Enquiry visit to Beatson West of Scotland Cancer Centre

October 2015
Healthcare Improvement Scotland is committed to equality. We have assessed the review process for likely impact on equality protected characteristics as defined by age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation (Equality Act 2010). You can request a copy of the equality impact assessment report from the Healthcare Improvement Scotland Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net
# Contents

1. **Background and methodology**  
   4

2. **Recommendations**  
   10

3. **Summary of findings and conclusions**  
   12

4. **Management of acutely unwell patients**  
   15

5. **Referrals, procedures and clinical governance**  
   24

6. **Leadership and engagement**  
   31

Appendix 1 – **Timeline of key dates**  
   38

Appendix 2 – **Enquiry team**  
   45

Appendix 3 – **Assurance group**  
   46

Appendix 4 – **Glossary of abbreviations**  
   47
1 Background and methodology

1.1 Background

This report sets out the findings of a recent Healthcare Improvement Scotland enquiry visit to the Beatson West of Scotland Cancer Centre, hereafter referred to as the Beatson.

On 20 May 2015, 86 members of medical staff at the Beatson signed a letter to the General Medical Council (GMC)\(^1\), describing what they considered to be a number of potentially serious risks to patient safety at the Beatson. The signatories to the letter included clinical and medical oncologists and haematology consultants. The GMC passed the letter to Healthcare Improvement Scotland to consider and take action.

Concerns expressed in the letter to the GMC were categorised under the following broad headings:

- the lack of a high dependency unit (HDU) affecting ability to deliver level 2 (high dependency) care
- inappropriate anaesthetic cover, and
- compromised out of hours care.

It is acknowledged that the suitability for training of all grades of doctors in training in the Beatson is currently under scrutiny through the GMC’s enhanced monitoring process. Issues raised in the letter about medical trainee support and the training environment at the Beatson are within the scope of that separate ongoing process and not covered by this enquiry.

When concerns of this nature arise, Healthcare Improvement Scotland has a duty to make sure there is appropriate follow-up and that patient safety is not being compromised. On 28 July 2015, the enquiry team undertook an enquiry visit to assess the evidence base for the concerns raised, including the governance arrangements. The purpose of the visit was to establish the validity of the concerns that had been raised and the potential impact on, and implications for, the quality of care for patients. It is recognised that this was not a full scrutiny visit, but an assessment to hear the views of staff members working in this service. The team had further meetings during week commencing 10 August 2015 with key members of staff who were unable to attend the 28 July visit.

In preparation for the visit, the enquiry team considered additional contextual information provided by NHS Greater Glasgow and Clyde. This included information about the planning and reconfiguration of services at the Beatson due to the relocation of services from the Gartnavel General Hospital to the new Queen Elizabeth University Hospital in Glasgow.

1.2 Methodology

The purpose of the enquiry was to consider the concerns that had been expressed in the context of the arrangements put in place by the NHS board to ensure the safety and quality of care for patients in the Beatson.

Healthcare Improvement Scotland established an enquiry team which included external clinicians. Membership of the enquiry team is included at Appendix 2. The enquiry team used the following methodology as part of the enquiry:

---

\(^1\) The General Medical Council (GMC) is the organisation with statutory responsibility for the regulation of doctors ([http://www.gmc-uk.org/index.asp](http://www.gmc-uk.org/index.asp))
• analysis of the information provided by NHS Greater Glasgow and Clyde and members of staff, relating to the concerns raised (reviewing over 100 pieces of evidence)
• a visit by the enquiry team to the Beatson on 28 July 2015. This involved structured sessions with senior management and key staff and drop-in sessions for staff
• further meetings on 11 and 14 August 2015 with key members of staff who were unavailable on 28 July, and
• a confidential email mailbox for Beatson staff to share their experiences with the enquiry team.
In total, the enquiry team met with 58 members of staff as follows:
• senior management team (six members of staff)
• middle management team (seven members of staff)
• consultants (11 members of staff)
• junior doctors (17 members of staff)
• senior charge nurses/specialist nurses (six members of staff)
• critical care staff (five members of staff), and
• clinical team leads (six members of staff).

Healthcare Improvement Scotland also established an assurance group in early August 2015 to provide:
• a wider pool of expert advice to complement the knowledge and skills of the enquiry team
• appropriate professional scrutiny of the findings, and
• an external reference function to quality control the report and the final recommendations including the potential sources of support.

Membership of the assurance group is included at Appendix 3.

The enquiry team reviewed the evidence received and what was heard during discussions with staff. The team’s findings, conclusions and recommendations are presented in this report.

1.3 History of when and how concerns were raised

NHS Greater Glasgow and Clyde is currently undergoing a major reorganisation of its acute service provision. Hospitals from across the city have been moving services to the recently opened Queen Elizabeth University Hospital, which is on the site of the former Southern General Hospital in Glasgow. There was a series of phased service moves from the Victoria Infirmary, Western Infirmary and Gartnavel General Hospital from end April to end May 2015. The Royal Hospital for Sick Children also moved onto the Queen Elizabeth University Hospital campus in June 2015.

It is widely recognised that the redesign of NHS Greater Glasgow and Clyde’s acute services are amongst the most substantial and complex changes in hospital services within Europe.

The Beatson is one of the largest cancer centres in Europe providing regional specialist oncology and haematology-oncology services, predominantly to the West of Scotland population. It also provides a national specialist service for many cancer conditions. It opened in February 2008 on the Gartnavel General Hospital campus in Glasgow. The campus is just over three miles from the new hospital, the
Queen Elizabeth University Hospital, when using the Clyde river tunnel. Before 2008, cancer services had been spread across four hospitals (the Western Infirmary, Gartnavel General Hospital, Glasgow Royal Infirmary and Stobhill Hospital, Glasgow). The Beatson hosts a range of cancer services, including radiotherapy and chemotherapy as well as inpatient care. It is also an accredited clinical trial centre.

Over the past few years, the consultant body at the Beatson has raised concerns about the sustainability of some Beatson services, due to elements of the supporting clinical infrastructure moving from Gartnavel General Hospital to the new Queen Elizabeth University Hospital. They perceived that the move of services away from Gartnavel General Hospital would have a negative impact on their ability to provide safe and effective care for patients at the Beatson. Appendix 1 provides an outline of the key dates related to the issues raised.

In advance of the Beatson opening at the Gartnavel General Hospital site, Professor Alan Rodger, former medical director of the Beatson, produced a report in 2006\(^2\). The report highlighted a need to maintain key elements of acute support for the Beatson, and stated that the Beatson could not function without on-site surgical, medical and anaesthetic support.

The view of the Beatson consultant body about the proposed change in services provided at the Gartnavel General Hospital site, have been reiterated in a number of subsequent letters and reports. In September 2013, the consultant body wrote to the chief executive and medical director\(^3\) to raise their concern about the planning for the provision of services in light of the impending move to the new Queen Elizabeth University Hospital. In October 2013, a meeting was held between senior management and haematology, oncology and oncology representatives. The inquiry team was informed that this meeting was not formally minuted and that haematologists had raised concerns at the meeting about the uncertainty of the service reconfiguration and requested assurances from senior NHS Greater Glasgow and Clyde management that adequate support would be retained on the Gartnavel site.

At the request of Beatson consultants, a meeting was convened in January 2014 between cancer directorate management and team leads for surgery and anaesthetics. Anaesthetic staff stated that they would be unable to provide on-site continuous anaesthetic support due to staffing levels. It was agreed that three short-life working groups (SLWGs) would be established (covering medical, surgical and diagnostic services). The SLWGs would report into an overarching steering group. The SLWGs were established “in response to a need to establish and agree infrastructure support requirements for the Beatson West of Scotland Cancer Centre (BWoSCC) in light of the reconfiguration of medical, surgical and diagnostic services in the West of Scotland”\(^4\).

The aim of the SLWGs was to consider:

- the level of support that was required to maintain safe clinical services
- service models that could be developed to support this, and
- the development of protocols for patient transfer.

In June 2014, Beatson consultants wrote a letter to the chief executive and medical director expressing serious concern over the safety implications for Beatson cancer patients from the reconfiguration with loss of support services\(^5\). The letter highlighted that the SLWGs proposed in January 2014 had yet to

\(^2\) Clinical Support Services for the new West of Scotland Cancer Centre (2006)
\(^3\) Letter from consultant haematologists to the Chief Executive and Medical Director (September 2013)
\(^4\) Surgical Services SLWG final draft minute (30 September 2014)
\(^5\) Consultants letter to the Chief Executive and Medical Director (26 June 2014)
be convened. The letter also included a list of the services that the consultants considered essential to maintaining the cancer centre on the site.

In August 2014, the chief executive and medical director responded in a letter. The letter stated that the SLWGs would now be convened to develop standard operating procedures, and that the skills of Beatson staff would be assessed to ensure they could assess and, if necessary, transfer patients to the new hospital site. The letter confirmed that the recommendations from the SLWGs would go to the overarching steering group and would be discussed at the Beatson consultant meetings. The recommendations would then be submitted to the Clinical Executive Group for approval and onward to the Management Executive Group. The letter included an offer to meet with consultants at the end of September or early October 2014. The letter also stated that the critical care requirement for the Beatson was less than one bed per year.

On 15 September 2014, the consultants responded to the chief executive and medical director by letter. The letter stated that critical care requirement was higher than senior management had been informed and that it was not appropriate for Beatson staff to take on the role of critical care transfer. The letter also suggested that Royal Colleges should be invited as external reviewers of the service proposals to get an independent assessment of patient safety.

The three SLWGs (covering diagnostics, medical and surgical specialties) each met three times during autumn 2014 to discuss issues around surgery, medicine and radiology. The SLWGs were chaired by the then general manager for specialist oncology and clinical haematology. The enquiry team was informed that there was active participation in these groups from both medical staff and management. On 24 October 2014, a visit was undertaken to Mount Vernon Cancer Centre near London to learn about its approach to providing high dependency care on a stand-alone cancer site. The minutes of the November 2014 SLWG steering group reflected the visit’s findings that 24/7 anaesthetic cover was critical for four HDU beds, even though Mount Vernon was a much smaller cancer centre.

The steering group, chaired by the acting director of regional services, also met three times and had its final meeting on 17 December 2014 to consider the findings from each working group. The steering group agreed an action to produce and circulate a report to the wider group for comment. Consultants informed the enquiry team that the chair of the meeting (the acting director of regional services) had confirmed that an HDU facility would be retained on site following the Mount Vernon visit and that a final report would be compiled for sign-off by the medical director by the end of 2014.

A draft report was completed in February 2015, by the then acting director of regional services. The draft report concluded that:

“There is a requirement to provide a High Dependency Unit (HDU) to support the needs of the Beatson West of Scotland Centre. The preferred option is to retain a 4 bed HDU facility within Gartnavel General Hospital. This would also allow greater flexibility for service delivery overall to the Gartnavel General Hospital campus.
Alternatively, a High Dependency Unit could be developed specifically for Oncology and Haematology patients within one of the wards at the Beatson West of Scotland Cancer. This would require critical care led consultant management.”

However, the enquiry team heard that the February 2015 report was not widely shared with clinical staff. Consultants informed us that they made repeated requests for a copy of the report.

6 Chief Executive and Medical Director letter to consultants (4 August 2014)
7 Consultants letter to the Chief Executive and Medical Director (15 September 2014)
Consultants also told us that the then clinical director informed the March 2015 area medical committee meeting that the final report would be available soon and that most Beatson staff were “happy” with the plans.

