Colchester Hospital University NHS
NHS Foundation Trust

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Retrospective Review of Cancer Care

Public & Stakeholder Report

December 2014

Embargoed

Contents

Executive Summary

In the summer of 2013, information about alleged bullying and waiting list manipulation at the Colchester Hospital University NHS Foundation Trust was passed to the Care Quality Commission (CQC). On investigation the CQC identified "serious concerns" and said staff reported to the CQC that they were "pressured to change data… to make it seem people were being treated in line with national guidelines".

A multi-agency Incident Management Team (IMT), chaired by NHS England, was established to oversee the NHS response to these serious allegations. It included representatives from the Trust, North East Essex Clinical Commissioning Group, Essex Police, Essex County Council, HealthWatch and the General Medical Council.

The Trust immediately commissioned an independent governance review (the Troop/Taylor-Brown review) and at the request of the IMT the Trust also commissioned a retrospective review of the experience of a number of patients treated at the Trust between April 2010 and March 2014 who may have been affected by misreporting.

Over the period covered by the review the Trust treated approximately 33,000 cancer patients. The review examined around 3,000 data points for 822 of these patients. It found 16 cases of possible deliberate and inappropriate data entry but in none of these cases could the reviewers establish intent to deliberately falsify the figures.

The review found a number of small discrepancies between recorded and actual patient data and concluded that these were most likely to be the result of minor, but erroneous interpretations of the Cancer Waiting Times (CWT) guidelines. These discrepancies sometimes made waiting times appear longer than in reality and sometimes shorter.

While the review found no evidence of systematic, deliberate data manipulation it did find evidence of poor documentation and record keeping with multiple causes including data entry errors, misinterpretation of national guidance, operating process issues, poor information sharing and poor record keeping. It also identified a number of patients who had experienced suboptimal care, diagnosis or treatment.

Following the Care Quality Commission report of November 2013 a total of 25 independent medico-legal reviews were commissioned on patients identified by the CQC who may have suffered suboptimal care at the Trust. These reports are being shared with the patients or their families and where any concerns have been identified they have also been shared with the relevant regulatory authorities.

The review concluded that a small number of patients may potentially have been harmed (emotionally and/or physically) as a result of this suboptimal care. The review team assessed potential harm in a number of ways including the number of

patients referred for Serious Incident (SI) investigation. A total of 44 patients were referred for SI. It is impossible to say at this stage whether any of these patients have suffered harm as a result of suboptimal care since the success of cancer treatment is measured against five-year survival rates. The exception, however, is one patient where it is clear that harm has been suffered.

Patients who were identified as having been subject to any form of clinical error had their care scrutinised by clinical auditors to ensure any outstanding remedial actions had been taken and the Trust is in contact with all of the patients who have suffered significant suboptimal care including the one patient identified above.

Meanwhile the retrospective review also finds that the Trust's cancer mortality statistics are now within the normal national range for NHS Trusts in England.

The cases selected for review were specifically selected as being those most likely to have experienced problems in data recording or clinical care. They were not, therefore, a random sample of patients treated at the Trust and their care is not representative of overall care at the Trust during the period of this retrospective review.

As part of the review the Trust considered whether any cases of potential data manipulation could have led to patient harm and should, therefore, be referred to the police for further investigation. None of the 16 cases referred to above lead to patient harm and they were not, therefore, referred to the police.

The East of England Strategic Clinical Network conducted an external review of a 10% sample of the work conducted by the retrospective review team and concluded, "the overarching impression was there was evidence of inaccuracies in the cancer waits data but this was as likely to negatively impact on the trusts performance statistics as enhance them. This suggested the issue was one of effectiveness and competence in the cancer management team rather than a deliberate manipulation."

Arising from this review the Trust has made a number of improvements to its cancer services and working closely with specialist colleagues at the Royal Marsden Trust it has developed a comprehensive improvement action plan. All the recommendations from the retrospective review have either been implemented or are in the process of being implemented.

Actions to date include the recruitment of additional staff, the development of a programme of regular, continuous training and the reestablishment of the Trust's Cancer Board. The Trust has also made significant strides in improving its data collection and handling for cancer patients. It has now replaced the previous regime of multiple databases for cancer patients with the highly regarded Somerset Cancer Waiting Times management system.

