SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 52 - Volume 1
Miscellaneous Documents

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From: Allan L (Lara)
To: Gregg N (Naomi)
Cc: Kay L (Louise); Law R (Robert); Henderson C (Calum); HIS Sponsorship
Subject: RE: HIS assurance of QEUH
Date: 22 December 2021 11:34:08
Attachments: Stages in Review - QEUH.docx

Hi Naomi,

I have already provided a table to HIS (attached for ease of reference), which includes the ARHAI comments on aspergillus reporting. The two reviews will be the final pieces of work to kick this assurance piece off.

If HIS could confirm that they will be able to commence after they receive the review from NHS Lothian (on or around 8 January), that would be really helpful.

Kind regards

Lara

Lara Allan I Team Lead I HAI Policy and Strategy Unit I Chief Nursing Officer's Directorate
Scottish Government
[redacted]

From: Gregg N (Naomi) [redacted]
Sent: 22 December 2021 11:28
To: Allan L (Lara) [redacted]
Cc: Kay L (Louise) [redacted] Law R (Robert) [redacted] Henderson C (Calum) [redacted] HIS Sponsorship [redacted]
Subject: RE: HIS assurance of QEUH

Hi Lara,

From recollection HIS agreed to start work on this once they had received the data? Does below include all the data – or is there not more?

Happy to raise at this afternoon quarterly strategic meeting – but grateful if you can clarify in the interim.

Best wishes
Naomi
Strategic Liaison and Policy - Team Leader
[redacted]
Safety Alerts, Messaging and Guidelines; CAMS; CLAGS; HIS

From: Allan L (Lara) [redacted]
Sent: 22 Decem
To: Gregg N (Naomi) [redacted]
Cc: Kay L (Louise) [redacted] Law R (Robert) [redacted]; Henderson C (Calum) [redacted]

Subject: HIS assurance of QEUH

Good morning Naomi,

The CNO is wondering when HIS are likely to be able to undertake the commission on the wider assurance of QEUH? The NHS GGC review of case notes is now complete and can be requested from NHS GGC.

NHS Lothian have now also conducted their initial peer review and require further clarification from NHS GGC on some points identified. This is likely to conclude by 8 January.

Would you be able to confirm with HIS, their likely start date?

Many thanks

Lara

Lara Allan I Team Lead I HAI Policy and Strategy Unit I Chief Nursing Officer's Directorate
Scottish Government
[redacted]

Stages in Review / SG Escalation for NHSGGC

	Document	Purpose	Date	Document
1	*The Independent Review* conducted by Dr Andrew Fraser and Dr Brian Montgomery	Report into the design, build, commissioning and maintenance of the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC)	Published June 2020	https://webarchive.nrscotland.gov.uk/20200903233034/https://qeuhprodwebsite.blob.core.windows.net/media/yutnag4j/final-report-published-version-458529_sct0220167968-002_queen-elizabeth-university-hospital-independent-review_p3.pdf
2	Inquiry into the construction of the QEUH, Glasgow and the RHCYP/DCN, Edinburgh – terms of reference	Terms of reference for the inquiry into the construction of the Queen Elizabeth University Hospital Campus (QEUH), Glasgow and the Royal Hospital for Children and Young People and Department of Clinical Neurosciences (RHCYP/DCN), Edinburgh	15 June 2020	https://www.gov.scot/publications/inquiry-into-the-construction-of-the-qeuh-glasgow-and-the-rhcyp-dcn-edinburgh-terms-of-reference/
3	*The Oversight Board Final Report*	The Final Report of the QEUH Oversight Board setting out findings and recommendations in relation to the escalation of NHS Greater Glasgow and Clyde to Stage 4 of the NHS Scotland performance framework for reasons of infection control and governance in the Health Board	22 March 2021	Queen Elizabeth University Hospital/ NHS Greater Glasgow and Clyde Oversight Board: final report - gov.scot (www.gov.scot)

4	*The Overview Report of the Case Note Reviews*	Examines the incidence and impact of qualifying episodes of infection in paediatric haemato-oncology patients cared for at the QEUH and RHC from 2015 to 2019 and the potential link to the hospital environment	22 March 2021	Queen Elizabeth University Hospital: case note review - overview report - gov.scot (www.gov.scot)
5	Advice, Assurance and Review Group (AARG)	First meeting – ToR	7 June 2021	QEUH-RHC Advice Assurance and Review
6	Advice, Assurance and Review Group (AARG)	Second meeting –sample of evidence requested by CNOD members of AARG for review	19 August 2021	AARH - 11 August 2021 - Briefing Note.p 190821 - AARG - 9 meeting2 FINAL.pptx The following documents were shared by NHSGGC upon request from CNOD for review prior to the AARG meeting on 19 August 2021: CN - 4.2 - sop-pseudomonas-ae CN - 5.2 - MAIN IMT Process Framework CN - 5.3 - Dipcat-schedule-and-pr CN - 5.4 - ENHANCED SUPERVI CN - 8.2 - Outbreak & Incident Manageme CN - 14.1 - Paediatric Line- Related Sepsis M CN - Case Note Review Actions 3.1 3. CN - Case Note Review Actions 3.1 3. Let_ActionPlans.13Aug21.pdf

				OB - 18 - 2019-08-20 QEUH SC OB - Final 10 - ipct-assurance-and-ac OB - Final 14 - Duty of Candour Draft Polic
7	NHS Greater Glasgow and Clyde - QEUH/RHC Improvements –	Summary update requested by CNOD	2 December 2021	NHS Greater Glasgow and Clyde - I
8	NHS GGC Case note review of AS	Clinical case note review	December 2021	Contact Elaine Vanhagan at NHS GGC for review Elaine.Vanhegan[redacted]
9	NSS ARHAI aspergillus data	Summary of aspergillus reporting. Please note that we have asked further questions of NSS ARHAI in red.	9 December 2021	Unlike other isolates such as those from blood cultures, it is not a mandatory requirement for all fungal isolate data to be submitted through ECOSS how was this decided and by whom and when?. This means there is variable reporting both between boards and within boards (e.g. GGC where some have been reported and not others why? Why would GG&C decide to report some and not all and is there different reporting across different hospital sites for example?). In addition to issues with incomplete reporting, ECOSS holds laboratory reports of Aspergillus isolates only and is not indicative of clinical diagnosis of infection. Aspergillus species in lower respiratory specimens can occur as a result of colonisation or contamination. Local context would be required to confirm clinical infection rather than colonisation as ARHAI do not hold these data. This isn't really clear to me, so could this be expanded upon and clarified?

				The Public Health Microbiology ECOSS Quality Improvement group (EQIG) have being undertaking a data improvement programme (EDRIP) but due to COVID-19 pandemic only five health boards have undergone the review and subsequent improvement work (NHS Forth Valley, NHS Lanarkshire, NHS Orkney, NHS Shetland and NHS Tayside).where all Boards asked to participate? Was there an opt out? How will other Boards get involved again? Process for this and who is leading? It is therefore likely that not all Aspergillus samples have been reported through ECOSS. Not just for GG&C but across all those other boards not participating? The EDRIP programme remains paused though ARHAI have raised with PHS on the importance of this work. Who makes the decision to recommence it and when it does, will it involve all boards? What would any requirements be to ensure aspergillus is captured?
10	Independent peer case note review by NHS Lothian	To seek assurance on NHS GGC case note review of AS	Yet to be completed	Contact Tracey Gillies NHS Lothian Tracey.Gillies[redacted]

Chief Nursing Officer Directorate
Professor Alex McMahon, Chief Nursing Officer

Scottish Government
Riaghaltas na h-Alba
gov.scot

QEUH Advice, Assurance & Review Group (AARG)

28 February 2022

Time: 14:15 – 15:00 (Microsoft Teams)

Attending:
Alex McMahon, Chief Nursing Officer, Scottish Government (Chair)
Jane Grant, Chief Executive, NHS Greater Glasgow & Clyde
Elaine Vanhegan, Head of Corporate Governance and Administration, NHS GGC
Angela Wallace, Nurse Director, NHS Forth Valley
Tom Steele, Director of Estates & facilities, NHS GGC
Mary Morgan, Chief Executive NSS
Laura Imrie, Lead Consultant for National ARHAI, NHS Assure

Apologies:
Julie Critchley, Director of NHS Scotland Assure

Christine Ward, CNO Deputy Director Scottish Government
John Burns, Chief Operating Officer Scottish Government
Alan Morrison, Deputy Director Infrastructure, Investment and PPE
Irene Barkby, Professional Nursing Advisor – Infection Prevention and Control, Scottish Government
Shalinay Raghavan, Head of QEUH Response Team, Scottish Government
Calum Henderson, QEUH Response Team Leader, Scottish Government
Lezli-an Glennie, Scottish Government (Covering Secretariat)

Agenda

1. Welcome and introductions – Chair (5 Mins)

2. Minutes and actions from previous meeting – Chair (5 Mins)

3. Update on recruitment of the Director of IPC – Jane Grant (5 mins)

4. Update on readiness assessment of opening Wards 2A and 2B– GGC/NHS Assure (15 mins)

5. Review of decisions and agreed way forward – All (10 mins)

5. AOCB – Chair (5 Mins)

From:	Henderson C (Calum)
To:	"BORLAND, Hazel (NHS AYRSHIRE AND ARRAN)"; Raines P (Philip); "CONNOR, Martin (NHS DUMFRIES AND GALLOWAY)"; "Frances.Lafferty [redacted] "RITCHIE, Lisa (NHS NATIONAL SERVICES SCOTLAND)"; "BUCHANAN, Helen (NHS FIFE)"; "Christina.Coulombe [redacted] Shepherd L (Lesley); "Sandra.Aitkenhead [redacted] "BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)"; White C (Craig)
Cc:	Murray D (Diane); Henderson C (Calum)
Subject:	RE: IPCG Minutes
Date:	30 January 2020 16:58:45
Attachments:	Minutes IPCG 6 Jan.docx NHS GGC Oversight Board - Infection Prevention & Control and Governance subgroup - 16 January 2020 meeting - minute - draft.docx image001.png image002.png

Please find minutes reattached.

Calum

From: Henderson C (Calum) [redacted]
Sent: 30 January 2020 16:05
To: 'BORLAND, Hazel (NHS AYRSHIRE AND ARRAN)' [redacted] Raines P (Philip) [redacted] 'CONNOR, Martin (NHS DUMFRIES AND GALLOWAY)' [redacted]; 'Frances.Lafferty [redacted] <Frances.Lafferty [redacted] 'RITCHIE, Lisa (NHS NATIONAL SERVICES SCOTLAND)' [redacted] 'BUCHANAN, Helen (NHS FIFE)' [redacted] 'Christina. [redacted] Shepherd L (Lesley) [redacted] 'Sandra.Aitkenhead [redacted] 'BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND)' [redacted]; White C (Craig) [redacted]
Cc: Murray D (Diane) [redacted] Henderson C (Calum) [redacted]
Subject: IPCG Minutes

All,

Diane has asked that going forward minutes are handled as a correspondence item and only brought to the meeting if a significant issue is requiring to be raised.

I would be grateful if you can confirm you are content with the following minutes:

16 January

6 January

I would be grateful for a response by close of play Monday 3 February

Calum Henderson
St Andrew's House, Edinburgh, EH1 3DG
[redacted]

Infection Prevention & Control and Governance Sub Group
NHS Greater Glasgow and Clyde Oversight Group
Meeting 1: 6 January 2020, 14.00 – 15.30

Minute of Meeting

Attendees:

Phil Raines, Scottish Government(chair)
Pamela Joannidis, NHS Greater Glasgow & Clyde
Alistair Leanord, NHS Greater Glasgow & Clyde
Jennifer Armstrong, NHS Greater Glasgow and Clyde
Sandra Devine, NHS Greater Glasgow & Clyde
Elaine Vanhegan, NHS Greater Glasgow and Clyde
Mark White, NHS Greater Glasgow and Clyde
Andy Crawford, NHS Greater Glasgow and Clyde
Martin Connor, NHS Dumfries and Galloway
Lisa Ritchie, HPS
Christina Coulombe, NHS Lanarkshire
Hazel Borland, NHS Ayrshire and Arran
Sandra Aitkenhead, Scottish Government (secondee)
Lesley Shepherd, Scottish Government
Calum Henderson , Scottish Government (Secretariat)

Apologies:
Irene Barkby MBE, NHS Lanarkshire
Frances Lafferty, NHS Ayrshire & Arran
Helen Buchanan, NHS Fife

1. Welcome, introductions and apologies
The chair welcomed members to the meeting. Roundtable introductions took place and apologies for the meeting were noted by the chair.

2. Minute of Previous Meeting

The minute of the previous meeting was accepted.

3. Terms of Reference, Governance and Membership

Members reviewed the final draft of the Terms of Reference for the IPCG sub-group. HB to provide any thoughts to the secretariat in advance of discussion to clear the Terms of Reference with the Chair. The Deliverables will be discussed at a future meeting but this meeting would focus on the Governance Structure on infection prevention and control.

4. NHSGGC Board Governance Presentation and Discussion of Associated Papers

NHS GGC took the Sub Group through a presentation describing the governance structures as they pertain to IPC and risk at an organisation level in NHS GGC. The

Board was in agreement that the governance structure was comprehensive and that the group recognised the issue of scale as a factor in shaping IPC. However, the Group requires further assurances around the processes within the governance structure specific to the IPCT.

The IPCG highlighted the need to see a paper trail of the governance and accountability issues. This includes the detail within actions plan to highlight where the ownership of specific actions sit. The IPCG also seek assurance on the consolidation of learning around infection control (board to ward), i.e. clarity on the processes in place for reporting/feeding back to staff nearest to the patient and the wider IPCT (e.g. interactions between microbiology and infection control) as well as the reporting/feeding forward to senior management.

The IPCG agreed that the priority for the group would be to understand the structure and working relationships of the IPCT (who does this include?) across NHS GGC; and the group agreed to look at the IPCT resource in more detail at the next meeting. The IPCG also agreed it would be helpful to examine specific examples of both proactive responses to business as usual and the governance of reactive responses (for example around outbreaks). This should also highlight the focus on implementation of learning and how this learning is brought into the governance process.

The Sub Group also requested examples of 'local' issues with wider learning implications such as the response to an outbreak in order to examine how IPC national standards are applied into local areas to reflect the specific measures and circumstances.

The Sub Group agreed that it would focus on 2019 before considering previous years with regards to examining IPC governance with. The methodology will be discussed with the Chair and also fed into the work of the Oversight Board.

5. Next steps

The chair summarised the high level next steps and the subgroup agreed early priorities with meetings:

- examining how IPCT structures operated in practice by taking a deep-dive on particular issues and following their treatment through the different groups/locations;

- reviewing examples of 'local' issues with wider learning implications (eg response to an outbreak)

- reviewing the application/implementation of IPC national standards locally;

- looking at how immediate operational issues were addressed as well as how wider lessons were extracted and taken forward; and

Actions to take forward:

- Highlight how the governance structure is working and determine how this operates in practice: two dimensions to this a)reactive response (immediate operational response) b)proactive response (looking forward, what is the learning across the system and how do we assure ourselves this is happening).
- Provide evidence of the reporting systems in place and how these feed up the system and back down
- Provide evidence of the system adapting to national asks and how this is implemented and shared across the system
- Provide evidence of the scale of the IPC resource
- Drill into the IPC structure and provide this as it was not in the content of the presentation
- Scottish Government to consider final Terms of Reference with Chair of IPCG
- NHS GGC to provide terms of reference of all Board Sub Committees that have oversight of infection control.
- NHS GGC to provide the IPCG with the role and Terms of Reference of the clinical governance forum
- NHS GGC to share a copy of the internal audit plan.
- NHS GGC to provide examples of implemented learning from previous reports including internal audits and HEI.
- Scottish Government and SA to develop a work programme for future meetings and the specific deep dives required to provide assurance

Next meeting

The Next meeting will be 16 January 2020.
Secretariat to provide dates for the IPCG up until the end of March 2020.

Infection Prevention & Control and Governance Sub Group
NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital Oversight Board
Meeting 2: 16 January 2020, 15.00 – 17.00

Minute of Meeting

Attendees

Diane Murray, Scottish Government (chair)
Sandra Aitkenhead, Scottish Government (secondee)
Christina Coulombe, NHS Lanarkshire
Martin Connor, NHS Dumfries and Galloway
Frances Lafferty, NHS Ayrshire & Arran
Lesley Shepherd, Scottish Government
Craig White, Scottish Government
Phil Raines, Scottish Government (secretariat)
Jennifer Armstrong, NHS Greater Glasgow and Clyde (NHS GGC)
Linda Bagrade, NHS GGC
Sandra Devine, NHS GGC
Al Leonard, NHS GGC
Aleks Marek, NHS GGC
Jennifer Rodgers NHS GGC
Elaine Vanhegan, NHS GGC

Apologies

Hazel Borland, NHS Ayrshire and Arran
Helen Buchanan, NHS Fife
Calum Henderson, Scottish Government
Lisa Ritchie, HPS

1. Welcome, Introductions and Apologies

The chair began by noting that Irene Barkby had to stand down as chair and withdraw from the group for reasons of health and competing responsibilities. On behalf of the group, the chair noted her contributions to the work of the Oversight Board and on behalf of the group, DM thanked her. DM said she had been asked the chair of the Oversight Board to act as interim chair until a more permanent solution was decided.

The chair welcomed members to the meeting, particularly Craig White for the first time, who as chair of the Communications and Engagement group, would be able to make key links between the work of both groups. Roundtable introductions took place and apologies for the meeting were noted by the chair.

2. Minute of Previous Meeting

The minute of the previous meeting was considered and a number of corrections were proposed. A revised minute would be circulated next week for approval.

DRAFT

Action: secretariat to circulate revised minute of 6th January meeting in w/b 20th January.

3. Terms of Reference, Governance and Membership

PR noted that the ToR for the group differed from those of the Oversight Board and the Communications and Engagement group by the inclusion of a defined quorate threshold. It was suggested that the ToR should be revised to bring into line with the parent and sibling group ToR.

Action: secretariat to circulate revised ToR for clearance in w/b 20th January.

4. Structure, Resourcing and Operation of NHS GGC IPCT

NHS GGC provide a presentation on the main topic of the meeting on the structure, resourcing and operation of the Infection Prevention and Control Team across NHS GGC. Advanced papers were provided by NHS GGC colleagues, but too close to the meeting for circulation to members. A presentation in several parts was made by NHS GGC representatives, and there were questions and discussions in between the different parts.

(i) ICD Sessions in NHS GGC and IPC Team Structure

This part of the presentation was led by SD and AL. It covered:

- the structure of the ICT as of January 2020, including the geographical division of teams;
- rations of ICT staff in terms of WTE and ration to beds; and
- the number of ICD sessions and their breakdown.

Discussion covered the following issues:

- it was noted by NHS GGC that the differences in ratios – and the difference with national 'norms' – had not had a significant impact on the responsiveness and effectiveness of the ICT;
- NHS GGC was asked about the meetings of the ICNs and ICDs: their frequency, how their agendas were set and how discussions between both sets of meetings were linked/coordinated;
- there was discussion around differences between the different geographical teams, and whether there were any current or historic imbalances in resourcing – NHS GGC confirmed that any such imbalances had only ever been short term; and
- questions were asked about whether water safety was given dedicated ICD sessions, or whether there was a dedicated individual for this work.

(ii) Royal Alexandra Hospital/Stenotrophomonas case-study

This part of the presentation was led by LB. This was an example of a 'reactive' event: an infection incident in the Royal Alexandra Hospital in 2019. It covered:

- the timeline for the incident and what happened (the outbreak resulted in a death);

DRAFT

- the operation (and interaction) of the Problem Assessment Group (PAG) and the Incident Management Team (IMT) and how they related to patients/families, wider clinical teams, the relevant governance structures, and relevant external bodies; and
- lessons learned and how they were followed up.

Discussion covered the following issues:

- the incident was acknowledged as one where the response was swift and effective and demonstrated the IPC system in NHS GGC working well;
- the separate processes for environmental and water sampling were subject to significant discussion, particularly the different approaches to water sampling by different facilities teams across the Board, the need to use an external sampling lab and how the two sets of processes – which have different processes, approaches and competences – were brought together;
- environmental sampling was raised in the lessons learned from this incident, but has also been highlighted in the RHC in 2018 stenotrophomonas outbreak – it was asked whether the 2018 lessons learned had been sufficiently mainstreamed;
- it was noted that a SCI process had been considered in this case, but the decision was taken not to proceed with a full SCI; and
- it was highlighted that there was a national gap in terms of a clearly-defined scope of the methodology and 'set' of organisms for undertaking environmental sampling.

Action: the issue of how environmental and water sampling results and risks were brought together would be explored further in a future meeting of the group.
Action: the group would consider the issue of the national gap in terms of national guidance on environmental sampling in a future meeting of the group.

(iii) S.aureus Bacteraemia case-study

This part of the presentation was led by AM. It was an example of a pro-active, Board-wide approach to addressing a significant IPC challenge. It covered:

- the background to the 'SAB' challenge;
- action taken as a result of the initiative; and
- a review of the data on hospital-acquired SAB and IVAD over time.

Discussion covered the following issues:

- the success of the initiative – while still being assessed – was acknowledged; and
- it was a strong example of collaborative working in the Board and how concerted/targeted action could lead to improvements in IPC.

(iv) A Quality Improvement Project to Reduce the CLABSI Rate in the Paediatric Haemato-oncology Population case-study

This part of the presentation was led by JR. It described a QI response to a significant IPC challenge (not just in Scotland, but globally) and how concerted, coordinated action could bring benefits. It covered:

- the initial inspiration from the work in Cincinatti's Children Hospital;
- the team established to drive change in the QEUH; and
- the application of QI processes, and the results to date and reflections.

Discussion covered the following issues:

- as with the previous example, this demonstrated the scope for targeted, collaborative working within NHS GGC.

5. Workplan for Future Meetings

PR tabled a paper setting out a schedule of topics for the group's meetings to the end of March. As part of the discussion, the group noted the importance of having in-depth case-specific examinations of the IPC system in action. It was suggested that in preparation for such a meeting, members of the group might work with relevant NHS GGC representatives in the preparation of relevant materials.

The group was invited to comment on the topics before the next meeting, and agreed that the topic for the 30th January meeting should be '*governance of audit/risk with respect to infection prevention and control, with particular attention to how issues relating to facilities/environmental risks are considered alongside IPC risks*'.

Action: secretariat to send out the work schedule paper and seek comments from the group members before the next meeting of the group.
Action: secretariat to write to EV setting out the issues/questions to be covered in 30th January meeting of the group in detail by 17th January.

6. AOB

The chair thanked NHS GGC and the group members and noted that the next meeting would be Thursday, 30th January.

Actions to take forward

1. Secretariat to circulate revised minute of 6th January meeting in w/b 20th January.
2. Secretariat to circulate revised ToR for clearance in w/b 20th January.
3. The issue of how environmental and water sampling results and risks were brought together would be explored further in a future meeting of the group.
4. The group would consider the issue of the national gap in terms of national guidance on environmental sampling in a future meeting of the group
5. Secretariat to send out the work schedule paper and seek comments from the group members before the next meeting of the group.
6. Secretariat to write to EV setting out the issues/questions to be covered in 30th January meeting of the group in detail by 17th January.

