who were written to individually by the Trust to offer a face-to-face meeting with an appropriate consultant and the Trust Medical Director or interim Director of Nursing to discuss any concerns. Thirteen patients from this group of 910 who require further review or changes to their care have been recalled by the Trust.

The Retrospective Review of cancer services, led by the Incident Management Team, will examine the processes and performance of cancer services at the Trust from 2010 to November 2013. Where patients are identified as possibly not having received treatment within national waiting time standards or there are other concerns

* apart from Paediatrics where the visiting consultant works at the Regional cancer centre for this specialty which therefore receives referrals from the Trust

about care, their cases will be reviewed in detail and any necessary changes made to their treatment. The Trust will make contact with patients or relatives, giving them the opportunity to discuss with them the review that has been carried out on their case.

In agreement with the IMT, the Trust has set up a Helpline (0800 028 2026) for the public to raise any concerns or issues with cancer services for themselves or family members. Calls were handled by clinical staff at the Trust with the aim of resolving the issues as quickly as possible. Where appropriate this includes a discussion between the patient (or their representative) and their responsible consultant. Since 5th November the Helpline has received 272 calls, as of Friday 13th December.

5.2 North East Essex Clinical Commissioning Group

From September 2013 NHS North East Essex Clinical Commissioning Group (CCG) began enhanced surveillance of the cancer waiting list on a weekly basis. This process includes local GPs, Trust consultants and NHS managers. Progress of all patients' treatment against national waiting time standards is checked. A detailed review is conducted for any patient whose treatment is significantly delayed with a view to resolving the delay as quickly as possible. In addition a random sample of case notes is audited each week to validate the cancer waiting list data provided by the Trust.

The CCG has also established a process for local GPs to raise concerns about patient care, including cancer. This is an on-going process but initial data were used to identify further issues for the clinical site visits to the Trust.

5.3 Essex County Council Adult and Children's Services & NHS England

A review of Adult and Children's Safeguarding processes and governance was undertaken jointly between Essex County Council as the lead Safeguarding Authority for Essex, NHS England, North Essex CCG and the Trust.

5.4 Monitor

Monitor have placed the Trust in special measures and have imposed a number of requirements and a change to the Trust's licence conditions. For further information please see the Monitor website: <http://www.monitor.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/colchester-hospital-university>

5.5 Essex Police

Essex Police have undertaken an initial assessment of the evidence presented to them. On 26th November 2013 they announced that they had opened a criminal investigation, Operation Torquay. They issued this statement:

Essex Police – Operation Torquay

Following its initial review, Essex Police has decided it is necessary to begin a criminal investigation into the alleged manipulation of cancer waiting lists at Colchester Hospital Trust. The investigation will aim to establish whether or not any criminal offences have been committed and then take any appropriate action dependent on the evidence. Essex Police is working with NHS England, Colchester Hospital Trust and other health organisations to ensure that, throughout its investigation, the priority remains the safety and welfare of the public.

Current and former cancer patients of the hospital, their relatives and members of the public who have any concerns as a result of the CQC report are advised to contact a special helpline that the Trust has set up on 0800 028 2026.

6 Summary of themes and issues identified

A number of serious failings in cancer services organisation, management and infrastructure have been identified during the immediate review. Analysis of the clinical site visits and the Key Line of Enquiry (KLOE) self-assessment proformas completed by the Trust identifies some common issues across cancer teams. These include failures of basic governance processes, unsafe information and records systems, poorly documented clinical pathways, a lack of training for key staff, inadequate or unsustainable levels of staffing in key services, poor handover of patients between cancer teams and with other hospitals. More worryingly the immediate review confirmed the CQC finding that some Trust staff had a lack of confidence that concerns would be listened to, borne out by experience of trying unsuccessfully to do so in the recent past.

At times the responsibility for a patient's care may be shared between more than one Trust, in common with all areas of England. These findings provide an opportunity for other hospitals to reflect on the organisation of their own services.

6.1 Governance of Cancer services

Clinical governance of cancer services was found to have a number of significant failings including the absence of clear, consistent clinical pathways (or parts thereof) and variable functioning of Multi-Disciplinary Teams (MDTs).

6.1.1 Clinical pathways

Poorly documented clinical pathways were found in two thirds of cancer teams (which describe the correct flow of patients through the complexity of diagnosis and treatment for each cancer). In some cancer teams there appeared to be no agreed pathway, including Sarcoma^{4,5}, Anal cancer⁶, Brain⁷ and Skin⁸.

In several clinical pathways this included lack of "milestones" which would allow the Trust to identify if patients treatment was becoming delayed⁹, for example in Skin cancer¹⁰, Haematology¹¹ and Urology¹². There was also a lack of clarity regarding

the pathway for diagnosing patients with cancer of Unknown Primary origin¹³ although this is an emerging area of good practice and is not standardised in many hospitals.

The detail is addressed within the assurance by Cancer team in section 5.

6.1.2 Multi-Disciplinary Teams

There were a number of problems identified with the processes, documentation, communication and attendance at Cancer Multi-disciplinary team meetings (MDTs).

MDTs are not always fully attended by all the relevant experts¹⁴, including Colorectal¹⁵, Breast¹⁶ and Skin¹⁷. Some MDTs clashed with each other making attendance of key staff impossible. Some MDTs were not scheduled for long enough to complete their work, for example Skin¹⁸. Some staff could not attend due to clashes in their work plan or lack of capacity in their professional group (some clinical nurse specialists). This sometimes led to delays in decision making¹⁹.

Some MDTs operate in a way which could reduce their effectiveness, including hierarchical discussions²⁰ and poor documentation²¹.

Not all MDTs monitored the progress of patients through the clinical pathways and no routine root cause analysis (RCA) was done when patients were not treated within the national cancer standard times⁶¹.

Clinical audit in some MDTs was not planned in a standardised way and did not systematically review their effectiveness and safety²², including Sarcoma²³, Gynaecology²⁴ and Brain²⁵.

6.1.3 Handover between cancer teams or hospitals

Handover protocols between some MDTs and between the Trust and other hospitals were not standardised or documented, for example Haematology²⁶ and Brain²⁷. This led to patients having delays in diagnosis or treatment²⁸ which could be at either the referring or receiving hospital, for example Gynaecology²⁹, Brain³⁰, Colorectal³¹ and Urology³². For some types of cancer there was poor communication with members of the MDT when particular rare types of cancer were suspected but tests needed to be done or samples sent to other hospitals, for example in Sarcoma³³.

The process for “consultant upgrade” is not well documented or standardised (where a patient is seen in a routine setting but the consultant suspects cancer and the patient is therefore added to the appropriate cancer pathway).

6.1.4 Corporate governance

Corporate governance had very serious failings including

- a lack of clarity within the cancer teams as to the Trust executive lead for cancer services³⁴
- there is no documented cancer strategy for the Trust³⁵

- there was no lead cancer nurse for the Trust, which should be standard practice³⁶
- the Trust Cancer committee, which should oversee the quality and performance of cancer services, did not meet for a significant period from the end of 2012 until June 2013³⁷
- internal audit within some cancer teams and of the cancer waiting time system was not done in a systematic way and did not detect these problems^{22,23,24,25}
- staff in two cancer teams indicated that they felt unable to raise concerns with management³⁸ or that if they did so they would not be listened to. Some staff cited experience of trying to raise concerns and being unsuccessful³⁹, for example Haematology⁴⁰ and Gynaecology⁴¹
- staff in some Cancer teams felt inadequately supported following the CQC inspection and report which caused significant stress and anxiety for them⁴²

6.2 Information and record systems

Half of the Cancer teams visited cited issues with recording or tracking important data. The Trust has several separate systems for recording key information about patients referred with suspected cancer. The Trust had purchased, in 2010, a licence for the Somerset Cancer information system which would provide a single, industry standard record system and would have avoided many of the problems identified in this report. Unfortunately, this system has never been implemented in the Trust⁴³. This means that:

- Multiple separate data systems, including paper-based systems are in use⁴⁴ and are not updated in real time^{45,46}. This was cited by the following clinical site visits: Colorectal⁴⁷, Lung⁴⁸, Breast⁴⁹, Haematology^{50,51}, Radiology⁵².
- Staff are required to enter data multiple times into different systems⁵³, leading to some errors⁵⁴. This was cited by the following clinical site visits: Head & Neck⁵⁵, Breast⁵⁶.
- Tracking of patients on pathways is subject to errors in recording and potential delays^{57,58}. This was cited by the following clinical site visits: Sarcoma⁵⁹.
- Audit of cancer waiting times data and of changes made to the records is not routinely performed, so errors can remain undetected^{60,61}.

For the majority of suspected cancer referrals the Trust is also reliant on faxed referrals from GP services and between hospitals⁶². These are not all received in one office and there was evidence of some referrals going missing leading to delays in treatment⁶³. There were also delays in sending clinic letters back to GPs⁶⁴.

Some parts of the reporting system between diagnostic tests and cancer teams are paper based and at risk of information being lost in transit⁶⁵.

6.3 Staffing levels, workload, training and accommodation

Excessive or pressured workload was identified as an issue within two thirds of cancer teams. This related either to a generic issue for the team, or to specific

individuals. Half of cancer teams had concerns regarding dependency on a single individual for some parts of the cancer pathway.

The Multi-Disciplinary Team co-ordinators and clinical nurse specialist teams in several cancer teams were found to be understaffed^{66,67}. This led to these staff being unable to provide the best level of care to all patients and to be absent from important discussions such as the MDT meetings. These included Acute Oncology⁶⁸, Haematology^{69,70}, Skin^{71,72}, Colorectal⁷³, Paediatrics⁷⁴ and Sarcoma⁷⁵. Of particular concern was the lack of any formal training or induction for the MDT co-ordinators⁷⁶.

Some cancer teams found overall workload to be excessive including Breast⁷⁷, Urology⁷⁸, and Paediatrics⁷⁹. There are particular concerns over the workload of the Oncology team with one specialist leading for at least five cancer teams including Gynaecology⁸⁰, Teenage & Young Adult cancer⁸¹, Brain⁸² plus Head & Neck and Cancer of Unknown Primary origin.

One third of cancer teams had inadequate accommodation, including:

- disparate locations for team members, for example Skin⁸³
- lack of flexibility of clinic accommodation, for example Breast⁸⁴ and Skin⁸⁵
- MDT meeting room size and facilities, for example Colorectal⁸⁶.

6.4 Specialist Cancer services arrangements

Issues were identified in Urology, where Colchester is one of two specialist cancer sites in Essex, the other being Southend. These included long-standing capacity issues in Urology cancer surgery at Colchester leading to patients' treatment being routinely delayed due to lack of operating list availability. In addition, the national Improving Outcomes Guidance for specialist cancer services suggests that there should only be one specialist site in Essex⁸⁷.

For Anal cancer, a rarer condition, there is no specialist cancer centre identified in Essex leading to unstandardized treatments potentially involving multiple hospitals. Improving Outcomes Guidance suggests that there should be a designated team⁸⁸.

There is further work needed with the East of England Strategic Clinical Cancer Network and the Essex Local Cancer Forum, which the Essex working group supported by the Network, particularly to agree standardised arrangements for the speedy transfer of patients from one hospital to another⁸⁹.

7 Are arrangements in place to ensure the safety of cancer services?

Each cancer team at the Trust was assessed for safety and quality of service. This section includes a summary of the assessment of safety for each cancer team including:

- good practice and strengths within the team
- immediate risks identified and actions taken to mitigate them

- serious concerns and next steps
- an overall assessment of the assurance of each cancer team as a safe service

For an explanation of the assessment of immediate risk and serious concerns please refer to section 1.5.1 Peer review levels of assurance.

The Clinical Oversight Group has considered each clinical site visit report and has determined whether each cancer team is currently providing a service that meets safety standards. The full site visit reports can be found in Appendix 6 – Clinical site visit reports. These determinations are included in this section of the report.

7.1 Explanation of summary assessments

The Incident Management Team (IMT) has made a summary assessment of the safety of each cancer pathway at the Trust on the basis of the reports of the clinical site visits, the Intensive Support team and the recommendation of Clinical Oversight Group. These are based primarily on the immediate risks and serious concerns identified, if any, and whether the Trust has been able to take appropriate steps already to manage these risks. This report indicates whether, in the view of the IMT, each cancer service is currently operating to an acceptable standard.

In addition the IMT has identified some general immediate risks which are common to several cancer teams or are general risks in cancer services. Each of these risks were significant when identified. This report indicates whether, in the view of the IMT, sufficient steps have been taken to manage them acceptably and therefore to be assured that the risk is being managed.

For each cancer team, or each general immediate risk the IMT has made a judgement on the current safety of each service, as of 13th December 2013. The judgements should be interpreted as follows:

Judgement at 13/12/13	Interpretation and subsequent actions
YES	Either the IMT were assured of the safety of the cancer service or the Trust has made changes which acceptably manage the risks
NO Measures have already been put in place to meet acceptable standards. Enhanced monitoring required	The Trust has made changes, which if consistently followed, will manage the cancer service risk or general risk. However, further review will be required to confirm that the changes are fully embedded in normal practice. At present the IMT judge that enhanced monitoring of the service is required to assure that it is safe meanwhile
NO The service was not compliant with	The service was not compliant with acceptable standards. The commissioners (NHS England and NHS North East Essex CCG) have put in place immediate additional actions or

acceptable standards. Intensive monitoring required	required the Trust to take further immediate action to ensure safety. The service will undergo intensive monitoring by Commissioners, the Trust and regulators.
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How risks are being managed

In this section are summaries of the general immediate risks (section 7.2 General immediate risks) and cancer service specific risks / serious concerns (section 7.3 Assessment by cancer team). For each risk or serious concern the steps taken by the Trust are detailed. Where these were not sufficient to assure the IMT that the risk had been adequately mitigated the additional monitoring by commissioners or actions put in place to ensure the safety of the service are described. However, in the case of patients requiring complex Anal cancer surgery in the Colorectal (lower GI) cancer service the Trust has been instructed by commissioners to direct patients to IOG compliant specialist centres for their care.

For all immediate risks, the date by which required changes will be (or have already been) put in place is indicated. Some changes require significant infrastructure or staffing changes and therefore may take some time to complete. Beyond the immediate actions to ensure safety, where there is a need for significant improvement, due to either complexity or scale the improvement may take some months. This will be included in a Cancer Action Plan which the hospital will be required to produce for Monitor and the Clinical Commissioning Group.

7.2 General immediate risks

These are immediate risks which are common to all the Cancer services in the Trust and require assurance in their own right.

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
a) Cancer Pathways All cancer teams should have up to date, quality assured clinical pathways which are agreed within the team and followed consistently. For best practice, and to help identify patients at risk of delayed treatment, these should include “milestone” timings for key processes like imaging or biopsy.	<p>The Trust has provided documentary evidence of established pathways to the review team(s). However, some cancer teams have not been able to provide one or more clinical pathways in an agreed, quality assured document; these are Urology (bladder and prostate pathways), Brain & Central Nervous System, Cancer of Unknown Primary origin and Sarcoma.</p> <p>The following pathways are being developed based on national IOG models and will be operational and implemented fully :</p> <ul style="list-style-type: none"> • Sarcoma (Soft Tissue and Bone) – by 31st December 2013 • Isolated Liver Lesions 	Pathways documented by 31 st December 2013 except CUP by 31 st March 2014	NO The service was not compliant with acceptable standards. Intensive monitoring required	YES Intensive monitoring: North East Essex CCG will continue to monitor the progress of all patients on the cancer waiting list on a weekly basis and to investigate the management of any patients whose care is not proceeding in line with national standards. These measures will remain in place until the immediate risk is addressed	End of June 2014

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
	<p>discovered on imaging (to UGI) – completed 13th December 2013</p> <ul style="list-style-type: none"> • Cancer of Unknown Primary – by 31st March 2014 <p>Cancer of Unknown Primary – interim arrangements have been implemented immediately. The Trust Medical Director has confirmed to all cancer teams which MDTs should host the investigations for Cancers of Unknown Primary origin while this service is developed.</p> <p>Further work is required to agree and document clinical pathways for Bladder cancer, Prostate cancer and Brain & Central Nervous System cancers by 31st December 2013. Implementation of these pathways will be reviewed in February 2014.</p>	<p>Audit of compliance with pathways commences February 2014</p>			

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
	<p>The Trust Cancer Board will undertake a rolling review of all pathways and compliance through an audit programme commencing in February 2014, the first cycle of audits will be complete by July 2014. Audit of compliance will be conducted thereafter at a frequency of no less often than once each year. The Trust's Patient Safety Committee will receive a detailed review of this programme and compliance quarterly in 2014/15 and then annually once assurance is in place.</p> <p>Regular audits of at least 10 patients per cancer service to ensure the published pathways are being followed.</p>				
b) Failsafe paper processes Cancer services at the Trust are dependent on a	Whilst the Trust will remain reliant on manual data handling until the implementation of the Somerset Cancer information system, the Trust has put in	Central office operational by 18 th December 2013	NO The service was not compliant with	YES Intensive monitoring: North East Essex CCG has embedded a manager	End March 2014

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
<p>number of paper-based processes. These include:</p> <ul style="list-style-type: none"> • faxed GP referrals • inter-MDT transfers and inter-Hospital transfers • radiology urgent requests and upgrades of patients with suspicious findings on imaging to cancer pathways • upgrades by consultants of patients on routine pathways to cancer pathways <p>These processes create multiple risks that patients will be “lost” in the transfer</p>	<p>place a central office to log and track all referrals and transfers of patients between cancer teams in the Trust and to other hospitals. Internal management of referrals will be operational by 18th December 2013, but external management of referrals will be as follows :</p> <ul style="list-style-type: none"> • Inter-Trust incoming referrals – by 7th January 2014 • 2 week wait referrals – by 31st March 2014 <p>An audit of performance of the central office is required by end of February 2014.</p> <p>The Trust has appointed a Cancer Programme Director (from outside the organisation) who has a wealth of experience overseeing the management of cancer pathway data and who is an expert in the correct</p>	<p>Audit of performance by February 2014</p> <p>Cancer Programme Director started November 2013</p>	<p>acceptable standards. Intensive monitoring required</p>	<p>on and a quality manager in the Trust to assure the safe management of cancer services on a daily basis.</p>	

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
between one part of the service and another	<p>interpretation of national guidance. This post holder will oversee the work of the MDT co-ordinators and will be responsible for training and supporting them in this role.</p> <p>The cancer waiting times (CWT) management module of Somerset implementation is planned to commence at end February 2014, subject to SCR ability to provide and install the software. This is being undertaken with the support of ECRIC (Eastern Cancer Registry Information Centre) to ensure compliance with all national dataset requirements.</p> <p>The development and implementation of the clinical modules of the Somerset system will commence once installation of the CWTs element has been completed, and full</p>	<p>Implement Somerset Cancer information system waiting times module by end February 2014. Full implementation by end of 2014</p>			

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
	implementation will be complete by the end of 2014.				
<p>c) Audit of cancer waiting times data</p> <p>The CQC report stated that “during the inspection we were provided with examples by three members of staff where they told us that they felt they had been pressured, bullied or harassed to change the data on the cancer pathways to prevent a breach of the pathway”. The Intensive Support Team and clinical site visit teams identified the need to audit cancer waiting times data regularly to validate that the</p>	<p>The Trust and the CCG have established a weekly mechanism to review all cancer waiting times data with effect from October 2013. This process, which will continue until full assurance can be given, will ensure frequent systematic audit of the CWT data to ensure correct entries are made</p> <p>The Trust will also conduct a weekly audit to review all changes to appointment or treatment dates on the cancer waiting times tool to ensure they are valid. This audit will be reviewed at the weekly meetings with the CCG.</p> <p>A review of changes to the “decision to treat” dates will be a manual process comparing snapshots of the cancer waiting</p>	<p>Weekly audits of CWT data commenced September 2013</p> <p>20th December 2013</p> <p>Protocol to be agreed with CCG by end January 2014</p> <p>End February 2014</p>	<p>NO</p> <p>The service was not compliant with acceptable standards. Intensive monitoring required</p>	<p>YES</p> <p>Intensive monitoring: North East Essex CCG will continue to monitor the progress of all patients on the cancer waiting list on a weekly basis and to investigate the management of any patients whose care is not proceeding in line with national standards; this includes audit to validate the cancer waiting times data. In addition it has North East Essex CCG has embedded a manager on and a quality manager in the Trust to assure the safe</p>	<p>End January 2014</p>

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
correct data is recorded and review any amendments to ensure they are appropriate	list between different dates. The Somerset Cancer information system module which will address these data collection and audit issues and is expected to be implemented by end February 2014			management of cancer services on a daily basis; they will review amendments to the cancer waiting times data	
d) Oncology workload Issues with the workload of the oncology team were identified in a number of cancer Teams. Additional oncology capacity is required to provide a full range of oncology services.	Additional locum oncologist time has been secured for the period of 6 months from December 2013. This locum is now providing additional capacity for 3 days per week. The IMT agrees that this is now sufficient to provide oncology support to all cancer teams at the Trust. The Trust has approved the funding and recruitment of an additional oncologist (recruitment process to commence December 2013 – appointment anticipated in February 2014, with the successful appointee in post by June 2014.	Completed 13 th December 2013	YES	N/A	Completed

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
e) Review of all cancer services workforce Workload pressures, difficulties in providing cover for leave or staff absence and shortages of clinical nurse specialists or MDT co-ordinators were identified in a number of cancer teams including Head & Neck, Urology and Cancer of Unknown Primary origin	A full workforce review, benchmarking the Trust cancer services' workforce against peers will commence in January 2014. The Board of Directors will be briefed on this process and outcome. An agreed plan to address any identified resourcing deficiency will be implemented, and monitored by the Board.	Commences January 2014 Review to complete by 28 th Feb 2014	NO Measures have already been put in place to meet acceptable standards. Enhanced monitoring required	Trust will commission an external review of its cancer services workforce. Rolling job planning is on-going. Clinical Nurse Specialist workload is being reviewed by the new Trust Director of Nursing and will be completed by the end of March 2014	End March 2014
f) Governance arrangements Good governance is required to oversee and ensure the delivery of high quality cancer services. The Trust Cancer committee had lapsed between	The Medical Director has been nominated as the Executive responsible for Cancer. The Trust Cancer Committee is being reconstituted as a Cancer Board, to be chaired by an experienced clinician involved in cancer care, which will meet monthly (2-weekly in the first	Completed 13/12/13 From December 2013	NO The service was not compliant with acceptable standards. Intensive monitoring required	YES Intensive monitoring: North East Essex CCG has embedded a manager on and a quality manager in the Trust to assure the safe management of cancer services on a	End June 2014

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
the end of 2012 and June 2013. Executive leadership for cancer was poorly recognised by staff, clinical leadership roles, particularly the Trust Lead cancer nurse were unfilled or poorly defined. Clinical audit did not systematically review all areas of performance or the effectiveness of Cancer MDTs. Root Cause Analysis was not conducted for patients who were not treated within national waiting time standards.	<p>instance).</p> <p>The Cancer Board will agree its annual work plan with the Medical Director and will report on this at least quarterly. The Cancer Board will oversee all cancer performance and alert the Medical Director of any concerns.</p> <p>The Cancer Board will report to the Executive team, via the Medical Director, and will also make a formal report to the Board annually (quarterly in 2014/15)</p> <p>A Trust Lead cancer Nurse will be recruited. The newly appointed Trust Director of Nursing will fill this role pro-tem.</p> <p>The responsibilities of the clinical leads of each MDT have been clarified and circulated, these will</p>	<p>First report by end January 2014</p> <p>First report to Board in February 2014</p> <p>Advert in January, aim to appoint by April 2014</p> <p>Agreement at Cancer board 16th December 2014. Job planning is a rolling process</p> <p>Report to</p>		<p>daily basis; they will assess the understanding of cancer services staff regarding governance arrangements. In addition the CCG will continue to monitor the progress of all patients on the cancer waiting list on a weekly basis and to investigate the management of any patients whose care is not proceeding in line with national standards.</p> <p>Monitor have commissioned a review of all Trust governance which will report in February 2014</p>	

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
	<p>form part of the individual clinician's annual appraisal and objectives in respect of each MDT will be agreed and monitored through the Cancer Board.</p> <p>Board assurance will be received through the Quality and Patient Safety Committee, through regular reports from the Medical Director and Chair of the Cancer Board.</p> <p>The MDT Co-ordinator Team will receive training on the Cancer Waiting Times national standards which will be assessed annually.</p> <p>Systematic audit schedules for MDTs and root cause analysis (RCA) of all breaches of the national waiting times standards will be implemented.</p>	<p>committee in January, to Board in February 2014</p> <p>Training undertaken in December and complete by end January 2014</p> <p>RCA incorporated into responsibilities of MDT clinical lead with immediate effect. Audit schedules to be agreed with Cancer Board by end March 2014</p>			

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
g) Safeguarding Adults and Children The IMT were not assured by the Trust's arrangements for the Safeguarding of Adults and Children. The Trust must ensure that people who use Trust cancer services are protected from abuse, or the risk of abuse.	<p>The Trust has established policies and procedures in place for safeguarding children and safeguarding vulnerable adults.</p> <p>The Trust will confirm the Non-Executive Director lead for Adult and Children's Safeguarding and ensure that all board members receive training in their responsibilities.</p> <p>In respect of learning disability, the Trust has policies and procedures in place specific to the needs of patients with learning difficulties and learning disability.</p> <p>The Trust's internal intranet has a section containing an e-training module advice and information for staff needing additional information on safeguarding vulnerable adults.</p>	<p>Completed 12th December 2013</p> <p>From 16th December 2013</p>	NO Measures have already been put in place to meet acceptable standards. Enhanced monitoring required	YES Essex County Council and CCG staff are conducting weekly unannounced visits to the Trust which include observing and reviewing Safeguarding practice and questioning Trust staff about their understanding of procedures	End March 2014

Immediate risk area	How has this been addressed by the Trust?	When will this be done by?	Was the service safe as of 13 th December?	Have further immediate measures been taken to improve the safety of this service?	When are all required improvements expected to be completed?
	<p>During week commencing 16 December 2013 the Trust will be undertaking additional communication (via email, intranet, chief executive's briefing, and trust newsletter) to all staff reminding them of the availability of this support and promoting its use where appropriate.</p> <p>In addition the Trust will ensure that all staff in cancer services are trained in Safeguarding working practices in line with national guidance and Essex protocols</p>	31 st March 2014			

7.3 Assessment by Cancer team

7.3.1 Acute Oncology

Cancer service name

Acute Oncology

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
There is only one nurse covering the Acute Oncology Service, without any clear contingency for annual leave or absence which can compromise the service [the peer review standard is two nurses supporting this service]	A review of the clinical nurse specialist workforce requirements is being undertaken to comply with IOG guidance. A minimum of two clinical nurse specialists is required to ensure adequate cover. Further details are in section 7.2 General immediate risks	Review underway by Trust Director of Nursing – complete by end March 2014
	Recruitment for additional workforce review clinical nurse specialist post to commence and appointment made.	By end April 2014
	Phased The move of oncology services from Essex County Hospital to Colchester General Hospital will consolidate all Cancer nursing services on the CGH site.	Radiotherapy will be moved by April 2014, move complete end October 2014
	Acute Oncology CNS annual leave cover plan in place by other CNS or partner site	From 16 th December 2013

What good practice was found in this Cancer service?

Examples of good practice
Have worked hard to set up the service
Work well as a team
Link in well with Palliative Care

7.3.2 Brain & Central Nervous System

Cancer service name

Brain & Central Nervous System

Was the service safe as of 13th December?

NO

Appropriate mitigation in place, but follow-up review required
Enhanced monitoring

Have further immediate measures been taken to improve the safety of this service?

YES

North East Essex CCG will continue to monitor the progress of all patients on the Cancer waiting list on a weekly basis and to investigate the management of any patients whose care is not proceeding in line with national standards

When are all required improvements expected to be completed?

End of February 2014

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
Lack of clear documented pathway	<p>A revised pathway has been received – 16th December 2013. The Trust needs to show that the pathway is being used and audited. This will be reviewed by end February 2014 This will be reviewed by end February 2014.</p> <p>Pathways for solitary and oligometastases pathways have been provided to the Review Team.</p> <p>The Brain MDT will be auditing the pathway for Glioblastoma Multiforme (WHO 2007) grade IV (the most common type of brain tumour) for six months commencing January 2014, as part of the London Cancer Alliance and East of England Strategic Clinical Cancer Network.</p>

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Oncology consultant has multiple responsibilities	<p>A locum Consultant has been appointed for six months from December 2013. Substantive post approved in December 2013. Recruitment process underway and appointee to be in post.</p> <p>Consultant Oncologist workforce review to be completed. This is dealt</p>	Completed 13 th December 2013

	with as a General Immediate Risk in section 7.2 General immediate risks	
Pathway issues for metastatic spinal cord compression with clinicians referring to 3 different pathways	There is a policy in place for all referrals to be to the one official referral centre for metastatic spinal cord compression (MSCC), which is Queens Hospital, Romford. The Trust will confirm this policy with all referring Clinical staff.	By 20 th December 2013
There is no clearly identified point of contact for an MSCC coordinator [at the neurosurgical centre]	The MSCC co-ordinator is always the on call neurosurgical registrar at Queens Hospital Romford, contactable on a dedicated phone, via BHR Queens Hospital main switchboard, as documented in the MSCC pathway in the local operational policy (Appendix L) (Appendix L). This can also be found in the Trust's Acute Oncology Operational policy	Completed 16 th December 2013
Provision over weekends for patients with spinal cord compression is limited to an emergency MRI list on Saturday mornings	There is availability of MRI scanning on site at Colchester 365 days a year. The Trust has confirmed this Policy to staff. MRI policy circulated to all staff on 12 th December	12 th December 2013
Appendix K in the Operational Policy outlines a referral pathway but does not give any contact details	The Trust has reviewed Appendix K and updated as appropriate. All the contact numbers are at the bottom of Appendix K labelled "Contacts" on page 37	16 th December 2013
No Policy within the Trust to undertake a system of referral when there is a suspect tumour.	<p>The Trust is implementing a policy and protocol whereby all radiology incidental findings where Cancer is suspected will be sent electronically to the Contact Centre (for central logging) and electronically forwarded to the MDT Co-ordinator Team nhs.net email account (clearly identifying the tumour site).</p> <p>On receipt of the copy of the abnormal radiology report, the MDT coordinators will add the patient to the MDT meeting for discussion of on-going care</p> <p>A letter implementing the new arrangement has been sent by the Medical Director to all appropriate staff on 12 December 2013.</p>	Completed 12/12/13
GPs refer to neurologist,	There are 2.5 permanent neurologists	Completed

there has been a staffing issue and posts filled by locums. There does not seem to have been consultant upgrade.	<p>on staff with locums to support.</p> <p>Staffing establishments will be reviewed. This is dealt with as a General Immediate Risk in section 7.2 General immediate risks</p> <p>The operational policy has been amended to include prompts for consideration of upgrade in clinic – 16th December</p>	16 th December 2013
Appendix K outlines a pathway for patients with 1 brain metastases but not guidance for oligometastases or leptomeningeal disease	Oligometastases treatment is covered on p.18 of the local operational policy, in section 6.3 The Treatment Pathway; Brain & CNS Cancer Pathway. There is no established treatment pathway or guidelines for leptomeningeal diagnosis. This is not included in any of the Brain and CNS policies for Queens Hospital and East of England Cancer Network; and this is not addressed in the "Improving Outcomes for People with Brain and Other CNS Tumours" guidelines, from NICE 2006.	By 31 st March 2014
No representation from the hospital management so it is not clear if there is a governance structure	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A
There does not appear to be a Trust policy for internal validation of standards for peer review.	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A
Lack of evidence that there is sufficient team working between Colchester and Ipswich	<p>Ipswich is not an IOG compliant centre for the treatment of Brain tumours. Colchester works with Queen's Hospital in Romford (Neurology and Neurosurgical Centre for the region). The Trust will maintain a central recording of NSSG attendance in all Cancer service</p> <p>This is dealt with as a General Immediate Risk in section 7.2 General immediate risks</p>	N/A

What good practice was found in this Cancer service?

