

# **Review of the management of the two week cancer pathway at West Hertfordshire Hospitals NHS Trust**

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# 1. Executive Summary

## 1.1 Background

This external review was commissioned by the NHS Trust Development Authority (NHS TDA) to determine the reasons for non-compliance with national and local guidance for managing the two week wait cancer pathway (2WW) at the West Hertfordshire Hospitals NHS Trust (WHHT).

This review was part of the response to the incident following the Trust's internal review, and took place between January and March 2014. The external panel focussed both on the Trust's internal systems, organisational and governance arrangements and also on the local external health system, including primary care, commissioners and the local cancer network. The full terms of reference are included in Appendix 8.1.

The Trust operates three sites presenting a degree of complexity in running cancer services. The Trust management team is actively addressing quality and governance concerns and an ongoing improvement programme is working to improve governance, leadership, patient experience, workforce and safety, operational effectiveness and clinical effectiveness. This programme aims to embed the principles of patient and public participation, listening to the views of staff, openness and transparency and cooperation between organisations.

## 1.2 Management of the two week wait cancer pathway

As part of its wider improvement programme, the Trust arranged for re-training of administrative staff to address issues around referrals and at one of these sessions it became apparent that patients who did not attend (DNA) their first appointment on a cancer 2WW referral pathway were not always being given another appointment. This triggered an internal review - Operation Bloom.

It is clear that inconsistent compliance with local and national cancer access policies had been an issue for several years without the knowledge of senior personnel, although the external review team found there had been an earlier opportunity to rectify this when a GP complaint was investigated in 2013. As the appropriate complaints management systems were not in place at that time, with the necessary continuity in leadership and ownership to address the issues, no further action was taken until the internal review (Operation Bloom) later in the year.

The external panel supports the action taken under Operation Bloom and concluded that this was a thorough review, which identified the full extent of harm potentially caused to patients through non-compliance with guidance for managing cancer 2WW pathways.

The external investigation team found a range of reasons for the non-compliance with national protocols relating to cancer 2WW DNAs, summarised below:

- I. Cancer 2WW referrals were scheduled into routine clinic appointment slots, which led to staff not recognising these DNAs as cancer 2WW.
- II. Inconsistency in clinical review of the notes of patients attending clinics contributed to lack of clarity over cancer referrals, and whether patients had attended appointments or not. The

documentation processes were inconsistent and in some cases administrative staff were unclear of the clinical decision about a new appointment or discharge.

- III. Demand and capacity issues in some clinics contributed to scheduling 2WW referrals into available routine clinic slots.
- IV. The administration of outpatient department (OPD) services across very complex Trust sites was not well organised. Additionally, training on complex administration systems was minimal up until the last six months.
- V. The cancer 2WW office required more organisation and resourcing to manage risks around continuity during absences and work was allocated to the booking office team.
- VI. The booking culture focussed on allocating appointments efficiently to meet 2WW standards rather than ensuring the patient was given sufficient notice to enable them to attend.
- VII. More clinical ownership and engagement was needed to manage and understand the cancer 2WW and OPD booking systems.
- VIII. There was misinterpretation and lack of knowledge around complex national/local cancer waits guidance regarding DNAs.
- IX. Laudable attempts by the Trust to reduce the number of general outpatient DNAs contributed to misinterpretation and, in some cases, the practice of discharging cancer referral patients who did not attend their first or second appointment.
- X. Limited safety net systems in primary care. Some practices who use the Choose and Book system can track where 2WW patients are, and some use manual systems to do so. There is currently no standard system consistently applied for primary care professionals to track patients.
- XI. WHHT, the Mount Vernon Cancer Network and commissioners did not request data quality for cancer waits to be audited. The panel found no evidence to show the National Cancer Action Team guide for commissioning cancer services (July 2011) had been followed.
- XII. Trust cancer services have traditionally been managed separately to clinical directorates/divisions, which need more ownership of the cancer services agenda.
- XIII. Trust outpatient services used to be managed separately, although this has changed in recent years. There is still perceived to be a lack of integration and ownership of outpatient management by clinical directorates.
- XIV. The ambiguity in management arrangements means that between outpatients, the cancer team and clinical divisions, these departments did not have clearly defined responsibility for managing the 2WW standard and compliance with standards around DNAs. Lack of leadership and responsibility for addressing these system issues has led to inaction and opportunities for improvement being missed.

### 1.3 Other cancer waits

The review terms of reference asked the external panel to look more broadly at the Trust's compliance with other cancer protocols, such as the national 31 and 62 day wait pathways. The panel was concerned at the overall arrangements for managing cancer services, including the disengagement of many clinicians and identified the need for more effective processes and systems to track cancer patients to ensure compliance with national access targets. The review team was aware that the national Intensive Support Team has also been working with the Trust on these issues and has made recommendations to build on this excellent work. Also the new Beds and Herts Local Cancer Forum has recently initiated a review of cancer pathways that will also address these issues systematically.

The Trust has now reviewed the issues around non-compliance with other cancer waiting time standards, such as 31 and 62 day waits, and completed reviews of patient cohorts according to clinical priority. This recent audit concluded that errors in the data on the Trust's systems have led

to both under and over reporting of breaches against the national cancer standard. The level of understanding of cancer guidance varies between staff at all levels, clinical and non-clinical.

## 1.4 Key recommendations from the independent review

The external panel summarised the findings and recommendations under the following themes:

### Governance

The bulk of the recommendations relate to implementing process improvements and changes to organisational and governance arrangements.

- Some improvements to systems and processes are already underway, but the new access policy is complex and standard operating procedures with individual action cards are needed. Training needs to be continuous and technological improvements to the Patient Administration System (PAS), including Choose and Book access, should be pursued.
- Similarly, changes to the organisational arrangements have already been made but further work will be needed to develop the management of cancer referral pathways between the outpatient team, divisional management and the cancer team.
- The Board and its sub-committees will want regular assurance that the systems are working as designed and that patient care is not being compromised, with performance against national targets and standards monitored in line with performance reports.
- In addition, the panel found that IT systems needed development to support improvements in data quality across the Trust, and strengthened governance arrangements would be required.

The panel found an impressive approach to improvement in the Trust and concluded that the leadership team has managed this internal incident well. Additional support for the senior team will help to implement the recommendations of this review.

### Clinical leadership

The panel found there was a lack of clinical engagement and clinical leadership of the cancer services agenda. Clinicians needed to be fully engaged in a whole systems review of cancer services to create a new cancer plan. Clinicians are responsible for working within local and national access policies and complying with the local system of completing clinic outcome forms to communicate decisions on all individual patients (including DNAs) to outpatient administrative staff.

## Culture

An important underlying issue was the delay in staff acting when practice fell below standards and taking ownership and responsibility to resolve concerns. Administration staff need to be supported by timely clinical advice on patient management. The Trust has a work programme in place called 'Onion' which focuses on 'peeling back the layers' to understand issues and listening to and supporting staff to raise concerns and resolve issues. The Trust leadership team needs to build on this valuable work to further encourage staff to escalate concerns. From this review process it is clear that Trust complaints investigations can identify underlying issues that require more in depth review and closer monitoring of follow-up actions.

Improvements in the appointments processes should be made to support a booking office culture where appropriate appointment slots are provided to suit patients, rather than arranging them in order to comply with the national standards. The review found that a more patient-focussed approach was needed.

## External

Outside the Trust, the external panel found a very diverse set of arrangements in primary care ranging from some excellent practice utilising Choose and Book to track 2WW, to GPs transferring responsibility for the patient to the Trust following acknowledgement of the referral. In this report, the panel has included a number of considerations to improve governance in primary care. It has also made recommendations for commissioners and national bodies:

- Commissioners and the local Cancer Network need to prioritise assuring cancer data quality and systematically work through the National Cancer Action Team's guidance on Commissioning Cancer Services (2011).
- NHS England, the NHS TDA and Monitor should require all Trusts to assure the quality of data used to measure performance in cancer pathway management, to manage the risk and prevent any breaches in compliance with national policy and standards.

## 2. Review and terms of reference

This is the report of an external review by an independent panel, into the two week cancer pathway at the West Hertfordshire Hospitals NHS Trust (WHHT or Trust), commissioned by the NHS Trust Development Authority (NHS TDA).

### 2.1 The full panel membership

Dr April Brown – NHS TDA representative  
Mr Geoff Brown – Healthwatch (patient representative)  
Dr Fiona Moss – Independent Clinician  
Professor Kathy Pritchard-Jones – Independent Cancer Clinician UCLPartners, Academic Health Science Partnership  
Mr Stephen Ramsden – Independent Panel Chair  
Dr Nicolas Small – GP Chair of Herts Valleys Clinical Commissioning Group  
Ms Fiona Wheeler – Independent Manager  
Dr Sarah Whiteman- Medical Director, Hertfordshire and South Midlands, NHS England  
Ms Charlotte Williams – Independent Cancer Manager UCLPartners

Biographies of panel members are included in the report appendix 8.2.

### 2.2 Purpose of the independent review

The review took place between January-March 2014 and worked to the following objectives (full terms of reference are provided in Appendix 8.1):

- To identify the reasons behind the non-adherence to the national protocols for management of the cancer “two week wait” pathway” as identified by the West Hertfordshire Hospitals NHS Trust, in particular the root causes and the duration of time (and thus number of patients) affected.
- To identify the process by which decisions were taken to implement a process that did not comply with national policy and what governance processes were in place.
- Provide assurance regarding compliance with other related elements of national cancer protocols in the Trust.
- Recommend any additional actions the Trust should take to secure the management of the two week cancer pathway (and any other elements) so as to avoid a recurrence of the failure identified.
- To ensure the Trust’s improvement programme will address the underlying fundamental reasons for this breach in policy, providing additional recommendations for improvement as required.

### **2.3 Approach to the external review**

The independent panel first met at the beginning of January 2014 and agreed an approach to the external review. This consisted of dividing the panel into two teams, one focussed on the internal Trust systems and the other more on external stakeholders, particularly GPs and practice staff. The panel Chair participated in both aspects of the review and also undertook interviews with other commissioners and the local Cancer Network.

Each panel member contributed in their own specialist field but also corporately across the whole review. Panel members' findings were collated into this composite external report by the panel Chair, Stephen Ramsden.

