SPSO Scottish Public Services Ombudsman

The Scottish Public Services Ombudsman Act 2002

Investigation Report

UNDER SECTION 15(1)(a)

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Scottish Parliament Region: Central Scotland and Glasgow

Case ref: 201406017 and 201503127, Lanarkshire NHS Board and Greater Glasgow and Clyde NHS Board
Sector: Health
Subject: Hospitals; clinical treatment; diagnosis

Summary
Mrs C had previously suffered from mouth cancer and was treated at Monklands Hospital. After finding an ulcer in her cheek, she contacted the consultant previously in charge of her care, and was seen at Monklands Hospital again, where the ulcer was found to be cancerous. Mrs C's case was discussed at the multi-disciplinary team (MDT) meeting, who decided to refer Mrs C to the Southern General Hospital for treatment.

However, this was not done until a week later. The referral was by email from the consultant to his colleagues with details of Mrs C's (and other patients') cases, rather than a formal referral by letter. It is not clear whether the email was received. Around this time the head and neck / maxillofacial (the diagnosis and treatment of diseases affecting the mouth, jaws, face and neck) consultants at the Southern General Hospital decided that, due to lack of capacity, they would no longer accept referrals of patients they considered could be treated locally (such as Mrs C). It is unclear whether the management team instructed the consultants to do this, or whether the Southern General Hospital was required to accept Mrs C's referral under the existing funding arrangements. Mrs C was not told that there was a problem with her referral.

Mrs C grew increasingly concerned about the delay, and phoned the consultant at Monklands Hospital several times over the next few weeks to follow this up. Finally, about a month after the MDT, Mrs C emailed the consultant, outlining her strong concerns, and the consultant phoned the Southern General Hospital and arranged an urgent appointment for Mrs C. Mrs C said that her treatment from Southern General Hospital staff was excellent from that point on.

Mrs C complained about the delay in the scan and the MDT meeting, as well as the delay in referring her to the Southern General Hospital. Mrs C was concerned that the delay may have worsened her outcome, as she was initially told that surgery would be performed with the aim of providing a cure. However, the surgery that she subsequently received significantly reduced her

quality of life and gave her a low chance of surviving her cancer. Mrs C also complained about the lack of communication from Monklands Hospital staff about what was happening.

My investigation found that the delay in arranging Mrs C's surgery was unreasonable, and outwith the national HEAT (Hospital Efficiency and Access Targets) standards. I found it was unreasonable for the Monklands Hospital consultant to wait one week before referring Mrs C, and also that the email sent by the consultant was not an adequate referral. I also found that there was a breakdown in the referral process between Monklands Hospital and the Southern General Hospital, which meant that no plans were made for Mrs C's surgery at either hospital until she followed this up repeatedly. I am concerned that an important decision (not to accept certain referrals) could be made and implemented at NHS Greater Glasgow and Clyde without clear, recorded management approval. I am also strongly critical of the poor communication between the consultants at both health boards, as they apparently discussed Mrs C's case without clearly agreeing who would be responsible for her treatment (both hospitals appeared to think the other would be responsible). It was only through Mrs C's courage and perseverance in following up her own appointment that this matter was resolved.

I also found that Monklands Hospital staff failed to communicate reasonably with Mrs C about her treatment. Staff did not return her calls on at least one occasion and, although the consultant phoned the Southern General Hospital to follow up the referral and offered to perform the surgery himself, no-one contacted Mrs C to explain what was being done or to check that the appointment had come through.

In reporting on this complaint, I outlined significant concerns about the way in which both boards provided information during my investigation. NHS Lanarkshire failed to provide a key piece of evidence relating to this complaint until after my investigation was concluded. NHS Greater Glasgow and Clyde also provided new evidence at a late stage, which directly contradicted information they had previously given during the investigation. This caused unnecessary difficulties and delays in completing the investigation, and undoubtedly added to Mrs C's distress. I also raised concerns at the lack of appreciation both boards have shown of the impact these events have had on Mrs C, and of the value of her complaint. This case involves a patient who was left without any plans for her cancer surgery for several weeks, as the boards

were unable to effectively communicate about, and resolve, an administrative disagreement over who was responsible for the surgery. In this context, I am disappointed that the boards were not more proactive about acknowledging that Mrs C's experience was unacceptable, and acting to prevent a recurrence.

Redress and recommendations

The Ombudsman recommends that Lanarkshire NHS Board:	*Completion date*
(i) issue a written apology to Mrs C for the failings I found; and	18 November 2015
(ii) bring my findings to the attention of Consultant 1, for reflection as part of his next annual appraisal.	16 December 2015

The Ombudsman recommends that Greater Glasgow and Clyde NHS Board:	*Completion date*
(i) issue a written apology to Mrs C for the failings I found;	18 November 2015
(ii) feedback my findings to all staff involved, for reflection and learning; and	16 December 2015
(iii) ensure there is a clear procedure for authorising and recording any decisions not to accept referrals, and that staff are aware of this.	16 December 2015

The Ombudsman recommends that both boards:	*Completion date*
(i) conduct a joint significant event analysis to investigate and address the cause(s) of the delay in Mrs C's referral, and share the results with my office and with Mrs C, if she wishes.	21 January 2016

Who we are

The Scottish Public Services Ombudsman (SPSO) investigates complaints about organisations providing public services in Scotland. We are the final stage for handling complaints about the National Health Service, councils, housing associations, prisons, the Scottish Government and its agencies and departments, the Scottish Parliamentary Corporate Body, water and sewerage providers, colleges and universities and most Scottish public authorities. We normally consider complaints only after they have been through the complaints procedure of the organisation concerned. Our service is independent, impartial and free. We aim not only to provide justice for the individual, but also to share

the learning from our work in order to improve the delivery of public services in Scotland.

The role of the SPSO is set out in the Scottish Public Services Ombudsman Act 2002, and this report is published in terms of section 15(1) of the Act. The Act says that, generally, reports of investigations should not name or identify individuals, so in the report the complainant is referred to as Mrs C. The terms used to describe other people in the report are explained as they arise and in Annex 1.

Introduction

1. The complainant (Mrs C) complained to the Ombudsman about NHS Lanarkshire (Board 1)'s care and treatment for her mouth cancer. In investigating Mrs C's complaints, we also found failings by Greater Glasgow and Clyde NHS Board (Board 2), and this report considers the actions of both boards.

2. The complaints from Mrs C I have investigated are that Board 1:

(a) did not provide reasonable care and treatment between 16 April 2014 and 9 July 2014 (*upheld*); and

(b) did not communicate reasonably with Mrs C about her treatment (*upheld*).

