Witness Name: Dr David Dodds

Statement No:

Exhibits:

Dated:

UK COVID-19 INQUIRY

WITNESS STATEMENT OF DAVID DODDS

Witness statement of Dr David Dodds, Chief of Medicine, Beatson West of Scotland Cancer Centre, NHS Greater Glasgow and Clyde.

I qualified in Medicine as a Glasgow University graduate in 1986. Appointed as Consultant in clinical Oncology in 1996 after training in oncology mainly in the West of Scotland. Served as both Clinical Lead and subsequently Clinical Director of the Beatson West of Scotland Cancer Centre 2009-2017. I was appointed Chief of Medicine for West of Scotland Regional Services in 2017 and remain in this post at present. During this period, I chaired the Beatson Oncology Centre response to the COVID Pandemic holding regular meetings with the core team from 2020 until 2022.

I will say as follows:

Background.

1. Greater Glasgow Health Board was established on 1 April 1974, under the National Health Service (Scotland) Act 1972, with responsibility for providing healthcare services for the residents of Greater Glasgow. On 1 April 2006 the area covered by the Board was enlarged to include the Clyde area of the former Argyll and Clyde Health Board. NHS Greater Glasgow and Clyde (NHSGGC) was established and serves a population of approximately 1.3m.

2. The Board also provides a wide range of clinical services to the West of Scotland region, as well as a number of nationally designated services.

3. NHSGGC's structure comprises an Acute Division, Corporate Directorates, and a shared interest - with local authority partners - in six Health and Social Care Partnerships (HSCPs), which are overseen by Integration Joint Boards (IJBs). The Beatson West of Scotland Cancer Centre (BWoSCC) sits within the Regional Services Directorate of NHSGGC's Acute Division and is directly managed by the Regional Services Management Team - led by an Operational Director, a Chief of Medicine, a Chief Nurse, and Directorate Managers. I have outlined the NHS GGC/GRI COVID-19 governance structure under Exhibit DD/01 INQ000412898.

4. The Beatson is Scotland's largest cancer centre, and the largest in the UK based on activity. The Centre provides specialist oncology services to 60% of the Scottish population and sees over 10,000 new patients a year, and over 70,000 return patients. Over 100,000 fractions of radiotherapy and 32,000 cycles of chemotherapy are given each year in the centre alone. The clinical teams also deliver medical cancer treatments in 13 local hospitals, in partnership with local specialist cancer teams. The centre employs over 800 staff including 75 consultants in oncology and haemato-oncology. The annual budget of Specialist Oncology Services is over £100m.

5. The centre has 122 beds in 6 wards (1 ward of 19 beds is for haemato-oncology). One of these wards runs as an 8-bedded Brachytherapy Unit (delivering internal radiation). There is also a large and busy Day Case Chemotherapy Unit comprising 48 treatment stations. The centre has a self-contained Acute Oncology Assessment Unit - staffed by Advanced Nurse Practitioners - which provides unscheduled care for cancer patients on treatment. There is also a dedicated High Acuity Unit (HAU) specifically to manage patients requiring a higher level of medical and nursing input to that provided on the general wards. The centre has its own out-patient department and a large aseptic facility for cytotoxic reconstitution. The unit has an accredited gene therapy aseptic facility. Up to 10 appropriate patients are accommodated in a local hotel while they undergo radiotherapy. The BWoSCC is superbly equipped with 13 linear accelerators, in the Gartnavel campus and the satellite unit at Monklands Hospital, all of which incorporate facilities for Volumetric Modulated Arc Therapy (VMAT) and on-board imaging (OBI). We continue to install state-of-the-art Varian

TrueBeam™ and Ethos units through the Capital Equipment Replacement Programme (CERP) utilising Scottish Government (SG) funded ring-fenced monies.

6. Patients are referred to the clinical teams at the Beatson only once a cancer diagnosis has been confirmed typically in the secondary care centres throughout the geographical area served i.e. the West of Scotland. Primary surgical treatment takes place generally within the hospital site where the diagnosis was initially made, often after a Multi-Disciplinary Team (MDT) meeting and discussion has agreed an overall treatment plan for an individual patient. Colo-rectal cancer patients will often receive non-surgical therapy such as Systemic Anti-Cancer Therapy (SACT) and radiotherapy either pre and/or post-surgery.