Examples of good practice
Dedicated clinicians
Good MDT coordinator
Excellent CNS – who has set up a North and Mid Essex Brain Cancer Support Group

7.3.3 Breast

Cancer service name

Breast

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None Identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Staffing at all levels on the team leaves the service vulnerable, as they are working to full capacity including extra evening clinics	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	End of December 2013
Accommodation does not allow the team to be as flexible as they would like to be	Accommodation for the breast service will be reviewed and addressed as part of the Trust plans to rationalise space on the ECH site and agree the future disposition of services between CGH and the ECH sites.	Radiotherapy to complete move in April 2014, other services to follow. Agreed plans by 30 th June 2014
Data collection systems are out-dated, with data being uploaded onto separate systems	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A

What good practice was found in this Cancer service?

Examples of good practice
Close team all feel able to raise and discuss concerns
All new patients seen at One Stop clinic
Award winning Secondary Cancer Nurse service

7.3.4 Colorectal (lower GI)

Cancer service name

Colorectal (Lower GI)

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Anal Cancer pathway remains unclear despite previous identification at peer review over a number of years	<p>The IMT has agreed with the Trust that all patients requiring complex Anal Cancer surgery in the Colorectal (lower GI) Cancer service are to be directed to IOG compliant specialist centres for their care with immediate effect.</p> <p>This is an NHS England Specialist commissioning and Essex CCGs responsibility</p> <p>1) agree and document a single pathway for anal Cancer in Essex</p> <p>2) Need an IOG compliant centre in Essex – long term issue.</p>	<p>17th December 2013</p> <p>Confirm plan by July 2014</p>
Capacity of the colorectal nurse specialist team with current responsibilities appears unsustainable	This is also dealt with as a General Immediate Risk in section 7.2 General immediate risks	By end of December 2013
MDT co-ordinator service appears vulnerable due to a lack of cover arrangements, training and support.	<p>A workforce review will be completed. A workload review and assessment of MDT resources/skills has commenced.</p> <p>Training for MDT administrative staff has commenced and will continue through to the end of January 2014 with on-going training and support</p>	Complete by end January 2014

	<p>thereafter.</p> <p>Supported by additional resource of Cancer Programme Director, commenced November 2013.</p> <p>This is dealt with as a General Immediate Risk in section 7.2 General immediate risks</p>	<p>Started November 2013</p>
Poor organisational infrastructure for IT systems, resulting in a lack of a robust system to collate and review clinical outcome data	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A

What good practice was found in this Cancer service?

Examples of good practice
Hardworking, cohesive and dedicated team
Robust pathway in place with mechanisms for capturing patients entering from alternative routes

7.3.5 Cancer of Unknown Primary origin (CUP)

Cancer service name

Cancer of Unknown Primary origin (CUP)

Was the service safe as of 13th December?

NO

The service was not compliant with acceptable standards. Additional measures required by the dates indicated. Intensive monitoring in place.

Have further immediate measures been taken to improve the safety of this service?

YES

North East Essex CCG will continue to monitor the progress of all patients on the Cancer waiting list on a weekly basis and to investigate the management of any patients whose care is not proceeding in line with national standards. This will include patients who are transferred from one Cancer service to another which is often the case with Cancer of Unknown Primary origin

When are all required improvements expected to be completed?

End of June 2014

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
The Trust is currently setting up the MDT structure	<p>Interim operational policy has been implemented stating to which MDT Cancers of Unknown Primary will be referred.</p> <p>For example, in a patient with multiple liver metastases, if further investigations proves this to be of lung origin, there care will be transferred to the Lung team.</p> <p>The Trust is implementing a policy and protocol whereby all radiology incidental findings where Cancer is suspected will be sent electronically to the Contact Centre (for central logging) and electronically forwarded to the MDT Co-ordinator Team nhs.net email account (clearly identifying the tumour site). To be completed by 20th December 2013</p> <p>On receipt of the copy of the abnormal radiology report, the MDT coordinators will add the patient to the MDT meeting for discussion of on-going care</p> <p>A letter implementing the new arrangement has been sent by the Medical Director to all appropriate staff</p>

	<p>on 12 December 2013.</p> <p>CUP MDT will be developed and in place by 31st March 2014</p> <p>The Trust has not yet fully set up this Cancer service and key members of the core MDT are not yet in post. The MDT co-ordinator and histopathologist have still to be assigned. Service development in progress to be completed by end of March 2014. Patients are currently being managed by other specialties within the Trust.</p>
[The Trust] have not audited CUP patients	<p>CUP cases will be reviewed for audit as part of the process of the existing MDTs. When established the CUP MDT will take over this responsibility, by 31st March 2014.</p> <p>The Trust will build in audits as a part of the service development plan.</p>
No capacity or defined pathway to manage [isolated] liver lesions	<p>Develop and implement an interim pathway to clarify where patients with isolated liver lesion will go prior to the development of the MDT service.</p> <p>Put together a pathway to clarify where liver lesion patients will go prior to the development of this service. A protocol for the referral of isolated liver lesions identified on imaging to be referred to the Upper GI MDT was confirmed with Trust staff on 13/12/13.</p>

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
No trust guidelines for systemic therapy treatment for these patients	Patients are referred to the appropriate Cancer team once the Cancer type is identified and there are guidelines for the specialist areas. This will be incorporated in the CUP operational policy. The guidelines developed by the Essex Cancer Network for chemotherapy are followed in planning and delivering treatment by the Trust.	31 st December 2013
No evidence that patients are being entered into CUP trials	<p>Study development is in progress with the Sanger Wellcome Whole-Genome Unit, and will be subject to R&D and ethical approval.</p> <p>Further trials will be considered once MDT structure is in place</p>	By 31 st March 2014

What good practice was found in this Cancer service?

Examples of good practice

Network teleconference set up to discuss complex patients of unknown primary

7.3.6 Gynaecology

Cancer service name

Gynaecology

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
Oncology arrangements – a locum consultant is providing the gynaecological service to cover pressure on the service	This is also dealt with as a General Immediate Risk in section 7.2 General immediate risks

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Difficulty in raising concerns and getting them resolved.	Staff helpline put in place, listening sessions scheduled, general staff information and support has been improved.	Commenced 5 th November 2013
Leadership not always effective in identifying risk and resolving problems	Monitor are undertaking a review of governance arrangements at the Trust, see section 5.4 Monitor for further details. The Trust have appointed an interim Cancer Programme Director to lead development of Cancer services	Expected to report end of February 2014 In post full time from 9 th December
Reported high levels of non-attendance at divisional and governance meetings	Attendance at Divisional and service governance meetings has been reinforced with all members of the team. Attendance will be monitored, reported and reviewed as part of the on-going audit process and peer review	Confirmed 16/12/13
Difficulty planning interval surgical slots at Ipswich often necessitating a forth cycle of pre-op	When patients are first discussed at the Specialist MDT, with Ipswich surgeons, the Trust will confirm with Ipswich that the planned theatre slot is	End of January 2014

chemotherapy, which is not standard	booked at that stage. This will avoid delays due to delayed booking of theatre slots.	
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What good practice was found in this Cancer service?

Examples of good practice
Clear responsible clinician for each patient
Good teamwork and commitment in the clinical team
Same-day hysteroscopy available in outpatients

7.3.7 Haematology

Cancer service name

Haematology

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Lack of electronic data system	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A
Lack of an E-prescribing system	E-prescribing system currently being implemented	By 31 st March 2014
Lack of dedicated junior staff within department	There is a plan to review the operational policy for designated medical staff and beds when inpatient beds move from the Essex County Hospital site to Colchester General during 2014. At this point oncology and haematology will share the same ward and medical staff, with designated resources allocated to each specialty.	By 31 st October 2014
Consultant job plans not reflecting the amount of work undertaken	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	By end of March 2014
Clinical nurse specialist used as a regular resource outside the normal duties of a haematology clinical nurse specialist	The Trust Director of Nursing is reviewing the roles and responsibilities of the clinical nurse specialist to ensure sufficient time to complete the core duties, associated with an IOG compliant service. This is also dealt with as a General	By end of March 2014

	Immediate Risk in section 7.2 General immediate risks	
Lack of support and full cover for the MDT co-ordinator who is shared across other sites	MDT coordinator is now supporting only Haematology This is also dealt with as a General Immediate Risk in section 7.2 General immediate risks	Completed 13/12/13
Frustration over staff not being heard with regard to the need for additional resources	Reconstitution of Cancer Committee which will oversee Cancer service and Monitor which will oversee the governance issues This is also dealt with as a General Immediate Risk in section 7.2 General immediate risks	

What good practice was found in this Cancer service?

Examples of good practice
Good teamwork and commitment in the clinical team
Clear responsible clinician and key worker for each patient
Resources and process for following up patients who miss clinic appointments – particularly for those patients with learning disabilities.

7.3.8 Head & Neck (incl. Thyroid)

Cancer service name

Head & Neck (Including Thyroid)

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Staffing at all levels on the team leaves the service vulnerable as single handed clinicians are working at maximum capacity	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	End of March 2014
There is no contingency for the rising number of referrals as team members are working at capacity	NE Essex CCG and NHS England Specialist commissioning to undertake a capacity review with the Trust of diagnostic services available in the community Workforce review in Cancer Service by end of December 2013 Trust to review with the East Anglia Specialist Commissioning Team the arrangements for Head & Neck Cancer across Colchester and Chelmsford. Trust led audit of 2 week wait referrals against NICE criteria for suspected H&N Cancer referrals CCG to review 2 week wait referral process with GPs	September 2014 End December 2013 31 st January 2014 31 st March 2014
Additional clinical nurse specialist support as required	Head & Neck CNS annual leave cover plan in place by other CNS or partner site	By 20 th December 2013

	This is also dealt with as a General Immediate Risk in section 7.2 General immediate risks	
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What good practice was found in this Cancer service?

Examples of good practice
Excellent working relationships in a stable team evident during the team review.
Excellent and clear Operational Policy document.
Good completeness of upload to the National Audit Data Base.

7.3.9 Lung

Cancer service name

Lung

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Clarity of referral pathway from the Emergency Department	Established pathway in place	Confirmed in place by IMT on 13/12/13
Delays to the pathway caused by EBUS capacity	Local service proposal for EBUS being developed. Business Case being to be submitted to the CCG for consideration as part of the 2014/15 contract. Subject to CCG approval EBUS to be initiated by April 2014	Submitted 16/12/13 30 th April 2014
Histopathologist cover and succession planning for imminent retirement of current very experienced histopathologist	Cover has been identified in the immediate term within existing staffing. Further actions to secure the service long term: <ul style="list-style-type: none"> 6th histopathologist commences Additional locum Staff Grade appointed November 2013 Recruitment of additional histopathologist commenced December 2013 Potential locum to cover retiree being identified This is dealt with as a General	Complete 16 th December 2013 23 rd Dec 2013 Complete 31 st Dec 2013

	Immediate Risk in section 7.2 General immediate risks	31 st Dec 2013
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What good practice was found in this Cancer service?

Examples of good practice
Very close clinical team who work well together
Excellent clinical lead, very supportive of the team
Holistic assessment being carried out routinely

7.3.10 Paediatric

Cancer service name

Paediatric

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
None identified		

What good practice was found in this Cancer service?

Examples of good practice
The transfusion nurse ran a training session, redesigned the forms with the doctors to make them more user friendly and the form filling improved significantly. The new forms have been cascaded to the whole paediatric team.
Most of the team attend the Addenbrookes MDT teleconferences
ICP has been streamlined and a review has been undertaken with the new NICE guidelines.

7.3.11 Radiology

Cancer service name

Radiology

Was the service safe as of 13th December?

NO

Appropriate mitigation in place, but follow-up review required. Enhanced monitoring

Have further immediate measures been taken to improve the safety of this service?

YES

North East Essex CCG has embedded a full-time commissioning manager and a full-time quality manager in the Trust to assure the safe management of Cancer services on a daily basis. This will include reviewing the tracking of Cancer related radiology requests and patients upgraded to Cancer services from radiology

When are all required improvements expected to be completed?

End of February 2014

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
Only the chest team appeared to have a direct referral process for suspect Cancers picked up by radiology	<p>The Trust has implemented a policy and protocol whereby all radiology incidental findings where Cancer is suspected will be sent electronically to the Contact Centre (for central logging) and electronically forwarded to the MDT Co-ordinator Team nhs.net email account (clearly identifying the tumour site) - 16th December 2013</p> <p>On receipt of the copy of the abnormal radiology report, the MDT coordinators will add the patient to the MDT meeting for discussion of on-going care</p> <p>A letter implementing the new arrangement has been sent by the Medical Director to all appropriate staff on 12 December 2013.</p>
If liver lesions are seen [as an incidental finding] they may phone a consultant but no formal protocol is in place.	The Trust has implemented a policy and protocol whereby all radiology incidental findings as detailed in the response to the first immediate risk listed for this Cancer service - 16 th December 2013
No protocol in use for urgent findings	The Trust has implemented a policy and protocol whereby all radiology incidental findings as detailed in the response to the first immediate risk listed for this Cancer service - 16 th December 2013

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
None identified		

What good practice was found in this Cancer service?

Examples of good practice
Two new leads in post
Radiology does not outsource target patients (patients on suspected Cancer pathways)
An internal tracking system for Target patients, managed by two individuals, has recently been introduced.

7.3.12 Radiotherapy

Cancer service name

Radiotherapy

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Small consultant oncology team	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A

What good practice was found in this Cancer service?

Examples of good practice
Managing the move, use of outside support for technical commissioning of equipment
Strong radiographer leadership and multi-professional working
New fully staffed department in new build.

7.3.13 Sarcoma

Cancer service name

Sarcoma

Was the service safe as of 13th December?

NO

Appropriate mitigation in place, but follow-up review required. Enhanced monitoring

Have further immediate measures been taken to improve the safety of this service?

YES

North East Essex CCG will continue to monitor the progress of all patients on the Cancer waiting list on a weekly basis and to investigate the management of any patients whose care is not proceeding in line with national standards. In addition it has embedded a full-time commissioning manager and a full-time quality manager in the Trust to assure the safe management of Cancer services on a daily basis; they will review communications between Histopathology and Oncology

When are all required improvements expected to be completed?

End of June 2014

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
Histopathology could go to London without the Oncology Department knowing it was a diagnosed sarcoma for 2 nd review	The Trust is not a receiving site for 2 week wait sarcoma referrals. A revised pathway has been produced, 16 th December 2013, modelled on the London & South East pathways. The pathway has been received by the IMT and needs to be reviewed by the clinical site visit team for assurance.
No safety netting internally with no clear pathway structures in place.	<p>The Trust is implementing a policy and protocol whereby all radiology incidental findings where Cancer is suspected will be sent electronically to the Contact Centre (for central logging) and electronically forwarded to the MDT Co-ordinator Team nhs.net email account (clearly identifying the tumour site). To be implemented by 20th December 2013.</p> <p>On receipt of the copy of the abnormal radiology report, the MDT coordinators will add the patient to the MDT meeting for discussion of on-going care</p> <p>A letter implementing the new arrangement has been sent by the Medical Director to all appropriate staff on 12 December 2013.</p>

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
When patients were returned post-surgery, there was no dedicated team other than the oncologist who said he referred back to London if there were post –operative complications.	<p>Sarcoma patients are referred back to Colchester from London for radiotherapy. All inter-Trust referrals to be directed to Trust contact centre in accordance with revised management of all Cancer referrals.</p> <p>Improved communications with the relevant London provider, for tracking purposes through the relevant MDT co-ordinators. For Colchester this will be via a single central e-mail address.</p>	<p>20th December 2013</p> <p>End February 2014</p>
Not clear how the patient is tracked through the system and how they are put on a pathway. No single consultant in charge.	<p>Included in the revised pathway. Tracking detailed above</p> <p>The IMT is awaiting confirmation of a designated Consultant oncologist for Sarcoma</p> <p>Shared care arrangements defined.</p>	<p>16th December 2013</p> <p>End December 2013</p>

What good practice was found in this Cancer service?

Examples of good practice
None noted

7.3.14 Skin

Cancer service name

Skin

Was the service safe as of 13th December?

NO
Appropriate mitigation in place, but follow-up review required. Enhanced monitoring

Have further immediate measures been taken to improve the safety of this service?

YES
North East Essex CCG has embedded a full-time commissioning manager and a full-time quality manager in the Trust to assure the safe management of Cancer services on a daily basis. This will include review the attendance at the MDTs on a weekly basis to assure compliance with national standards

When are all required improvements expected to be completed?

End of April 2014

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
Current triage pathway appears to be inconsistent with the Two Week Wait pathway as some patients may not be seen face to face by a consultant dermatologist for up to 4 weeks	Trust has taken immediate action by putting in more photographic sessions from 16 th December to allow consultant face-to-face review as appropriate within two weeks.
Histopathology cover for the MDT and therefore MDTs are meeting without a Histopathologist being present and slides are not viewed	<p>For difficult to diagnose cases the full multidisciplinary team needs an opportunity to discuss diagnosis and treatment options. With difficult cases or those requiring a further opinion, the slides are sent to the tertiary referral centre at St Thomas' Hospital for their opinion.</p> <p>Histopathology resources are being enhanced:</p> <ul style="list-style-type: none"> • Cover for the Skin MDT has been identified in the immediate term from 31st December 2013 • 6th histopathologist in post 23rd December 2014 • Additional histopathology locum Staff Grade appointed November 2013 • Recruitment of additional histopathologist commenced December 2013 • Potential locum to cover retiree being identified

	This is also dealt with as a General Immediate Risk in section 7.2 General immediate risks
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What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Governance issues regarding community skin providers – [the Trust is] not clear who is responsible for their clinical governance	The commissioner, North East Essex CCG, has given assurance about the governance of this service.	Confirmed to IMT 13/12/13
MDT Chair is based at Broomfield Hospital which limits the amount of support given to the MDTs	The Trust will work with Mid Essex Hospitals Trust and the East of England Specialist Cancer Network to review Specialist MDT lead job plan and ensure adequate time to support the unit MDT at Colchester.	End January 2014
Time allocated for MDT discussion is not adequate due to lack of space	The clash between Skin and Germ Cell MDTs has been resolved – new arrangements to commence early January 2014.	17 th January 2014
Lack of clinical nurse specialist support – a single [nurse] is working at full stretch	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A
CNS has the role of breaking bad news to many of the patients singlehandedly	The role of clinical nurse specialist and Consultant Dermatologist in breaking bad news to be reviewed by the Trust This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	End January 2014
Out of date data collection systems, requiring duplication of data into different systems	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A

What good practice was found in this Cancer service?

Examples of good practice
Easily identifiable responsible clinician for each patient
Single person responsible for removing patients from the PTL on consultant approval
Supportive Team

7.3.15 Teenage & Young Adults

Cancer service name

Teenage and Young Adults

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
None identified	

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
[The] nature of lead clinician consultant oncology role was at risk... a workload that may be unsustainable	This is dealt with as a General Immediate Risk in section 7.2 General immediate risks	N/A
The site specific consultants don't themselves [very often] link into the Teenage & Young Adult MDT and the London Specialist MDTs.	Trust to review link protocol and attendance at Teenage & Young Adult Specialist MDT	31 st December 2013

What good practice was found in this Cancer service?

Examples of good practice
None noted

7.3.16 Upper GI

Cancer service name

Upper GI

Was the service safe as of 13th December?

YES

Have further immediate measures been taken to improve the safety of this service?

None required

When are all required improvements expected to be completed?

N/A

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
No dedicated Cancer data system, data not easily accessible or easily uploaded to national data sets. Information is manually uploaded from different sites which is time consuming and open to error	This is also dealt with as a General Immediate Risk in section 7.2 General immediate risks
Stopping of pathways by Non-consultant	The Trust have put in place a policy whereby a consultant must sign-off when stepping a patient down from a Cancer pathway. This was confirmed at the site visit on 20 th November 2013.

What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Lack of clarity around who should investigate liver lesions and how they were tracked	<p>The Trust is implementing a policy and protocol whereby all radiology incidental findings where Cancer is suspected will be sent electronically to the Contact Centre (for central logging) and electronically forwarded to the MDT Co-ordinator Team nhs.net email account (clearly identifying the tumour site). To be implemented by 20th December 2013.</p> <p>On receipt of the copy of the abnormal radiology report, the MDT coordinators will add the patient to the MDT meeting for discussion of</p>	A protocol for the referral of isolated liver lesions identified on imaging to be referred to the Upper GI MDT was confirmed with Trust staff on 13/12/13.

	<p>on-going care</p> <p>A letter implementing the new arrangement has been sent by the Medical Director to all appropriate staff on 12 December 2013.</p>	
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What good practice was found in this Cancer service?

Examples of good practice
None noted

7.3.17 Urology

Cancer service name

Urology

Was the service safe as of 13th December?

NO

The service was not compliant with acceptable standards. Additional measures required by the dates indicated. Intensive monitoring in place.

Have further immediate measures been taken to improve the safety of this service?

YES

North East Essex CCG has embedded full-time commissioning manager and a full-time quality manager in the Trust to assure the safe management of Cancer services on a daily basis.

When are all required improvements expected to be completed?

End of June 2014

What Immediate Risks were identified and how have they been addressed?

Immediate Risk as stated in site visit report	How has it been addressed?
Lack of up to date, accurate and agreed timed pathways for prostate, renal and bladder Cancers	<p>Renal pathway assured 13th December 2013. Testicular and Penile Cancer pathways were assured at the clinical site visit.</p> <p>Amendments have been made to Bladder and Prostate pathways as per recommendations by Medical Director, NHS England Essex Area Team. Quality assurance by the clinical site visit leads is awaited</p> <ul style="list-style-type: none"> • Bladder Cancer pathway <ul style="list-style-type: none"> ○ Simplified and clarified • Prostate Cancer pathway <ul style="list-style-type: none"> ○ Simplified ○ Agreed commitment to increase MRI resource to additional 2 PAs ○ Additional histopathology (1 to 2 sessions per week) ○ Prostate template equipment purchased ○ Increased theatre capacity to perform Template biopsies ○ Local MDT expanded to two hours to discuss all biopsies including negative ones <p>Trust to put in place a continuous audit system and the CCG will review and validate the audits via the weekly Cancer pathway enhanced surveillance</p>

	<p>group.</p> <p>A follow up review is required to assure compliance – to be completed by end of February 2014.</p>
Capacity issues / waiting time breeches [in the Urology Service]	<p>A detailed capacity and activity plan has been produced for Quarter 4 2013/14, this will provide capacity for 176 additional cases in the quarter, and is intended to address the immediate capacity concerns associated with delivering the national standards.</p> <p><u>IMMEDIATE ACTIONS (0 to 3 months)</u></p> <ul style="list-style-type: none"> • Consultant Urologist all-day Saturday operating lists (6 cases per week for 8 weeks = 48 cases starting Jan 4th 2014 • Associate Specialist freed up to deliver two operating lists per week (6 cases per week) and two out-patient clinics per week from Jan 2nd 2014 (Temporary locum Registrar to backfill with immediate effect) • Agreement with third party provider to outsource from 13 January 2014, ten cases per week for eight weeks initially, as identified in detailed capacity and activity plan • Commencement of 2WW raised prostate specific antigen (PSA) clinic 23rd December 2013 • Commencement prostate Cancer Active Surveillance Clinic 23rd Dec 2013 • Increased pre-assessment slots from three to five days per week with additional contingency on Saturdays. <p><u>MEDIUM TERM ACTIONS (3+ months)</u></p> <ul style="list-style-type: none"> • Extend two half day operating lists to full day lists from Feb 2014 • Exploration of extra Day Case operating list per week. • Third full time Cancer Urologist commencing March 2014 • Appointment of 6th Consultant Urologist agreed ; appointment April 2014 • Appointment of two extra middle grade Urologists

	<p>to back fill Associate Specialist and increase clinical capacity agreed; appointment by April 2014</p> <ul style="list-style-type: none"> • Appointment of 1 additional CNS agreed; appointment by April 2014 • Upgrade existing CNS support nurse to CNS status agreed; to be complete January 2014 • Appointment of two Advanced Nurse Practitioners (Cancer and Stone/BPH) agreed; appointments by April 2014
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What other concerns were there and what will be done about them?

Serious concern as stated in site visit report	What will be done about it?	When will it be done by?
Lack of clarity between primary care and Urology MDT around access for patients onto a 2WW pathway	<p>Establish single point of referral for all 2 week waits with the CCG</p> <p>Trust to lead an audit of 2 week wait referrals against NICE criteria for suspected urological Cancer referrals</p> <p>CCG to review 2 week wait referral process with GPs</p> <p>CCG to increase the use of Choose and Book by GPs. Aim to achieve 100% of 2 week wait referrals through Choose & Book</p>	<p>End of March 2014</p> <p>End of March 2014</p> <p>Complete 16th December 2014</p> <p>End of March 2014</p>
Team did not demonstrate a current, robust failsafe system across all elements of Cancer pathways, including not losing patients to follow-up	<p>Computerised database for follow up of bladder Cancer patients , being trialled with full implementation in end February 2014</p> <p>Back-up system to cross-check electronic discharge system data against manual system.</p> <p>New Cancer pathway co-ordinator post agreed; appointment process to be commenced immediately</p> <p>Urology Day unit administration support agreed, appointment process</p>	<p>By 28 February 2014</p> <p>Complete</p> <p>In post: End February 2014</p> <p>In post: End January</p>

	to be commenced immediately Dedicated staff to receive and resolve all phone/fax enquiries	2014 20 December 2013
Logistics of implementing necessary identified service redesign	A dedicated full time manager post with sole responsibilities in urology has been established.	In post 16th December 2013
MDT and SMDT do not sufficient time allocated to adequately discuss all cases	Local MDT will increase the time allocated for discussion of cases (from 1 hour to 2 hours per week). SMDT to increase from 1 to 2 hours. Start date subject to agreement with other networked hospitals, as agreed in principle by the Network Site Specific Group (NSSG) This is subject to final agreement with the NSSG Clinical Lead. Consultant have agreed to modify job plans to reflect the above changes.	By 30 th January 2014 By 30 th June 2014 Complete 16 th Dec 2013

What good practice was found in this Cancer service?

Examples of good practice
Good links with radiology/histopathology/oncology
Plans to redesign the patient pathway in response to workload issues and the desire to streamline the patient journey, e.g. PSA clinic
Clear leadership, well-functioning and motivated MDT with the patient at the centre of all that they do.

8 Recommendations and next steps

Colchester Hospital University NHS Foundation Trust has been subject to reviews by the Care Quality Commission, the NHS Intensive Support Team (IST) and NHS England. This report by NHS England has considered relevant information, sought expert advice and shared pathway findings with the regulators.

For each pathway, the Clinical Oversight Group has agreed with lead clinicians from the Trust, the steps to be taken to improve pathways. All the mitigating actions to improve safety are presented in this report. Separate recommendations have been made in the IST report and these are also reflected in this report.

At this stage:

- Colchester Hospital University NHS Foundation Trust is completing the Monitor-led review of Trust governance and implementing its recommendations, including,
- Colchester Hospital University NHS Foundation Trust is completing and publishing its Cancer action plan,
- Colchester Hospital University NHS Foundation Trust has re-established the Trust Cancer Board which, as a sub-group of the Trust Board, will work across the clinical directorates in the organisation to implement the findings of this report,
- Trust developments which were already at the planning stage have had to be accelerated, such as increasing the capacity in oncology,
- The commissioners of the Cancer services (Clinical Commissioning Groups and for those services designated as specialist Cancer services, NHS England) have assessed and managed risk to ensure that pathways are adequate for the continued provision of Cancer care on the hospital sites.

8.1 Recommendations

These recommendations have been directly compiled from the findings of Section 7 – ‘Are arrangements in place to ensure the safety of the cancer services?’ including the:

- general immediate risks, and
- individual Cancer team immediate risks and serious concerns.

The specific immediate actions to address the immediate risks for the internal management of Cancer services in the Trust are detailed in the general (Section 7.2) and specific tables for each individual Cancer team (Section 7.3). All findings of this review will be incorporated into the Trust Cancer action plan and be performance managed by the commissioners and regulators.

The key recommendations are:

i. The Trust must introduce organisational development for Cancer services.

Creating the environment in which clinical excellence can flourish is a prerequisite for safe services. As such the Trust needs to engage in a process of organisational development in which clinical governance and leadership is an essential feature. One practical application is to ensure that each Cancer specialty has up to date, practical Cancer pathways that are adequately resourced, and where the volume of work is matched with the supply of appropriately trained clinical staff who work in sustainable rotas.

ii. The Trust must ensure it has up to date pathways for all Cancer teams.

Clinical leadership is vital, and it is important that the medical knowledge on service redesign is fully integrated with that of management and nursing colleagues. Cancer services are regulated and this is part of that regulation.

iii. The Trust must ensure milestones are agreed for all Cancer clinical pathways and establish mechanisms to monitor these.

iv. The Trust must improve failsafe handling of paper processes including referral, inter-MDT transfer, inter-hospital transfer, radiology 'urgent findings and upgrades' (incidental findings) and 'consultant upgrades'.