3. Mrs C raised concerns about delay in diagnosing her cancer and arranging surgery (which was carried out by Board 2). Mrs C was also concerned about the lack of communication from hospital staff during this time.

Investigation

4. In order to investigate Mrs C's complaint, my complaints reviewer made further enquiries of both boards, and obtained independent medical advice from an experienced head and neck surgeon (the Adviser). In this case, we have decided to issue a public report on Mrs C's complaint because of the significant injustice to Mrs C in terms of the distress and anxiety caused by the failings we found. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked.

Overview

5. I would like to state at the outset my significant concerns about the way in which both boards have provided information during my investigation of this complaint. In particular, Board 1 failed to provide a key piece of evidence relating to this complaint until after my investigation was concluded, despite my complaints reviewer asking specifically for any evidence on this issue. Board 2 also provided new evidence at a late stage which directly contradicted information they had previously given during the investigation. While I note that Board 1 has now apologised for their failure to provide key evidence earlier and taken steps to avoid a recurrence, I am disappointed that both boards failed to engage properly with this investigation at an earlier stage. My investigations rely on the information obtained from the parties involved, and I expect organisations to be able to give a clear, consistent and organisation-wide response to my office's enquiries. The failure to do so in this case has caused

unnecessary difficulties and delays in completing the investigation and has undoubtedly added to Mrs C's distress.

6. I am also concerned at the lack of appreciation both boards have shown of the impact these events have had on Mrs C, and the value of her complaint. This case involves a patient who was left without any plans for her cancer surgery for several weeks, as the boards were unable to effectively communicate about, and resolve, an administrative disagreement over who was responsible for the surgery. In this context, I am disappointed that the boards were not more proactive about acknowledging that Mrs C's experience was unacceptable and acting to prevent a recurrence. When Mrs C originally complained, Board 1's response focussed on justifying their own actions, rather than fully exploring with Board 2 why the problem occurred and how it might be prevented. Similarly, Board 2's responses to my investigation have focussed on justifying their own position, rather than giving a clear and complete account of events. In this regard, the boards' responses appear to have lost sight of the fundamental principle of a patient-centred approach to care.

7. In view of these concerns, I have taken the unusual step of writing to the Chairs of both boards, to draw this report to their attention.

Background

8. Mrs C previously suffered from squamous carcinoma (a type of cancer) in her mouth. She received surgery for this under the management of a consultant head and neck surgeon (Consultant 1) at Monklands Hospital (Hospital 1), which is within Board 1. Mrs C subsequently underwent radiotherapy.

9. Some years later, Mrs C developed an ulcer in her cheek, and consulted her dentist, who recommended she contact the hospital as a matter of urgency. Mrs C called Consultant 1's secretary and was given an appointment about two weeks later.

10. At this appointment, Mrs C was reviewed by an associate specialist, who arranged a biopsy of her cheek. The biopsy was carried out a few days later, and Mrs C had another appointment a few days after this. She was told that, although the biopsy was not conclusive, it was likely she had mouth cancer. A second biopsy was arranged to confirm whether the ulcer was cancerous, as well as a computerised tomography (CT) scan (a scan which uses x-rays and a

computer to create detailed images of the inside of the body) to determine how far this had progressed (if it was cancer).

11. The second biopsy was carried out two days later, and the CT scan was performed 13 days later. As the CT scan was performed on a Monday (the same day as the weekly multi-disciplinary team (MDT) meeting), Mrs C's case was not able to be discussed at the MDT meeting that week. No MDT meeting was held the following week, as this was a bank holiday. Therefore, Mrs C's case was discussed two weeks after the CT scan.

12. The MDT meeting agreed that Mrs C should be referred to the Southern General Hospital (Hospital 2), which is within Board 2, for surgery. The MDT also recommended that a magnetic resonance imaging (MRI) scan (a scan to show health conditions affecting soft tissue, organs and bone) should be carried out. Consultant 1 met with Mrs C after the MDT meeting to explain her diagnosis and planned surgery.

13. Four days after the MDT meeting, Consultant 1 attended a Clinical Network Study Day, at which he discussed Mrs C's treatment and future referral to them with colleagues from Hospital 2. Three days after this, Consultant 1 sent an email to four colleagues (who are part of the clinical network) at Hospital 2 to refer Mrs C. The email was titled 'complex oncology cases' and said:

> 'Further to conversations with some of you… please find attached short PowerPoint presentations with relevant pathology and radiology reports. Scans are available on [the computer system]. I am currently in the process of seeking UNPAC (unplanned activity) funding for these cases. As with previously referred patients, I would like to continue to be involved in treatment and would be happy to look after these patients in Lanarkshire once considered fit enough for transfer.'

The email attached PowerPoint presentations relating to Mrs C and other cases.

14. However, no appointment was made as a result of this email. Mrs C said she telephoned Consultant 1 two weeks after the MDT meeting because she hadn't yet received an appointment, and he said he would follow this up with Hospital 2.

15. Board 1 said Consultant 1 spoke to one of the head and neck consultants at Hospital 2 about a week after this, and expressed surprise that Mrs C had not yet been seen. Consultant 1 said he requested that she be seen as soon as possible, and offered to facilitate treatment at Hospital 1 with appropriate support from colleagues from Hospital 2 if this should prove quicker.

16. A few days after this, a consultant head and neck surgeon at Board 2 (Consultant 2) wrote to Consultant 1, indicating that the letter was 'from the team here at the Southern and follows on from our recent conversation.' The letter explained that Board 2 did not currently have capacity to cope with the level of workload being referred from Board 1 and said 'in view of this, our management team have asked us to no longer take referrals'. The letter noted 'we understand that there is a Service Level Agreement with GGC and such that the care of these patient[s] in Glasgow would be paid for, however that does not resolve our ongoing capacity issues'. The letter referred to future negotiations to resolve the resourcing issues, but did not specifically mention Mrs C (or any patients). The letter was copied to a member of the management team (the Manager). Mrs C was not told about this letter.

17. About this time, Mrs C said she called Consultant 1 again to follow up her appointment, but was unable to speak with him and so left a message. About a week later, Mrs C emailed Consultant 1 to express her on-going concern that she had not yet been seen at Hospital 2 and to ask what was happening. Mrs C also telephoned Consultant 1 the next day, and he said he would contact Hospital 2 again. Mrs C said she asked if it would be necessary to repeat the CT scan, as this was now about six weeks old, but she said Consultant 1 told her this would not be necessary as CT scans were accurate for a three month period. Consultant 1 disagreed with this account, and said he actually told Mrs C that, if further scans were required, these would be carried out at Hospital 2.