Background

Colchester Hospital University NHS Foundation Trust (the Trust) provides a range of hospital services for the people of Colchester, North East Essex and South Suffolk. The Trust's main hospital - Colchester General Hospital - opened in 1984 and has around 600 inpatient beds.

The Trust employs over 4,000 members of staff and each year over 400,000 people attend outpatient clinics, around 75,000 patients visit A&E, approximately 90,000 inpatients are treated and the Trust delivers over 4,000 babies.

In February 2013 the Prime Minister asked Prof. Sir Bruce Keogh, Medical Director of NHS England, to undertake a review of the quality of care and treatment at 14 hospital trusts that had higher than average mortality rates over the previous two years. This group of Trusts included Colchester Hospital University NHS Foundation Trust.

The review of Colchester Hospital University NHS Foundation Trust referred to "great examples of excellent care being delivered to patients" but it also noted a number of areas where improvements were necessary. Prof. Sir Bruce Keogh made a series of recommendations designed to bring about quality improvements. These included:

- The need for better processes to recognise and treat deteriorating patients
- A review of staffing and skill mix
- Improved communication and engagement with staff
- Improved complaints management processes

In response the Trust developed a comprehensive action plan and was in the process of implementing it when, in the summer of 2013, a member of Trust staff contacted the Keogh review team with information about alleged bullying and waiting list manipulation which the Keogh team passed on to the Care Quality Commission (CQC).

The Trust had been aware since 2011 of allegations that cancer waiting lists at the Trust had been improperly manipulated. The Trust's finance director had conducted an inquiry into these allegations, though later the Trust apologised for the fact that this inquiry was not "adequate" and "didn't go deep enough".

Faced with the allegations that had been passed to them the CQC undertook an inspection of the hospital in August and September of 2013 and published its report of the inspection in November 2013. The CQC identified "serious concerns" and said staff reported to the CQC that they were "pressured to change data… to make it seem people were being treated in line with national guidelines". The CQC's Chief Inspector of Hospitals, Professor Sir Mike Richards, recommended that Monitor place the Trust into special measures.

A multi-agency Incident Management Team (IMT), chaired by NHS England, was established to oversee the NHS response to these serious allegations.

Following the Care Quality Commission report of November 2013 a total of 25 medico-legal reviews were commissioned on patients identified by the CQC who may have suffered suboptimal care at the Trust. These reports were compiled by independent cancer experts and have been shared with the patients or their families. Where any concerns have been identified they have also been shared with the relevant regulatory authorities. All 25 of these reports have been shared with the CQC and where patients have consented they have also been shared with the police.

Working with regulatory oversight from Monitor (the health regulator) the Trust also commissioned an independent governance review (the Troop/Taylor-Brown review) to explore the allegations of systemic bullying and waiting list manipulation.

In addition, at the request of the IMT, the Trust commissioned a retrospective review of the experience of a number of patients treated at the Trust between April 2010 and March 2014 who may have been affected by misreporting. The objective of the retrospective review was to investigate any data inaccuracies and to determine whether these had any impact on clinical care. The retrospective review team was supported by an independent Assurance Panel which included senior cancer experts and an independent Professor of Cancer Epidemiology to ensure probity and impartiality.

The patients reviewed were specifically selected as being those most likely to have experienced problems in data recoding or clinical care. They did not comprise a random sample of patients treated at the Trust. Together they represent a relatively small proportion of the 33,000 patients seen at the Trust over the study period and their care cannot be seen as being representative of care at the Trust over this period.

Shortly after the publication of the CQC report in November 2013 Monitor decided the Trust had breached its licence to provide health services and put the organisation into special measures. This meant:

- The Trust had to develop an action plan to put right the concerns highlighted by the CQC
- An Improvement Director would be appointed by Monitor
- A high performing Foundation Trust - the Royal Marsden, an NHS Foundation Trust with a world-leading reputation for cancer services - would be asked to offer support to the Trust

These waiting time allegations were a “wake up call” for the Trust that prompted a number of actions designed to radically improve services. In addition to investigating how misreporting had happened the Trust began to work with its health partners to review the quality of its cancer services, waiting time information, treatment outcomes and the organisation of each cancer specialty.

In December 2013 NHS England conducted an immediate review of cancer services at the Trust. A subsequent follow up report in July 2014 concluded that NHS England (on behalf of the Incident Management Team) “is currently assured of the safety of the cancer service provided by Colchester Hospital University NHS Foundation Trust.”