There are key stages in the Cancer pathway which patients have to progress through and in this instance the administrative support had to be increased. Such improvements need to be maintained and monitored until electronic systems are implemented and thereafter. This includes referral, inter-multidisciplinary team transfer, inter-hospital transfer, radiology 'urgent findings and upgrades' (incidental findings), and 'consultant upgrades'. Consultant upgrades refer to when a consultant changes a non cancer referral to a cancer diagnosis.

v. The Trust needs to confirm the expectations regarding timeliness of data validation by MDT co-ordinators and agree on-going monitoring and escalation where appropriate.

vi. The commissioners need to continue to insist on audit of the Cancer Waiting Time Tool data for validation and review of amendments.

While some cases will be reviewed at the weekly Patient Tracking List (PTL) meeting with the Trust, the Trust needs to provide assurance that changes to the Cancer waiting tool are legitimate. The new central office should prevent delays in the timeliness of tertiary referrals to the Trust and help in the agreement of milestones for inter-provider transfers.

vii. The Trust must invest in a Cancer pathway management tool.

Informatics is central to the modern management of Cancer pathways. The need for investment in modern communication systems which aid the progress of patients along the suspected Cancer pathway is clear. In this situation, special measures had to be taken to make secure out-dated methods of transferring requests for tests or for entry into pathways, such as the use of faxes. The administration had to be enhanced to support these out-dated means of communication, until more modern communications are put in such as the Choose and Book system and a Cancer pathway management tool. The management of patients along pathways needs to be consistently and reliably managed.

viii. The Trust must address all the concerns raised in the pathway reviews as presented in this report.

The Trust has already taken steps to deal with the processes for managing consultant upgrades. Similarly the Trust has begun to address the high priority areas cited in the IST report e.g. in upper GI, a Cancer nurse specialist, and cancer service workforce review. This should be part of normal continuous quality improvement in the Trust.

ix. The Trust should include consideration of Cancer services as it updates its workforce plans.

Many Cancer specialties had only part time support staff, associated with Cancer specialties on different sites. Ultimately decisions have to be made on the centralisation of specialist procedures that should only be done in recognised centres where specialists, equipment and staffing comply with national standards. One practical application of workforce planning is to ensure that each Cancer specialty has up to date, practical Cancer pathways that are adequately resourced, and where the volume of work is matched with the supply of appropriately trained clinical staff who work in sustainable rotas. This requires agreement in job plans. Specific reference needs to be made to the numbers of Cancer nurse specialists.

x. The Trust must ensure that the substantive post of a Consultant Oncologist is filled, and that there is sufficient capacity in the oncology team.

xi. The Trust must review the Multidisciplinary Team Co-ordinator roles and workload, along with training and induction.

xii. The Trust needs to be pro-active with the regulator Monitor in the review of its own governance systems.

Clinical leadership is vital, and creating the environment in which clinical excellence can flourish is a prerequisite for safe services. As such the Trust

needs to engage in a process of organisational development in which clinical governance and leadership is an essential feature. The Trust Executive lead for Cancer is now the Trust Medical Director and a lead Cancer nurse is being recruited.

xiii. The Trust must ensure that vulnerable people are safeguarded and that there are systems in place for adult and childrens' safeguarding.

xiv. NHS England with the Trust must conduct retrospective reviews.

Tracking patients through their Cancer pathways is a recognised priority now both for Colchester Hospital University NHS Foundation Trust and its commissioners, including North East Essex CCG and NHS England. The findings from all three recent reviews at the Trust, including a lack of evidence of failsafe systems in place within the Cancer pathways at Colchester Hospital University NHS Foundation Trust and examples where patients have stopped pathways without clinical sign-off or been lost to follow up, have prompted NHS England to decide that a retrospective review is required.

This review has a number of identified elements:

- Firstly, to look at a random sample of notes to define the accuracy of the recording of information on the historic Cancer Waiting Tool (CWT), and to look at the implications of any errors which may be identified.
- Secondly, to learn from the recent external clinical reviews, looking at those parts of Cancer pathways where there was any pattern of loss to follow up or the stopping of pathways without clinician oversight.
- Thirdly, and important for public reassurance, is the continuation of the helpline for any patients or professionals who have concerns about how their care was managed.
- The review will also look at the numbers of patients with delays over 100 days and breaches

These reviews are technically audits and can be undertaken by those who have a legitimate clinical relationship with the patient. However given the amount of scrutiny that the Trust is under, the protocols for such reviews will be agreed with NHS England, who will also provide external assurance, validity and scrutiny of the process (including the checking of the accuracy of any reviews through the analysis of anonymised records, as appropriate).

19th December 2013

Andrew Pike
Director
NHS England Essex Area

Dr Shane Gordon
Chief Officer
NHS North East Essex

Dr Christine Macleod
Medical Director
NHS England Essex Area

Team, Chair Incident
Management Team

CCG, Member of the
Incident Management
Team

Team
and Chair Clinical
Oversight Group on behalf
of the Incident
Management Team

9 References

- ¹ National Cancer Peer Review Handbook, March 2011. National Cancer Action Team
- ² Colchester Hospital University NHS Foundation Trust corporate information August 2013
- ³ National Cancer Intelligence Network report – North East Essex 2012/13 Q1 to Q4
- ⁴ There appeared to be no safety-netting internally with no clear pathway structures in place. Communication and referrals were reliant on possible phone calls with no system for assurance (Clinical site visit report - Sarcoma).
- ⁵ It was noted [that] the tumour site has not agreed and documented clear pathways (IST report, Appendix B - Sarcoma).
- ⁶ [The] anal cancer pathway remains unclear despite previous identification at peer review over a number of years (Clinical site visit report - Colorectal).
- ⁷ There appears to be a pathway issue for metastatic spinal cord compression, with clinicians referring on three different pathways [to] Barts and the London, Queen's Hospital Romford and Ipswich Hospital... There is no clearly identified single point of contact for a Multi-Disciplinary Spinal Cord Compression co-ordinator and no clear direction for consultants or GPs on who to contact in the event of suspecting spinal cord compression (Clinical site visit report - Brain).
- ⁸ The clinical pathway provided in the documentation for the review did not reflect the actual pathway used by the team (Clinical site visit report - Skin).
- ⁹ Tumour specific milestones have been identified for some tumour sites and where they are set up they are available on QlikView [a data visualisation tool], unless the patient has already breached their waiting time standard in which case milestones can't be seen... One MDT co-ordinator has set up their own spreadsheet for tracking patients rather than using the Cancer Waits System (IST report, section 3.6 Cancer PTL and tracking).
- ¹⁰ It was confirmed [that] the appointment timeframe for first outpatient appointment is stretching up to 4 weeks (IST report, section 3.8 Tumour site MDTs - Skin).
- ¹¹ The team is in the process of setting clinically appropriate internal pathway milestones and currently include patient breach dates as part of the MDT proforma (IST report, Appendix B – Haematology & Lymphoma).
- ¹² Staff report that only one patient has breached their planned [check cystoscopy] date so far this year but this was by 18 months (IST report, section 3.8 Tumour site MDTs - Urology).
- ¹³ There is no capacity or defined pathway to manage liver lesions which currently are managed by the Upper GI team, but who are keen to devolve responsibility to the CUP team (Clinical site visit report – Cancer of Unknown Primary).
- ¹⁴ There are capacity... issues regarding new MDTs, including [the] meeting for cancer of unknown primary, along with the breast MDT (IST report, section 3.9 Support services).
- ¹⁵ Lack of consistent attendance at colorectal MDT meetings from surgeons appears to impact on the optimal working of the MDT... Lack of cross-cover arrangements [to cover leave] for histopathologist (Clinical site visit report - Colorectal).
- ¹⁶ The pathologist is not available for both weekly MDT meetings (Clinical site visit report - Breast).
- ¹⁷ [There is] only one histopathologist named as a core member [of the MDT] with no cover [for leave] and therefore MDTs are taking place without a histopathologist being present. There is no review of histology slides at the MDT (Clinical site visit report - Skin).
- ¹⁸ Time allocated for MDT discussion is not adequate. A Germ Cell MDT follows the Skin MDT limiting time for discussion (Clinical site visit report - Skin).
- ¹⁹ Some staff feel that the weekly MDT meeting can hold up decision making as things are not always progressed between meetings (IST report, Section 3.1 Leadership and governance).
- ²⁰ It was reported that MDT meetings can be very hierarchical and that it can be difficult for Cancer Nurse Specialists [to participate] (IST report, section 3.8 Tumour site MDTs).
- ²¹ Staff report that the outcomes of MDT meeting discussions are sometimes not clearly documented which makes it difficult to track and progress the patients along their pathway (IST report, section 3.6 Cancer PTL and tracking).
- ²² The effectiveness of MDT meetings is not reviewed (IST report, section 3.1 Leadership and governance).
- ²³ There appears to have been no audit of Sarcoma pathways and exact numbers of annual patients and treatments were unknown (Clinical site visit report - Sarcoma).
- ²⁴ Audit should be planned more systematically and systems [are] needed to ensure that recommendations for service development are implemented (Clinical site visit report - Gynaecology).

²⁵ There does not appear to be a Trust policy for internal validation of standards for peer review with the Cancer Manager and the [Cancer] Network... It is usual for another department to do the reviewing and for it to be signed off by the Trust Director responsible for Cancer. In the case of CNS (Brain Cancer) the lead doctor is also the Trust Cancer lead (Clinical site visit report - Brain).

²⁶ The team is very reliant on... informal agreements with other departments. The consequent lack of formal pathways that interconnect departments [is of] particular concern (Clinical site visit report - Haematology).

²⁷ It was reported [that] there are issues with non-compliance with the agreed pathway for malignancy identified within Neurology, with the neurology team referring patients to Barts and the London Hospital rather than the designated centre – Romford (IST report, Appendix B – Brain and Central Nervous System).

²⁸ Trust staff report significant delays with tertiary referrals particularly those from / to Broomfield Hospital in Chelmsford... [particularly] late referral of patients with upper GI cancer...as well as delays for patients referred for radiotherapy (IST report, section 3.7 Inter-provider transfers).

²⁹ Difficulty planning interval surgical slots at Ipswich often necessitates a fourth cycle of pre-operative chemotherapy, which is not standard practice (Clinical site visit report - Gynaecology).

³⁰ There was a significant period of time where there was no MDT co-ordinator in post at Queen's [Hospital Romford]. This led to... occasional delays... They now have a co-ordinator (Clinical site visit report - Brain).

³¹ There are delays in bowel screening referrals from Ipswich and Chelmsford (IST report, section 3.8 Tumour site MDTs – Lower GI).

³² Some patients are referred to Southend... for brachytherapy and have usually breached [their waiting time standards] when they return... Referrals are received from other centres and the team reported delays for referrals from Chelmsford... and sometimes from Southend (IST report, section 3.8 Tumour site MDTs - Urology).

³³ Histopathology could go to London without the Oncology department knowing it was a suspected Sarcoma going for second review (Clinical site visit report - Sarcoma).

³⁴ There appears to be a lack of clarity amongst some staff about who the executive lead for Cancer is within the Trust. Some staff said they didn't know and others that they didn't think there was one. Others identified the Director of Operations. It was confirmed cancer performance information is included in the scorecard, as part of the assurance committee's report on standards (IST report, section 3.1 – Leadership and governance).

³⁵ It was confirmed that there is no documented Trust wide Cancer strategy which is a potential missed opportunity (IST report, section 2.2 Context).

³⁶ There is no Trust Lead Cancer Nurse. The post was funded by MacMillan and recruited to internally by the Trust around 18 months ago but due to difficulties replacing the promoted individual the post was then disbanded (IST report, section 3.1 Leadership and governance).

³⁷ There was a gap in the frequency of [Cancer committee] meetings... in the earlier part of 2013... Staff report that there is a lack of clarity about where the Cancer committee reports to (IST report, section 3.1 Leadership and governance).

³⁸ The process for escalating issues was documented earlier this year but some MDT co-ordinators and service managers were not aware of it. Issues identified by the MDT co-ordinators are generally escalated to the Cancer Manager not to the relevant Division (IST report, section 3.6 Cancer PTL and tracking).

³⁹ Staff report that there is little support for implementation of Peer Review recommendations and that they are competing with other services for available funding (IST report, section 3.1 Leadership and governance).

⁴⁰ Some members of the team expressed frustration... that they had raised business cases and requests for additional resources many times, which continue to be rejected. Little seemed to have changed as a result of the last Peer Review visit 3 years ago and the concerns raised as a result (Clinical site visit report).

⁴¹ Some members of the team expressed difficulty in raising concerns and getting them resolved effectively... Leadership was not always effective in identifying risk and resolving problems (Clinical site visit report - Haematology).

⁴² Staff were also enthusiastic about resolving the current issues provided there was an on-going commitment to sustaining performance going forward, although staff expressed concern about the level of support available to colleagues under the current circumstances and in light of the CQC report (IST report, section 7 Conclusion).

⁴³ The Trust purchased the Somerset system three years ago as an alternative to [the] Cancer Waits [system] but it hasn't been implemented yet (IST report, section 3.3 Data capture).

⁴⁴ It was acknowledged [that] there is a reliance on manual paper based systems, which includes a number of handoffs between teams... Staff have established manual workarounds to track patients referred for diagnostics (IST report, section 3.9 Support services).

-
- ⁴⁵ Staff report delays in the comments fields on the Patient Administration System being populated which means that cancer pathway information on the system is not live (IST report, section 3.3 Data capture).
- ⁴⁶ Consultant upgrades are entered onto the Cancer Wait system by the MDT co-ordinators as a comment – the date of upgrade also needs to be added, for them to be visible to the Open Exeter and QlikView uploads (IST report, section 3.3 Data capture).
- ⁴⁷ Apparent lack of / poor organisational infrastructure for IT systems and tools... has resulted in a lack of a robust system to collate and review clinical outcome data (Clinical site visit report - Colorectal).
- ⁴⁸ MDT process – hand written paper system being used (Clinical site visit report - Lung).
- ⁴⁹ The bespoke data systems are known only to the MDT co-ordinator, such that data is not collected in her absence and builds up until she returns (Clinical site visit report).
- ⁵⁰ Lack of an electronic data system such as Somerset (Clinical site visit report - Haematology).
- ⁵¹ There are too many bespoke elements in their processes – for example, the Lymphoma Cancer Nurse Specialist tracking the radiology for her patients (Clinical site visit report - Haematology).
- ⁵² Most clinical specialties operate a manual check and chase system operated either by the Cancer Nurse Specialist or by the Medical Secretaries but systems vary by consultant (IST report, section 3.9 Support services).
- ⁵³ Staff report a significant amount of double entry of data into the Cancer Waits System and the national audits (IST report, section 3.3 Data capture).
- ⁵⁴ Common errors include dates the wrong way round and wrong months and wrong years (IST report, section 3.4 Information quality).
- ⁵⁵ Data collection systems are not efficient and require multiple data uploads with a large margin for error (Clinical site visit report).
- ⁵⁶ The data collection systems are out-dated, with data being uploaded onto separate systems increasing the capacity for error (Clinical site visit report – Head & Neck).
- ⁵⁷ There is an internal service standard of seven to ten days turnaround from requests to results for radiology and pathology for patients on Cancer pathways. It isn't clear how this is monitored and specialty staff were unaware of current performance against the SLA (IST report, section 3.9 Support services).
- ⁵⁸ The current paper system provides no assurance that requests have been received in pathology (IST report, section 3.9 Support services).
- ⁵⁹ Not clear how the patients were tracked through the system and how they were put on a pathway. No single consultant in charge (Clinical site visit report - Sarcoma).
- ⁶⁰ Some staff expressed concern that validation of patient records on Cancer Waits [system] is not done in a timely enough way... Pathway adjustments are done by the Cancer services and are not reviewed or monitored by the [Trust] information team (IST report, section 3.4 Information quality).
- ⁶¹ There is no routine Root Cause Analysis (RCA) for breaches [of the national waiting times standards] across all tumour sites. This represents a missed opportunity for the Trust to learn from previous breaches and make improvements to prevent future breaches (IST report, section 3.2 Performance management).
- ⁶² The majority of two week wait referrals are received by fax... Referrals should go to the Trust Contact Centre... Staff report some non-compliance with use of the Contact Centre by some GPs which presents potential clinical risk of delayed management (IST report, section 3.5 Access and choice).
- ⁶³ There are delays with Broomfield [Hospital, Chelmsford] pathways in terms of information coming back to the team regarding plastic surgeon review, and on occasion patients have been put on a routine list and not an urgent list (IST report, section 3.8 Tumour site MDTs - Skin).
- ⁶⁴ Some MDT co-ordinators report delays in clinic letters being typed which impacts upon them tracking patients and progressing pathways (IST report, section 3.6 Cancer PTL and tracking).
- ⁶⁵ Requests for radiology are on hard copy paper with "target" stickers used to identify suspected cancer patients. The current paper system provides no assurance that requests have been received... and staff report that there have been instances of requests going astray (IST report, section 3.9 Support services).
- ⁶⁶ In some tumour site areas the Cancer Nurse Specialist workforce is very stretched (IST report, section 3.1 Leadership & Governance).
- ⁶⁷ There appears to be an imbalance in the workload of the MDT co-ordinators with some supporting more than one tumour site (IST report, section 3.6 Cancer and PTL tracking).
- ⁶⁸ There is only one oncology nurse covering the Acute Oncology service, without any contingency planning for annual leave or other absence, which can compromise the service (Clinical site visit report – Acute Oncology).

⁶⁹ Cancer Nurse Specialists are used as a regular resource outside [their] normal duties... which reduces their ability to fully deliver all aspects of an IOG-compliant service to their haematology patients (Clinical site visit report - Haematology).

⁷⁰ There is limited Cancer Nurse Specialist cover with consultants picking up additional tasks outside of their job plans (IST report, Appendix B – Haematology & Lymphoma).

⁷¹ Lack of Cancer Nurse Specialist (CNS) support – a single [nurse] is working at full stretch and consequently unable to perform holistic needs assessments and to be present in some clinics when bad news is being broken; the CNS has the role of breaking bad news single-handedly – this occurs when patients attend to have sutures removed by the [nurse] (Clinical site visit report - Skin).

⁷² Staff report that the most recent Peer Review advised that the clinical nurse Specialist workload is too large for one person (IST report, section 3.8 Tumour site MDTs - Skin).

⁷³ Capacity of the colorectal Cancer Nurse Specialist team with current responsibilities appears unsustainable (Clinical site visit report - Colorectal).

⁷⁴ The part-time Cancer Nurse Specialist is extremely stretched with the growth [in number] of patients as she only works 22 ½ hours [per week]. In addition she has to cover the community and schools work (Clinical site visit report - Paediatrics).

⁷⁵ The MDT co-ordinator is part time and supports a number of other smaller tumour sites (IST report, Appendix B - Sarcoma).

⁷⁶ MDT co-ordinators don't receive any formal induction or training but learn on the job and by working alongside a colleague for their first few weeks; this impacts on their effectiveness and also presents a potential risk to the management of [patients] (IST report, section 3.6 Cancer and PTL tracking).

⁷⁷ Staffing at all levels on the team leaves the service vulnerable as the whole team appear to be working at full capacity, including regular extra evening clinics (Clinical site visit report - Breast).

⁷⁸ Staff report that the current system of allocating GP urgent referrals [for consultant review] means that at times, patients suspected of having cancer are seen in clinic by a consultant who doesn't treat cancer and that this results in consultant to consultant referral to the cancer consultants and an extra step in the pathway (IST report, section 3.8 Tumour site MDTs - urology).

⁷⁹ The middle grade [doctor] covering the lead clinician is on the general on-call rota which leaves the service very short [staffed] and the clinics find it hard to cover [staffing] at times (Clinical site visit report - Paediatrics).

⁸⁰ A locum consultant is providing the gynaecological service to cover pressure on the service [requiring supervision by another oncologist] (Clinical site visit report - Gynaecology).

⁸¹ There appears to be no identified allocation of time in the [oncologist's] job plan for this [service] in addition to a workload that may be unsustainable (Clinical site visit report – Teenage & Young Adult).

⁸² There is an oncology consultant in charge of this pathway who has multiple responsibilities. There is a lack of clarity as to how the formal cover arrangements for [Brain] tumours works (Clinical site visit report - Brain).

⁸³ The MDT chairman is based at Broomfield Hospital, Chelmsford which limits the amount of support he can give to the MDT (Clinical site visit report - Skin).

⁸⁴ The accommodation does not allow the team to be as flexible as they would like to be (Clinical site visit report - Breast).

⁸⁵ The clinical environment is not conducive to best practice (Clinical site visit report - Skin).

⁸⁶ The MDT room facilities appear inadequate for quality and productive meetings (Clinical site visit report - Colorectal).

⁸⁷ Improving Outcomes in Urological Cancers. NICE 2002. Recommendations p29: patients with cancers which are less common or require complex treatment should be managed by Specialist Multidisciplinary (SMDT) cancer teams... [which] should carry out at least 50 radical operations for prostate or bladder cancer per year... The population served by each of the teams is no less than one million.

⁸⁸ Improving Outcomes in Colorectal Cancers - update. NICE 2001. Recommendations p43: Colorectal Cancer MDTs should refer patients with anal cancer to designated teams with expertise in the management of this condition... p47: Clear referral systems should be established within each Network to ensure that responsibility for the management of every patient with anal Cancer is passed to the appropriate MDT when the initial diagnosis is made... Each anal Cancer MDT requires access to plastic surgery and should have links with a gynaecological oncologist with expertise in vulval Cancer.

⁸⁹ The Trust has been working with Cancer Network colleagues to try and agree target timelines for tertiary referral (IST report, section 3.7 Inter-provider transfers).

Appendix 1 – Glossary of Terms

Term	Definition
Cancer Network	Cancer networks consist of a number of NHS organisations working together to deliver high quality, integrated Cancer services for their local population. They focus on delivering the national Cancer strategy, improving performance of Cancer services and to facilitate communication and engagement around Cancer issues.
Cancer of Unknown Primary origin	When a Cancer is found but the source is unable to be located.
Care Quality Commission (CQC)	The Care Quality Commission makes sure hospitals, care homes, dental and GP surgeries and all other care services in England provide people with safe, effective, compassionate and high quality care, and encourages these services to make improvements.
Clinical nurse specialist	A qualified nurse with a special interest
Colorectal (Lower GI)	Pertaining to the colon and the rectum
Concern	A concern is an issue that is affecting the delivery or quality of the service that does not require immediate action but can be addressed through the work programme of the teams/services.
Gynaecology	The science dealing with the diseases of the female reproductive system.
Haematology	The science of dealing with the formation, composition, function and diseases of the blood
Immediate risk	An “Immediate Risk” is an issue that is likely to result in harm to patients or staff or have a direct impact on clinical outcomes and therefore requires immediate action.
Improving Outcomes Guidance (IOG)	Cancer service guidance published by National Institute for Clinical Excellence (NICE). Hospitals are required to comply with this guidance
Incident Management Team (IMT)	Led by NHS England in response to the publication of the CQC inspection report. This is a time limited team established to provide strategic direction, co-ordination between all organisation, and external assurance in order to resolve all

	concerns associated with Cancer services at Colchester Hospital University NHS Foundation Trust.
Intensive Support Team (IST)	Since April 2009, the NHS Interim Management and Support service has incorporated the Intensive Support Teams (ISTs) who specialise in Urgent and Emergency Care, Elective Care and Cancer, focusing on improving performance, quality assurance and programme enhancement. Assignments typically include working with local health communities jointly to diagnose areas for performance improvement; supporting implementation planning and delivery; and transferring knowledge to produce sustainable and resilient solutions.
Metastatic Spinal Cord Compression (MSCC)	Is an uncommon condition that affects people with certain Cancers that have spread to the bones in the spine, or have started in the spine.
Multi-Disciplinary Team (MDT)	A team made up of clinical and support staff from a variety of disciplines who provide the range of expertise required to effectively manage Cancers. Core membership is defined for each Cancer team and usually includes a surgeon, oncologist, histopathologist and radiologist plus a clinical nurse specialist and an MDT co-ordinator
Multi-Disciplinary Team co-ordinator	The MDT co-ordinator is a non-clinical member of the MDT whose role is to co-ordinate the work for each patient and to ensure that patients are treated as quickly as possible and that problems are identified and reported to the MDT
Monitor	Monitor is the sector regulator for health services in England. Their job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. They exercise a range of powers granted by Parliament which include setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences they issue to NHS-funded providers.
Multi-Disciplinary Team	A setting with representation comprising all relevant clinical specialties.
Network Site Specific Group (NSSG)	A multi-disciplinary group which brings

	together representatives from professionals across the care pathway, all MDT leads from the relevant network organisations, and patient representatives.
Oncology incl. Acute oncology	The science of Cancer medicine
Paediatric	The branch of medicine dealing with children and their diseases.
Patient Tracking lists (PTL)	Provides a prospective viewpoint and so can act as a planning tool for managing patient waiting lists in a way that the (retrospective) monthly RTT data collection cannot. PTL at patient level is used to identify groups of patients who may be at risk of waiting longer than 18 weeks, to enable intervention which may include the commissioning of care from an alternative provider. PTL at aggregate level is used to inform the Commissioners of numbers waiting and length of wait to support commissioning and performance management decisions.
Pathway	Care pathways describe the route that a patient will take from their first contact with an NHS member of staff to the completion of their treatment.
Radiology	The use of medical imaging
Radiotherapy	Treatment with radiation
Risk Summit	A meeting of high-level leaders called to shape a programme of action which is focussed on sharing information willingly, to help achieve a consensus about the situation under scrutiny and the actions required to mitigate the identified risks.
Safeguarding	The multi-disciplinary work undertaken to minimise and manage risk to adults and children who may be vulnerable.
Sarcoma	A rare soft tissue or bone Cancer
Serious Concern	A 'serious concern' is an issue that, whilst not presenting an immediate risk to patient or staff safety, could seriously compromise the quality or clinical outcomes of patient care, and therefore require urgent action to resolve.
Skin	The tissue which forms the outer covering of the body.
Upper GI	From the mouth to the small intestine
Urology	The surgical specialty of the urinary tract

Appendix 2 – Terms of Reference for the Incident Management Team

TERMS OF REFERENCE

Incident Management Team (IMT)

CANCER SERVICES COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST

Overview

This is a time limited team established to provide strategic direction, coordination between all organisations, and external assurance in order to resolve all concerns associated with Cancer services at Colchester Hospital University NHS Foundation Trust.

Background:

In response to an inspection carried out by the Care Quality Commission (CQC) into Cancer care at Colchester Hospital University NHS Foundation Trust (CHUFT) a multi-agency Risk Summit was recently held. The CQC report relates to the quality and safety of Cancer services provided.

It has been agreed by the Risk Summit that the Risk Summit should cease in its current format and be replaced with an incident management structure. This strategic Incident Management Team aims to continue the undertakings of the risk summit

Purpose of the IMT:

The aims of the IMT are:

1. Provide strategic leadership and accountability to resolve any concerns, identifying all strategic and operational objectives to manage the incident and maintaining a comprehensive action plan.
2. Ensure clear and regular communication and effective co-ordination between all members of the Incident Management Team (IMT).
3. To ensure clinical quality and patient safety of Cancer services at Colchester Hospital and to provide public reassurance, including;
 - To determine the actions necessary to secure and assure the safe and effective management of the current Cancer pathway.
 - To determine the actions necessary to carry out any necessary retrospective reviews of Cancer pathway management.
4. Provide oversight for the effective completion of actions agreed under 3 above.

5. To direct all undertakings of the operational support group, operating as a subcommittee of the IMT, ensuring the delivery of the work programme. Receiving a regular update of the operational action plan. To determine the number of task and finish groups necessary to complete actions.
6. To agree how the work of the IMT will be communicated to patients and public, including the conduct of any necessary patient recall exercises.
7. Maintain a log of all decisions, timescales and outcomes.
8. The conduct of the meeting is confidential but there will be agreement to ensure that there is regular public awareness of the work of the IMT and regular publicly available briefings.

Governance

The chair of the IMT reserves the right to request that the CHUFT representatives withdraw from the meeting if an issue requires confidential discussion between the regulators and commissioning members. Organisations can change representatives with the agreement of the Chair, and the Chair may request a change to representation.

All members of the IMT will coordinate actions and no member organisation will take significant action without the knowledge and/or agreement of the IMT as appropriate.

All IMT member organisations are required to provide a formal update on progress and actions outstanding at each IMT meeting. The NHS community, i.e., CHUFT, CCG and NHS England will report through the operational group action plan.

The IMT will report to Midlands & East Regional Director / Executive Team as required.

Membership

NHS England

- David Levy, NHSE Regional Medical Director
- Andrew Pike, Area Team Director & Chair
- Dr Christine Macleod, Area Team Medical Director
- Pol Toner , Area Team Nurse Director
- Chris Kerrigan, Area Team Director of Operations

North East Essex CCG

- Dr Shane Gordon, Chief Officer & Chair Operational Group

CHUFT

- Dr Gordon Coutts, Chief Executive
- Dr Sean MacDonnell, Medical Director
- Carmel Connell, Associate Director – Service Improvement

EoE Cancer Network

- Dr Rory Harvey, Medical Director Strategic Cancer Network

IST

- David Boothey

Care Quality Commission

- Maggie Hannelly, Head of Regional Compliance

Essex County Council

- Angela Gibson, Adult Social Care Lead

Monitor

- Adam Cayley, Regional Director (Midlands & East of England)
- Naresh Chenani, Senior Regional Manager (Midlands & East of England)

Essex Police

- Tracy Hawkings

The IMT may co-op any additional members as necessary.

Quorum

The IMT will be quorate when attended by the Chair or nominated deputy, plus three other members.

Meeting frequency

The IMT will meet weekly initially, either face-to-face or by telephone.