DRAFT

From:	Henderson C (Calum)
To:	DG Health & Social Care
Cc:	McQueen F (Fiona); Chalmers G (Greig); Raines P (Philip); Henderson C (Calum)
Subject:	FOR CLEARANCE - Oversight Board Terms Of Reference
Date:	10 January 2020 12:59:12
Attachments:	NHS GGC Oversight Board - Terms of Reference - January 2020 - Final.docx

Carole

At yesterday's Oversight Board, the Terms of Reference were cleared by the Board.

We would be grateful for Malcolm to clear the final Terms of Reference.
John Brown is keen to share this with the wider GGC Board so grateful for Malcolm to confirm he is content.

Best

Calum

SCOTTISH GOVERNMENT
HEALTH AND SOCIAL CARE DIRECTORATES
OVERSIGHT BOARD – QUEEN ELIZABETH UNIVERSITY HOSPITAL AND ROYAL HOSPITAL FOR CHILDREN, NHS GREATER GLASGOW AND CLYDE (NHS GGC)

Terms of Reference

Authority

The Oversight Board (OB) for Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), NHS GGC (hereinafter, "the Oversight Board") is convened at the direction of the Scottish Government Director General for Health and Social Care and Chief Executive of NHSScotland, further to his letter of 22 November 2019 to the *Chairman and Chief Executive* of NHS GGC. These terms of reference have been set by the Director General, further to consultation with the members of the OB.

Purpose and role of the group

The purpose of the OB is to support NHS GGC in determining what steps are necessary to ensure the delivery of and increase public confidence in safe, accessible, high-quality, person-centred care at the QEUH and RHC, and to advise the Director General that such steps have been taken. In particular, the OB will seek to:

- ensure appropriate governance is in place in relation to infection prevention, management and control;
- strengthen practice to mitigate avoidable harms, particularly with respect to infection prevention, management and control;
- improve how families with children being cared for or monitored by the haemato-oncology service have received relevant information and been engaged with;
- confirm that relevant environments at the QEUH and RHC are and continue to be safe;
- oversee and consider recommendations for action further to the review of relevant cases, including cases of infection;
- provide oversight on connected issues that emerge;
- consider the lessons learned that could be shared across NHS Scotland; and
- provide advice to the Director General about potential de-escalation of the NHS GGC Board from Stage 4.

Background

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement issues, the Director General for Health & Social Care and Chief Executive of NHSScotland has concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of the Performance Framework. This stage is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required'.

Approach

The OB will agree a programme of work to pursue the objectives described above. In this, it will establish sub-groups with necessary experts and other participants. The remit of the sub-groups will be set by the chair of the Oversight Board, in consultation with Board members. The Board will receive reports and consider recommendations from the sub-groups.

In line with the NHSScotland escalation process, NHS GGC will work with the OB to construct required plans and to take responsibility for delivery. The NHS GGC Chief Executive as Accountable Officer continues to be responsible for matters of resource allocation connected to delivering actions agreed by the OB.

The OB will take a values-based approach in line with the Scottish Government's overarching National Performance Framework (NPF) and the values of NHSScotland.

The NPF values inform the behaviours people in Scotland should see in everyday life, forming part of our commitment to improving individual and collective wellbeing, and will inform the behaviours of the OB individually and collectively:

- to treat all our people with kindness, dignity and compassion;
- to respect the rule of law; and
- to act in an open and transparent way.

The values of NHSScotland are:

- care and compassion;
- dignity and respect;
- openness, honesty and responsibility; and
- quality and teamwork.

The OB Members will endeavour to adopt the NPF and NHSScotland values in their delivery of their work and in their interaction with all stakeholders.

The OB's work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives and also NHS GGC staff.

The OB is focused on improvement. OB members, and sub-group members, will ensure a lessons-learned approach underpins their work in order that learning is captured and shared locally and nationally.

Meetings

The OB will meet weekly for the first four weeks and thereafter meet fortnightly. Video-conferencing and tele-conferencing will be provided.

Full administrative support will be provided by officials from CNOD. The circulation list for meeting details/agendas/papers/action notes will comprise OB members, their PAs and relevant CNOD staff. The Chairman and Chief Executive of NHS Greater Glasgow and Clyde will also receive copies of the papers.

Objectives, deliverables and milestones

The objectives for the Oversight OB are to:

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- improve the provision of responses, information and support to patients and their families;
- if identified, support any improvements in the delivery of effective clinical governance and assurance within the Directorates identified;
- provide specific support for infection prevention and control, if required;
- provide specific support for communications and engagement; and
- oversee progress on the refurbishment of Wards 2A/B and any related estates and facilities issues as they pertain to haemato-oncology services.

Matters that are not related to the issues that gave rise to escalation are assumed not to be in scope, unless OB work establishes a significant link to the issues set out above.

In order to meet these objectives, the OB will retrospectively assess issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement; having identified these issues, produce a gap analysis and work with NHS GGC to seek assurance that they have already been resolved or that action is being taken to resolve them; compare systems, processes and governance with national standards, and make recommendations for improvement and how to share lessons learned across NHSScotland. The issues will be assessed with regards to the information available at the particular point in time and relevant standards that were extant at that point in time. Consideration will also be given to any subsequent information or knowledge gained from further investigations and the lessons learned reported.

Governance

The OB will be chaired by the Chief Nursing Officer, Professor Fiona McQueen, and will report to the Director General for Health & Social Care.

Membership

Oversight Board	
Member	Job Title
Professor Fiona McQueen (Chair)	Chief Nursing Officer, CNOD, Scottish Government
Keith Morris (Deputy Chair)	Medical Advisor, CNOD, Scottish Government
Professor Hazel Borland	Executive Director of Nursing, Midwifery and Allied Health Professionals & Healthcare Associated Infection Executive Lead, NHS Ayrshire and Arran
Professor Craig White	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Irene Barkby MBE	Executive Director of Nursing, Midwifery and Allied Health Professionals & Healthcare Associated Infection Executive Lead, NHS Lanarkshire
Dr Andrew Murray	Medical Director, NHS Forth Valley and Co-chair of Managed Service Network for Children & Young People with Cancer (MSN CYPC)
Professor John Cuddihy	Families representative
Lesley Shepherd	Professional Advisor, CNOD, Scottish Government
Alan Morrison	Health Finance Directorate, Scottish Government

Sandra Aitkenhead	CNOD, Scottish Government (secondee)
Greig Chalmers	Interim Deputy Director, Queen Elizabeth University Hospital Support, CNOD, Scottish Government
Calum Henderson (Secretariat)	Queen Elizabeth University Hospital Support Unit, CNOD, Scottish Government

The Co-chair of Area Partnership Forum and the Chair of the Area Clinical Forum will be in attendance at the meetings. In addition to these members, other attendees may be present at meetings based on agenda items, as observers: senior executives and Board Members from NHS GGC including, Medical Director, Nurse Director, Director of Estates and Facilities, Director of Communications, Board Chair and Chief Executive; and representatives from HPS, HFS, HIS, HEI and HSE.

Stakeholders

The OB recognises that a broad range of stakeholder groups have an interest in their work, and will seek to ensure their views are represented and considered. These stakeholders include:

- Patients, service users and their families
- The general public
- The Cabinet Secretary for Health and Sport
- The First Minister
- The Scottish Parliament
- Scottish Government, particularly the Health and Social Care Management Board
- The Board of NHS GGC and the senior leadership team of NHS GGC
- The staff of NHS GGC and Trade Unions

Special focus will be given to patients of the haemato-oncology service and their families, as highlighted by their direct involvement in the Communications & Engagement sub-group.

Chief Nursing Officer's Directorate
The Scottish Government
January 2020

DRAFT

From: Wright M (Malcolm)
To: DG Health & Social Care
Cc: Henderson C (Calum)
Subject: FW: Update on Royal Hospital for Children and Young People - 17 January 2020
Date: 19 January 2020 16:57:52
Attachments: Update on Royal Hospital for Children and Young People - 17 January 2020.docx

I would like to be involved in the visits, and I would suggest that CMO is as well, consistent with previous visits

From: Henderson C (Calum) [redacted]
Sent: 17 January 2020 16:22
To: Cabinet Secretary for Health and Sport [redacted]
Cc: DG Health & Social Care [redacted] McQueen F (Fiona) [redacted] McCallum R (Richard) [redacted] Calderwood C (Catherine) [redacted] Smith G (Gregor) [redacted] Connaghan J (John) (Health) [redacted] Morrison A (Alan) [redacted]; Hutchison D (David) [redacted] Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted] Henderson C (Calum) [redacted]
Subject: Update on Royal Hospital for Children and Young People - 17 January 2020

PS/ Cabinet Secretary for Health and Sport

Please find attached requested briefing on RHCYP.

Many Thanks

Calum

Calum Henderson
St Andrew's House, Edinburgh, EH1 3DG
[redacted]

Update on Royal Hospital for Children and Young People

Priority
Urgent – Cabinet Secretary has indicated that she requires an update by 17 January.

Purpose
To provide an update to the Cabinet Secretary on the progress on the Royal Hospital for Children and Young People and Department of Clinical Neuroscience (DCN).

Timescales
1. IHSL had made progress against the design of the Critical Care & Lochranza Ventilation, however it was noted that the overall programme had moved to Red Status, primarily because the Estimated Programme of Works shows handover at end November 2020. This is the result of further rectification works in isolation rooms in the Haematology and Oncology wards. NHS Lothian have confirmed that they will continue to work with the contractors to shorten this programme if at all possible and also to look at reducing the commissioning period required before migration of services. They will also examine the possibility of whether or not some services can move earlier than others. A more concrete timeframe will be known in Februray.

2. NHS Lothian are in the process of finalising the DCN programme. The Senior Programme Director has confirmed that DCN work is expected to be complete in May 2020 and this would see services move into the building late spring 2020.

3. There continues to be positive engagement with the CAMHS team over recent weeks in relation to the consolidation of board changes. IHSL are now looking at how best to deliver these and the outcomes of such progress would result in CAMHS moving to the new site before November 2020.

4. The Oversight Board have commissioned a more detailed timeline that will provide more assurance on the expected completion dates. This is expected to be completed by the beginning of February.

5. As discussed with officials on 16 January, a GIQ will be lodged to inform parliament of the update to timescales if the more detailed programme timeline is unable to demonstrate that the planned dates for the migration of services is achievable.

Commercial Progress
6. Commercial negotiations continue to move constructively with both parties focused on resolving the outstanding contractual issues, further meetings of the commercial sub-group are scheduled for next week.

Follow Up to General Question 16 January 2020
7. Ms Ballantyne raised points around the contractors for the Sick Kids' hospital and NHS Lothian's/Scottish Government's handling of the project.

8. The Senior Programme Director has confirmed IHSL are still delivering the changes required but through different contractors ie they are not using Multiplex. She has confirmed the level

of scrutiny and requirements around time line required have impacted on the willingness for some to take on the job. However, suitably experienced contractors have been identified and are working on the site.

9. Multiplex remain on site to address snagging and other technical issues for which they are responsible for. Once the hospital is open and operational, then maintenance arrangements will follow the existing contractual arrangements.

Recruitment at Existing Sites

10. Progress in recruiting to additional winter nursing posts in RHSC has been disappointing, however due to additional recruitment which took place in anticipation of the move to the new site, the hospital currently has good staffing levels and has been managing well.

11. Resources have been made available to sustain pharmacy services at the Royal Infirmary and RHSC until they are brought onto the same site; recruitment has commenced but the service is working with significant vacancies and pressures. There has been a reduction of opening hours at RHSC from 20th January which was agreed with the Clinical Management Team, though a pharmacist is available out with these hours via bleep system.

12. DCN vacancies have reduced. There are now 69.62 wte registered nurses in post against the planned establishment of 77.89 wte which is a vacancy level of 8.27 wte - better than previous levels; recruitment remains ongoing. Plans are in place to recruit additional anaesthetists to cover DCN out of hours for the period they will be in the new building without RHCYP, at that point the neuro trainee rotas will be combined.

13. Catering staff recruited for RHCYP & DCN moved back to existing site to extend restaurant opening hours and provision at RHSC. Domestic services staffing has been augmented at the existing sites to maintain the environment in older facilities. Security staff recruited for the RHCYP & DCN are taking on the security for the RHSC site, allowing NHS Lothian to terminate a third party contract.

St John's Children's Ward

14. The Ward has continued to run 4 nights /week over the winter pressures period, including Christmas and New Year. The last consultant vacancy was successfully recruited to at the end of 2019 and the post holder is expected to start at end February. The most recent advert at the end of 2019 for trained Advanced Paediatric Nurse Practitioners did not produce any applicants.

15. The Royal College of Paediatrics and Child Health have confirmed their follow up Review visit will take place on 11 and 12 February.

16. The Paediatric Programme Board (PPB) will be reviewing the current and anticipated out of hours rota position, to make an assessment of the most likely timing for increasing the service to 7 nights /week. Any further actions to achieve this which can be taken now (before the College visit) will be discussed and agreed. The Board are in the process of appointing two Parent/ Public representatives from West Lothian to join the PPB - one has been identified and the second will be identified imminently.

RHSC- Emergency Department

17. Some outpatient clinics have been moved out of the main Out Patient Department to create more Emergency Department capacity (an additional 7 consultation rooms), this has allowed some separation of major and minor activity, which has significantly benefited patient management and flow in the ED.

INR Biplanar Angiography Equipment at DCN

18. NHS Lothian has confirmed the equipment will be operational on 6 February 2020

Haematology/Oncology Service at Royal Hospital for Sick Children

19. The service at RHSC supported the GG&C Paediatric service from August to December 2019 by taking patients while they were closed to new admissions. GG&C were able to resume taking new patients in December 2019. The additional workload was challenging at times, particularly for Pharmacy colleagues but was well managed overall by the RHSC clinical team.

20. The plan to move the 4 bed Day care service out of the Ward into a 6 bed space elsewhere in the hospital has had to be revisited as the room identified was not large enough. Alternative accommodation is now being assessed with a view to making the move by end January. This will give more space for the Day care service, free up space in the inpatient ward and allow staff to trial the running a day care service separate to the inpatient service, in line with arrangements in the new hospital.

HEI Inspection Report

21. On 15 January, HEI published a report into DCN and the Sick Kids Hospital.

22. Inspectors found a high standard of environmental cleanliness throughout the two sites and there was good staff compliance with standard infection control precautions. The Senior Management of NHS Lothian highlighted the significant work of nurses, domestic staff and other teams across both facilities and the commitment being put place to maintain the high standards which was reflected in the positive reports.

23. Officials would recommend that the Cabinet Secretary visits both sites to see the progress and all actions taken by the Health Board to support staff in delivering quality care.

Auditor General Appearance at PAPLS Committee – 16 January 2020

24. The Auditor General for Scotland presented her report to the PAPLS on 16 January 2020. The report draws Parliament's attention to the issues surrounding the delay to the opening of the Royal Hospital for Children and Young People, the Department of Clinical Neurosciences and the Child and Adolescent Mental Health Service in NHS Lothian. The Auditor General notes that there has been much speculation about the issues and the costs incurred and this report sets out a factual account of what she currently understands about the situation.

25. NHS Lothian had dispute over meeting the building specification with contractors which ultimately led to the signing of the settlement agreement. The committee questioned why NHS Lothian signed the settlement agreement rather than taking legal action against the

contractor. The Auditor General explained the complexity around the contract and the external legal advice led to the decision being taken. The AG could not answer the wider issues around advice and suggested that this should be explored further by the Public Inquiry.

26. Mr Sarwar asked about SG attendance at the Programme Boards of both QEUH and RHCYP. The Auditor General confirmed the Scottish Government was invited to the Programme Board but could not confirm how many times they attended. The Auditor General was asked if Government involvement was sufficient. The AGS highlighted quarterly reports that came from NHS Lothian to Scottish Government as well as regular dialogue. The Auditor General also confirmed that through normal governance processes the Board of NHS Lothian and the Scottish Government were informed of progress.

27. The Auditor General was asked if NHS Lothian could have learned from NHS Greater Glasgow and Clyde. She was clear that when the issues were identified at the QEUH, the RHCYP project was well advanced, however that the Programme Board took the necessary steps to seek assurance around standards once it became apparent there were issues that needed to be addressed.

28. The Auditor General spoke of a lack of clarity of roles and responsibility around all those involved in the project, in particular the Independent Tester. The Auditor General highlighted this is an example of a lesson learned for future infrastructure projects and would be in line with Lord Cole's recommendations who undertook a review of Edinburgh Schools following the collapse of a wall at Oxgangs Primary School.

29. The Auditor General mentioned the Internal Audit review that is currently ongoing within NHS Lothian; the Interim Director of Health Finance has briefed you separately on this issue.

30. I have separately contacted the Clerk of the Public Audit and Post Legislative Scrutiny Committee to ask about next steps and they have indicated the Committee is unlikely to take further action until the Public Inquiry is complete.

The Cabinet Secretary is invited to:

- Note the contents of the update
- Confirm that officials are to take forward arrangements for a visit to the Royal Hospital for Children and Department of Clinical Neuroscience

Calum Henderson
17 January 2020

OFFICIAL:SENSITIVE

Paper no:	**HSCMB/140/2019**
Meeting date:	**22 November 2019**
Agenda item:	**1**

Standing items and Updates

Title:	**NHS Greater Glasgow and Clyde (NHSGGC) – Consideration of Escalation**

Background and Key Issues:	There are on-going concerns around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), NHSGGC, following a number of high profile infection incidents and outbreaks. There is complete confidence in the clinical teams to deliver high quality clinical care on a day to day basis. The concerns surround the fact there improvements require to be made with regards to a systematic approach to Infection Prevention and Control. In light of this, consideration should be given to whether or not the current stage of escalation of NHSGGC is appropriate.

Action(s) Required:	This paper provides an assessment of the specific issues related to infection control, based on the information provided to SG by NHSGGC, and is not a system wide performance review of the Board. Therefore HSCMB is asked to consider: a) That NHSGGC is escalated to level 4, in light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC, NHSGGC. The intention of the escalation would ensure appropriate governance is in place to increase public confidence and strengthen current approaches that are in place to mitigate avoidable harms. b) Building on the work that is already underway with respect to communication with families and for a focus on supporting the effectiveness of the Incident Management Team (IMT) and related governance processes, it is recommended that this is augmented with specific support around Infection Prevention & Control (IPC), and also communications and engagement. This support, including Professor White would report to an oversight board chaired by CNO. Professor White, having established arrangements for improved oversight of family liaison and support, will be asked to consider how similar arrangements can be put in place in

		respect of a review, oversight and action to ensure effective implementation of clinical governance (to include the discussions already taking place re investigation and organisational duty of candour)
Author: Jo Ives/Lesley Shepherd **Date: 21 November 2019**		**Director: Fiona McQueen** **Date: 21 November 2019**

NHSGGC – consideration of level of escalation

Purpose

1. To consider whether the current stage of escalation of NHSGGC remains appropriate in light of the on-going issues around the systems, processes and governance in relation infection management at the QEUH.

Priority

2. Urgent. A decision by HSCMB is required to provide advice to the Director General in order that intervention can be taken as a matter of urgency in order to provide reassurance to the public.

Background

Infection Management – QEUH and RHC

3. There have been a number of high profile infection incidents and outbreaks at the QEUH and the RHC over the past 18 months. A timeline providing an overview of high profile infection outbreaks and associated patient deaths is included at **Annex A**.

Ward 6A (Paediatric Haemato/Oncology), QEUH – Gram-negative bloodstreams infections

4. Most recently, in June this year, the Scottish Government was informed of 4 cases of Gram-negative bloodstream infections linked to Ward 6A (paediatric haemato-oncology) at the QEUH. Since June, 16 cases (15 confirmed, one possible) have been reported to Scottish Government from NHSGGC, via Health Protection Scotland (HPS), as part of this incident/outbreak.

5. While the Board has put in place a number of robust control measures, there have been concerns raised in relation to this latest incident/outbreak from staff at NHSGGC, representatives of HPS, families of young patients, and a whistle-blower who first approached HPS and then the Scottish Government (SG).

6. The central concern raised by each of these parties relates to the lack of information sharing,and transparent and open communication and decision making amongst members of the Incident Management Team (IMT), and also amongst the wider group of clinicians and families.

7. These concerns were again raised explicitly by families and patients with the Cabinet Secretary at meetings held on 28 September and 1 October. Since then, the Cabinet Secretary has made clear that information sharing and communication from the Board, to families and patients in particular, has not been good enough.

8. In addition to this, feedback from staff at NHSGGC, HPS and, latterly, Professor Craig White, is that the Incident Management Team (IMT) could be more systematic in its approach and would benefit from more appropriate business processes. The IMT has been characterised by an inability to reach consensus.

9. Due to concerns over lack of transparency and progress in the management of the incident, a meeting was convened on 25 September by the CNO with NHSGGC, HPS and Health Facilities Scotland (HFS) in attendance. At that meeting, NHSGGC indicated that Root Cause Analysis (RCA) had been undertaken for each case, however evidence to support that a full, thorough analysis was not forthcoming. Since then, a full RCA, based on the investigation i.e. potential source and transmission of infection, has been done retrospectively for each of the bloodstream infections reported since June as part of the on-going incident on Ward 6A.

10. Investigation of an outbreak should follow a methodical approach which involves careful review of the potential cases, and any apparent clinical and epidemiological links which would suggest a cause and effect relationship. A problem assessment group will be formed to support the decision to further investigate and assess the risk of the outbreak via Healthcare Infection Incident Assessment Tool (HIIAT). An incident management team IMT will then be formed to support outbreak investigation. This methodical approach is not apparent within NHSGGC.

11. Information contained with the Healthcare Infection Incident and Outbreak Reporting Templates (HIIORT) received from NHSGGC often raise more questions than answers. There seems to be a focus on using a stock investigative response. This does not always reflect mode of transmission and outline of specific control measures based on the agreed hypothesis are often lacking. There is also an emphasis on ‘ruling out’ rather than ‘ruling in’ cases based on typing. This only reflects one point source transmission such as person to person spread and does not rule out other point source transmission from for example, the environment or contaminated equipment

Infections from 2017 – whistle-blower claims and media coverage

12. On 14 October,following reports that a whistle-blower from NHSGGC had contacted Anas Sarwar MSP about additional cases of infection amongst paediatric cancer patients – including a child who died in 2017 – Scottish Government officials contacted NHSGGC for urgent briefing.

13. Since then, NHS GGC have informed Scottish Government that 26 bacterial organisms were identified in 14 children receiving cancer treatment in 2017

14. Of the 14 children affected, three sadly died. NHSGGC state that appropriate communication was had with families at the time and that routine processes in respect of Healthcare Infection Incident Assessment Tool (HIIAT) /Healthcare Infection Incident and Outbreak Reporting Template (HIIORT) reporting were

undertaken. At least one of the families denies having had appropriate information about their child's death.