18. Consultant 1 called Hospital 2 that day and arranged for Mrs C to be seen as a matter of priority. He also re-sent the referral email and PowerPoint presentation to the doctor he spoke with. Hospital 2 called Mrs C the next day and made an appointment for six days later. However, when Mrs C attended this appointment, she was told they had no record of any referral, or any of her clinical details from Hospital 1. Despite this, the medical staff reviewed Mrs C, carried out a further CT scan and blood tests, and told Mrs C that she would now be under their care. Mrs C was also reviewed that day by a consultant

head and neck surgeon (Consultant 3). Mrs C's case was discussed at Hospital 2's MDT two days later, and she met with Consultant 3 immediately after this to discuss her treatment options. Consultant 3 explained that Mrs C's cancer was very aggressive, and gave her the options of expecting her life expectancy to be limited to six months, or choosing extensive surgery to remove sections of her jaw, cheek and neck, which would significantly affect her quality of life and still only give her a low chance of surviving her cancer. The surgery was described as a 'high grade palliative' option, highlighting how limited the chances were of a complete cure.

19. Mrs C decided to have the surgery, and this was carried out about two weeks later. Mrs C said her physical appearance has been drastically changed by the surgery, and she continues to suffer complications from the effects of the surgery and infections, as well as being in considerable pain. Mrs C is no longer able to talk normally, or to eat and drink. Mrs C said she has had to take early retirement from her job, which she loved, and the impact on her family has been devastating. Mrs C said she has been told she now has a 20 percent chance of being alive in three to five years.

(a) Board 1 did not provide reasonable care and treatment between 16 April 2014 and 9 July 2014

Concerns raised by Mrs C

20. Mrs C raised concerns about the delays in her treatment. Mrs C said she was told the initial CT scan would be done within ten days, but this actually took 13 days, which meant the MDT's consideration of her case was delayed for two weeks (as it missed that Monday's MDT meeting and the next was a bank holiday). Mrs C also raised concerns that Consultant 1 said he had referred her to Hospital 2, whereas Hospital 2 told her they had no record of this, and she was not given an appointment until about a month after the MDT meeting, after repeatedly following this up. Mrs C said she was in significant pain during this time, and her GP had prescribed her morphine. She was also concerned that her outcome could have been better if she had been treated earlier.

21. Mrs C also raised concerns about her treatment. She said she told Consultant 1 at the second biopsy appointment that she felt a lump in her neck and was worried the cancer had spread, but Consultant 1 dismissed her concerns after briefly examining her. Mrs C said cancer was subsequently found in her neck. Mrs C was also concerned that, when she asked about repeating the CT scan, Consultant 1 told her CT scans were accurate for a

three month period, which she said was in direct contradiction to advice she received from a doctor at Hospital 2 who said CT scans are only accurate for six weeks.

Responses from Board 1 and Board 2

22. Board 1 said a formal referral was made to Hospital 2 via email a week after the MDT meeting, with copies of all relevant pathology reports and scans. Board 1 considered that the treatment provided at Hospital 1 was carried out in a timely manner.

23. As Consultant 1's email said he was seeking unplanned activity (UNPAC) funding for the referral, my complaints reviewer asked Board 1 to explain how the funding of Mrs C's case worked. Board 1 explained that there are service level agreements (SLAs) in place between them and Board 2, which provide for the provision of specific services. They said Mrs C's referral was actually covered by an existing SLA, so no specific unplanned activity (UNPAC) funding was necessary (although staff had also prepared the paperwork for specific funding, and sent it to Board 2, in case there were any funding issues).

24. In relation to the delay in the appointment at Hospital 2, Board 1 said that, when Consultant 1 first discussed Mrs C's case with staff from Hospital 2, they told him that they had a high number of referrals. Consultant 1 also recalled that, after Mrs C complained, he followed this up with Board 2 and was told that Hospital 2 was no longer accepting referrals from Board 1 at that time. My complaints reviewer asked for further explanation of this and any written record of these conversations, but Board 1 said this information was given in conversations and it was Consultant 1's understanding that there were no paper copies of these conversations. Board 1 did not provide or refer to the letter from Consultant 2 (which clearly indicated that referrals were not being accepted at that time), and Consultant 1's recollection (based on his statement in the Board 1 complaints file) was that he first heard about this after Mrs C's complaints.

25. My complaints reviewer also contacted Board 2, and asked whether Hospital 2 was accepting referrals from Board 1 at this time, and any restrictions on this (such as the funding basis for referrals). Board 2 said there were no restrictions for this type of case or procedure as a result of funding or anything else.

26. My complaints reviewer also asked whether Board 2 had received Consultant 1's email and why this was not treated as a referral. Board 2 were not able to confirm whether the email had been received (as relevant staff were not available at that time), but they said they had no record of a formal referral for Mrs C aside from one made the day she was seen (which appeared to be in response to the verbal request made by Consultant 1, as there was no accompanying referral letter on the system). Board 2 explained that all referrals to Oral and Maxillofacial Surgery should be made by formal letter, which are processed by a secretary and medical records staff. While a telephone referral may be made if a case is urgent, this is normally followed up by letter. In this case, Board 2 said they had no record of receiving a formal referral until Consultant 1 called, about a month after his email.

New evidence provided by Board 1

27. When I released a draft copy of this report, Board 1 provided a copy of the letter from Consultant 2, which stated that Board 2 were not accepting referrals at the time of Mrs C's treatment. My complaints reviewer asked why this letter had not been mentioned or provided during the investigation, despite two specific enquiries about this issue. Board 1 said they had no reasonable explanation for this and apologised for failing to provide this earlier.

28. My complaints reviewer also sought Board 2's comments on the letter. Board 2 advised that 'the service did not make a decision not to accept referrals at the time of Mrs C's referral, in fact there are no restrictions for this type of case or procedure.' As this appeared to contradict the content of Consultant 2's letter, my complaints reviewer asked for further explanation. Board 2 advised that the statement in the letter that 'our management team have asked us to no longer take referrals' did not reflect the Manager's understanding of the position at the time, as there were no instructions given not to take referrals. The Manager had no recollection of seeing the letter at that time, and explained that, if the referral is clinically appropriate, the patient should be seen and any discussion around the overall funding and referral arrangements would be taken up separately.