On 17 April 2015, the consultant body was made aware of the final conclusions and recommendations contained in a different version of the report which was circulated to them (dated April 2015). The April 2015 report stated:

“It was generally agreed that the preferred model of escalated care would be to develop a model of Higher Acuity Care with a footprint within the existing bed complement of the BWOSCC, but with the defined up skilling of nursing and medical staff to support such a facility. There would also have to be described specialist anaesthetic/critical care input on a regular basis into such a unit. Such a unit would be owned by oncology/haematology and staffed from within.”

As part of this proposal, patients requiring a higher level of care than could be provided by the high acuity unit (HAU) would be transferred to the Queen Elizabeth University Hospital.

Consultants were concerned to discover that there would be no HDU, no anaesthetic cover and no plans in place for a cardiac arrest team, interventional radiology and hospital at night cover. They were also concerned that oncology trainees would become the resident on-call to cover the entire Gartnavel General Hospital site as the most senior doctor, even though many were insufficiently trained.

On 14 May 2015, senior management presented to medical staff the proposed plans to support the Beatson following the reorganisation of acute services in Glasgow. The presentation outlined plans for supporting deteriorating patients, hospital at night cover and arrangements for resuscitation, and that plans would take effect from 29 May 2015 when the new hospital opened.

On 20 May 2015, the consultant body escalated their concerns in a letter to the GMC. The letter highlighted the removal of the HDU beds and support (previously situated at Gartnavel General Hospital), the lack of anaesthetic care impacting on the ability to deliver level 2 care, and concerns about out of hours cover. The consultants felt that there was now a significant risk to the safety of the service and the level of patient care that they perceived they could deliver, particularly for acutely ill patients.

The GMC forwarded the letter to Healthcare Improvement Scotland on 21 May 2015. In response, Healthcare Improvement Scotland wrote to NHS Greater Glasgow and Clyde on 22 May 2015. We informed them that we would be undertaking an enquiry visit to understand if there were patient safety risks, and to look at plans put in place by the NHS board to address the concerns raised.

On 29 May 2015, the haemato-oncology team notified senior management that they could not continue to admit patients as the HDU would close later that day and there would be no safe cover in place. On the evening on 29 May 2015, the management team convened an urgent meeting with the haematology clinical director to discuss the issues and offered to meet with the haematologists on the Saturday if there was an immediate safety issue which meant that haematology could not function as normal in the

---

8 Consultant letter to the General Medical Council (20 May 2015)
9 Healthcare Improvement Scotland letter to NHS Greater Glasgow and Clyde Chief Executive (22 May 2015)
course of the following week. The haematologists indicated their agreement to work within the model the following week and a meeting was scheduled with them collectively for the morning of Monday 1 June 2015 to explore and understand their specific concerns.

The concerns of the consultant body working at the Beatson still persist at this time. While NHS Greater Glasgow and Clyde management team has put measures in place, these are viewed by the Beatson consultant body as provisional measures and insufficient to offer a sustainable answer to the concerns they have raised.
2 Recommendations

The enquiry team has identified the recommendations below for NHS Greater Glasgow and Clyde to take forward. It expects that these recommendations will be used by the NHS board to provide guidance and support for those working in the Beatson to help them deliver the necessary improvements.

The enquiry team expects NHS Greater Glasgow and Clyde to develop an action plan to implement the recommendations. It is important that the recommendations are carefully considered and a detailed improvement plan developed, with appropriate timescales, ownership, accountability and measures incorporated.

Recommendations

Management of acutely unwell patients

1. NHS Greater Glasgow and Clyde should urgently agree and implement a risk-assessed, safe and sustainable model for the recognition and management of acutely unwell patients with oncological and haemato-oncological conditions coming into the Beatson and Queen Elizabeth University Hospital.

The model of care should include the following.

- Include recognition that in most cases, the consultant in charge will be an oncologist, and that their job plan will support this.

- Ensure that all patients have an appropriate team around them to deliver regular and timely assessment and care. The team should be clear about the consultant in charge of each patient at any time. The team should also have mechanisms to consult with other clinical teams, including acute physicians or critical care, and transfer care when appropriate.

- Include a review of the current role and remit of the out of hours anaesthetic and critical care support, which will allow detailed and clear standard operating procedures (developed with anaesthesia and critical care colleagues) to ensure resuscitation, stabilisation and transfer of patients in a resource effective manner.

- Enable oncology staff to obtain support 24/7 for resolving or escalating problems, either through advice or by active management, regardless of whether the patient is at the Beatson or at the Queen Elizabeth University Hospital.

- Have detailed and clear standard operating procedures that ensure all relevant staff understand the patient pathways to ensure the right patient is being cared for in the right place. All referral routes for patients into the Beatson should take account of patient risk and acuity, with clear links to deteriorating patient pathways.

- Take into account the ongoing work concerning the Deanery recommendations to ensure appropriate training of junior doctors.
Referral, procedures and clinical governance

2. NHS Greater Glasgow and Clyde should put into place governance arrangements that regularly monitor the effectiveness of the implementation of the model of care (referred to in Recommendation 1). These arrangements should:

- include a clear and inclusive process to allow short, medium and longer term plans to be discussed and agreed by all key stakeholders across the Beatson and Queen Elizabeth University Hospital
- include the performance of newly developed standard operating procedures and guidance that support the agreed model of care for acutely unwell patients
- include appropriate measures to monitor the effectiveness and sustainability of the new model, and
- support a culture of openness and transparency to promote reporting, escalation, response and sharing learning from adverse events.

3. NHS Greater Glasgow should review its area clinical forum and supporting advisory structure to ensure appropriate engagement across its professional advisory committees using the guidance set out in Chief Executive Letter (CEL) 16 (2010)\(^\text{10}\) as a basis for this review.

Leadership and engagement

4. NHS Greater Glasgow and Clyde should take urgent action to restore and rebuild working relationships and respect between consultants at the Beatson and the NHS Greater Glasgow and Clyde management team.

\(^{10}\) Scottish Government letter to NHSScotland Chief Executive’s on 11 May 2010 concerning area clinical forums
3 Summary of findings and conclusions

This summary presents the findings and conclusions of the enquiry visit.

The enquiry team considered material provided by staff and NHS Greater Glasgow and Clyde and spoke with staff on the day of the visit (28 July 2015) and through subsequent meetings with key staff.

The enquiry team considered each of the concerns set out in paragraph 1.1. Based on the information that the team heard, these concerns have been broken down into the following areas within this report:

- management of acutely unwell patients
- referrals, procedures and clinical governance, and
- leadership and engagement.

3.1 Feedback

On the visit, the enquiry team heard positive feedback from staff on their experience of working at the Beatson, including the following.

- Nursing staff feel more empowered with the new HAU and reported a high quality service for patients with good availability of consultants.
- Consultants commended the quality of nursing care within the HAU.
- Nurses undertake practice development sessions on how to manage deteriorating patients.
- Constructive review meetings are held to discuss HAU issues on a patient by patient basis. The meetings include management representation, acute medical consultants, nursing staff and anaesthetists from Queen Elizabeth University Hospital.
- Staff are now more keen to undertake audits and to review the results.
- Patient feedback is extremely positive.

Staff that the enquiry team spoke with said they would be happy to recommend the Beatson for elective cancer treatment.

3.2 Conclusions

The enquiry team concluded that the changes around the Gartnavel General Hospital and Beatson campus were clearly high profile, complex and sensitive issues, within a major change process. The enquiry team is very aware of the multiple and sometime conflicting perspectives and interests that needed to be negotiated and reconciled. It heard about the work that NHS Greater Glasgow and Clyde had undertaken to seek to provide a resolution to these issues.

The enquiry team was also aware that this was not a minor issue within a complex and difficult change programme. The reconfiguration of services and the consequential implications for the major cancer centre in Scotland required careful consideration and intense engagement with all interested stakeholders. The enquiry team noted the close and continued attention of the NHS Greater Glasgow and Clyde area medical committee and the hospital sub-committee in this particular matter since 2013.

The enquiry team concluded that due to the factors detailed in this report, the current arrangements for managing acutely unwell patients at the Beatson pose an unacceptable risk to the quality of care for patients. Immediate action is required by NHS Greater Glasgow and Clyde, through the
implementation of the recommendations set out in section 2 of this report, to ensure a risk-assessed, safe and sustainable model of care for these patients.

Listed below are the enquiry team’s conclusions for each section of the report. The detailed findings which led to these conclusions are provided in sections 4, 5 and 6 of the report.

Management of acutely unwell patients

High acuity unit, high dependency unit and intensive care unit

- The enquiry team concluded that the new HAU was a positive and welcome development at the Beatson (see 4.1.6 for a definition of a high acuity care). There was good evidence of the impact that the unit was having in the effective management of unwell patients, but also in providing outreach support to wards in respect of the care of deteriorating patients. However, the enquiry team noted some negative effects of the HAU, including the increasing pressures on doctors in training working in ward B5. The team also noted that the HAU is operating at level 1 and is dependent on other elements working effectively, such as standard operating procedures, specialty support, the confidence of medical staff, availability of junior staff and seamless, rapid patient transfers. The HAU needs to be seen as part of an integrated system of care.

- The enquiry team also concluded that there is current ambiguity and confusion over who is responsible for patients. All relevant staff need to be clear about who is in charge of each patient and the arrangements for escalating clinical issues.

Anaesthetic arrangements

- The enquiry team concluded that the current arrangement of 24/7 anaesthetic cover is not economically sustainable in the long term. Anaesthetics and critical care medicine are increasingly separate and distinct specialties, but share core skills necessary for initial resuscitation and stabilisation of patients. The oncologists are unclear about the different role of anaesthetic and critical care colleagues. This needs to be clarified, defined and understood. Critical care and anaesthetics need to agree joint working that makes best use of effective skills.

Acute Oncology Assessment Unit

- The enquiry team concluded that there was a lack of an active, clear and systematic approach to the consultant-led management of acutely unwell patients at the Beatson. This was reflected in the confidence of the consultant oncologists to manage acutely unwell patients. The enquiry team heard concerns that this was resulting in unacceptable delays in the length of time for consultant assessment of unwell patients. There is also a perception of insufficient time for consultants to be actively engaged in ward-based issues or to contribute to ensuring the continuity of care for patients transferred to the Queen Elizabeth University Hospital.

Referrals, procedures and clinical governance

Referrals and transfer process and protocols

- The enquiry team concluded that there was a need for stronger staff engagement and communication in the design and the dissemination of the standard operating procedures. It is important that the standard operating procedures have sufficient detail and clarity around each step in the pathway, and there is a shared understanding of the respective contributions each individual or service makes in supporting the smooth management and, if necessary, transfer of patients.
Support from medical, surgical and diagnostic services

- The enquiry team concluded there is a need to ensure that the Beatson is owned and valued by all elements of NHS Greater Glasgow and Clyde as a critical element of an integrated system of care. This should include appropriate and timely clinical support to patients at the Beatson and specialist oncology support to patients at the Queen Elizabeth University Hospital.

Clinical governance

- The enquiry team concluded that there was a lack of a reliable system to escalate concerns and risks highlighted by clinicians and a lack of confidence among staff that concerns would be addressed. There was also a lack of feedback to staff on the outcomes from adverse events, including learning points.

Leadership and engagement

Relationship management and clinical engagement

- The enquiry team concluded there has been a serious breakdown in relationships between the consultant body at the Beatson and NHS Greater Glasgow and Clyde management.

Developing the proposals

- The enquiry team concluded that NHS Greater Glasgow and Clyde did not fulfil its original commitment regarding the process for the development, formal sharing and agreement on the final report and conclusions from the SLWGs ahead of circulation of the report on 17 April 2015.