15. However, Officials have urgently requested clarity from the Board on why SG were not made aware of either the 14 cases or the three associated deaths given the infections relate to an alert (unusual)organism (as outlined in Appendix 13 of the National Infection Prevention and Control Manual).

16. In addition to this, similar to the on-going incident, affected families have raised significant concerns about the lack of information sharing and communication.

Broader issues in relation to infection incident/outbreak reporting

17. Outbreak reporting from Board to Scottish Government HCAI/AMR Policy Unit via HPS should contain robust information, which will provide policy colleagues with confidence that the outbreak / incident is being managed appropriately and within the guidance laid out in the National Infection Prevention and Control Manual (NIPCM) as well as the Managing Public Health Outbreaks and Incidence (MPHI) guidance where appropriate.

18. However, the information provided in HIIORT can lack detail and leads to further questions by both HPS and SG Professional Nursing and Medical Advisors. In addition, this information is not always forthcoming.

19. In addition to this, based on information received and discussions had with HPS, NHSGGC's approach to overall reporting of incidents/outbreaks via HIIAT appears to be inconsistent. There also seems to be a lack of insight in terms of the bigger system impact of the outbreak. An example of this would be during the 6A outbreak where HIIAT was de-escalated from Amber to Green at an IMT following a weekend of heightened media interest around the outbreak. When questioned by HPS around the rationale for this given the heightened media interest and subsequent increase in public anxiety, NHSGGC did not feel that these wider issues reflected the local context and therefore HIIAT remained at Green.

20. More broadly, HPS have reported a number of HIIAT green assessments from NHSGGC which have resulted in them going back to the Board to question the decision making process around this.

21. For example, in September 2019 NHS GGC reported 6 cases of Salmonella associated with one ward within the Royal Alexandria which were epidemiologically linked by time, place and person to HPS. HIIAT assessment of this incident was Green. HPS and SG queried this with the Board, however it remained Green.
22. Finally, recently, two children died within a week of each other in the Paediatric Intensive Care Unit (PICU) who had both been cardiology patients. These deaths were only brought to our attention by GGC because the Daily Record had been in touch with GGC. Whilst Officials are seeking further information, initial observations suggest that these cases ought to have been

reported to HPS (with onward transmission to SG) rather than the cases being reported to SG because the Daily Record was aware of them.

Current level of escalation

23. The Scottish Government are currently providing Stage 2 support to NHSGGC for scheduled and unscheduled care. Stage 2 is defined as some variation from plan; possible delivery risk if no action.

24. A summary of all levels of escalation is provided below, with details of stage 3-5 provided in **Annex B.**

Stage	Description	Response
Stage 1	Steady state "on-plan" and normal reporting	Surveillance through published statistics and scheduled engagement of ARs/MYRs
Stage 2	Some variation from plan; possible delivery risk if no action	Local Recovery Plan – advice and support tailored if necessary. Increased surveillance and monitoring Scottish Government. SG Directors aware.
Stage 3	Significant variation from plan; risks materialising; tailored support required	Formal Recovery Plan agreed with Scottish Government. Milestones and responsibilities clear. External expert support. Relevant SG Directors engaged with CEO and top team. DG aware.
Stage 4	Significant risks to delivery, quality, financial performance or safety; senior level external support required	Transformation team reporting to Director General and CEO NHS Scotland.
Stage 5	Organisational structure / configuration unable to deliver effective care.	Ministerial powers of Intervention.

25. **Annex C** summarises the level of escalation of other NHS Boards, to ensure a consistent approach is taken to escalation.

Consideration of further escalation and recommendation

26. Based on the information outlined above and that provided to the Scottish Government by Health Protection Scotland (HPS) and NHSGGC, in relation to the on-going incident on Ward 6A and other recent incidents and outbreaks, there is limited assurance that there is robust and effective strategic oversight to ensure that infection incidents and outbreaks are managed effectively at the QEUH or reported appropriately to HPS and SG.

27. Based on the most recent discussion at the National Performance Oversight Board there is no evidence to suggest a systemic issue at NHSGGC which would require whole system escalation beyond stage 2. However given the concerns about the delivery of a safe and effective service for paediatric haemato/oncology in-patients, and the significant risks to public confidence in the delivery of the wider service, the recommendation is that NHSGGC is escalated to level 4 for IPC issues, and as such, external, expert support is sought (IPC, as well as communications and engagement) and an oversight board is established, chaired by the CNO. A separate paper covering broader

aspects of the performance of NHSGGC is being prepared and will be discussed at HSCMB next week. At this early stage, we do not expect that there will be a recommendation to escalate NHSGGC for a more general purpose.

Fiona McQueen
Chief Nursing Officer
21 November 2019

Annex A – High profile incidents and outbreaks resulting in patient deaths

Stenotrophomonas maltophilia at the RHC – 3 deaths in 2017. This figure was confirmed to Scottish Government officials in an SBAR from NHS GGC on 18 November 2019 **[not in the public domain]**. We know that one of the patients who sadly died is one of the cases that has been covered by the media in recent days.

Cryptococcus neoformans at the QEUH – A [redacted]-year-old [redacted] died in [redacted] **2018** after being treated for cancer at the RHC. A [redacted]-year-old [redacted] died in [redacted] **2019** after treatment at the QEUH; the family of this patient have been featured in the press and attended the Independent Review's launch on 27 June. Both deaths are the subject of investigations for the Procurator Fiscal (PF); at least one is likely to conclude that *Cryptococcus neoformans* was the cause of death. This could lead to the recommendation of a Fatal Accident Inquiry to the Lord Advocate. The Cabinet Secretary was briefed on this in July 2019.

[redacted]

Mucoraceous mould – A [redacted]-year-old [redacted] died in [redacted]. This death is also the subject of a PF investigation.

Gram-negative bloodstreams infections Paediatric Haemato/Oncology – RHC – **June-October 2019** - in June this year, the Scottish Government was informed of 4 cases of Gram-negative bloodstream infections in linked to Ward 6A (paediatric haemato-oncology) at the QEUH. Since June, 16 cases (15 confirmed, 1 possible) have been reported to Scottish Government from NHSGGC, via HPS, as part of this incident/outbreak. The last positive case was reported on 3 October 2019.

Annex B – Description of Escalation at Stage 3-5

Stage 3 – Significant variation from plan; risks materialising; tailored support required

If the performance issues are deemed to be serious or if the recovery actions are not delivering the expected improvements in performance then there is scope to escalate to Stage 3 which includes external tailored support for the board concerned. This is normally instigated by the Director of Health Workforce & Performance in consultation with the Director General and the HSCMB. Stage 3 is a formal engagement with the Board and particularly its Executive Team. Recovery Plans are submitted to Scottish Government with clear milestones, responsibilities and with clarity on resources required to deliver. While the responsibility for delivering remains with the Board, Scottish Government will at its discretion provide external tailored support. This can include HIS as part of the engagement strategy to deliver turnaround.

Tailored support typically involves assembling an expert team to carry out a diagnostic visit or visits. The expert team will have access to in-depth data and information on the system compiled before the visit. The team walks the relevant patient pathways or business processes, listening to a range of staff and patients. The team's feedback findings to the NHS Board senior management team at the end of the visit and produce written reports and recommendations. The NHS Board is then required to develop a recovery plan. The NHS Board is supported through access to expert advice and resource to help deliver the recovery plan. The recovery plan is closely monitored while the relevant SG Directors are engaged with the CEO and top team.

There is considerable flexibility within this basic approach which can draw upon a wide range of resources in order to provide the support required. This can be positioned according to requirements, be it as an additional supportive resource to help address complex and difficult issues.

Stage 4 – significant risks to delivery, quality, financial performance or safety; senior level external transformational support required

Exceptionally where Scottish Government believes that a Board's capacity or capability requires enhancement to address local issues then additional direct management or transformation support can be provided.

This will normally take the form of a transformation team led by a Scottish Government Director, Board Chief Executive or other responsible person appointed by the Director General and CEO NHS Scotland to initiate change and support the delivery of a sustainable transformation plan.

The Board Chief Executive as Accountable Officer continues to be responsible for matters of resource allocation to deliver any transformation plan. The Board Chief Executive and his/her executive team are expected to work in conjunction with the transformation Director to construct the required plan, and to take full responsibility for delivery. The transformation Director will be provided with an appropriate level of local support and external as required.

Stage 5 - Organisational Structure / Configuration Unable to Deliver Effective Care.

If the Cabinet Secretary is of the opinion that any functions of a health board are not being exercised adequately Ministers have the power of intervention under the National Health Service (Scotland) Act 1978 and the Community Care and Health Act 2002.

Annex C

Board	Current Stage	Date Escalated/De-Escalated	Primary Factors
NHS Tayside	4	Stage 5 April 2018 Stage 4 February 2019	Financial position and financial management; governance and leadership
NHS Highland	4	Stage 3 July 2018 Stage 4 November 2018	Financial position and financial management; governance, leadership and culture
NHS Borders	4	Stage 3 July 2018 Stage 4 November 2018	Financial position and management; leadership
NHS A&A	3	Stage 3 July	Financial position and management
NHS Lothian	3 4	Stage 3 July 2019 Stage 4 September 2019	Financial position and management Children's Hospital & DCN

Scottish Government
Health and Social Care Directorates
NHS Greater Glasgow and Clyde (NHS GGC) Oversight Board

INFECTION PREVENTION and CONTROL AND GOVERNANCE SUBGROUP REPORT OF THE PEER REVIEW

August 2020

Report by:

Lesley Shepherd, Professional Nurse Advisor of Healthcare Associated Infections and Antimicrobial Infections, Scottish Government

Frances Lafferty, Senior Infection Prevention and Control Nurse, NHS Ayrshire and Arran.

Background

1. On 22 November 2019, NHS Greater Glasgow and Clyde (NHS GGC) was escalated to Stage 4 of the NHS National Performance Framework in light of ongoing issues around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) and the associated communication and public engagement issues. On 24 January 2020, special measures were extended to cover the entirety of NHS GGC.

2. Stage 4 is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.' Escalation to Level 4 requires the Scottish Government to have direct oversight over the operation of QEUH and the RHC initially, and from 24 January, for a range of additional issues, NHS GGC in its entirety. An Oversight Board was established in December 2019 to address the QEUH/RHC issues, chaired by Professor Fiona McQueen, Chief Nursing Officer and reporting to the Chief Executive Officer of NHS Scotland.

3. An Infection Prevention and Control and Governance (IPCG) Subgroup was established in December 2019 to support the Oversight Board by focusing on issues relating to infection prevention and control and associated governance that gave rise to escalation to Stage 4. It is currently chaired by Diane Murray, the Deputy Chief Nursing Officer.

4. As part of this work, the IPCG Subgroup has examined an array of documentation from NHS GGC which outlines the form and function of governance regarding infection prevention and control. The purpose of the Peer Review has been to understand how these systems are operationalised at all levels of the organisation. This report sets out findings and recommendations following the first phase of the Review. It was conducted – and the report has been drafted by – Lesley Shepherd,

professional advisor to the Scottish Government, and Frances Lafferty, Senior Infection Prevention and Control Nurse, NHS Ayrshire and Arran, both of whom are members of the IPCG Subgroup.

Peer Review Approach

5. The Peer Review process was designed to adopt a values-based approach in line with the National Performance Framework and the values of NHSScotland (NHSS). The focus of the review is to gain an understanding of how infection prevention and control (IPC) systems and processes are embedded, and establish how the governance framework which supports these systems and processes is operationalised.

6. The objectives of the Review are to:

- to investigate the ways in which the IPC governance framework at NHS GGC is operationalised across the system; and
- to determine the ways in which national policy has been implemented within NHS GGC, identifying areas where this has carried out in line with national requirements as well as areas where this could be improved.

7. Having reviewed documentation provided by NHS GGC, five areas of focus were originally identified for the Review:

i. implementation of HAI-System for Controlling Risk In The Built Environment (HAI-SCRIBE);
ii. implementation of the National IPC Manual;
iii. Audit and Surveillance;
iv. Outbreak and Incident Investigation (including escalation/de-escalation); and
v. Water Safety.

8. Outputs of the Peer Review highlight good practice relating to Healthcare Associated Infection within NHS GGC, and set out recommendations to build improvement in the system. Outputs will also consider national level recommendations to further strengthen IPC governance and processes across Scotland. The Peer Review will inform the IPCG Subgroup findings and recommendations, which in turn will inform the final recommendations of the Oversight Board.

9. A team comprising members of the IPCG Subgroup was established to undertake the Peer Review. Membership of the Review team and the full terms of reference can be found at Annex C. The initial stage of the Peer Review took place on the 16 March, and was undertaken by Lesley Shepherd and Frances Lafferty. The review was structured in line with a question set (set out in Annex B), which was shared with NHS GGC in advance.

10. Due to exceptional circumstances in light of the Covid-19 outbreak, the Peer Review did not proceed with the full team as set out in the Terms of Reference and some representatives from NHS GGC were unavailable to participate. The remit of the Review was therefore reduced, covering the first three set of issues highlighted in paragraph 7 above. The following report treats with each of these issues in turn.

REVIEW AREA 1: IMPLEMENTATION OF HAI-SCRIBE

Background

11. Health Facilities Scotland (HFS) published the Scottish Health Facilities Note (SHFN) 30) in January 2007 to support Health Boards to manage IPC in the built environment. The guidance comprises:

- Part A: The Manual: Information for teams to support decision making so that identified risks can either be eliminated or successfully managed; and
- Part B: The HAI-SCRIBE Implementation Strategy and Assessment Process, which supports built environment project groups to identify, manage and record built environment infection control risks.

12. The main aim of the guidance is to ensure that prevention and control of infection issues are identified, analysed and planned for at all stages of a project in the healthcare built environment. HAI-SCRIBE ensures that IPC measures are designed as part of plans and can be maintained throughout the lifetime of the healthcare facility. It also highlights potential IPC risks so that these can be designed out. Infection control risks are identified at each of the following stages:

- **Development Stage 1** – consideration of the initial brief and proposed site for development. This coincides with Business Case Stage;
- **Development Stage 2** – design and planning;
- **Development Stage 3** – construction and refurbishment; and
- **Development Stage 4** – pre-handover check, ongoing maintenance and feedback.

13. **Maintenance-related projects** do not necessarily have to go through this approval process but the need for collaboration remains important. To ensure that all Health Boards implement the HAI-SCRIBE process the following directives have been issued.

- CEL (2007) 18 Healthcare Associated Infection: SHFN 30 and HAI-SCRIBE Implementation Strategy. This letter announced the publication by HFS of an Implementation Strategy and a Contractor Endorsement Document to assist Health Boards in taking forward the guidance set out within SHFN 30: 'Infection control in the built environment: Design and planning' and HAI-SCRIBE (Healthcare Associated Infection System for Controlling Risk in the Built Environment).
- DL (2015) 19 was issued to confirm HAI and Antimicrobial Resistance (AMR) policy requirements in all NHS healthcare setting, including the requirement for Health Boards to adopt and implement SHFN 30 Parts A and B.

- DL (2019) 23 updated and replaced DL (2015) 19. Its purpose was to provide an update on mandatory HCAI and AMR policy requirements for all NHS healthcare settings. This included the requirement for Health Boards to continue to adopt and implement HAI-SCRIBE when undertaking any refurbishment, new builds or remedial works within the healthcare environment. It is also set out the expectation that the HAI-SCRIBE should be led by Estates/project teams with input from IPC, key professional groups and clinical teams, and regularly reviewed throughout the lifetime of the project.

Peer Review Approach

14. The findings of this section of the Peer Review are based on discussions informed by Review Area 1 of the question set (set out in Annex B) with senior level IPC nurses and senior level facilities staff. The Lead ICNs (LICNs) did not speak about linking in with capital planning teams, they only spoke about liaising with Estates colleagues regarding HAI-SCRIBE.

15. HAI-SCRIBE implementation was chosen as part of the objectives within the terms of reference for the IPCG Sub-Group, review of IPC governance processes around the relevant national HAI standards i.e. those within DL (2019)23. Given the issues raised as part of the work of the oversight group, review of the systems and processes regarding Board implementation of HAI-SCRIBE are very relevant to the overall outcome.

16. HAI-SCRIBE states that there should be robust processes are in place which must be followed when planning, constructing, maintaining and refurbishing the built environment in healthcare settings. The Peer Review group was tasked with reviewing how these were undertaken across NHS GGC.

17. Participants in this section of the Peer Review from NHS GGC included two Lead Infection Control Nurses (LICN) based at QEUH and two senior members of the Estates team. It should be noted that neither of the Estates representatives were based in QEUH and, therefore, had no direct knowledge of the specific processes undertaken there in relation to HAI-SCRIBE. However, they were able to provide a high level overview of the processes and systems for governance in place relating to IPC.

18. Using Review Area 1 of the question set at Annex B, the key points ascertained in relation to implementation of the HAI-SCRIBE are set out below.

Summary of Discussion and Key Findings

Infection Prevention and Control Team

At what point are the IPCT informed of built environment works?

19. LICNs described a close working relationship with their colleagues in the Estates Department. Estates colleagues would normally discuss work plans by phone or email, with the mode of communication depending on the timeframes for work commencing. In addition, they reported that the use of HAI-SCRIBE was fully

embedded across the organisation, and correct procedures were followed insofar as the responsibility for completion of the HAI-SCRIBE sat with Estates (also refer to point 37).

20. The HAI-SCRIBE details which members of staff from the key professional groups should be involved in completing the document, including IPC, Health and Safety and other specialist advisors as necessary. Recognising the size and scale of the site, Estates staff described the use of agreed generic risk assessments where there was ongoing work in place e.g. replacement of flooring. However, the LICNs informed the review team that unless the work was significant they would only have informal meetings with Estates teams to discuss the HAI-SCRIBE documents with lead services. Examples of work where the IPCT would not be involved were cited as tap and straightener removal. The review team were also informed that it would be unlikely to include health and safety representatives or other key professional groups at these meetings.

21. The guidance for low risk or minor works does not require formal meetings to take place. However, Risk Assessed Method Statements (RAMS) for the works should be completed and reviewed regularly by the IPCT to ensure compliance. However, the LICNs stated that they did not have sight of the completed RAMS.

22. The LICNs also indicated that, due to time pressures, they were not able to attend all meetings relating to projects. It, therefore, had become normal practice for the Estates teams to complete the HAI-SCRIBE and then forward it to the IPCT for review. The LICN would then sign off the HAI-SCRIBE. The LICN would phone the Estates manager for the project to discuss the HAI-SCRIBE if there was uncertainty or concern relating to the content. As a minimum for completion of an HAI-SCRIBE at Stage 2 and 3, the Project Manager would meet with representatives from IPC, Health and Safety, Estates, Clinical, Environment, Domestic Services and Fire Safety.

23. To ensure HAI SCRIBE is addressed a system of recording control measures, agreeing and signing-off projects and accurate recording of meeting notes agreed by all participating parties is required. It was recognised that IPC professionals were core members of project teams. However, due to time pressures, it was noted that an ICN would not attend every project meeting. Instead, normal procedure was for an ICN to review the HAI-SCRIBE to ensure that matters relating to IPC were addressed. There was no mention of a process for reviewing and commenting on meeting notes, or dialogue to ensure that the IPCT were fully informed of any changes to the project or issues encountered in relation to IPC. NHS GGC provided a number of HAI-SCRIBE documents of varying risk categorisation is terms of work and patient population. These indicated that the HAI-SCRIBE document was first completed by the Estates Manager with the understanding that they required review by the IPCN / ward Senior Charge Nurse. Some of these documents indicated an IPCN by name, however, the certification page was signed by a different IPCN. From the documentation received by the Review Team, it is not clear what projects (irrespective of risk) the IPCNs would be involved in from the outset. The HAI-SCRIBE would be a live document and should be a standing item on the project meeting agenda – the documentation provided to the review group showed no evidence to suggest that this guidance was being followed.

24. LICNs reported that they would contact Estates colleagues to raise an issue if there was a breach in the control measures as outlined in the completed HAI-SCRIBE. It was noted that Estates tended to provide checks on control measures as the work progressed. LICNs would also complete checks if the area where the work was being carried out was high risk. Checks by LICNs tended to be undertaken daily. Other staff would also raise concerns with LICNs in relation to IPC.

How often and in which forum are HAI-SCRIBE control measures reviewed?

25. There was no indication of a formal process in relation to monitoring projects or breaches in control measures – for example, to set out who would be responsible for identifying and reporting breaches, who would be responsible for recording the incident, what actions would be taken, and what assurance would be given to prevent a recurrence. The LICNs said that the SCNs or senior managers would normally contact Estates if there were any issues with agreed control measures. The HAI-SCRIBE should clearly identify: (1) the parties responsible for monitoring the project; and (2) those who have the authority to stop works if the control measures fail.

26. LICNs noted the importance of Estates colleagues understanding the needs of patient groups and what kind of care was being provided, and indicated that it was the responsibility of the IPC nurse to support this. The HAI-SCRIBE process clearly identified the nature and level of risk when followed correctly. Control measures should then be implemented to reduce or mitigate risks.

Estates Representatives

27. Based on a recent review of HAI-SCRIBEs completed across NHS GGC by their Associate Director of Estates and Facilities, it was thought that a significant amount of detailed information was being captured. However, it was noted that there was no system for ensuring that HAI-SCRIBEs were completed in a consistent manner across NHS GGC. In addition Development Stage 4 – Pre-handover check, ongoing maintenance and feedback (Post contract evaluation) was not completed for the majority of projects.

28. According to the Estates representative, the Estates Manager would speak with the LICN to ascertain the nature and extent of work required for each project, irrespective of the nature of the work. Estates representatives stated that formal HAI-SCRIBEs were undertaken at all levels of work, which did not appear consistent with the information provided by the LICNs. It was deemed not possible at the QEUH for all stakeholders to be involved in development of the HAI-SCRIBE, which would only be likely in larger, higher riskprojects.

29. The Estates representatives also stated that the due to the size and scale of NHS GGC, the IPCNs were rarely involved in HAI-SCRIBE assessments for minor works. In addition to this, the Estates representatives stated that depending upon the size and scale of the project, the HAI-SCRIBE document may be disseminated electronically to the project group. As stated in point 24 (above), the HAI-SCRIBE documentation provided to the Review team indicated that even where the project was deemed higher risk (Category 3-4), the HAI-SCRIBE risk assessment was undertaken electronically. The Review team surmised that this could create a risk of unsafe

practices and/or inappropriate control measures due to the lack of discussion at the outset between the Estates and IPC team. In turn, this could lead to unintended consequences which might impact on the safety and security of patients, staff, contractors and visitors. There was a need for clarity as to how multi-profession engagement would be assured and how relevant information would be disseminated and reviewed, as well as the ways in which appropriate remedial actions were taken and recorded by the designated individual.

30. It was noted that there was an IPC Built Environment Group and a number of fora relating to work taking place. However, no further information was provided relating to its purpose or remit.

31. Representatives from Estates indicated that all levels involved in work to the built environment – from tradespeople to management – understood that work did not commence until an HAI-SCRIBE was in place, which must include a meeting with an IPCN. This appeared to contrast with information provided by the LICNs, who stated that SCRIBE meetings did not take place for all works undertaken and that it was not the responsibility of the IPCT to sign off completed works. Again, the HAI-SCRIBE risk assessments provided to the Review team supported that the relevant personnel were not always present at SCRIBE meetings.