7. Collaborative working is normal practice in any tertiary referral centre as referrals and MDT input is established throughout the Health Board regions within the agreed geographical boundaries. These relations are described in the extant service level agreements (SLAs). The Beatson also has representation to both Radiotherapy and SACT National Programme Boards. I would say that effective collaborative working was maintained during the relevant period however engagement and collaboration moved to the virtual environment rather than face-to-face.

8. The SG Oncology advisor is currently a consultant within the Beatson and took up his position as senior medical officer with the SG Cancer Policy Team at the start of the pandemic in March 2020. Within 2-3 weeks a national Cancer Treatment Response Group was established by the SG, and this was chaired by the Oncology Advisor.

9. The group's membership included clinical leads from all five cancer centres in Scotland. The purpose of this group was to streamline, on a national basis, any changes being considered to treatment pathways/algorithms in a way that was evidence-based and had clinical consensus across Scotland. As a result of the groups' efforts, Scotland managed to continue providing cancer care and SACT in a safe and effective manner and recovered from the initial dip quickly, and as a nation. This is acknowledged/confirmed in a paper published in British Medical Journal (Exhibit DD/02 INQ000470377).

10. The paper highlighted that the recovery reflected a coordinated national approach and associated patient and clinician support structures, which facilitated the creation

of COVID-19 protected areas for SACT delivery in Scottish cancer centres, enabling rapid sharing of successful and innovative strategies. Whilst not specifically relating to patients with colorectal cancer, the data show that these actions have limited the potential disadvantage to cancer patients.

IMPACT

11. The referral pathways during the relevant period were unchanged although greater use of virtual patient appointments was made. Non-surgical cancer treatments were adjusted based on National (UK) NICE guidelines during the pandemic due to concerns of infection in an immunosuppressed population. In April 2020 the Scottish Government National Cancer Treatment Response Group produced 'Guidelines for Cancer Treatment During COVID' which we adopted. This guideline is included as exhibit DD/07 **INQ000479062** SACT priority levels were consistent with the CRTG guidelines (Exhibit DD/06[INQ000414606]) and defined as:

- *Priority level 1*
  Curative therapy with a high (>50%) chance of success.

- *Priority level 2*
  Curative therapy with an intermediate (15-50%) chance of success.

- *Priority level 3*
  Non-curative therapy with a high (>50%) chance of >1 year of life extension.

- *Priority level 4*
  - Curative therapy with a low (0-15%) chance of success.
  - Non-curative therapy with an intermediate (15-50%) chance of >1 year life extension.

- *Priority level 5*
  Non-curative therapy with a high (>50%) chance of palliation/temporary tumour control but <1 year life extension.

- *Priority level 6*
  Non-curative therapy with an intermediate (15-50%) chance of palliation.
  Temporary tumour control and <1 year life extension.

Radiotherapy priority levels were defined as:

- *Priority level 1*
  - Patients with category 1 (rapidly proliferating) tumours currently being treated with radical (chemo) radiotherapy with curative intent where there is little of no scope for compensation of gaps.
  - Patients with category 1 tumours in whom combined External Beam Radiotherapy (EBRT) and subsequent brachytherapy is the management plan and the EBRT is already underway.
  - Patients with category 1 tumours who have not yet started, and in whom clinical need determines that treatment should start in line with current cancer waiting times.

- *Priority level 2*
  - Urgent palliative radiotherapy in patients with malignant spinal cord compression who have useful salvageable neurological function.

- *Priority level 3*
  - Radical radiotherapy for Category 2 (less aggressive) tumours where radiotherapy is the first definitive treatment.
  - Post-operative radiotherapy where there is known residual disease following surgery in tumours with aggressive biology.

- *Priority level 4*
  - Palliative radiotherapy where alleviation of symptoms would reduce the burden on other healthcare services, such as haemoptysis.

- *Priority level 5*
  - Adjuvant radiotherapy where there has been complete resection of disease and there is a <20% risk of recurrence at 10 years, for example most Estrogen Receptor (ER) positive breast cancer in patients receiving endocrine therapy.
  - Radical radiotherapy for prostate cancer in patients receiving neo-adjuvant hormone therapy.