Communicating the proposals

- The enquiry team concluded that the final proposals were communicated very late in the process and there was a breakdown in relationships in the handling of the final proposals and the associated communication of changes.
4 Management of acutely unwell patients

4.1 High acuity unit, high dependency unit and intensive care unit

Background

4.1.1 Before the reconfiguration of services, the Beatson depended on services provided outwith the cancer centre. Clinicians had access to acute medical and surgical services at Gartnavel General Hospital which is located on the same site as the Beatson. This included access to what was perceived as an “HDU” at Gartnavel General Hospital.

4.1.2 The reconfiguration of services within NHS Greater Glasgow and Clyde resulted in the “HDU” at Gartnavel General Hospital being closed and new facilities opened at the Queen Elizabeth University Hospital. Consultants highlighted concerns in their original correspondence that not having an HDU on site would put patients at clinical risk. Consultants believed that this has been deemed unacceptable in all other cancer centres in the UK. Consultants stressed that without this level of support, patients receiving intensive or curative therapy will need to be moved to another site. They highlighted that the efficiency of chemotherapy treatments and potential to achieve a cure are compromised by interruptions to the treatment regimens (which can result when patients are transferred out of the Beatson). Consultants stressed the need to have immediate access to practitioners with appropriate skills for assessment and management of acutely ill or deteriorating patients.

4.1.3 The senior management team (the NHS board senior management and Beatson senior management) informed us that the “HDU” previously at Gartnavel General Hospital was part of an “open” model of care. An open model is where patients are admitted and managed under the care of a consultant oncologist with escalation, if required, to intensive care. When necessary, patients were transferred to the Western Infirmary which was two miles away. Critical care staff informed us that the HDU was not a fully recognised HDU as it was staffed by junior doctors and did not include consistent regular attendance from specialty consultants.

4.1.4 The senior management team reported that there were four critical care sessions per week on average at Gartnavel HDU and that the HDU bed requirement was very low (approximately one bed per year). However, consultant oncologists informed the enquiry team that they felt that the critical care requirement is higher than senior management had been informed.

4.1.5 The new model introduced at the Beatson on 29 May 2015 features a “closed” model of care. A closed model features someone taking responsibility for patients while they are in the unit with input, if required, from specialty consultants. This new model features a resident junior doctor, critical care nurses and escalation if required to the intensive care unit (ICU) at the Queen Elizabeth University Hospital. The senior management team emphasised the significant improvements arising from having HDU and ICU co-located at the new hospital.
4.1.6 Table 1 below outlines the differences between level 1, level 2 and level 3 care for patients.

**Table 1: Definitions of the levels of care**

<table>
<thead>
<tr>
<th>Level 1 (High acuity care)</th>
<th>Level 2 (High dependency care)</th>
<th>Level 3 (Intensive care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care whose needs can be met on an acute ward with additional advice and support from the critical care team.</td>
<td>Patients requiring more detailed observations or interventions including support for a single failing organ system of post-operative care, and those stepping down from a high level of care.</td>
<td>Patients requiring advanced respiratory support alone, or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.</td>
</tr>
</tbody>
</table>

4.1.7 In place of HDU care, the new model includes a four bed HAU located within ward B5 at the Beatson.

4.1.8 Table 2 below shows the old model of care compared to the current arrangement that has been in place since 29 May 2015.

**Table 2: Old model of care compared to the new model**

<table>
<thead>
<tr>
<th>Before the changes</th>
<th>Current position</th>
</tr>
</thead>
<tbody>
<tr>
<td>An open “HDU” model (also known as level 2 care). This involves limited cover from specialty consultants with patients transferred from Gartnavel General Hospital HDU to the Western Infirmary intensive care unit if they required more intensive (level 3) care.</td>
<td>An HAU providing what is known as level 1 care with four beds and offering outreach nursing support to wards. HDU (level 2 care) is now provided at the larger facility situated at the new Queen Elizabeth University Hospital.</td>
</tr>
</tbody>
</table>

4.1.9 The HAU is run by a Band 7 team lead, with one oncology nurse and one critical care nurse. Staff from critical care are seconded to the HAU on a 6-month rotation basis. The senior management team reported that ward rounds are undertaken at least once a day, supported by junior doctors and nursing staff. The enquiry team was also informed that staff speak with colleagues at the Queen Elizabeth University Hospital by phone about management plans and patient care. If the patient deteriorates, they discuss possible transfer. The enquiry team noted that staff have agreed regular consultation with critical care colleagues at the Queen Elizabeth University Hospital to discuss any patient causing clinical concern. These discussions and consultations are facilitated by a contingent of outreach critical care nurses, on rotation to the HAU, who provide regular input to all wards at the Beatson to support staff to recognise deteriorating patients.

4.1.10 Patients requiring more than level 1 care are transferred to the Queen Elizabeth University Hospital. The NHS board reported that it has developed a service which allows rapid retrieval and transfer of appropriate patients to the HDU and ICU facilities at the new hospital, whenever appropriate. This includes a referral pathway to critical care. The enquiry team was informed that all patients who are transferred have their case retrospectively reviewed through

---

the Board’s governance processes, to ensure their care has been appropriate. An HAU clinical governance sub-committee has been established to monitor this new model.

4.1.11 Some consultant oncologists the enquiry team spoke with reported a lack of training in early recognition and response to deteriorating patients. Under the previous model, these skills were provided by supporting medical staff at Gartnavel General Hospital. Senior management informed us that work is being undertaken through the Scottish Patient Safety Programme (SPSP)\(^{12}\) to improve early recognition and response for the deteriorating patient. A pilot is currently being undertaken on ward B5 to support this early recognition. NHS Greater Glasgow and Clyde informed us that it expects all relevant clinical staff at the Beatson will be appropriately trained in recognising and managing the deteriorating patient.

4.1.12 Staff in the unit use the National Early Warning Score (NEWS) system to support clinical assessment. However, it is recognised that any early warning scoring system does not detect every signal of deterioration in a patient’s condition.

**Staff perception of the HAU**

4.1.13 Management staff informed the enquiry team that the introduction of the HAU had been welcomed by the majority of staff. Some reported that the new model is an improvement as the previous arrangements could involve two transfers of the patient in some cases (to “HDU” at Gartnavel General Hospital and then to ICU at the Western Infirmary.) There is a dedicated critical care nurse and oncology nurse per shift. Other services are accessed either by telephone or through clinicians from the Queen Elizabeth University Hospital visiting the Beatson. The critical care nursing post has now been advertised on a 6-month secondment basis and interest in the post has been high. The critical care nurses currently providing the immediate cover have applied for the post which is a good reflection of how well the unit is working.

4.1.14 Critical care staff also view the HAU as a positive introduction and believe the rotas featuring one critical care nurse and one oncology nurse are working well. Even with the outreach programme and the work this involves, critical care staff consider staffing levels to be appropriate for the size of the unit and the workload. The outreach nurse has undertaken 160 visits since the unit opened on 29 May 2015 and this has proved successful. The enquiry team was informed that historically 40–50 patients would have been transferred out of the Beatson each year to either the HDU at Gartnavel General Hospital or the ICU at the Western Infirmary, with 8–10 ICU transfers. The critical care team has contact with the critical care team in the Queen Elizabeth University Hospital and access to a consultant anaesthetist around the clock. Critical care staff noted that whilst there is a desire from some staff at the Beatson to have an HDU on site, the volume of patient numbers does not support the establishment of an HDU or ICU.

4.1.15 Critical care staff informed us that the Faculty of Intensive Care Medicine and the Intensive Care Society had issued guidance in 2015. The guidance: “Guidelines for the Provision of Intensive Care Services (2015)” recommends against having an HDU without an ICU on the same site. There is concern among critical care physicians that the number of patients at the Beatson currently requiring critical care is not sufficient for a stand-alone HDU. However, there is also a recognition and understanding that the number of patients requiring critical care is likely to increase.

\(^{12}\) The Scottish Patient Safety Programme is a national initiative that aims to improve the safety and reliability of healthcare and reduce harm, whenever care is delivered.
4.1.16 The enquiry team noted that whilst 40–50 transfers off the Beatson site each year is the expectation, the initial experience within the HAU suggests that the actual number is going to be higher. Data reported to the HAU clinical governance committee showed 29 patients being transferred in the three months, June to August 2015, of whom 19 were transferred to critical care and 10 to other specialties. Consultants noted that with future oncological treatments associated with higher critical care needs, this figure is likely to increase again.

4.1.17 Nursing staff welcomed the work undertaken in the HAU and agreed that the model is supporting the identification of sick patients. However, they noted that a level 2 HDU would be preferable. They believe that the removal of the HDU service has had a detrimental effect on the care that can be offered to patients. They noted that patients are being transferred unnecessarily to the Queen Elizabeth University Hospital “just in case” and it would be a better service if there was still an HDU facility.

4.1.18 Oncology nursing staff expressed appreciation for the support they have received from critical care nurses and the benefit of this support in recognising deteriorating patients. They highlighted that where a patient is not suitable for the HAU, the critical care nurses still offer advice and support, and this is particularly appreciated by nightshift nurses on other wards. Nursing staff noted the positive impact of the unit on patients who would previously have been kept in high dependency support for longer. There were some concerns raised about the visibility of medical staff. Nursing staff highlighted that the HAU room was set up at short notice and that the junior doctor rota had not been amended in time to reflect their additional HAU duties.

4.1.19 Medical staff were also supportive of the introduction of the HAU and stated that the unit has taken some of the pressures off nursing staff. However, they raised concerns about how patients were being moved off site in a way that did not happen before, and provided examples of this to the enquiry team. There was a perception that patients would have been previously managed at Gartnavel General Hospital and that the threshold for sending patients off site is now much lower.

4.1.20 The enquiry team heard from consultants that the majority of them support the HAU and see it as a positive model for delivering level 1 care. They stated that the HAU is well managed with highly qualified nursing staff. However, having no HDU facilities at Gartnavel General Hospital poses a significant concern for consultants we spoke with. They stated that patients are being transferred off site “just in case” and this is impacting on their treatment regimen and the continuity of their cancer treatment. Also, there is no dedicated oncology expertise at the Queen Elizabeth University Hospital, so there is a lack of specialist support at that site for the patient or their family. The enquiry team noted this would have an impact on the continuity of care due to the HAU dealing with patients with less complex needs compared to the former “HDU” model.

4.1.21 The oncology consultants voiced concern about the lack of a clear, practical and agreed plan for who stabilises deteriorating patients and transfers them off site to the new hospital. They informed us that the out of hours foundation doctors have done less critical care work and are not skilled enough at a practical level – critical care, acute physicians and outreach teams are required.

4.1.22 The HAU is still relatively new and staff are working to raise awareness of the service it provides across the Beatson site. Criteria have been developed to support ward staff in recognising patients who would benefit from being transferred to the HAU. The critical care nurse for the HAU also provides an outreach service to the rest of the Beatson and undertakes
ward visits where suitable patients are identified at an early stage and transferred to the unit. The enquiry team noted that as the HAU becomes busier, one critical care nurse for the unit may not be sustainable. The enquiry team understands that a further registered nurse is currently being recruited. The outreach service also means that the oncology nurse is left in charge of the HAU at times. This has been a challenge as the oncology nurses are not yet fully confident in managing critical care. A safety brief has been introduced as a handover for nurses so that they are aware of any concerns or treatment required before the critical care nurse leaves the unit.

Skills, training and support

4.1.23 Critical care staff recognised that the new model has highlighted a need for clarity in nursing staff roles and informed us of a competency-based programme of work being taken forward. The enquiry team was informed that the skill mix and competencies of the critical care nurse and oncology nurse are different, and a package has been put in place to develop the skills of both sets of nurses. The enquiry team noted that while this had presented some challenges in terms of the confidence of each nurse in treating the patient, the sharing of knowledge and the opportunity to learn new skills is welcomed by staff.