Action Log & Reporting

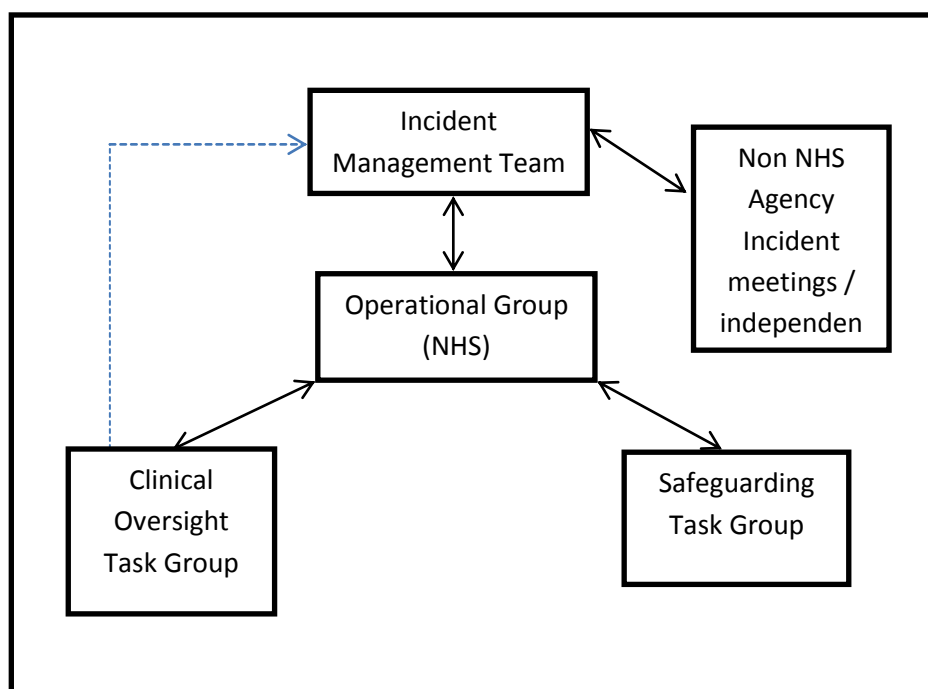
The IMT will maintain an action log of all multi agency actions, completed and outstanding.

The IMT requires the operational group to maintain and regularly communicate the NHS organisations action log, completed and outstanding, raising any specific issues of concern.

Administration

The IMT will be administered by the Operations & Delivery directorate of the Essex Area Team.

Incident Management Structure



Appendix 3 – Report of the national Intensive Support Team review



Interim Management and Support

Colchester Hospital University NHS Foundation Trust

Final Cancer Diagnostic Report

V1.02 signed off 15th December 2013

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1.0 Executive Summary

The Intensive Support Team (IST) was asked by Colchester Hospital University NHS Foundation Trust (the Trust) and North East Essex Clinical Commissioning Group (the CCG) to support them in reviewing the historical and current provision of Cancer services at the Trust in response to concerns raised by the Care Quality Commission (CQC) related to the quality and safety of Cancer services provided.

Specific objectives of the review were to:

- Establish whether current processes place patients at risk;
- Look for improvements rather than to apportion blame;
- Establish how safe practice can be maintained where opportunities for improvement are identified;

- Provide a report as a record of the investigation process;
- Assist the Trust in formulating an action plan for improvement based on recognised national best practice;
- Provide assurance on execution of any improvement plan by undertaking a further review 6 weeks after action plan development to assess implementation of agreed actions; and
- Provide assurance on sustainability and successful embedding of any improvement – time to be determined once improvement plan developed.

It was agreed that the review would prioritise the Cancer service identified in the CQC report; Breast, Skin (Dermatology/Plastics), Upper GI, Lower GI, Head and Neck and Urology.

The diagnostic review took place over two days and consisted of discussions with key staff from Cancer services and from within the six identified Cancer site teams.

This report sets out the findings of the diagnostic review and recommendations for improvement. The findings of this review - based on the evidence from staff interviews and observations - are set out in detail below. This formal report follows on from the initial diagnostic review conducted within the Trust on 25th October and 7th November 2013.

Key Findings

- Lack of clarity of Trust Executive Lead for Cancer;
- A need to confirm membership for the operational Cancer Network;
- Clinical Leadership at Trust and tumour site level identified but no clear job descriptions or allowance within job plans;
- No Trust Lead Cancer Nurse – the role was disestablished by the Trust;
- There is no mechanism to reconcile or check consultant upgrades have been added to the system and therefore no assurance that they are being appropriately managed;
- Concerns regarding the supports available for staff as a result of the CQC visit;
- There appear to be significant delays in the timeliness of tertiary referrals to the Trust and gaps in the information included with the tertiary referrals;
- Absence of agreed milestone for inter provider transfers/referrals;
- Need to clarify requirements for clinician lead and tumour site lead clinician roles, including appropriate sessions within job plans;
- Need to review MDT coordinator roles and workload, along with training and induction processes;
- Need to establish mechanisms to monitor milestones for Tumour site pathways, and ensure milestones are agreed for all tumour site pathways;
- Need to ensure more timely validation of Cancer data;
- Need to clarify pathway for patients with non-specific symptoms, where GP has requested specific tumour type review – and where there may be a need for further diagnostics to exclude other Cancers

Key Recommendations

Requiring immediate action:

- Review of processes for managing unexpected findings from diagnostics. Please refer to NPSA guidelines:
<http://www.nrls.npsa.nhs.uk/resources/?entryid45=59817>
- Review of processes for managing consultant upgrades – mechanisms to reconcile or check they have been added to the system;
- Review of processes for reviewing adjustments entered by services, to enable review and monitoring by the information team;
- Should be addressed as a high priority (in consideration of lead time and potential positive impact):
- Clarification of pathways for patients with non-specific symptoms – particular issue for Upper GI – a risk patients could be discharged without a definitive diagnosis;
- MDT coordinator roles, responsibilities, training and induction – given the issues regarding support consistency, a competency process would also be beneficial;
- Implementation of Root Cause Analysis for all breaches – missed opportunity for the Trust to learn from breaches and devise strategies for avoiding breaches in the future;
- CNS tumour site workforce review;
- Confirmation of expectations regarding timeliness of data validation by MDT coordinators and on-going monitoring and escalation where appropriate;
- Agreement of suitable milestone for cross site referrals, and mechanisms to monitor and escalation requirements.

2.0 Introduction

The Intensive Support Team (IST) was asked by Colchester Hospital University NHS Foundation Trust (the Trust) and North East Essex Clinical Commissioning Group (the CCG) to support them in reviewing the historical and current provision of Cancer services at the Trust in response to concerns raised by the Care Quality Commission (CQC) related to the quality and safety of Cancer services provided.

It was agreed that the review would prioritise the Cancer service identified in the CQC report; Breast, Skin (Dermatology/Plastics), Upper GI, Lower GI, Head and Neck and Urology.

The diagnostic review took place over two days and consisted of discussions with key staff from Cancer services and from within the six identified tumour site teams.

This report is based upon the discussions with Trust staff and information taken from data supplied to the IST by the Trust and sets out the findings of the diagnostic review and recommendations for improvement.

A list of Trust staff involved in the Cancer diagnostic review can be found at Annex A.

2.1 Specific Objectives

Specific objectives of the review were agreed as:

Operational processes

- Review current Cancer patient access policy and associated standard operating procedures and advise on any improvements
- Review current Cancer PLT information provided to speciality teams, for usefulness, accuracy, timeliness.
- With the Trust identify any areas of concern in relation to non-compliance with policy to enable targeted review of processes.
- Work with the Trust to identify tumour site trigger points along the patient pathways and devise appropriate reporting arrangements.

Clinical processes

- Review current clinical processes in all of the Cancer tumour sites, prioritising Cancer service identified in the CQC report (Breast, Skin (Dermatology/Plastics), Upper GI, Lower GI, Head and Neck and Urology).
- Review MDT processes and documentation of patient plans.
- Review patient record documentation and make recommendation for opportunities for standardisation in line with best practice.
- To take due regard of pathways that straddle multiple provider organisations and identify opportunities for improvement that will enable the Trust to share with partner organisations.

Performance management and Governance

- Observe and report on current arrangements for performance management, weekly PTL meeting, Cancer performance meeting. Is the right information available? Are the right people in the meetings? Do the meetings address the issues?
- Agree mechanism for performance reviews of trigger points at pathway and tumour site level
- Review Trust Board reporting, does the Trust Board receive the right information to understand current performance and potential risks. Advise on any improvements
- Review Trust Board scrutiny and challenge processes for Cancer performance data

2.2 Context

The Trust is a specialist Cancer treatment unit. It has a specialist palliative care team and links to the local hospice. Radiotherapy is provided on site for local patients and for those from Chelmsford. Chemotherapy is also provided on site. The Trust has two inpatient oncology wards where care is provided for North and Mid Essex patients and one day case chemotherapy unit. The Trust is shortly moving radiotherapy and the inpatient oncology wards from its Essex County Hospital site to the Colchester General Hospital site.

The Trust used to be part of the Essex Cancer Network. The Network structure was dissolved in April 2013 and as a result some support to the Trust has disappeared. The Cancer Lead Nurses Group and the Users Group which both used to meet regularly supported by the Network have been disestablished. An Essex Cancer Forum has recently been established under the auspices of the new Strategic Clinical Network and has met twice.

The Divisions are accountable for achieving their own standards for their respective Cancer service. There are plans to move all Cancer services to the Colchester site, though breast screening will continue at the Essex County site.

Trust staff feel that there is no longer any oversight of Cancer at the Trust by the Network and that no forum exists for discussing and addressing Cancer pathway issues.

It was confirmed there is no documented Trust wide Cancer strategy which is a potential missed opportunity for the Trust, and could be developed as an overarching activity that is inclusive of all activities which support Cancer services.

3.0 Findings and Recommendations

This section of the report sets out in detail the findings of the Cancer diagnostic review along with the recommendations for each section.

3.1 Leadership and Governance

There appears to be a lack of clarity amongst some staff about who the executive lead for Cancer is within the Trust. Some staff said they didn't know and others said that they didn't think there was one. Other identified the executive lead as the Director of Operations. It was confirmed Cancer performance information is included in the scorecard, as part of the assurance committee's report on standards.

The Trust has an identified Trust Clinical Lead for Cancer who is a Consultant Oncologist. There is an agreed job description (agreed March 2013) and an agreed responsibility payment for the Trust Clinical Lead. There is no Trust Lead Cancer Nurse. The post was funded by Macmillan and recruited to internally by the Trust around 18 months ago but due to difficulties replacing the promoted individual the post was then disbanded.

There are tumour site leads identified for each tumour site but staff report a lack of clarity about the role, though it has been confirmed additional clinical responsibilities (such as tumour site lead responsibilities) should be included in Consultant job plans via the annual job planning round.

Divisional Associate Directors interviewed during the review were very clear that they are responsible for Cancer performance for the Cancer service within their division.

Cancer is part of the Clinical Support Services and Cancer Division and is managed by an Associate Director (AD) who reports to the Director of Operations and a Cancer Manager who reports to the AD for Cancer. The Cancer Manager manages the MDT Coordinators and Data Clerks. There are two Nurse Consultants within the Trust, one in lower GI (who sits in Surgery Division) and one in Haematology (who sits within Cancer Services). There are a number of Clinical Nurse Specialist (CNS) posts which sit within the different divisions. In some tumour site areas the CNS workforce is very stretched.

The Trust Cancer Committee now meets monthly, however they previously met quarterly, with four Cancer Committee meetings in 2012, however there was a gap in the frequency of meetings during a management transition period in the earlier part

of 2013. The committee structure was revisited in June 2013 with the Chair moving to the Trust Cancer Clinical Lead from the Associate Director Cancer and Clinical Support Services.

The Committee is chaired by the Trust Cancer Lead and attended by tumour site clinical leads, the Divisional Clinical Director for Cancer, Divisional Associate Directors, the Service Manager and Deputy Service Manager for Cancer, the Cancer Matron and representatives from palliative care, pathology and radiology. Divisional managers are invited to attend the committee but are not regular attenders. Staff report that there is a lack of clarity about where the Cancer Committee reports to.

The Cancer Committee receives reports on Cancer performance including the number and percentage of breaches and reasons for breach. It also receives information on the Cancer patient survey and implementation of NICE guidance.

Two local GPs act as a link between the acute Trust and their GP colleagues. The Trust holds a weekly review of mortality and there is a locality SHMI group with cross economy partner organisations including Commissioners, The Hospice, The Ambulance Trust and Anglian Community Enterprise.

All Cancers have been subject to internal Peer Review during summer 2013. All divisions are represented at the Cancer Committee at Tumour Site and Associate Director level, with peer review findings (including work programmes) discussed at this meeting. It was reported that until around 6 months ago divisions were not given copies of the Peer Review reports which impacted adversely on their ownership of any issues the reviews identified. Staff report that there is little support for implementation of Peer Review recommendations and that they are competing with other services for available funding.

Some staff feel that the weekly MDT meeting can hold up decision making as things are not always progressed between meetings. This was felt to be an issue across all tumour groups. The effectiveness of MDT meetings is not reviewed.

Recommendations:

1. Clarify executive leadership for Cancer and communicate within the Trust.
2. Clearly define the role and responsibilities of the Trust Clinical Lead for Cancer and ensure that appropriate time is allowed within the individuals' job plan for the role.
3. Review arrangements for the Trust Lead Cancer Nurse.
4. Ensure clinical lead roles for tumour sites are clearly defined, and incorporated as part of job planning.
5. Review governance arrangements for the Cancer Committee to ensure that lines of accountability are clear and documented appropriately in terms of reference.
6. Review arrangements for monitoring the effectiveness of MDT meetings to ensure that decisions are taken in a timely way and clearly documented.
7. Clarify mechanisms to discuss and progress patients outside of MDT meetings where appropriate.
8. Review CNS staffing numbers across Cancer service.
9. Trust to explore with Divisions why peer review reports have not been cascaded to the wider members of their teams.

3.2 Performance Management

Performance is reported to the Trust Board by the Director of Finance. Cancer performance is included in the Trust performance scorecard which is produced by the information team who report to the Director of Finance. Actual compliance with the standards and actions was previously reported through the performance assurance committee but has recently been moved to the Quality and Patient Safety Committee (July 2013) and is reported to the Trust Board via this committee. The Chief Executive Board report also includes Cancer performance and actions being taken.

There is no routine root cause analysis for breaches across all tumour sites. This represents a missed opportunity for the Trust to learn from previous breaches and make improvements to prevent future breaches.

Recommendations:

10. Implement root cause analysis and reporting for all breaches to ensure that trends and patterns are identified and actioned. Analysis should be shared with clinicians.

3.3 Data Capture

The Trust uses a custom built Cancer Waits tool to hold detailed information of patients on Cancer pathways. The tool has a web front end and is able to hold more information than the PAS system including; diagnostic dates, treatment dates and other pathway information including the patients breach date.

QlikView is a presentation tool which is fed by the Cancer Waits data and by the CRIS system and allows a drill down to patient level data. There is no link between the Trust PAS and the Cancer Waits system. The BI data warehouse is updated overnight from PAS and an extract is taken daily to update the Cancer Waits system with 2WW data.

Consultant upgrades are entered onto the Cancer Wait system by the MDT Coordinators as a comment because of the source of referral (i.e. consultant referral) – the date of upgrade also needs to be added, for them to be visible to Open Exeter and QlikView uploads. There is no mechanism to reconcile or check consultant upgrades have been added to the system and therefore no assurance that they are being appropriately managed.

Staff report delays in the comments fields on PAS being populated which means that Cancer pathway information on the system is not live. If a patient is taken off a Cancer pathway and added to an 18 week RTT pathway staff have to look at PAS and QlikView to be able to see the patient pathway.

A standard suite of reports are available on QlikView. Ad hoc requests for information are dealt with by the Trust informatics team.

Staff report a significant amount of double entry of data into the Cancer Waits System and the national audits.

A new PAS (System C) was due to be implemented in October 2013 but this has been delayed until spring 2014. The Trust purchased the Somerset System three years ago as an alternative to Cancer Waits but it hasn't been implemented yet. Staff are unclear when it will be implemented but implementation would help to resolve a number of system issues. Additionally, as Somerset is not used, there is a requirement to manually enter tumour site audit data into relevant systems.

Open Exeter is used to upload the monthly data. There is a reconciliation done monthly at the point the data is uploaded onto Open Exeter and sign off of the data at three levels; Service Manager, Associate Director and Director of Operations.

Recommendations:

11. Establish a process to provide assurance that patients with a consultant upgrade or incidental finding of Cancer are added to the Cancer Waits system within 24 hours.
12. Clarify arrangements and timescales for updating patient information on PAS to ensure that Cancer pathway information is up to date. Data should ideally be updated daily.
13. Clarify timescales for the implementation of the Somerset system.

3.4 Information Quality

A weekly report run by the Information Team highlights missing data fields, where sequencing of the pathways looks wrong and breaches of the waiting time standards. The report goes to the MDT Coordinators for checking. Common errors include dates the wrong way round and wrong months and wrong years.

A duplicate report is available on the Cancer Waits system but this isn't used as it is not felt to be very accurate. The Information Team used to run a predictor report but this was stopped two or three months ago because it wasn't being used by the Service Managers.

Some staff expressed concern that validation of patient records on Cancer Waits is not done in a timely enough way but left until close to the cut-off date for reporting (26 working days after the month end), possibly because of delays getting information from other hospitals.

Pathway adjustments are done by the services and are not reviewed or monitored by the Information Team.

Recommendations:

14. Reduce the amount of double entry of data wherever possible to minimise opportunity for data entry error.
15. Consider re-establishing duplicate report on Cancer Waits to highlight duplicate / incorrect data entries.
16. Consider re-establishing the predicted performance report.
17. Review timelines for validation of Cancer pathway information to ensure that it is done in real time wherever possible.

18. Establish regular monitoring, audit and sampling of pathway adjustments to ensure they are only done where appropriate and in line with the Trust Access Policy for Cancer.
19. Review arrangements for pathway adjustments, including staff applying adjustments, frequency and monitoring, length of adjustment versus access policy and national guidance.

3.5 Access and Choice

A standard proforma is used for all two week wait referrals. The proforma is currently being revised. The majority of two week wait referrals are received by fax with the remainder via Choose and Book. Referrals should go to the Trust Contact Centre where the aim is to contact the patient within 24 hours and book the first appointment within four days of the referral being received. Staff report some non-compliance with use of the Contact Centre by some GPs which presents potential clinical risk of delayed management of the referrals.

Staff report that the number of two week wait referrals has increased significantly with Upper GI seeing an increase from around 300 to 1000 referrals per year in the last three years. There have been particular challenges in Upper GI with the former PCT decommissioning GP direct access to gastroscopy. The PCT had expressed concern regarding the high reliance on locum consultants within Endoscopy in particular, and there is a need to confirm clinical responsibilities for patients who have been reviewed by a locum within the Trust.

Staff report that patients frequently appear to be unaware that they have been referred urgently for suspected Cancer and that this often results in them not wishing to attend appointments within the two week wait period. A letter was developed by the Patient User Group last year but this has not been used.

Staff report that there are high volumes of inappropriate two week wait referrals in some specialties but these don't appear to be formally monitored or reported.

The IST did not meet with the booking or admissions team during the visit, so are unable to provide details of booking and admissions arrangements.

Recommendations:

20. Improve GP communication with patients regarding the reason for their referral to hospital and the likely timescale for appointments.
21. Need to confirm clinical responsibility for patients who are reviewed by locums within the Trust, particularly given continuity of care considerations.
22. IST to meet with booking team and admissions teams to review processes.

3.6 Cancer PTL and Tracking

The Cancer PTL is ordered by the number of days waiting, longest first and highlights in red those patients who have breached or who have been dated beyond their breach date and in amber those patients close to their breach date.

Tumour specific milestones have been identified for some tumour sites and where set they are visible on QlikView, unless the patient has already breached their

waiting time standard in which case the timing milestones can't be seen on the system. One MDT Coordinator has set up their own spread sheet for tracking patients rather than using the Cancer Waits System.

Many Trusts are now putting internal milestones in place, typically these include milestones for delivery of a first outpatient appointment (typically within seven days), for delivery of the diagnostic element (typically seven days from request to report) and for discussion of the patient at the MDT meeting to decide on a treatment plan (typically by day 35 of the pathway).

Internal milestone targets facilitate closer monitoring of the patient pathway and assurance that patients are progressing in an appropriate timeframe. They also provide advance warning of patients with extended waits early in their pathway and those who potentially may not achieve the overall waiting time standard. Where internal milestones are agreed there needs to be an appropriate Performance Management Framework in place to monitor progress against these standards and escalate any potential issues.

There are two separate weekly Cancer PTL meetings, one on the County Hospital site and one on the General Hospital site. The meetings are chaired by the Cancer Service Manager or the Deputy Cancer Service Manager. There are no terms of reference for the PTL meeting and no notes or action points are recorded. The PTL meetings are attended by the MDT Coordinators. There is no representation from pathology or radiology. Service Managers are invited to attend and whilst some attend regularly others don't attend at all. The CNS for gynaecology attends the PTL meeting.

Cancer PTL meetings were suspended for a few months earlier in the year – it is not clear why this was or where the decision was made to suspend the meetings.

Staff report that a few weeks ago it came to light that patients were being removed from the Cancer PTL by the MDT Coordinator following a negative diagnostic test but before it was confirmed by a consultant that they didn't have Cancer. The process for removing patients has since been tightened and patients can now only be removed upon the instructions of a consultant.

There are nine MDT Coordinators (around 7.5 WTE) and four Data Clerks working within Cancer services. They are all line managed by the Cancer Manager but some sit within the divisions. The MDT Coordinator for gynaecology is employed and managed by the division not the Cancer Manager. Some MDT Coordinators are based at the County Hospital site and some at the General Hospital site.

Divisional staff feel that the MDT Coordinator role is quite fragmented and report that there are frequent changes of MDT Coordinator for the tumour sites and that these are made, often at short notice, without discussion with the divisional team or tumour site leads. There appears to be an imbalance in the workload of the MDT Coordinators with some supporting more than one tumour site. It was reported the MDT Coordinator for lung Cancer is currently unable to attend the lung MDT meeting due to a clash with the other MDT which they support. The IST have since been advised that the MDT Coordinator for Lung attends all MDT meetings as evidenced

by MDT meeting notes, however that there was a period in 2012 when the previous MDT Coordinator was unable to attend, but cover was provided by her line manager, the Cancer Services Manager at all meetings.

Each MDT Coordinator has an identified ‘buddy’ who is supposed to cover their MDT when they are on leave. This system doesn’t appear to work very well due to the size of some of the MDTs and the unequal workload. MDT Coordinators report frequently working in excess of their contracted hours with some regularly coming to work at weekends to keep on top of their work. Excess hours are supposed to be taken as time off in lieu but staff find it difficult to take time back because of their workload.

Some staff felt that there was variation in the understanding and skills of the different MDT Coordinators and that some may not be tenacious or confident enough to challenge clinical teams appropriately. MDT Coordinators don’t receive any formal induction or training but learn on the job and by working alongside a colleague for their first few weeks, this impacts on their effectiveness and also presents a potential risk to the management of patient pathways. Their performance appraisal is done by the Cancer Manager with no input from the divisions.

Staff report that the outcome of MDT meeting discussions is sometimes not clearly documented which makes it difficult to track and progress the patients along their pathway.

The process for escalating issues was documented earlier this year but some MDT Coordinators and Service Managers were not aware of it. Issues identified by the MDT Coordinator are generally escalated to the Cancer Manager not to the relevant division. Divisional ADs feel that there is frequently a difference in the perspective of the division and the Cancer team of how issues are viewed.

Staff report that filing in case notes is inconsistent and that it is often difficult to find information. There is variability in MDT documentation and notes are organised differently in different departments. Some MDT Coordinators report delays in clinic letters being typed which impacts upon them tracking patients and progressing pathways. Staff also report delays in making clinic appointments where there has been a decision at the MDT that the patient needs to be seen in clinic but no appointments are available – this results in a lot of to-ing and fro-ing between the MDT Coordinator and Medical Secretary to get the appointment over-booked. Some MDT Coordinators are able to make outpatient appointments themselves others are made by the Medical Secretary and Booking Clerk.

On occasions there is a lack of clarity about who is responsible for completing referral forms for new patients discussed at the MDT.

Recommendations:

23. Review the MDT Coordinator and Data Clerk role, structure and reporting arrangements to ensure that they are clear and appropriate and to strengthen linkages and communication with the specialties.

24. Review the workload of the MDT Coordinator and Data Clerks to ensure that workload is manageable and that appropriate support is provided to all tumour site MDTs.
25. Ensure MDT meeting discussions are concise, clear, action oriented and documented clearly in the patient medical record.
26. Document terms of reference for weekly PTL meeting and ensure action notes are recorded and reviewed at each meeting to demonstrate the progress of actions and issues.
27. Develop and document a range of internal milestones to support the delivery of the national Cancer indicators across all tumour sites and monitor and report performance against the milestones at an appropriate internal forum.
28. Document policy and timescales for escalation of issues raised at the PTL meeting which have not been resolved.
29. Clarify and document the process for flagging urgency of clinic letters for typing and for MDT Coordinators to access dictated letters prior to them being typed.
30. Confirm terms of reference for PTL meetings, and ensure meetings are action oriented and that actions are noted and followed up.
31. Identify opportunities to ensure divisional participation at PTL meetings.

3.7 Inter-provider Transfers

The Trust receives tertiary referrals from Broomfield Hospital (Mid Essex Hospital Services NHS Trust) in Chelmsford and Basildon and Thurrock University Hospital NHS Foundation Trust for patients requiring radiotherapy. There are a number of other referral pathways between providers.

Trust staff report significant delays with tertiary referrals particularly those from / to Broomfield Hospital in Chelmsford. There have been particular issues with the late referral of patients with upper GI Cancer and staff report that a significant number of urology referrals from Broomfield have already breached upon referral as well as delays for patients referred for radiotherapy.

Tertiary referrals are made on a referral form, by letter as well as proforma and face to face at MDT meetings.

There are particular issues with access to Endoscopic Ultrasound (EUS) at Chelmsford for patients with upper GI Cancer and with access to Endo-bronchial Ultrasound (EBUS) at Basildon for patients with lung Cancer. Access to EBUS is difficult due to the Basildon team performing EBUS for 4 Trusts. There are two Consultants trained in EBUS at Basildon but one was on sick leave during the spring/summer. The Trust also reports difficulties in repatriating inpatients to Chelmsford.

Communication links with other Trusts appear to be quite variable ranging from excellent to poor and there is need for a consistent communication strategy.

The Trust has been working with Cancer Network colleagues to try and agree target timelines for tertiary referral. Staff report that there are delays in tertiary referral from Broomfield Hospital for radiotherapy but this isn't formally monitored.

Communications with Broomfield Hospital appear to be quite poor at times with periods of consultant absence which impact upon tertiary referral to Broomfield not being communicated to the Trust so that they can make alternative arrangements for patients. This has resulted in a delay of three weeks on one occasion.

Recommendations:

- 32. Agree, document and monitor performance against milestones for inter provider transfers/ referral.
- 33. Review inter-provider transfer form to ensure there is space for all relevant information and that it is clear what information is required prior to patient referral / transfer.

3.8 Tumour Site MDTs

During the two day diagnostic visit the IST met with key members of a number of tumour site MDTs. Detailed below are the feedback and observations from these meetings. It was reported that MDT meetings can be very hierarchical, and that it can be difficult for CNS participation.

Breast

Breast clinics are held at Essex County Hospital, and see approximately 400 new cases per year, with Consultant, Nursing, Radiologist, and Breast Oncologists within the unit. There are established links with Broomfield.

The volume of patients has continued to be challenging, with the service highly dependent upon radiology support and image guided biopsies. There are difficulties during consultant leave, and increasing levels of specialisation add to this challenge.

Patients are referred to the service and reviewed, with clinical examination and biopsy undertaken in a one stop clinic. There are two weekly MDT meetings per week, being on Tuesday (diagnostic MDT) and Wednesday (review of post operative patients). The service holds clinics throughout the week (Tuesday & Wednesday PM, as well as Thursday and Friday clinics) which enables timely scheduling of patients after discussion at the Tuesday MDT meeting. The IST were advised that 60% of patients have a straight forward pathway, with the remaining patients requiring additional diagnostics and/or staging tests which can add two weeks to the pathway.

MRI breast services are provided by Alliance mobile imaging, though only available on a Wednesday though they are on site all week. Patients require bloods to be taken before imaging is completed due to contrast agent requirements. Broomfield provides reconstruction services, though difficulty facilitating access for patients due to requirement for frequency of visits and need for sentinel lymph node before reconstruction can take place.

The MDT Coordinator reportedly works closely with the team, and is physically located next to the consultant office, so has good access to them, patients are escalated and proactively managed. There is a need to review MDT Coordinator workload, as well as ensuring adequate support is provided by the Cancer team Data Clerk function.

Screening patients undergo core biopsy and are then discussed at Diagnostic MDT. When diagnosed, screening or symptomatic pathways are the same. There are some cross site requirements with regard to patient pathways, where patients are admitted to a ward at the General Hospital site for surgery but have to be transferred by ambulance to Essex County Hospital for localisation on the day of surgery and then returned to the General Hospital site for their procedure. This is due to equipment limitations on the General Hospital site.

The service reported an increase in both the number of referrals and the number of Cancers detected, partly due to the screening age range being extended from 47 to 73 (previously 50 to 70 years). Radiologist capacity and availability of equipment and appropriate accommodation were cited as significant issues for the service. Some patients are referred to Northwick Park for MRI Guided Biopsy – which creates a delay for patients, although the numbers are very small. There are on occasion requirement for a second opinion, in which case patients are referred to the Royal Marsden which also causes delay.

The team confirmed that patients referred via the two week wait are currently being offered appointments on day 12 and 13 of their pathway and that this is only achievable through the use of ad hoc clinics. Therefore demand and capacity analysis could be beneficial, particularly in consideration of subspecialisation and split site working.

Recommendations:

34. Undertake demand and capacity for the breast service.

35. Review opportunities for provision of MR Breast Imaging on other days during the week.

Head and Neck

The service is supported by one Head and Neck Consultant, along with a part time, interim, CNS and part time Oncologist. Chelmsford is the hub, and the service has links to two consultants at that site, a consultant is Maxillo-facial and a consultant in Plastics. The Colchester consultant provides a surgical service at Chelmsford on Tuesday each fortnight. The service advised there has been a steady increase in referrals from 2004 (approx. 150) to approx. 890 in 2012. The service reported good access for first appointment, though they have aspirations to ensure patients attend the first appointment within 7 days.

It was confirmed every new and recurrent upper aerodigestive and thyroid Cancer and complex patients are discussed at the SMDT every Friday at Broomfield. There is a fortnightly MDT clinic at Colchester and weekly MDT clinic at Broomfield.

Radiotherapy treatment is provided at the Trust, and PET and MRI is available on Tuesdays to support Head and Neck. The service reported timely vetting of referrals for PET, which are sent via the Trust Radiology department, and forwarded on to InHealth once vetted. Due to service clinic days and the availability of the PET, both on Tuesdays only, this can cause a delay in the

pathway as it is not possible to schedule patients for PET for the following Tuesday, if they attend a Friday clinic.