Arising from all of this work the Trust began making improvements to its cancer services. Working closely with specialist colleagues at the Royal Marsden Trust it developed a comprehensive action plan to improve cancer services. The plan includes:

- The recruitment of additional staff
- A programme of regular and continuous training
- The implementation of a new cancer information system (the nationally recognised Somerset Cancer Registry)
- The re-establishment of the Trust’s Cancer Board
- A complete review of diagnosis, treatment and care to ensure full compliance with national standards

In addition a £25m purpose-built, state-of-the-art radiotherapy centre was opened at Colchester General Hospital on 9 June 2014.

Methodology

A multi-agency Incident Management Team (IMT), chaired by NHS England, was established to oversee the NHS response to the serious allegations raised by the CQC. It included representatives from the Trust, North East Essex Clinical Commissioning Group, Essex Police, Essex County Council, HealthWatch and the General Medical Council.

The retrospective review was commissioned by the Trust, at the request of the IMT, as part of a suite of measures arising from the CQC inspection described above. The retrospective review team was supported by an independent Assurance Panel which included senior cancer experts and an independent Professor of Cancer Epidemiology to ensure probity and impartiality.

The review aimed to investigate, through a transparent audit process, the extent of data inaccuracy in cancer waiting times at the Trust and its impact on clinical care. It was one of the most detailed reviews of cancer care ever undertaken in the NHS costing almost £500,000 and taking 10 months to complete.

Following the Care Quality Commission report of November 2013 a total of 25 independent medico-legal reviews were also commissioned on patients identified by the CQC who may have suffered suboptimal care at the Trust. These reviews were undertaken by cancer experts and, of course, each report contains detailed patient confidential information. These reports will not therefore be published but they were available to clinicians within the retrospective review team. Where any concerns have been identified these independent medico-legal reviews have been shared with the relevant regulatory authorities and they have all been shared with the CQC.

The retrospective review comprised five specially commissioned audit reports as follows:

- Audit 1 - Cancer Waiting Tool - data error rate
- Audit 2 - Cancer pathways over 91 days ("long waits")
- Audit 3 - Delays in diagnosis in patients on consecutive cancer pathways
- Audit 4 - Pathway changes in upper gastrointestinal (upper GI) cancer
- Audit 5 - Follow up care in superficial bladder cancer

Together these five audits involved a review of 822 patients and a review of over 3,000 data entry points and/or patient interactions with the Trust. The rationale for undertaking each of these studies was that a risk for these specific patients had been identified from within the original cohort of patients identified by the CQC.

Each audit involved a six stage process including data sampling, template development, case note review, expert cancer wait pathway and clinical review, analysis and report writing. Each audit also involved analysis of the cancer waiting time data pathway to identify any data inaccuracy and analysis of the clinical pathway to identify any potential clinical harm.

In addition to the five audits listed above the retrospective review also comprises several other reports:

- A summary report from the retrospective review of cancer care.
- A detailed report reconciling the actions delivered through the Trust's Cancer Action Plan during 2014 against the findings and/or recommendations of the retrospective review studies and reports.
- An independent review - conducted by the East of England Strategic Clinical Network - of 10% of the patient records and case notes reviewed in Audits 1-5 described above. This was an independent, external review by senior doctors to judge whether there was any evidence of data manipulation, if patients had experienced harm as a consequence, and whether appropriate actions had been taken by the Trust. These independent doctors provided assurance to the Trust's investigation. Their review emphasised the deficiencies in the Trust's cancer management processes but concluded the issue was "one of effectiveness and competence in the cancer management team rather than a deliberate manipulation."
- A Retrospective Review of Cancer Care Public & Stakeholder Report (this report).

The number of patients reviewed, the sample type for each audit and the dates covered by each review are detailed in the table below.