32. It was outlined that contractors generally had not undertaken formal training to work in a healthcare environment. However, it was noted that projects carried out by external contractors tended to be overseen by a single site supervisor, who had experience of the requirements of projects in healthcare settings. It is imperative that these individuals were involved in the development of the HAI-SCRIBE and carry out their responsibility to disseminate the relevant information to tradespeople. A system of assurance should be in place to support this.

33. Contractors are required to have an understanding of HAI-SCRIBE as set out within Procurement Frameworks. It was not made clear during the Peer Review if contractors for NHS GGC were involved in the HAI-SCRIBE process, as it was suggested that control measures were developed by the Estates team. It is essential that contractors are appropriately involved to ensure control measures are implemented and that any potential unintended consequences of the measures are identified. Assurance is required to ensure that there is an awareness of the risks to patients by those involved in undertaking the work.

For capital planning projects, to what meetings would the IPCT be invited to attend in relation to work in the built environment?

34. The review team were informed that the depending upon the size and scale of the project (more often larger, higher risk projects), the project manager would ‘often set up a meeting with new contractors to enable LICNs to formally meet’. HAI-SCRIBE guidance states that this should always form part of the pre-start meeting for every Capital Planning project and should not be a viewed as optional.

36, The review team asked how often the Estates / IPC Teams are alerted to failures or breaches in the control measures. We were told that the contractors were

involved in the HAI-SCRIBE process and that there were daily visits by both IPC and Estates teams including a daily 'housekeeping' role by the contractor.

37. The review team asked both the Estates and LICNs if there is a consistent systematic approach to HAI-SCRIBE risk assessment across NHS GGC. The Estates representatives stated that there was, however, the LICNs stated that there was not and intimated that QUEH was further ahead than other NHS GGC sites.

38. Review of the completed HAI-SCRIBE documents issued for review by the Review team highlighted.

- Inconsistencies in approach regarding levels of work, patient risk categorisation and subsequent control measures required to mitigate risk to patients.
- Of the HAI-SCRIBE documents reviewed by the Review Team, it did not appear that the IPCT were involved in compiling the document. It appears that the this was the responsibility of the Estates Manager with the intent of the IPCT reviewing remotely.
- There were also inconsistencies within the documentation in terms of the type of work and control measures as well as those personnel involved in the document completion. For example, the names of those involved were found on the front of the HAI-SCRIBE document, however, at the foot, there were no signatures and on occasion, a different LICN noted.
- The impression the Review Team got from the supplied documentation is that rather than these being assessed individually, they appear to have been 'cut and pasted' from previous HAI-SCRIBE documents with the LICNs being asked for comment retrospectively.

Local Recommendations for NHS GGC

Implementation of HAI-SCRIBE	
1.	There should be an internal review of current practice against SHFN 30 to check that HAI-SCRIBEs are being developed consistently across the whole of NHS GGC and in line with national guidance. This review should include: • the level of engagement and input from the IPCT to take account of level of risk to the patient group and also the scale of the project; • the level and nature of the required input from the IPCT for projects which are deemed smaller, based on SHFM30 Part B; • the overall use of HAI-SCRIBE (and RAMS) and the consistency of use across NHS GGC, as per SHPN 30 Part B, ○ Including consistency training for those undertaking HAI-SCRIBE; and • HAI-SCRIBE – post-contract evaluation.

National Recommendations

Implementation of HAI-SCRIBE	
1.	HFS should work with Boards to develop a governance system though the Centre for the Built Environment ensuring HAI-SCRIBEs are completed consistently across and within all Health Boards.
2.	A national forum should be established to enable better sharing of design issues and lessons learned. This should be supported by a review of the current HAI-SCRIBE guidance which would include, for example, both task and patient groups specific RAMS

REVIEW AREA 2: AUDIT AND SURVEILLANCE

Background

35. In 2018 Health Protection Scotland issued the National Monitoring Framework for Safe and Clean Care Audits. This provides an agreed recommended minimum approach to auditing for all Health Boards with the purpose of providing a set of principles for quality assurance of all Safe and Clean Care auditing while supporting a Quality Improvement (QI) approach for compliance and improvement. It clearly defines where the responsibility for undertaking audits, development of action plans and action taken to address any issues lies. It stresses that IPC within Health Boards is not the sole responsibility of the IPCT, which also falls to local teams, and is underpinned by organisational governance structures which ensure strategic oversight.

36. Introduced in 2008, the National Standards for Healthcare Associated Infection emphasised the need for all Health Board staff to be involved in infection control initiatives. Healthcare Improvement Scotland has since revised the standards with an emphasis on ensuring clarity in relation to roles and responsibilities around IPC. The revised Standards were published in February 2015 and are aligned to the National Infection Prevention and Control Manual (NIPCM) with the aim of supporting adherence to IPC practice and policy across all healthcare and social care settings at organisational level.

37. Surveillance is crucial in order to gather intelligence to identify HAIs and outbreak clusters, and to facilitate rapid action to address them. Standard 4 sets out a requirement that organisations have a surveillance system to ensure a rapid response to HAI. DL (2019) 23 outlines Health Boards' current responsibilities in relation to the national HCAI Surveillance Framework.

IPC Audits – Peer Review Approach

38. The findings of this section of the Peer Review are based on discussions informed by Review Area 2 of the question set (set out in Annex B) with members of the IPC team, senior level nursing management and a Senior Charge Nurse.

39. The key points ascertained from the Peer Review in relation to Audit and Surveillance are set out below.

Summary of Discussion and Key Findings

Audit

41. The Audit process within NHS GGC has been recently updated in line with the National Monitoring Framework for Safe and Clean Care Audits. A bespoke quality dashboard has been developed to provide an overview of other quality metrics which can impact staffs' ability to undertake good IPC practice such as staffing levels and patient acuity. This dashboard is currently in its second iteration. The intention is that it will eventually be able to show a breakdown of information by each individual clinical area. SCNs have access to dashboard for monitoring quality within their area and are

owners of their local improvement plans. There are 4 IPC-related audits undertaken within NHS GGC:

- IPC Team audit - Infection Prevention & Control Audit (IPCAT)
- Clinical Team audit –
    - Biannual Standard Infection Control Precautions Audit (SICPs)
    - Monthly hand hygiene audit
    - Weekly cleaning assurance checklists
    - Combined care assurance tool (CCAT)
- Facilities Teams - Facilities Monitoring Tool (FMT) (frequency of these is based on risk)

The IPCAT audit is a combined tool used by the IPCT to measure staff knowledge and practice in relation to Standard Infection Control Precautions (SICPs), transmission based precautions (TBPs), safe patient environment (SPE) and quality assurance. The SPE element of IPCAT includes environmental criteria which are not captured by the FMT. The quality assurance measures clinical risk assessment compliance for multi-drug resistant organism clinical risk assessments as well as compliance with clinical care bundles for invasive devices. These bundles are aimed at reducing the risk of infection from invasive devices including urinary catheters, central lines and peripheral venous catheters.

42. On the day of the Peer Review, the IPC team shared a new IPC audit schedule and process strategy which was developed in November 2019 to provide guidance for local teams around changes to the IPCAT audit process in light of the national requirements in terms of the National Monitoring Framework for Safe and Clean Care Audits. This document outlines an agreed methodology and approach to IPC auditing in Scotland which is designed to align with other quality indicators.

40. SICP audits have been undertaken to ensure local compliance with the National IPC Manual. These have evolved over time using intelligence gathered during previous reviews of the audit process and link directly to NHS GGC's CAIR (Care Assurance Improvement Response) dashboard. There is a minimum requirement to audit all SICPs every six months, however, the SCN is able to increase the frequency of audits within their area. Each ward/department input 20 sets of audit data for each of the ten SICPs. Currently the collection of the data is carried out manually on paper, however, as part of the Excellence in Care programme, funding has been provided by the Scottish Government for collection via mobile devices. This is a very innovative way to present this SICPs data as there is international evidence that poor IPC practice is an indicator of broader system failures.

41. The design of the SICPs audit tool was being tested to ensure ease of use by the auditor. The SCN and Head of Department have been accountable at ward and department level respectively to ensure that these audits were undertaken. IPC nurses have been accessible and can provide support and guidance when required.

42. A potential issue was identified around the recording of the data. At present, the audit tool does not have the functionality to note that risk assessments have been undertaken. This would enable the detailing of information to highlight whether risks

are being mitigated and the reason for deviating from standard policy, for example, a door of an isolation room being left open for patient safety reasons or a non-compliant sink within an area. This information would enable the recording of issues relating to the built environment or individual patient needs. This is particularly relevant where there are infrastructure issues such as the environment as this adds additional governance to risk assessments which are placed on local risk registers; providing a platform for these to be locally assessed and mitigated. This is an addition support for SCNs when dealing with environmental non-compliances within their ward/department which are outwith their gift to correct.

43. NHS GGC have been using the Red/Amber/Green (RAG) system from the HEI inspection tool for reporting on audits. This system showed the outcome of the overall audit score. However, the audit system is unable to show whether the issues underpinning a score were ongoing, or a result of isolated incidents. For example an old environment may score less than a new build due to the design, however if practice is good and there is evidence of risk mitigation then the level of risk that an issue might pose would be reduced. Members of the IPCT indicated that there was room for improvement as to how audits were conducted and reported. The National Monitoring Framework for Safe and Clean Care Audits document makes specific reference to the use of RAG rating when reviewing audit scores. It states that scoring alone does not improve practice that audit scores must identify risk enabling the direction in which to focus improvement activity. Recognising that NHS GGC have recently developed a Standard Operating Procedure (SOP) around this, it would be prudent to ensure that any improvement work undertaken around IPC includes review of audit scoring as a minimum.

44. Each amber or red score is re-audited by a member of the IPCT with the SCN for that area. It was the responsibility of the SCN and Head of Department, not the IPC team, to address issues identified in the audit and to re-audit to ensure that any issues have been resolved. This is a sensible approach and supports ownership of the audit outcomes by the local teams.

45. IPCAT audits are undertaken using a collaborative approach to enable the appropriate individuals to take ownership of relevant actions and respond accordingly. Estates and Facilities teams are involved in audit processes in some areas, but there is no standard specifying who should be involved in the audit process at local level. A Combined Care Assurance Audit tool is currently being developed, which is expected to further strengthen collaborative working.

46. NHS GGC reported that the IPCAT audit report and action plan are shared with ward staff, and discussed during ward huddles. The IPCAT report is also stored in the CAIR dashboard, and can be used to inform discussion at 1-2-1s between SCNs and line managers. In particular, it might create opportunity to focus on issues which were not addressed within the required timescales. It should be noted that IPCAT audit reflects a point in time and gives a snapshot of IPC policy into practice and risk therein and that repeated audit alone does not improve compliance. This is achieved through a change in behaviours, adaptations to practice or process, and, where required, repairs/alterations to the built environment. Investigatory management beyond the immediate rectification is essential in order to achieve sustained change. Therefore action plans arising from IPC need to use a quality improvement approach with local

team review of current systems and processes; agreeing, testing and implementing change ideas with improvement progress regularly assessed via local data collection. It was not evident from either the IPCAT strategy or discussion with the IPC Team how local improvement is measured other than re-audit at set intervals based on the RAG status. The

47. With respect to Audit Governance, a separate report by the ICM is submitted to the Acute Clinical Governance Committee (ACGC) and provides an additional route to inform the Board of any outstanding issues. It was not made clear to the Peer Review team how long-term issues were addressed once logged on the organisational risk register in terms of the action that the ACGC would take, or the mechanism by which this information would be escalated to more senior management.

Surveillance

48. NHS GGC use the IPC clinical surveillance platform, ICNet, to record surveillance data. ICNet is designed to enable a comprehensive approach to clinical surveillance, outbreak management and antimicrobial stewardship, and is customisable to the specific requirement of the user. Having used the system for a number of years, NHS GGC are confident that the system is effective. IPCT at NHS GGC included data analysts, who support data collation and outputs of surveillance enabling the ICNs to focus on their clinical remit.

49. ICNet provides a local view as well as centralised oversight of alert organisms, including all actions taken by the IPCT and the local area to address them. Linked to the laboratory information management system (LIMS), it is designed to include all of the LIMS data, however, IPC Teams will identify alert organisms which would be of interest in terms of healthcare-associated infection (included in Appendix 13 of the NIPCM). New alert organisms can be added or removed depending upon local context and epidemiology. This may be in response to an incident or outbreak or intelligence from laboratory surveillance.

50. Appendix 13 is a nationally agreed minimum list of alert organism/conditions with a purpose of alerting NHS Board IPCTs and Health Protection Teams (HPT) (if out with the healthcare environment) of their occurrence which may require further investigation. Unless otherwise stated, one case would require an IPCT or HPT review to advise that the correct infection prevention and control measures were in place to reduce transmission risk. Typically, two or more linked cases should trigger further investigations into a possible outbreak. The list provided in Appendix 13 is not exhaustive and specialist units – e.g. bone marrow transplant or cystic fibrosis – will also be guided by local policy regarding other alert organisms pertinent to these areas. Table 1 of Appendix 13 describes bacteria which should be considered an alert organisms – some of these in all care settings and some of these in high risk units such as intensive care (including paediatrics and neonatal) and oncology/haematology. The section on 'environmental bacteria' includes 4 Gram-negative organisms – *P. aeruginosa*, *Acinetobacter* spp, *S. maltophilia* and *S. marcescens* – whose presence in any specimen should be considered within high risk areas; in particular, clinical infection caused by these 'opportunistic' organisms should be considered. The Peer Review team understand that despite previous infection outbreaks within NHS GGC, no additional environmental alert organisms out with

those within Appendix 13 have been added to their ICNet system. This means that the IPCT are purely reliant on laboratory surveillance alerting them to the presence of other environmental Gram-negative isolates within patient specimens.

51. Reporting through ICNet occurs when a laboratory clinical sample identifies an alert organism from the database list. Once authorised by a microbiologist, the alert would automatically appear in the ICNet system as a referral for the IPCT. However, we understand from the IPCT that they are not notified of the case pre-authorisation e.g. a call from the laboratory which would allow the IPCN to review the case, discuss with the local teams and commence IPC precautions where required earlier. This will potentially result in positive cases not being actioned on in a timely manner as authorisation can take 48 hours plus. The only exception to this at the moment is *Clostridioides difficile*. If this organism was identified then there would be a requirement to fill in set criteria to ensure all correct IPC measures were being met.

52. As well as alert organism surveillance, NHS GGC also undertake mandatory surveillance as set out in DL (2019)23. This includes surgical site infection (SSI)surveillance – hip arthroplasty, elective large bowel, major vascular and caesarean section – as well as *Staphylococcus aureus* and *Escherichia coli* bacteraemia and *Clostridiodes difficile* infection. The ICNet system is used within NHS GGC for data capture and national reporting of SSI and *Clostridiodes difficile* infection as well as enhanced surveillance of *Staphylococcus aureus* and *Escherichia coli* bacteraemias. This demonstrates a very positive use of the ICNet system as all surveillance data are in the one system and supports ease of both internal and external reporting.

Quality improvement

53. Since the inception of the Scottish Patient Safety Programme (SPSP) in 2008, quality improvement work has been undertaken across health and social care settings in Scotland. The first improvement programme focussed on ’10 Essentials of Safety’ which was based on review of system and process requirements in order to improve outcomes for patients. Within these ten Essentials, there are a number of IPC-related areas namely – hand hygiene, peripheral venous cannula (PVC) / central line (CL) care (insertion and maintenance), ventilator-associated pneumonia and surgical-site infection bundle. Key frontline staff lead on this work with **support** from other disciplines including IPCTs to provide specialist expertise. This includes supporting implementation of evidenced-based interventions such as care bundles, which, if applied correctly every time, can reduce the risk of infection to patients.

54. Based on collaborative international work undertaken between the Institute of Healthcare Improvement in Boston and Healthcare Improvement Scotland the Model for Improvement (MFI) is the most widely used improvement methodology used within healthcare in Scotland. The MFI asks three questions – *What are we trying to accomplish* (Aim), *How will we know that change has made an improvement* (data collection), and *What change can we make that will result in improvement* (change ideas). These can be laid out in terms of the improvement journey which outlines the stages on an improvement initiative or project. Successful change occurs when there is commitment, a sense of urgency or momentum (e.g. higher infection rates), stakeholder engagement, openness and a clear vision that is communicated well.

Involvement of those people in the system is vital to success as they understand the system better than anyone else as development of change ideas will come from their experience of the local practice. Once the system is understood, then change ideas should be tested by the local team with support from others. These changes require small-scale, iterative testing (Plan, do, study act or PDSA); refining and adapting these using the knowledge from each successive test and all the time gathering data to indicate whether change is resulting in improvement. Once the local team are confident that the process change is improving outcome, then and only then, should wholesale local implementation commence. Time-series data will indicate the direction of travel in terms of improvement and alert the local team of sustained improvements or potential issues in the system.

55. The Peer Review team asked NHS GGC for examples of how local surveillance data is used to inform quality improvement work. The IPCT have been involved in much of the quality improvement work including developing PVC care plans which support frontline staff in undertaking the correct, evidenced-based care of PVCs. As discussed above, the IPCAT audits include a section on care of invasive devices including PVCs, CLs and urinary catheters. IPC staff described recent use of orthopaedic SSI data to target improvement where an increased infection rate had been noted.

56. NHS GGC also described PVC improvement work they were involved in based on intelligence from the SAB surveillance data. They had identified an area were PVCs were widely used and where there was evidence of associated infection access devices. They described the use of various tools such as safety cross used to identify how many devices and infections in one day and the use of the 'DRIFT' decision-making tool which supports clinical staff decide whether PVCs should be inserted or are still required. The IPCT spoke about the use of audits (PVC sweeps) where they reviewed the insertion/maintenance bundles.

57. Ward/department safety briefs and handovers were used to highlight all patients who had a VAD inserted and any issues that might have occurred with the device would be discussed. Twice daily checks were also carried out for PVCs which formed part of the ward safety sweep.

58. However, from the discussion with the IPCT, the Peer Review team were left with the impression that this work has been led by them and that rigor around the improvement journey as described above was not applied. There was no evidence of a structured use of quality improvement which would include the use of PDSA or learning from testing – and importantly, it was not evident that the frontline team was leading this work with infection prevention and control expertise from the IPCT. The Peer Review team did not see any evidence of where these process changes were linked with outcome.

Local Recommendations for NHS GGC

	Audit
1.	Further work is required to ensure alignment with the National Framework for Safe and Clean Audits including: • review of audit scoring and subsequent re-audit in terms of risk rating associated with the RAG status; • inclusion of quality improvement within the post-audit action plan this includes evidence of system review, testing of change ideas, regular local data collection in order to ensure reliability; and • scope to include any local risk assessments within the IPCAT and SICPs databases to ensure that frontline teams are not penalised for issues which are out with their gift to rectify themselves, for example, non-compliant sinks.
	Surveillance
1.	Use to be made of the intelligence from infection incidents / outbreaks to add local alerts via the ICNet system beyond what is currently within Appendix 13 of the NIPCM.
2.	Consideration to be given to the current system of notification of likely alert organisms prior to authorisation and inclusion on ICNet to ensure that any potential issues are acted on timeously.

National Recommendations

	Audit
1.	NHS GGC have innovatively included SICPs audit data within both CAIR and local quality dashboards. The use of IPC measures as an indicator for quality is internationally recognised and recommended within the National Monitoring Framework for Safe and Clean Audits. There should be further discussions nationally around how this can be achieved at a local level to support frontline teams in identifying areas for improvement.
	Surveillance
1.	IPCTs across Scotland are involved in vast amount of data collection in terms of audit and surveillance. It is vital that this data is used to support both local and national quality improvement in terms of patient outcomes. The Peer Review team consider that this should include: • a national surveillance system for Scotland which would seamlessly follow each patient across each interface of health and care – this would ensure that IPC and HP Teams have the ability to act timeously where there individuals who may pose a public health risk e.g. those who are isolating multi-drug resistant organisms; and • provision of training for IPCTs regarding quality improvement; utilising the data and intelligence from both audit and surveillance to ensure better outcomes for patients.

REVIEW AREA 3: IMPLEMENTATION OF THE NATIONAL INFECTION PREVENTION AND CONTROL MANUAL (NIPCM)

Background

59. The NIPCM was launched by the CNO in January 2012. First in the UK to take a national approach to IPC, this manual aimed to:

- facilitate the effective application of infection prevention and control precautions by appropriate staff;
- reduce variation and optimise infection prevention and control practices throughout Scotland;
- improve the application of knowledge and skills in infection prevention and control;
- help reduce the risk of HAI; and
- help alignment of practice, education, monitoring, quality improvement and scrutiny.

The recommendations for practice within the NIPCM are based on real-time reviews of the current scientific literature and best practice. The NIPCM also includes resources such as posters, guides and education and training material. In terms of governance, any changes to the NIPCM content are agreed by a consensus group with representation from every IPCT in Scotland as well as experts from Health Protection, microbiology and others. There is also a National Policies, Guidance and Outbreaks Steering Group which overseas production of the NIPCM.

Peer Review Approach

60. The findings of this section of the Peer Review are based on discussions informed by Review Area 3 of the question set (set out in Annex B) with members of the IPC team and senior level nursing management.

61. The key points ascertained from the Peer Review in relation to the national manual are set out below.

Summary of Discussion and Key Findings

62. NHS GGC have placed the NIPCM as a link on the IPC Portal on their intranet site. In addition to this, the IPCT have developed a series of Standard Operating Procedures (SOPs). NHS GGC describe these as a way of 'operationalising' the NIPCM, making it easier for frontline staff to understand. However, the aim of the NIPCM is to 'make it easy for care staff to apply effective infection prevention and control precautions'. It was not clear to the Peer Review team why NHS GGC have developed many of these SOPs (including hand hygiene) which require regular updating based on the current scientific evidence reviews within the NIPCM. Given that this work is already undertaken as part of the NIPCM review, it would seem that production of these SOPs are likely to consume a significant resource requirement for NHS GGC and in fact may be a redundant step.

63. At present, the NHS GGC IPC Portal does not differentiate between local SOPs and the NIPCM. This is likely to cause confusion as to what is National policy and what is local guidance. This led the Peer Review to the conclusion that it appears the NIPCM has not been implemented within NHS GGC. Moving forward, NHS GGC must ensure that staff are directed initially to the NIPCM.

64. It is recognised that disease specific SOPs or aide-memoires may be a useful tool for facilitating easy access to key IPC information which is supported by the NIPCM. This may be especially useful for those novel and emerging pathogens which are likely to cause large outbreaks of infection. The NIPCM includes information around transmission-based precautions required for specific pathogens/conditions within Appendix 11. However, the Peer Review team accepts that it may be appropriate for some additional disease specific evidence-based SOPs or aide memoires for some novel pathogens to be produced nationally for inclusion within the NIPCM.