The panel conducted over 70 interviews with Trust staff, clinicians and Board directors, including several former Board directors as the period covered by the incident dates back to 2010, as well as key leaders with a commissioning role (past and present) and the local cancer network. The panel also visited 19 GP practices and held a GP focus group.

The panel acknowledges the time and support provided by all interviewees and thanks them for contributing freely, willingly and openly in the spirit of trying to establish what happened and how it could have happened.

## Review findings and analysis

### 3. The Trust's non-compliance with the 2WW pathway: How did it happen?

*"Identify the reasons behind the non-adherence to the national protocols for management of the cancer "two week wait" pathway" as identified by the West Hertfordshire Hospitals NHS Trust, in particular the root causes and the duration of time (and thus number of patients) affected." Terms of Reference (TORs)*

**Excerpts from national guidance:** Cancer Waiting Times (CWTs) A Guide, version 8.0, July 2012

**Q:** What happens if a (cancer) patient cancels or DNA's their appointment?

**A:** If a patient cancels or fails to attend (DNA) he/she should be offered another appointment within 14 days (taken from Referrals Guidelines for Suspected Cancer – NHS Executive, April 2000).

**Q:** Is there a national DNA policy for cancer waits?

**A:** National position:

- Suspected cancer patients should not be referred back to the GP after the first DNA of their first appointment.
- Suspected cancer patients can be referred back to their GP after multiple (two or more) DNAs of any appointment if this is the agreed local policy.

#### 3.1 Trust cancer services

WHHT was formed in 2000 following the merger of the Mount Vernon and Watford Hospitals NHS Trust and the St Albans and Hemel Hempstead NHS Trust.

It provides acute healthcare services to around 550,000 people. The Trust is therefore a complex organisation with three hospital sites – Watford General Hospital, Hemel Hempstead Hospital and St Albans City Hospital – together with a complex cancer network including nearby Mount Vernon Hospital providing specialist radiotherapy and chemotherapy services. Specialist cancer surgery is "dispersed" between Watford General, Luton and Dunstable Hospital and the Lister Hospital, Stevenage (as well as more specialist tertiary services in London centres). Together they formed the Mount Vernon Cancer Network until April 2013.

#### 3.2 When did the issues first come to light?

In November 2012, WHHT received a GP's formal complaint that patients referred with suspected cancer on a 2WW pathway may have been discharged after one DNA. In response to the investigation clinicians were reminded of the policy around cancer 2WW DNAs. The formal complaint response in July 2013 acknowledged the issues and committed to actions to resolve them.

As the appropriate systems were not in place to deal with complaints management at that time and due to a lack of continuity in leadership and ownership to address the issues, progress was not followed up.

As part of an ongoing Trust-wide improvement plan to address issues with referral systems and processes, the Trust arranged for re-training of administrative staff managing referral pathways and at one of these sessions, it became apparent that patients who did not attend appointments for cancer 2WW referrals were not always being given another appointment. This was the trigger to instigate the internal incident investigation - Operation Bloom - in November 2013 to conduct the look-back exercise and clinical review. The GP complaint was reviewed again as part of this investigation which looked at complaints around cancer referral pathways for 2WW.

### **3.3 Issues with cancer referral management practice**

One of the issues appeared to be the culture and perceptions in departments around why patients DNA, presuming they don't want the appointment. When there were particular concerns about patients they would be followed up, but not automatically if they DNA'd. This practice was reported to the panel as being common for years without concerns being escalated or any apparent incident reporting until August 2013.

Additional steps to safeguard the patients such as dictating a letter to the GP after discharge seemed to be inconsistently used by clinical staff, with different local practices in different departments. This seems to have persisted over a number of years, with ineffective relationships between the outpatients department (including the booking office) and clinical services, and apparent acceptance that the information on the Patient Administration System (PAS) about patient outcomes was inaccurate or incomplete. This would indicate that clinical services did not always ensure they had fail-safe systems in place for informing patients and their GPs around patient discharges.

From interviews with staff it appears that in some cases there was an assumption that after a patient DNA'd, a letter to the GP was automatically generated and sent from the PAS and no further checks appear to have been made by clinical or non-clinical staff, or confirmation sought from outpatients. If patients were incorrectly discharged after DNA, then this practice may have exacerbated the risks of this issue by not notifying the GP, or letting the patient know that they had been discharged.

In addition to the lack of adherence to Trust Access Policy within some departments where 2WW patients were being discharged after one DNA, it also appears possible that patients referred on 2WW may have been inadvertently discharged due to lack of clarity regarding their 2WW status at the time of the outpatient clinic. This may have arisen due to over-booking or use of less urgent slots to accommodate 2WW patients.

The administrative processes used in OPD to identify 2WW patients generally relied on patients being in a designated "very urgent/EB2" slot (depending on whether it was a paper or electronic referral). On its own, this did not cause the breach of Trust and national policy, but coupled with inconsistencies in checking medical records and completing clinical outcome documentation, with no fail-safe systems for patient tracking, it could be a root cause of the problem.

### 3.4 Issues with booking systems and lack of fail-safe processes

Appendix 8.3 illustrates how prior to late 2013, 2WW patients may have been booked appointments via a process that did not make it obvious to administrative staff if the patient was referred with suspected cancer (as above). In these instances the priority of the appointment slot occupied by the 2WW patient was less urgent than the usual “very urgent (vu)” slot used for 2WW, and this broke the chain of administrative labels/flags that staff rely on to identify 2WW patients.

Supervisors told the panel that slots were not always converted to “vu” status appropriately, and not all clinics had the option to convert slots enabled on PAS. This error may be more likely to occur when staff are less experienced in booking or make bookings infrequently. It should be impossible for this to occur for patients referred via Choose and Book, as the electronic system prevents booking into non-2WW slots. This could explain any discrepancy between proportionally higher discharges after 2WW DNAs amongst patients referred via paper letter, rather than via Choose and Book.

The panel found that when the central booking office contacted medical secretaries for help in accommodating 2WW patients, they would sometimes book new appointments by over-booking a 2WW patient into an existing new patient slot, which was not always a “vu” slot.

The same could arise if clinicians approved over-booking or re-use of slots that staff were not authorised or qualified to convert to “vu”. Patients not booked into “vu” slots would not appear to a clinic receptionist to be 2WW without opening the medical notes - generally held with the clinic nursing staff-or removed from the clinic for administration purposes. It was also common for there to be two or three clinics running at the same time that a single receptionist might be serving.

As clinic staff were empowered to discharge routine DNAs without seeing an outcome form (according to senior staff) and generally assumed (the panel was told) that DNAs in the Trust were to be discharged, they may have failed to notice these were high priority (cancer 2WW) patients who should not be discharged. The issues are explained in more detail below:

- The panel heard that in some clinics, doctors approved re-allocation of slots and over-booking at short notice for 2WW purposes. Whilst this is, of course, a helpful and flexible service for patients, it can make the possibility of DNAs and then discharge more likely: firstly because of the reduced notice to patients of an appointment date, and secondly because this will require over-booking or conversion of slots more often and maybe at a speed that would not allow the time to convert the slots properly. 2WW patients were sometimes booked into new routine or new urgent slots.
- Staff reported that problems with bookings and enabling additional clinic capacity had been made worse by the restructuring of the outpatient administrative function between 2008 and 2009. The creation of a booking centre on the St. Albans site meant that there was less access to medical staff and secretaries, as St. Albans City Hospital has fewer specialties based there, creating a challenge for regular communication and close relationships working with clinicians.
- The reorganisation of the clerical teams also resulted in staff being allocated to booking, clinic preparation or receptionist roles, rather than covering all areas. This has led to staff being “siloesd” and they have continued silo working both in their own roles and between sites. Sometimes clinic outcome forms were printed and marked with “routine” or “urgent”

rather than “very urgent, vu” which is the term for cancer 2ww referrals, and there was limited opportunity to check correct outcomes with other staff.

- The reallocation of staff posed issues for booking appointments, as not all staff had the same experience or training. Lack of awareness of other parts of the outpatient process must have caused confusion over the urgency of referrals, particularly those booked at short notice, and there were 360 users working outside the booking office with access to PAS. This issue around dysfunctional working in the outpatient department prompted a programme of support focussed on these teams, working on engagement with staff and awareness of roles. The work of the Intensive Support Team can build on this to better understand the issues with booking processes and potential risks.

### 3.5 Incomplete processes in clinics

None of the above issues on its own should have resulted in patients on 2WW being discharged after one DNA, as a clinical review of the medical notes – which is required by Trust policy for all clinics - would reveal that the patient was referred for cancer 2WW, and an instruction to offer a further appointment should have been included on the clinic outcome form. However, interviews with clinic staff and consultants revealed a number of issues with this process:

- Clinicians sometimes did not complete clinic outcome forms (or they took them away).
- Clinic nurses sometimes left notes for patients who DNA to discuss with doctors at the end of the clinic, but the doctors sometimes left before they could be approached to decide on follow-up for these patients. This was a particular problem at Watford where the site is very busy with other clinical commitments, or when a clinician had to travel to another site for the next session (common in some specialty job plans) leaving little time to review notes at the end of a clinic.
- Outcomes were not recorded or forms were lost if staff had to leave before the end of a clinic.
- When patients DNA'd, clinicians would sometimes write in the notes to offer a further appointment, but not dictate a letter, or complete the outcome form, or consistently inform the GP that the patient did not attend. Consequently staff co-ordinating the process were not aware of the need to offer another appointment.

Clinicians should always review the notes of patients in their clinic, whether the patient has attended or not, but this has not always been the case in practice in cancer specialties in the Trust.

This breakdown in collection of clinic outcomes and its consequences can be seen in Appendix 8.3. The panel were told that following 2011 when nursing establishments were reduced, reception staff could no longer rely on clinic nurses to assist in recording outcome forms.

With the assistance of the Intensive Support Team, numerous updates and additional operational guidelines have recently been produced (late 2013/early 2014 following discovery of this 2WW problem) on “cashing up” clinics to review clinic activity and agree actions, with additional training provided. The Trust has clearly understood that this process was an area of weakness and these are positive steps. If sustained, they should help ensure that staff understand better how patients must be managed, and when checks should be made to prevent errors.