	Audit/report description	**Number of cases**	**Sample type**	**Dates of review**
1	To determine the error rate of the Cancer Waiting Tool (CWT)	250 case notes	Stratified sample	April 1, 2010 - October 31, 2013
2	Long waits - to identify long waits (over 91 days) in cancer.	290 case notes	Cohort & look back	April 1, 2010 - October 31, 2013
3	To determine the prevalence of 'delayed diagnoses' in cancer pathways (defined as 'those patients restarting a cancer pathway within 90 days from stopping an initial cancer pathway')	364 case notes	Cohort of 147 patients	April 1, 2010 - October 31, 2013

	Audit/report description	Number of cases	Sample type	Dates of review
4	Upper Gastro-intestinal - to identify patients whose pathway was changed without appropriate clinical input	120 case notes	Two samples	April 1, 2010 – Dec 31, 2013
5	Urology - to identify patients who have been lost to superficial bladder cancer surveillance.	15 case notes	Stratified sample	January 2013 - March 2014
6	East of England Strategic Clinical Network review of 10% sample of studies 1-5	81 patients	10% sample	April 1, 2010 - March 2014
7	A technical summary report on the retrospective review	822 patients	Studies 1-5	April 1, 2010 - March 2014
8	Report on the cancer action plan and action taken against recommendations by Cancer Programme Director	N/A	N/A	December 2014
9	Summary report of the retrospective review for public and stakeholders	N/A	N/A	N/A

Key themes

Key themes emerging from the retrospective review included:

Possibility of data manipulation

The review found a number of minor discrepancies between recorded and actual patient data. Deliberate, inappropriate data manipulation was considered to be a possibility in a small number of cases (16 in total). These cases were carefully reviewed by the independent Assurance Panel which concluded that the errors were most likely to be the result of erroneous interpretation of the Cancer Waiting Times guidelines.

The East of England Strategic Clinical Network (Cancer) conducted an external review of a 10% sample of the work conducted by the retrospective review team and concluded, "the overarching impression was there was evidence of inaccuracies in the cancer waits data but this was as likely to negatively impact on the trusts performance statistics as enhance them. This suggested the issue was one of effectiveness and competence in the cancer management team rather than a deliberate manipulation."

Quality of care

Although the study primarily looked at data errors it also identified patients who had experienced suboptimal care in their investigation, diagnosis or treatment. This included poor recording and documentation, delayed investigations, delayed diagnosis, delayed treatment and potentially incorrect diagnosis.

A small number of patients may potentially have been harmed (emotionally and/or physically) as a result of this suboptimal care. The retrospective review assessed potential harm in a number of ways including:

- Three assessments by different clinicians using CQC categories of emotional and/or physical harm
- According to the rate of SI investigations measured against national criteria (remembering, of course, that the threshold for SI investigation varies between NHS Trusts).

The review concluded that levels of potential harm varied between 4% and 9% in each of the five different retrospective review audit studies. According to research from the Health Foundation this compares with general levels of harm that might be expected in acute NHS care that vary between 3% and 25%. (Health Foundation. Evidence Scan. Levels of Harm… http://www.health.org.uk/public/cms/75/76/313/2593/Levels%20of%20harm.pdf?realName=PYiXMz.pdf)

The number of patients referred for Serious Incident (SI) investigation from the total sample was 44 (25 patients whose care was referred for further investigation from the audit and 19 patients whose care had previously been investigated as a result of issues raised through other routes following the CQC report).

It is impossible to say at this stage whether specific patients have suffered harm as a result of suboptimal care since the success of cancer treatment is measured against five-year survival rates. The exception, however, is one patient where it is clear that harm has been suffered.

Patients who were identified as having been subject to any form of clinical error had their care scrutinised by clinical auditors, one of three lead doctors, a multidisciplinary panel and the Trust Medical Director to ensure any outstanding remedial actions had been taken and the Trust is in contact with all of the patients who have suffered significant suboptimal care including the one patient identified above.

Meanwhile the retrospective review also finds that the Trust's cancer mortality statistics are now within the normal national range for NHS Trusts in England. The North East Essex Clinical Commissioning Group combined one-year survival index is within the normal range for all cancers for adults, the 1-year and 5-year survival rates are within the normal range and mortality rates by cancer type are all within the normal range.

Poor documentation and record keeping

Every patient will have many data items recorded in their notes. Over half of all cases reviewed had at least one data error in the records and there were errors in approximately one in ten recorded data items. The upkeep of case notes was poor including poor legibility, filing and maintenance of data. (This level of data point inaccuracy is in line with the 57% figure for incorrectly recorded or not recorded data in a National Audit Office review of non-cancer specific waiting time data.)