New information from Board 2

29. However, in response to a further draft of this report, Board 2 provided comments from Consultant 2 (who wrote the letter). It appeared that Consultant 2 had not previously had an opportunity to comment on the

investigation. In relation to the management position, Consultant 2 said it was his:

> 'clear understanding [at the time of these events] that the [Hospital 2] Management Team did not wish the Maxillofacial/Head and Neck Surgeons to accept referrals from health boards where the reason for referral was one of capacity. Where patients could be treated by services locally with appropriate consultant support where necessary, then that was what should happen … It was also clear that the management decision did not apply to patients who could not be managed locally for good clinical reasons.'

Consultant 2 said that this view was not communicated directly to him, but via his consultant colleagues (and Consultant 2 offered to provide email evidence to support this, from the then lead clinician).

30. Consultant 2 explained that his letter to Consultant 1 was prompted by a discussion at a regular weekly meeting of the Maxillofacial / Head and Neck team, in which it became apparent that the team was having difficulty progressing treatment at Hospital 2 for patients referred from Lanarkshire who, in their view, could be managed locally. Consultant 2 said he volunteered to communicate this information to Consultant 1, and did so immediately after the meeting by telephone and an urgent letter copied to the Manager. Consultant 2 could not recall any discussion about a particular Lanarkshire patient at the team meeting, although he said it was possible such a discussion occurred. He said that, although he accepted conversations about Mrs C's clinical care did take place with his colleagues, he was not party to them or aware of them at the time.

31. Board 2 also provided comments from the Manager, who explained that:

> 'in the instance of where a service has been and can be provided locally but where another parent board for whatever reason sends that referral to Board 2, this is not covered under any SLA and as such Board 2 does not require to accept that referral in any instance … Boards within Scotland including Board 2 however do work together to facilitate cancer treatment for patients when services run into significant difficulties. In this type of instance funding for care is discussed and agreed on a named patient basis, however, the discussion regarding funding and the review of the patient run concurrently in order that no clinical delay is invoked as a result of obtaining a financial agreement.'

Further comments from Board 1

32. In response to the second draft report, Board 1 indicated that they accepted the draft report and recommendations, as they acknowledged there was valuable learning for both health boards and did not wish to delay publication. However, they provided some detailed comments from Consultant 1 on the draft report for information. In relation to the delay in the referral, Consultant 1 said he knew from his conversations with colleagues at the time that they had received his email and understood this to be a referral. In relation to the delay in providing Consultant 2's letter, Consultant 1 said he was aware of the existence of the letter, but had passed this to one of his managers who was unable to locate it at the time of my complaints reviewer's enquiry.

Relevant guidance

33. The Scottish Government's HEAT (Hospital Efficiency and Access Targets) standards for cancer waiting times set out the following timeframes:

- patients diagnosed with cancer to begin treatment within 31 days of decision to treat; and
- patients referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.

34. The General Medical Council (GMC)'s 'Good Medical Practice' explanatory guidance on 'Delegation and referral' (2013) states:

> '6. Referral is when you arrange for another practitioner to provide a service that falls outside your professional competence.
>
> 7. Usually you will refer to another doctor or healthcare professional registered with a statutory regulatory body.
>
> …
>
> 9. The following applies whether you are delegating or referring.
>
> a. You should explain to the patient that you plan to transfer part or all of their care, and explain why.
>
> b. You must pass on to the healthcare professional involved:
>
> relevant information about the patient's condition and history
>
> the purpose of transferring care and/or the investigation, care or treatment the patient needs.
>
> c. You must make sure the patient is informed about who is responsible for their overall care and if the transfer is temporary or permanent. You

should make sure the patient knows whom to contact if they have questions or concerns about their care.'

Advice

35. In relation to the delay with the CT scan, the Adviser noted that there is no specific HEAT standard or guideline for scans. The Adviser said it was unfortunate that, in this case, the delay meant Mrs C's case could not be discussed at the next MDT meeting (and the one after that was cancelled). The Adviser acknowledged that one to two weeks could have been saved if the CT scan had been done a few days earlier. However, the Adviser explained that the requesting clinician normally has little control over when the radiology appointments will be allocated. While it is their duty to request the scan promptly, it is then up to the radiology department to allocate scan appointments in a timely manner. In this case, the Adviser said the scan was requested promptly and the timing of the scan and the MDT meeting meant there were still approximately 30 days left to meet the 62 day HEAT target. However, the Adviser suggested Board 1 may wish to consider arranging dedicated weekly CT slots for urgent cancer cases, such that patients can be booked directly into these slots when they are seen in an out-patient clinic.

36. In relation to the week's delay between the MDT meeting and the referral, the Adviser said it was then unreasonable for Consultant 1 to add additional delay by waiting this long before referring Mrs C to Hospital 2. The Adviser said Consultant 1 should have sent the referral the same day as the MDT, with a letter to one of his colleagues at Hospital 2.

37. The Adviser also considered Consultant 1's email to colleagues at Hospital 2 was not an appropriate method of referral. While it is not unreasonable to send an email to a colleague to alert them to the fact that an urgent referral has been sent, this should usually be followed up by a formal letter. The Adviser explained that an email referral to several colleagues could lead to the situation that no-one takes ownership, assuming another colleague is dealing with it. Alternatively, the recipient may be away and unable to act on the email. If the referral is made by formal letter to a named consultant, even if they are absent, a secretary can pass the referral on to ensure another member of the team will deal with it. Additionally, the referral is placed in the patient's medical record, ensuring that clinical information about the case is available to whichever clinician subsequently deals with the case. The Adviser noted that Consultant 1 did follow up on the referral (by telephone and email) when Mrs C

contacted him a month later. However, the Adviser said it would have been better if this had also been done by formal letter, to ensure the patient's information was available when she was seen in the clinic.

38. The Adviser said the delay in referring Mrs C was unacceptable, and caused Mrs C significant unnecessary anguish, as she knew that surgery had been recommended but had to wait for an appointment to discuss all the details and the impact this would have on her life (as well as feeling that the delays may change the extent of the operation required and, ultimately, her chances of survival).