4.1.24 Nursing staff noted that early detection of the deteriorating patient is crucial and spoke of training and support being provided to develop their skills in this area (linked with the SPSP deteriorating patient work). They stated that training in NEWS is also being rolled out and further sessions are planned for medical and nursing staff. The HAU team constantly reviews any transfers off site to ensure the referral has been appropriate.

4.1.25 Management highlighted the changes required to on-call consultant cover and job plans, and the impact on both middle grade and junior doctor workloads since the HAU was introduced on ward B5. Patients within the HAU have always been within the Beatson so while the unit does not bring in new patients (which had been a perception among some staff), it now means that the more seriously unwell patients are located in one place within the Beatson. This has its benefits in terms of having one safe and appropriate environment. However, it means the workload within ward B5 is greater than any other ward in the centre, and doctors in training suggested that resources have not been redistributed within the Beatson to reflect this.

4.1.26 Doctors in training assigned to ward B5 informed us they had to undertake HAU duties on top of their normal ward B5 duties (particularly for patients who require more support and treatment). They felt that this increase in their workload has not been recognised by management. An example was given that within 2 weeks there had been at least two incidences of junior doctors in distress on ward B5 due to the pressures.

4.1.27 Doctors in training also shared difficulties about the escalation of a patient they were concerned about. While they were aware of the escalation process, they experienced practical difficulties in working out who was on call, who to refer patients to and the number to contact, as there was no comprehensive, up-to-date list.

4.1.28 They stated that the lack of the HDU provision at the Gartnavel General Hospital site alongside the loss of specialty support was a concern. They also perceived ambiguity and confusion about who is looking after patients and who is responsible for their care and treatment. In this regard, they reported a lack of medical and clinical leadership. They explained that when the HAU was opened, they were under the impression there would be a regular ward round undertaken with teleconferencing to the Queen Elizabeth University Hospital. However, this has not happened.
The enquiry team concluded that the new HAU was a positive and welcome development at the Beatson. There was good evidence of the impact that the unit was having in the effective management of unwell patients, but also in providing outreach support to wards in respect of the care of deteriorating patients. However, the enquiry team noted some negative effects of the HAU, including the increasing pressures on doctors in training working in ward B5. The team also noted that the HAU is operating at level 1 and is dependent on other elements working effectively, such as standard operating procedures, specialty support, the confidence of medical staff, availability of junior staff and seamless, rapid patient transfers. The HAU needs to be seen as part of an integrated system of care.

The enquiry team also concluded that there is current ambiguity and confusion over who is responsible for patients. All relevant staff need to be clear about who is in charge of each patient and the arrangements for escalating clinical issues.

4.2 **Anaesthetic arrangements**

4.2.1 Before the reconfiguration of services, anaesthetic support was provided to the Beatson as part of the Gartnavel General Hospital model.

4.2.2 The visit to the Mount Vernon Cancer Centre in October 2014 provided an example of a model of care which provided 24/7 on-site anaesthetic cover. The minutes of the November 2014 SLWG steering group reflected the visit findings that 24/7 anaesthetic cover was critical for four HDU beds, even though Mount Vernon was a much smaller cancer centre.

4.2.3 Management informed the enquiry team that they received commitment from medical and surgical staff to always have someone with advanced life support training available to manage patient airways. However, consultants had concerns that not all clinicians would have up-to-date and appropriate advanced life support experience so an alternative solution had to be arranged. As part of the new model, anaesthetic support is available 24/7. A designated anaesthetist is available on site in hours and a resident “on-call” anaesthetist is available out of hours and at weekends.

4.2.4 Staff experience of the anaesthetic support varied greatly. The consultants we spoke with described an uncertainty about the on-call anaesthetist arrangements and what support they provide for on-site resident staff. Doctors in training reported an “informal” arrangement for out of hours anaesthetic cover.

4.2.5 The enquiry team heard that staff do not understand the distinction between the role of the anaesthetist and that of the critical care intensivist.

4.2.6 Critical care staff informed us that oncologists were not sufficiently engaged in understanding the differences between critical care and anaesthetics, which has caused some difficulty in defining the needs for the service at the Beatson.

4.2.7 Nursing staff noted concern in relation to anaesthetists being on site and suggested that the Beatson should not be looking after very unwell patients due to the lack of anaesthetist cover. Previously, patients would have been stabilised in the HDU at Gartnavel General Hospital before being transferred to the Western Infirmary. It was acknowledged that under the current model, patients need to be much more stable at the Beatson before they can be transferred to the Queen Elizabeth University Hospital.
4.2.8 The majority of doctors in training said they had not seen an anaesthetist on site. Medical staff (consultants and doctors in training) reported that they are aware that the anaesthetist is located in a nearby hotel during the out of hours period. However, they would only contact them if they have a critically unwell patient. In their view, the ongoing liaison and dialogue that existed in the previous arrangements had been lost. They also noted that the previous system meant an anaesthetist would have been on the ward within minutes to support transfer. Critical care staff highlighted an anaesthetist was not always readily available under the old model as they may have been in theatre. Under the new system, the decision whether to accompany a patient to the Queen Elizabeth University Hospital or wait for critical care retrieval, will be made on an individual basis dependent on clinical need.

4.2.9 Senior management informed the enquiry team that the on-call anaesthetist is there to provide airway support, and not critical care. However, this has not been clearly communicated to relevant staff. The critical care team staff noted that the role and responsibilities of the anaesthetist (both on site and off site) need to be defined and communicated to make sure everyone is clear on this.

4.2.10 The consultant group raised concern over the long-term sustainability of the locum anaesthetic arrangements that have been put in place, and the cost that this is incurring (approximately £1,500 per shift). Critical care staff informed us that the instances of patient requiring intubation is rare.

The enquiry team concluded that the current arrangement of 24/7 anaesthetic cover is not economically sustainable in the long term. Anaesthetics and critical care medicine are increasingly separate and distinct specialties, but share core skills necessary for initial resuscitation and stabilisation of patients. The oncologists are unclear about the different role of anaesthetic and critical care colleagues. This needs to be clarified, defined and understood. Critical care and anaesthetics need to agree joint working that makes best use of effective skills.

4.3 Acute Oncology Assessment Unit

4.3.1 The Acute Oncology Assessment Unit was established in October 2013 supported by a telephone service for patients who feel unwell or need advice outwith their appointment schedule. The telephone line is open from 8am-8pm and patients can call the nurse practitioner led service 7 days a week. Staff triage the patient and the patient is either given advice, invited to come into the centre, or told to go to their GP or A&E department. The unit sees an average of eight patients each day. During out of hours, patients are redirected to NHS 24 for advice and support. If treatment is required, patients would go to A&E or their GP out of hours service.

4.3.2 The enquiry team heard from NHS Greater Glasgow and Clyde management team that there had been resistance from the oncologists to the way the proposed service had been set up. Whilst oncologists were supportive of the model medical staff were concerned that acutely unwell patients would be coming to the centre and they would not have the skills to treat all their conditions. The management team informed the enquiry team that data showed that the Beatson delivered a safe service and that patients coming into the centre were not unstable or requiring acute medical support. The enquiry team heard that patient experience data demonstrate that patients are happy with the service and that the model is working well.

4.3.3 Consultant staff informed the enquiry team of concerns about the management of acutely unwell patients that may present at the Acute Oncology Assessment Unit. They explained that
their training and skills set are not kept up to date for acute oncology and they are not always confident to manage acutely ill patients. It was emphasised that the Acute Oncology Assessment Unit works well for managing patients whose symptoms are oncology related. However, there is an increased risk of bringing acutely ill patients to the Beatson without the supporting clinical infrastructure that previously existed at Gartnavel General Hospital.

4.3.4 The enquiry team heard from doctors in training that the opening of the Acute Oncology Assessment Unit was a good step and the nursing care within the unit was excellent.

4.3.5 The senior management team informed us that there are daily ward rounds (at least one a day) supported by doctors in training and nursing staff. Medical staff informed us that management had agreed to review job plans, to provide additional time to implement the new model, including ward rounds. However, consultants informed the enquiry team that there was insufficient time in their job plans for ward rounds and for managing acute oncology patients. Consultants also highlighted that there was insufficient time in their job plans to visit wards at the Queen Elizabeth University Hospital. Given that the Beatson acts as a hub site, with consultants practising in other areas of Scotland, they are not at the Beatson every day to provide medical cover and to undertake ward rounds. Consultants also referred to the lack of time available to teach and support doctors in training.

4.3.6 The enquiry team heard of ambiguity about the management and co-ordination of patients once they are admitted. This was reflected in delays and confusion in the management of the more acutely unwell patients as there is no defined arrangement once a patient is admitted to a ward. We were told that there were occasions where an acutely unwell admitted patient may not be seen by a consultant for over 4 days. Management informed us that consultants are expected to be able to supervise the care and drug treatment and should review inpatients within a reasonable period of time.

4.3.7 There is no consistent approach to scheduling consultant ward rounds. Some teams have just one scheduled ward round each week while other teams do not undertake any scheduled ward rounds. The lack of a structured approach can lead to delays for patients if the ward round does not happen or if the patient is not seen. The informal approach is also reflected in confusion in the handover of patients and the management of patients between consultants.

The enquiry team concluded that there was a lack of an active, clear and systematic approach to the consultant-led management of acutely unwell patients at the Beatson. This was reflected in the confidence of the consultant oncologists to manage acutely unwell patients. The enquiry team heard concerns that this was resulting in unacceptable delays in the length of time for consultant assessment of unwell patients. There is also a perception of insufficient time for consultants to be actively engaged in ward-based issues or to contribute to ensuring the continuity of care for patients transferred to the Queen Elizabeth University Hospital.
Management of acutely unwell patients recommendations

1. NHS Greater Glasgow and Clyde should urgently agree and implement a risk-assessed, safe and sustainable model for the recognition and management of acutely unwell patients with oncological and haemato-oncological conditions coming into the Beatson and Queen Elizabeth University Hospital.

The model of care should include the following.

- Include recognition that in most cases, the consultant in charge will be an oncologist, and that their job plan will support this.

- Ensure that all patients have an appropriate team around them to deliver regular and timely assessment and care. The team should be clear about the consultant in charge of each patient at any time. The team should also have mechanisms to consult with other clinical teams, including acute physicians or critical care, and transfer care when appropriate.

- Include a review of the current role and remit of the out of hours anaesthetic and critical care support, which will allow detailed and clear standard operating procedures (developed with anaesthesia and critical care colleagues) to ensure resuscitation, stabilisation and transfer of patients in a resource effective manner.

- Enable oncology staff to obtain support 24/7 for resolving or escalating problems, either through advice or by active management, regardless of whether the patient is at the Beatson or at the Queen Elizabeth University Hospital.

- Have detailed and clear standard operating procedures that ensure all relevant staff understand the patient pathways to ensure the right patient is being cared for in the right place. All referral routes for patients into the Beatson should take account of patient risk and acuity, with clear links to deteriorating patient pathways.

- Take into account the ongoing work concerning the Deanery recommendations to ensure appropriate training of junior doctors.
5 Referrals, procedures and clinical governance

5.1 Referrals and transfers process and protocols

5.1.1 One of the aims of the SLWGs was to consider processes, protocols and standard operating procedures to support patient transfers to other sites and specialities.

5.1.2 The senior management team stated that pathways and protocols have been developed for advice, and, if required, for the transfer of patients. Standard operating procedures have been specifically developed for critical care, medical and surgical input. The enquiry team was informed that there is a robust process with multidisciplinary review of patient care before any transfer. Protocols are also in place for the care of patients during out of hours and who to contact.