Inconsistency between the cancer waiting times (CWT) tool and patient records

There was some inconsistency between dates recorded in the notes and on the CWT tool. Most discrepancies were minor resulting in CWT calculated waiting times being both shorter and longer than reality.

Cause of data errors

There were multiple causes of data error including data entry errors, misinterpretation of national guidance, operating process issues, poor information sharing and poor record keeping.

Uncoordinated and protracted patient pathways

Individual patient care pathways were often not actively managed with patients not being tracked through the system and therefore experiencing delays in booking and re-arranging appointments.

Availability, use and recording of diagnostics

Investigations were not always sequentially ordered or acted upon responsively. Patients reviewed in the delayed diagnosis audit experienced a delayed diagnosis as a result of waiting for investigations and results or delays in booking appointments.

Patient choice

The studies identified some patients who presented late despite having symptoms for a significant time. Many delays in treatment were attributable to patient choice such as attending family events before treatment, patients cancelling appointments, holidays, taking time to consider treatment options etc.

Review Findings

Key findings from the retrospective review include the following:

- The retrospective review was designed, in part, to determine whether there had been any deliberate, inappropriate manipulation of cancer waiting times data at Colchester Hospital University NHS Foundation Trust. The review found a number of small discrepancies between recorded and actual patient data and concluded that these were most likely to be the result of minor, but erroneous interpretations of the Cancer Waiting Times (CWT) guidelines. These discrepancies sometimes made waiting times appear longer than in reality and sometimes shorter.
- The East of England Strategic Clinical Network conducted an external review of a 10% sample of the work conducted by the retrospective review team and concluded, "the overarching impression was there was evidence of inaccuracies in the cancer waits data but this was as likely to negatively impact on the trusts performance statistics as enhance them. This suggested the issue was one of effectiveness and competence in the cancer management team rather than a deliberate manipulation."
- The five retrospective review patient audits confirmed that the CWT tool was not used for individual patient tracking but rather for audit and reporting purposes only. This is significant because it means that any erroneous data changes could NOT have caused a change to any patient's care and so could NOT have led to individual patient harm. (It should be noted that the Trust has recently implemented a new cancer information system.)
- A number of patients experienced suboptimal care in part because the collection, recording and reporting of national Cancer Waiting Times (CWT) data were poor.
- Data errors and delays occurred for several reasons including poor understanding and application of the national Cancer Waiting Times guidance, problems booking appointments, delays in undertaking investigations, patient choice or availability, transfers of care within the Trust and between hospitals.
- Care pathways for individual patients were stopped erroneously by clinicians and non-clinicians alike and were often poorly coordinated.
- There were a significant number of preventable delays unrelated to data recording.
- Four cancer specialties within the Trust had more data irregularities and clinical issues than others. These were urology, upper gastro-intestinal cancers, lower gastro intestinal cancers and dermatology.
- The Trust's cancer mortality statistics are now within the normal national range for NHS Trusts in England. The North East Essex Clinical Commissioning Group combined one-year survival index is within the normal range for all cancers for adults, the 1-year and 5-year survival rates are within the normal range and mortality rates by cancer type are all within the normal range.

Recommendations

The individual reports that comprise this review were retrospective studies looking at past care. They will be used as a catalyst to develop excellence at the Trust. This will require strong clinical leadership, improved team work, adherence to agreed standard operating procedures and national guidelines and clear personal, team and divisional accountability to improve standards of care.

The review makes a number of recommendations under the following headings:

- Clinical and managerial leadership and dissemination
- CWT data and recording
- Quality assurance
- CWT and clinical pathways
- Speciality action
- Capacity
- System issues

These recommendations include:

- The Trust Cancer Board should incorporate any additional recommendations arising from the retrospective review report - that have not already been addressed in the 2014 Cancer Action Plan - into the 2015 Cancer Board Work Programme.
- The Trust should seek to become a national case study for necessary interventions to improve cancer care using the latest evidence on improvement science methodologies as a pilot to inform other Trusts.
- The Trust needs to emphasise the importance of clinical and administrative record-keeping, with legible and well-ordered case notes and computer records and ensure that it is reflected in job descriptions.
- The Trust should consider implementing an electronic patient record as a high priority. Patient paper records should be stored together, a central inventory of clinical systems should be created and departments and service areas should develop clear maps of where they store data and who has access rights.
- The Trust should ensure it has robust, thorough and continuous training in the use of the CWT national guidelines.
- There should be a process to assess data quality in cancer through a rolling programme of audits reporting to the Board, which also reports on the quality of case notes as well as accuracy of electronic records.
- This report and others have highlighted deficiencies in the way that the Trust monitors and gathers data relating to patient experience. Systems to capture and triangulate this kind of data need to be established and should form part of routine performance monitoring and governance.
- All staff should be reminded that only practicing clinicians are authorised to stop cancer pathways following appropriate training.
- Until malignancy is excluded through clinical presentation the patient pathway should remain open.