65. IPC is an advisory service which provides support to frontline staff in terms of guidance and policy as well as evidence into practice. For example, the IPCT are likely to be members of a variety of local groups or committees such as health and safety, clinical governance. In addition, they are likely to support local quality improvement or investigation of adverse event reviews. However, their purpose at these committees / groups are for **support** as an expert IPC advisor of NHS GGC local SOPs by the Peer Review team revealed that in addition to the individual standard infection control (SICPs) and transmission-based precautions, there were a number of other SOPs including – staff screening, outbreaks and indwelling devices. Of note was a SOP for insertion and maintenance of urethral urinary catheters which included a care plan. The Peer Review team found this particularly confusing as catheter insertion and maintenance is the role of local bowel and bladder teams. Whilst the IPCT should support this work, it is not their role to produce SOPs around care and maintenance of these devices. It is also not clear whether the local bowel and bladder reference group were involved in this work which should have been led by them and not the IPCT. The Peer Review team felt that this does not reflect an IPC service which is integrated and collaborative; rather it appears siloed.

Local Recommendations for NHS GGC

Implementation of the NIPCM	
1.	NHS GGC should review their local implementation of the NIPCM. This would include portal should direct clinical staff to the NIPCM in the first instance and not to the local NHS GGC SOPs
2.	NHS GGC ICPT should work collaboratively with other groups as support and expert advice, contributing to their policy and guidance from an IPC perspective and providing a link to these policies within the IPC Portal.

National Recommendations

Implementation of the NIPCM	
12.	HPS should consider the addition of disease specific aide-memoires in addition to Appendix 13 of the NIPCM, providing an evidence-based guide for frontline staff – in particular for outbreaks of novel, emerging pathogens.

ANNEX A: KEY RECOMMENDATIONS

Implementation of HAI-SCRIBE	
Local recommendations	
1.	Internal review of current practice against SHFN 30 to check that HAI-SCRIBEs are being developed consistently across <u>all</u> NHS GGC and in line with national guidance. This review should include: • the level of engagement and input from the IPCT to take account of level of risk to the patient group and also the scale of the project. • the level and nature of the required input from the IPCT for projects which are deemed smaller based on SHFM30 Part B • Of the overall use of HAI-SCRIBE (and RAMS) and the consistency of its' use across NHS GGC as per SHPN 30 Part B o Including consistency training for those undertaking HAI-SCRIBE • HAI-SCRIBE - Post contract evaluation
National Recommendations	
1.	HFS to work with Boards to develop a governance system though Centre for the Built Environment ensuring HAI-SCRIBEs are completed consistently across and within all Health Boards
2.	Establish a national forum to enable better sharing of design issues and lessons learned. This should be supported by a review of the current HAI-SCRIBE guidance which would include e.g. both task and patient groups specific RAMS
Audit	
Local Recommendations	
1.	Further work required to ensure alignment with the National Framework for Safe and Clean Audits including: • Review of audit scoring and subsequent re-audit in terms of risk rating associated with the RAG status; • Inclusion of quality improvement within the post-audit action plan this includes evidence of system review, testing of change ideas, regular local data collection in order to ensure reliability; • Ability to include any local risk assessments within the IPCAT and SICPs databases to ensure that frontline teams are not penalised for issues which are out with their gift to rectify themselves e.g. non-compliant sinks.
Surveillance	
1.	Using the intelligence from infection incidents / outbreaks to add local alerts via the ICNet system beyond what is currently within Appendix 13 of the NIPCM;
2.	To consider the current system of notification of likely alert organisms prior to authorisation and inclusion on ICNet to ensure that any potential issues are acted on timeously.

Audit	
National Recommendations	
1.	NHS GGC have innovatively included SICPs audit data within both CAIR and local quality dashboards. The use of IPC measures as an indicator for quality is internationally recognised and recommended within the National Monitoring Framework for Safe and Clean Audits. There should be further discussions nationally around how this can be achieved at a local level to support frontline teams in identifying areas for improvement.
Surveillance	
National Recommendations	
1.	IPCTs across Scotland are involved in vast amount of data collection in terms of audit and surveillance. It is vital that this data is used to support both local and national quality improvement in terms of patient outcomes. The Peer Review team consider that this should include: • A national surveillance system for Scotland which would seamlessly follow each patient across each interface of health and care. This would ensure that IPC and HP Teams have the ability to act timeously where there individuals who may pose a public health risk e.g. those who are isolating multi-drug resistant organisms; • Provision of training for IPCTs regarding quality improvement; utilising the data and intelligence from both audit and surveillance to ensure better outcomes for patients.
Implementation of the NIPCM	
Local Recommendations	
1.	NHS GGC should review their local implementation of the NIPCM. This would include portal should direct clinical staff to the NIPCM in the first instance and not to the local NHS GGC SOPs
2.	NHS GGC ICPT should work collaborative with other groups as support and expert advisor; contributing to their policy and guidance from an IPC perspective and providing a link to these policies within the IPC Portal.
National Recommendations	
12.	HPS to consider the addition of disease specific aide memoires in addition to appendix 13 of the NIPCM; providing an evidence-based guide for frontline staff – in particular for outbreaks of novel, emerging pathogens.

ANNEX B: NHS GGC PEER REVIEW QUESTION SET

Review Area 1: Implementation of HAI-SCRIBE **Reviewer: Frances Lafferty**

Section One: IPC Team Involvement in HAI-SCRIBE

Number	Question
1.1	At what point do you get informed of works in relation to the built environment? ○ Capital Projects ○ Estates projects ○ Turnkey projects
1.2	What meetings do you attend in relation to work in the built environment? ○ Capital Projects ○ Estates projects ○ Turnkey projects
1.3	How often and in which forums do you review HAI-SCRIBE control measures?
1.4	How are you alerted to failures or breaches in HAI-SCRIBE control measures?
1.5	What involvement do you have in each stage of HAI-SCRIBE for the following projects: • Capital Projects • Estates projects • Turnkey projects
1.6	What process is in place for minor works e.g. TV/computer cabling, power washing
1.7	What process is in place for emergency works
1.21	What point do you inform the IPCT of works in relation to the built environment
1.22	What meetings do you invite the IPCT to attend in relation to work in the built environment
1.23	How often and in which forum do you review HAI-SCRIBE control measures
1.24	How are you alerted to failures or breaches in HAI-SCRIBE control measures

Number	Question
1.25	How are you alerted to failures or breaches in HAI-SCRIBE control measure
1.26	How do you ensure the IPCT are aware of failures or breaches and what is the process for addressing them
1.27	What IPCT involvement is there at each stage of HAI-SCRIBE – (there are 4 stages)
1.31	What point do you inform the IPCT of works in relation to the built environment
1.32	What meetings do you invite the IPCT to attend in relation to work in the built environment
1.33	How often and in which forum do you review HAI-SCRIBE control measures
1.34	How are you alerted to failures or breaches in HAI-SCRIBE control measure
1.35	How do you ensure the IPCT are aware of failures or breaches and what is the process for addressing them
1.36	What IPCT involvement do you have at each stage of HAI-SCRIBE – (there are 4 stages)

Review Area 2: Audit and Surveillance **Reviewer: Lesley Shepherd**

Section 1: Audit	
Number	**Questions**
2.11	How is the current audit programme planned? • IPCAT • SICPs
2.12	How have NHS GGC implemented the "National Monitoring Framework to Support Safe and Clean Care Audits" • Structure and governance • Consistency of results (audit definitions and (aggregated) scoring) • Audit execution – stakeholder engagement, feedback, local governance (short term actions) • Reporting, scoring (RAG scoring based on risk, re-audit • Quality improvement • Risk assessment
2.13	What is the process for SCNs / Senior nurses to access IPCAT audits?
2.14	How are SCNs supported with regards action plan completion? How are identified local IPC risk such as incorrect sinks / taps raised and recorded? How are gaps in IPC knowledge into practice fed back locally and how are staff supported to 'do the right thing'?
2.15	How are audit findings in terms of IPC practice linked in with other outcome metrics such as: • Infection rates • Staff sickness / absence • Complaints • Acuity • Bed occupancy
2.16	How are identified Estates / Facilities issues raised and rectified during / post audit and how are they involved in the audit process?
2.17	How are nursing / general management teams reviewing progress with audit action plans within their directorate?
	How do stakeholders work collaboratively to support reliable closure of the audit loop?

Section 2: Surveillance	
2.21	Who currently uses ICNet within NHS GGC? • IPCNs • ICDs • Data teams • Surveillance • Microbiologists (not ICDs) • Others
2.22	Is routine QA of the data feed between local LIMS and ICNet undertaken. If so, how often?
2.23	How are IPCNs notified of alert organisms?
2.24	How are unusual isolates (including those with exceptional resistance) reported to the IPCNs and how are these monitored via ICNet?
2.25	How often is the current list of alert organisms reviewed?
2.26	Gram-negative blood cultures: What are the triggers which would prompt investigation and how are these decided? What organisms have NHS GGC classed 'exceptional' and therefore prompt review following one case? Environmental GNBCs Where triggers have been breached, what are the immediate actions taken as part of the investigation?
2.27	High-risk areas e.g. cystic fibrosis: What other alert organisms/conditions are included in the surveillance from these areas? What are the organism triggers which would prompt investigation within these areas and how are these decided?
2.28	High risk patients in low risk areas: How are high risk patient risk assessed within these areas? For example an immunocompromised individual cared for within a general medical ward.
2.29	Quality Improvement; How is intelligence from surveillance data used to develop interventions for improvement? How do the IPC team members support the teams locally with this work and how is this learning shared across NHS GGC? Using surveillance data, how does the IPC team work collaboratively with the patient safety team as part of the Scottish Patient Safety Programme?

2.30	<u>*S.aureus* bacteraemias</u> Source identification – Line 'sweep' audits. Where bundle compliance is found to be low, what action is taken? What is the governance process which supports this? Source identification – how are NHS GGC using intelligence around source of infection and known patient risk factors to support improvement? For example, those patients receiving renal replacement therapy.

Review Area 3: Implementation of the NIPCM **Reviewer: Lesley Shepherd**

Number	Questions
3.11	How has the NIPCM been implemented within NHS GGC • Strategies used • Testing • Feedback from staff

3.12	NHS GGC Standard Operating Procedures:
	• What is the rationale for producing SOPs based on the NIPCM?
	• How are these used in practice and how are NHS GGC measuring staff compliance with these?
	• BICC minutes suggest that there is variation in practice across some of the GGC sites e.g. decontamination of near patient equipment
	  ○ Why is this?
	  ○ What is the governance to support this practice variation?

	What is the mechanism for development testing, approval and implementing of SOPs locally and what is the governance process which supports this?
3.13	What mechanisms are NHS GGC using to ensure reliable implementation of the NIPCM? How is this learning shared across teams within NHS GGC?
3.14	In which areas do NHS GGC deviate from the NIPCM?
3.15	How are these deviations assessed via the risk management route? Are HPS involved in this process?
3.16	What is the governance process around deviation from the NIPCM and how are these deviations escalated and reported from Board to ward?
3.17	What are the mechanism why which changes to the NIPCM highlighted to: • Frontline teams inc. nursing, facilities • Nursing/senior management What is the governance which supports this process?

ANNEX C: TERMS OF REFERENCE – PEER REVIEW

Purpose and Governance

The Infection Prevention and Control Governance (IPCG) Subgroup of the NHS GGC Scottish Government Oversight Board was established in December 2019 has examined an array of documentation from NHS GGC which outlines the form and function of governance regarding infection prevention and control (IPC). The purpose of the Peer Review is to understand how these systems are operationalised at all levels of the organisation.

The Peer Review group will report to the IPCG Subgroup which itself reports directly into the Oversight Board, Chaired by the Chief Nursing Officer, Professor Fiona McQueen.

Background

In light of the on-going issues regarding the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC, as well as communication issues, the Director General for Health and Social Care concluded that further action was necessary. This action is to support the Board to ensure appropriate governance is in place to increase public confidence in relation to these specific issues for which the Board was escalated to Stage 4 of the performance framework. This stage is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.'

The IPCG Subgroup focuses on issues relating to infection prevention and control (IPC) and associated governance which gave rise to escalation to Stage 4. Under the auspice of the IPCG Subgroup and commissioned by the CNO, the Peer Review aims to gain an understand of how the IPC Team are supported across the organisation to ensure the delivery of a safe and effective IPC service.

Approach

The Peer Review will take a values-based approach in line with the National Performance Framework (NPF) and the values of NHSScotland (NHSS).

The focus of the Peer Review is to gain an understanding of how IPC systems and processes are embedded and also establish how the governance framework which supports these systems and processes is operationalised.

It is important to state that ensuring that IPC systems and processes are embedded and governed is not the sole responsibility of the IPC Team. It requires support and collaboration at all levels of the organisation; across specialties, teams and directorates both at Board and also at national level. Therefore, the Peer Review plans to liaise with many other disciplines where patient safety associated with IPC is key. This liaison will include directors and managers, estates and facilities, senior charge nurses as well as local IPC teams.

The Peer Review will take place on **Monday 16th March 2020**.

Objectives

The Peer Review objectives are:

- To review how the IPC governance framework provided and described by NHS GGC at the IPCG Subgroup is operationalised across the system;
- To determine how national policy has been implemented within NHS GGC; identifying areas where this has carried out in line with national requirements as well as areas where this could be improved.

Having reviewed the documentation provided by NHS GGC, the Peer Review has identified 5 areas of focus:

- Implementation of HAI-SCRIBE
- Implementation of the National IPC Manual
- Audit and surveillance
- Outbreak and incident investigation (including escalation/de-escalation)
- Water safety

In Scope

In order to meet these objectives, and with the support of NHS GGC Programme Management Office, the Peer Review team will retrospectively review the relevant (and perhaps supplementary) documentation with the objective of developing a question set. The Peer Review will also review how IPC intelligence and lessons learned are communicated and shared across disciplines, including within the IPC Team.

The Peer Review Team will then meet informally with various stakeholders as described above to gain a deeper understanding of how these systems and processes operate and how key information and lessons learned are communicated locally. This will allow the Team to develop a set of recommendations based on their expert knowledge and skills in IPC and Estates.

Out of Scope

As stated in the Terms of Reference for the IPCG Subgroup, the Peer Review Team will not undertake a review of the roles and responsibilities of individual staff members within NHS GGC. However, the Peer Review will review how IPC key information and lessons learned are shared across disciplines, including within the IPC Team.

Governance

The Peer Review Team will report to the IPCG Subgroup, which is Chaired by Diane Murray.

Reporting

A report and recommendations will be developed by the Peer Review Team and submitted through the IPCG Subgroup to the Oversight Board by 31 March 2020.

Peer Review Team Members

Member	Job Title	Review area
Frances Lafferty	Senior IPCN, NHS Ayrshire & Arran	Implementation of HAI-SCRIBE
Lesley Shepherd	Professional Nurse Advisor, HCAI/AMR, Scottish Government	Audit and surveillance Implementation of the NIPCM
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From: Campariol-Scott C (Carole)
To: Campariol-Scott C (Carole)
Subject: FW: UPDATE ON NHS GGC/QEUH OVERSIGHT BOARD WORK
Date: 25 September 2020 15:32:50
Attachments: QEUH and NHSGGC - Oversight Board - 2015-19 timeline report - Sandra Aitkenhead - April 2020 - conclusions (excerpt).ppt
NHSGGC - Further SBAR to CabSec re Staff & Family Feedback - 110520.docx
QEUH and NHSGGC - Oversight Board - update note on progress for Cabinet Secretary for Health and Sport - 14 May 2020 - draft.docx

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Working days: Mondays, alternative Tuesdays, Wednesdays and Fridays.

From: Raines P (Philip) [redacted]
Sent: 13 May 2020 08:55
To: Cabinet Secretary for Health and Sport [redacted]
Cc: McQueen F (Fiona) [redacted]; DG Health & Social Care [redacted]; Chalmers G (Greig) [redacted] Campariol-Scott C (Carole) [redacted] Dryden J (Jim) [redacted]; Hegarty L (Lee) [redacted] Mooney S (Sharon) [redacted] Birch J (Jason) [redacted]; Ives J (Josephine) [redacted]; Shepherd L (Lesley) [redacted]; Murray D (Diane) [redacted]; White C (Craig) [redacted]; Hutchison D (David) [redacted] Connaghan J (John) (Health) [redacted]; House D (Dan) [redacted]; Morrison A (Alan) [redacted]
Subject: R: UPDATE ON NHS GGC/QEUH OVERSIGHT BOARD WORK

Jack/Andy

Fiona McQueen is keen to give the Cabinet Secretary an update on the work of the NHS GGC/QEUH Oversight Board in advance of Ms Freeman's meeting with the two chairs of the Independent Review on Friday, 15 May. I will be participating in the latter meeting, and would be happy to follow up/discuss any of the issues set out in the attached note in advance. Full briefing for the meeting for the Chairs is being provided presently by Sharon Mooney.

Attached is an update note and a draft of the conclusions on the timeline of infections from the independent expert, Sandra Aitkenhead, of KPMG. I would add that these are likely to be revised with final work by Sandra. (A full draft is available on request, though this is still being fact-checked with NHS GGC.) Also attached is Professor White's recent SBAR on family issues in the QEUH.

With regards

Phil Raines

CNOD
M: [redacted]

Introduction and Summary of Timeline

Introduction

The slides in this report set out a timeline of the infections and colonisations which occurred in the Royal Hospital for Children (RHC) and latterly the Queen Elizabeth University Hospital (QEUH) during the years from 2015 to 2019. The timeline only looks at paediatric patients in the Haemoncology/Oncology Bone Marrow Transplant (BMT) wards that were affected by these incidents. It does not contain reference to any instances where such infections occurred in adults wards.

The timelines includes any infection or colonisation either caused by a Gram Negative Bacteria (GNB) or a Fungus. Some Gram Positive Bacteria are also included in the timeline but only as a result of being included within a wider set of GNBs or is relative to the context that is being described.

An Incident Management Team (IMT) is set up when certain triggers (which are laid down in the National Infection Prevention and Control Manual which is written by Health Protection Scotland (HPS)) are reached. The trigger is normally based on a certain level of an organism in a specified period. The level and period are dependent on which organism is being considered.

An IMT will normally follow a Programme Assessment Group (PAG) which will look at any infection or colonisation that has occurred in a patient. If the trigger is breached, then an IMT will be convened to investigate the incident more fully. The timeline consider each of the incidents from when the IMT was convened, rather than the PAG. However, if the incident was only considered by a PAG this will be included in the timeline.

The timeline looks at both the activities of the Infection Prevention and Control Team (IPCT) and also the Facilities and Estates Team (F&E) who are normally both involved in the IMT and to show the interaction between these two teams. In respect of the F&E team, the timeline also incorporates activities performed by the team in responding to issues with the hospital campus following it being handed over by the main contractor who built the hospitals. The timeline also considers the development of the F&E team over the period in respect of development of its levels of compliance and also the handling of a two reports prepared by a company called DMA which highlighted concerns with the water system at the time the hospital was handed over.

Summary of Timeline

Haemoncology/Oncology and BMT patients were originally accommodated in Ward 2A and day patients were seen in Ward 2B of the RHC. Patients could also be accommodated in or transferred to and from the Paediatric Intensive Care Unit (PICU) depending on the severity of their condition. The timeline shows that an increasing number of incidents occurred in Wards 2A from 2017 onwards. In 2018 the level of incidents results in Wards 2A and 2B being closed and BMT patients were moved to Ward 4B in the QEUH and the remainder of patients were moved to Ward 6A in the QEUH. This relocation occurred at the end of September 2018 but was intended only to be for a short time.

The timeline shows that the hypothesis that infections were caused by contamination of the water system starts to develop in 2018 when the first incidents starts to occur in March of that year. A Technical Water Group (TWG) was set up in the April of that year to investigate this hypothesis further and to consider and come up with both short and long term solution to this problem.

The decant of patients from Ward 2A and 2B was in order to allow a thorough investigation of the wards to understand what was the cause of the infections/colonisations and if indeed was the water supply. It was also to allow replacement of taps, showers and drains to be fitted. As work begun further issues in relation to the ventilation of the ward became apparent and the extent of the work required became much more extensive. As work has progressed other problems have been discovered, such as mould in shower rooms due to faulty floor sealings. At the time of writing the work on the wards is still progressing and the estimated timescale for completion is [September 2020]

Following the move to Ward 6A infections continue to be seen during 2019 and leads to more detailed analysis of patient pathways and their access to other sources of water and locations outside of the wards. New admissions to the ward are restricted until no further cases are reported for a period of time. The ward continue to accommodate these patients to the present day and BMT patients still remain accommodated in Ward 4B.

It should be noted that the timeline also included infections in other areas of the RHC such as PICU and wards 1E, 3A and Theatre 6 which are all contained in the RHC. The level of occurrence of incidents in these Wards was much less, with the exception of PICU which also saw more incidents in 2019. All these Wards remained open and preventative measures were taken to control the spread of the organism involved in the incident.

The TWG has continued since it was first convened in April 2018 and initially conducted a large number of water tests across the whole campus to ascertain whether the issues with the water supply were confirmed to just Ward 2A or beyond. The results of these tests revealed that the problem was widespread and a solution to address this would have to cover the entire campus. Following discussion with third parties and water experts, the long term solution that a chlorine dioxide (CD) plant should be installed and continual dosing of the water supply in both the RHC and QEUH would take place. The CD plant was installed and the RHC has received dosing of the water supply since November 2019 and the QEUH since January 2020. Weekly water tests are conducted and the results producing a large number of negative results, indicating that the CD is having a positive effect.

Also included in the timeline are incidents which occurred in the Neonatal Intensive Care Unit (NICU) in the Maternity Building which is connected to the RHC. The unit cares for very premature babies and is included in the timeline as the building's water supply is dosed with CD. This was building was part of the original site and is not a new building. This is the reason that it is dosed with CD.

Structure of Report

There are a number of sections contained in this report as follows

- **Timeline for 2015 to 2019** – these sections set out the investigations made by the IMTs and also the control measures put in place to prevent the spread and transmission of the infection/colonisation. The type of GNB or Fungus is noted together with the which ward or location in the RHC they were when the infection/colonisation occurred and also the number of patients that were affected. Timeline of the Technical Water Group

Introduction and Summary of Timeline

- **Timeline of Technical Water Group –** this looks at the work of this group and the decisions taken in relation to the instalment of the CD plant. It is shown as a timeline for the group from April 2018 up to December 2019. The TWG continues to meet on a monthly basis to the present day. The timeline also details the development of the further issues identified with wards 2A and 2B and details the reasons for the delay in being able to return patients to these wards.

- **Heat Map of Infections –** this table brings together in one table all the incidents that occurred during the time from 2015 to 2019. The table shows where the incident occurred, which month it occurred, the organisms involved and the number of patients that were identified with that organism at the time. The table highlights the increase in incidents in years 2018 and 2019.

- **Reflections on Governance** – this table shows how each of the above incidents detailed in the heat map have been reported up to the GGC Board and the governance structure that is in place around such incidents.