5.1.3 Doctors in training described confusion in relation to the protocols and procedures for referral and transfer. They informed the enquiry team that there was poor dissemination of the protocols which made the transfer process difficult and time consuming. They described particular concerns about the escalation policy. They stated that they had told the consultant body and management that the process was not working, but there had been no change.

5.1.4 Consultants and doctors in training indicated that standard operating procedures for referral and transfer needed to be developed in collaboration with staff to clearly define medical and surgical cover and input, including up-to-date contact details. It was highlighted that switchboard staff at the Queen Elizabeth University Hospital also need this information. Plans for transferring a patient are dependent on who is on call at the time and staff shared examples of cases where the time to transfer took up to 9 hours. The more junior doctors in training also spoke of their frustration in trying to speak to middle grade colleagues for input or advice and noted that consultant to consultant conversations appeared to work better. They also stated that there is an informal process for managing a patient once they are admitted to a ward at the Beatson and there is no clear ownership of their care, and no apparent formal handover between consultants.

5.1.5 It was noted that all transfers are reviewed, and delays in transfer are also being looked at to understand any issues. Successful transfer relies on discussion between the Beatson team and the receiving consultant. Challenges in the process have been identified and improvements are being made. For example, the role of the ambulance service in the transfer process has been considered. The HAU team met with the ambulance service to share with them how the unit works, and to discuss how they could improve the process.

5.1.6 Consultants raised similar issues with the ambulance service about confusion and difficulties with patient transfers and gave an example of a 12-hour wait for transfer on one occasion. Consultants also stated that more patients are being transferred than they would like “just in case” so that they are put in a “place of safety”. They emphasised the impact of this on the continuity of the patient’s cancer treatment as there is no specialist oncology presence located at the Queen Elizabeth University Hospital.

5.1.7 Consultants highlighted their considerable dissatisfaction with the level of engagement with them in the design and implementation of standard operating procedures for referral and transfer and for surgical and medical support. They provided an example of standard operating procedures for medical and surgical escalation which they perceived were developed in isolation. The enquiry team was informed that the standard operating procedures were
developed by the then clinical director and circulated to team leads. The consultant body was not involved.

5.1.8 The standard operating procedures were circulated on 11 May 2015 for discussion at the meeting on 14 May 2015. The enquiry team heard from junior doctors that they believed no one was checking whether the new standard operating procedures for liaising with critical care and anaesthetics were actually working in practice.

5.1.9 The review team saw evidence of a letter sent from the chair of the Beatson consultants’ committee (on behalf of consultants) to senior management dated 16 September 2014\textsuperscript{13}. The letter stated:

“We wish to challenge the validity of a process by which the Directorate and Board Clinical Governance Committees have reviewed and endorsed the standard operating procedure (SOP) document relating to Acute Oncology Assessment Unit and management of patients by on-call consultants. This document was circulated initially by the Beatson Clinical Director in October 2013 and has since then been referred to in emails and other documents as though it is an agreed policy document. The SOP describes working practices involving consultants on-call and those not on-call, with implications for clinical duties and hours of work required. None of this has been formally agreed with the consultant body and the additional hours worked have not been included in job plans.”

5.1.10 The letter highlighted that many consultants were physically unable to deliver the care described in this standard operating procedure (due to their commitments to other areas of Scotland) and it places patients and consultants in a position of clinical risk. The letter also expressed major concern that the clinical governance committees had approved the standard operating procedures without support and agreement from the consultant body.

The enquiry team concluded that there was a need for stronger staff engagement and communication in the design and the dissemination of standard operating procedures. It is important that the standard operating procedures have sufficient detail and clarity around each step in the pathway, and there is a shared understanding of the respective contributions each individual or service makes in supporting the smooth management and, if necessary, transfer of patients.

5.2 Support from medical, surgical and diagnostic services

5.2.1 The enquiry team heard about the move of a range of services, such as respiratory medicine, from Gartnavel General Hospital to the Queen Elizabeth University Hospital.

5.2.2 Consultants and doctors in training highlighted difficulties in getting specialist advice and support from other services such as cardiology, respiratory, neurology and acute medicine. They provided an example of it taking a week to access a cardiologist for a patient who was already admitted to the Beatson (patients receiving chemotherapy can be at risk of cardiac complication). They provided another example of a 2-week wait for an echocardiogram (a heart ultrasound) for a patient with suspected endocarditis.

5.2.3 Doctors in training highlighted an example of waiting 7 days for a respiratory opinion on a patient. Senior nurses also indicated difficulties and delays in getting a respiratory physician to review patients. Senior management informed the enquiry team that the Queen Elizabeth University Hospital has recently recruited a clinical fellow who will have responsibility for

\textsuperscript{13} Letter from Chair of the consultants’ committee to senior management (16 September 2014)
Beatson respiratory from September 2015. The doctors in training highlighted problems in accessing blood facilities and gave examples of blood samples going missing and delays of up to 7 hours overnight and at weekends to get investigation results back.

5.2.4 Before the reconfiguration of services, a radiographer was on call overnight from home and X-rays were readily available at Gartnavel General Hospital during out of hours. Since the reconfiguration, consultants and doctors in training have experienced difficulties in accessing a radiographer and obtaining X-rays outwith day-time rotas. During the out of hours period, they rely on a radiographer from the Queen Elizabeth University Hospital to travel to the Beatson to do X-rays which can lead to delays. The delays outwith day-time rotas could lead to an unacceptable risk to the quality of patient care.

5.2.5 NHS Greater Glasgow and Clyde management acknowledged that they did not often see specialty staff from other hospitals on site within the HAU. However, they were confident that if staff required support they would get it.

5.2.6 The enquiry team noted that access to specialty support outlined within the standard operating procedure is not matched by the actual experience of staff seeking this support.

The enquiry team concluded there is a need to ensure that the Beatson is owned and valued by all elements of NHS Greater Glasgow and Clyde as a critical element of an integrated system of care. This should include appropriate and timely clinical support to patients at the Beatson and specialist oncology support to patients at the Queen Elizabeth University Hospital.

5.3 Clinical governance

5.3.1 Figure 1 below outlines the clinical governance structure for the regional services directorate (which includes the Beatson) within NHS Greater Glasgow and Clyde. This depicts how the clinical governance forum for each service is expected to feed into the directorate clinical governance forum, acute clinical governance forum and upwards to the Board clinical governance forum.
5.3.2 NHS Greater Glasgow and Clyde has a medical advisory system that includes an area medical committee which is attended by the chief executive, medical director and clinical director. There is also a hospital sub-committee attended by the chief officer for acute services and the lead director for acute medical services. The enquiry team noted that the director for regional services and the clinical director had attended the hospital sub-committee of the area medical committee.

5.3.3 The senior management team informed the enquiry team that they had been developing the infrastructure to support the moves to the new hospital. This included regular clinical governance meetings, area medical committee meetings and Beatson consultant meetings, all focusing specifically on patient care.

5.3.4 The enquiry team were informed that the reconfiguration of acute services and implications for the Beatson remained a recurrent item on the agendas of the hospital sub-committee, area medical committee and Beatson consultant meetings.

5.3.5 The enquiry team heard that the area medical committee reports into the area clinical forum and provides very brief points to include on the area clinical forum meeting agenda, as well as other advisory committees. The chair and vice chair of the area medical committee are members of the area clinical forum. However, on review of the area clinical forum minutes between February 2013 and June 2015 (a total of 14 meetings), the area medical committee chair attended two meeting in 2013, no meeting in 2014 and none to date in 2015 (a new chair started in May 2015). Through review of these minutes it does not appear that the concerns relating to the Beatson have been formally raised or discussed within the area clinical forum and therefore onto the NHS Greater Glasgow and Clyde Board through this route. The Scottish Government letter to NHSScotland chief executives on 11 May 2010 (CEL 16
Risk and adverse events reporting

5.3.6 NHS Greater Glasgow and Clyde management reported that there are well-defined governance arrangements with a healthy culture of reporting risks and issues. This includes the reporting and review of adverse events. They were unaware of any themes as yet that would suggest significant issues with the recent set up of the HAU.

5.3.7 The enquiry team saw evidence of the HAU clinical governance sub-committee meeting held on 23 June 2015 which had considered the care of recent patients and highlighted points of learning and improvement. Clinical team leads informed us that these meetings were very constructive as they included relevant nurses, oncologists, acute medical consultants and anaesthetists from the Queen Elizabeth University Hospital.

5.3.8 NHS Greater Glasgow and Clyde has a policy for the management of adverse events which requires staff to record adverse events on an electronic risk management system called Datix. Consultants, medical staff and doctors in training at the Beatson informed us that they have recorded adverse events on Datix, but do not normally receive a response or feedback on the outcome. They reported a lack of faith in the system and, as a result, believe that some staff do not report adverse events through the system.

5.3.9 Consultants told us that morbidity and mortality meetings are held routinely and featured discussions on patient deaths and adverse events, some of which had not been reported on Datix. The enquiry team acknowledge that separate reporting of this nature is not unique to the Beatson and that further work across NHS Scotland is ongoing to ensure appropriate linkages to these improvement processes.

5.3.10 We heard of one example of an adverse event reported in January 2015 where the person reporting the event was later told by a manager that they should not have recorded the event as it had upset staff and it was inappropriate to report. The enquiry team saw evidence that the adverse event had been reviewed by appropriate staff. However, the person reporting the event did not feel they had the opportunity to feed into the review conclusion. There also appeared to be insufficient focus on identifying the learning from the adverse event and sharing this with staff. We heard that there have been other instances of adverse events where there has been a lack of feedback and engagement with operational staff to help shape the outcomes, learning points and required improvements following adverse events.

5.3.11 NHS Greater Glasgow and Clyde management reported that there is a relatively high reporting rate into Datix at the Beatson. They acknowledge that further improvement is required for ensuring feedback from reported incidents. The enquiry team was informed that NHS Greater Glasgow and Clyde will shortly be updating Datix to a version which includes an automatic feedback to the reporter of the event once the learning section has been completed. The enquiry team welcomes this action and asks that further consideration should be made to the implementation of the Healthcare Improvement Scotland guidance document: Learning from adverse events through reporting and review (April 2015).

---

14 Scottish Government letter to NHSScotland Chief Executive's on 11 May 2010 concerning area clinical forums
Clinical trials

5.3.12 Clinical trials are of significant importance to the Beatson as a leading research centre both nationally and internationally. The Beatson recruits 800–1,000 patients each year into clinical trials and has a reputation for conducting early phase clinical trials.

5.3.13 Before the reconfiguration of services, the consultant body raised concerns about the Beatson’s ability to undertake clinical trials. They noted that the Beatson might not be able to undertake Phase 1 trials without the availability of an HDU or ICU. Consultants were concerned about how the Beatson could function as a major cancer centre if it could not undertake Phase 1 trials.

5.3.14 In response, the chief executive wrote to explain that there are research facilities at the Queen Elizabeth University Hospital and Glasgow Royal Infirmary and that discussion is ongoing to develop a safe trial environment at the Beatson. The consultants suggested that split site research would have a negative impact on the ability to undertake early phase trials and this was not a viable solution.

5.3.15 The enquiry team asked the senior management team during the visit about the impact of the new model on clinical trials. Senior management informed us that there was academic involvement in the SLWGs to help ensure there was no detrimental effect.

5.3.16 The medical staff we spoke with said that they had sought advice on undertaking clinical trials and that the current configuration is considered adequate. However, going forward it will depend on the sustainability of the service. If the ability to resuscitate and provide critical care changes then there would be implications on the ability to undertake trials.