39. My complaints reviewer asked the Adviser if there was evidence that Mrs C's cancer had spread during the month's delay, and whether this impacted on her eventual treatment options. The Adviser compared Mrs C's CT scans (one at Hospital 1 and another subsequently at Hospital 2) and MRI scans, and explained that, although it is not possible to compare the two CT scans completely accurately (as the first was carried out without contrast), there seemed to be a slight progression of the disease between these. However, a second MRI scan taken about six weeks after the first (which was done about ten days after the MDT meeting) was essentially unchanged, suggesting a relatively stable appearance of her cancer at that time. Furthermore, the Adviser explained that, although the second CT scan suggested the cancer may have spread to the maxilla (a bone in the jaw) and neck, the subsequent histopathological reports (microscope tests of tissue samples collected during the surgery) showed there was no bone invasion by the cancer, and none of the neck nodes removed contained cancer. Overall, the Adviser said there was probably a small increase in the size of the tumour whilst waiting for treatment, but not significantly so. The Adviser also said the delay did not mean that the cancer spread to other areas, such as the neck nodes or chest. The Adviser considered that the extent of the surgery would likely have been of a similar magnitude, even if it had been carried out sooner.

40. As Mrs C said she was in severe pain at times while waiting for treatment (and her GP had prescribed her morphine), my complaints reviewer asked the Adviser whether Consultant 1 should have done more to manage Mrs C's pain. The Adviser said there was no evidence in the correspondence or medical notes that Mrs C directly asked Consultant 1 about pain relief, or that Consultant 1 was aware that pain had become an increasing issue and did not

act on this (although the Adviser noted that there may have been telephone conversations about this, not included in the documentary evidence available).

41. In relation to Mrs C's concerns that Consultant 1 dismissed her worry that the cancer may have spread to her neck, the Adviser explained that the CT scan which was arranged would have given a far more accurate assessment of whether the cancer had spread to her neck than any clinical examination. Therefore, the correct investigations were arranged to consider how far the cancer had spread, and the Adviser considered this was reasonable.

42. My complaints reviewer asked whether it was reasonable for Consultant 1 not to repeat the CT scans when Mrs C asked about this. The Adviser explained that there is no fixed guideline about when scans need to be repeated, rather, this is the decision of the operating surgeon and the MDT, and depends on whether there have been any changes to the clinical picture, as well as the time elapsed since the last scan. In this case, the Adviser noted Consultant 1 was still under the impression that he had referred Mrs C to Hospital 2. Therefore, the Adviser considered it was appropriate for him not to arrange another scan at this stage, as he would not have known when the planned surgery was due to take place at Hospital 2.

(a) Decision

Delay in treatment

43. Having considered the medical advice provided, I have concluded that the delay in Mrs C's treatment (90 days from her first appointment to surgery, and 56 days from decision to treat to surgery) was unreasonable, and outwith the HEAT standards quoted. The delay appears to have been caused by a combination of failings by both health boards involved.

44. First, the referral from Consultant 1 was made a full week after the MDT and by email (rather than formal letter). I accept the Adviser's explanation that Consultant 1 should have made the referral immediately after the MDT, and by formal letter, and I am critical of his failure to do so. On the evidence available it is not possible to determine the extent to which the email referral contributed to the delay in this case: Board 2 have not confirmed whether or not the email was received, whereas Consultant 1 said he was aware from conversations at the time that the email was received and understood to be a referral. However, in view of the advice provided, I am critical of the week's delay in referring

Mrs C, and consider this referral should have been made immediately after the MDT and by formal letter.

45. The second key factor in the delay was Board 2's decision not to accept the referral of Mrs C, and the breakdown in communications between Board 2 and Board 1 about this. In this regard, I am concerned at the conflicting information provided by Board 2 about the appropriateness and funding of the referral. From the final comments provided by Board 2, it appears Board 2 do not consider they were required to accept the referral of Mrs C, as it could have been managed locally (at Hospital 1). The Manager has explained that surgery that can be managed locally is not covered under any SLA. However, this conflicts with the statement in Consultant 2's letter that the consultants at Hospital 2 'understand that there is a [SLA] with GGC and such that the care of these patients would be paid for' (suggesting that the declined referrals were in fact covered by the SLA). It also conflicts with the repeated statements provided by Board 2 that there were and are no restrictions on referrals for this type of case or procedure. From the conflicting information provided, there appears to be real and unacceptable confusion within Board 2 as to whether or not this referral was covered under the SLA, and precisely what the practice was with regard to accepting referrals of this kind. I am concerned at this lack of clarity, and in particular that a decision not to accept certain referrals could be implemented without clear recorded management approval.

46. I am particularly critical of the lack of clear communication between the consultants at both health boards about what would happen with the specific referrals in this situation. From the information provided by both health boards it is clear that Consultant 1 was aware there were problems accepting Mrs C's referral, while the team at Board 2 were aware that Consultant 1 had attempted to refer patients who they did not intend to accept. In this context I am concerned that Consultant 1 and his colleagues at Board 2 apparently discussed Mrs C's case without making any firm decision about her treatment, or agreeing who was now responsible for her care: the team at Board 2 appears to have considered the referral had been declined, whereas Consultant 1 appears to have considered the referral would still go ahead. This situation is unacceptable, and I am strongly critical of all staff involved for failing to clearly agree responsibility for Mrs C's immediate treatment (and that of the other patients referred in the email) as a matter of priority. It was only due to Mrs C's own courage and perseverance in continuing to chase her appointment that the matter was ultimately resolved. Mrs C said staff at Hospital 2 subsequently

commented that she had 'fallen between two stools', and this appears to be an accurate assessment – responsibility for Mrs C essentially fell between the two hospitals, with nobody taking action to progress her treatment.

47. In making this criticism, I would like to note Mr and Mrs C's positive comments on the care of Consultant 3 and other staff at Hospital 2, once the appointment was finally arranged. On meeting Mrs C these staff immediately took responsibility for her treatment and arranged the relevant scans and reviews necessary to expedite the surgery. Mrs C and her family have indicated that her care from this point on was excellent, and I am pleased to note that the good practice of these staff went some way to reassure Mrs C and her family regarding her on-going treatment.

Other issues

48. In relation to Mrs C's concerns about the delay in the first CT scan, I acknowledge that it would have been preferable for this to have been undertaken more promptly. However, the Adviser has explained that the timing of the scan would still have enabled Board 1 to meet the HEAT standards, and on balance, I do not consider this delay unreasonable. However, I have raised the Adviser's suggestion about providing dedicated CT slots for urgent cancer patients with Board 1 for their consideration.

49. In relation to Mrs C's concerns that the possibility of cancer in her neck was adequately considered, I accept the advice that the appropriate investigation was undertaken for this (a CT scan), and the results from the surgery showed the cancer had not spread beyond the initial site to other sites in her neck. I also accept the advice that Consultant 1 did not act unreasonably in not repeating the CT scans at Hospital 1 when Mrs C asked about this, as he expected the surgery to be managed at Hospital 2 (and the decisions about further scans would more appropriately be made by the surgeons there). Even if the surgery was subsequently rearranged for Hospital 1, the need for further scans would have been considered as part of the planning for the surgery. At this stage the priority was to confirm who would be responsible for the surgery.