Patients requiring radiotherapy for tongue base, tonsils or Cancer of unknown origin need to have teeth extracted, which can create a further delay in the pathway, and is one of the causes for breaches within the service, along with inter-provider transfers from Chelmsford for Radiotherapy. Cancers of unknown primary often need multiple scans including PET scan, multiple biopsies and teeth extraction. Their diagnostic pathways are complex which delays their first treatment.

The team advised that pooled surgical input post biopsy would provide an opportunity to reduce delays in the pathway, along with increased maxillofacial support at Colchester. The service had undertaken a considerable amount of work to map and streamline the clinical pathway, and have implemented a number of improvements to the pathway.

The service reported good MDT coordinator support. The Cancer PTL is currently reviewed fortnightly with the Consultant Head and Neck Surgeon, along with the MDT Coordinator and Service Manager and actions are agreed and confirmed to expedite treatment. There is a wish to meet weekly but this is apparently not possible because of other commitments.

Recommendations:

- 36. Undertake demand and capacity analysis to determine capacity requirements for first appointment to enable initial patient appointment within 7 days of referral where possible.
- 37. Identify opportunities to improve MR and PET access.
- 38. Consider increasing frequency of PTL Meeting from fortnightly to weekly.

Lower GI

All treatment options for primary colorectal Cancer are offered on site. The Trust is also a regional centre for early colorectal Cancer.

There are no direct to test protocols for Lower GI referrals so all patients are seen first in outpatients. Referrals are not vetted so all referrals have an appointment booked, although staff identified concerns over the appropriate use of the two week wait pathway. The specialty has recently reviewed outpatient demand and capacity. Waiting time for routine patients is usually around 8 weeks but is currently running at 10-12 weeks. Lower GI consultants work on annualised job plans which provide more flexibility for running extra evening clinics when required.

Staff report that there has been a marked improvement in access to endoscopy over the last year following the provision of additional capacity by the Trust and by process redesign. Typically patients requiring endoscopy are able to have their test within two weeks of the request.

Tertiary referrals are received by hard copy or fax. There is no template form for tertiary referrals so information provided can vary. Staff report that there are some delays in tertiary referrals and also some instances of missing information regarding earlier parts of the patient pathway for tertiary referrals. There are delays in bowel screening referrals from Ipswich and Chelmsford.

The turnaround time for radiology tests and results is generally two weeks as is the turnaround time for tests and results from the mobile PET scanner.

There are two whole time equivalent CNS's for colorectal Cancer the second of which started recently. There is a CNS present in all Lower GI consultant clinics. There is also a CNS results clinic for patients who prefer to receive their results as they are available rather than wait to see the consultant with all their results.

The CNS meets weekly with the booking team to review patient pathways and the colorectal Clinical Lead meets with the MDT Coordinator each week to go through the PTL and where appropriate to expedite patients. There is a fortnightly surgical meeting to review performance and identify issues.

The colorectal team report some challenges in accessing operating theatres due to lack of physical space and shortages of anaesthetists and theatre nurses. There are some three session days worked in theatres but in colorectal surgery they are predominately two session days.

Recommendations:

- 39. Consider opportunity to audit 2 WW referrals to determine number of inappropriate referrals and to inform referral processes.
- 40. Service to review access times for routine appointments, which may impact on the volumes of 2 week wait referrals, and may lead to routine patients being re-referred as urgent or 2 week wait referrals.
- 41. Identify opportunities to address theatre workforce and capacity issues.
- 42. Consider developing a referral proforma for referrals to the service.

Skin

Referrals are sent straight to Medical Photography as the first stage of the pathway. Patients come in for a digital photo which is reviewed by the consultant within 24 to 48 hours and triaged either as urgent or not Cancer / routine. Biopsy or excision is undertaken if needed after consultant review. There is a high reliance on locums for service, so only one clinician will undertake biopsies/excision on the day of clinic attendance when possible. A clinician will review in clinic and then the patient will be brought back on another day for excision if required. Patients remain on the Cancer pathway until histology results are back. The MDT Coordinator receives biopsy/excision results on a daily basis. The removal of patients from the Cancer PTL is carried out by the MDT coordinator using evidence from clinic letters and histology results. Where doubts exist, the decision is made by direct reference to a clinician.

It was confirmed the appointment timeframe for first outpatient appointment is stretching up to 4 weeks, and separate clinics are held for punch biopsies.

It was confirmed melanomas are fast tracked, and that there are minor operations or theatre lists during the week – with 10 to 12 lists per week. The service is currently providing additional weekend lists, but is reliant upon theatre capacity and other infrastructure issues, such as nurse staffing.

The tumour site lead is based in Chelmsford, and it was confirmed there was no lead from April until July 2012. The clinical lead in North Essex attends Essex County Hospital on Mondays and Thursdays, weekly. The pathway for patients from skin to plastics is problematic, with occasional referrals being lost or delayed, and also not being marked as urgent Cancer.

The CNS confirmed the reliance upon locum consultants has been challenging due to variations in clinical practice and thresholds for referral. It has been difficult to recruit to a vacant consultant position. A community dermatology service has been established, but the governance arrangements in respect of this are unclear and there is the potential for delayed referral from them to secondary care. A community photography service is commissioned by the CCG and does not link with the secondary care service. The links with the Trust and community service are not well developed, and there is a need to ensure referrals are sent to the appropriate provider. IST were advised there is no information shared with the Trust regarding community provided capacity or activity. There was a good understanding of the clinical pathway, which had been mapped, and it was confirmed the pathway from punch biopsy on to plastics or radiotherapy needs to be reviewed as delays are occurring.

The service has a staff grade that can undertake advanced procedures, and has several weekly lists a joint clinic on Friday. Histopathology support was reported as generally good, though there are delays with Broomfield pathways in terms of information coming back to the team regarding plastic surgeon review, and on occasion patients have been put on a routine list and not an urgent lists. On occasion patients come back to the Trust without their tumour being fully excised – and require further surgery.

Staff report that the most recent Peer Review advised that the CNS workload is too large for one person. Feedback regarding support provided by the MDT coordinator was good, and confirmed they provide very good support, good escalation of issues, and chase and follow up, though sometimes they need to be prompted to chase things up. .

Demand and capacity is an issue for the tumour site, partly due to reliance on locum consultant, varying clinical practice, and varying requirements in terms of patient contact time and follow up.

The IST were advised that root cause analysis of breaches is undertaken routinely within Skin, but we did not see an example of the tool used.

Recommendations:

43. Identify and address obstacles that prevent locum Consultants to undertake biopsy on same day of attendance.

- 44. Undertake demand and capacity analysis for two week wait clinic requirements.
- 45. Review pathways to plastics to ensure patients continue on a priority Cancer pathway.
- 46. Explore opportunities for closer working with community dermatology facility.
- 47. Review CNS workload and staffing requirements to ensure appropriate CNS support.

Upper GI

Tertiary referral for patients with upper GI Cancer for surgical management are sent either to Mid Essex Hospital Services NHS Trust in Chelmsford or to the Royal London Hospital” – non surgical patients remain at Colchester.

GPs direct access to gastroscopy was decommissioned by the previous PCT in 2010 due to safety concerns. Gastroenterologists have been working with Clinical Commissioning Group to re-introduce open access gastroscopy service. The CCG has not agreed to commission this service to date.

Staff reported that no action had been taken to implement previous peer review recommendations for improvement in Upper GI because the service has to compete with other services for funding.

Until a few weeks ago patients with a negative diagnostic test were removed from the Cancer PTL by the MDT Coordinator prior to confirmation by a clinician that the patient didn't have Cancer and could be removed. In some cases the patient may still have been under active investigation and Cancer may not yet have been excluded. This practice was stopped a few weeks ago and patients can now only be removed from the Cancer PTL when authorised by a consultant.

Two week wait referrals are vetted daily by the consultants with most patients going straight to endoscopy. The specialty used to downgrade inappropriate referrals without discussion with the referring GP. Downgrading of two week wait referrals without discussion with the referring GP is not consistent with national guidance and presents a clinical risk to the Trust. The IST were advised that this practice was stopped around 18 months ago.

Staff report significant increases in two week wait referrals but the conversion rate remains fairly constant indicating that some of the referrals are inappropriate. The specialty doesn't currently monitor the number of inappropriate referrals but is planning to do an audit in the future. A 'huge' number of patients referred under the two week wait don't appear to know that they have been referred on a suspected Cancer pathway.

Patients requiring surveillance procedures are added to a planned waiting list and are supposed to be seen within six weeks of their planned treatment date. In March / April 2013 the Trust reported to the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy that they had a backlog of planned patients 'several' months past their planned treatment / review dates. The Trust report that the backlog has now been cleared, though IST have not reviewed the PTL so can't

verify this information, and staff confirmed that a process of rolling three month validation is in place and is undertaken by the CNS. Letters are sent to patients on the planned list six weeks before their due date asking them to confirm they still need an appointment and to ring in the arranged a date.

There are some issues in accessing Endoscopic Ultrasound (EUS) which is usually done at Royal London Hospital, for suspected HPB Cancer patients, they currently do not have sufficient capacity to meet demand and are onward referring patients on to St Thomas' Hospital. The Trust is unable to refer patients directly to St Thomas' as the commissioners don't have a contract with them for this service. This is resulting in delays in getting EUS done.

Staging laparoscopy for patients with oesophago-gastric (OG) Cancers is done at Broomfield Hospital. The lack of adequate EUS facility for OG Cancer at Mid Essex Hospital Service (MEHT) has resulted in delay in staging of some of the patients. There is only one EUS specialist for MEHT & other referring centre. MEHT has been working on this issue and is training a gastroenterologist from Ipswich.

Recommendations:

- 48. Divisional team to review recommendations from Peer Review last year, and develop action plan to take forward where appropriate.
- 49. Need to clarify pathway for patients with non-specific symptoms, where GP has requested specific tumour type review – and where there may be a need for further diagnostics to exclude other Cancers.
- 50. Facilitate an audit of referrals to determine number of inappropriate referrals and to inform referral criteria.
- 51. Review process for informing patients they have been referred on an urgent pathway to exclude Cancer.
- 52. IST to review process for managing planned waiting lists.
- 53. CCG to review commissioning arrangements for Endoscopic Ultrasound.

Urology

The Trust is an IOG surgical centre for Urology. A specialist MDT is held once per week with surrounding hospitals. The Trust had recently appointed a fifth Urologist who starts in April 2014. The Trust met recently with clinicians from Mid Essex Hospitals to review the urology pathway – TRUS and MRI ordering of tests.

Tumour site pathways within urology cover prostate, bladder, kidney, testicular and penile Cancer. It was confirmed that penile Cancer and testicular pathways are clearly defined and rarely cause delay, with onward referral to St George's Hospital (Tooting, South London) for penile Cancer, and referral to UCLH for testicular Cancer.

There have historically been some issues with subsequent treatment dates for patients requiring check cystoscopy who were on planned lists with patients going beyond their planned date. Changes were made in 2012 to make planned lists more visible and breach reports are now required each time a patient

breaches their planned date. Staff report that only one patient has breached their planned date so far this year but this was by 18 months.

The prostate pathway is the largest by volume and delays are experienced. The service also sees patients suitable for active treatment for prostate and bladder Cancer from Chelmsford, who have their surgery and first follow up at the Trust. Upon referral Colchester patients are reviewed, there is a decision whether a biopsy is required, which may be undertaken in a one stop clinic. Patients are sent for MRI first where PSA criteria is met, then TRUS biopsy if required. Hormone treatment may be provided in clinic after the TRUS biopsy is completed and when histopathology received. Template biopsy can be an addition to the pathway, which can cause delay and needs monitoring and control. A consultant urologist will lead on monitoring this pathway.

It was confirmed there historically tends to be more patient breaches during the summer months due to staff and patient holidays - this causes some delays. At a consultant level cross cover is usually provided to try to try to deal with The Consultant staffing leave issues. Further Consultant appointments will help with this. The team have reviewed middle grade doctors' rosters over this period and appointed an additional consultant who will start in March 2014. There are currently four consultants in post, a fifth consultant is to be appointed, however only two are Cancer consultants.

Staff report that the current system of allocating GP urgent referrals means that at times patients suspected of having Cancer are seen in clinic by a consultant who doesn't treat Cancer and that this results in consultant to consultant referral to the Cancer consultants and an extra step in the patient pathway. Patients are sometimes dated on to a general consultant clinic after TRUS biopsy which also causes delay. Patients requiring template biopsy are currently batched with 6 patients per list because the biopsy machine is currently hired. The Trust have recently purchased a machine which will address this issue.

Secretaries are instructed not to overbook clinics for Cancer patients, despite specific outcome of the MDT meeting discussions. This is as a safety measure to prevent mistakes, and to allow enough time to be seen in the clinic. As a result the pathway can be delayed – this hopefully will be addressed by more nurse led clinics and appointment of the fifth consultant.

Penile Cancer patients are always referred before day 41, some issues with patient indecision where they need more time to think or are considering treatment options. Some patients are referred to Southend to see for brachytherapy and have usually breached when they return.

A new PSA clinic is being implemented from November, which will ensure patients are on the correct pathway from the beginning.

The tumour site had a good understand of pathways, and have put in place virtual clinics to review patients by phone and confirm results and make treatment plans for benign patients.

Bladder Cancer patients may experience delay due to the requirement for prolonged investigations. The team have reviewed the clinical pathway and plan to move pre-operative assessment of these patients to earlier in the pathway, to within 5 days of decision to treat in order to reduce delay. It was confirmed pre assessment is currently overloaded, providing services on 3 days, and also additional sessions on Saturday. Pre-operative assessment (POA) nurses are receiving additional training to enable them to move from a specialty specific POA to a more generic assessment which should further reduce delays. A health screening questionnaire has been developed to stratify patients to determine if anaesthetic POA is required.

Referrals are received from other centres, and the team reported delays for referrals from Chelmsford, and that they have already breached when referred on from Chelmsford and sometimes Southend. The team have regular meetings to review pathways, with a focus to align pathways and ensure consistency. Chelmsford is to adopt the prostate pathway developed by the Trust, and joint clinics with Chelmsford are in place, and include a Nurse, Oncologist and Consultant Urologist.

Consultants regularly review Cancer waiting times for individual patients, and confirm actions that are required. Consultants are responsible for reviewing their own lists with the MDT coordinator and confirm whether they can be removed from the pathway.

Recommendations:

54. Identify opportunities to improve departmental consultant leave planning and cover to optimise clinical throughput and efficiency.
55. Review booking processes for booking team to ensure patients are booked into correct clinic in the first instance and after TRUS biopsy has been completed. This will include the planned setting up of fast track Cancer clinics.
56. Review GP understanding of the referral process and when it is appropriate to make a two week wait referral to ensure that patient suspected of having Cancer are referred on the correct pathway
57. Review information given to patients by their GP when making an urgent referral to ensure that patients are aware of the nature of the referral
58. Develop guidelines for all staff to prevent overbooking but allow timely identification and management of urgent patients, and should include an escalation process.
59. Review pre-assessment capacity to ensure suitable access for Cancer and non Cancer patients.

3.9 Support Services

There is an internal service standard of seven to ten days turnaround from request to results available for radiology and pathology for patients on Cancer pathways. It isn't clear how this is monitored and specialty staff were unaware of current performance against this standard.

Most clinical specialties operate a manual check and chase system operated either by the Clinical Nurse Specialists (CNSs) or by the Medical Secretaries but systems vary by consultant.

There has been some outsourcing of radiology and pathology but staff were unaware of how this was decided, how much outsourcing there had been or how long it had been going on for. However it was confirmed the Trust does not outsource the imaging of patients on a Cancer target pathway.

Radiology

Requests for radiology are on hard copy paper with 'target' stickers used to identify suspected Cancer patients. The current paper system provides no assurance that requests have been received in the radiology department and staff report that there have been instances of requests going astray.

The service aims to vet referrals on the same day of receipt, and is undertaken manually. Vetting is completed on the referral form – with no process to vet referrals electronically. There are plans to introduce protocol led vetting by administrative staff and radiographers for CT and MR protocols.

The team had established processes for escalating capacity issues to the Radiology Services Manager, Clinical Lead or Modality Lead Radiographers, with an expectation that capacity issues are resolved on the day they are escalated.

The booking team use the manual referral requests to prioritise and schedule patients – there is a risk here of workload displacement and the possibility of misplaced forms.

Reporting for radiology is done electronically and images are stored electronically. There is no audit trail on the system to show who has viewed the images, and so no mechanism to confirm whether diagnostic results have been reviewed by clinical staff within tumour sites.

The QlikView system provides a measure of the date in clinic and time to reporting, with a reported 90% of referrals attended and reported within 7 days of clinic. Whilst some reporting is outsourced, all target Cancer referrals are reported in house. Escalation processes and thresholds for reporting delays were confirmed, and are based on date of exam. There may be an opportunity of revising to escalate on the basis of the referral received date. Radiographer led plain film reporting has been implemented for Accident and Emergency. There are long term plans to increase procedures which can be reported by radiographers.

The Trust has a policy relating to the management of unexpected findings, which includes requirements for the management of unexpected findings, including responsibilities of key staff. The Trust has provided evidence indicating the process is effective in relation to the Lung Pathway. The policy will be updated to make the process more robust for unexpected Cancers.

It was acknowledged there is a reliance on manual paper based systems, which includes a number of handoffs between teams. There is a nominated member of the administrative team who has the responsibility to ensure patients move through on a timely basis. Radiologists attend the MDT meetings, with imaging double reported. It was reported that Radiology has an excellent attendance record for all established MDT's. There are capacity and remuneration issues regarding new MDT's, including the MDT meeting for Cancer of unknown primary, along with the Breast MDT Meeting, due to radiologist workforce limitations.

On occasion there are inconsistent details provided on imaging requests, which can lead to delay in vetting and prioritising where required. It was confirmed there are no processes in place to provide MDT Coordinators with visibility of patients awaiting imaging procedures. This could be achieved by enabling access to CRIS for the MDT Coordinators, or through developing a standard report which provides the status of Cancer patients referred to diagnostic imaging (for example referral received date, date of diagnostic, date of attendance, date reported, date vetted etc.).

Staff have established manual work arounds to track patients referred for diagnostics – linking Cancer PTL system and imaging system would enable electronic cross referencing.

Recommendations:

60. The Trust review metrics for the monitoring of service performance by modality to support service monitoring (i.e. referral rates, imaging or treat dates, reporting turn around, reporting variation for example maximum reporting time (with a focus on reducing and improving consistency of performance), waiting time profiles etc. This should include the establishment of quality indicators for the purposes of supporting consistent service standards, for example 95% of reports reported within agreed timeframes.
61. Establishment of a process to ensure tumour sites can readily identify missing referrals and ensure they are followed up with diagnostic imaging.
62. Review of vetting referral rejection rates to confirm the percentage of requests that are rejected as a result of vetting. The Trust may be able to identify diagnostic requests where 100% of referrals are vetted as appropriate, which would enable the booking of these referrals without the need for vetting, reducing vetting workload and reducing the delay between referral and booking the appointment.
63. Department could investigate implementation of electronic vetting of referrals, which would eliminate the need to print the hard copy referral, and would also eliminate transporting of paper referrals between office locations. Many RIS systems have this functionality. It is our understanding that IRMER regulations enable the use of an electronic signature in place of a hard copy signature – however the Trust may like to obtain formal confirmation of this.
64. Opportunity for department to implement use of diagnostic imaging PTL as mechanism for prioritising bookings of patients.
65. Ensure diagnostic imaging staff are aware of requirements outlined in the Trust policy "Procedure for Action to be Taken Following a New or

Unsuspected Cancer or Other Unexpected Diagnosis from a Radiological Investigation”.

- 66. Trust to consider opportunity for electronic referral for diagnostic services.
- 67. Review Radiologist job plans and workforce to ensure appropriate attendance at MDT Meetings.
- 68. Identify opportunities to enable Cancer team better visibility of patients awaiting diagnostic imaging.
- 69. Review demand and capacity for radiology to confirm whether the reliance on outsourcing is to clear backlog or to meet a shortfall in capacity.

Pathology

Requests for pathology are on hard copy paper with suspected Cancer patients requests marked urgent or identified by pathology as urgent because of the indications written on the request or the place the request has originated from e.g. one stop clinics. Urgent requests are generally reported within 48 hours of receipt. If special stains are required a provisional report is issued and the relevant MDT pathologist informed. The special stains are usually done within an additional 24 hours and a final report issued. Routine requests are usually reported within one week of receipt.

The current paper system provides no assurance that requests have been received in pathology. Clinicians have access to the pathology system and can see the reports once they have been authorised. The pathology system doesn't have the functionality to confirm or annotate the results when they have been reviewed by the consultant.

In the event of unexpected findings the department will email the relevant consultant and their Medical Secretary.

Staff report that there were sometimes delays with turnaround of CA19.9 blood tests as these were being batched by pathology for sending for specialist analysis at Sheffield. The batching has now stopped.

There is a nominated Pathologist for most of the MDTs but no cover currently for Cancer of Unknown Origin and Breast Treatment MDT, with alternate week support provided for the Lymphoma MDT. There are currently two vacancies for Consultant Pathologists and it is therefore not always possible to provide cover to the MDTs during periods of leave.

Recommendations:

- 70. Review system for pathology requests to identify opportunities to enhance pathology request management and receipt confirmation.
- 71. Endeavour to expedite recruitment of Pathologist vacancies.

Palliative Care

It was reported that there is a perceived lack of community resource to support patients requiring Palliative Care who would be more appropriately cared for at home, and that patients who have said that they want to die at home are

sometimes being kept on inpatient wards because of a lack of community resource.

A new service has been established in the community called SinglePoint (encompassing “My Care Choices Register”- our locality end of life register) which looks to identify those whose prognosis is likely to be less than 12 months, to encourage advance care planning and prevent unnecessary admission to hospital for end of life care. This service started at the end of September and will include a rapid response service. It is part commissioned by the CCG and part funded by the hospice. This should help to enable patients to remain at home for end of life care if they wish.

It was reported that North East Essex has the lowest percentage of inpatient Cancer deaths at 30.88% compared to the rest of Essex. In addition, it was reported the region has the highest percentage of Cancer home deaths in Essex at 39.06%.

IST have reviewed with the CCG, and was confirmed there are considerable palliative resource in the community which include a 24 hour end of life helpline, a shared end of life document database, and out of hours community palliative care services. In addition, the Marie Curie Improving Choice programme has been implemented over the last two years, and has seen 60% of patients dying in their preferred place of care, which is above the national average.

The Trust has initiated work to review the pathway for palliative patients on Cancer pathways.

IST were advised the trust frequently meets with community services and CCG to discuss palliative care community resources and palliative care facility capacity. These meetings include the Summary Hospital-Level Mortality Indicator (SHMI) group, The Project Board and The Locality Group. The SHMI group is attended by the Trust Chief Executive, Medical Director and Deputy Chief Executive and Director of Nursing, the Chief Executive of St Helena Hospice, Director of Operations at ACE, Director of Nursing at CCG, Clinical Lead for End of Life Care at CCG, ambulance representation, Palliative Care Consultant, Director of Audit and Effectiveness, and Matron for Cancer Services.

Recommendations:

72. Trust and CCG jointly review palliative care community resources and palliative care facility capacity and pathways as part of the on-going SHMI meetings.
73. Review clinical protocols for determining the appropriateness of palliative care pathway / palliative treatment / and subsequent treatment pathways.

4.0 Resources

MDT Coordinators

It was reported that many staff within the Divisions feel the MDT Coordinator roles are fragmented, and that there have been many changes to MDT Coordinator allocations, often with very short notice and without discussion with

the Divisions. There appeared to be disparity between MDT Coordinator workloads, and it is felt there is a need to review the scope and function of their roles to ensure clarity.

Staff reported a notable variation in the skills, knowledge and ability of the MDT Coordinator team, and it was confirmed there is no formal process for induction and training of MDT Coordinators. MDT appraisals are completed by the Cancer Management team without discussion with the Divisional teams they support. Escalation of issues by the MDT Coordinators to divisional staff was inconsistent. Escalation processes within the Cancer team have been documented, but some MDT Coordinators were not aware of the process.

Recommendations:

- 74. Undertake a review of MDT Coordinator roles and responsibilities.
- 75. Review training and induction processes for MDT Coordinators.
- 76. Develop a competency framework for MDT Coordinators and facilitate evaluation of existing staff against core competencies, and implement training and development to support staff where required.
- 77. Review reporting arrangements of MDT Coordinators, and ensure divisional teams are involved in appraisal processes.
- 78. Ensure escalation process is clearly communicated to MDT Coordinators and divisional staff where relevant.
- 79. Review standard operating procedures in place to support MDT Coordinator roles and functions, and to support consistency of support provided.

CNS Workforce

It was noted that some tumour sites have variable CNS support, which creates inequity in terms of CNS caseload and quality of care provided to patients. The Trust should ensure all tumour sites have key workers confirmed. The CNS and key workers are important for ensuring patients have access to treatment, and can help expedite appointments and assist with patient compliance with treatment attendance and access.

Recommendation

- 80. Trust to review CNS support across tumour sites, and ensure key workers are identified and incorporated within each tumour site.

Cancer Management Support

It was noted during the visit that the Cancer Manager was on extended leave. Subsequently this will impact on the availability of designated Cancer support within the Trust, and should be considered as a priority.

Recommendation:

- 81. Trust to identify opportunities to provide cover for the Cancer Manager role.

5.0 Notes from visit on 29th November 2013

Please refer to Annex B.

6.0 Useful Resources

Transforming your Radiology Service, Focus on: Improving Booking Processes:

http://www.institute.nhs.uk/news/quality_and_value/launch_of_transforming_your_radiology_services_kit%3a_focus_on_reporting_process.html

The National Imaging Board best practice guidance for radiology reporting times can be found at the link below:

http://www.improvement.nhs.uk/documents/radiology_reporting_times_best_practice_guidance.pdf

The National Patient Safety Alerts (NPSA) Guidance regarding unexpected findings:

<http://www.nrls.npsa.nhs.uk/resources/?entryid45=59817>

7.0 Conclusion

The delivery of Cancer waiting times targets are clearly a priority for the Trust, with the Board and Senior Management Team committed to provide care for their Cancer patients within the national targets. However there is work required both in order to provide assurance regarding data quality and consultant upgrades/unexpected findings, and a need to clarify the appropriate pathway for patients with non-specific symptoms.

Whilst the Trust has recently re-established the Cancer PTL Meetings, they will need to ensure divisional participation in these meetings, and that they are managed consistently, and are action oriented.

There is a need to ensure appropriate milestones are identified for each tumour site pathway, along with milestones for key points in the pathway including inter provider / cross site referrals.

Demand and capacity was generally well understood, there may an opportunity to undertake demand and capacity analysis for the Breast tumour site, which will be vital to ensure sustainability and management of Cancer services within Breast going forward.

The IST found the review of the Trust an informative process which gave an overview of the current position and challenges. The staff and teams that were interviewed were open with the IST about the challenges they are facing in achieving performance. Staff were also enthusiastic about resolving the current issues provided there was an on-going commitment to sustaining performance going forward, although staff expressed concern about the level of support available to colleagues under the current circumstances and in light of the CQC report.

The IST noted a number of areas of good practice as outlined above, including the work undertaken across all tumour sites to clearly document and protocolise pathways. Whilst there is a need to support and develop the MDT Coordinator team, along with reviewing the scope of their role and function, this should provide notable benefits to the tumour sites, and individual staff. Whilst CNS support was reported

as inconsistent across tumour sites, it was noted that all staff interviewed had a strong patient focus.

This report highlights a number recommendations for where improvements can be made, however, the key priorities are:

Requiring immediate action:

- Review of processes for managing unexpected findings from diagnostics. Please refer to NPSA guidelines:
<http://www.nrls.npsa.nhs.uk/resources/?entryid45=59817>
- Review of processes for managing consultant upgrades – mechanisms to reconcile or check they have been added to the system;
- Review of processes for reviewing adjustments entered by services, to enable review and monitoring by the information team;

Should be address as a high priority (in consideration of lead time and potential positive impact):

- Clarification of pathways for patients with non-specific symptoms – particular issue for Upper GI – a risk patients could be discharged without a definitive diagnosis;
- Clarification of pathways for sarcoma tumour site and processes for the identification and management of patients within this tumour site;
- Review of MDT coordinator roles, responsibilities, training and induction – given the issues regarding support consistency, a competency process would also be beneficial;
- Implementation of Root Cause Analysis for all breaches – missed opportunity for the Trust;
- CNS tumour site workforce review;
- Confirmation of expectations regarding timeliness of data validation by MDT coordinators and on-going monitoring and escalation where appropriate;
- Agreement of suitable milestone for cross site referrals, and mechanisms to monitor and escalation requirements.

8.0 IST Support

The IST would be pleased to offer support to the Trust to take forward the recommendations contained in this report. Specifically the IST can offer expertise in the following areas:

1. Undertake diagnostic review of remaining tumour sites;
2. Use of IST tools to review the role and workload of MDT Coordinators;
3. Review of Trust Access Policy and provide feedback and suggested amendments;
4. Review processes for managing planned patients;
5. Obtain copies and provide feedback of breach reports;
6. Observe two MDT meetings and provide feedback and suggestions to enhance;
7. Attend Cancer PTL meeting and review Cancer PTL;
8. Review copies of recent board reports / Cancer committee reports and provide comment and feedback;
9. Review copies of a sample of root cause analysis reports where completed, and provide feedback;
10. Process observation admissions and booking teams making and managing TCIs and appointments and provide feedback;
11. Review and provide feedback on the terms of reference for Cancer committee;
12. Provide training in the use of the IST Demand and Capacity tools where required.