- **Conclusions and Lessons Learned –** this sets out the conclusions drawn and also the lessons that that can be learned from the incidents which have occurred at the QEUH and RHC and how they can be managed. The lessons learned section incorporates now only those for GGC as a Board but also from a national perspective for other organisations and heath boards..

Information Source

The information contained in this report has been taken from a number of sources including, but not limited to, the following

- Interviews with members of the GGC Infection Prevention and Control Team and Facilities and Estates team;
- Minutes of IMTs and/or PAG set up to investigate each incident
- Minutes of meetings of the GGC Board, Acute Infection Control Committee (AICC), Board Infection Control Committee (BICC), Board Clinical Governance Forum (BCGF), Clinical and Care Governance Committee (CCGC) and the Acute Clinical and Governance Committee (ACGC)
- Minutes of the Technical Water Group (TWG), the Board Water Safety Group (BWSG) and the South and Clyde Sector Water Group (SCSWG)
- Papers provided by Facilities and Estates in relation to water risk assessments, audit and compliance documents.
- IPC Summary documents attached to papers of the AICC.

A full list and details of the information used to the preparation of this report is contained in the folder "Information Sources for Timeline" attached to this report. It should be noted that some of the documents used were contained on a secure SharePoint site and in this case, the physical document can not be included and therefore the title of the document is included within the folder. It would require the reader of this report to request a copy of the relevant document from GGC or permission to gain access to the SharePoint site.

Limitations

The timeline has been completed for the period 2015 to 2019 and has not taken into account, unless otherwise specifically stated, the events that have occurred after that period. The minutes of the GGC Board and its various committees have not been reviewed for 2020.

The timeline does not include any information in relation to infections and colonisations that occurred during the period 2015 to 2019 in the adult hospital or within the adult patient population. The exception to this is when the paediatric haemoncology/oncology patient group moved to wards 6A and 4B in the adult hospital The absence of any such similar incidents relating to the adult population from the timeline should not be taken to mean that such incidents did not occur.

The information for this report is based on that provided up to and including 27 March 2020. If any further information comes to light that changes the content of this report, then the right is retained to update the report accordingly.

Conclusions

The situation faced by GGC was a complex one and one that would not have been expected in a recently new build hospital. Water experts and the reports produced by HPS/HFS concluded that the water supply was likely contaminated at the point of handover. The HPS/HFS report also noted that some of the water tests for TVCs conducted by the main contractor initially failed and that in subsequent tests, only some areas which had failed previously now passed. It was not clear from the documentation provided by the main contractor whether those areas that failed a second time, ultimately passed. The HPS/HFS report notes that these results were not raised by the main contractor with the project board or any other agency. There appears to be agreement that the water supply was potentially contaminated before handover however it is clear that there were opportunities where this issue could have been discovered but these were lost.

There are a number of conclusions that can be drawn from the timeline which can be split between different periods of time. These being, the period before and after handover, management of the incidents themselves, and future plans and actions.

Pre and post handover period

A number of lost opportunities occurred when potential issues with the water system could have been noted but were not. These were as follows:

- ***Commissioning***

Based on discussions held (see appendix 1) it is noted that the commissioning of the hospital was carried out by an assessor appointed by the main building contractor rather than being a joint appointment made with GGC. Normally the role of the assessor is to confirm that the building has been built in line with the specifications agreed between the client and the main contractor. Any anomalies are reported so that these can be corrected. Normally the appointment is made jointly by the client and main contractor to ensure independence. On this occasion the assessor was appointed purely by the main contactor and therefore independence was lost and the opportunity for issues to be missed may have been created.

- ***GGC Water Testing post handover***

Based on discussions with the F&E team, it is noted that at the instigation of a senior estates manager, water testing was conducted by 2 members of the estates team throughout the campus after handover. The tests were for legionella only as there is no longer a standard requirement to test for TVCs. The members of the estates team conducting the sampling were not trained in how to take samples and potential contamination when taking the samples could have occurred as a result. Where positive results were found, sanitisation of the area was conducted, until 3 consecutive negative tests were obtained. Despite the lack of training, this would have been a good opportunity to test also for TVC counts, while although no longer a standard requirement it does provide an indication of the quality of the water supply i.e. high counts would indicate that the water was contaminated with faecal material and dirt.

It should also be noted that during this time and before occupancy, the water system was being flushed on a regular basis to ensure that the water in the system was turned over and to prevent stagnation. The F&E team advised that agency staff as well as domestic staff were used to ensure that each outlet on the campus was turned on for a period of time to keep the water moving in the system.

- ***DMA 2015 report and lack of clarity over roles and responsibilities in the F&E team***

The receipt of the DMA 2015 report should have alerted GGC to the fact that there were issues with the water system but this was “lost”. The report was received by a senior estates manager who passed it off to a more junior member of staff to action. There is no clear evidence to confirm whether or not action was taken in respect of the report, however the DMA report of 2017, contained most of the same recommendations which would indicate that little or no action was taken with the 2015 report.

The context around this is laid out in Appendix 1 but it is important to note the impact of the situation at the time and why the report got “lost”. At the time of handover the hospital was incomplete and over 300 sub-contractors arrived the next day to complete work started. F&E staff had to sign these sub-contractors into the site and gain an understanding of what work they were there to do. Issues with the hospital quickly started to arise as clinical services started to move into the campus and these also had to be handled by the F&E team.

The “fire fighting” being conducted by the F&E team to rectify issues that were arising meant that the team was working long hours. The DMA 2015 reports appears to have got “lost” in the flurry of activity that was taking place. GGC acknowledge that the “ball was dropped” and that had the report been actioned at the time, this would have alerted GGC to potential issues with the water system.

One of the reasons that appears to have contributed to the “loss” of the DMA report was that there was a lack of clarity over the roles and responsibilities within the F&E team at that time. Based on discussions with the F&E team and the consultant who investigated the “loss” of the DMA report, there was no formal Authorised Person responsible for the water system. It was recognised that people had particular expertise or knowledge of an area, such as water but they were not formally assigned responsibility for looking after than area. In addition, based on information provided in Appendix 1, there was also a high turnover of staff at this time and lack of proper handovers. This also contributed to the “loss” of the report.

It should be noted that the structure of the F&E team has now significantly changed and there is assignment of specific roles and responsibilities in the team. Since the “water incident” in 2018 and the appointment of the new Directors of F&E, there has been a greater level of formal compliance systems introduced within the organisation and formal training and appointment of Approved Persons, not only for water, but for other systems as well. SOP have also been introduced to ensure consistency among the work performed by the various sector estates teams.

- ***Lack of controls***

According to the HFS/HPS report the main contractor was also on site after handover of the campus, performing work on the water system. This was without the knowledge of the project board and consequently there was a lack of control over the work being progressed by the main contractor and the impact of this on the water system itself and potential contamination.

- ***Lack of maintenance records***

The F&E team also acknowledge that while some maintenance was performed on the water system, the full

Conclusions

scale of the maintenance which is now performed was not done initially. The F&E team advised that maintenance schedules should have been provided by the main contractor but was never supplied. It was not until late 2018 and what was received was a list of assets detailing the parts of each system. The F&E team were required to draw up maintenance schedules from this list. Based on discussion with the F&E team, it is clear that the information received from the main contractor in relation to systems in place, was confusing and incomplete and the labelling and referencing of systems and its parts was incorrect. This made identification of the various parts of the system difficult and consequently to maintain in line with the manufacturers guidelines. If these records had been in place, this may have provided opportunity to identify the issues with the water system.

Management of GNB and Fungal Incidents

There are a number of key conclusions when considering how the incidents were managed. Much revolves around the lack of guidance and research around managing such incidents as well as a large degree of reliance on the decisions made at a ground level.

- ***Research and development of national policy***

It is clear that there is a lack of research and guidance available when it comes to managing an infection or outbreak that is suspected to be associated with the water supply. It is noted that HPS now have 2 aide memoires on its website on how to manage water associated and ventilation associated outbreaks and infections. It is also noted on the website that additional guidance will be included in a new chapter of the National Infection Manual.

While GNB are known to exist within the environment and also in and on a person's body, knowledge about their development and growth within a water system seems to be much less common. In addition knowledge on how the organisms are transmitted from a water system to a patient does also not appear to be understood other than by water experts. These comments equally about the development and growth of bio-film which protects organisms and allows them to multiple.

The matter is also complicated by the build of the new hospitals as was noted by the water experts. One water expert noted that because new builds were hermetically sealed, then hospitals were seeing issues such as this, were previously there had been none. However it is also noted that through the course of the timeline, MB reports comparing infection rates at the hospitals previous location of Yorkhill did not show that the level of infection rates had increased.

Of course, infection rates are only one part of the equation, the others being the severity of illness of the patients, their length of stay, the mix of patients, number of patients, line practice etc as well as many more factors. Such large hospitals have not been built before and therefore the growth, development and transmission of such bacteria and fungus in these complexes is as yet unknown.

The lack of clear research and guidance on how to handle such incidents was very clear to the IMT team and they sought advice and guidance outside of the organisation. This included HPS, HFS, water and ventilation experts, contacting other health boards and Public Health in England to see if they had any similar experiences of such incidents. Facilities, such as Great Ormand Street hospital was also visited to understand and see their practices and facilities in relation to water and ventilation system. GGC asked for help and it was acknowledged that external advice, guidance and expertise was required in order to resolve the issues that were being faced. GGC also asked for help from other health boards when the decision was. taken to restrict admissions to Ward 2A and also Ward 6A.

The lack of research and guidance that was available in this area hindered GGC's response and the organisation was on a "learn as you go" footing. Much of its actions seem reactive but given the lack of policy and guidance this is to be expected. However now that this experience has been gained, there needs to be a period of reflection as to how this knowledge can be retained and utilised going forward to ensure that investigation of any further incidents benefit from this prior experience and can be resolved much more quickly and effectively.

- ***Typing of organisms***

An observation from the timeline is that attention and focus placed on determining the type or strain of the bacteria in order to determine whether cross transmission has occurred and also whether a source can be identified. While the benefit of this can be understood and seen, there is also the consideration that when dealing with such incidents the fact that a bacteria or several different bacteria have occurred should also be considered. The incidents should be seen as a whole incident rather than a collection of incidents.

The timeline highlights that clinicians were of the opinion that they were seeing more instances of GNB than usual and this raised their concerns. This observation is from the benefit of hindsight but had this position been taken in 2017, there is a possibility that questions may have been raised when the two STM infections appeared. This is a matter of conjecture however, but certainly was a taken by SG in 2019 when they asked GGC to look at the incidents as a whole and not separately. This flexibility of thought and interpretation while still being guided by policies and procedures may be necessary when managing and dealing with unusual circumstances such as those faced by GGC.

- ***Development of the hypothesis***

It is noted from the timeline that the hypothesis around the water system did not start to develop until 2018. Any actions taken before then in connection with water outlets, wash hand basins or any other connection to the water system either appears to be a cautionary measure or the link has been made specifically to that outlet was the case in the aseptic pharmacy in 2016 when a patient had CU following food being prepared in that area. Even though there was a number of GNB incidents in 2017, a connection was not made on the basis that each had a unique strain and the period over which they occurred was to long to create a trigger for further investigation i.e. in that the STM infections were several months after the EM infections.

The hypothesis around contamination of the water system was, from the timeline, that of one particular ICD although concerns around the environment had also been expressed by other MB and clinicians. It is noted however, that had the drive of, and actions instigated by, this individual not been there, it is possible that the number of incidents could have been potential higher and a longer time taken to implement a permanent solution not been instigated. One of the first actions taken by the TWG was water samples for all parts of the campus and the results showed that positive samples were returned from across the campus indicating that there was a widespread problem with the water, thereby supporting the hypothesis. However as noted by

Conclusions

the TWG itself, that it was not clear whether it was water outlets that was the problem and were creating the bio-film holding these organisms or the water itself which contained them and was infecting outlets.

It is also fair to say that other hypothesis were investigated, but the focus on water, may have distracted from the full investigation and further research of these hypothesis. It is noted that towards the end of 2019, actions were taken to look at full patient pathways. This considered patient's access to areas where water was unfiltered. It also highlighted took a much wider view of what happens to a patient when they are outside the ward and at home. Development of this analysis is in value both in determining whether there are any other cause of the infections but is also likely to provide assurance to the public that all avenues are being investigated.

- ***Governance and Risk***

In the previous section on governance it was noted that there seemed to be a lack of discussion and debate on incidents that have been reported. The committees and boards appear content to place assurance on the work of the individuals managing the incident and there appears to be lack of rigour and challenge as to the actions being tested. This is not to say the actions are wrong, but if there is a lack of testing or discussion around the actions being taken, there is a lack of rigour to the whole process. It is appreciated that minutes are by their nature a summarised version of events and this could just be the result of the summary process.

It is clear that GGC has a governance structure and process in place which appears to be reasonable but having a structure in place is not enough in itself. The structure needs to apply the necessary rigour to ensure that the appropriate actions and decisions are being taken. It is possible that given the nature of the issues that were being faced that the committees and board did not have the requisite expertise to pose such challenge and were also "learning as they went along". It may be that consideration should be given to an alternative reporting structure where water incidents occur. As noted in the Heat Map of Infections section of this report, if a expert/specialised group is formed to look at any future incidents then they should report directly to the Board who along with the assistance of an expert can understand the full implications of what they are told. The group should also report to the CCGC so that risks can be reported directly into the RMSG and included within the CRR.

In terms of risk, there is a lack of transparency as to how risks are escalated up the organisational structure and there appears to be a disconnect between the concerns expressed at the ground level with those articulated in the CRR. Again a peer review should be considered to really understand this process in practice. It is noted that the structure and the minutes of the RMSG have not been reviewed and this should be performed as part of the peer review.

In addition it is noted that the ARC covers both audit and risk but the focus of this committee is more on more on the former rather than the latter. It is also concerning that ARC does not have representation from the MD when it is being asked to consider and approve medical risks. It was also noted that the members of the ARC were unclear of the process of how risks found their way into the risk register. This has probably now been addressed but it does raise the question as to whether the CRR is complete. Furthermore given the dual focus of the ARC, consideration could be given to appointing an experienced chief risk officer to achieve a more dedicated focus on the risk process and to address the apparent disconnect which has already been noted by the BICC.

Future Plans and Actions

The long term solution implemented by GGC to address the potential water system contamination was the Implementation of CD dosing plant. This decision was taken after discussions with water experts, MB and various outside agencies as noted in the TWG timeline. CD was considered the best option for stripping bio-film and had the longest contact time of all the chemicals considered. An extract of the water results provided by the F&E would seem to support their view that water samples are relatively clear. However there are a number of issues that still require attention and corroboration as noted below

- ***Analysis of water samples***

It was noted in the TWG timeline section of this report, that while the water results on first glance appear to indicate low levels of bacteria, there is no point of reference or comparison as to the baseline that was created prior to the CD being installed into the system and therefore whether the counts are reducing or increasing. In addition the results are at one point in time, rather than showing the results per outlet over time.

It is noted in the December 2019 minutes for the TWG that statistical analysis was being proposed but it is unclear whether or not this was taken forward. If this has not taken forward, then this would be recommended to ensure that there is a continuing trend downwards in respect of all bacteria across the whole campus and to ensure that the CD is adjusted according for "hot spots" identified by such analysis which show variable or persistently high results. .

- ***Water outlet replacements***

The TWG has also researched, analysed and investigated various water outlets as suitable replacements. It is however noted from the TWG minutes that issues were experienced with the tap that was selected and these taken up with the manufacturer. Other replacements were considered but not found to be as viable of as the one already selected. It is not clear from the minutes whether these issues have now been resolved and this should be checked with GGC.

- ***Contingency plans if CD is no longer viable***

It was noted in discussions with the F&E team that the level of CD can be increased and decreased as required in the water supply, not only for the whole campus but for individual areas to treat "hot spots". This means that should the current dosage not be sufficient to kill off the bacteria then the dosage can be increased to a point where this occurs. It is noted in the TWG timelines that the current doses are within WHO guidelines. It is noted that it can take 3 to 4 years for the negative results to be obtained therefore the use of POUFs in high risk areas and water testing is likely to continue for a considerable time yet.

Apart from increasing the dosage of the CD, there is no contingency plan if the CD stops working or there is a requirement to exceed the WHO maximum levels. There is of course, that the organisms could mutate and become more resistant to the CD. While it may be sometime before either of these two scenarios are reached, consideration should be given to discussing contingency plans with water experts to ensure that if this does occur then action can be taken. Further research into the nature of these organisms would also

Conclusions

help inform this discussion. It is appreciated that this may not be an alternative at the current time, but keeping up with advancements in the industry may provide alternative solutions in the future, so there will be benefit in monitoring these to see if a contingency plan can be developed sooner rather than later.

- ***Replacement plans for corroded parts of the water system***

Following on from the above observation is that the CD does have an impact on the water system and can potentially corrode values and reduce the life expectancy of these parts. Discussion with the F&E team, it is acknowledged that a plan needs to be developed to address the shortened life expectancy of these parts and to determine when and what action needs to be taken.

The F&E team advised that some parts can easily be checked through observation or access, and this is performed. However many of the parts that could be affected are not accessible and cannot be seen as they are contained in walls, ceiling etc. The impact of the CD will eventually cause these parts to fail and cause a leak. The F&E team acknowledge that it is not practical or reasonable to wait until this happen and that the TWG need to determine a solution to this problem. This solution also needs to ensure that there is no or minimum disruption to clinical services as wards and rooms cannot be put out of action for long period of time.

Further discussion with the water experts may help to resolve this matter and provide further clarification as to when these problems may start to occur and how they can be resolved and allow a plan to be developed.

The timeline also notes that prior to introduction of the CD, certain water meters and other products within the system are already corroded due to the use of cleaning agents and due to type of paint coating that was on these products. DMA had been asked to conduct a survey of the system to identify where such parts were located so that the extent of the work required could be assessed. It is not clear from the minutes whether this survey took place and what was the outcome. This should be clarified with GGC.

- ***Sharing of experiences***

The construction issues that have been found with the hospital campus and the solutions that have bee implemented to address those issues should be recorded and shared. This would be with the aim of preventing a repetition of the issues faced by GGC when further new hospitals are built.

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NHS GREATER GLASGOW AND CLYDE LEVEL 4 ESCALATION
PAEDIATRIC HAEMATO-ONCOLOGY SERVICE

Further Briefing re Staff, Parents and Families

Situation

Following a prior request for briefing on the mood of staff and patients within the paediatric haemato-oncology service at NHSGGC (which remains subject to SG oversight in accordance with Level 4 on the Performance Framework), the Cabinet Secretary for Health and Sport agreed to recommendations that concerns about medical staff in respect of casenote review and parents feedback re facilities and environment were subject to further communications between officials and NHSGGC.

Background

Professor Marion Bain has confirmed that medical staff within the paediatric-heamato-oncology service have continued to express concerns in respect of the scope and approach for specific elements of the casenote review.

The areas of most concern to medical staff are the inclusion of some cases outside of the operational definition and the incorporation of the paediatric trigger tool as part of the case review. The concerns about the latter are in relation to the appropriateness of the tool to care episodes being reviewed and that this is extending to scope to include quality of care.

Professor Mike Stevens has, with Professor Bain, discussed and continues to discuss these with clinicians and has assured them data from the application of the tool will be useful, considered appropriately within the review and have committed to further discussion on the specific details of this at a meeting to be arranged later this month. Information has been provided to articulate the basis for adding cases to those being reviewed where additional case reviews have been added by agreement with individual parents and families.

Professor White has asked that a meeting be arranged with Professors Bain and Stevens and supporting officials later this week. This has been confirmed for 14 May 2020 with a view to ensuring that the required actions inform the casenote review communication and engagement plan.

The General Manager of the service has confirmed the each of the areas of improvement feedback provided through the new processes to elicit this from parents (see Annex A) have been considered and actioned as below:

Car Parking

Although the are no car parking restrictions currently in place and no immediate plans to reinstate these, the challenge for parents and families has been recognised and the service is working with Facilities on an improvement.

Lost Blood Samples

Following feedback from parents the system was reviewed and problems with the software were identified and the software platform was rebuilt. This has led to measurable improvements in the problems raised by parents, though the service recognises that the risk of the problems raised by

parents could recur. The Directorate has agreed to test the impact of a dedicated porter being appointed to transfer bloods and other samples from ward / outpatient to labs and back (avoiding Ward 6a samples sitting in a labs queue). A plan has been developed to ensure that a local lab technician and equipment will be based in outpatients for haemato-oncology patient clinics. Samples will be taken / reported locally without having to be sent to labs. The timescale for implementation of this improvement has been delayed due to Covid 19 restrictions and the Estates work required to facilitate the change.

Kitchen Facilities

The ward kitchen is closed due to C-19 restrictions. The catering team is supplying parents with up to three meals per day and if necessary additional snacks as required. When the kitchen re-opens the service intends to improve the process issues raised

TV Not Working

The service has received a report they commissioned in response to parents feedback from the supplier (which is different from that in RHC). Technical issues are now being addressed to avoid a recurrence. The service has not been assured that this effectively addresses all risks of further problems and has therefore introduced an immediate escalation process and a plan to address issues even rooms are occupied, a plan that is awaiting final approval on the basis of infection prevention and control advice.

Theatre Doors Not Functioning

The QEUH campus hospitals are going through a plan for manual doors on the theatre (and other patient) pathways being replaced with automatic ones. RHC is included in this plan although the service is not able to provide a timescale for when this will be changed.

<u>Assessment</u>

The concerns about medical staff in respect of the scope of the trigger tool element of casenote review appear to be contributed to by prior experiences of scrutiny and dialogue relating to concerns about the hospital environment, compounded by apprehension in respect of some of the principles implicated by the use of trigger tools in general (e.g. recognition and openness to continuously review quality of care as part of a Directorate-wide learning and improvement system).

Recently expressed staff concerns about casenote review appear to be a manifestation of concerns previously expressed about the legitimacy of external scrutiny and apprehension that this will result in unjust criticism of the quality of care when the primary focus should be on the hospital environment. This represents a risk to the effectiveness of the communication and engagement activity undertaken to date and requires specific mitigation.

NHSGGC have confirmed that actions have been taken in response to all of the feedback received from parents. These have been considered and are proportionate, appropriate and if reliably implemented will lead to improvements.

Within the next 4 weeks the service expect to have reviewed options for car parking once restrictions are lifted, a dedicated porter being in place to augment the improved pathway as result of more robust pod system for blood samples.

Not all of the actions required to act on improvements have been linked with timescales and will require ongoing monitoring.

It is not clear from the information provided by the Directorate what feedback has been provided to parents and families about the way in which their feedback has been used to identify improvements and/or how they might become involved in the testing, implementation and/or monitoring of the intended improvement action on process, experiences and outcome.

It is not clear how monitoring of the implementation and effectiveness of improvement actions will be undertaken.

Recommendations

Ms. Freeman is invited to consider the foregoing assessment of further responses received and the implementation of the following recommendations:

Professors Marion Bain and Mike Stevens are invited to engage more directly with the medical staff concerns as they relate to the principles of case review as they relate to open and learning focused identification of opportunities for improvement in a way that reflects the range of complex and interacting processes influencing the impact and outcomes of gram negative infections. This will be further supported through the oversight of the Communications and Engagement plan for the casenote review which Professor White is sponsor of.