### 3.6 Decisions and governance

*“Identify the process by which decisions were taken to implement a process that did not comply with national policy and what governance processes were in place.” TORs*

It is not possible from the evidence received to identify if, or how, decisions were actively made to implement a process that did not comply with the national policy on the management of cancer waiting times for 2WW patients. The management of patients on 2WW in outpatients is very inconsistent across the Trust, and has developed from a combination of historical practice, ignorance of and/or misunderstanding of existing formal guidance, and lack of fail-safe processes to track that guidance was being followed. Some of the key issues which may have contributed to the development of this non-compliant process are discussed below.

### 3.7 Trust Access Policy, procedures and training

For the period examined in this review the Trust had a thorough and accurate Access Policy, consistent with the national guidance, identifying the necessary process for handling cancer patients, including DNAs for patients referred under 2WW. The last policy was ratified in September 2012 and has been recently revised and ratified by the Trust Board in March 2014. Access policies based on national guidance created by the Trust date back to 2009. Corporate Trust management did not take responsibility for cancer waits and access when revising access policies as it was understood that the cancer team and cancer manager managed this.

During the external review interviews, senior staff within OPD reported that they did not know about the Access Policy and had received no formal training on it or training materials for induction or ongoing programmes for staff prior to late 2013. Senior administrators were not clear on which team members had permission to manage referrals on PAS, and/or what the standard procedures were for the handling of clinic slots. It also seems that prior to work with the Intensive Support Team and new managers in late 2013, these procedures were not written down or made available to booking staff. Lack of formal training can perpetuate any local habits and non-compliant practice from learning on the job.

Prior to 2014, there does not appear to have been any guidance for clinic staff. The 2014 “Cashing up OP Appointments” guidance states quite clearly *“.... no patients should be discharged without confirmation from the consultant/Doctor in charge of the patient’s care...special attention ... to Cancer 2WW ..then the cancer rules are set out .... if the details are going against the Trust’s policy this must be flagged to clinician or ADM.”*

Administration staff and medical secretaries interviewed said they received no formal training on patient access and booking appointments. They felt that the data quality of clinic outcomes on PAS was unreliable. Responsibility for tracking clinic outcomes was not shared between teams in order that they could comment or respond to any breaches of the standard. For instance, OPD managers believed that the Trust 18 weeks team (a separate team from OPD, and the cancer information analyst) was responsible for tracking clinic outcomes, and had never been asked to comment on or respond to any breaches of the cancer 2WW standard.

It was clear from the interviews that OPD did not take ownership of the Access Policy, maybe because they had not been involved in developing it, along with training and procedures to ensure staff were aware so the policy was adhered to. Future policies will require better consultation and engagement as well as co-developed operating instructions to train and guide staff.

Clinicians and senior managers were not all aware of the Access Policy or the specific guidance on DNAs, and followed historical local practice. On 28 March 2013, the Trust Medical Director did email all consultants to ask them to follow local guidance (prompted by the GP complaint where issues with cancer 2WW DNAs were identified):

*“If a patient on a 2WW pathway DNAs a first appointment, he or she should be re-booked, and the 18 Week form used to summarise the outcome should reflect this.”*

However, no additional audits or fail-safe tracking reports were put in place to monitor compliance and this is partly due to the ambiguity of management arrangements between the Cancer Team/managers and OPD/divisional management, and the departure of key Trust directors.

The GP complaint appears to be the first time senior leadership in the Trust became aware of a problem around compliance with the national and local policy on patients who DNA on the 2WW pathway. This investigation highlighted the confusion and lack of ownership of the problem between several different managers.

In July 2013 the deputy chief executive was assured that a new weekly check system had been put in place and that an audit would be undertaken. The Trust replied to the GP accordingly. Unfortunately, the audit was never undertaken, believed to be a consequence of the confusion and lack of clarity on responsibility and management of cancer waits between OPD management and cancer team, as well as leadership changes at executive level.

### **3.8 Isolation of the Trust cancer services**

The panel was told that cancer services sat in corporate services within the Trust, so did not constitute a clinical division. Therefore managers were not part of the Trust peer group with assistant and divisional managers. Low visibility across the Trust of how cancer patients were managed, and the practices in this area, could have contributed to the non-adherence to cancer access policies. There was no peer challenge, and the cancer services appear to have been isolated from Trust management. Wider responsibility for cancer waiting times and management systems for cancer patients was not taken outside the cancer team.

### **3.9 Management of the Outpatients Department**

During the course of the review, serious concerns were raised by managers and clinicians about the management and organisation of the outpatients service, both appointment bookings and clinic administration. There is some evidence that this has been an ongoing issue for a number of years and supervisors and clerks feel unsupported. This may have been exacerbated by the decision to reorganise the function in 2008/9, when all bookings were centralised to the St. Albans City Hospital site, resulting in local visibility and ownership of the booking process being eroded.

It was reported by one manager that the running of OPD was a concern that had been escalated at Trust Access Meetings and via the OPD management over a couple of years, but with no visible action as a result. However, the OPD did offer the opportunity for users to feedback and contribute

by attending a monthly “Outpatients User Group” but this was poorly attended by staff outside of OPD and never attended by clinicians. This may indicate that those with concerns or complaints did not take all the opportunities available to them to influence the service.

Another example was when the content and design of clinic outcome forms were reviewed, and only a very limited number of consultants took the opportunity to contribute to the redesign. This lack of engagement with OPD was a key theme in interviews held with some clinicians, who felt they have no influence over how OPD works. The Cancer Team felt they had little influence over the booking team and OPD, even when they had concerns.

Between 2009 and 2011, there was a major attempt to review and improve outpatient services, including the patient experience, through a variety of external consultancies. Some of this was aimed at developing an outpatient services training day, and asked outpatient staff to list their problems and develop action plans to improve. For example, a receptionist wrote: *“At the end of the clinic sessions, some nurses do not come and collect the DNA sheets to take back to the Drs to fill out”*.

Later in 2011 and more recently in 2013, as part of a drive to improve patient access, the Trust and commissioners were working to reduce the number of DNAs and attempts to make efficient use of appointment slots may have led to 2WW patients being discharged.

### **3.10 Lack of clarity on responsibility and accountability for 2WW**

Until late 2013, the process for receiving and logging 2WW referrals (except the minority coming via Choose and Book) was paper-based. There was no tracking system generating a report on all 2WW referrals listed for a given day to ensure patients were being managed as swiftly as possible and delays are not incurred or patients missed.

Divisional management staff outside the cancer services department appeared to be unaware of cancer waiting times guidance, and did not take responsibility for cancer waiting times or cancer management processes, other than releasing additional outpatient capacity when required to enable all 2WW patients to be accommodated.

At Board level, several current and previous directors acknowledged that there has been some ambiguity about the Board level leadership for cancer; some also accept that the cancer team were more isolated. Responsibility for the cancer 2WW target has been equally ambiguous between outpatient management, clinical divisions and the cancer team. It is now clear in the current arrangements that the chief operating officer is the Board lead for cancer.

Most of the divisional management staff never had any involvement with cancer tracking or cancer waiting times compliance, and assumed this was all looked after by the Trust’s cancer services department. The cancer team regarded the outpatient service as being responsible “up to day 14” until a 2WW patient was added to the cancer pathways for the 31 and 62 day wait targets and managed by the cancer team. The external panel found a variable level of clinician ownership and responsibility for dealing with 2WW referrals. Tensions between clinical understanding of the booking process and the OPD’s management created the perception that OPD did not provide a responsive service to clinicians. Clinicians were also unclear on consultant upgrade processes for cancer; a significant area of concern.

The evidence received by the panel illustrates a lack of understanding amongst senior clinical staff and senior managers outside of cancer services of their role in, and responsibility for, cancer waiting times and referral via 2WW. Most of the clinicians interviewed had not been aware that some patients who DNA on the cancer 2WW pathway were not being offered another appointment, until the recent issue and internal review.

None of them had been aware of any of their patients being affected by this. Clinicians interviewed thought there had been a significant increase in the number of referrals via the 2WW pathway and an increase in the number of people with cancer cared for through WHHT and the Mount Vernon Cancer Network and at multi-disciplinary team (MDT) meetings.

### **3.11 Tracking processes**

The Cancer Services team was seen as being accountable for cancer targets. Processes for tracking patients were inadequate partly because of the problems with the Trust's PAS and Inflex IT systems. It was also noted in internal audits (2010) that cancer records and MDT arrangements were unsatisfactory; and through external peer reviews (2010 onwards) and attendance at the Trust's CQuaC (Clinical Quality Advisory Committee – Board sub-committee twice in 2011) that the current cancer information and data collection systems were not fit for purpose and a business case would be produced. The Trust Board has considered a major IT investment over recent years and a business case has recently been approved.

If inappropriate management of 2WW patients was reported previously (including discharge after first DNA), it appears that no incident form was completed, and multiple examples do not seem to have triggered any action to change processes, re-train staff or feed-back to the Trust 18 weeks team, who compiled the Access Policy. The panel were told no reports were put in place to measure discharges after DNA in 2WW patients. There was no system to provide assurance that policies were being followed.

### **3.12 Systems for sharing and reviewing information on cancer waiting times**

Prior to the establishment of a Trust-wide access meeting in July 2013, at which the cancer team was asked to give performance updates, no data relating to cancer waiting times was regularly shared at any forum with the managers within divisions other than cancer, or with clinicians responsible for providing cancer care.

Data produced for use in the Trust showed aggregate performance figures, which would not reveal challenges within individual specialities, or trends in metrics over time. The only exception appears to be discussions about some specialty-specific concerns at the Trust Cancer Board meeting, which was not routinely attended by divisional managers. Divisional managers assumed that the cancer team was managing cancer patients and performance, and as data was not clearly shared via Trust information and performance platforms, there was low visibility of any issues outside this team.

The cancer team held weekly meetings with its full team of nurse lead, clinical lead and executive lead prior to joining the Trust Access meeting in September 2013. As a general rule, where 2WW access problems arose consistently they would be investigated but not if the 93% access target were

being achieved. The Cancer Team did appear to have regular contact with the Trust's senior leadership through this forum.