Findings

50. In view of the failures in the referral process noted above, I uphold this complaint.

51. While the Adviser has explained that the delay is unlikely to have significantly affected the ultimate clinical outcome for Mrs C, the delay itself was unacceptable, as was the fact that Mrs C had to follow up the arrangement of her surgery, since neither board was proactively taking responsibility for this. As the Adviser has acknowledged, the month of waiting and uncertainty caused Mrs C and her family significant unnecessary distress, as they waited to hear further details of her treatment and prognosis, while worrying about the impact of the delay on the extent of the operation and her chances of survival. Mrs C has also described the stress of having to chase up her appointment, as she did not want to appear 'pushy' and was afraid of following up more than she did.

52. I would also like to acknowledge the stress and anxiety caused to Mrs C by the investigation process itself, particularly with the production of significant new evidence after Mrs C had been given my draft findings. While my amended report will no doubt also be distressing for Mrs C, as it highlights significant failings in her care, I hope that it will also help to answer Mrs C's questions and provide some measure of closure for her and her family.

53. When she brought her complaint to my office, Mrs C said she wanted an explanation for the delays in her case and the confusion with the referral. While I hope this report has helped to provide some explanation of events, I recognise that there are still key issues on which the information provided by the boards is unclear or inconsistent (in particular, the issue of what (if any) instructions were given at Board 2 about not taking referrals; the question of whether Board 2 was required to accept the referral under the existing arrangements; and the precise content and timing of the discussions between Consultant 1 and his colleagues about this). Therefore, I have recommended that the boards conduct a joint significant event analysis to investigate and address the cause(s) of the delay in Mrs C's referral. I have also recommended that both health boards apologise to Mrs C for the failings I found, that Consultant 1 reflect on my findings as part of his next annual appraisal; that the findings of my investigation be fed back to all Board 2 staff involved for reflection and learning; and that Board 2 take steps to ensure that there is a clear procedure for authorising and recording any decisions not to accept referrals, and that staff are aware of this (see recommendations at the end of this report).

(b) Board 1 did not communicate reasonably with Mrs C about her treatment

Key Events

54. Mrs C said she telephoned Consultant 1 about a week after her first appointment with him, as she was concerned about the delay in the CT scan and her condition (her mouth ulcer had spread to her gum, and her jaw had seized up so she could not eat anything solid). Mrs C said she spoke to Consultant 1's secretary, and asked for him to call her back, but he did not. Mrs C said she called again some time later and spoke with Consultant 1's secretary, who told her that her case would likely be discussed at the MDT meeting in two weeks' time (due to the delay in the CT scan). Mrs C said the secretary told her that Consultant 1 said this would make no difference to her treatment.

55. Mrs C emailed Consultant 1 a few days after this (the first email), noting that the secretary had told her it would be two weeks before her case would be discussed by the MDT and asking if Consultant 1 could tell her in the interim whether the biopsy showed cancer, or when she would find this out. Mrs C said she never received a response to this email, but Consultant 1 came to see her at the CT scan appointment three days later and told her the biopsy showed cancer.

56. Mrs C met with Consultant 1 two weeks after this, following the MDT meeting, and her diagnosis and treatment plan were discussed. A Macmillan Specialist Nurse also attended part of this meeting. Mrs C said that, at this meeting, Consultant 1 told her and her family that the cancer was in its early stages, and he could cure her. Board 1 said Consultant 1 told Mrs C the surgery would be done with 'curative intent'.

57. Although an MRI scan was carried out a few days after the MDT meeting, Mrs C said Consultant 1 never communicated the results of this.

58. Mrs C said she called the Macmillan Specialist Nurse about ten days after the MDT and asked what would happen next (now the MRI scan was completed), and the nurse told her she thought Mrs C would be given an appointment at Hospital 2. Mrs C said the nurse agreed to confirm this and get back to her, but this never happened. Mrs C said she telephoned Consultant 1 a few days later, and he agreed to get in touch with Hospital 2 to remind them to contact Mrs C. However, Mrs C did not hear anything further. Consultant 1

said he spoke with colleagues at Hospital 2 around this time (about two weeks after sending the referral) and asked for Mrs C to be seen as soon as possible, as well as offering to facilitate the surgery at Hospital 1 if that would be quicker. However, the letter from Consultant 2 (sent about this time) suggested that Board 2 had declined to accept Mrs C's referral (or any referrals of this kind).

59. As Mrs C did not receive any contact, she telephoned Consultant 1's office again ten days later. Mrs C said she left a message with the secretary asking him to call back, but no return call was received.

60. About a week after this, Mrs C emailed Consultant 1 with her concerns (the second email). She noted that she had still not received any notification about a date for surgery, and said:

> 'Whenever I call you I never hear back from you ([your secretary] did ring me back on one occasion) … I still don't even know if my cheek is having to be reconstructed or not which is causing me a great deal of anxiety. I know you'll deal with cancer every day, but I don't therefore think it's acceptable that I am not receiving any information or support.'

61. Mrs C telephoned Consultant 1 the next day, and he took the call and told Mrs C he would contact Hospital 2. Mrs C said he also told her that if she 'now wanted' the surgery to be performed at Hospital 1, the earliest date would be in about a month's time, as he had other cases he needed to prioritise. Consultant 1 called back later that day to advise that Hospital 2 would be in touch regarding an appointment, and Mrs C received a call from Hospital 2 the next day making an appointment for six days later.

62. A few days later, Mrs C attended her GP, who attempted to contact Consultant 1 to ask about Mrs C's surgery date. Consultant 1 was not available, but the GP spoke with his secretary the next day. Mrs C said the secretary told the GP a provisional date of 31 July 2014 had been scheduled for Mrs C to have the surgery at Hospital 1, but this needed to be confirmed by Consultant 1 (who was then on annual leave). An internal email from Board 1 confirms that Mrs C was given a provisional date of 31 July 2014 for surgery at Hospital 1.

63. Mrs C's husband (Mr C) called Hospital 1 and spoke with the Surgical Services Manager to try to sort out what was happening, as they had been getting mixed messages about where the surgery would be performed. Mrs C

said the Surgical Service Manager told Mr C the surgery was never going to be performed at Hospital 2, as no funding had been applied for. However, the Surgical Service Manager's notes from this call state that he agreed to 'follow up on the [Hospital 2] appointment and outcome' as well as following up with Consultant 1.