Professor White ask the Directorate to ensure that an improvement plan reflecting the feedback received from parents is developed for submission to officials by 22 May 2020 and that this specifically include target completion dates for all actions raised, measures of implementation and measures of effectiveness. He will offer to support and advise the team on the ways in which such plans can better reflect best practice in measurement of impact. He will also confirm that parents are involved with testing of improvements and receive an update on the ways in which their feedback has been used to implement changes and improvements.

Professor Craig White
11 May 2020

5.8.4 The environment and facilities not being appropriate for need sub-theme was the most prominent of the defects reported (n = 9). Parking and other facilities (n = 3) and activities and stimulation for parents (n=1) also received some negative feedback.

‘The TV set doesn't work which is a loss as we both like to watch certain programmes what we could enjoy together, looking at the same monitor. The blinds at the window are jammed shut so there's no light coming into the room and no view, which is tough when you're in here 24/7 for endless days.’

‘I went along to have a look in the parents kitchen, took one look at the contents of the fridge and shut the door leaving the room. Some things are labelled giving no clue if I can use the unlabelled as a free for all, or what.’

‘I like going into the kitchen area to have a cuppa and a sit down in a soft seat, as I miss my own couch at home and while I shouldn't complain about not having these things, it's nice to go along and just chill for ten minutes every so often. I noticed it said you could have a massage but it didn't say how I book one?’

‘There have been one or two instances where bloods have been lost which is infuriating, and something I just don't understand. The Drs explain it the best they can but it seems odd that blood can be lost in the system, and of course it delays the process for everyone involved in the wee ones care that day.’ (Day-care)

‘The doors coming and going to theatre aren't set to open automatically so when we've been going back and forth over different visits, the theatre Porter has been ramming the doors at speed to ensure they open. I didn't say anything at the time and wouldn't now but honestly, that noise from metal on metal was terrible to experience both going down and coming back from theatre.’

Cabinet Secretary for Health and Sport

NHS GREATER GLASGOW AND CLYDE/ QUEEN ELIZABETH UNIVERSITY HOSPITAL OVERSIGHT BOARD: UPDATE ON PROGRESS

Purpose

1. To provide an update on the work of the Oversight Board to improve the performance of NHS Greater Glasgow and Clyde (NHS GGC) at the Queen Elizabeth University Hospital (QEUH), in relation to infection prevention and control and connected communication with patients and their families.

Priority

2. Routine. No specific urgent action is required from this note, but the Cabinet Secretary will wish to note this update in advance of her meeting with the chairs of the Independent Review, Drs Andrew Fraser and Brian Montgomery, scheduled for Friday, 15 May. Phil Raines will be participating in that call as official support on Oversight Board issues. Full briefing for that meeting is being provided separately by the sponsor unit for the Independent Review.

Background

3. NHS GGC was escalated to Stage 4 of the NHS Scotland Performance Framework on 22 November 2019. An Oversight Board, chaired by the Chief Nursing Officer, Professor Fiona McQueen, was established, with a programme of work being taken forward through a series of Subgroups, continuing refurbishment work on Wards 2A and 2B in the Royal Hospital for Children (RHC), expert support for the Board and the commission of a Case Note Review.

4. As highlighted previously, the Covid-19 pandemic has significantly affected the working of the Oversight Board. Meetings of the Board itself and its constituent Subgroups were suspended as part of the lockdown and competing Covid-19 pressures drew CNOD staff away for a short period. However, work on key elements – such as the Timeline and Peer Review reports below and the Case Note Review – has been progressing, albeit at a necessarily reduced pace, and internal resourcing issues have now been resolved.

Progress in findings and recommendations of the Oversight Board

5. Although the Oversight Board is currently not meeting as part of the pandemic, work is continuing on developing a final report for the Cabinet Secretary on this phase of escalation. All three Subgroups – Communications and Engagement; Infection Prevention and Control (IPC), and Governance; and Technical Issues – are currently preparing their findings and recommendations to inform that final report. The aim is to finalise the Oversight Board report by the end of June. Advice will be presented in due course with a more detailed timescale for the Cabinet Secretary.

6. As part of the Oversight Board programme of work, there are two key reports which have been commissioned to inform the final report.

i. Timeline report. Sandra Aitkenhead of KPMG has provided a detailed timeline of how the infections were uncovered and dealt with in the NHS GGC governance structure. The draft report is being fact-checked by NHS GGC. Its provisional findings – which will inform the Oversight Board report – are attached under separate cover, though these may be revised before finalisation. When the full report is finalised, we will provide the draft to you with advice on handling/publication.

ii. Peer Review report. At the request of the Oversight Board, Lesley Shepherd – professional advisor to CNOD – led a team to undertake a peer review of the operation of IPC within the QEUH. Covid-19 pandemic work has made completion of the draft of that report difficult, but a draft will be completed in early June and will inform the final report of the Oversight Board.

7. With the drafting of its report in June, the Oversight Board is aiming to complete this phase of activity on escalation. It is likely that the report will carry a number of recommendations that will need to be overseen going forward, so some form of oversight will continue to be necessary. However, it may be that a bespoke issue-specific board may not be required. Advice/options on how this might be taken forward will also be provided in June.

Work on Wards 2A/2B in the Royal Hospital for Children

8. An update on the construction work on Wards 2A/2B was set out in Alan Morrison's note of 30 April on advice for the FM. While the Ward 2A/2B project was identified as an essential project in guidance, NHS GGC found it difficult to maintain progress because the main contractor stopped all physical work on the site. The sub-contractors had stood down their staff, as a result of concerns around the health and safety of staff, and the project was not deemed large enough to justify these companies remaining open. There have also been concerns around the supply chain's ability to obtain the necessary materials to complete this project.

9. As the 30 April note set out, DG Health and Social Care officials are liaising with the Restart Group (chaired by the Minister for Local Government, Housing and Planning), which aims to increase activity across the construction sector in a safe and controlled manner. A further update on the implications of this for Wards 2A/2B will be provided to you in June.

Expert assistance

10. Professor Marion Bain was appointed to NHS GGC to lead and have Board level responsibility for Healthcare Associated Infection, as well as lead on any transformation work required in NHS GGC to ensure improvements to the systems, processes and governance in relation to IPC. She was supported in that role by Professor Angela Wallace as Operational Director of IPC within NHS GGC on secondment from NHS Forth Valley.

11. Professor Bain has now been appointed as the Deputy Chief Medical Officer in the Scottish Government and will consequently not continue the range of her responsibilities in NHS GGC. In updating on different elements of hers and Professor Wallace's work below, arrangements for taking forward her different responsibilities are set out below.

12. Under Professor Wallace, an operational plan is now in place to ensure required IPC actions are agreed and progressed. There has been an ongoing focus and rigour around addressing the Gram-negative incident in the Paediatric Intensive Care Unit. It has also been agreed that Professor Wallace will take over the Executive Lead role for IPC within NHS GGC for the time being.

13. In terms of addressing issues within IPC, the key areas for action are:

i. pressures on overall capacity to be able to respond to current IPC requirements (even ahead of Covid-19), in particular within the QEUH and RHC;

ii. challenges around problem solving in the current complex IPC environment; and

iii. ensuring effective linkages and joint working, with clarity about respective roles and responsibilities – this applies within IPC, and between IPC and other parts of the system, both clinical and managerial.

14. There is a clear consensus between NHS GGC and the Scottish Government that ongoing senior IPC leadership is going to be crucial. NHS GGC will proceed with the permanent appointment of a Director of IPC as soon as possible, but this recruitment will take into account the findings and recommendations of the Oversight Board and the Independent Review. In addition to the Director role, additional capacity for IPC operational delivery and expert Infection Control Doctor input is also being taken forward. The Covid-19 pandemic has meant that this has not yet been progressed. However, the substantive Director of IPC, once appointed, will take forward recruitment to strengthen the IPC function as an early priority.

15. External Organisational Development work is now underway with leadership from Jenny Copeland and practical plans are in place for delivery. It is recognised that this will need continued focus over a period of time to deliver the changes that are required.

16. With respect to those staff who raised concerns about IPC within NHS GGC, Professor Bain has been liaising with the relevant individuals regularly. Concerns continue to be raised and are being systematically considered and addressed wherever possible. Specific issues with NHS GGC's responses to the families' questions and media releases are being addressed. This work will now be overseen by Professor Wallace going forward.

17. Lastly, Professor Craig White has continued to provide a key role in supporting families and liaising with NHS GGC on emerging issues, not least those arriving in the Covid-19 pandemic. He has written to you with recent update notes/SBARs on issues relating to the families – most recently on 11 May, attached with this submission (you have asked for additional work on the back of this). Good progress has been made in identifying the contributory processes and factors as set out before, and an improvement in communication, engagement and information provision that has been recognised by the families. The work is being reflected in the findings and recommendations of the Communications and Engagement Subgroup to the Oversight Board.

Case Note Review

18. Work on the Case Note Review is progressing at a steady pace. The first meeting of the Expert Panel is taking place on 15 May, when the first set of cases will be fully reviewed by the experts. Staff at NHS GGC have been populating the Paediatric Trigger Tool with clinical data which will be analysed by the Expert Panel as they go through the cases. Capacity issues due to COVID-19 have affected the pace of the work carried out by National Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland (formally Health Protection Scotland) on epidemiological data, but colleagues are still progressing work, albeit at a reduced pace. ARHAI is committed to supporting the work and will continue to review capacity over the course of the project.

19. Discussions have started around a communications strategy for the review and how to communicate emerging findings with key audiences. Professor Craig White is leading on the development of a communication strategy that addresses the issues. We will review the case note review timeline as the review progresses in the context of COVID-19 and update accordingly.

Conclusions

20. **You are asked to note this update, especially the aim of completing the Oversight Board's report for the end of June and the provision of further advice on the future of the Oversight Board, as set out in paragraphs 5 and 7 above.**

Phil Raines: CNOD
13 May 2020

QEUH Oversight Board meeting
Friday 4th of September 2020 – 14:00 to 17:00
Via Ms Teams

Minutes

Attending

- Fiona McQueen, Chief Nursing Officer (Chair), Scottish Government Chief Nursing Officer Directorate
- Diane Murray, Deputy Chief Nursing Officer, Scottish Government Chief Nursing Officer Directorate
- Lesley Shepherd, HAI/AMR Professional Nurse Advisor, Scottish Government Chief Nursing Officer Directorate
- Angela Wallace, Nurse Director, NHS Forth Valley (and Interim Director of Infection Control, NHS GGC)
- Sandra Aitkenhead, KPMG Consultant
- Hazel Borland, Executive Director of Nursing, Midwifery and Allied Health Professionals & Healthcare Associated Infection Executive Lead, NHS Ayrshire and Arran (joining after 3 pm)
- John Cuddihy, Parents representative
- Craig White, Communications and Engagement Lead, Scottish Government
- Phil Raines, Unit Head, Scottish Government QEUH Business Support Unit
- Carole Campariol-Scott, Policy Officer, Scottish Government QEUH Business Support Unit (OB Secretariat)
- Jim Dryden, Policy Officer, Scottish Government QEUH Business Support Unit (OB Secretariat)

Apologies

- Marion Bain, Deputy Chief Medical Officer, Scottish Government
- Dr Andrew Murray, Medical Director, NHS Forth Valley

1. Introduction/ update

The Chair welcomed everyone to the meeting. She took the opportunity to formally thank a number of colleagues who were previous members of the Oversight Board (OB) for their contributions to the work of the OB, namely: Greig Chalmers, Keith Morris and Marion Bain.

She acknowledged the unprecedented challenges the COVID-19 pandemic brought and which caused for the OB work to be slowed down, but not stopped. One unintended consequence was for the Case Note Review reporting to be delayed to early 2021.

Among the aims of this meeting was to:

- Take stock on where the OB was in its work programme. Reports were now available from all the workstreams which had been commissioned, including the Subgroup;
- Agree on the steps to preparing a final report, including whether an interim report may be necessary, and what other work was needed before the OB could complete its work; and
- Come to a view to what practical steps to recommend NHS GGC in the report which would make a difference to patients' safety going forward.

Commented [RP(1]: Not sure what this means?

Commented [CC(2R1]: It was something Fiona had said at the time of the meeting, which related to patient's safety and how to reflect this in the report. I typed it pretty much verbatim, I have reworded it to make it sound a bit clearer.

Commented [RP(3R1]: That reads well – thanks.

It was also noted this was a private meeting without NHS GGC representatives, providing an opportunity for open discussion by the OB.

2. Infection and Governance Timeline: draft final report

Sandra Aitkenhead (SA) presented her paper to the OB. SA was asked by the OB to create a timeline between 2015 and 2019 of the infection incidents in the haemato-oncology paediatric patient group, and how they were handled by various groups/committees within NHS GGC. The Chair acknowledged the complex and challenging task in producing the timeline and thanked SA for her work.

SA made the following points:

- The findings were not based on detailed forensic investigation of all information sources, but on documents provided by NHS GGC, which included minutes of meetings of relevant groups and committees.
- The timeline had been revised in line with comments made by NHS GGC on an earlier version. It also incorporated comments from a number of NHS GGC clinicians who had raised concerns about the hospital with the Cabinet Secretary.

John Cuddihy (JC) acknowledged the considerable work SA had put in to produce the timeline. He also added that the analysis was only as good as the information SA was provided with and asked how confident SA was about the information she had been supplied with. The Chair asked JC whether he thought some of the information was missing, to which JC agreed. SA responded to say the timeline was a factual representation of the information provided in the minutes of the key groups and committees in the NHS GGC clinical governance hierarchy.

Diane Murray (DM) suggested that the Infection Prevention and Control and Governance (IPC&G) Subgroup should examine the timeline and report, and reconvene for a meeting to discuss.

Action: OB Secretariat to arrange a meeting of the IPC&G Subgroup.

3. IPC and Governance Subgroup: draft summary report

DM summarised the work of the IPC&G Subgroup, as set out in the summary report provided to the OB. She explained that the Subgroup had not yet had the opportunity to review its draft report in light of the comments on an initial draft shared with NHS GGC. The Subgroup should reconvene to consider the comments by the Health Board and agree a final report. DM added the current draft of the report echoed findings in SA's timeline report.

The key issue for the OB to explore was whether it felt the evidence suggested that NHS GGC's response to the infection incidents could have been improved significantly.

The aim of the Subgroup report was to ensure that IPC processes and systems and escalation procedures within the Health Board were fit for purpose. While the Subgroup had not been able to conclude its work programme because of the pandemic, it had been able to review a range of issues, including in-depth examinations of key periods. Key areas that needed further consideration included:

- Considering issues raised by several NHS GGC clinicians about the effectiveness of IPC arrangements within the Health Board; and
- Looking at the organisation's ability to learn, and the deeper implications for the organisation's culture.

Phil Raines (PR) updated on engagement with several NHS GGC clinicians. The three clinicians had contacted the Cabinet Secretary previously with issues relating to IPC, governance and communications. The Chair met with them to hear the concerns in the context of the work of the OB. PR advised that their evidence warranted further engagement with the Health Board before the OB prepared its final report.

JC added that this discussion suggested that not all relevant information may have been provided to the OB yet, citing the example of how some Gram-positive bacteria infection incidents within this group of patients and the timeline of the OB were being regarded. It was agreed that the Secretariat would liaise further with JC to ensure that these issues were properly considered before the final report was prepared.

Action: PR to liaise with JC on key information gaps in the timeline and IPC&G Subgroup work.

4. Case Note Review

PR explained that the Case Note Review was part of the OB process, but running to a different timescale. The Case Note Review would examine individual infection cases and draw observations and conclusions for the OB (as well as the individual families). The impact of Covid-19 meant that the work had continued at a slower pace, so the current anticipated deadline to complete the final report is early 2021.

One of the emerging findings related to record-keeping issues within NHS GGC. The Case Note Review team had made a number of observations about record-keeping in a paper to the OB. The findings were recommended to the OB for consideration for its final report.

PR suggested that when the Case Note Review report was completed, the OB should reconvene to consider the findings and recommendations.

5. Peer Review

On behalf of Lesley Shepherd (LS), PR set out the Peer Review work. LS, Frances Lafferty (NHS Ayrshire & Arran) and Claire McGrath (SG) worked with NHS GGC on bringing the report together. NHS GGC commented on a draft of this report, and Lesley Shepherd considered these comments for her final draft. As a full Peer Review could not be conducted because of the pandemic, the report recommended that such a full Review should be completed on IPC processes in NHS GGC at some stage.

In discussion, DM suggested that she meet with members of the IPC&G Subgroup to discuss key aspects of IPC that could not be covered by the Peer Review. This would be picked up as part of the proposed meeting of the Subgroup.

6. IPC/organisational development work within the Board

The Chair explained that, following escalation to Stage 4, Marion Bain (MB) and Angela Wallace (AW) were placed within NHS GGC to undertake senior IPC roles. MB had since moved on to take up a new role as Deputy Chief Medical Officer in the SG. Both provided reports on their experiences and the work they had undertaken in NHS GGC. AW was invited to provide her view of the current state of IPC, and what further work might be required.

DM added that these issues had not been explored before in the context of a complex and large organisation such as NHS GGC, and that acknowledgement was required of the different structure and processes to capture all of the issues. Craig White (CW) added that the role of clinical leadership was important in this context, not least the role of the Clinical Care and Governance Committee.

7. Communications and Engagement Subgroup: final summary report

In presenting the work of the Communications and Engagement (C&E) Subgroup, CW thanked JC, Alfie Robson, Lara Allan (SG), PR and Calum Henderson (SG) in supporting the work of the Subgroup. The C&E Subgroup summary paper had been finalised, following comments by NHS GGC on an earlier draft.

CW acknowledged that over the course of the Subgroup's work, the relationship with NHS GGC had become significantly less adversarial and real improvements had been noted. Working through the issues had resulted in the following outcomes:

- More senior executive engagement had been noted with the families.
- The Subgroup offered consistent transparency, and was a consistent and reliable way to ensure families were demonstrably at the centre of action.
- Some improvement in thinking more innovatively had occurred, such as the closed Facebook group for the families, giving an opportunity for NHS GGC to embrace social media as one other means of engagement with the families.

The Subgroup had also discussed the issue of the organisational Duty of Candour. NHS GGC reported on the duty of candour as required by legislation, although no events had been activated under Duty of Candour within the period of QEUH infections. The Subgroup had raised issues about the Health Board's interpretation of the triggers for the organisational Duty of Candour.

JC also acknowledged there had been improvement in the Health Board, but there was still more to do. Engagement with the families had to be a corporate responsibility, especially with the Duty of Candour. It had to be embedded in the organisational culture to allow freedom to talk openly to families. He endorsed CW's comments and his particular role in engaging with the families especially around the Duty of Candour.

8. Technical Issues Subgroup

Alan Morrison (AM) reported that he had spoken to the Director of Facilities and Estates at NHS GGC this week to ask for an update on refurbishment of Wards 2A and 2B in the RHC and plans to invite HFS to review the current water safety policy of NHS GGC. On refurbishment, as a result of the pandemic, the revised timeline for completing Wards 2A/B was now May 2021.

9. Outstanding work: summary and discussion

PR talked through the remaining work that OB should consider taking forward before it prepared its final report. In the ensuing discussion, the following points were made:

- Work had been identified which still needed to be done. The OB would need to go back to NHS GGC with specific questions and information requests.
- Laura Imrie of ARHAI Scotland would be commissioned by the OB to produce a SBAR on HIIORTs by NHS GGC.
- Further work on the Health Board's approach to Significant Adverse Event Reviews would be taken forward.
- Follow up engagement with the NHS GGC clinicians – and the Health Board itself – was needed on selected issues.

The Chair noted the following as part of the discussion:

- The meeting had demonstrated the huge amount of work that the Subgroups and others had done. They were to be thanked for these contributions.
- However, to fulfil the OB's role of providing assurance, it needed to be satisfied that the relevant issues had been explored before the final report was prepared.

10. Final report and next steps: discussion

The Chair thanked all and rounded up the meeting, with the following key questions:

- Was there sufficient evidence for the OB to provide recommendations?
- Should the OB consider 'phasing' the recommendations: an interim set based on the work to date, and a final view once the Case Note Review has reported?
- What were the key themes we would want to reflect in our report?

- How should we engage with NHS GGC in the development of the final report?

PR said there to be an emerging consensus around key themes for recommendations. In the following discussion, the OB concurred with this view.

The Chair agreed that the OB should reconvene to consider its reports.

11. A.O.B and date of next meeting

The OB agreed to work on reports building on today's discussions and other reports. It was agreed the next meeting would take place in October.

Commented [CC(4]: Same here – copied/ pasted the script from the Chair's Brief as not sure the notes I took (just below this section here) were all that was discussed.

Commented [CC(5R4]: Are you OK with this section being a copy of the Chair's Brief Phil?

Commented [RP(6R4]: I am, thanks.

From: Grant, Jane [Chief Exec]
To: Brown, John; Bustillo, Sandra
Subject: M Lennon letter
Date: 03 December 2019 08:38:41
Attachments: cab-sec-6A-v4.docx
image001.png

Changed paragraph 5 back to original wording.
Sandra –can you send to SG comms right away with wording from last night? Will re-send email.
Thanks.
jane

Jane Grant
Chief Executive
NHS Greater Glasgow and Clyde
JB Russell House
1055 Great Western Road
Glasgow, G12 0XH
[redacted]

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Private and Confidential

Ms Monica Lennon MSP
The Scottish Parliament
Room M1.19
The Royal Mile
Edinburgh
EH99 1SP

Date: 2 December 2019
Our Ref: JJB/GD

Enquiries to: Mr John Brown
Direct Line: [redacted]
E-mail: JJBrown[redacted]

Dear Ms Lennon

Thank you for your recent letter concerning water related infections within the Royal Hospital for Children in Glasgow.

I'd like to begin my response by assuring you that the NHS GGC Board is taking the current situation extremely seriously and have been working alongside colleagues in the Scottish Government, and Health Protection Scotland to better understand the issues and the actions required to re-establish public confidence in the facilities at both the Queen Elizabeth Hospital and the Royal Hospital for Children.

The death of a child is tragic in any circumstance, and our priority is always to support families and carers at this difficult time. We recognise that the concerns around the water supply have made this an even more distressing time for families and for our front line staff. However, I can confirm that a wide range of clinical and managerial staff at all levels of the organisation continue to work hard to ensure the safety of the hospital environment and deliver high quality care to our patients. Patient care remains our highest priority and we are confident the actions taken to date have resulted in a safe environment being available to patients, including the children in the paediatric haemato–oncology ward.

While I can assure you that at no time has there been any intent to be anything other than open and transparent with our patients, their families and their elected representatives, we must at the same time respect individual patient confidentiality. This makes it difficult for me to comment on a specific patient without the necessary consent being in place. I appreciate this position may disappoint you and after careful consideration, taking into account the public interest in this case, I will attempt to answer your questions in broad terms.