5.3.17 Management informed us that confirmation has been received from the West of Scotland research governance board that there is no issue with continuing to provide phase 1 trials as long as there is an HAU on site. The enquiry team noted there would be benefit in the management team communicating this to staff to provide assurance.

"The enquiry team concluded that the impact on the ability to undertake clinical trials at the Beatson should be considered in the development of any future models of care."

Referrals, procedures and clinical governance recommendations

2. NHS Greater Glasgow and Clyde should put into place governance arrangements that regularly monitor the effectiveness of the implementation of the model of care (referred to in Recommendation 1). These arrangements should:

- include a clear and inclusive process to allow short, medium and longer term plans to be discussed and agreed by all key stakeholders across the Beatson and Queen Elizabeth University Hospital
• include the performance of newly developed standard operating procedures and guidance that support the agreed model of care for acutely unwell patients

• include appropriate measures to monitor the effectiveness and sustainability of the new model, and

• support a culture of openness and transparency to promote reporting, escalation, response and sharing learning from adverse events.

3. NHS Greater Glasgow should review its area clinical forum and supporting advisory structure to ensure appropriate engagement across its professional advisory committees using the guidance set out in Chief Executive Letter (CEL) 16 (2010)\textsuperscript{15} as a basis for this review.

\textsuperscript{15} Scottish Government letter to NHSScotland Chief Executive's on 11 May 2010 concerning area clinical forums
6 Leadership and engagement

6.1 Background

6.1.1 The enquiry team received a large amount of information on the interaction between NHS Greater Glasgow and Clyde management and the consultant oncologists at the Beatson.

6.1.2 In September 2013, the consultant body wrote to the chief executive and medical director to raise concerns about the planning for the provision of services in light of the impending move to the new Queen Elizabeth University Hospital. In October 2013, a meeting was held to discuss these concerns and it was agreed that the arrangements for support services would be reviewed. Consultants told us that they were assured at this meeting that support requirements would be prioritised.

6.1.3 In January 2014, the consultants met with the Beatson management team and it was agreed that three SLWGs would be established to consider medical, surgical and diagnostic services. The working groups would report into an overarching steering group. NHS Greater Glasgow and Clyde reported that various groups were set up to support transformational change and the links between the Beatson and the new Queen Elizabeth University Hospital. These included an executive group, a clinical executive group and a working group called ‘On the move’.

6.1.4 The 4 August 2014 letter from the chief executive and medical director to all Beatson consultants indicated the line of accountability and governance for the work of the SLWGs:

“The recommendations from the work of the SLWGs and the Steering Group will be discussed at the BWSCC [Beatson] consultants meetings and will go to the Clinical Executive Group (CEG) for approval and then to the Management Executive Group (MEG).”

6.2 Developing the proposals

6.2.1 When the SLWGs were established, a clear governance structure was set up as described in the terms of reference and in the letter from the chief executive to the consultant body dated 4 August 2014. Figure 2 below outlines the governance structure for the SLWGs.

Figure 2: Governance structure for the SLWGs

![Governance structure for the SLWGs diagram](image-url)

(each SLWG chaired by the acting director of regional services)
6.2.2 The SLWGs each met three times between September and December 2014. The steering group also met on three occasions, with their final meeting held on 17 December 2014. The original expectation was that the report of the steering group would be ready by the end of December 2014. The enquiry team was provided with minutes of the SLWGs and the steering group.

6.2.3 During the enquiry visit, staff informed us that they were generally aware of the SLWGs. However, concern was expressed that the groups did not communicate sufficiently or effectively with other staff. This point was accentuated by the absence of communications between the conclusion of the SLWGs work in December 2014 and the communication of final proposals to staff in the presentation on 14 May 2015.

6.2.4 It was clear to the enquiry team that mixed, ambiguous and sometimes conflicting messages were emerging from the separate SLWGs. Consultants informed us that there had been uncertainty over the past 2 years around what services were moving as part of the hospital reconfiguration. The enquiry team noted that there had been considerable fluidity about the timing and moving of certain services to the new hospital. This uncertainty remained in the latter half of 2014 (such as in information reflected in the risk register). The enquiry team noted that one of the minutes of the steering group referred to HDU provision not moving from the Gartnavel General Hospital site until the end of 2015. This was also reflected in the discussions through the SLWGs.

6.2.5 The minute of the surgical services SLWG (28 October 2014) stated: “Current working options are for a small number of dedicated HDU beds located in the BWOSCC [Beatson]...or a larger HDU facility is developed in the same area.” Similarly the minute of the same SLWG (25 November 2014) cited work to “suggest a 4 bedded area located somewhere within the BWOSCC [Beatson]...it was likely that a Level 2 HDU will be suggested in the paper.” While the minute of the earlier SLWG for medical specialties (22 September 2014) noted that the “plan for GGH [Gartnavel General Hospital] was not to have HDU facilities on site. There was no deviation from the original ASR [acute services review] planning assumptions.”

6.2.6 Based on these minutes, it was evident to the enquiry team that there was some confusion about the planned reconfiguration of services on the Gartnavel General Hospital site and within the Beatson, or at least the parameters for the negotiation of further changes to the configuration.

6.2.7 The August 2014 risk register for specialist oncology and clinical haematology further highlighted the unsettled position for some services. The risk register had a risk rating for the provision of HDU provision on the Gartnavel General Hospital site as at the highest rating (25/25). The register stated: “Further clarity required from CEO [chief executive officer] regarding the plans for GGH [Gartnavel General Hospital] campus post 2015.”

6.2.8 A key element of the SLWG process was the visit to the Mount Vernon Cancer Centre to learn about its approach to providing high dependency care on a stand-alone cancer site. The

---

16 Infrastructure steering group minutes (17 December 2014)
17 Minutes of the SLWG for Surgical Services (28 October 2014)
18 Minutes of the SLWG for Surgical Services (25 November 2014)
19 Minutes of the SLWG for Medical Specialties (22 September 2014)
20 Risk Register for Specialist Oncology and Clinical Haematology Services (August 2014)
21 Mount Vernon is a cancer centre covering a population of 2 million patients in Middlesex. It has 47 in-patient beds and two high dependency unit beds.
outcome of the visit identified the importance, in the minds of the consultant body, of the need to retain the presence of high dependency care. The consultants indicated that they were reassured that the evidence from the visit to the Mount Vernon Cancer Centre would mean that the Beatson would have the same level of service as Mount Vernon. In turn, this encouraged them to believe that they would have continuing access to an HDU at the Beatson.

6.2.9 The enquiry team heard that there had been discussions between NHS Greater Glasgow and Clyde management with anaesthetics and critical care around the emergent conclusions from the SLWGs during the first half of 2015. These discussions focused on the appropriateness and viability of anaesthetic and critical care support to the Beatson.

6.2.10 NHS Greater Glasgow and Clyde explained that from an anaesthetic standpoint, there was a view that alternative care arrangements could be safely introduced to support airway management without resorting to round-the-clock anaesthetic support. From a critical care viewpoint, the intensive care clinicians took the view that the former “HDU” at Gartnavel General Hospital was not a formally recognised HDU (in terms of its clinical input) and, moreover, that there was not a perceived need for HDU presence at the Beatson. However, it was acknowledged that there would be patients that would require early detection and transfer to the Queen Elizabeth University Hospital for HDU level care, underpinned by effective standard operating procedures.

6.2.11 NHS Greater Glasgow and Clyde said that they had also discussed an acute physician model to support the consultants at the Beatson. They highlighted that this would have required extra investment, which they were ready to fund. However, the NHS board indicated that this model had been rejected as the Beatson consultants were concerned about the lack of continuity of care and expertise to support acutely unwell patients during out of hours when acute physicians were not on site.

6.2.12 In reviewing the approach to the development of the proposals, the enquiry team noted the apparent absence of the SLWGs and the steering group in the design of final proposals between December 2014 (the conclusion of the SLWGs) and 17 April 2015 (the sharing of the report with consultants).

6.3 The final proposals

6.3.1 The enquiry team was provided with a copy of the steering group report (dated February 2015) and a further version of the report (dated April 2015) setting out the final proposals.

6.3.2 The essential difference between the February and April versions of the report was that the February version recommended the retention of HDU beds. The April version presented an alternative model without such beds and offered a different level of care at the Beatson.

6.3.3 NHS Greater Glasgow and Clyde confirmed that the February 2015 version of the report was not shared with clinical staff at the Beatson. The April 2015 report was circulated to the consultants on 17 April 2015.

6.3.4 The appearance of a report in April 2015, that had not been subject to the governance process agreed and shared at the start of the exercise, resulted in a serious and fundamental breakdown in the relationship between the consultants at the Beatson and NHS Greater Glasgow and Clyde management.
6.3.5 The enquiry team concluded that there was a clear and reasonable expectation that the findings of the SLWGs would be used to inform the drafting of a final report by the steering group. As the report was to be issued in the name of the steering group, it would also have been anticipated and expected that all members of the steering group would have had an opportunity to carefully consider, discuss, contribute to drafting and collectively agree a final report. The enquiry team envisaged that the steering group members would have wished to ensure that not only the conclusions and recommendations reflected a shared position, but equally that the process at arriving at these recommendations was open, transparent and inclusive.

6.3.6 It was evident to the enquiry team that there was a material disconnect between the work and the conclusions reached by the SLWGs and the final report. There was also deviation from the process set out in the letter of 4 August 2014 to all the Beatson consultants.

6.3.7 The enquiry team does not under estimate the complexity and difficulty of the issues identified in this enquiry, nor the need for careful and sensitive negotiation between all parties in reconciling different views. Indeed, the enquiry team commended the work of the SLWGs and the sharing of ideas and perspectives over the latter half of 2014. However, the nature of the issues and the apparent growing breakdown in relationships ahead of the establishment of the SLWG review process, reinforced the need for open and transparent communications, as well as positive and honest engagement throughout the deliberation of the SLWGs and in reaching final conclusions. It was clear that this did not happen.

6.3.8 The enquiry team noted that warnings had already been issued ahead of the release of the report about the referral to the GMC if concerns by consultant staff at the Beatson were not heard or heeded. For NHS Greater Glasgow and Clyde this may have been perceived as negotiating positions being expressed during a difficult set of discussions rather than real threats of escalation. But whatever way, the letter to the GMC did herald a very steep decline in relations between the consultant body and NHS Greater Glasgow and Clyde management.

The enquiry team concluded that NHS Greater Glasgow and Clyde did not fulfil its original commitment regarding the process for the development, formal sharing and agreement on the final report and conclusions by the SLWGs ahead of circulation of the report on 17 April 2015.

6.4 Communicating the final proposals

6.4.1 The steering group report was circulated to all consultant staff at the Beatson on 17 April 2015. Between the conclusion of the work of the SLWGs in December 2014 and the production of the final and circulated report, there were repeated requests by consultant oncologists for the report to be shared.

6.4.2 The enquiry team was informed that proposals presented by the NHS Greater Glasgow and Clyde management at a meeting for staff on 14 May 2015 entailed:

- maintaining anaesthetic support
- developing the HAU, and
- developing an escalation policy and procedures for deteriorating patients.

22 Hospital Sub-Committee minutes (3 September 2013) and Area Medical Committee minutes (19 September 2014)
6.4.3 The recommendations for the future were presented by NHS Greater Glasgow and Clyde management to the consultants at the Beatson at the 14 May 2015 meeting. The consultants told us that the proposal was presented by way of what they described as a “lecture” and they had to insist on the senior management team having a discussion with them about the changes. Consultants told us that senior managers appeared surprised about the concerns that were aired in the meeting.