64. However, when Mrs C attended her appointment at Hospital 2 a few days later, her care was taken over by Consultant 3 who arranged the surgery there.

Concerns raised by Mrs C

65. Mrs C was dissatisfied with the lack of communication about her treatment overall, and that Consultant 1 and the Macmillan Specialist Nurse failed to return calls and answer her questions. She felt that she had to chase up staff to get any information about what was happening. Mrs C said she found this stressful, as she did not want to appear 'pushy', but was extremely concerned about the delay in her treatment.

66. Mrs C said she and her family clearly remembered Consultant 1 saying that he could 'cure' her cancer at the appointment after the MDT meeting, although Board 1 said he would not have said this. Mrs C said her family left the meeting feeling positive that the cancer could be removed.

67. Mrs C was also concerned that there was no contact from Consultant 1 regarding the results of the MRI scan.

Board 1's response

68. Board 1 said Consultant 1 always responded promptly to any requests from Mrs C for information. In relation to the appointment with Mrs C after the MDT meeting, Board 1 said Consultant 1 told Mrs C that the planned surgery would be performed with 'curative intent' (as opposed to palliative intent), but he did not say he could 'cure' her cancer.

69. My complaints reviewer asked Board 1 whether the Macmillan Specialist Nurse had any recollection or record of Mrs C's telephone call (following the MRI scan), but Board 1 said they did not.

Advice

70. My complaints reviewer asked the Adviser whether Consultant 1 communicated reasonably with Mrs C, both in terms of keeping her updated

about her diagnosis and treatment, and in terms of responding to her telephone calls and emails. The Adviser said Consultant 1 clearly communicated the diagnosis, the outcomes of investigations and the plan for surgery at Hospital 2 in his letters to Mrs C's GP, up to the point where he last saw Mrs C (after the MDT meeting). The Adviser said this was reasonable, as all the relevant information up to that point was communicated.

71. In relation to the MRI scan, the Adviser said it was not unreasonable that Consultant 1 did not inform Mrs C or her GP of the results of this scan. The Adviser explained the purpose of the MRI scan was to help plan the extent of the proposed surgery, which was to be carried out by the surgeons at Hospital 2. The results of both the CT scan and the MRI scan would, therefore, be discussed with Mrs C when she was seen at Hospital 2 to explain the planned surgery. The Adviser said that providing a copy of an MRI report to a patient or their GP without an explanation of what this means in terms of surgery and prognosis is not helpful, as it can create more uncertainty and anxiety unless accompanied by this information. Therefore, it was reasonable for Consultant 1 to assume the results of the MRI scan would be discussed with Mrs C by the surgeons at Hospital 2.

72. In relation to responding to Mrs C's emails and telephone calls, the Adviser observed that there was no documentary evidence about the content of the telephone calls. The Adviser noted that Mrs C's first email asked about the result of the second biopsy, and thus she seemed to be requesting a cancer diagnosis by telephone or email. The Adviser explained that the issue of discussing a cancer diagnosis by telephone is not straightforward, as this is more appropriately done in a clinic setting with patient support available.

73. My complaints reviewer asked the Adviser whether there was any evidence in the medical notes that Consultant 1 told Mrs C he could 'cure' her cancer during the appointment after the MDT meeting. The Adviser said that there was not. The Adviser noted that, at this stage, the MRI scan had not yet been carried out, so all that was available was the first CT scan (which was carried out without contrast, making it less useful in delineating the tumour). The Adviser said it seemed the extent of the tumour was not fully appreciated at this stage, because the MRI scan had not been done. The Adviser explained that there is nothing in the report of the first CT scan to indicate that it would not be possible to operate and potentially get a curative outcome on the cancer. However, the report of the MRI scan suggests that this would be a very difficult

tumour to treat. The Adviser said the information on the MRI report, including the size of the cancer (three centimetres), the fact that it had probably spread from the mouth to the skin of the cheek and into the pterygoid muscles (muscles around the jaw, from which it is difficult, if not impossible, to completely remove cancer) and possibly also the upper jaw, all mean that the cancer was approaching not being operable, especially as a further course of radiotherapy would not be possible (as Mrs C had already received radiotherapy for her previous tumour a few years previously).

(b) Decision

74. While there is no documentary evidence of the contents of Mrs C's telephone calls, Mrs C has provided copies of her telephone bill which confirm that she made calls to Hospital 1 on the dates she stated. The call durations also match Mrs C's descriptions of whether calls were short messages or longer conversations. Mrs C has also provided copies of the two emails she sent to Consultant 1, and I note that the emails are consistent with Mrs C's chronology in their references to previous conversations and attempts at contact.

75. On balance, I consider there is evidence that staff failed to return Mrs C's calls on at least one occasion, and I am critical of this. The records show that Mrs C received no contact from Hospital 1 after her first telephone call with Consultant 1 alerting him to the delay (about two weeks after the MDT meeting) until her second email and telephone call about two weeks after this. Consultant 1 said he did contact Hospital 2 during this time and asked for Mrs C to be seen as soon as possible, as well as offering to facilitate the surgery at Hospital 1 if this would be quicker (and the letter from Consultant 2 reflects that there were discussions between Consultant 1 and Hospital 2 about referrals around this time). However, no-one contacted Mrs C to tell her that he had done this, to alert her that there were problems with Board 2 accepting the referral, or to check that Hospital 2 had got in touch. Mrs C was waiting on treatment for cancer, and worried that the delay could be limiting her options for treatment, or her life expectancy. As Consultant 1 had not told Mrs C to whom he had referred her, or identified who at Hospital 2 would be responsible for her on-going care, she had no contact at Hospital 2 to discuss this with. Her only means of contact were him and the Specialist Macmillan Nurse. In these circumstances, and particularly as Consultant 1 was aware there were problems with Board 2 accepting the referral, I consider Consultant 1 should have been more proactive in managing Mrs C's care and onward referral and more responsive to her telephone calls to keep her informed about what was

happening. This could have reassured Mrs C that Consultant 1 remained concerned about her care and was seeking to minimise any delays for future surgery. It would also have clarified earlier why the possibility of surgery at Hospital 1 was being considered. Instead, Mrs C felt that Consultant 1 did not treat her case with any urgency, and she was understandably concerned and confused when the possibility of surgery at Hospital 1 was subsequently raised one month after she was told she was being referred to Hospital 2 specifically for surgery there.