15th December 2013

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NHS IMAS

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Annex A Trust staff involved in the review

- Ann Morris, Service Manager, Surgery
- Anna Bjorkstrand, Associate Director Clinical Support Services and Cancer
- Clare Foster, MDT Coordinator, Haematology and Lymphoma
- Dawn Smith, MDT Coordinator Lung Tumour Site
- Dawn Stiff, Colorectal Cancer Clinical Nurse Specialist
- Denise Walters, Interim Associate Director, Surgery
- Donna Booton, Cancer Matron
- Dr Achuth Shenoy, Consultant Gastroenterologist and Clinical Lead
- Dr Alan Lamont, Consultant Oncologist and Service Lead for Oncology
- Dr Angela Tillet, Clinical Lead Paediatrics Tumour Site
- Dr Bruce Sizer, Consultant Oncologist and Trust Cancer Lead
- Dr Gavin Campbell, Clinical Lead Haematological and Lymphoma Tumour Site
- Dr Gillian Urwin, Divisional Clinical Director Clinical Support Services and Cancer
- Dr Ian Seddon, Consultant Histopathologist and Interim Clinical Lead for Pathology
- Dr Jonathan Even-Jones, Clinical Lead Gynaecology Tumour Site
- Dr Samantha Cooper, Clinical Lead Lung Tumour Site
- Dr Soumadri Sen, Consultant Cellular Pathologist
- Elaine Westall, CNS Brain and Central Nervous System
- Fiona Crump, Service Manager, General and Specialist Medicine
- Fiona Crump, Service Manager, Skin
- Graham Fletcher, Cancer Information Lead
- Hayley Peters, Senior Analyst, Cancer Services
- Jackie White, MDT Coordinator, Specialist Urology
- Joanne Tonkin, CNS Haematological and Lymphoma Tumour site
- Julie Gormer MDT Coordinator, Gynaecology
- Karen Buckland, CNS Haematological and Lymphoma Tumour site
- Kay Selfe, Upper GI Clinical Nurse Specialist
- Lauren Smith, Team Leader Palliative Care Team
- Liz Adlair, Associate Director, Medicine
- Lucy Powell CNS Urology
- Maggie Braithwaite CNS Urology
- Mandy Green, CNS Gynaecology Tumour Site
- Matt Tutton, Consultant General and Colorectal Surgeon and Colorectal Clinical Lead
- Michelle Figg, Head of Business Informatics
- Mr Arcot Maheshwar, Consultant Head and Neck
- Mr Chandra Sekharan, Consultant Surgeon Breast
- Mr John Corr, Consultant Surgeon Urology
- Mr Rowan Casey, Consultant Surgeon Urology
- Niki O'Shea, MDT Coordinator, Breast
- Paul Hudson, Radiology Service Manager
- Sarah Underhay, MDT Coordinator, Lower GI

- Sian Gooding, MDT Coordinator, Urology
- Suzy Hawkins, CNS Head and Neck
- Tracey Roots, Cancer Analyst
- Vicky Barber, Assistant Cancer Services Manager
- Will Howard, Clinical Director Radiology

Annex B Additional observations from visit on 29th November 2013

Lung

The team provided a copy of the clinical pathway for Cancer patients, and demonstrated a good understanding of the pathway and pressure points through the pathway, with agreed milestone at key points. The team reported a notable increase in 2 week wait referrals from around 70 per annum in 2007 to 447 in 2012. The service indicated a good understanding of demand and capacity, and has responded to increased demand by undertaking additional clinics when required. Designated two week wait clinics are provided at Clacton on Wednesday PM, Essex County Hospital on Thursday (Consultant and Registrar), in parallel with an Oncology clinic, and patients can see an Oncologist the same afternoon in clinic if required, except on alternate Wednesday afternoons, as the Oncologist is only there in the morning.

Diagnostic imaging support was reported as good, with 8 days for first appointment, and up to 2 weeks for CT scan following an abnormal chest x-ray, though was noted it can be as little as one week. There are a number of diagnostic investigations that may be required after CT, the team has developed guidance to support pathway decision making post CT, which can include referral for PET which is provided on site with a mobile scanner visiting the Trust on a Tuesday, EBUS which is provided by Basildon and Papworth, and surgical biopsies which are undertaken at Basildon and Royal Brompton. Some patients specifically request not to be seen at Basildon, requiring onward referral to Royal Brompton, which has caused some delays in the pathway, due to limited capacity at Royal Brompton. The team reported good processes for highlighting incidental findings from diagnostic imaging, and have established systems to enable visibility of patients referred to diagnostics and diagnostic report completion.

It was noted there has been an increased demand for PET scans, with some delays in access this service, however generally patients were offered an appointment within 5 days, but this would potentially require travel to another hospital location which some patients are reluctant to do. PET is provided on Tuesday, and if it is not possible to schedule patients from the Thursday clinic for PET on the following Tuesday, delaying the pathway where the patient does not wish to attend another site. Report turnaround after the scan was usually 48 hours, therefore patients having a PET on a Tuesday would be discussed at the MDT meeting on Thursday morning and seen in clinic the same day. However as PET scans are reported by Trust radiologists, it can be expedited if needed earlier to accommodate patients being seen in Clacton on Wednesday afternoons.

The team reported delays in accessing EBUS which is currently provided by Basildon, with delays of up to four weeks the EBUS procedure and histology results over the summer. IST noted the Trust has recently approved a business case for EBUS at Colchester Hospital, and plan to commence this service in April 2014.

The MDT meeting is held on Thursday AM, with breach dates and treatment plans are discussed, agreed and documented during the MDT meetings, and filed in patient notes following the MDT. Good support from radiology and histopathology was reported. The majority of surgical patients are referred to Basildon for treatment, however some patients have requested treatment at Royal Brompton which has been a cause for delays. It was noted there has been on-going issues with late referrals for radiotherapy from Broomfield.

The team have established robust processes for reviewing the PTL, which is undertaken by a designated Consultant Lung Physician twice weekly, to check patient pathways, progress and expedite where required, and reported good support from the MDT coordinator, including arrangements for cross cover during leave. It was confirmed patients are only stepped down from tracking on instruction from the consultant, after reviewing the PTL. It was reported there have been occasional issues with absence of histopathology cover for MDT Meetings, however histopathology information is provided to enable discussion. The team have implemented a number of initiatives to reduce delays for patients across the pathway, including digital dictation of clinic letters enabling clinic letters to be available on the day of attendance in some instances.

The team routinely undertake root cause analysis of breaches, and reported late referrals from Broomfield Hospital as a regular cause of breaches.

Recommendations:

82. Please refer to recommendations regarding PET access and inter provider transfer milestones.

Paediatrics

It was confirmed the service does not receive 2 week wait referrals for paediatrics, and that diagnostics and treatment is mostly undertaken at the primary treatment centre, Addenbrooks, with Colchester providing a Level 1 shared care unit. Diagnostic and treatment decisions are confirmed at the primary treatment centre, with inter-provider pathways to both Addenbrooks and Great Ormond Street Children's Hospital (GOSH).

The team reported timely communication by fax and phone with Addenbrooks regarding patients identified locally for onward referral and management, and also with regard to the progress of patients. The MDT coordinator function for paediatrics is undertaken by a CNS. The service has a trained oncology nurse who provides in reach services to clinics. A paediatric elective care unit is located at Colchester which incorporates the majority of paediatric services, with the exception of Neonatal Intensive Care Unit (NICU) and Paediatric Accident and Emergency. The team noted Colchester and Addenbrooks use different

shared care protocols, between Primary Treatment Centre with Colchester using the Anglia Cancer Network guidelines.

The tumour site participates in a MDT meeting on the third Monday of the month which is held at Colchester with teleconference link to Addenbrooks, with full multidisciplinary input, including Play Specialist, Hospital Teacher, Dietician, Pharmacist, etc. Haematology provides a fast track service for paediatric patients, with results available in 15 minutes for chemotherapy dose confirmation.

The team highlighted concerns regarding consultant and CNS capacity going forward, and the potential loss of structure and administrative support provided by the former Anglia Cancer Network.

Recommendations:

- 83. Review opportunities to align shared care protocols between Primary Treatment Centres.
- 84. Review CNS and Consultant workload and staffing requirements to ensure appropriate support.
- 85. CCG, East of England Cancer Network and Trust to undertake a gap analysis of support provided by the former Anglia Cancer Network.

Haematology & Lymphoma

The service reported good visibility of referral numbers, and indicated the majority of referrals came as a result of incidental findings identified through routine access to treatment. The service has a designated on call duty consultant of the week, who is responsible for patients referred during the period of on call, and ownership of the patient going forward, with a total of four haematologists within the team, and no junior medical staff. There is limited specialist CNS cover, with consultants picking up additional tasks outside of their job plans. Whilst the team demonstrated a good understanding of the clinical pathway, they acknowledge it would be beneficial to agree milestones to assist in expediting pathways.

Referrals are sent directly to the medical secretary, and patients can also be referred directly to the facility where they can be seen on the same day. It was noted that where a GP patient has an abnormal result the patient is often referred directly to MDT meeting for discussion; however the Trust will not take ownership of the patient until a referral is received, though clinicians will start agreeing the treatment plan. We were advised the Medical Secretaries will contact GP's to chase patients requiring referral to the Trust, or to follow up for additional information when required. The service is entirely consultant led, and there are no junior doctors. The team has established processes to flag incidental findings, para-proteins in biochemistry direct to the haematology consultant at the same time as providing results to the GP. The team proactively send a letter to GP requesting referral/discussion

Inpatients identified as requiring review by the team can be referred 24 hours a day, with the on call consultant reviewing the patients first thing the following day, 7 days per week. It was reported the team would see same day generally but at worst the following day if referral overnight and not an acute leukaemic.

The team has established processes for notification of new diagnosis of lymphoma which are notified to the haematologists by copy of report. Weekly meetings are held with diagnostic imaging to review diagnostics which are suggestive of myeloma, along with receiving notification from bio-chemistry of myeloma patients identified.

The team reported frequent changes to MDT coordinator support, and highlighted concerns regarding workload as MDT coordinator covers more than one tumour site. The tumour site has not established weekly PTL review meeting with the Consultant and MDT coordinator, however it is reviewed weekly with the CNS.

The team is in the process of setting clinically appropriate internal pathway milestones, and currently include patient breach dates as part of the MDT proforma. Peer review identified concerns about workload of the haematology CNS as a significant part of their time is spent with non-malignancy. It was confirmed patients are stepped down from the Cancer pathway only after discussion and agreement at the MDT meeting.

It was noted breaches had historically occurred due to delays in pathways from ENT and the General Surgeons, however a new rapid access lump clinic has been implemented which has led to a significant improvement and reduction in delays. The tumour site has refers patients to Bart's and the London and Addenbrooks for some diagnostic procedures and intensive chemotherapy, and there is opportunity for delay in the pathway with regard to securing a second opinion on histology at other sites, typically with respect to complex lymphomas. Such delays are managed proactively by the lymphoma team.

Recommendations:

- 86. Trust to review consultant job plans and medical staffing for the tumour site.
- 87. Trust to review MDT coordinator support and cover arrangements for the tumour site.
- 88. Refer to recommendation regarding the development of internal milestones to support delivery of the national Cancer indicators.
- 89. Review CNS workload and staffing requirements to ensure appropriate CNS support.

Gynaecology

The service has a single gynaecology Cancer consultant, with some difficulties experienced in terms of cover from staff grade as they have a number of other non-Cancer responsibilities. Colchester is a hub linked to the Ipswich centre; however the team advised Colchester has more Cancers diagnosed than the Chelmsford and Ipswich sites.

The team has established processes to instantly update patient's Cancer status following clinic, and a proforma is in use. It was confirmed removals from tracking are only initiated after instruction by consultant using the proforma. The MDT coordinator support model is slightly different within the service, in that they are employed and managed by the specialty, and sit in the same location as the

CNS with the gynaecology team. Cross cover for the MDT coordinator is provided by the central Cancer team.

Two-week wait referrals are sent directly to the gynaecology office, and vetted by the CNS who orders blood tests if needed before they come to clinic. It is the intention that a one stop clinic including ultrasound is provided, but this is not always possible due to ultrasound capacity. There have been on-going issues regarding the quality and availability of ultrasound report if completed by private providers in the community – which creates an additional delay and cost in repeating diagnostics when reports aren't available.

The team advised there are capacity issues at gynaecology Cancer centre (Ipswich) for specialist surgery. The team feel they are under pressure to avoid breaches in order to offset the impact of breaches in other tumour sites. It was noted the service has a single CNS, and that there are a number of complex pathways where staff feel pressured to achieve Cancer targets, though IST was assured they would not hasten a patient if they are not ready for treatment.

The team indicated there have been issues regarding staff grade support, with a number of repeated issues impact on appropriate cover and support arrangements, due to timetabling issues not being resolved in advance. This is an on-going cause of frustration for the team, and often results in the staff grade being pulled from the Cancer clinic and theatre duties to cover routine requirements. Additionally, the team advised that understanding of Cancer pathways and requirements by the wider gynaecology team was limited, staff grade knowledge and understanding was good.

Recommendations:

90. Trust to review consultant cover arrangements within the service, include ensuring staffing issues relating to staff grade support are resolved.
91. CCG and Trust to review joint arrangements with regard to provision and timely sharing of ultrasound reports i.e. where accessed within the community – improving patient flow and reducing unnecessary repeat of diagnostic tests.
92. East Anglia Specialist Commissioning Group to take forward issue regarding capacity concern at the Gynaecology Cancer Centre in Ipswich to ensure suitable capacity to meet demand, in liaison with the Trust.
93. Opportunity to provide Cancer awareness training to the wider gynaecology team.
94. Need to review CNS workload and ensure appropriate cross cover is provided.

Sarcoma

The MDT coordinator has recently taken over supporting Sarcoma, and the service does not have CNS support. The MDT coordinator is part time, and supports a number of other smaller tumour sites, and clinicians provided strong praise of her support, though it was acknowledged there is a need to further develop knowledge and understanding of the tumour site.

It was noted the tumour site has not agreed and documented clear pathways, and it was acknowledged that there is need to develop. It was reported

Orthopaedic surgeons are less familiar with Cancer pathway requirements; however there are plans in place to attend meetings in January to provide training in Cancer pathway requirements. Surgical services are provided in London at the Royal National Orthopaedic Hospital (RNOH), with subsequent treatments i.e. chemotherapy and radiotherapy completed at Colchester.

There is no local MDT Meeting, with MDT being completed in London by Royal Marsden, University College Hospitals London (UCLH), and the RNOH. Medical secretaries are advised of patients who have been referred to London with sarcoma and discussed at the MDT meeting. The IST was unable to review further details of the tumour site, given staff availability, and the relatively short time the MDT coordinator has been covering the post. Subsequently, there is a need to ensure the Trust reviews as a matter of urgency to ensure suitable assurance for the timely identification and management of patients within this tumour site.

Recommendations:

- 95. Review requirements for CNS support for tumour site.
- 96. Urgent need to review, develop and document clinical pathway for patients within this tumour site.
- 97. Urgent need for Trust to review as a matter of urgency to ensure suitable assurance for the timely identification and management of patients within this tumour site.

Teenage and Young Adults

This tumour site was established in summer 2012, and supports treatment provided to patients from ages 19 to 24, with patients aged 16 to 18 being treated at UCLH, which is the primary treatment centre. Referrals for teenagers and young adults are sent directly to specific tumour sites. UCLH provides an allocated slot for the Trust to review and discuss patients jointly on Wednesday PM.

The team have documented pathways for each tumour site, and it was reported these have been adopted by partner Trusts. The team has been proactive in establishing clear pathways and communication between UCLH and the Trust. UCLH provides the team with copies of discharge summaries for patients, which includes requirements for on-going care, which is taken forward by the MDT coordinator and CNS.

An operational policy is in place, which includes support arrangements and links to UCLH, including specialist social workers and youth workers to support patients if needed. It is noted that the last 2 peer reviews identified concerns about lack of designated CNS support for this tumour site – which is currently covered by the lymphoma CNS who was previously undertaking the lymphoma role full time. The current incumbent is due to commence maternity leave in coming weeks, and it will be essential the Trust confirms cover arrangements as a priority.

The team has established daily reports from histology for all tumour sites to identify patients within this age range that have a positive histology, and add to

their Cancer PTL. At present there are no systems established to proactively identify patients with positive radiological diagnosis, and it was noted the team are sometimes advised by UCLH after the patient has been referred on to UCLH for treatment.

It was reported there is currently no data clerk support to this tumour site, as a result of two data clerk vacancies within the central team. The tumour site reported that sarcomas are not routinely notified to the team until they have started treatment at the centre.

Recommendations:

- 98. Review CNS workload and staffing requirements to ensure appropriate CNS support.
- 99. Review arrangements for the timely identification of patients within age range that have a positive radiological diagnosis.
- 100. Review staffing support arrangements for the data clerk role supporting the MDT coordinator function for the tumour site.
- 101. Review arrangements for notification of patients from the sarcoma tumour site.

Cancer of unknown primary

It was reported the MDT for this tumour site commenced in April 2013, and the MDT is completed via video conferencing weekly with Southend and Basildon. At present there is no radiology or histology input into the MDT meeting, with no real workforce to support this tumour site, and no designated CNS. The team advised they do not currently have designated clinics to review patients, and that there have been issues regarding the liver metastases pathway within Upper GI due to lack of a clear clinical pathway.

Unfortunately IST had limited time with the Clinical Lead for this tumour site, and the meeting was interrupted by some urgent telephone calls.

Please refer to head and neck tumour site report for additional details regarding tumour of an unknown primary.

Recommendations:

- 102. Need to review workforce requirements for this tumour site, and arrangements to support MDT meetings (radiology and histology).
- 103. Need to clarify pathway for patients with liver METS jointly with Upper GI.

Brain and Central Nervous System

The team receives a number of referrals from outside of the network. The service refers patients to Romford, however it was confirmed some neurologists also refer to Royal London for non-malignancy. It was confirmed the most common reason for delays to pathways are referrals to Romford and Chelmsford, where there is no single point of contact, and difficulty contacting CNS and consultants at the site to discuss individual patients.

At present there is no process for flagging patients with positive imaging to the Neurosciences MDT, however the Brain and Central Nervous System team have initiated discussions with radiology and oncologists to agree a process. Additionally the team advised there is no MRI available within the Trust on Sundays necessitating referral to Romford in cases of extreme urgency.

It was reported there are issues with non-compliance with the agreed pathway for malignancy identified within neurology, with the neurology team referring patients to Barts and the London rather than the designated centre – Romford. It was reported this can be a cause for delay, and some issues for patients with regard to travel. The team advised there are delays in referring patients to the tumour site with low grade seizures, with delays in onward referral for Cancer assessment.

A previous peer review identified the lack of spinal cord compression clinical coordinator role as a cause for concern, and whilst this issue has not yet been resolved, it has been escalated within the Trust. It was confirmed complex spinal surgery for Cancer pathway has been agreed, including pathway for inter-provider transfer to Romford, however one clinician continues to refer to Ipswich as they provide good access, and good communication with the team.

Recommendations:

104. Need to confirm inter-provider transfer requirements for neuro-oncology to ensure appropriate inter-provider transfer to the designated treatment centre.
105. Trust and CCG to work with East Anglia Specialist Commissioning team to confirm central points of contact for patients at Romford and Chelmsford.
106. Review opportunities to establish processes to notify the tumour site of patients with positive diagnostic imaging, to enable visibility and timely management of pathway.
107. Identify opportunities to improve MRI access at weekends.
108. Need to review clinical pathway for malignancy identified within neurology, to ensure clarity of requirements, and consistent patient management.
109. Need to review clinical pathway for patients with low grade seizures, including confirmation of criteria for onward referral for Cancer assessment.
110. Trust to review requirements to support the spinal cord compression clinical coordinator role.

Appendix 4 – Terms of Reference & methodology of clinical site visits

Site Specific Clinical Teams Review

Terms of Reference

Purpose of the review

This review follows a Care Quality Commission (CQC) report into Cancer standards at Colchester Hospital University NHS Foundation Trust, published on 5th November 2013. This report identified a number of failings in Cancer Services in the Trust including unwarranted delays to diagnosis and treatment which may have caused harm to patients. This review will provide expert external assessment of the current safety of Cancer Services. Where these fall short, it will identify immediate remedial action to make the services safe, or indicate where services cannot be made safe immediately. The primary aim of the visit is assurance of Colchester Hospital Cancer pathways and the role of the external clinical teams is to provide a critical but facilitative perspective.

Definitions

CQC	The Care Quality Commission
CQC report	The report published on 5 th November into Cancer standards at Colchester Hospital University NHS Foundation Trust
CHUFT (the Trust)	Colchester Hospital University NHS Foundation Trust
Review teams	Teams of independent clinical and administrative staff performing the review
The CCG	North East Essex Clinical Commissioning Group
IMT	The Incident Management Team overseeing this review process
Clinical Oversight Group (COG)	The team of senior and expert clinicians overseeing the clinical teams review
Clinical team	A specialist Cancer team responsible for diagnosing and treating Cancers at particular sites such as breast Cancer, lung Cancer etc.
Key Line of Enquiry	An issue identified as a potential problem in Cancer Services

Key questions to be answered

The key question in this review is “are the Cancer Services safe now?” To answer this question the Clinical Oversight Group (COG) has identified Key Lines of Enquiry (KLOE) from evidence gathered to date which have identified a number of issues which need to be explored in each clinical team under review. The visits will take place in the 2 weeks commencing 18th November.

Key lines of enquiry

These have been identified from multiple sources of data and are set out in Appendix 1.

Approach to evidence gathering

This review is seeking strong assurance as to the safety of Cancer Services at CHUFT. Therefore, the evidence reviewed should be robust and the Review Teams should be prepared to justify their conclusions on the basis of this evidence. The Review Teams should record evidence provided prior to visit (by agreement) or on the day of the visit only. They should avoid second-hand evidence and concentrate on directly viewed evidence or direct testimony from staff.

Outputs of the review

This review will produce a report detailing:

the process of the review

its key findings

a judgement on whether each Clinical Team is operating a safe service at present

any immediate actions taken to make the services safe

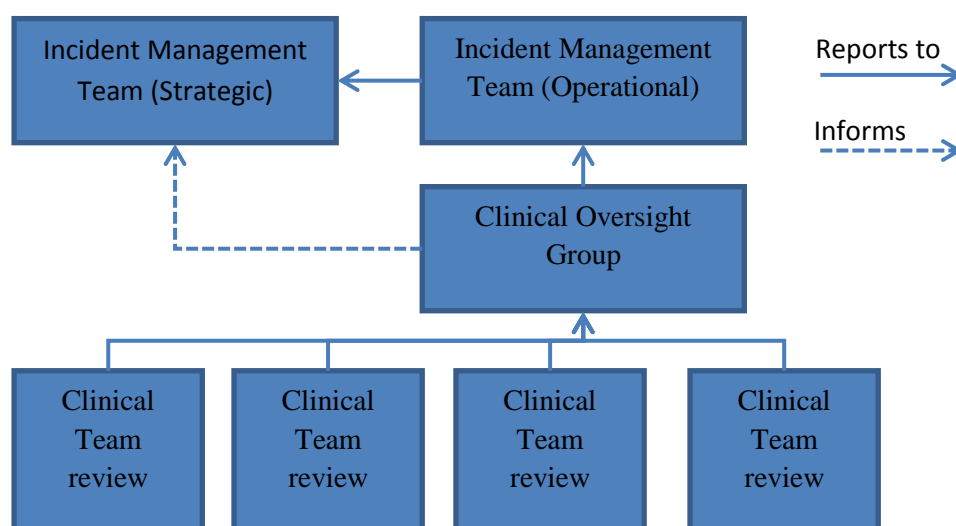
recommendations for further development to raise the quality of the services

Leadership of the Clinical Teams review

The review process will be co-ordinated by the Clinical Oversight Group under the Chairmanship of Dr Christine Macleod, Medical Director NHS England Essex Area Team. There are 14 Clinical Teams to be reviewed and each will require an expert Review Team. Each Review Team will have an accountable lead clinician.

Line of reporting

The Clinical Teams review will report to the Clinical Oversight Group of the Incident Management Team.



Process of review

There are 14 Clinical Teams to be reviewed in a short space of time.

Clinical Teams to be reviewed

All Cancer Clinical Teams in CHUFT will be reviewed. These are:

Urology incl. Testicular Cancer	Upper Gastrointestinal	Breast
Lower Gastrointestinal	Skin	Head & Neck
Brain and CNS	Gynaecology	Haematology
Lung	Children	Sarcoma
Cancer of unknown origin	Oncology	

Membership of review teams

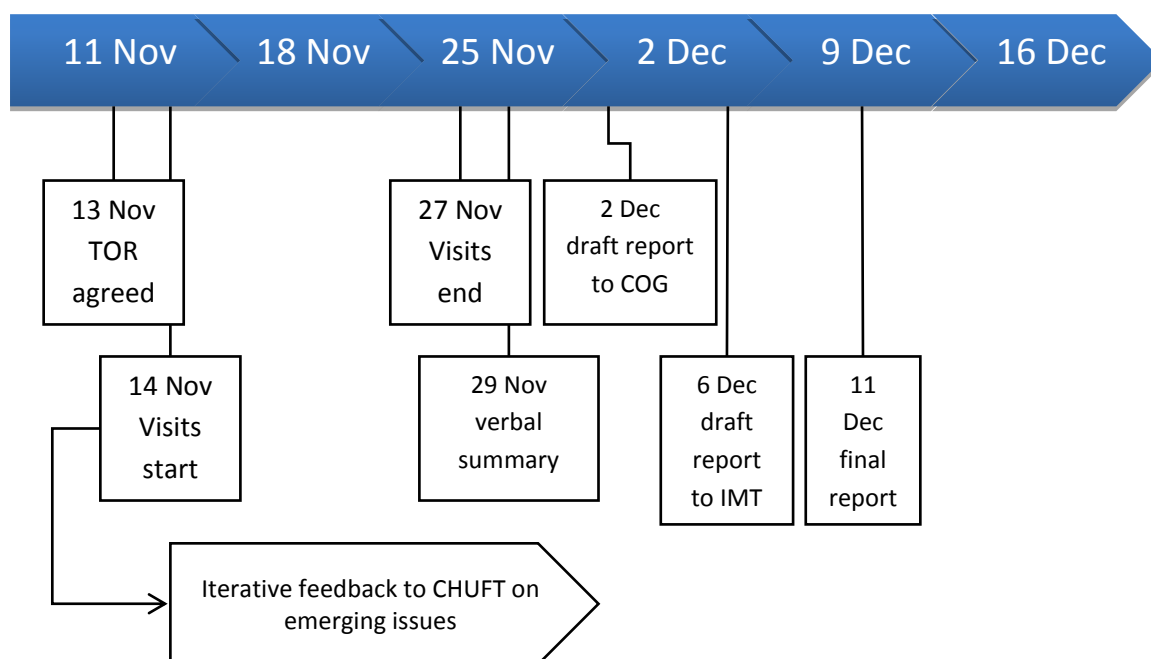
Review Teams will consist of clinicians and expert administrators independent of CHUFT, plus a local GP.

Each Review Team will consist of:

Accountable lead clinician	A consultant specialising in the same field as the Clinical Team under review
Specialist Nurse	A nurse specialist in the same field as the Clinical Team under review
General Practitioner	A local GP from NE Essex CCG
Cancer administrator	An NHS manager with expertise in Cancer Services
Review Team support worker	A support worker to co-ordinate the planning, record keeping and smooth running of the visit
Area Team input	A member of the Medical or Nursing Directorate

Timescales

The review will be completed in the shortest possible timescale, whilst allowing for thorough review by expert clinicians and administrators. Given the time constraints, a priority will be given to the availability of the external clinical leads. The visits will be coordinated by the Clinical Oversight Group facilitated by a member of the East of England Cancer strategic clinical network.



Site visit protocol

Pre-visit preparation

All documentation listed below should be available to the clinical team at least 24 hours before the visit. This should be emailed and available in hard copy for the visit.

Peer review documents including:

- Annual report
- Work plan
- Operational policy
- Terms of reference
- Diagnostic pathways
- Serious Incident reports from the last 3 years, including never events
- Internal & external audits from the last 3 years

Peer review reports from the last 3 years

- Intensive Support Team findings
- Patient Tracking System summaries

Complaints & compliments from the last 3 years

Plan for the day

Logistics for the visit:

Base for Review Team & site of initial meeting	NE Essex CCG offices, 2 nd floor Colchester Primary Care Centre Turner Road, Colchester, CO4 5JR Also a room in CHUFT
Parking	Colchester Primary Care Centre car park

The details of members of the CHUFT Cancer Team who will be interviewed by the visiting team should be clearly communicated both internally and externally.

Outline timetable

Session	Task
Visit start	Review team assemble to discuss Key Lines of Enquiry and identify key conversations and key evidence to review during the visit. Tasks should be divided between team members where appropriate. Collated information presented to visitors.
Introductions	Meet trust representatives & clinical team Review team explain purpose & process of visit
First evidence collection session	This will include: Visiting the environment Detailed discussion with staff of Clinical Team practice, processes, relationships and governance
Mid-way	Review team reconvene for 30 minutes to discuss issues identified during first evidence collection session, and to request any further information for assurance
Second evidence collection session	This will include: Visiting the environment Detailed discussion with staff of Clinical Team practice, processes, relationships and governance. Rapporteur to finalise information gathering for KLOE. Quality of record keeping, (availability of 5 to 10 recent case notes during the day)
Summation	Review team reconvene to agree key findings and feedback, with emphasis on: Level of Assurance Concerns identified Immediate remedial actions Start to compile report
Feedback	Feedback to Trust and Clinical Team
Draft Report	Accountable lead clinician and Review Team support worker compile the draft report, with opportunity for the clinical oversight group to provide quality assurance of the reports.

Staff to meet

- Service clinical lead
- Consultants involved in the service
- Specialist nurses
- Directorate lead
- MDT coordinator
- Other staff who wish to meet the team

Selection of case notes for review

A random selection of 10 case notes from the preceding 6 weeks will be made available to the Review Team at CHUFT.

Appendix 1 – Key Lines of Enquiry (KLOE) identified to date

These KLOEs are identified from the analysis of multiple sources of data including

The CQC report 5th November 2013

Complaints relating to Cancer services from 2010 onwards
Concerns raised by local GPs including audit data from Cancer referrals
Cancer teams key documents:
Peer review documents
Annual report
Work plan
Operational policy
Terms of reference
Diagnostic pathways

The public Helpline calls received by CHUFT

Serious Incidents & Never Events relating to Cancer from 2010 onwards
Clinical outcomes data including East of England Cancer Intelligence Report
National Intensive Support Team rapid review of CHUFT Cancer Services October / November 2013
Intensive Support Team findings
Patient Tracking System summaries

Key Lines of Enquiry

Pathway management

- Key dates not recorded e.g. date of referral, date of receipt etc.
- Flow through pathway milestones not managed
- Risk of breach not identified early
- Alternative plans to avoid breaches not identified early / not resolved at MDT
- Patients lost to follow up. Active surveillance not well managed

Clinical oversight

Responsible clinician

- Responsible clinician not identified
- Clinical continuity with responsible clinician not occurring at start and end of pathway
- Clinicians working in silos along pathway / not communicating e.g. locums undertaking key investigations and discharging patient
- Discharge without clinical review (poor safety netting)

MDTs

- MDT not well supported by admin
- MDTs not well structured
- MDTs not well chaired
- MDTs failing to address and resolve potential or actual pathway breaches

Record keeping

- Poor and inconsistent record keeping
- Key decisions not recorded
- Inaccurate data recorded on Cancer Waiting Times tool

Access

- Patients offered impossible appointments (yesterday, same / next day)
- Choose & Book slot availability poor (often none)
- GPs unable to access secretaries or consultant advice
- Access to diagnostics
- Access for vulnerable patient groups

Audit

- Audits failed to address access, continuity of care, record keeping, pathway and breach management

Governance & Culture

- Existing governance processes failed to detect these issues
- Staff found it difficult to raise concerns
- When concerns were raised they were not addressed
- Internal whistleblowing processes failed to bring the concerns to the attention of the Board

Appendix 2 - Questions to be answered by visit team

KEY QUESTION: Are Cancer Services safe now?