All validation and review of cancer patients on the pathway or after treatment was done by the Cancer Team. A newly appointed manager in 2013 identified that there was no available route to obtain cancer performance data other than person-to-person requests from the Cancer Unit manager. Patient access issues were not properly discussed. All external data reports for cancer waiting times, and internal information was produced by the Cancer Unit manager using the Infoflex system. Cancer waiting times were shared at the Mount Vernon Cancer Network.

There was some attempt to involve the wider Trust community in cancer management via the Trust Cancer Board, established in 2011 after external audits were undertaken. At the Cancer Board the issues discussed were highly operational in nature, with detailed discussion on issues within each service (e.g. need for additional resources/cover arrangements and general progress up-dates).

The Trust Board would receive regular cancer waits target performance as part of its performance reports. Occasionally these showed red in a RAG rating system, in which case more detailed discussion and action was called for. Otherwise cancer was only infrequently discussed at Board level. The chief executive and executive would also challenge as necessary when national cancer waits targets weren't being achieved but the Trust had many other priorities for the senior leadership to concentrate on – financial recovery, four hour emergency department waits, 18 week waits, Foundation Trust status, Hospital Acquired Infections amongst them.

This is a complex, challenged Trust and the senior leadership prioritised the known performance issues, giving lower priority to seeking assurance that the performance measures marked green on the RAG rating really had no problems.

The leadership of the Trust has changed significantly over the last 12 months with a new chief executive, new chair, and virtually a new Board. The chief executive's programme "Onion" is a new approach to Trust management "peeling back the layers" and "challenging everything we currently do and seeing if there are ways we can do things differently, and better." This involves the executive directors meeting daily with staff, listening and supporting improvement.

### **3.13 A summary of the causes of the failure to comply with the two week wait cancer pathway relating to DNAs**

Reflecting on all the evidence available to the external team and described above, the panel summarised the identified causes as follows:-

- I. Cancer 2WW referrals were scheduled into routine clinic appointment slots, which led to staff not recognising these DNAs as cancer 2WW.
- II. Inconsistency in clinical review of the notes of patients attending clinics contributed to lack of clarity over cancer referrals and whether patients had attended appointments or not. The documentation processes were inconsistent and in some cases administrative staff were unclear of the clinical decision about a new appointment or discharge.

- III. Demand and capacity issues in some clinics will have contributed to scheduling 2WW referrals into available routine clinic slots.
- IV. The administration of outpatient department services across very complex Trust sites was not well organised. Additionally, training on complex administration systems has been minimal up until the last six months.
- V. The Cancer 2WW office required more organisation and resourcing to manage risks around continuity during absences, and work was allocated to the booking office team.
- VI. The booking culture focussed on allocating appointments efficiently to meet 2WW standards rather than ensuring the patient was given sufficient notice to enable them to attend.
- VII. More clinical ownership and engagement was needed to manage and understand the cancer 2WW or outpatient department (OPD) booking systems.
- VIII. Misinterpretation or lack of knowledge of complex national/local cancer waits guidance regarding DNAs.
- IX. Laudable attempts by the Trust to reduce the number of general outpatient DNAs contributed to misinterpretation and, in some cases, the practice of discharging cancer referral patients who did not attend their first or second appointment.
- X. Limited safety net systems in primary care. Some practices who use the Choose and Book system can track where 2WW patients are, and some use manual systems to do so. There is no standard system, consistently applied currently for primary care professionals to track patients.
- XI. WHHT, the Mount Vernon Cancer network and commissioners did not request data quality for cancer waits to be audited. The panel found no evidence to show the National Cancer Action team guide for commissioning cancer services, July 2011 had been followed.
- XII. Trust cancer services have traditionally been managed separately to clinical directorates/divisions, which need more ownership of the cancer services agenda.
- XIII. Trust out-patient services used to be managed separately, although this was changed in recent years. There is still perceived to be a lack of integration and ownership of out-patient management by clinical directorates.
- XIV. The ambiguity in management arrangements means that between out-patients, the cancer team and clinical divisions, these departments do not have clearly defined responsibility for managing the 2WW target and compliance with standards around DNAs. Lack of leadership and responsibility for addressing these system issues has led to inaction and opportunities for improvement being missed.

## **4. Compliance with other related elements of national cancer protocols in the Trust**

### **4.1 National guidance**

There are several cancer waiting time standards all brought together in a national guidance document from the Department of Health: “DH Cancer Waiting Times version 8 - A Guide 2012”. This guide gives definitions of the cancer waiting times standards especially around 31 days from decision to treat, to the first definitive treatment; and 62 days from urgent GP referral (or consultant upgrade or screening ) to the first treatment for cancer.

There are rules relating to tracking and times between trusts and when and how the clock can be stopped along a pathway. Guidance on handling DNAs is also given. However, in addition to this waiting times guidance, the National Cancer Action team has also provided guidance on other standards, monitored under the Cancer Peer Review process. The panel has therefore taken a very broad view of national cancer protocols under the review Terms of Reference.

### **4.2 Local practice**

The panel found many dedicated staff working at WHHT treating patients with cancer and there are examples of very good practice in some clinical departments/multi-disciplinary teams (MDTs) which should be shared. Staff are well motivated and aspire to provide the best care possible to patients, so they are concerned when processes within the Trust impede this. Staff explained there was limited support for the cancer service in terms of data collection for national audit, investment in MDT meeting facilities, or even priority for booking meeting rooms and obtaining medical records. Staff in the cancer team felt the service was not given the profile, recognition and importance they felt it deserved in the Trust.

The panel found a lack of clear team working between senior clinicians, managers and administrators so that problems and concerns remained in “silos”. The panel found no overarching Trust “Cancer Plan” to describe the strategic development agenda for cancer services and flag up priorities to be addressed. Due to prioritising other performance issues, cancer services were not being proactively examined by the Trust Board as they were RAG rated green for performance against cancer referral waiting times. Proactive review would have helped address performance issues as they arose.

### **4.3 Priority given to cancer in the Trust – other indicators**

Internal audits following peer reviews from 2009 and 2010 found issues with incomplete patient records, and sometimes case-notes were not made available for MDT meetings, making it difficult to discuss the patient and make appropriate decisions, which could delay treatment. Trust systems for capturing cancer audit data were not fit for purpose. An audit in 2010 examining multidisciplinary team working also found a lack of management support to prepare for Peer Review and a lack of support for clinicians in cancer services. The evidence considered in this review indicated that this had not changed in the period to date and many of the clinicians interviewed felt that cancer services were not an immediate priority for the senior management of the Trust.

The Cancer Services team was responsible for the Cancer Peer Review programme and other Trust executives and consultants were often not involved, unless they needed to respond to breaches in national targets. The panel found that clinical leads and divisional managers interviewed were not engaged with a mandatory national quality assurance programme for cancer care or peer review.

#### 4.4 The multi-disciplinary teams (MDTs)

Cancer surgery is dispersed across the following sites, creating complexity for tracking cancer patients:

- Gynaecology – Watford General
- Upper GI – Watford General
- Skin- the Lister Hospital
- Urology – the Lister Hospital
- Head and Neck – Luton and Dunstable Hospital (or Northwick Park)
- Radiotherapy and specialist chemotherapy remain at Mount Vernon Hospital under the new management of the East and North Hertfordshire NHS Trust

This organisation of services requires complex arrangements for the specialist MDTs, on top of the normal requirements for the other cancer MDTs, generating a range of problems and concerns. Some relate to the difficulty of working across three Trust sites and with external partners in cancer networks without adequate administrative or IT support. Some problems relate to equipment not being available on some sites and also the need for better communication between different departments.

The external panel also found issues with partnership working across sites including difficulties securing video-conferencing facilities for MDT meetings and priority bookings for this equipment at Watford General Medical Education Centre (MEC).

Several interviewees commented that there weren't enough clinical leaders running cancer MDTs. All consultants interviewed felt that more support was needed. The MDT co-ordinators reported they were stretched and stressed, with some of the MDTs they led running at the same time. MDT co-ordinators were not always supported with enough resources, including adequate IT and office facilities. It was also felt that MDT co-ordinator roles could be extended as their expertise is underused.

There were problems with WHHT operating the SMDTs across the network, particularly with recording all patient outcomes, illustrated by the Cancer Network's performance report which stated that: *"The Trust records only outcomes for WHHT patients and expects the other hospitals' MDT co-ordinators to record the outcomes for their respective patients and sends them to WHHT to compile into consolidated minutes of the SMDT. For the other IOG services hosted by L&D and E&NHT (Head and Neck; Urology; Skin) WHHT expects the MDT co-ordinators at these hospitals to record the outcomes for all patients discussed at the SMDT (including WHHT patients) and provide comprehensive minutes from the SMDT. It is the responsibility of the hospital hosting the SMDT to record the outcomes of all patients and provide the referring hospitals with the appropriate paperwork re outcomes of MDT discussions."*

It was perceived that there were not enough clinical nurse specialists (CNS) allocated to different specialities to recognise the specific needs and pressures of cancer care in these areas. Both Gynaecology and Upper GI, the two "network centres" based at Watford, expressed concern about CNS shortfalls and capacity to answer patient enquiries in stretched services.

One clinician involved in the Urology MDT expressed concern about long hidden delays for patients receiving bladder cancer surgery after chemotherapy treatment started, due to demand and capacity issues and organisation of pre-operative assessments. The Urology MDT was also felt to be dealing with too many cases.

The Cancer Network commissioned a head and neck cancer pathway review for WHHT patients in 2010. This reported in November and highlighted:

- A lack of clarity about the role of the WHHT ENT team during the diagnostic stage of the cancer pathway with evidence of delays arising.
- No CNS support for WHHT ENT head and neck patients.
- No access for WHHT ENT patients to clinicians who have attended Advanced Communications Skills Training.

An internal audit in 2010 concluded that: *“The Trust has not established and embedded effective MDT working arrangements in cancer services”*, and the evidence from this external review showed that this still required improvement.

#### **4.5 Risks in patient tracking**

Communication between MDT Coordinators and staff within the specialities (consultants, secretaries and managers) was described as unsatisfactory, and MDT co-ordinators used varying terms and parameters for patient tracking. The panel found that relationships and support between consultants and MDT coordinators required strengthening.