6.4.4 Moreover, the consultants also had significant concerns that the proposals did not take into account the findings of the SLWGs or the list of requirements for a safe service that they had developed in June 2014. The enquiry team heard that the consultant oncologists considered that the proposed new model of care would not enable them to deliver a consistently safe and quality service which they had in place before the changes.

6.4.5 The consultants therefore expressed concern that they did not find out about the new model’s operational detail (which did not include a HDU) until 2 weeks before it was due to be operational. Doctors in training also informed the enquiry team that they were not engaged on the proposed new model. Anaesthetic staff present at the 14 May 2015 meeting informed us that they hadn’t heard or agreed to any of the proposals before the meeting. The enquiry team also heard that some critical care staff had been unaware of the proposals until after the consultants had written to the GMC.

6.4.6 The management team acknowledged that the debate regarding the provision of high dependency had become what they described as a “binary” argument between the critical care staff making it clear that an HDU was not viable or necessary at the Beatson, and the Beatson oncologists’ view that the retention of a HDU was an essential component.

6.4.7 NHS Greater Glasgow and Clyde subsequently changed its plans to provide anaesthetic support through the deployment of middle grade anaesthetic staff. It was acknowledged that this did not have the support of the Deanery so it was withdrawn.

6.4.8 A key element of the changes proposed was hospital at night and out of hours cover. The enquiry team was told that none of the middle grade doctors found out about the proposed hospital at night cover directly from managers – they all heard about it indirectly. Consultants told us that it was very late on in the planning when doctors in training were included in the hospital at night team. When staff asked management whether the Deanery would be comfortable with this proposal, management responded that the Deanery approved the plans for anaesthetic middle grade cover at night. However, this turned out not to be the case. The Deanery rejected this proposal following discussion with NHS Greater Glasgow and Clyde management a week before supporting services moved from Gartnavel General Hospital to the new hospital. The GMC agreed with the Deanery decision.

The enquiry team concluded that the final proposals were communicated very late in the process and there was a breakdown in relationships in the handling of the final proposals and the associated communication of changes.
6.5 Relationship management and clinical engagement

6.5.1 It was clear to the enquiry team that there had been a serious fracture in the relationships between the consultant body and the former clinical director in particular and senior managers more generally. The enquiry team saw and heard evidence of deep mistrust, poor communications and an adversarial relationship between NHS Greater Glasgow and Clyde management and the oncologists at the Beatson.

6.5.2 The enquiry team heard that the former clinical director had decided, in April 2013, to stop meeting with the Beatson consultants committee as he had, in his view, been “mis-represented and vilified” by the committee. Subsequently, the method of engagement and dialogue between the consultants – as a body at the Beatson - had been reduced to formal letters and emails from the clinical director. On the other hand, the consultants highlighted in their view that there were similar concerns they had about the behaviour of NHS Greater Glasgow and Clyde management.

6.5.3 Similarly, doctors in training told us that communication between senior management and consultants was very poor. Medical trainees also highlighted poor communication with frontline staff. For instance, the enquiry team was told that staff were given a week to set up the HAU. Consultants informed us that senior managers would resort to what they described as ‘emotional blackmail’ to coerce them into accepting planned changes.

6.5.4 Consultants indicated that they believed senior managers did not fully understand what support clinicians were required to offer for acutely unwell patients and were being forced to adopt the new model of care at the Beatson. Consultants also highlighted a believed misperception among senior managers that all oncology consultants were acute physicians and skilled in managing acutely unwell patients. For consultant staff, whilst very welcome, the IMPACT course reinforced a perception that a short training course would be considered sufficient to refresh out-of-date clinical skills to support the care of the most acutely unwell patients.

6.5.5 Management indicated that they felt that they had a fair and reasonable view that consultant oncologists trained to MRCP level should be capable and confident to manage the most common presenting emergencies in oncology and more generally in medicine. They further advised that as consultants were teaching and supporting junior and middle grade staff within their duties, such a level of competence was expected. The enquiry team, however, acknowledged that simply holding an MRCP should not imply competence to manage a scope of practice in which they will not be revalidated, appraised or undertake any professional development in, for example, the management of acute cardiac events, renal failure or diabetes. The enquiry team noted the need for all clinical staff to recognise deteriorating patients and that appropriate practical, safe and timely support should be available.

6.5.6 The consultants expressed concern that they believed that middle management would misrepresent or block issues and concerns they wanted to raise with senior management. Consultants highlighted the lack of proactive planning of services and the tendency to react to current issues even though concerns had been raised a number of years ago. Consultants were perplexed that management had not recognised their concerns about patient safety and the lack of involvement in any planning process. For example, medical staff and consultants told the enquiry team that they had no input into the development of the new standard operating procedures.
Consultants informed the enquiry team that some meetings are not formally minuted or the level of detail within notes does not always reflect the exchange of views, decisions and actions of the discussions taking place. The enquiry team saw evidence of an email from consultants to middle managers expressing concern that views expressed by consultants in the 27 May 2015 meeting to discuss the new model, had not been reflected in the meeting notes. Whilst an attempt had been made to provide a balanced note to reflect all of the discussions that had taken place, the final note of the meeting did not reflect all the consultants’ contributions or views.

The enquiry team did not seek to determine which party was, on balance, the most culpable. The overall impression, however, was that there had been a serious and detrimental breakdown in relations between NHS Greater Glasgow and Clyde and the consultants at the Beatson.

The enquiry team concluded there has been a serious and fundamental breakdown in relationships between the consultant body at the Beatson and NHS Greater Glasgow and Clyde management.

**Leadership and engagement recommendation**

4. NHS Greater Glasgow and Clyde should take urgent action to restore and rebuild working relationships and respect between consultants at the Beatson and the NHS Greater Glasgow and Clyde management team.
## Appendix 1 – Timeline of key dates

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>Report by Alan Rodger (medical director at the time)</td>
<td>Document prepared by the then medical director. This was before the move of the cancer centre from its site at the Western Infirmary to the Gartnavel General Hospital site. The purpose of the report was to identify what services would be necessary for the Beatson going forward.</td>
</tr>
<tr>
<td>3 September 2013</td>
<td>Hospital sub-committee meeting</td>
<td>The chair referred to the intention to transfer the bone marrow transplant service to the new hospital. The lead director for acute medical services detailed the sound clinical reasons for this transfer, including immediate access to intensive care if required, and pointed out that the consultants who delivered this service supported the transfer.</td>
</tr>
<tr>
<td>October 2013</td>
<td>Acute Oncology Assessment Unit opens</td>
<td>Haematologists raise concerns about the uncertainty over the service reconfiguration and requested assurances from senior management that adequate support would be retained on the Gartnavel site. This meeting was attended by senior management, haematology and oncology representatives. The meeting was not formally minuted.</td>
</tr>
<tr>
<td>29 October 2013</td>
<td>Meeting between the chief executive, medical director and haematologists</td>
<td>Letter raises concern that there were no formal minutes from the 29 October 2013 meeting and referring to an email from the medical director on 12 November 2013 setting out the discussion points from the meeting. The letter expressed concern that the recorded discussion points were factually inaccurate and did not reflect clinicians’ concerns about the closure of medical beds, loss of the HDU and loss of specialty support which would clinically compromise the Beatson.</td>
</tr>
<tr>
<td>12 November 2013</td>
<td>Email from medical director to clinicians about the 29 October meeting</td>
<td></td>
</tr>
<tr>
<td>19 November 2013</td>
<td>Haematologists letter to the chief executive and medical director</td>
<td>At the request of Beatson consultants, a meeting was convened between directorate management and leads for surgery and anaesthetics. Anaesthetic staff suggested they would be unable to provide on-site continuous anaesthetic support due to staffing levels. The outcome of this meeting was that final details of the service reconfiguration were still to be agreed and the NHS board would set up short-life working groups to address the need for service support. The three SLWGs would also develop standard operating procedures.</td>
</tr>
<tr>
<td>15 January 2014</td>
<td>Meeting between consultants and the directorate management</td>
<td>Consultants write to the chief executive and medical director</td>
</tr>
</tbody>
</table>
services essential to maintaining the cancer centre on the site. The list included:
- an HDU facility
- resuscitation and a rapid transfer team
- acute medical and surgical access
- radiology and laboratory services, and
- clinical trials (which require an HDU).

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2014</td>
<td>NHS Greater Glasgow and Clyde proposes the removal of the bone marrow transplant unit from Gartnavel General Hospital site as it would fail accreditation due to the lack of support services available following the reconfiguration in 2015.</td>
</tr>
<tr>
<td>4 August 2014</td>
<td>Chief executive and medical director response letter to consultants The letter acknowledges that progress had not been as fast as consultants would have wished. The letter stated that SLWGs would now be convened; medical and radiology specialties would draw up standard operating procedures and that the skills of Beatson staff will be assessed to ensure they can transfer patients to the new hospital site. The letter also stated that the critical care requirement for the Beatson was less than one bed per year. The recommendations from the SLWGs will go to the overarching steering group and will be discussed at the Beatson consultant meetings. The recommendations will then go to the Clinical Executive Group for approval and onward to the Management Executive Group. The letter also included an offer to meet with consultants end September or early October 2014.</td>
</tr>
<tr>
<td>15 September 2014</td>
<td>Consultants letter to the chief executive and medical director Beatson staff responded pointing out that critical care requirement is higher than senior management have been informed and that it is not appropriate for Beatson staff to take on the role of critical care transfer. The letter also suggested that the Royal Colleges be invited as external reviewers of the service proposals for the Beatson to get an independent assessment of patient safety.</td>
</tr>
<tr>
<td>19 September 2014</td>
<td>Area medical committee The minutes refer to concerns raised by the consultants in their 15 September 2014 letter and note that the three SLWGs were in the process of being set up and that the groups “will work with the Beatson staff to give answers to their concerns.” The minutes also noted that a member of staff had raised a concern about the apparent disconnect between the clinical director and the clinicians.</td>
</tr>
<tr>
<td>22 September to 25 November 2014</td>
<td>Short-life working group meetings The three SLWGs (covering diagnostics, medical specialties and surgical specialties) each meet three times to discuss issues around surgery, medicine and radiology. There was active participation in these groups from medical staff and management.</td>
</tr>
<tr>
<td>24 October 2014</td>
<td>Visit to Mount Vernon Cancer Centre A visit was undertaken to Mount Vernon Cancer Centre near London to see how they functioned. They had two dedicated HDU beds housed in the male ward. These beds have consultant anaesthetist input in core hours and specialist</td>
</tr>
</tbody>
</table>
4 November 2014  Steering group meeting  SLWG steering group discusses feedback from the Mount Vernon Cancer Centre visit and the updates from the working groups:
- Medical – improvement highlighted including senior input required for acutely unwell patients, semi acute input where opinion is required, and ownership required for those patients from neighbouring NHS boards who are receiving treatment at the Beatson.
- Surgical – main discussion is the HDU provision.
- Diagnostic – brief update provided.

17 December 2014  Steering group meeting  The final steering group met with an action to produce and circulate a report to the wider group for comment. The chair of the meeting confirmed that the HDU facility would be retained on site following the Mount Vernon visit and that a final report would be compiled for sign-off by the medical director before the end of 2014.

January–April 2015  Beatson remains a recurrent item on the hospital subcommittee, area medical committee and on the Beatson consultant meeting agendas. Consultants make repeated requests for the final report.

February 2015  Draft report on the findings from the SLWGs  Further assurance provided to the Beatson consultants meeting that HDU would be retained. The draft report is finalised. The report author is the chair of all three SLWGs. However, this report was not circulated to consultants.

March 2015  Staff informed the enquiry team that the then clinical director attended the area medical committee meeting in March 2015 and informed the meeting that the final report would be available soon and that most Beatson staff were happy with the plans.