LEVELS OF RESPONSE: **IMMEDIATE RISK – remedial action**
required immediately to make the service safe

SERIOUS CONCERNS – urgent action required

CONCERNS – development required

APPROACH TO EVIDENCE: Avoid hearsay – record what you see and what you are told first-hand

Q1. Are the records accurate?

Question	Evidence reviewed / staff spoken to	Findings	Remedial actions required Indicate urgency: immediate / urgent / developmental
Are Key dates recorded? E.g. date of referral, date of receipt at CHUFT, date of first appointment			
Are clinical records consistent? Are decisions regarding pathway stops / pauses consistently recorded?			
Does Cancer Waiting Time data tally with clinical records?			

Q2. Can patients access the service easily?

Question	Evidence reviewed / staff spoken to	Findings	Remedial actions required Indicate urgency: immediate / urgent / developmental
Were 2WW Choose and Book slots available to book every day over the last month?			
Are appointments sent in a timely, realistic way to enable patients to attend?			
Can GPs access consultant advice and admin staff? How is this made easy?			
Are the needs of vulnerable patient groups addressed, such as those with visual impairments, learning difficulties?			

Q3. Is the pathway well managed?

Question	Evidence reviewed / staff spoken to	Findings	Remedial actions required Indicate urgency: immediate / urgent / developmental
Is every patient tracked along the PTL?			
Is there daily review of the PTL? By whom?			

Are potential breaches identified well before actual breach?			
Are remedial actions taken quickly & effectively to prevent breach?			
Are key clinical concerns at referral identified for each patient?			
Is a responsible clinician identified for each patient?			
Is a key worker is identified for each clinician?			
Have the clinical team identified any bottlenecks in the pathway and what is being done to address these?			

Q4. Safety-netting

Question	Evidence reviewed / staff spoken to	Findings	Remedial actions required Indicate urgency:
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			immediate / urgent / developmental
Is there evidence that the Responsible Clinician reviews all decisions to discharge or step down from Cancer pathway?			
Is Active Surveillance tracked in a robust, auditable manner? Are red flags identified? How is this done? By whom?			
Is there effective communication with primary care regarding the outcomes of assessment & treatment? Are further actions for the GP clearly identified, if necessary?			
What are the plans for accessing diagnostics?			

Q5. Clinical team functions well

Question	Evidence reviewed / staff spoken to	Findings	Remedial actions required Indicate urgency: immediate / urgent / developmental
Is there adequate administrative support for the MDT (including any specialist MDTs)?			

Are MDT meetings well-structured with enough time allocated to manage the caseload?			
Is the MDT routinely well attended? Is a record of attendance kept?			
Does the MDT discuss and address potential or actual breaches? Are breaches avoided by the MDT?			
Is there evidence of effective team working in the MDT?			
Are there constructive, supportive relationships between members of the MDT?			
Is there dialogue and feedback when there is an inter-hospital transfer?			

Q6. Audit

Question	Evidence reviewed / staff spoken to	Findings	Remedial actions required Indicate urgency:
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			immediate / urgent / developmental
Have regular audits been undertaken in the last 3 years?			
Have the audit cycles been completed, including improvement and re-audit?			
Has audit considered patient access and GP satisfaction / concerns with the service?			
Has audit considered record accuracy / consistency?			
Has audit considered PTL management & breach prevention / remediation?			
Has audit considered clinical oversight / safety netting of patients on Cancer pathways?			
Has audit considered the performance /			

effectiveness of the MDT?			
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Q7. Governance & Culture

Question	Evidence reviewed / staff spoken to	Findings	Remedial actions required Indicate urgency: immediate / urgent / developmental
Are concerns are identified and can they be raised easily within the MDT or if needed the wider organisation?			
Is there evidence that once raised, concerns are addressed effectively?			
Are mechanisms in place for the Trust board to systematically identify areas for further in-depth review? Is there evidence of this happening?			
Is there evidence of proactive challenge from the board and involvement of non-executive directors in ensuring good governance?			
Are staff aware of and confident in the internal whistleblowing			

process?			
Do staff know how to bring their concerns to non-executive directors if necessary?			

Appendix 5 – Biographies / roles of clinical site visit teams

Alasdair Drake is a sub-specialised consultant gynaecological oncology surgeon operating at the Cancer centre at Watford General Hospital and at Lister Hospital Stevenage. He is lead surgeon for the Mount Vernon Cancer Network and Chairman of the Gynaecology Network Site Specific Group. He is also Clinical Director for Gynaecology at East and North Herts NHS Trust

Alison Marker is a Consultant histo/cytopathologist at Addenbrooke's hospital and an Associate Lecturer at the University of Cambridge. I have a special interest and expertise in head, neck and endocrine pathology and chair the head and neck site specific group for the Anglia Cancer network.

Dr Christine Macleod is the Medical Director, NHS England Essex Area Team. Graduated in medicine from Aberdeen and became a member of the Royal College of Physicians before completing her training in public health medicine at Newcastle upon Tyne. Consultant in public health Trent, Peterborough and Cambridge. Medical Director with NHS Cambridge and NHS Peterborough. Faculty Advisor for public health working closely with the Deanery.

David Gilligan Director of Cancer Division CUH 2006-2011; Trust Lead for Acute Oncology May 2011 - present CUH; Chair Lung Cancer MDT Papworth 2011 – present; Chair Lung Cancer Network Group May 2013 - present

James Hernon Consultant Colorectal Surgeon, Colorectal Cancer lead, Chair old Anglia Cancer Network

James Nicholson Consultant Paediatric Oncologist at Addenbrookes Hospital since 2000, service director for Paediatric Oncology and Haematology from 2005 to 2009, and Lead Clinician for Children's Cancer Network (previously Anglia Cancer Network Paediatric Pan-Network Group) and SSG from 2005 to present, MDT chair for solid tumours, executive member and chair elect of the national Children's Cancer and Leukaemia Group (CCLG)

Jennifer Garioch has been a Consultant in Dermatology at the Norfolk and Norwich University Hospital since 1996 and has a special interest in the diagnosis and management of skin Cancer. She specialises in Mohs micrographic surgery and was responsible for setting up the Mohs micrographic service at Norwich in 2008. She has been the Chair of the Skin Cancer Specialist MDT at the Norfolk and Norwich University Hospital since 2001 and Co-Chair of the Anglia East Skin Cancer Site Specific Group since 2007

Kristian Bowles – Consultant haematologist, Norfolk & Norwich University Hospitals NHS Foundation Trust

Dr Linda Mahon-Daly MB BS MRCGP has been a GP partner in Colchester since 1987.

She has been the Primary Care Cancer Lead for Colchester since 2001 (Cancer lead for Colchester and Tendring since 2005) however she has represented Colchester CCG and its equivalent predecessors for Cancer services since 1994. She has been the North East Essex Macmillan GP facilitator since April 2011.

Mark Roberts – local GP and CCG elected member

Max Hickman - local GP and Vice clinical chair of the CCG

Mr Robert Brierly Consultant Urologist Ipswich Hospital NHS Trust; Urology Cancer lead and Chair Urology LMDT Ipswich Hospital Since 2007; Foundation Training Programme Director Ipswich Hospital since 2009; Co-Chair Urology SSG Anglia Cancer Network since 2012

Dr Sarah Jefferies PhD FRCP FRCR is a Consultant Clinical Oncologist and Associate Lecturer at Addenbrooke's Hospital in Cambridge. I trained at the Royal Marsden Hospital and undertook a PhD studying the genetics of head and neck Cancer at the Institute of Cancer Research. My clinical practice is now highly specialised including the management of Central Nervous System, Skull Base and Head and Neck Cancers.

I am interested in optimising how we plan and deliver radiotherapy for brain tumours, skull base lesions and head and neck Cancers. I am also keen that we deliver a service that is embedded in clinical research and I am principal investigator for National and International clinical trials within each specialty.

I am a member of the Clinical Trials Advisory Committee (CTAAC) which provides national peer review of research and I was Network Lead for Neuro-Oncology from 2008 until 2013 for the Anglia Cancer Network overseeing the implementation of the Improving Outcomes Guidance.

Dr Shane Gordon is a GP and the Chief Officer for North East Essex CCG. He has been a clinical commissioning lead with Essex SHA and subsequently for East of England SHA where he was also associate medical director for 3 years. Dr Gordon has extensive experience of clinical service redesign and innovation. He is an honorary senior lecturer with Anglia Ruskin University's Postgraduate Medical Faculty and a member of both the Royal College of Surgeons and the Royal College of GPs.

Simon Pain Consultant Breast and Endocrine Surgeon, NNUH, Chair of old Anglia Cancer Network Breast SSG; Breast Screening Programme QA Surgeon for East of England

Sonica Goel – local GP and CCG elected member

Dr Rory Harvey Qualified University of London 1987; Consultant Gastroenterologist Bedford Hospital 1999 Lead Bowel Cancer Screening Program Bedfordshire 2009 Medical Director Anglia Cancer Network 2009-2013 Cancer Clinical Director East of

England Strategic Clinical Network and Cancer Clinical Director Eastern Academic Health Science Network April 2013 onwards.

Vivekanandan Kumar is a consultant urological surgeon specialising in urological oncology providing services at Norfolk and Norwich University Hospital, a lead surgeon for the Anglian Cancer Network and Co-Chairman of the Urology Network Site Specific Group. He is the lead penile Cancer surgeon for East of England and Chairman of penile Cancer supra network for East of England.

Dr Richard Wright – local GP and ex-chair of the LMC

Appendix 6 – Clinical site visit reports

Clinical Team: Acute Oncology

Date: 21/11/13

Review Team:

Rory Harvey - Clinical Lead

Teresa Dowdeswell - LAT

Tonia Dawson - SCN Cancer Manager and Lead Nurse

Team Members Interviewed (Name & Role):

Alan Lamont - Lead Clinician

Michelle Pledger - CNS

Summary of Review:

We are grateful to this small team for giving up their time to help us with this review and describe the service to us

They are a team that work well together and have worked extremely hard to set the service up over the last two years.

There are 5 consultants timetabled to cover the service but it appears that one gets the majority of the calls.

They have a chemo alert card for patients and we were told that they use the national UKONs triage tool for patients that phone in acutely ill but we didn't see it in action.

We assured the service but recognised out of hours limitations and reliance on one nurse.

Immediate Risk:

- None Identified

Serious Concerns:

- There is only one oncology nurse covering the Acute Oncology Service, without any clear contingency planning for annual leave or other absence, which can compromise the service.

Concerns:

- The PAS system is due to change so their current flagging system of oncology patients is at risk if not built into the new system.
- Currently two site working is a real issue as a neutropaenic patient could present at either end.
- With one person it is difficult to do all the necessary training of A and E and

EAU staff.

Recommendations:

- Arrangements need to be put into place to have cover for the nurse.
- An audit of admissions out of hours will show what proportions of patients are not covered by the 9-5 service (Anglia audit showed 50% of calls and visits out of hours).
- Consider linking with Haematology emergency service for cover.

Areas of good practice:

- Have worked hard to set up the service
- Work well as a team
- Link in well with Palliative Care
- Collect clear data

Clinical Team: Brain & Central Nervous System	Date: 28/11/13
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Review Team:

Sarah Jefferies - Clinical Lead, Oncologist
 Max Hickman - CCG
 Yomi McEwen - AT
 Tonia Dawson - SCN Cancer Manager and Lead Nurse

Team Members Interviewed (Name & Role):

Alan Lamont - Lead Clinician
 Richie Clayton - MDT Coordinator - MDT coordinator
 Elaine Westall - CNS

Summary of Review:

The team were willing to share honestly and openly with us about the Brain Cancer service and we are grateful to them.

The team are small but clearly come across as working well together to provide a good service to patients. The nurse specialist works both at Chelmsford and Colchester and therefore there are days when she is not at Colchester but her patients know that from the outset. She has clearly implemented a number of the IOG recommendations and provided an excellent synopsis of evidence within the submitted portfolio.

The team must be commended for implementing a Cancer network MDT.

The lead clinician is responsible for a number of clinical sites, the TYA service and acute oncology. It was apparent that he is extremely busy but at the moment but some support is currently being provided by a retired clinical oncologist, working under his instruction and guidance.

There have been issues with the neurosurgical centre, Queen's Hospital, Romford. There was a significant period of time where there was no MDT coordinator in post at Queen's. This led to coordination issues and brain images not always being shown and occasional delays (see peer review self-Assessment). They now have a coordinator but images are still not always available. (Usually 1 out of 4 not shown). This appears to be due to an image transfer problem within Queen's Hospital. Images are sent from Colchester but there is insufficient resource to upload the images onto the system at Queen's. The videoconference platform also does not allow the CNS to link in to when the Mid Essex patients are discussed.

They have a clear written operational policy but it is questionable how well it is established and known throughout the Trust.

Immediate Risk:

- Lack of clear documented pathway.

Serious Concerns:

- There is an Oncology Consultant in charge of this pathway who has multiple responsibilities. There is a lack of clarity as to how the formal cover arrangements for brain tumours work.
- There appears to be a pathway issue for metastatic spinal cord compression, with clinicians referring on 3 different pathways to Barts and the London, Queen's Hospital, Romford and Ipswich hospital.
- There is no clearly identified single point of contact for an MSCC coordinator and no clear direction for consultants or GPs on who to contact in the event of suspecting spinal cord compression. At present this role is being managed by the lead clinician, CNS & acute oncology.
- The provision at weekends for patients with spinal cord compression is limited to an emergency MRI list on Saturday mornings and referral to another provider at other times. However the Trust does not have a clear documented protocol for access to MRI out of hours.
- The operational policy outlines that any abnormal brain imaging where a tumour is suspected should be referred to the brain MDT within 2 working days. There did not appear to be a policy within the trust to undertake such a system. Images that were abnormal are often returned to the GPs with no consultant upgrade or referral to the brain MDT.
- GP's can refer patients to neurologists. It is highlighted in the peer review self-assessment that there has been some staffing issues and posts filled by locums. As a consequence there does not seem to have been consultant upgrade a referral to the brain MDT from neurologists. Patients have been referred back to the GP or to hospitals outside of the Oncology pathway and referred straight to Bart's and the London instead of Queens.
- The annual report indicates that 2 week waits were seen for Basildon (16) and Southend (13) whereas none were listed for Colchester and Mid Essex. This may reflect the lack of consultant upgrade from radiology and neurology but could also indicate that GP's have greater access to MRI in Basildon and Southend.
- Appendix K outlines a pathway for patients with 1 brain metastases – but there is no guidance for oligometastases or leptomeningeal disease.
- As we did not have a representation from the hospital management – it was not clear that there is a governance structure within the Trust for monitoring previous external and internal peer review concerns with a dedicated action log. I.e. who within the trust escalates the concerns to the Board and how is it monitored?
- There does not appear to be a Trust policy for internal validation of standards for peer review with the Cancer manager and Network reviewing the department. It is usual for another department to do the reviewing and for it to be signed off by the Trust Director responsible for Cancer. The Trust Cancer lead is the lead for Brain Cancer and so has signed off the peer review.
- There is lack of evidence of sufficient team working between Colchester and Ipswich which is important given all patients have their radiotherapy in

Colchester.

Concerns:

- They used to participate in clinical trials but unable to for some time due to capacity issues. Used to link in with the Royal Marsden. Trial entry is not generally discussed at first presentation but is if appropriate later in pathway. CNS does provide information to patients about clinical trials, explaining in general terms about the different phases of trials and how to access them. In addition CNS promotes Brain Tumour Charity patient education days, through a patient support group.
- Appeared to be no or limited neuro-rehabilitation.
- There was a query around the effectiveness of the NSSG because some of the pathways issues had not been resolved for a couple of years.

Recommendations:

- Lead Clinicians Job Plan needs addressing urgently.
- All pathways need to be clear and in diagrammatic form with telephone numbers, so there is no confusion as to where patients are referred.
- There needs to be clear instructions for on-call clinicians around neurosurgical on call rota for MSCC.
- Clinicians also need clear guidance on how to access MRI 24/7
- There need to be clear guidance around internal peer review. I.e. departments should not do their own review and other trust clinicians should be involved otherwise this is not peer review.
- There needs be clear guidelines for primary care re management of MSCC and referral for suspected brain tumours. Consider combining this with guidance for other rare tumours.
- Support is required for the oncology department over the next 6 months leading up to transfer of all oncology services to CGH.

Areas of good practice:

- Dedicated clinicians
- Good MDT coordinator
- Excellent CNS - who has set up a North and Mid Essex Brain Tumour Support Group

Clinical Team: Breast**Date: 21/11/13****Review Team:**

Mr Simon Pain - Consultant Breast Surgeon, Norfolk & Norwich Hospital
 Mary Wood - Breast Care Nurse Specialist, Norfolk & Norwich Hospital
 Dr Teresa Dowdeswell - Assistant Director of Nursing, Essex Area Team
 Kate Patience - SCN Interim Essex NSSG/Peer Review Support Manager

Team Members Interviewed (Name & Role):

Dr Shaobin Wu - Consultant Histopathologist
 Monica Dale - Superintendent Radiographer
 Dr Sharmila Rao - Consultant Radiologist
 Dr Diane Johnston - Consultant Radiologist
 Karen Reeve - Breast Care Nurses Secretary
 Becky Rix - Secondary Care CNS
 Andrea Nears - Clinical Trials Nurse
 Morven Angus - Breast CNS
 Anna Bjorkstrand - Associate Director, Cancer & Clinical Support Services
 Nicki O'Shea - Breast MDT Co-ordinator
 Mr S Chandrasekharan - Consultant Breast Surgeon
 Dr M.B. Mukesh - Consultant Clinical Oncologist

Summary of Review:

We are grateful to the all those who supported and participated in this review for their co-operation and openness, especially at such short notice.

The Breast team were reviewed as a large group and then invited back in smaller groups (nurses & admin staff followed by consultants and radiology staff). It was especially evident that the breast team were saddened by the current loss of the service manager who they felt has always been extremely supportive and instrumental in making many positive changes within the department.

Some areas of concern were identified and set out below. This review process found no immediate risks within the current Breast Cancer pathway.

The review team were assured that the breast Cancer pathway is safe.

Immediate Risk:

- None identified

Serious Concerns:

- Staffing at all levels on the team leaves the service vulnerable as the whole team appear to be working at full capacity, including regular extra evening clinics.
- The data collection systems are out-dated, with data being uploaded onto separate systems increasing the capacity for error.

- The accommodation does not allow the team to be as flexible as they would like to be.

Concerns:

- The Pathologist is not available for both weekly MDT meetings
- The histopathology and breast teams are not involved in current planning around accommodation which is causing some concern within the teams
- There is a lack of training for clerical staff at induction and for on-going development
- The director of the screening service is employed by Mid Essex Trust – this causes a potential governance issue as this person should be responsible to Colchester CEO

Recommendations:

- Data collection system needs to be updated and systems in place to enable validation
- A full capacity and demand survey should be carried out, with a review of job plans for oncologists, surgeons and CNSs to ensure capacity for increasing referrals is built in
- The management team needs to ensure that the clinical teams are involved in planning around accommodation
- Family history clinics - dates need to be audited to ensure they are appropriate

Areas of good practice:

- Close team all feel able to raise and discuss concerns
- All new patients seen at One Stop clinic
- Live typing at MDT with consultant review of outcomes
- Good tracking of breaches on PTL
- Single person responsible for removing patients from PTL on instruction from consultant
- Award winning Secondary Cancer Nurse service
- Patients followed by named clinician where possible
- Involved in local, network and national audits

Clinical Team: CUP pathway	Date: 21/11/13
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Review Team:

Rory Harvey - Clinical Lead

Teresa Dowdeswell - LAT

Tonia Dawson - SCN Cancer Manager and Lead Nurse

Team Members Interviewed (Name & Role):

Alan Lamont - Lead Oncologist

Richie Clayton - MDT Coordinator

Summary of Review:

The NICE guidelines were published in July 2010 to improve the diagnosis and management of malignant disease of patients with an unknown primary origin. These patients often are not treated by one particular team and can be passed from test to test. The CUP pathway is to try and get these patients cared for by a set team. The measures for the guidance were published in April 2013

We learnt that this is a key service development area for the Trust led by Alan Lamont, that is an on-going development. They have set up a network wide MDT teleconference to discuss these complex patients between Southend, Colchester and Basildon.

They are currently writing a Trust investigation and management policy so although they have started to develop this service it was difficult to review as behind with implementation.

Immediate Risk:

- Currently setting up the local MDT structure but currently no real workforce, no histopathologist, no radiologist, no named nurse.
- They have not audited CUP patients so it is difficult to know their length of stay and the pathways they took.
- No capacity or defined pathway to manage liver lesions which currently are managed by the upper GI or other Cancer teams, who are keen to devolve to the CUP team.

Serious Concerns:

- No trust guidelines for systemic therapy treatment for these patients.
- No evidence patients are routinely being entered into CUP trials although initial discussions are taking place with local research institutions.

Concerns:

- None identified

Recommendations:

- To implement the service as rapidly as possible.
- Suggest adopt guidance from within EoE.

Areas of good practice:

- Network teleconference set up to discuss complex patients of unknown primary.

Clinical Team: Gynaecology	Date:14/11/13
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Review Team:

Mr Alasdair Drake - Clinical Lead, Gynae-oncology Surgeon

Shane Gordon - CCG

Tonia Dawson - SCN Cancer Manager and Lead Nurse

Kate Patience - SCN, Interim NSSG/Peer Review Support Manager

Sam Brown - SCN

Team Members Interviewed (Name & Role):

Mr Jonathan Evans-Jones - Lead Clinician

Julie Gormer - MDT Co-ordinator

Amanda Green - clinical nurse Specialist

Alan Lamont - Clinical Oncologist

Karen Hull - Service Manager

Summary of Review:

We are grateful to the all those who supported and participated in this review for their co-operation and openness.

The Gynaecology Cancer team appeared to be a well-functioning team with good support between staff members and good internal communication.

Many areas of good practice were identified including clear clinical responsibility and an excellent pathway tracker document which could be produced for each patient showing milestone dates. It was noted that the team performed well and consistently in terms of compliance with national standards for Cancer waiting times.

Some areas of concern and one immediate risk were identified as set out below.

Immediate Risk:

- Oncology arrangements – a locum consultant is providing the gynaecological service to cover pressure on the service.

Serious Concerns:

- Some members of the team expressed difficulty in raising concerns and getting them resolved
- Leadership not always effective in identifying risk and resolving problems
- Reported high levels of non-attendance at divisional and governance meetings
- Difficulty planning interval surgical slots at Ipswich often necessitating a fourth cycle of pre-op chemotherapy, which is not standard practice

Concerns:

- Over-reliance on a single gynaecologist in the diagnostic pathway
- Lack of appropriate support and cover for the oncologist
- Single handed CNS being diverted to routine ward duties with no cover for oncology caseload
- Lack of systematic training for MDT co-ordinators – informal induction programme only
- Some staff felt that their roles were not fully understood by their line managers
- Delays in transferring imaging from Primary Care sometimes, resulting in imaging being repeated unnecessarily
- Lack of a radiologist in attendance from Ipswich at the SMDT

Recommendations:

- Divisional board to routinely analyse and monitor Cancer Wait Times.
- Analyse the collected pathway milestone data to accurately map the average diagnostic times and identify bottle-necks
- Review of diagnostic workload and consideration of additional consultant gynaecological staff
- Review of the appropriateness of interim cover for gynaecology by oncologist
- Consideration of alternative centre arrangements for Head and Neck oncology – issue for gynaecological team relates to availability of oncologist
- Review of the oncologist's job plan
- Forward planning with Ipswich regarding dates for interval de-bulking surgery to reduce delays in the pathway i.e. book the date at start of pre-op chemotherapy
- Audit should be planned more systematically and systems needed to ensure that recommendations for service development are implemented

Areas of good practice:

- Clear responsible clinician for each patient
- Patient breach tracker sheet
- Qlik-view system to allow review of all patients on the Cancer pathway
- Good teamwork and commitment in the clinical team
- A well-used referral review and upgrade / downgrade process
- Good Choose & Book 2WW slot availability
- Same-day hysteroscopy available in outpatients

Clinical Team: Haematology**Date: 21/11/13****Review Team:**

Professor Kristian Bowles - Consultant Haematologist, NNUHFT and Chair of the Anglia Haematology NSSG
 Dr Christine Macleod - Medical Director, NHS England Essex Area Team
 Dr Jennifer Wimperis - Consultant Haematologist, NNUH Local MDT Lead Clinician
 Mrs Sally Hardwick - NNUH Haematology MDT Coordinator
 Mrs Sarah Steele - SCN

Team Members Interviewed (Name & Role):

Dr Mike Hamblin - Consultant Haematologist
 Dr Gavin Campbell - Consultant Haematologist
 Clare Foster - Haematology MDT Coordinator
 Dr Sudhakaran Makkuni - Consultant Haematologist
 Dr Marion Wood - Consultant Haematologist
 Juliet Mills - Haematology CNS
 Linda Sherman - Haematology CNS
 Karen Buckland - Lymphoma CNS
 Joanne Tonkin - Nurse Consultant Haematology
 Tina Hickey - Clinical Research Nurse
 Debbie Whittle - Oncology and Haematology Pharmacist (for a brief part of the meeting)

Summary of Review:

We are grateful to all those who supported and participated in this review for their co-operation and openness.

The Haematology Cancer team appeared to be a well-functioning and close-knit team with good support between staff members, good internal communication, and an obvious dedication to their patients whether in the hospital or out in the community. They were clearly in the habit of reviewing their service and understanding their resourcing shortfalls.

The review team were very impressed with the variety of audits undertaken. The overall impression left was one of patients being in good hands once they reach the team.

When asked, team members said that they were shocked to hear about the allegations surrounding Cancer Waiting Times data and were confident this was not happening to Haematology patients.

Some areas of concern were identified as set out below but the team were assured the pathway is safe.

Immediate Risk:

- None identified

Serious Concerns:

- Lack of an electronic data system such as Somerset.
- Lack of an E-Prescribing system.
- Lack of specific junior staff within the department, leaving consultants to bear the additional load of tasks such as audits that would normally be part of the junior doctor role.
- Consultant job plans not reflecting the amount of work undertaken, for example the recent transfer of responsibility for all lymphoma patients, acknowledgement of departmental lead duties, and work associated with recruiting patients to clinical trials.
- CNSs used as a regular resource outside the normal duties of a Haematology CNS - for example central line insertion, access and education service for the Trust - which reduces their ability to fully deliver all aspects of an IOG-compliant service to their haematology patients .
- Lack of support and full cover for the MDT Coordinator, who is also shared across other tumour sites. Due to the increasing requirements for data collection (currently falling to the MDT Coordinator) and complexity of pathways there are serious concerns over the sustainability of this post remaining stand alone.
- Some members of the team expressed frustration with the fact that they had raised business cases and requests for additional resources many times, which continue to be rejected. Little seemed to have changed as a result of the last peer review visit 3 years ago and the concerns raised as a result.

Concerns:

- The team is very reliant on people knowing each other and on informal agreements with other departments. There is a consequent lack of formal pathways that interconnect departments – of particular concern is in respect of notifying the Haematology Cancer team of new patients in a timely fashion.
- There are too many bespoke elements in their processes – for example, the Lymphoma CNS tracking the radiology for her patients
- There is no obvious mechanism in place for inter-departmental root cause analysis
- Concern that the Trust should recognise that haematology is not just a Cancer specialty and that non-Cancer work makes up a significant part of the workload
- Previous inability of the consultants to keep abreast of key outcome indicators for their service – such as recent 1 year survival rates – due to only having a paper-based system of patient data. Central collection of minimum data set information is now in place.
- The Haematology Cancer team are concerned that they do not have a dedicated inpatient ward and that the number of beds in the new ward at Essex County Hospital, and the criteria for admitting patients to it, may make it difficult to admit haematology patients.

Recommendations:

- Imperative that an electronic data system and an E-Prescribing system are introduced as soon as possible and supported with appropriate resource
- Staffing should be reviewed and improved: the department is not optimally staffed

without junior medical doctors; the CNSs should be dedicated to haematology patients only; the pivotal MDT Coordinator role should be dedicated to Haematology and underpinned by at least a data collector

- Pathways and agreements between departments should be formally documented and signed off at directorate level
- Job plans (particularly those of the consultants) should be updated to reflect the current situation
- The Haematology department should seriously consider taking ownership of their own clinical governance rather than being part of a shared oncology/haematology governance
- Due regard should be paid to the continued co-location of team members which enables their close-knit working – at least until all the above recommendations have been implemented

Areas of good practice:

- Good teamwork and commitment in the clinical team
- Clear responsible clinician and key worker for each patient
- Culture of auditing their processes and outcomes
- Resources and process for following up patients who miss clinic appointments - particularly for those patients with learning disabilities
- Openness of consultants to GP phone calls at any time
- Use of the e-mail facility in Choose & Book to record the replies to GP enquiries

Clinical Team: Head & Neck (including Thyroid)	Date:20/11/13
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Review Team:

Dr Christine Macleod - Medical Director, Essex AT
 Dr Alkison Marker - Consultant Histopathologist Addenbrookes Hospital, Anglia
 Cancer Network Head & Neck NSSG Chair
 Dr Richard Wright - GP, CCG Representative
 Kate Patience - SCN, Interim Essex NSSG/Peer Review Support Manager

Team Members Interviewed (Name & Role):

Dr Alan Lamont - Consultant Oncologist, Service Lead for Oncology
 Mr Arcot Maheshwar - ENT Surgeon Lead Consultant for Head & Neck and
 thyroid Cancers
 Denise Walters - Interim AD for Surgery
 Mr Dennis Faulkner - Maxillo-facial surgeon
 Mel Crouch - Service Manager for Surgery
 Suzie Hawkins - Interim Head & Neck CNS
 Miss Tzafetta - Plastic Surgeon, Broomfield

Summary of Review:

We are grateful to the all those who supported and participated in this review for their co-operation and openness, especially at such short notice.