12. The tables in Exhibit DD/03 INQ000470378 detail the number of colorectal cancer patients who received SACT/radiotherapy treatment within the Beatson and satellite unit 2018-2023, however this is not reflective of all patients treated for colorectal cancer. The Specialist Oncology Team maintained service provision during the pandemic period and referral pathways were unchanged.

13. Treatment would differ pre and post pandemic depending on the clinical opinion on prioritisation status as described in paragraph 11. Treatment decisions were based on an individual risk benefit analysis bearing in mind the generic prioritisation levels described and into which individual patients would fall. These decisions were made at the peak of the pandemic, before the impact of mass vaccination, and were always made by consultant staff in association with individual patients and their relatives following MDT agreement. Exhibit DD/04 INQ000470379 includes details of treatment management guidelines for colon cancer, rectal cancer, and metastatic colorectal cancer.

14. This treatment guideline was extant during the Covid pandemic. In addition, the Managed Clinical Network guidance on surveillance of rectal cancer patients demonstrating complete clinical response to neo-adjuvant chemo-radiotherapy was in place.

15. Exhibit DD/05 INQ000470380 reflects guidance relating to Watch-and-Wait Surveillance following Complete Response to Chemotherapy for Rectal Cancer (v1.0.pdf) published as a later addendum to the Clinical Management Guideline and applicable during the relevant period. Throughout this time, protocols relating to specific systemic anti-cancer therapies used in the management of colorectal cancer were maintained by oncology and pharmacology colleagues. Systemic anti-cancer therapy treatment protocols were maintained and accessible to all prescribers via electronic prescribing system and aligned with nationally agreed criteria adjusted to mitigate the effects of the pandemic where required (referred to in paragraph 11). Others remained extant.

16. At this time there was also published national/regional guidance on the management of [all] cancer patients during the pandemic and this was communicated to clinical teams managing colorectal cancer (Exhibit DD/06 INQ000414606)

17. The scheduled review of the Clinical Management Guideline for Colorectal Cancer was impacted by the onset of the pandemic and further postponed as all available time and resources were applied to service recovery. The review was initiated in 2023 and the clinical guidance has since been revised to reflect current evidence and contemporaneous practice; the resultant guidance document (Exhibit DD/08[INQ INQ000479063]s currently being progressed through the regional governance processes required in order to publish.

18. There was no change in the referral criteria to the Beatson from the individual site for colorectal cancer patients or indeed any of the specific tumour teams during the relevant period.

19. I think a response to the questions raised around concerns relating to the diagnosis of colorectal cancer during the relevant period would be best served by a response from the Acute Hospital Sector. It is accepted that the number of patients referred to hospital with suspected lower gastrointestinal cancer, and the number subsequently diagnosed fell sharply during the first lockdown and a deficit persisted up until September 2020. This was due to the suspension of the colorectal cancer screening programme, and the limited access to lower gastrointestinal endoscopy during the pandemic (see 24 below).

20. The main concerns relating to non-surgical cancer treatments at the Beatson (i.e. both SACT and radiotherapy) related to the requirement to postpone patient treatment during periods of patient self-isolation. At all times national guidance for managing systemic anti-cancer therapy and radiotherapy in cancer patients who test positive for COVID-19 was followed. This involved the creation of COVID-19 protected areas for delivery of essential SACT and radiotherapy in specially designated areas with the cancer centre.

21. Some changes and adaptations were made to the management and treatment of colorectal patients. Wherever possible face-to-face appointments were replaced by virtual consultations. Non-surgical treatment regimens were adjusted to minimise the need for hospital attendance (e.g. 6-weekly instead of 3-weekly appointments for SACT), the use of oral therapies was introduced where clinically indicated, and delivery as close to home as possible. For clinical and safety reasons radiotherapy

treatment has less opportunity for change or adaptations and so necessitated physical attendance in a designated cancer centre.

22. Compliance with national physical distancing guidance led to the removal of SACT treatment chairs, which could have impacted capacity adversely. The service reviewed the configuration of day-case units and implemented an extended day model to mitigate against the loss of treatment chair time. This ensured continuity of day-case SACT treatment provision and capacity across the relevant period.

23. I am unable to comment on any reported issues around the cancellation, delay or de-escalation of surgery for colorectal cancer and again, this would be best served by a response from the Acute Hospital Sector.