Patients are tracked by MDT co-ordinators against the cancer waiting times using the Infoflex system, and it appeared that no other members of staff previously used this as a cancer system, instead taking information about patient waits from the “Witchdoctor” and “IReporter” analytics systems (in the case of managers), or by looking up patients on PAS. The use of parallel systems and lack of cross-talk between Infoflex and PAS is a risk that should be addressed.

The panel found that systems for patients and the quality of information recorded needed to be improved urgently. MDT coordinators interviewed said they perceived the reliability of clinic outcome data on PAS to be poor, so they sometimes waited for clinic letters to be typed and uploaded to the Infoflex system to track patients which could contribute to delays in pathways.

An external audit carried out in November 2010 found duplication of efforts in recording cancer patient care data between Infoflex, the Patient Activity System (PAS) and work sheets maintained by the MDT coordinators. The review panel recommends that this duplication is streamlined and minimised as far as possible.

This review has found evidence to indicate that, until the Trust enlisted help from the Intensive Support Team in mid-2013, no streamlining or improvement of these administrative and managerial processes had been achieved. Actions identified in the recommendations from a November 2010 review into MDT working were all assigned to members of the Trust’s cancer services management team, rather than shared across the Trust for wider management.

## 4.6 Responsibility for patients treated elsewhere

Following interviews with administrative and middle management staff, the panel was concerned that the national guidance regarding the recording of cancer waiting times other than 2WW (31 day and 62 day standards), and the process regarding breaches of the waiting times standard, had not been followed in the past. The evidence obtained indicated that this arose from a genuine lack of knowledge and understanding of the guidance.

For example, it was brought to the panel's attention that prior to mid-2013, patients who were referred to WHHT for Head and Neck Cancer on 2WW, but then sent to other Trusts for further diagnosis and treatment, were routinely taken off cancer pathway tracking on the Infoflex system when they were transferred out, with a code recorded of "no cancer diagnosed in this Trust".

This contravened national guidance which indicates that in a commissioning arrangement like this, the provider in a 62 day cancer pathway (as with 2WW patients) where the patient was first seen and the provider where the patient was treated are both jointly responsible for the activity and waiting time. Patients on these pathways didn't appear to have been tracked by WHHT. Rather than being the sole responsibility of cancer services, the panel found there was a need for closer working with other Trust managers to liaise with other Trusts, working in partnership to oversee cancer waiting times, report breaches and conduct cancer peer reviews.

## 4.7 Other reviews

The external review team considered reports from reviews commissioned by the Trust in late 2013/early 2014 and many of the findings of these reports resonate with the findings from this review:

- West Hertfordshire Hospitals invited in the Intensive Support Team (IST) to undertake a referral to treatment times (RTT) Information Review in September 2013
- Diagnostics Review 10 February 2014
- WHHT Cancer Service Review IST Jan 2014- specific concerns were summarised early on in the report:
  - The recording and monitoring of inter-provider transfers.
  - The correct application of cancer waiting times rules across 62 day pathways.
  - The risk of 'losing' visibility of patients from cancer monitoring, particular urology patients.
  - Shortcomings in the cancer information system and data quality.
  - Concerns about the level of MDT Coordinator provision.
- In addition to these reports, it is understood that work commenced in early 2014 to review all cancer pathways across the whole of Bedfordshire and Hertfordshire to involve all Trusts providing cancer services and ensure pathways are used effectively.

The scope of this external review was to concentrate on the non-compliance with national guidance on the 2WW cancer pathway DNAs and other cancer wait protocols, rather than duplicate the efforts of other reviews, but the panel acknowledged the discovery of many of the same issues. The Intensive Support Team has offered to continue to help the Trust with the implementation of findings from their reports and the Beds and Herts Cancer Forum pathway review has just started.

Finally, towards the end of this review (March 2014), in line with their approach to reviewing patients according to the highest clinical priority, the Trust was able to report on cohort 2 (the 31/62 day waits sample) of its internal investigation. This concluded from the outcomes that the patients were not at risk, but errors in the data on the Trust's systems had led to both under and over reporting of breaches against the national cancer standard and to differences in understanding of cancer guidance between staff at all levels, clinical and non-clinical. The Trust has also discovered further errors in recording, from the new cancer Patient Tracking List (PTL). Further training and work to improve recording systems and processes is required, as part of a Trust cancer action plan.

## 5. Review of local partners in West Hertfordshire

While the review focussed on WHHT and its systems and organisational arrangements, the review team also examined the local healthcare system to determine any influences on cancer patient pathways. This chapter summarises the role of commissioners, the local cancer network and GPs/GP Practices in the Trust's management of cancer patients, particularly the 2WW pathway.

### 5.1 Primary care

Members of the external team conducted interviews with 19 primary care providers to review specific patients identified as part of the Trust's look-back exercise and to ascertain views on the 2WW system generally. A GP focus group meeting was also held during the review to explore the issues that had arisen from the interviews. This was well attended by about 30 GPs.

### 5.2 Practice procedures

These varied enormously between GP Practices but included:

- Faxed 2WW referral (not always acknowledged by the Trust) sent ASAP from the clinician/practice.
- Appointments made via Choose and Book or telephone call from the practice; inconsistent availability of specialty appointments via this route.
- Hand-outs to the patients regarding the nature of the 2WW appointment, not all GPs at the focus group were aware of these.
- A book of all 2WW referrals updated by GP reception staff regularly; this followed a significant event when a young patient referred routinely initially presented with late stage cancer in Spain having been lost to follow up locally.
- Monthly computer searches of all 2WW referrals sent to the responsible GP to review care received.
- Use of NHS net to send emails for any urgent referrals and a system for follow-up; different forms populated via the IT system linked to electronic record of the patient.
- Advice to the patient to report back if no date for an appointment received within one week.
- Local follow up arrangements using secretarial/administrative support and computer systems.
- Date/time of appointment entered into medical record manually.
- Urgent letter dictated to medical secretary, translated to proforma.
- All specialist trainee referrals discussed with clinical/educational supervisor.
- Clinicians use a range of approaches to track progress with referrals.
- Recognition that some patients in vulnerable groups are at greater risk of not attending so more support is needed. Variation in GP views on roles and responsibilities once a patient was referred, who ensures that the patient is followed up and seen and confusion over the legal responsibility as stated in GMC guidance.

- One practice had reflected on its own processes and had changed its mechanisms for 2WW in light of the Watford issues.

### 5.3 Impressions of the 2WW cancer pathway

- “Probably the best development for patients in General Practice in the past 27 years.”
- Effective, particularly for some specialities; Breast, Gastroenterology and Haematology were highlighted. Overall seen as a responsive and good service.
- A more holistic view of the patient is needed, rather than focussing on excluding a malignancy in the specialty for the original referral.
- Concerns about the confidentiality and reliability of a fax based system. An NHS email or web based system could improve the system.
- Observation that the Minor Oral Surgery referral system seems more reliable than the 2WW pathway for suspected oral cancers (although appointments for oral cancer were scheduled quickly in most cases).
- Generally communication from WHHT could be improved by more timely and consistent correspondence relating to out-patient attendances and in-patient stays. Patients often revisited their doctor or dentist before communication is received from WHHT.
- Different Trusts have different criteria for 2WW referrals and different forms to be completed, accepting different symptoms.
- Recognition that experience of the practitioner may impact on the likelihood of referral to the 2ww pathway.
- 95% of those interviewed were unaware of the two opportunities to have a 2WW appointment if the patient didn’t attend the first.
- Concern around the logistical sense or benefit of having a system in primary care to check acute provider systems, when GPs already have responsibility for a wide range of issues.

### 5.4 Potential reasons for patient DNAs:

- Patient decision to go elsewhere e.g. privately or to another Trust
- Better communication needed from the clinician (GP) on the significance of the referral and the importance of attending the appointment to check for malignancy
- Potential language barriers
- Holiday plans and other commitments
- Hospital error in notifying the patient
- Inaccurate or out of date contact details if patient has moved - risk of homeless people and transient communities moving away
- Support needed for patients with learning disabilities, cognitive impairment or literacy challenges to encourage attendance
- Patient fear or conflict of priorities underpinned by personal health beliefs

## 5.5 Observations on specific patients flagged in Operation Bloom

All practices that were visited as part of this external review, had reviewed the patients identified by the Trust's investigation. No material harm has been evidenced in most cases, and no new cases came to light.

Practices saw these reviews as an opportunity to learn and share good practice; wishing to make earlier cancer diagnoses and ensure the best possible care for their patients.

## 5.6 GP discussion

The understanding of the need to establish robust governance arrangements created a lot of discussion. Some GPs took the view that they did not have a legal responsibility once their referral had been acknowledged by the Trust and felt that the Local Medical Committee had advised this, whilst others felt it was important to improve their processes.

All acknowledged there was wide variation between and even within GP practices and that they were happy to adopt good practice, providing these were not too complicated or onerous. There were many examples of good practice, with the Maltings practice in St Albans employing a Choose and Book administrator who was able to track where cancer 2WW referrals were in the system and if they had DNA'd. Only a small percentage of 2WW referrals couldn't be tracked in this way – Upper GI, Urology and some in Gynaecology because the patient needs a diagnostic test first. The Trust could make these diagnostic services directly bookable so that GPs can use Choose and Book for all 2WW cancer referrals.

There was a lack of understanding around the capabilities of the Choose and Book system from a minority of GPs. Some said that they used Choose and Book but not for cancer 2WW referrals. However all GPs felt that if the electronic referral system i.e. Choose and Book or its successor could be changed so that it is easier to track referrals, this would be helpful. The point was made that a system that relied on fax messaging was not fit for purpose.

## 5.7 Recommendations arising out of the work with primary care

The panel recommends that the governance of the two week cancer pathway should be reviewed in primary care, including dental practices, and standards should be agreed for all referring clinicians, including the use of "Choose and Book".

Review of the systems and standards should consider the following:

- The letter notifying the GP of a patient DNA should clearly state that the original referral was under the 2WW system.
- One 2WW clinic contact number accessible for patients and clinicians to up-date the Trust if they change their mind about the appointment, or a cancellation line that can be called 24/7.
- Choose and Book paperwork should include advice to keep people updated of decision changes and the value of appointments.