The Head and Neck Cancer team work across two sites, as the team are based within both Colchester and Broomfield Hospitals. The clinical team members that attended the review were clearly working well as a cohesive team.

Some areas of concern were identified and set out below. This review found no immediate risks within the current Head & Neck Cancer pathway and was assured the pathway is safe.

Immediate Risk:

- None identified

Serious Concerns:

- Staffing at all levels on the team leaves the service vulnerable as single handed clinicians are working at apparently maximum capacity.
- There is no contingency for the rising number of referrals as team members are working at capacity.
- Additional CNS support is required.

Concerns:

- Image transfer between trusts is an issue as images are not always ready for the MDT, causing delays in the patient management decisions.
- Access to PET scan needs to be reviewed (only available on a Tuesday) to ensure that there are no delays in MDT discussion
- The transfer of notes between trusts (Colchester and Broomfield) needs to be reviewed, as currently notes are photocopied and carried in a folder which has huge information governance risks (potential financial implications to Trust if found in breach confidentiality)

- The Trust still relies on faxed 2 week wait referrals which is dependent on a working fax machine, the correct number being used, and the fax not being picked up by mistake – difficult audit trail if a fax goes missing
- The Maxillo-Facial surgeon only attends clinic at Colchester one day per fortnight. Oral surgery referrals are triaged and given a Cancer diagnosis by oral surgeons who are not part of the MDT
- Dentists not using the 2 week wait pro-formas
- Data collection systems are not efficient and require multiple data uploads with a large margin for error

Recommendations:

- Data collection system needs to be updated and systems in place to enable validation
- 2 week wait referrals should be e-mailed to ensure audit trail is visible
- More sessions for Maxillo facial surgeon to be available at Colchester
- A full capacity and demand survey should be carried out, with a review of job plans for oncologist and surgeons to ensure capacity for increasing referrals is built in
- Need to audit routine conversion rate from oral surgery route (especially referrals from dentists).

Areas of good practice:

- Excellent working relationships in a stable team evident during the team review.
- Consultant sign-off for patients prior to being removed from the PTL tracker.
- Clear evidence folders presented for the review team.
- Excellent and clear operational policy document.
- Good completeness of upload to DAHNO.
- Good systems for monitoring breaches and Datix completion for over 100 day pathway, or delays due to non-medical events.
- SMDT enables critical discussion between clinicians.

Clinical Team: Colorectal**Date: 21/11/13****Review Team:**

Dr Andy Liggins - NHS England
 Mr James Hernon - Colorectal Consultant NNUH
 Mr Tim Justin - Colorectal Consultant WSH
 Dr Richard Wright - CCG
 Jane McCulloch - CNS NNUH
 Sam Brown - SCN

Team Members Interviewed:

Mr Tan Arulampalam - Colorectal Consultant
 Mr Greg Wynn - Colorectal Consultant
 Miss Sharmilla Gupta - Colorectal Consultant
 Dr Paul Conn - Histopathologist
 Mr Bruce Sizer - Consultant Oncologist
 Dr Nicola Lacey - Consultant Radiologist
 Mr Mark Loeffler - Clinical Divisional Director

Anna Wordley - Nurse Consultant
 Dawn Stiff - CNS
 Jan Edwards - CNS
 Emma Brown - Stoma care
 Jo Phelan - MDT Co-ordinator
 Denise Walters - Associate Director for Surgery
 Anne Morris - Clinical Services Manager

Summary of Review:

We are grateful to all those who supported and participated in this review for their co-operation and openness.

The colorectal Cancer team appeared to be a cohesive, well functioning and hard working dedicated team with good support between staff members and good internal communication.

No immediate risks were identified and it was noted that the team had a robust embedded pathway in place.

Some areas of concern were identified as set out below but the team were assured that the pathway is safe.

Immediate Risk:

- None identified

Serious Concerns:

- Anal Cancer pathway remains unclear despite previous identification at peer review over a number of years.
- Capacity of the colorectal CNS team with current responsibilities appears unsustainable.
- The Colorectal MDT co-ordinator service appears vulnerable due to a lack of cover arrangements, training and support.
- Apparent lack of/ poor organisational infrastructure for IT systems and tools, lack of implementation and training for the recently acquired Somerset

database system has resulted in a lack of a robust system to collate and review clinical outcome data.

Concerns:

- Lack of consistent attendance at colorectal MDT meetings from surgeons appears to impact on the optimal working of the MDT.
- Lack of cross cover arrangements for histopathologist.
- Liver referral pathway is unclear as not all cases discussed / referred to the Liver at SMDT.
- The Colorectal nursing team / MDT co-ordinator team accommodation is not co-located with the surgical team. This appears to impact on the efficiency and effectiveness of the teams work.
- The MDT room facilities appear inadequate for quality and productive meetings.

Recommendations:

- Anal Cancer - clarification needed as to where salvage surgery is performed with support from a dedicated plastic surgery team.
- Review of CNS team workload and the balance of nursing vs. non nursing duties with additional support allocated.
- Review of MDT service cover, training requirements and support.
- Organisational review of requirements (infrastructure, tools and resource) to support increased use and utilisation of data management systems for routine and ad hoc data collation to support audit, clinical outcome data reporting and service improvement.
- Relocation of MDT meetings to a more appropriate room with quality resources for video conferencing and radiology and histology reporting.
- Increased attendance and full participation by MDT members at MDT meetings.
- Review of team accommodation.
- Review liver referral pathway algorithm and include in operational policy.

Areas of good practice:

- Hard working, cohesive and dedicated team.
- Robust pathway in place with mechanisms for capturing patients entering from alternative routes.

Clinical Team: Lung**Date: 21/11/13****Review Team:**

Dr David Gilligan - Consultant Oncologist, Addenbrookes Hospital
 Pol Toner - Director of Nursing, Essex Local Area Team
 Dr Sonica Goel - GP
 Tonia Dawson - Lead Cancer Nurse, SCN
 Kate Patience - Essex NSSG Manager (interim), SCN

Team Members Interviewed (Name & Role):

Dr Samantha Cooper - Respiratory Consultant, Lung Cancer Lead
 Annette Brown - Lung Cancer CNS
 Lauren Smith - Lead Nurse Palliative Care Team
 Karen Hay - Assistant Service Manager Medicine
 Liz Adair - Associate Director Medicine
 Dr Rekha Badiger - Respiratory Consultant
 Dawn Smith - MDT co-ordinator
 Dr Julia Harris - Consultant Radiologist
 Dr Paul Conn - Histopathologist

Summary of Review:

The clinical team are thanked for their openness and honesty during the review visit. The team were reviewed as one group and then invited back in smaller groups for more focussed discussion.

The team were clearly very close and happy to raise any concerns they may have.

The review team have outlined concerns as below but are assured the pathway is safe.

Immediate Risk:

- None Identified

Serious Concerns:

- Clarity of referral pathway from Emergency Department (incidental finding)
- Delays to the pathway caused by EBUS capacity
- Histopathology cover and succession planning for imminent retirement of current very experienced histopathologist

Concerns:

- MDT process - hand written paper system being used
- Lack of training for MDT co-ordinators
- Business case for EBUS 'currently held up at CCG'
- Capacity for imaging reporting
- Lack of CNS at the cardiothoracic centre affects nursing links
- No histopathology cover during annual leave

Recommendations:

- CNS to attend Cardiothoracic centre to improve working relationships
- PET service under pressure
- Consider increasing responsibility for MDT co-ordinator (with appropriate training) to release clinical lead time

Areas of good practice:

- Very close clinical team who work well together
- Critical discussion from all members enabled in MDT meetings
- Excellent clinical lead, very supportive of the team
- Holistic assessment being carried out routinely
- Breach dates included on MDT sheets to enable tracking, and Clinical Lead checks PTL twice a week
- Root Cause Analysis completed for any patient that breaches

Clinical Team: Paediatric Team**Date: 21/11/2013****Review Team:**

Yomi McEwen - AT

James Nicholson - Lead Paediatric Oncology Clinician

Mark Roberts - GP

Tonia Dawson - Lead Cancer Nurse

Team Members Interviewed (Name & Role):

Angela Tillett - Lead Clinician,

Rachel Dooley - Lead Nurse,

Richard Gant - Lead Pharmacist,

Rasheed Hussien - Deputy Lead Clinician,

Alice Mann - Deputy Lead Nurse,

Shume Begum - Children's Service Manager,

Dymphna Sexton-Bradshaw - Associate Director

Summary of Review:

We are grateful to the entire team who came today and for showing enthusiasm about their successes as well as their honesty over challenging areas.

It is clear from the number of patients shared with us that their workload has been steadily increasing over the last 5 years, in which time it has doubled.

The team appeared to have adapted the system as much as possible to accommodate this but were finding it increasingly hard to cover adequately at all times.

The review team could not find any immediate apparent risks or serious concerns in the time they reviewed the team and were assured the team and pathway were safe.

Immediate Risk:

- None identified

Serious Concerns:

- None identified

Concerns:

- The review team felt that a third doctor that could undertake the oncology work is needed to cope with the increasing work load and to give the families the time they needed. The middle grade covering the lead clinician is on the general on-call rota which leaves the service very short and the clinics find it hard to cover at times
- The part time CNS is also extremely stretched with the growth of patients as she only works 22.5 hours. In addition she has to cover the community and schools work.
- Whilst the team have made good headway with their neutropaenic sepsis pathway they themselves said they are still looking at ways that they could

improve it so all children get their antibiotics within an hour.

- The MDT coordinator like all the others in the Trust has had no formal training around the role. However it was recognised that the POSCU MDT co-ordinator is a clinical role rather than an administrative role.
- The team voiced their concerns about the loss of support from Anglia Cancer Network for support with Network wide guidelines and protocols for the Primary Treatment Centre and shared care units. They asked how there would be consistency network wide without it?

Recommendations:

- Additional Consultant time would give more time and cover to ensure the service was covered at all times
- Additional nursing hours would again allow good coverage and support.
- Continue to audit all patients with neutropaenic sepsis
- Update operational policy
- Develop system to ensure adequate number of appropriately trained nurses are on the rota on the wards
- Address the issue of infection control in the clinic while using resources appropriately
- Trust to introduce training for MDT coordinators and/or a developmental element to their monthly meetings
- Network to explore nationally with NHS England future support for policies and guidelines
- Other specialities need reminding to send Cancers they discover to paediatrics and not refer directly to the Primary Treatment Centre

Clinical Team: Radiology**Date: 21/11/13****Review Team:**

Rory Harvey - Clinical Lead

Teresa Dowdeswell - LAT

Tonia Dawson - SCN Cancer Manager and Lead Nurse

Team Members Interviewed (Name & Role):

Dr William Howard - Radiology Clinical Lead

Paul Hudson - Radiology Service Manager

Summary of Review:

A brief review of Radiology took place during the Sarcoma review, so this report reflects that.

Both members that attended were very new to their role.

Radiology was not assured as a safe part of the pathway until confirmation the protocols below will be in place.

Immediate Risk:

- There is only a direct referral process to the lung team for suspected Cancers picked up by radiology. All other site suspicious lesions are referred back to the GP to await referral back in but with no clear guidance who to refer to.
- If liver lesions are seen radiology may phone a consultant but no formal protocol exists.

Serious Concerns:

- None identified

Concerns:

- They felt there needed to be workforce planning within radiology before introducing advanced roles - such as guided ultrasound for fna of thyroid.
- The Trust does not have a clear documented protocol for access to MRI out of hours.
- Within the trust in general they felt an introduction of new services that impacts on radiology is often not discussed with them or planned for.

Recommendations:

- Immediate policy to be put in place for suspicious/urgent findings
- A consultant upgrade policy to be put in place for obvious malignancies and a key person in the surgical/oncology department contacted.
- Review of protocol for out of hours access to MRI
- Plan introduction of new treatments that need radiological capacity with radiology

Areas of good practice:

- Two new leads in post

- Radiology does not outsource target patients. (patients on suspected Cancer pathways)
- An internal tracking system for Target patients, managed by two individuals, has recently been introduced

Clinical Team: Radiotherapy**Date: 9/11/13****Review Team:**

Dr Tom Roques - Clinical Oncologist, Norfolk & Norwich, Chair Network
Radiotherapy Group
Dr Andy Liggins - Public Health Consultant, NHS England Essex LAT
representative
Kate Patience - Essex NSSG Manager (interim), SCN representative

Team Members Interviewed (Name & Role):

Nick Chatten - Special Projects Director
Gail Threlfall - Quality Radiographer
Dr Muthukumar - Consultant Oncologist
Sonia Tankard - Lead for Radiotherapy
Dr Alan Lamont - Service Lead for Oncology and Radiotherapy
Jason Glassford - Physicist

Summary of Review:

The clinical team are thanked for their openness and honesty during the review meeting.

The team appear to be a close and cohesive team with excellent leadership.

The review team interviewed the team as a whole, and then invited team members to discuss issues individually if preferred.

The review team found no immediate risks. One serious concern and several concerns are outlined below, which were discussed with the clinical team at the end of the review meeting.

The review team are assured that the current radiotherapy pathway is safe.

Immediate Risk:

- None identified

Serious Concerns:

Small consultant oncology team leading to

- Consultants covering several tumour sites & MDTs
- Less time for developing new aspects of the service, such as IMRT / professional development
- Job plans are not sufficient and need reviewing & agreeing (need to include time for service development and outcomes data collection)
- Difficulty with cover arrangements for leave
- Lack of cover for MDT meetings
- Fragility of the service (current workload, vacant posts, lead time for new appointees)

Concerns:

- Lack of clinical audit outcomes data for consultants

- The departmental move to CGH site, though risks appear well mitigated
- Board assurance on departmental move and level of awareness of risks and issues
- Need to improve communication with Chelmsford oncologists and clarify re pathways
- Data clerk not integrated with team
- Lack of training for MDT televisual equipment

Recommendations:

- Job plan review for oncologists, incorporating planning sessions and review sessions
- Continue to work with Chelmsford team, including consideration of amalgamation into one oncology team
- Team would benefit from visiting radiotherapy department at Norfolk & Norwich to share good practice
- Information on potential late side effects info for GPs (breast and colorectal pathways in particular, in line with new follow up pathways)
- Training for team members in teleconferencing equipment
- Participate in outcomes audits
- Including data clerk in team
- Electronic requesting of radiotherapy – work in progress

Areas of good practice:

- Managing the move, use of outside support for technical commissioning of equipment
- Strong radiographer leadership and multi-professional working
- New fully staffed department in new build

Clinical Team: Skin**Date: 19/11/13****Review Team:**

Dr Andy Liggins - Public Health Consultant, LAT Team Representative
 Dr Jennifer Garioch - Consultant Dermatologist Norfolk & Norwich, MDT Lead
 Dr Mark Roberts - GP, CCG Representative
 Tonia Dawson - Lead Cancer Nurse, Strategic Clinical Network
 Kate Patience - Essex NSSG Manager, Strategic Clinical Network

Team Members Interviewed (Name & Role):

Dr David Shuttleworth - Consultant Dermatologist
 Michelle Marshall - Skin CNS
 Liz Adair - AD Medical Division
 Fiona Crump - General Manager, Medicine
 Sarah Steward - MDT Co-ordinator
 Dr Alan Lamont - Consultant Oncologist interviewed separately with Michelle and Sarah

Summary of review:

We are grateful to all those who supported and participated in this review for their co-operation.

All of the team members were interviewed together by the review team. A walk about of the department to see the environment was also conducted.

The Skin Cancer team appeared to be a small but well-functioning team with good support between staff members and managers with good internal communication.

Some areas of concern and an immediate risk were identified as set out below.

Immediate Risk:

- The current triage pathway appears to be inconsistent with the Two Week Wait pathway as some patients may not be seen face to face by a consultant dermatologist for up to 4 weeks.

Serious Concerns:

- Histopathology cover for the MDT – only one histopathologist is named as a core member with no cover. Therefore MDTs can place without a histopathologist being present.
- No review of histology slides at the MDT.
- Governance issues regarding community skin providers – not clear who is responsible for their clinical governance.
- MDT Chair is based at Broomfield Hospital which limits the amount of support he can give to the MDT. MDT related work does not appear to form part of the MDT Chair's job plan.
- No clinical overview of the MDT outcomes – this is done by the MDT co-ordinator in conjunction with the CNS. There is no clinical overview of data collected.

- Time allocated for MDT discussion is not adequate – the Germ Cell MDT uses the same facilities following the Skin MDT, which can limit time for discussion.
- Lack of CNS support – single provider who is working at full stretch and consequently unable to perform Holistic Needs Assessments and unable to be present in some clinics when the breaking of bad news is occurring.
- CNS has the role of breaking bad news to many of the patients singlehandedly - this occurs e.g. when patients attend to have sutures removed by the CNS.
- Out of date data collection systems requiring duplication of data uploads into different systems.

Concerns:

- The clinical pathway provided in the documentation for the review team did not reflect the actual pathway used by the team.
- Out of date guidelines are listed in the Operational Policy, for example, the melanoma guidelines and the extended membership list is inaccurate.
- The physical environment is not conducive to best practice.
- Pathway breaches often occur when patients are being treated surgically at Broomfield, and as such the management team need to agree an action plan with the MEHT team and CCGs.

Recommendations:

- There needs to be clarification of the types of cases being seen by the community dermatology service and clarification of the arrangements in place for the clinical governance of the community service.
- A capacity and demand survey should be conducted due to the increased demand on the service
- A job plan review is required for the MDT Chair to ensure there is time for planning and support of the team
- Adequate time is required for the MDT to discuss cases – need to resolve clash with the Germ Cell MDT.
- There needs to be a review of the current TWW pathway in place to ensure it is compliant.
- Additional CNS time is needed to help with the workload.
- Additional histopathology support is needed for the MDT and slides need to be reviewed at the meetings.
- The operational policy requires updating including pathways, guidelines and membership and their contact details.

Areas of good practice:

- Easily identifiable responsible clinician for each patient
- Qlik-view system reviewed regularly by clinical and management teams to track breaches
- Single person responsible for removing patients from the PTL on consultant approval
- Supportive team

Clinical Team: Teenage and Young Adults**Date: 21/11/2013****Review Team:**

Yomi McEwen - AT

James Nicholson - Lead Paediatric Oncology Clinician

Mark Roberts - GP

Tonia Dawson - Lead Cancer Nurse

Team Members Interviewed (Name & Role):

Dr Alan Lamont - Consultant Oncologist

Richie Clayton - MDT Coordinator

Summary of Review:

We are thankful for the honesty of the team and for spending time with us today to allow us to explore the Teenage and Young adult Cancer pathways.

It is clear that a lot of work had gone into the service, to develop it, by a small team of dedicated individuals.

We did, however, feel that there needed to be more of hospital effort to ensure all the site specific groups were routinely referring in all 16-24 year olds without having to be reminded.

With the recommendations, the team felt assured the service was safe.

Immediate Risk:

- None identified

Serious Concerns:

- Sustainable nature of lead clinician consultant oncology role was a risk. There appears to be no identified allocation of time in the job plan for this in addition to a workload that may be unsustainable. We think the organisation owes the post-holder a duty of care to address the workload distribution urgently.
- There was a concern that the site specific consultants don't themselves link into the TYA MDT's and the London SMMDTs, very often if at all. If they do link it is usually via a nurse member.

Concerns:

- The lead nurse role has been given to the haem/onc nurse specialist who is extremely busy and has very little time to fulfil the role
- The MDT coordinator is going above and beyond her role as an MDT coordinator by checking histopathology lists to make sure they are getting all patients

Recommendations:

- Immediate attention needs to be given to the lead clinician consultant oncologist job plan
- The lead TYA nurse needs time in her job plan
- Work around communications needs to be done to ensure the Site Specific

teams are linking into the TYA work

- Histopathology should flag all patients aged 16-24 with a malignancy and the list be sent to the MDT coordinator to double check the patients are being registered on the national register.
- Staff need timetable adjusted to enable attendance at MDT meeting

Areas of good practice:

- None Noted

Clinical Team: Upper GI**Date: 20/11/2013****Review Team:**

Visit 1 Rory Harvey - Clinical Lead. Medical Director East Anglia Strategic Cancer Clinical Network

Christine Macleod – NHS England Essex Area Team

Shane Gordon – NHS North East Essex CCG

Visit 2 Rory Harvey - Clinical Lead

Teresa Dowdeswell - LAT

Tonia Dawson - SCN Cancer Manager and Lead Nurse

Team Members Interviewed (Name & Role):

Anna Wordley - nurse consultant

Kay Selfe - CNS

Debbie Leonard - CNS

Dawn Smith - MDT coordinator

Matt Tutton - Colorectal Tumour site lead

Achuth Shenoy - Upper GI Tumour site lead

Ian Gooding - Consultant Gastroenterologist

Elizabeth Adair - Associate Director Medical Division

Kay Selfe - Upper GI clinical nurse Specialist

Jan Edwards - Colorectal nurse specialist

Summary of Review:

We are grateful to the team of nurses and MDT coordinator for their openness and honesty and for participating in this review.

The team appeared to be a well-functioning team who have obviously been reviewing their practice over the last year to try and improve their coordination and functioning of the team.

The clinical lead had reviewed the UGI team recently and this session was to complete that visit and therefore was relatively brief.

Since the inception of the Cancer of unknown primary service there has been a lack of clarity around managing patients with liver metastases alone.

Also due to their data collecting systems participating in network wide audits had proved difficult.

Some areas of concern and one immediate risk were identified as set out below

Immediate Risk:

- None identified

Serious Concerns:

- Lack of clarity around who should investigate liver lesions and how they were tracked. Query how and when they get put on a tracking pathway.
- Access of primary care to diagnostic tests and clinical opinion, needs

discussion.

- No dedicated Cancer data system and therefore data not easily accessible or easily able to be uploaded to national data sets such as COS, SACT etc. These are manually loaded from different sites, which is time consuming and open to error.

Concerns:

- Nurses expressed concern over having no Lead Cancer Nurse
- No MDT time in job plan for clinicians
- MDT scheduling difficult to allow attendance by all specialties
- The removal of patients from the suspect Cancer 2 week pathway, previously involved a delay before the consultant checked the cessation.
- Previously some patients were taken off Cancer pathways, in which investigation and treatment are completed within 62 days and transferred onto 18 week pathways or discharged back to primary care. These are now subject to audit.
- Even patients who have been referred on 2 week pathways, appropriately investigated and managed in secondary care should be reviewed by the referring primary clinician.
- Trust was given advice on the new 2 week referral form which it was designing at the time of the visit to make it more user friendly for GPs and patients.
- 20% of weekday scoping lists are done by locums because of difficulty recruiting, but trust is training nurse endoscopists.

Recommendations:

- Trust data systems need addressing urgently
- GPs need to complete the referral forms for 2 week Cancer referral better.
- Continue with the improvements in the 2 week wait referral form
- Direct access to diagnostics needs to be considered again.
- The support and tracking of patients with liver lesions needs investigating and streamlined to ensure all patients are tracked
- The Trust need to consider overall Cancer nurse leadership
- MDT scheduling needs to be reviewed.
- Job plans need to be reviewed

This review is part of the former review and report undertaken by the clinical lead.

Area of good practice

- The endoscopy unit is accredited by JAG
- Endoscopy unit has a good design and excellent level of equipment
- The Trust is training nurse endoscopists

Clinical Team: Urology**Date: 26/11/13****Review Team:**

Dr Andy Liggins - Public Health Consultant, NHS England Essex Local Area Team representative

Mr Robert Brierly - Consultant Urologist, Ipswich Hospital

Mr Vivek Kumar - Consultant Urologist, Norfolk & Norwich Hospital

Charlotte Etheridge - Macmillan Urology CNS, Ipswich Hospital

Wendy Baxter - Uro-oncology CNS, Norfolk & Norwich Hospital

Dr Linda Mahon-Daly - GP, North East Essex CCG representative

Dr Richard Wright - GP, North East Essex CCG representative

Team Members Interviewed (Name & Role):

Dr Ian Seddon - Consultant Histopathologist

Mr John Corr - Consultant Urologist

Dr Bruce Sizer - Consultant Oncologist

Dr Nicola Lacey - Consultant Radiologist

Maggie Braithwaite - Uro-oncology CNS

Lucy Powell - Uro-oncology CNS

Jacqueline White - SMDT Co-ordinator

Sian Gooding - LMDT Co-ordinator

Anne Morris - Clinical Services Manager, General Surgery, Urology and Ophthalmology

Denise Walters - Associate Director, Surgical Division

Day Case Admissions Clerk

Summary of Review:

The MDT are thanked for their openness and honesty during the review process. The clinical team were interviewed together as a large group and then invited back in smaller groups for more in-depth discussion about particular parts of the pathway for clarity.

Apparently some of the paperwork circulated to the review team did not reflect the current pathway as it had been developed without clinical input. The review team were therefore asked to disregard some of the pathway flow charts during the meeting.

The MDT were aware that some patients had been lost to follow up and had looked into this as a department previously. All MDT members stated they had not been previously aware of any dates being changed on the Cancer Wait Times system and had been shocked when this was discovered.

The review team cannot assure the prostate, renal and bladder pathways until updated versions of the pathways have been developed and reviewed. Testicular and penile Cancer pathways are supra-network wide (agreed across Cancer Networks) and therefore were considered safe and assured.

Immediate Risk:

- Lack of up to date, accurate and agreed timed pathways for prostate, renal and

bladder Cancers.

- Capacity issues / waiting time breaches (added by Clinical Oversight Group 11.12.13).

Serious Concerns:

- Lack of clarity between primary care and the Urology MDT around access for patients onto a 2WW pathway (use of Choose & Book system by GP and single point of contact clinic favoured by CHUFT, e.g. haematuria).
- The team did not demonstrate a current, robust, systematic failsafe system across all elements of Cancer pathways, including not losing patients to follow-up.
- Logistics of implementing necessary identified service redesign (know what needs to be done but are resources / planning / support identified for implementation?).
- The LMDT and SMDT do not have sufficient time allocated to adequately discuss all cases.

Concerns:

- Disparate accommodation for MDT members does not aid team working.
- Internal validation process did not pick up the issues raised by this review team regarding the patient pathways.
- Extra work being referred from the Southend team with no extra surgical capacity at Colchester, leading to additional pressure on the services (and this work could increase).
- Workload and capacity of MDT co-ordinator and CNSs.
- Interface between management and clinical teams requires improvement (including a lack of a specific manager and admin support for urology).
- Some evidence of intra-MDT professional communication dysfunction, although not perceived by all team members.
- Germ cell SMDT clashes with skin MDT which often overruns.
- Lack of training identified for admin staff particularly with regards to CWT and patient pathway management.
- MDT room facilities inadequate for optimal MDT functioning.
- Outpatient department physical environment impedes most effective working.
- Lack of images and reports available to the clinical team for patients having an ultrasound in the community with another provider (especially relevant to renal Cancer).

Recommendations:

- Patient pathways must be developed and reviewed in order for the prostate, renal and bladder pathways to be assured. Timelines for action with regards to key milestones within the patient pathway are recommended.
- A failsafe system is required to ensure that patients are not lost to follow up
- Job plans require review to ensure that LMDT and SMDT meetings have adequate time to facilitate full discussion for all patients
- Germ cell MDT requires alternative accommodation to enable full discussion of patients without clashing with another MDT
- More robust mechanisms for internal validation are required to critically

analyse pathways and evidence

- A scoping exercise is required to determine extra demand from South Essex to inform as to any extra surgical capacity which may be necessary

Areas of good practice:

- Good links with radiology/histopathology/oncology
- Team have been open and honest in their response to issues identified by themselves and latterly the CQC
- Plans to redesign the patient pathway in response to workload issues and the desire to streamline the patient journey e.g. PSA clinic
- Clear leadership, well-functioning and motivated MDT with the patient at the centre of all that they do.

Clinical Team: Sarcoma

Date: 21/11/13

Review Team:

Rory Harvey - Clinical Lead

Teresa Dowdeswell - LAT

Tonia Dawson =-SCN Cancer Manager and Lead Nurse

Team Members Interviewed (Name & Role):

Bruce Sizer - Clinical Lead

Alan Lamont - Clinical Oncologist

Richie Clayton - MDT Coordinator

Present: Anna Bjorkstandt

Summary of Review:

We are grateful to the team for giving so much time during a busy schedule.

We had the Sarcoma pathways explained to us, which described patients having their specialist surgery in two centres in London, mainly UCLH and the Royal Marsden who jointly send bone tumours to Stanmore Orthopaedic hospital.

How the patients got referred to London was not uniform but usually involved phoning the Consultant in London who would advise re treatments. Often though the Oncology Consultants said that they did not know about patients in the system until London doctors phoned them to transfer them back for local chemotherapy or radiotherapy treatment.

They referred to the histology being sent off for review and often triggering referrals from that second review.

Again it was not clear how they might be added to the 62 day pathway for tracking.

NB: 3 sets of notes were reviewed post meeting and it was still very unclear who was ensuring these patients were tracked and treated in a timely manner. One set

was raised as a serious incident due to the length they were in the system with no ownership by a single consultant and a large gap when they should have had radiotherapy.

We currently do not feel assured of the safety of the service

Immediate Risk:

- Histopathology could go to London without the Oncology Department knowing it was a diagnosed sarcoma going for 2nd review.
- There appeared to be no safety netting internally with no clear pathway structures in place. Communication and referrals were reliant on possible phone calls with no system for assurance.

Serious Concerns:

- When patients were returned post surgery, there was no dedicated team other than the oncologist who said he referred back to London if there were post operative complications. The patient therefore was given no keyworker either nurse or AHP for rehabilitation and support post complex surgery, for tumours often with a poor prognosis.
- Not clear how the patient was tracked through the system and how they were put on a pathway. No single consultant in charge.

Concerns:

- The new MDT coordinator(only had one for two months)Was the person who fed known patients onto the SMDT meetings and then post the meeting received feedback on the patients treatment requirements which was later followed up in writing. No one attended the SMDT apparently due to the London list being over loaded.
- There is no shared care arrangement between the Tertiary and local Trusts therefore Chemotherapy Algorithms and protocols are sent as when requested.
- The MDT coordinator is manually uploading all data on patients onto the trust system when they come to her attention.
- There appears to have been no audit of Sarcoma pathways and exact numbers of annual patients and treatments were unknown

Recommendations:

- A system needs to be put in place so that all patients with a sarcoma are owned by one area who will ensure they are tracked and treated in a timely manner.
- Notes need to be reviewed/audited and lessons learnt
- A clinician should be liaising with the SMDT not the coordinator
- There needs to be a clinical key worker for these patients