24. Most of the details provided in the Lancet paper apply equally to the Scottish population. I would say however that our experience of pre-operative radiotherapy for rectal cancer differed from the experience of NHS England. NHS England reported a spike, but the Beatson numbers don't mirror that in 2020/21. Pre-operative treatment would be considered on an individual patient basis but there did not appear to be an overall change in practice during the pandemic such that the proportion of those getting pre-operative treatment was similar to pre-pandemic figures. There was, however, a change in the radiotherapy dose and fractionation during the pandemic, with a move from long-term course treatment (i.e. five weeks) to short course treatment over one week. In many cases this was felt to be clinically indicated, based on individual patient risk/benefit analysis.

25. In the initial phases of the pandemic the NHS Bowel Cancer Screening Programme was paused, and the main diagnostic tests (colonoscopy and CT colonography) were being limited to the emergency setting. This inevitably led to delays in diagnosis and then treatment.

26. As I have previously highlighted, there are no surgical theatres within the Beatson, however the brachytherapy (delivering internal radiation) theatre continued to operate throughout the pandemic treating prostate and gynaecological tumours.

27. Whilst there is no critical care facility within the Beatson, we do have a High Acuity Unit (HAU) providing level 2 care to our patient population. During the pandemic the

unit saw an increase in activity due to the need to minimise patient transfer to the QEUH medical and critical care facilities. The clinical teams had been attempting to implement such a plan to enhance patient continuity on-site and ensure consistency in the treating clinical team. The pandemic helped us move to this model of care. This proved to be a successful clinical development and has been maintained post-pandemic. Processes were established for when patients required referral or transfer to the QEUH for level 3 care.

28. National guidance was followed regarding advice given to immunocompromised patients to shield during the relevant period. As highlighted in paragraph 21, national physical distance guidance was followed, resulting in a reduction in SACT treatment chairs however we responded to this by extending our working day to ensure that overall capacity was maintained.

29. In respect of the delivery of SACT and radiotherapy for colorectal patients there was no utilisation of resources from the private sector.

30. At all times patients are treated according to clinical need. As the referral routes into the Beatson were maintained during the pandemic, no effect on inequalities would be anticipated. Any influence on treatment would be noted earlier in the patient pathway if relevant.

Staffing capacity

31. The Beatson was impacted by the effect of the pandemic on staff as in any other self-contained workplace. The impact was managed internally by appropriate redistribution of staff with the aim of maintaining the clinical service. While this undoubtedly put additional strain on remaining staff, I believe that the quality of the service delivered was maintained throughout.

32. In April 2019, we reported that 0.5% of our staff were on special leave compared to 6.9% in April 2020. This included staff with COVID-19 and the need to self-isolate, staff who were shielding, or staff who had COVID-19 carer needs.

33. Nursing staff were occasionally redeployed to other areas within NHSGGC, but this was the exception rather than the rule. Staff normally employed in training roles or

providing specialist nursing were deployed into clinical areas to support ward staff. This level of support was invaluable in supporting the challenge of maintaining safe nurse staffing levels within the wards. At no stage were medical staff re-deployed.

34. A hybrid working model for some non-patient facing staff was implemented and utilised where appropriate.

35. I am not aware of any unequal impact of COVID-19 on our staff in respect of the Equality Act 2010. Our vaccination programme did prioritise Black and Minority Ethnic (BME) staff (and patients), in light of emerging learning about disproportionate impact. At a health board level, the Communications Team circulated details of this via the Core Brief and on the NHSGGC web site.

Infection prevention and control

36. National guidance was followed at all times and the IPC leads worked with local teams to apply the national guidance to specific contexts/locations.

37. Infection prevention and control guidance was coordinated by the Acute Tactical Group (ATG) of which I was a member. Where there were challenges with implementation or interpretation of the guidance, these were highlighted through the ATG and where necessary, papers were taken to this group to be approved through the Specialist Technological and Advisory Committee (STAC) and the Strategic Executive Group (SEG). Whilst there were no specific IPC escalation in respect of Colorectal Cancer patients, examples of issues highlighted through the ATG included a proposal for the screening of maternity cases (which was not in line with ARHAI guidance) and proposals relating to the timing of screening for' super green pathways'. In the case of the former, it was agreed that ARHAI guidance would be adopted and for the latter a set of actions were approved by ATG, STAC and the SEG and adopted across NHS GGC to enhance patient safety relating to potential transmission.