- A standard proforma should be developed for recording changes in patients' CWT pathways. These should be shared with patients' GPs.
- Named team members should be assigned to pro-actively track and manage patients through the systems. Complex patients with multiple tumours, multiple morbidity and safeguarding issues should be prioritised, with the Clinical Nurse Specialists coordinating and managing the pathways.
- The Trust should implement an IT system for ordering and reviewing test results to ensure they are acted on quickly.
- Outpatient capacity in booking appointments should be reviewed as this contributes to delay and systems should be put in place to flag patients who are vulnerable including patients who do not attend (DNA) appointments.
- Cases where GPs refer simultaneously to multiple pathways for the same symptoms should be reviewed.
- The procedures for Consultant-to-Consultant referral need to be reviewed to reduce confusion.
- There will remain a cohort of patients for whom initial, reasonable investigation based on the symptoms does not identify cancer but who will subsequently have a cancer diagnosed. For these patients a clear system of safety netting needs to established in primary care.
- The Trust should develop a communications plan to ensure that the findings from this review and other reports are widely disseminated throughout the Trust.
- Patient involvement and on-going use of patient experience is required to ensure care continuously improves. This should include training in communication skills, patient-centred care and self-care support.

These recommendations have been reconciled with actions already delivered through the Trust's Cancer Action Plan in a separate detailed report that forms part of this retrospective review.

In February 2015 the Trust will be receiving at its board meeting a surveillance report on the management of patients who used the Trust helpline, made complaints or were investigated as Significant Incidents (SIs) at the time of the CQC investigation. This paper will provide a concise overview of the concerns raised as a consequence of calls and complaints received. The February Trust board will also receive a response to the recent HealthWatch report on cancer patient experiences at the Trust.

Conclusions and actions taken

Arising from this review the Trust has been making improvements to its cancer services and has developed a comprehensive improvement action plan. The plan is regularly updated and is publicly available on the Trust website. All the recommendations from the retrospective review have either been implemented or are in the process of being implemented.

Actions to date include the recruitment of additional staff, the development of a programme of regular and continuous training and the reestablishment of the Trust's Cancer Board.

The Trust has also made significant strides in improving its data collection and handling for cancer patients. It has now replaced the previous regime of multiple databases for cancer patients with the highly regarded Somerset Cancer Waiting Times management system. This is an IT programme which has many of the CWT guidelines built into it. This means that any inaccuracies that are clearly not consistent with the guidelines are immediately flagged. In addition the Trust now undertakes regular checks to ensure that data on the Patient Administration System is consistent with data on the Somerset system.

As part of this retrospective review the Trust has compiled a detailed report mapping the actions it has taken to date against the review's findings and recommendations.

The Trust has also considered whether any cases of potential data manipulation should be referred to the police for further investigation. The agreed criteria for such a referral were:

- Whether potential data manipulation had taken place.
- Whether any such possible manipulation had led to a delay in treatment or diagnosis.
- Whether any harm was caused.

The review team concluded that inappropriate data manipulation was a possibility in a total of 16 reviewed cases but the team and the independent Assurance Panel could not establish intent to deliberately falsify the figures. They concluded that an erroneous interpretation of the Cancer Waiting Times guidelines was more likely. Furthermore, in none of these cases did erroneous data entry lead to patient harm. Therefore no cases were referred to the police.

Following the Care Quality Commission report of November 2013 a total of 25 medico-legal reviews were commissioned on patients identified by the CQC who may have suffered suboptimal care at the Trust. These reports are being shared with the patients or their families and any concerns raised have been shared with the relevant regulatory authorities.

One member of staff has been subject to disciplinary investigation as a result of alleged data inaccuracies. That investigation was put on hold until all the relevant reviews were concluded. It will now proceed in the normal manner.