17 April 2015  Subsequent version of the SLWGs report issued  Report authors are the chair of the three SLWGs and the clinical director (a member of the steering group).

May 2015  Area medical committee and hospital sub-committee  Final details for service reconfigurations presented by the medical director to the area medical committee and hospital sub-committee and disseminated to staff. At this point it was clear that all acute medicine would move off the Gartnavel site with the loss of the HDU facility.

14 May 2015  Meeting between management and clinicians  Presentation from senior management to Beatson medical staff confirming the content of the final report. Assurances were provided that the Deanery had approved plans for resident on-call trainees (which later proved to be incorrect) and that critical care had agreed to oversee the transfer of sick patients off site (also incorrect). The only plan in place at this point was the standard operating procedure, which had not been approved by the Deanery, consultants and trainers. The standard operating procedure had been shown to the registrar input overnight. Staff there noted anaesthetic cover was crucial. The visit demonstrated (for a much smaller cancer centre) the need to have 24/7 anaesthetic cover with four HDU beds.
lead for deteriorating patients who agreed it was not a workable model. Following this meeting, consultants decided to proceed to notify GMC of safety concerns.

Consultants informed the review team of extreme concern on reading the report to discover there would be no HDU, no anaesthetic cover and no plans in place for a cardiac arrest team, interventional radiology and hospital at night cover. They were also concerned that oncology trainees would become the resident on-call to cover the entire Gartnavel General Hospital site as the most senior doctors, even though many were insufficiently trained.

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 May 2015</td>
<td>Consultants letter to the chief executive officer at the General Medical Council (GMC) Letter seeking urgent advice about the removal of acute services which were completing in one week and formally notifying the GMC of significant patient safety risks. The letter outlined their concerns.</td>
</tr>
<tr>
<td></td>
<td>• Beatson would be the only site in the UK with no HDU, anaesthetic cover or the ability to deliver level 2 care.</td>
</tr>
<tr>
<td></td>
<td>• SLWG concluded that the minimum onsite requirement for the centre would be 24/7 anaesthetic cover and HDU facilities.</td>
</tr>
<tr>
<td></td>
<td>• Consultants were informed that the report outlining how this would be achieved would be available in December 2014, but they did not receive the report until April 2015. Medical management had refused to acknowledge the SLWG findings. An offer was made to meet with consultants on 14 May 2015 to discuss the report.</td>
</tr>
<tr>
<td></td>
<td>• Report states no HDU and no 24 anaesthetic cover beyond an ill defined temporary arrangement involving trainees. There was no approval for this from either the Deanery, Royal Colleges or training directors.</td>
</tr>
<tr>
<td></td>
<td>• Out of hours cover proposed is a risk as there are inadequate staff for resuscitation and no one onsite for insertion of drains.</td>
</tr>
<tr>
<td>22 May 2015</td>
<td>Healthcare Improvement Scotland letter to NHS Greater Glasgow and Clyde chief executive Letter notifying the NHS board of the concerns and our intention to undertaken an independent preliminary assessment (a short life enquiry visit) involving a small team of experts who would visit the Beatson to speak with key individuals.</td>
</tr>
<tr>
<td>Date</td>
<td>Sender</td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>27 May 2015</td>
<td>GMC to Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>27 May 2015</td>
<td>Letter from the GMC to NHS Greater Glasgow and Clyde consultants</td>
</tr>
</tbody>
</table>
| 27 May 2015| Meeting between medical director and team leads  | Management presented the new clinical model and pathways that reflected some of the concerns that had been raised. Key elements of the proposal are:  
• the development and training of clinical staff in the early recognition and response to deteriorating patients with National Early Warning Scores, identification and ceiling of care and escalation response  
• the development of an acute oncology HAU with enhanced middle grade staff, additional training for senior oncology staff and clear standard operating procedures for critical care, medical and surgical input  
• enhanced out of hours middle grade staff support to the Beatson together with 24-hour on-site anaesthetic support and 'resuscitation team', and  
• clear pathways of advice and, if required, transfer of patients who require further levels of care.  
(Note: Nine of the original 56 consultants who signed the letter to the GMC attended this meeting). |
| 29 May 2015| Meeting between senior management and Haematology clinicians | An email from haematology clinicians to management summarising the meeting earlier that day and expressing concerns:  
"We met this morning to discuss the proposed model of care which is indeed the model of care that will exist from 5pm today. This model would leave us in clear breach of British Committee for Standards in Haematology (BCSH) guidelines for most of our patients (see below). Without onsite HDU staffed by a resident anaesthetist and running as an outreach of HDU/ITU [intensive care] at NSGH [the new south glasgow hospital] we cannot meet these guidelines and so cannot safely provide our current service. Therefore we can see no alternative but to stop accepting new admissions to B7 as from Monday. It is with the greatest regret that we find ourselves in this position. We recognise that this will deprive the great majority of our patients access to the excellent..." |

23 NHS Education for Scotland is a special health board responsible for supporting NHS services in Scotland by developing and delivering education and training for those who work in NHSScotland.
29 May 2015 | HAU opens at 5pm | facilities (clinical and holistic), staff and colleagues at the Beatson Oncology Centre but is a necessary response to prevent any avoidable adverse clinical outcome.”

29 May 2015 | Urgent meeting convened | On the evening on 29 May 2015 the management team convened an urgent meeting with the haematology clinical director to discuss the issues and offered to meet with the haematologists on the Saturday if there was an immediate safety issue which meant that haematology could not function as normal in the course of the following week. The haematologists indicated their agreement to work within the model the following week and a meeting was scheduled with them collectively for the morning of Monday 1 June 2015 to explore and understand their specific concerns.

1 June 2015 | Feedback from launch team (via meeting note) | The lung cancer team recognises the significant improvement in suggestions compared to 2 weeks ago. All improvements still leave the Beatson with less immediate acute cover than any other cancer centre in the UK. As such these suggestions remain in experimental format for the delivery of care and are unique in the UK. As this is a trial of an untested structure of care arranged at very short notice, it should exclude non palliative patients receiving unscheduled care or those at risk of neutropenic sepsis.

4 June 2015 and 16 June 2015 | Communication session with staff | Two staff sessions held which were open to all staff. The sessions included a presentation on the new clinical model, managing the deteriorating patient, critical care outreach, HAU and governance framework.

17 June 2015 | Scheduled communication session with staff | Session cancelled due to lack of numbers.

23 June 2015 | HAU clinical governance sub-committee meeting | Minutes noted the HAU opened on 29 May 2014: 40 patients seen, 74 critical care outreach visits taken place, 18 patients admitted to HAU. Six patients transferred off site since the unit opened. Case study data for the six transfers was discussed, highlighting what went well and areas for improvement. Other than issues with transfer it was confirmed by the senior house officer and specialist registrar representatives that it was working well. Discussions held to identify how this could be improved. Deteriorating patient work plan was also discussed. Radiology – initial teething problems in accessing radiographers out of hours and at weekends. Revised protocol being developed.

Laboratory medicine – laboratory in the Gartnavel General Hospital is open from 8am-8pm and outwith these times samples go to emergency laboratory. Some confusion around this is being explored.

Medical training discussed. Concerns about junior grade
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 July 2015</td>
<td>HAU clinical governance meeting</td>
<td>doctor workload and training. Not enough junior staff to cope with sick patients in ward B5. Options discussed. Deanery report to be considered concerning rotas. Leads allocated to take this forward.</td>
</tr>
</tbody>
</table>
Appendix 2 – Enquiry team

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Robbie Pearson (Chair)</td>
<td>Director of Scrutiny and Assurance</td>
<td>Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Dr Tim Cooksley</td>
<td>Consultant Acute Medicine</td>
<td>The Christie NHS Foundation Trust</td>
</tr>
<tr>
<td>Dr Cathy Hughes</td>
<td>Consultant Nurse Gynaecology/Oncology</td>
<td>Imperial College NHS Trust</td>
</tr>
<tr>
<td>Dr Mike Jones</td>
<td>Acute Physician</td>
<td>University Hospital of North Durham</td>
</tr>
<tr>
<td>Professor Alastair McLellan</td>
<td>Postgraduate Dean</td>
<td>NHS Education for Scotland</td>
</tr>
</tbody>
</table>

Professor Simon Mackenzie, Medical Director, St George’s University Hospitals NHS Foundation Trust, provided advice to the enquiry team at the report writing stage.

Healthcare Improvement Scotland staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Aggleton</td>
<td>Senior Programme Manager</td>
</tr>
<tr>
<td>Leanne Hamilton</td>
<td>Programme Manager</td>
</tr>
<tr>
<td>Edel Sheridan</td>
<td>Project Officer</td>
</tr>
</tbody>
</table>
## Appendix 3 – Assurance group

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Brian Montgomery</td>
<td>Chair of Assurance Group and former Interim Chief Executive and</td>
<td>Leeds Teaching Hospitals NHS Trust</td>
</tr>
<tr>
<td>(Chair)</td>
<td>Medical Director, NHS Fife</td>
<td></td>
</tr>
<tr>
<td>Dr Adrian Crellin</td>
<td>Consultant Clinical Oncologist</td>
<td>Leeds Teaching Hospitals NHS Trust</td>
</tr>
<tr>
<td>Dr Nicholas Fluck</td>
<td>Medical Director</td>
<td>NHS Grampian</td>
</tr>
<tr>
<td>Dr Lynn McCallum</td>
<td>Acute Medicine Consultant</td>
<td>NHS Lothian</td>
</tr>
<tr>
<td>Dr Ernie Marshall</td>
<td>McMillan Consultant in Medical Oncology and Clinical Director of</td>
<td>The Clatterbridge Cancer Centre NHS Foundation Trust, Merseyside</td>
</tr>
<tr>
<td></td>
<td>Chemotherapy Services</td>
<td></td>
</tr>
<tr>
<td>Dr Ewan Ritchie</td>
<td>Clinical Lead in Anaesthesia</td>
<td>NHS Tayside</td>
</tr>
<tr>
<td>Mhairi Simpson</td>
<td>Nurse Consultant Cancer Care</td>
<td>NHS Lanarkshire</td>
</tr>
</tbody>
</table>
# Appendix 4 – Glossary of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMC</td>
<td>area medical committee</td>
</tr>
<tr>
<td>BWoSCC</td>
<td>Beatson West of Scotland Cancer Centre</td>
</tr>
<tr>
<td>CEL</td>
<td>Chief Executive Letter</td>
</tr>
<tr>
<td>GMC</td>
<td>General Medical Council</td>
</tr>
<tr>
<td>HAU</td>
<td>high acuity unit</td>
</tr>
<tr>
<td>HDU</td>
<td>high dependency unit</td>
</tr>
<tr>
<td>ICU</td>
<td>intensive care unit</td>
</tr>
<tr>
<td>MRCP</td>
<td>Member of the Royal College of Physicians</td>
</tr>
<tr>
<td>NEWS</td>
<td>National Early Warning Score</td>
</tr>
<tr>
<td>SPSP</td>
<td>Scottish Patient Safety Programme</td>
</tr>
<tr>
<td>SLWG</td>
<td>short-life working group</td>
</tr>
</tbody>
</table>
You can read and download this document from our website. We are happy to consider requests for other languages or formats. Please contact our Equality and Diversity Officer on 0141 225 6999 or email contactpublicinvolvement.his@nhs.net

www.healthcareimprovementscotland.org

Edinburgh Office: Gyle Square | 1 South Gyle Crescent | Edinburgh | EH12 9EB
Telephone: 0131 623 4300

Glasgow Office: Delta House | 50 West Nile Street | Glasgow | G1 2NP
Telephone: 0141 225 6999

The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and Scottish Medicines Consortium are part of our organisation.