38. At an NHS Board level, arrangements were established for COVID-19 testing for patients and staff and after initial laboratory capacity issues I believe the arrangements worked well for our service. Later into the pandemic, lateral flow tests (LFTs) were introduced to staff. The supply and distribution of LFT kits was

coordinated at an NHSGGC level and I am not aware of any reported issues from Beatson staff relating to accessing LFTs.

39. As a relatively new build, there were no reported issues relating to ventilation within our clinical settings.

40. PPE was handled by NHSGGC, and supplies provided to the Beatson in line with agreed volumes and in line with additional requests which were made to the local stores team. There were widespread issues with PPE availability in the early weeks of the pandemic, including FFP3 masks, aprons, and visor masks. To the best of my knowledge, we were able to supply staff with the necessary PPE, at all times.

41. Face fit-testing of staff began at the beginning of March 2020 and was coordinated by the NHSGGC Health and Safety Team with additional support from volunteers and latterly the British Army. Additional capacity was generated by peer-to-peer training to support the process. Daily sessions were available from March 2020 and evening sessions were provided for night teams. There were a small number of staff who proved very difficult to fit-test or for whom only one of the available masks was suitable. Such staff were placed in low risk environments after a formal risk assessment was completed. This also applied to staff who for religious reasons preferred not to shave and for whom effective and safe face fit testing could not be established.

42. Risk assessments for staff were managed by local managers and for nurses by the Lead Nurse. At a health board level, there was some concern raised regarding the time which was taken to agree the terms of the national risk assessment tool, and this was raised by staff-side colleagues (Unions and professional bodies). Following receipt of the tool in the early stages, there was a need for HR leads to provide clarification and support to line managers. The introduction and completion of staff risk assessments within the Beatson served to have a further impact on short and long-term staffing plans and the identification of staff who required redeployment away from frontline service.

43. NHSGGC Board-wide instructions were issued on 13th March 2020 to restrict visiting under certain circumstances to protect both patients and visitors. Visiting restrictions were imposed through national guidance on 25th March 2020. This caused much

upset for patients and relatives but also for staff who were faced with the need to turn away relatives under what were often very difficult circumstances. We did, however, feel that this step was necessary to protect both staff and patients.

44. Visitors were asked to call the wards prior to visiting and asked to refrain from visiting if they were showing any signs of COVID-19. Visitors were asked to keep their visits and numbers to a minimum, with priority given to immediate family/Next of Kin. No children were permitted to visit unless otherwise arranged with Nurse in Charge.

45. All wards were issued with iPads to allow virtual contact. At all times, our staff tried to manage this very difficult situation with compassion and understanding. NHSGGC Communications Team produced and circulated posters confirming visiting arrangements, and these posters were on display across the Beatson site. Posters were updated in line with SG changes when these took place.

46. There is no question that visiting restrictions within the Beatson during the pandemic had a negative effect on the patient experience and the experiences of family members/loved ones and our staff. Staff were faced with having to turn away relatives where often they could see that a visit from a relative would have a positive impact and serve to reduce anxieties on the patient or their relative, however national guidance precluded this from taking place.

Other concerns or issues

47. There have been some positive aspects on service delivery secondary to the pandemic. There was a necessary reliance on enhanced technology in order to maintain the clinical service. I believe that this has resulted in a positive impact on patient experience as a result of virtual as opposed to in-person clinic attendances.

48. In addition, it was advantageous to arrange for treatment to be delivered to patients in a community (as opposed to secondary care) environment. This was significantly more convenient to patients and also limited the need for unnecessary physical contact during periods of isolation. This practice has been maintained where clinically appropriate to do so.

49. As highlighted in paragraph 27, the reduction in transfer of patients from the BWoSCC campus to the Medical/ICU was initiated as a means to restrict patient movement and also to support the high dependency units managing COVID-19 patients. This practice has been maintained and I believe the patient pathway and experienced has been enhanced, as this has reduced the need for multiple medical teams to become involved in individual patients care and has served to ensure medical/nursing continuity.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 16th May 2024