76. While Consultant 1 did not respond by email to either of Mrs C's emails, Mrs C said that she spoke with Consultant 1 shortly after sending each of these (he met with her at the CT scan appointment three days after the first email, and took her telephone call the day after the second email). On balance, I do not consider it a failing that Consultant 1 did not reply to Mrs C's emails, as he did speak to her on each occasion within a reasonable timeframe, (although, in relation to the second email, I acknowledge that this contact was initiated by Mrs C, rather than Consultant 1). In relation to the first email I also accept the advice that it was reasonable for Consultant 1 to give Mrs C the diagnosis in person, rather than trying to do this by email.

77. I have also considered whether the Surgical Services Manager gave Mr C inaccurate information, as Mrs C said the Surgical Services Manager told them the surgery was never going to be performed at Hospital 2 due to funding issues. Having reviewed the Surgical Services Manager's notes from this telephone call, there is no evidence that they said this, and there is a note that they agreed to follow up with Hospital 2 about the appointment (suggesting they thought there was still a possibility the surgery would be performed there). However, at this stage the staff at Hospital 1 were aware that there was a problem with the referral and their records show that an alternative surgery date for Hospital 1 was being considered. Therefore, I consider it likely that the Surgical Service Manager would have indicated at this stage that there was uncertainty as to whether the surgery would be performed at Hospital 2. This would have been of great concern to Mr and Mrs C (as up to this point, they thought they were simply waiting for the appointment to come through). While I have found no evidence that the Surgical Services Manager gave incorrect information in this telephone call, I consider it unreasonable that Mr and Mrs C were first told at this point that there were problems with the referral (after waiting a month already), and I am critical that Board 1 did not keep Mrs C informed from the point when they first became aware of the issue.

78. In relation to the MRI scan, I accept the advice that it was reasonable for Consultant 1 not to communicate this directly to Mrs C, as he expected that this would be communicated by the surgeons at Hospital 2, together with information about the planned surgery. I understand why Mrs C would have wanted this information sooner, to know how serious her cancer was, and her prospects for surgery. I agree that it was unreasonable that this information was not given to her for a month. However, this delay was due to the failures in referring Mrs C (discussed in complaint (a) above), and at the time the priority was for Mrs C's surgery to be arranged. The Adviser has explained that it would be reasonable to leave the results of the MRI scan to be communicated in the context of planning the actual surgery. Therefore, I do not consider the delay in Mrs C receiving information about the MRI scan to be a separate failing (rather, it was a further consequence of the failings identified in complaint (a)).

79. In relation to the appointment after the MDT meeting, there is no contemporaneous or independent evidence to show whether Consultant 1 said he would 'cure' Mrs C's cancer, or that he would perform surgery with 'curative intent', and I am not able to determine which phrase was used. However, I accept the Adviser's explanation that the initial CT scan would not have shown the full extent of Mrs C's cancer, and it would be reasonable at this stage to think the cancer could be successfully removed, providing a cure. I acknowledge how distressing it would have been for Mrs C and her family to believe that the outlook was optimistic, only to find out (after a stressful delay), that the outlook was poor. However, in light of the information available at that time, I do not consider it was unreasonable for Consultant 1 to indicate that, in the opinion of the MDT and based on the CT result, the outlook was hopeful at that stage.

80. In view of the failure to return Mrs C's telephone calls and to keep her informed of the issues with the referral and the action being taken by Hospital 1 staff about the delay, I uphold this complaint. It is clear from Mrs C's emails how distressed she and her family were during this time, particularly at having to constantly chase up staff about what was happening, and receiving unclear and confusing information. In this sense, I consider the failings identified under complaint (a) above were amplified by the lack of clear communication to Mrs C and her family about what was happening with her treatment.

81. When she brought her complaint to me, Mrs C said she wanted an explanation for the lack of communication from Consultant 1, and for why he did not communicate the results of the MRI scan. I hope this report has helped to provide that explanation. I have also recommended that Board 1 apologise to Mrs C for the failings I found, and that Consultant 1 reflect on the findings of my investigation as part of his next performance appraisal.

General Recommendations

82. I recommend that Board 1:	*Completion date*
(i) issue a written apology to Mrs C for the failings I found; and	18 November 2015
(ii) bring my findings to the attention of Consultant 1, for reflection as part of his next annual appraisal.	16 December 2015

83. I recommend that Board 2:	*Completion date*
(i) issue a written apology to Mrs C for the failings I found;	18 November 2015
(ii) feedback my findings to all staff involved, for reflection and learning; and	16 December 2015
(iii) ensure there is a clear procedure for authorising and recording any decisions not to accept referrals, and that staff are aware of this.	16 December 2015

84. I recommend that both boards:	*Completion date*
(i) conduct a joint significant event analysis to investigate and address the cause(s) of the delay in Mrs C's referral, and share the results with my office and with Mrs C, if she wishes.	21 January 2016

85. Both boards have accepted the recommendations and will act on them accordingly. We will follow-up on these recommendations. The boards are asked to inform us of the steps that have been taken to implement these recommendations by the date specified. We will expect evidence (including supporting documentation) that appropriate action has been taken before we can confirm that the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	the complainant
Board 1	NHS Lanarkshire
Board 2	Greater Glasgow and Clyde NHS Board
the Adviser	a consultant head and neck surgeon who provided independent advice on the complaint
Hospital 1	Monklands Hospital (in the Board 1 area)
Consultant 1	a consultant head and neck surgeon at Hospital 1
CT scan	computerised tomography scan
MDT	multi-disciplinary team
Hospital 2	the Southern General Hospital (in the Board 2 area)
MRI scan	magnetic resonance imaging scan
Consultant 2	a consultant head and neck surgeon at Hospital 2
the Manager	a member of the management team at Hospital 2
Consultant 3	a consultant head and neck surgeon at Hospital 2

HEAT	Hospital Efficiency and Access Targets
GMC	General Medical Council
Mr C	Mrs C's husband

Annex 2

Glossary of terms

computerised tomography scan (CT) scan	a scan which uses x-rays and a computer to create detailed images of the inside of the body
magnetic resonance imaging (MRI) scan	a scan to show health conditions affecting soft tissue, organs and bone
service level agreement (SLA)	an on-going arrangement for the provision of specialist services by one health board for the patients of another health board
unplanned activity (UNPAC) funding	one-off funding from one health board to another for the provision of specialist medical services for a particular patient

Annex 3

List of legislation and policies considered

General Medical Council, 'Delegation and referral' (2013), Explanatory Guidance to 'Good Medical Practice'

Scottish Government, HEAT Standards: Cancer waiting times