- There are opportunities to develop dental pathways to undertake more work and triage in the community, thereby lessening the secondary care workload and mirroring the strategy in General Medical Practice.
- Better use of IT (on-line booking) and email systems using secure NHS.net
- Urgent non-cancer referrals and the management of DNAs in this context need to be considered too e.g. patient referred to Rapid Access Chest Pain Clinic.
- A standard response form completed by the hospital would improve consistency of information regarding the outcome of the referral. Faster responses would also be beneficial, as would clarity on the length of time a response should take.
- Whilst acknowledging business and financial pressures that practices face, GPs and commissioners may wish to consider the *governance* benefits of Choose and Book as an approach.
- Encourage those practices who have not yet reviewed their processes around the 2WW pathway to do so.
- Practices need to ensure good governance around referrals including auditing referral systems and ensure consistent practice between partners to enable this.
- Consider making the appropriate diagnostic services directly bookable so that GPs can use Choose and Book for *all* cancer 2WW referrals should they wish.

The panel felt there would be merit in establishing a patient and public participation forum for cancer services, if one does not already exist. This forum could explore ways of helping to reduce the number of DNAs on the 2WW pathway by examining why patients DNA. This work could be complemented by the use of existing patient groups in the Trust, CCG and Healthwatch.

## 5.8 Commissioners

One issue that emerged from interviews with past and present commissioners of WHHT services, senior leaders working at the NHS England Local Area Team for Hertfordshire and Cancer Network personnel, was the relationship between the commissioners (especially in Hertfordshire) and the Cancer Network and leadership for cancer commissioning.

The main role of commissioners over recent years, has been to performance manage the achievement of the national cancer waits targets. The panel felt that commissioners had not worked together with providers to take forward the recommendations of the National Cancer Action Team's Commissioning Cancer Services guidance from July 2011:-

*“Commissioners need to ensure that robust arrangements are in place, with:*

- *processes to identify and track patients along the waits pathways*
- *effective pathways – this may require pathway redesign where necessary (e.g. considering how breast clinics are run) and also building up capacity in areas such as radiotherapy, incorporating, where appropriate, the Cancer High Impact Changes identified by NHS Improvement as being of benefit to patients*
- *prospective patient management and navigation systems in place – implementation of a local Priority Target List (PTL) should support the steering of patients through the system including within and across organisations*

- *local systems in place to capture data on where patients are in the pathway so that it is possible to track patients and demonstrate that the standards are being achieved.”*

These standards for commissioning cancer services are still relevant in 2014 and if followed from 2011 could have identified problems at WHHT earlier. Herts Valley CCG has acknowledged that cancer needs to be a bigger priority, as one of the biggest killers and a crucial area for management in their “Healthier Herts” strategy. The current situation at WHHT has created a need for broader assurance of quality and governance around all cancer service provision from WHHT and their own GPs. Triangulation of information to support the monitoring of cancer as well as other performance metrics is now being pursued.

## **5.9 Cancer Network**

After the Cancer Network was abolished in 2013, a new East of England strategic clinical network for cancer was created, the Beds and Herts Cancer Forum. Senior Network leaders said they felt WHHT did not give cancer a high enough priority (compared to the other Trusts in the network). Internal systems weren’t felt to be robust, and they had been aware of problems with WHHT peer reviews and performance issues around cancer waiting times. They had not looked at data quality issues such as compliance with cancer 2WW DNAs in their operations and data group attended by the WHHT cancer manager.

The Network’s local cancer profiles illustrated trend analysis in cancer indicators by GP Practice. Hertfordshire practices are “under-referrers of cancer 2WW” and this linked with some work on 2WW to focus GPs on emphasising the importance of patients attending their 2WW appointments. GP education and campaigns aimed at primary care and patients/users were recognised nationally as being very innovative. The Network created an information sheet to be given to patients referred under the 2WW system, requested by the Trust to reduce the number of patients who DNA. The new Beds and Herts Cancer Forum has now commenced a review into local cancer pathways.

## **5.10 Recommendations for commissioners**

Commissioners should revisit Commissioning Cancer Services 2011 with its checklist of requirements from the National Cancer Action team and review the governance of cancer pathways in primary care. The Beds and Herts Cancer Forum clearly has a role to play in ensuring that the learning from these recent reviews is applied across Bedfordshire and Hertfordshire and support providers in addressing the issues identified in this report.

## **5.11 Other external bodies**

There is an important role for all regulatory bodies to learn from the findings in this external report and seek assurance on data quality to measure compliance with national cancer standards.

## 6. The Trust's broader improvement programme

### 6.1. Risk Summit Response Programme

The external review team understands that Risk Summits held in 2013 have formed a key part of the Trust's improvement approach, addressing concerns around governance, performance, care quality, infection prevention and control, Board leadership, organisational culture and issues (with cardiology and respiratory) referral systems and processes. In response to the risk summits, the Trust created a Risk Summit Response Programme which is a comprehensive plan delivery plan for improvements underway to address risks identified.

A time limited Risk Summit Response committee was created, chaired by a non-executive director with representation from Healthwatch, CCG Accountable Officer, Patients Panel and staff side representation as well as Trust executive directors. Reporting to the Board this committee has overseen the Risk Summit Response Programme and a single, overarching plan with a clear timeframe and ownership of actions.

The programme consists of six workstreams: Governance; Leadership; Patient Experience; Workforce and Safety; Operational Effectiveness; and Clinical Effectiveness and is using a framework designed to incorporate best practice for project management in healthcare to ensure effective delivery of improvements.

### 6.2. Key principles for the Risk Summit Response Programme

The Risk Summit Response Programme has been designed to embed the following principles:

**1) Patient and public participation** – public representatives play a key role in the improvement programme and are working in partnership with clinicians and directors on the Risk Summit Response Committee. In developing the improvement projects the Trust has listened to the views of the patients and also considered independent feedback from other stakeholders including local GPs and other partners involved in this work. These themes have been reflected in the project aims.

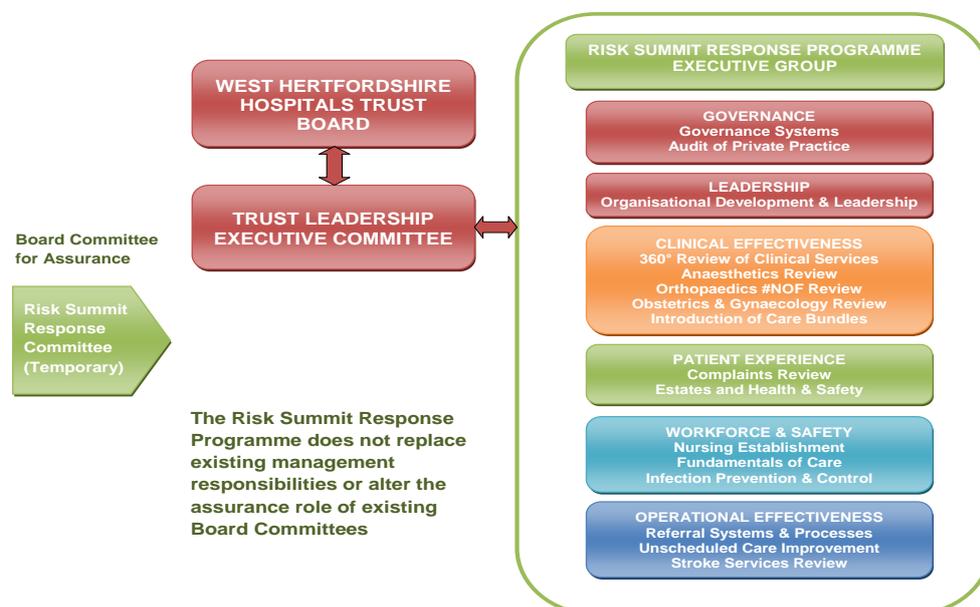
**2) Listening to the views of staff** – staff are supported to provide frank and honest opinions about the quality of care provided to hospital patients and what can be done to improve the way they serve patients, families and their friends. This daily process has been given the name "Onion" at West Hertfordshire because there is often a need to peel back many layers to find out: "*What we can do **today** that will make a difference to our patients **tomorrow***".

**3) Openness and transparency** – all possible information and intelligence relating to the quality of the care provided to patients has been and will continue to be made available to Trust partners and stakeholders.

**4) Co-operation between organisations** – this programme has been built around strong co-operation between all of the different organisations that make up the local health system.

The diagram below illustrates the governance structure in place to deliver improvements:

**Fig. 1: Governance structure for Risk Summit Response Programme**



### 6.3 Improvement approach

The Trust is very complex with multiple performance, governance, organisational, service and systems challenges, and the Trust’s innovative “Onion” approach is working to engage staff in exposing all issues and developing solutions.

In response to issues raised around 18 week and cancer waits, the Trust has engaged the Intensive Support Team to review internal systems and help to improve them. There is also a senior expert on secondment from the team to support improvements to patient administration systems needed for 18 weeks and cancer waits.

There has been turnover in leadership at Board and management level, with support from interim managers and the Trust will need to continue the focus on increasing management capacity. The Trust has recently recruited a new chief nurse and director of infection prevention and control, HR director, director of finance and a new improvement director role. Oversight of improvements across all areas is essential to ensure the workstreams work together to deliver benefits to patient care. Data quality issues form a key area to address from all recent reviews, with a clear lead and corporate process needed to manage improvement.

The internal investigation, Operation Bloom has required daily meetings of the chief executive and the executive team, as the urgent senior response to the initial incident. The chief executive is working to accelerate the Trust-wide improvement programme to urgently address all issues across the Trust, and the next chapter details the recommendations for the Trust to prioritise in improving cancer referral management, with support from additional senior management capacity and also local and national partners.

## 7. Recommendations to improve the management of cancer referral pathways

The following recommendations from the external review should build on the broader improvement work in place at the Trust to ensure the delivery of improvements to the management of cancer referral pathways.

The recommendations are based on the view that a “whole systems” approach is needed and that this is an opportunity to review the management of all cancer referral pathways.

### Recommendations for West Hertfordshire Hospitals NHS Trust

1. Stand down the immediate cancer waits incident management team and establish a steering group to oversee the implementation of the recommendations in this report and review other cancer pathways, applying best practice from the review of 2WW. The new steering group should report progress monthly to the chief executive/executive team and have CCG input to ensure wider system issues are addressed and to provide assurance for commissioning.
2. Create a new WHHT Cancer Plan:
  - Senior managers and clinicians need to work together to articulate a vision for cancer care as a whole, including each cancer care pathway. This could become a leading model for delivering district hospital cancer care.
  - Establish a clinically led governance structure to oversee and manage the delivery of cancer services with clear accountability through to Trust Board.
  - Identify a Data Quality lead and create a governance process to oversee data quality for the Trust.

The plan needs to include the following considerations:

- Deliver improvements to IT and communications infrastructure to support high quality care.
- Review all cancer management pathways as part of a whole system approach.
- Improve waiting/response times by increasing the “direct to test” element of the service to avoid unnecessary appointments and expedite investigations and diagnosis.
- Review the support structure and multi-disciplinary team organisation to improve team working.
- Share good practice between clinical departments/MDTs within the Trust.

## Culture and relationship building

3. Important work on strengthening relationships, understanding and trust is needed to improve the links and working between key clinical staff and the (OPD). Redesigning partnerships with medical staff is likely to be required. Job planning should be a specific focus to create flexibility and commitment to complete clinic outcome forms.
4. Staff need to be empowered to act upon poor practice and take responsibility for resolving concerns. This includes medical and nursing staff. Powerful patient stories and patient voices emerging from this incident must be shared to challenge culture and help with the cancer plan creation described above, working with patient groups wherever possible.
5. Appointments processes need to be improved, with a more patient focussed approach, so that cancer 2WW referrals are scheduled into appropriate appointment slots and arranged to suit the patient's needs, encouraging attendance as a result.

## Governance

The remaining recommendations for WHHT are about improved governance, including systems, processes and organisational arrangements:

6. Processes for developing, implementing and assuring adherence to policy:  
future policies will require better consultation and engagement to reinforce best practice. Standard operating procedures/individual action cards should be co-developed to support this.
7. Visibility of service outcome and performance data:  
the accountability of all staff for providing high quality services needs to be increased by making staff across MDTs aware of the performance of their services. Involve staff in the design of performance reports and provide regular opportunities to review these and act on them.
8. Skills:  
training in systems and processes relating to cancer patients, including national guidance and local Trust policy, needs addressing. All administrative staff in OPD need to be trained in all aspects of the booking pathway to increase flexibility, continuity and understanding. Continue the training started by the Intensive Support Team and ensure this is sustained and refreshed regularly.
9. Ownership of cancer pathways by the wider Trust including the Trust Board:  
the Cancer Team and cancer services in general need to be better integrated into the Trust organisational structure and arrangements (as well as OPD). This should be addressed and more ownership shared with clinical leads and divisional management for future peer review. Clear and visible Board lead responsibility is also required, and has been vested in the chief operating officer.

## Technical process recommendations

10. Handling referrals:  
review and improve the process within the Trust for noting receipt and tracking incoming 2WW cancer referrals. The continuing reliance on a paper-based log and email list is not sustainable. The Trust should also review with the CCG the potential for Choose & Book to be used widely in managing 2WW.
11. Booking Safeguards:  
although patients referred as 2WW on the PAS system have a code that distinguishes them with "C", the system will not prevent these referrals from being booked into routine, urgent or follow-up slots. It would seem sensible to engineer the PAS system (if possible) to prevent this, and/or to add a flag or warning to the system to alert the user when this operation is being performed. In addition to this, there should be better controls over who has permission and who has training to perform the relevant conversion of appointment slots on the PAS, to ensure that this is fit for purpose.
12. Data quality:  
a suite of reports to test compliance with booking policies and recording outcomes should be created and used regularly by senior managers, identifying barriers to compliance and regularly monitoring metrics in these areas, building on the recent work of the Intensive Support Team. The Board/sub-committees should request assurance on data quality regularly.
13. The Trust and local partners should move over to secure NHS email accounts to improve communication and information governance, eliminating the need to use facsimile communication.
14. IT systems:  
the use of parallel systems and lack of information sharing between Infoflex and PAS is a risk that should be addressed. Infoflex is slow, unreliable and should be re-examined in light of these issues above and the external and internal reviews. This is part of the Trust's IT business case.
15. The letter notifying GPs of a patient DNA should clearly state that the original referral was under the 2WW system; GPs read up to fifty pieces of correspondence daily and a routine notification is unlikely to require action, unlike a 2WW notice requiring follow up.
16. One 2WW clinic contact number should be accessible for patients and clinicians to allow the Trust to be updated in case the patient *or* clinician changes their mind about the appointment. Alternatively, a 24/7 cancellation line could be offered.
17. Changes to Choose and Book:  
enable direct access for GPs to make referrals to diagnostics on the 2WW pathways. The paperwork should include advice to keep people updated of decision changes and the value of these appointments.
18. Urgent non-cancer referrals and the management of DNAs in this context need to be considered too e.g. when patients are referred to the Rapid Access Chest Pain Clinic. Give the same attention to reviewing non-cancer urgent referral DNAs as cancer 2WW DNAs.

19. A standard response form at the hospital would improve consistency of information regarding the outcome of the referral. Faster responses would also be beneficial, as would clear guidance on response times to achieve.

### **Recommendations for commissioners: Herts Valley CCG**

20. To review the governance of the two week cancer pathway in primary care, including dental practices, and agree standards for all referring clinicians, including the use of Choose and Book.
21. Establish a patient and public participation forum for cancer services and work with it and the Beds and Herts Cancer Forum to strengthen public understanding about the importance of 2WW referrals and encourage patients to attend appointments.
22. Commissioners should ensure the implementation of actions arising from the recently initiated Beds and Herts Cancer Forum review of all cancer pathways between primary, secondary and tertiary care providers. They should also use the National Cancer Action Team toolkit and Commissioning Cancer Services report 2011 to inform commissioning of local cancer services.
23. Ensure CCG representation and input on the Trust's steering group overseeing delivery of the recommendations and new cancer plan, working with Beds and Herts Cancer Forum to ensure wider system issues are addressed and to provide assurance for commissioning.

### **Recommendations for regulatory bodies**

24. Regulatory bodies, the NHS TDA and NHS England should work together to obtain assurance that NHS trust systems and processes for monitoring cancer pathways are producing consistent and reliable data.
25. Leadership capacity and continuity to transform and improve services at the Trust should be a focus for development. The NHS TDA should continue to work with the Trust and partners to support senior level recruitment and strengthen the board.

## 8. Appendices

### 8.1. Terms of Reference

#### **Review of the management of the two week cancer Pathway at West Hertfordshire Hospitals NHS Trust**

##### **Introduction**

In November 2013, West Hertfordshire Hospitals NHS Trust identified that some patients were not being managed appropriately on the two week cancer pathway after referral from a General Practitioner. This came to light through a wider process of reviewing and improving the management of cancer pathways undertaken following the identification of concerns by the Trust and reviewed at a Risk Summit in May 2013. The terms of reference for this independent review are as follows:

##### **Purpose of the independent review**

- To identify the reasons behind the non-adherence to the national protocols for management of the cancer “two week wait” pathway” as identified by the West Hertfordshire Hospitals NHS Trust, in particular the root causes and the duration of time (and thus number of patients) affected;
- To identify the process by which decisions were taken to implement a process that did not comply with national policy and what governance processes were in place
- Provide assurance regarding compliance with other related elements of national cancer protocols in the Trust
- Recommend any additional actions the Trust should take to secure the management of the two week cancer pathway (and any other elements) so as to avoid a recurrence of the failure identified.
- To ensure the Trust’s improvement programme will address the underlying fundamental reasons for this breach in policy, providing additional recommendations for improvement as required

##### **Reporting of findings**

The report of the investigation will be to the head of quality NHS TDA (Midland and East), area director for Hertfordshire and South Midlands (NHS England), Trust Board of West Hertfordshire Hospitals NHS Trust, Chair of Herts Valleys CCG, and Bedfordshire and Hertfordshire Cancer network. The Trust will take the report through its internal governance process.

##### **Panel members**

The panel will be chaired by Stephen Ramsden  
Other panel members will be representatives of NHS TDA, HVCCG, NHS England, independent Clinical adviser and cancer management adviser

##### **Secretariat support and accommodation for the panel**

This will be provided by the Trust.

## 8.2 Biographies of external panel members

### **Dr April Brown, RGN, BSc, DHRes**

April is currently Head of Quality for the NHS TDA following a varied career in general nursing practice, the Department of Health, the National Patient Safety Agency and healthcare regulation. April was an assistant director at the National Patient Safety Agency during its infancy where she contributed to the Agency's requirement to develop partnerships with national and international organisations. April has been an assistant director of nursing at East and North Hertfordshire NHS Trust and has also worked as an area manager and assessor for the Healthcare Commission and the Care Quality Commission.

### **Mr Geoff Brown**

Geoff became Chief Executive of Healthwatch Hertfordshire in October 2012. He has a strong commitment to ensuring Healthwatch represents the voices of patients and service users and plays its role in helping to address health inequalities. His previous experience included running his own business - providing management services to public and third sector organisations, having previously undertaken a number of performance policy and customer service roles in the public sector. His particular expertise includes equalities, public involvement, performance improvement, and localism. Geoff also holds a number of voluntary sector positions and these include his role as the Chair of Crossroads Care, Hertfordshire North and being on the committee of his local Timebank.

### **Dr Fiona Moss, CBE, MD, FRCP**

Fiona trained in medicine in London and from 1991 and 2006 was a Consultant Respiratory Physician at Central Middlesex Hospital. During this time she was also Director of Clinical Studies (DCS) for Imperial College undergraduate medical students at Central Middlesex and chaired the Imperial College DCS committee. For three years from 1991 she was a consultant in quality improvement working with Trusts in North West Thames Health Authority. Fiona was founder editor of Quality and Safety in Health Care, a BMJ Publishing group journal (now BMJ Quality and Safety) and since 1994; she has been on the Strategic Advisory Group of the International (previously European) Forum on Quality and Safety in Health Care. Following her role as an Associate Postgraduate Dean for London and then a full time Postgraduate Dean, she was appointed to the role of Director of Medical and Dental Education Commissioning for London 2010-2013. In 2006 she was awarded a CBE for services to medicine.

### **Professor Kathy Pritchard-Jones, BMBCh, PhD, FRCPCH, FRCP (Edin), FMedSci**

Kathy joined UCLPartners in 2010 as Programme Director for Cancer and as Medical Director for the North Central London Cancer Provider network. In 2011, the latter role expanded and she was appointed Chief Medical Officer for *London Cancer*, the integrated system that provides cancer services to a population of nearly 3.5 million across north and east London and west Essex. She is responsible for leading a radical redesign of how 12 trusts work together and with patients, primary care, commissioners, public health and the voluntary sector, to drive step change improvements in

outcomes and experience for cancer patients, and to increase access to innovation and clinical trials. She has over 20 years' experience as a paediatric oncologist, with a specialist interest in childhood renal tumours and international expertise in running multinational clinical trials. She worked as a consultant paediatric oncologist at the Royal Marsden Hospital, Sutton, Surrey from 1994-2010 and led a research group in Wilms' tumour biology at the Institute of Cancer Research.

### **Stephen Ramsden, OBE**

Stephen was former Chief Executive of Luton and Dunstable Hospital NHS Foundation Trust from 1998 to 2010, and previously worked as Chief Executive of Mount Vernon Hospital NHS Trust (1991-94) and Mount Vernon and Watford Hospitals NHS Trust (1994-98). Stephen has had a career spanning 34 years in health services management in acute hospitals, serving as a Chief Executive Officer over the last 20 years. He is interested in transformational change, quality and service improvement and patient safety and was a member of the National Patient Safety Forum since its inception in 2007 to 2010. He was awarded an OBE in January 2008 for services to healthcare. In March 2008 he was appointed part time Patient Safety First Campaign Director, and chaired the Campaign Team for its two year lifespan. He became an independent consultant in April 2010, aiming to continue to help improve patient safety throughout the NHS and has worked with numerous NHS Trusts during this time. He became a Non-Executive Director and Deputy Chairman at Kettering Hospital NHS Foundation Trust in 2013.

### **Dr Nicolas Small**

Nicholas has been GP Chair of Herts Valleys CCG since April 2013. He trained at St Mary's Hospital London, spending significant time in Paediatrics, Obstetrics and Gynaecology and Psychiatry before joining the Northwick Park Hospital GP Training scheme in 1995. He has been a GP Partner at Schopwick Surgery, Elstree since 1996 and as the practice has a strong educational ethos, quickly became involved in GP education. He was the GP Appraisal lead for Hertfordshire until 2012 and is also a GP Trainer. Nicholas served on the Boards of Hertsmere PCT before Chairing Hertsmere's Commissioning Locality in 2006. He is also a member of Hertfordshire's Shadow Health and Wellbeing Board.

### **Fiona Wheeler**

Fiona has worked across the NHS for over 20 years mainly in the acute hospital sector. She has a background in management of cancer services and has participated in initiatives nationally and across London to improve cancer services. Fiona has been working as a freelance management consultant specialising in strategic and business development as well as a number of senior interim roles across London for the last six years.

### **Sarah Whiteman**

Sarah is the Medical Director for the NHS England Hertfordshire and South Midlands Area Team. She completed a short service commission in the RAF on qualification from the Royal Free Hospital School of Medicine in 1986. A GP by background, her portfolio career has included roles with the General Medical Council as a case examiner, Healthcare Commission and Parliamentary Health Services Ombudsman as an external reviewer, Health Education England as an associate

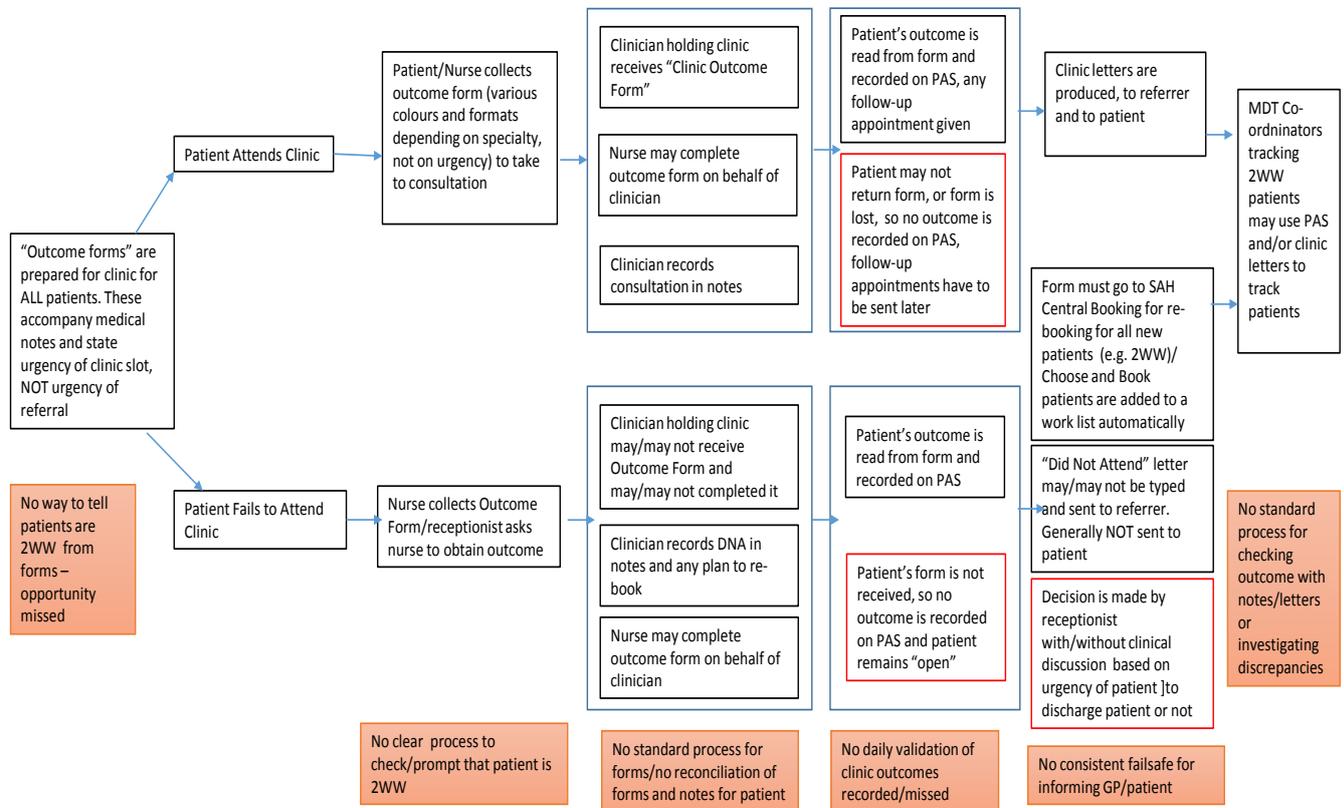
postgraduate dean, National Clinical Assessment Service as an adviser and the Royal College of General Practitioners as clinical lead for the medical educators group.

## **Charlotte Williams**

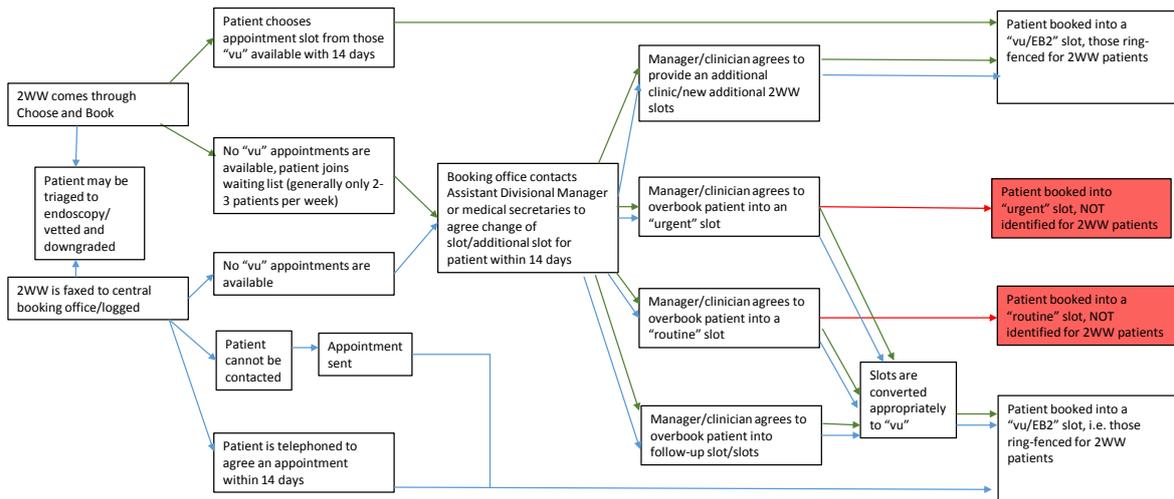
Charlotte Williams is Chief of Staff for UCLPartners. In this role she supports the development of UCLPartners to achieve its broader strategic aims: to secure an international profile for excellence in research, innovation and health improvement, as well as truly mobilising the translational pathway for the benefit of local people. Charlotte initially joined UCLP in 2010 as the Director for the Integrated Cancer Programme, becoming Executive Director of the *London Cancer* Integrated Cancer system in early 2013. Charlotte has held senior operational roles in hospitals for over 10 years, including at executive team level, in London, the east of England and the south east. She has significant experience of change in health services, acute commissioning and developing user engagement in design and planning.

## 8.3 Booking processes

Attachment 1 - Reported Processes in OPD Clinics in WHHT c.2008/9 to Autumn 2013



Attachment 2 - Process for booking new Two Week Wait (2WW) appointments at WHHT (c.2008-late 2013)



Those boxes shown in red indicate points in the booking where patients risk no longer being identified as 2WW patients to clinic administrative staff. Note that as patients referred through Choose and Book can only be booked into "EB" slots that are converted and made visible on the electronic system, it is not possible to book into less urgent clinical slots.