In your letter you ask about the date and by what means the Board were made aware that the death of a child was linked to the water supply at the Royal Hospital for Children. From the investigations undertaken so far, we have not been able to establish any direct causal link between any child's death and the water supply. Throughout this complex situation, parents were supported through bereavement and where a clear cause of death was established this was given to the families. The acute cause of death may have a direct, indirect or be completely distinct from, any underlying disease process or complication thereof.

We have endeavoured to keep parents up to date with details of any investigations being undertaken into the hospital environment. We accept that this support has not always been enough to reassure

some families. To improve this situation we are now in direct contact with all 400 families currently receiving care or being monitored by the clinical team in the paediatric haemato–oncology ward. As you know, we are being supported in this work by Professor Craig White, a Scottish Government advisor to the Cabinet Secretary for Health & Sport. Professor White has been meeting regularly with me and the Chief Executive to ensure issues raised by patients and families are properly considered and receive responses, information and support as necessary.

While not being able to disclose specific information about an individual's treatment, I think it would be helpful to give you some further insight into the situation that arose with the water supply.

The situation can best be summarised as follows:

- When the new hospital first opened in 2015, the technical reports on the water supply were not reported by the external advisors to the Board's senior leadership team, neither were they escalated to that level by the managers in the Estates and Facilities team who did receive this report. Therefore, there was no knowledge at Board level of any problem with the water in the new hospitals.

- A second report on the quality of the water raised some concerns but this too did not get escalated to either the senior leadership team or the Board at that time. A review of the governance processes within the Estates and Facilities Directorate has subsequently been undertaken by the new Director with actions put in place to address this issue.

- In 2018, a case of an unusual organism at the end of January 2018 prompted further investigation. Water testing of multiple outlets within Ward 2A was undertaken which revealed contamination. To address this and as part of our established infection management process, we conducted further investigations to identify the measures required to mitigate against a number of potential contamination mechanisms.

- The investigations in 2018 that were initiated exposed the existence of the 2015 and 2017 reports. These were taken into account when determining the action required.

- Following the completion of the investigations in 2018, extensive remedial work was undertaken to mitigate the level of risk in the environment and the water supply. This work included the installation of a water treatment system, as well as an additional precaution with the installation of point of use filters on water outlets in areas with immuno-compromised patients.

The water supply was then re-assessed by an independent authorising engineer, who described it as 'wholesome' which is the industry term to say that it is safe (as defined in the Public Water Supplies (Scotland) Regulations 2014). This means the water in both the RHC and QEUH is safe.

I'd also like to assure you that since the new hospitals were opened the Scottish Government was notified of specific cases of infection in accordance with the current Health Protection Scotland guidance. It is not possible for me to confirm what specific information was passed to the Cabinet Secretary by her officials on any particular case.

With regards to your comments about whistleblowing, I agree that a robust whistleblowing process is an absolutely essential mechanism within our organisation and these can only be effective when it has the trust of staff that use it. We once again, have given assurance to our staff that any concerns raised through the official whistleblowing channels will be taken seriously and dealt with in full confidence.

Of course, our staff are also encouraged to raise any concerns in the first instance with their line managers or trade unions. This should enable senior management to respond appropriately. The whistleblowing process is there to ensure that if staff believe senior management has failed to take action, they can quickly escalate their concerns to Board level. I believe that NHS GGC does have an effective whistleblowing system in place and staff are aware of the process and are encouraged to use this system. Unfortunately, some staff still chose to go elsewhere to make their concerns

public, sometimes making it more difficult for the senior leadership team to resolve the issue and, on occasion, information which may have led to patients being identified has been discussed in public which is obviously of concern in light of our statutory obligations in respect of the privacy and confidentiality of sensitive personal information held by NHS GGC.

You will be aware that the Cabinet Secretary is appointing new Whistleblowing Champions to all the NHS Boards to oversee the effectiveness of these arrangements. I would expect the Board to receive a report from the new Champion relatively soon after they have taken up this important role.

Speaking both personally and on behalf of the Board, I want to express our complete confidence in our Chief Executive. Mrs Grant joined the Board almost two years after the first patients had moved into the new hospitals and has worked hard with her senior leadership team to identify and resolve the issues caused by deficiencies in the design and build of the Queen Elizabeth University Campus. It is due to Mrs Grant's commitment, hard work and resilience that we have finally got to the bottom of these issues and have taken the necessary steps to resolve them.

I am disappointed that some sections of the public and their elected representatives believe that Mrs Grant should move aside. The skills, knowledge and experience that Mrs Grant have brought to NHS Greater Glasgow and Clyde are exactly what is required of a Chief Executive and she would be a great loss to this organisation and the public it serves should she decide to stand down.

Finally, I remain concerned about the level of incomplete or inaccurate information that is currently circulating about NHS Greater Glasgow and Clyde. Not only has this damaged public trust and confidence in the services they receive, it has also had a detrimental effect on staff morale and wellbeing. Therefore, I'd like to take this opportunity to thank you for contacting me to obtain a clearer idea of the situation and to invite you to meet with Jane Grant and me to discuss any other concerns you may still have about the Royal Hospital for Children or any related matter.

I hope you will accept my offer of a meeting and look forward to working with you in the best interest of the public we both serve.

Yours sincerely

Professor John Brown CBE
Chair
NHS Greater Glasgow and Clyde

From: Brown, John
Sent: 02 December 2019 16:50
To: Grant, Jane [Chief Exec]; Bustillo, Sandra
Cc: Duncan, Gillian; Vanhegan, Elaine
Subject: FW: Monica Lennon Letter
Attachments: 2019.11.15 Letter to Chair of NHS GGC - QEUH.pdf; DRAFT Response M Lennon.docx

Jane / Sandra

I know you are both in the eye of the media storm but I'm concerned we haven't yet replied to Monica Lennon's letter of 15 November. Partly my fault - I've had it since Wednesday. Of course, because it's taken this long the world has moved on so it needed a bit of updating. I've worked on this and attach Monica's original request and my proposed reply. You'll see that I've highlighted parts of the letter where I think you need to confirm the accuracy of what I'm saying.

As advised by Malcolm Wright yesterday, the SG believes that under Level 4, we must clear all correspondence concerning infection control, clinical governance and patient engagement with the Cabinet Secretary. So once, you're happy with what I'm saying can you ask them to ask Jeane Freeman to approve it's issue. Can you also suggest that we send Mr Sarwar a similar letter inviting him to meet us too and ask for Cab Sec's permission to take this step.

If we could clear this letter, we will also have cleared our statement on why Jane must not stand aside. We can't continue to ignore this and I'd also like SG approval to make a statement on behalf of the Board. I will be asked about this tomorrow at FP&P and don't want to give any impression that I am not taking this seriously.

As always, give me a call if we need to discuss.

Regards

John

Professor John Brown CBE | Chairman | NHS Greater Glasgow and Clyde
JB Russell House | Gartnavel Royal Hospital | 1055 Great Western Road | Glasgow | G12 0XH
[redacted]

From: Duncan, Gillian
Sent: 02 December 2019 16:19
To: Brown, John
Subject: Monica Lennon Letter



The Scottish Parliament
Pàrlamaid na h-Alba

Monica Lennon
Member of the Scottish Parliament for Central Scotland Region

Professor John Brown CBE
Greater Glasgow and Clyde NHS Board
NHS Greater Glasgow and Clyde Corporate HQ
J B Russell House
Gartnavel Royal Hospital Campus
1055 Great Western Road
GLASGOW
G12 0XH

15 November 2019

Dear Professor Brown

Following on from the Cabinet Secretary for Health and Sport's comments in the media yesterday and the press statements released by NHSGGC, I am writing to you with questions about water-related infections at the Royal Hospital for Children. The allegation that a doctor-led investigation found that the death of a child cancer patient in 2017 had been caused by contaminated water at the hospital is extremely serious. The idea that the family was not informed when this information came to light is hard to believe. The public must have full confidence in our health service and I am sure you will agree that it is vital that the facts are placed in the public domain without any further delay.

At the centre of this is the heartbreaking tragedy of parents who have lost a child, and it is deeply alarming that they were not told of the true cause of their child's death.

Can you please confirm:

- On what date and by what means was the board first made aware that the death of a child was linked to the water supply at the Queen Elizabeth University Hospital?
- What action did NHS Greater Glasgow and Clyde take upon learning this information, and what was the timeline for this action?
- Did NHS Greater Glasgow and Clyde notify the parents of the child upon learning this information?
- On what date did the board notify the Cabinet Secretary for Health and Sport or her officials?
- As Chair of the board, do you retain confidence in the Chief Executive of NHS GGC and the wider actions of the health board in responding to this matter?

The lack of transparency around the numerous scandals at the QEUH and the Royal Hospital for Children make it imperative that the affected parents, and the wider public, receive a full and transparent timeline over what has happened – including who knew what and when, and what action was taken in response. Please substantiate your answers by releasing all relevant correspondence or reports, redacting personal information as appropriate.

Scottish Parliament, Holyrood Road, Edinburgh, EH99 1SP

Tel: [redacted] monica.lennon.msp[redacted] Twitter: [redacted]
A53674650

I believe that the statements released by NHS Greater Glasgow and Clyde to date have been far from satisfactory and unfortunately appear to be attacking the whistleblower. I remain very concerned by this situation and I have also written to the Health Secretary today asking her to set out answers to a number of questions about what she knew and when.

I look forward to hearing from you.

Yours sincerely,

[redacted]

Monica Lennon
MSP for Central Scotland
Scottish Labour Shadow Cabinet Secretary for Health and Sport

Greater Glasgow and Clyde NHS Board

JB Russell House
Gartnavel Royal Hospital
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Private and Confidential

Ms Monica Lennon MSP
The Scottish Parliament
Room M1.19
The Royal Mile
Edinburgh
EH99 1SP

Date: 27th November 2019
Our Ref: JJB/GD

Enquiries to: Mr John Brown
[redacted]

Dear Ms Lennon

Thank you for your recent letter concerning water related infections within the Royal Hospital for Children in Glasgow.

I'd like to begin my response by assuring you that the NHS GGC Board is taking the current situation extremely seriously and have been working alongside colleagues in the Scottish Government, and Health Protection Scotland to better understand the issues and the actions required to re-establish public confidence in the facilities at both the Queen Elizabeth Hospital and the Royal Hospital for Children.

The death of a child is tragic in any circumstance, and our priority is always to support families and carers at this difficult time. We recognise that the concerns around the water supply have made this an even more distressing time for families and for our front line staff. However, I can confirm that a wide range of clinical and managerial staff at all levels of the organisation continue to work hard to ensure the safety of the hospital environment and deliver high quality care to our patients. Patient care remains our highest priority and we are confident the actions taken to date have resulted in a safe environment being available to patients, including the children in the paediatric haemato–oncology ward.

While I can assure you that at no time has there been any intent to be anything other than open and transparent with our patients, their families and their elected representatives, we must at the same time respect individual patient confidentiality. This makes it difficult for me to comment on a specific patient without the necessary consent being in place. I appreciate this position may disappoint you and after careful consideration, taking into account the public interest in this case, I will attempt to answer your questions in broad terms.

In your letter you ask about the date and by what means the Board were made aware that the death of a child was linked to the water supply at the Royal Hospital for Children. From the investigations undertaken so far, we have not been able to establish any direct causal link between any child's death and the water supply. Throughout this complex situation, parents were supported through bereavement and where a clear cause of death was established this was given to the families. The acute cause of death may have a direct, indirect or be completely distinct from any underlying disease process or complication thereof.

In general, we have endeavoured to keep parents up to date with details of any investigations being undertaken into the hospital environment. We accept that this support has not always been

enough to reassure some families. To improve this situation we are now in direct contact with all 400 families currently receiving care or being monitored by the clinical team in the paediatric haemato–oncology ward. As you know, we are being supported in this work by Professor Craig White, a Scottish Government advisor to the Cabinet Secretary for Health & Sport. Professor White has been meeting regularly with me and the Chief Executive to ensure issues raised by patients and families are properly considered and receive responses, information and support as necessary.

While not being able to disclose specific information about an individual's treatment, I think it would be helpful to give you some further insight into situation that arose with the water supply.

The situation can best be summarised as follows:

- When the new hospital first opened in 2015, the technical reports on the water supply were not reported by the external advisors to the Board's senior leadership team, neither were they escalated to that level by the managers in the Estates and Facilities team who did receive this report. Therefore, there was knowledge at Board level of any problem with the water in the new hospitals.

- A second report on the quality of the water raised some concerns but this too did not get escalated to either the senior leadership team or the Board at that time.

- In 2018, when our process for monitoring infections at ward level disclosed a spike in infections in Ward 2A, the environmental and water tests revealed organisms which can potentially cause infection in the water supply. To address this and as part of our established infection management process, we conducted further investigations to identify the measures required to militate against a number of potential contamination mechanisms.

- The investigations in 2018 that were initiated by the spike in the number of infections exposed the existence of the 2015 and 2017 reports. These were taken into account when determining the action required.

- Following the completion of the investigations in 2018, extensive remedial work was undertaken to mitigate the level of risk in the environment and the water supply. This work included the installation of a water treatment system, as well as filters on water outlets.

The water supply was then re-assessed by an independent authorising engineer, who described it as 'wholesome'. This means the water in both the RHC and QEUH is safe.

I'd also like to assure that since the new hospitals were opened the Scottish Government was notified of specific cases of infection in accordance with the current Health Protection Scotland guidance. It is not possible for me to confirm what specific information was passed to the Cabinet Secretary by her officials on any particular case.

With regards to your comments about whistleblowing, I agree that a robust whistleblowing process is an absolutely essential mechanism within our organisation and these can only be effective when it has the trust of staff that use it. We once again, have given assurance to our staff that any concerns raised through the official whistleblowing channels will be taken seriously and dealt with in full confidence.

Of course, our staff are also encouraged to raise any concerns in first instance with their line managers or trade unions. This should enable senior management to respond appropriately. The whistleblowing process is there to ensure that if staff believe senior management has failed to take action, they can quickly escalate their concerns to Board level. I believe that NHS GGC does have an effective whistleblowing system in place and staff are aware of the process and are encouraged to use this system. Unfortunately, some staff still chose to go elsewhere to make their concerns public, sometimes making it more difficult for the senior leadership to resolve the issue.

You will be aware that the Cabinet Secretary is appointing new Whistleblowing Champions to all the NHS Boards to oversee the effectiveness of these arrangements. I would expect the Board to receive a report on from the new Champion relatively soon after they have taken up this important role. This report will be published and I expect this to encourage more staff to use the system as it is intended.

Speaking both personally and on behalf of the Board, I want to express our complete confidence in our Chief Executive. Mrs Grant joined the Board a year after the first patients had moved into the new hospitals and has worked hard with her senior leadership team to identify and resolve the issues caused by deficiencies in the design and build of the Queen Elizabeth University Campus. It is due to Mrs Grant's commitment, hard work and resilience that we have finally got to the bottom of these issues and taken the necessary steps to resolve them.

I am disappointed that some sections of the public and their elected representatives believe that Mrs Grant should move aside. The skills, knowledge and experience that Mrs Grant has brought to NHS Greater Glasgow and Clyde are exactly what is required of a Chief Executive and she would be a great loss to this organisation and the public it serves should she decide to stand down.

Finally, I remain concerned about the level of incomplete or inaccurate information that is currently circulating about NHS Greater Glasgow and Clyde. Not only has this damaged public trust and confidence in the services they receive, it has also had a detrimental effect on staff morale and wellbeing. Therefore, I'd like to take this opportunity to thank you for contacting me to obtain a clearer idea of the situation and to invite you to meet with Jane Grant and me to discuss any other concerns you may still have about the Royal Hospital for Children.

I hope you will accept my offer of a meeting and look forward to working with you in the best interest of the public we both serve.

Yours sincerely

Professor John Brown CBE
Chair
NHS Greater Glasgow and Clyde

Directorate For Health Finance, Corporate Governance & Value
Christine McLaughlin, Director

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: [redacted]
[redacted]

Dear Colleague

NHS SCOTLAND HEALTH BOARDS AND SPECIAL HEALTH BOARDS - BLUEPRINT FOR GOOD GOVERNANCE

1. I am writing to provide you with the Blueprint for Good Governance that has been developed for NHS Scotland and to set out the range of work now being undertaken to address the recommendations.

Background

2. The Blueprint for Good Governance draws on current best practice to ensure all boards assess and develop their corporate governance systems. The matters considered by the Blueprint are consistent with the governance reviews undertaken in both NHS Highland and NHS Tayside as well as the work of Audit Scotland and the Scottish Parliament's Health and Sport Committee. The Blueprint is attached separately to this circular.

3. Additional work to underpin improvements in governance is also being progressed through the Corporate Governance Steering Group (set out in Annex A). This work will look at: board governance; attraction and recruitment of board members; and retention and development of board members.

4. A self assessment tool has also been developed to allow all boards to evaluate their current governance arrangements against the Blueprint. Access to this for all NHS Boards will be available in early February along with details on how the output of the assessment can be used locally.

Action

5. All boards should make themselves familiar with the Blueprint and the range of work that is underway to develop corporate governance in NHS Scotland. Boards should also prepare to undertake a self assessment using an on-line tool being developed by NSS.

Yours sincerely

Christine McLaughlin
Director of Health Finance, Corporate Governance and Value

DL (2019) 02

1 February 2019

Addresses

For action
NHS Board Chairs

For information
NHS Board Chief Executives
NHS Board Secretaries

Enquiries to:
Corporate Business Management Team
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Edinburgh
EH1 3DG

Tel: 0131 244 2083
E-mail: cbmt@gov.scot

Corporate Governance Steering Group

Introduction

It is necessary to ensure that the governance arrangements in NHS Scotland reflect good practice.

The Blueprint for Good Governance emphasises the importance of good corporate governance and describes how its adoption will help NHS Boards improve their corporate governance system. This means delivery of a consistent, effective and transparent governance approach across NHS Scotland.

Steering Group

To oversee the development and introduction of the Blueprint for Good Governance, a joint steering group has been established to provide the leadership, support and guidance necessary to take this initiative forward.

The Steering Group is jointly chaired by Christine McLaughlin, Director of Finance, Governance and Sustainability, Scottish Government and John Brown. Chair of NHS Greater Glasgow and Clyde.

The membership is as follows:

- John Brown, NHS Greater Glasgow and Clyde (Co-Chair)
- Christine McLaughlin, Scottish Government (Co-Chair)
- David Crichton, NHS Health Scotland
- Susan Douglas-Scott, Golden Jubilee Foundation Board
- Neena Mahal, NHS Lanarkshire
- Tricia Marwick, NHS Fife
- Tom Steele, Scottish Ambulance Service
- Robbie Pearson, Healthcare Improvement Scotland
- Mark White, NHS Greater Glasgow and Clyde
- Alan Payne, NHS Lothian
- Della Thomas, NHS Health Scotland
- Karen Kelly, Golden Jubilee Foundation Board
- Sharon Millar, NHS Education for Scotland
- Colin Brown, Scottish Government
- Jo Brown, Scottish Government
- Robert Kirkwood, Scottish Government

The Chair of the IJB Chairs Group is also being invited to join the Group.

Progress to Date

The Steering Group has prioritised determining the baseline position for the Boards' current governance systems. To take this forward a self-assessment survey is being prepared, which reflects the NHS Scotland Blueprint for Good Governance.

A prototype of the self-assessment survey was initially undertaken in NHS Greater Glasgow and Clyde in October 2018 and has been further refined following a pilot in NHS Lanarkshire. This will issue to all Boards in February 2019.

In addition to completing the survey, Boards will be expected to hold a development session to discuss the survey results and identify actions that they will take forward in accordance with the Blueprint for Good Governance. This will then form the basis of a report to their Board on the effectiveness of the existing corporate governance system.

The following timetable should be followed:

- Following receipt of the final version of the survey tool, all Boards will be asked to complete the baseline survey in February 2019.

- Boards will hold their development event on the survey output and develop an appropriate action plan by the end of March 2019.

- This should enable a report on the outcome of the self-assessment to be published and discussed by the Boards at their meetings in April 2019.

This local self-assessment work will also be incorporated into the broader range of tasks being taken forward by the joint steering group. This work will be progressed under 3 related streams:

Governance – looking at the governance systems that are currently in place across all NHS Boards, including committee structures, production of Board papers and the approach to the management of risk.

Attraction and Recruitment – how the NHS can attract high quality, diverse, candidates to the role of a non-executive director and the importance of values around the board table.

Retention and Development – looking at the package of induction, development and appraisal of those on NHS Boards and how we ensure Boards have the right mix of ability, skills and experience around the Board table both now and for the future.

NHS SCOTLAND

A Blueprint for Good Governance

January 2019
A53674650

Healthier Scotland
Scottish Government

Foreword

NHS Boards across the UK operate in an increasingly demanding environment. The impact of demographic change and the growth in long term health conditions bring their own challenges at a time of financial constraint.

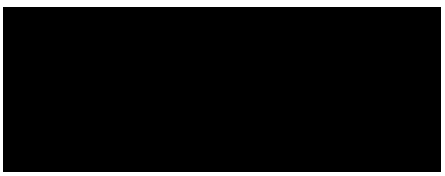
Good governance is essential in addressing the challenges the public sector faces and providing high quality, safe, sustainable health and social care services depends on NHS Boards developing robust, accountable and transparent corporate governance systems.

Governance issues are increasing in the public sector, as is the public interest in governance problems being experienced by public bodies.

The Scottish Government and the NHS Chairs Group have recognised the need to ensure that the governance arrangements in NHS Scotland keep pace with the changing policy and financial environment. The changes in how services are delivered and who is responsible for delivery as a result of health and social care integration also need to be considered. In response to this challenge, the Scottish Government commissioned a review of best practice in corporate governance with the aim of providing a blueprint for an effective corporate governance system that could be adopted across NHS Scotland.

This document emphasises the importance of good corporate governance, introduces a refreshed corporate governance blueprint and describes how adopting this blueprint can help NHS Boards improve their corporate governance system and deliver a consistent and transparent governance approach.

We would like to thank all those in the Scottish Government, NHS Scotland and the other public and private sector organisations who have contributed to this review into best practice in corporate governance. We are also grateful to NHS Highland and NHS Tayside for providing an opportunity to test the application of the corporate governance blueprint in a live environment. This has given us confidence that the approach described in this report has the potential to improve corporate governance across NHS Scotland.



John Brown CBE
NHS Greater Glasgow and Clyde
NHS Tayside



Susan Walsh OBE
Health Improvement Scotland

Foreward

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1. Introduction

The Review

1.1 The purpose of this report is to provide the Scottish Government and the NHS Chairs Group with the findings of the latest review of best practice in corporate governance and includes details of a refreshed corporate governance blueprint for NHS Scotland.

1.2 The scope of this review did not include the governance arrangements of the integrated health and social care system or the delivery of the national and regional planning initiatives being developed to deliver the NHS Scotland Health and Social Care Delivery Plan. These issues are key to the success of the Delivery Plan and are the subject of other initiatives currently being taken forward by NHS Scotland, working in partnership with COSLA as appropriate.

1.3 As the principles and framework that the governance blueprint offers can equally be applied to the Integration Joint Boards and the arrangement currently being developed to implement regional service planning, this report will be shared with colleagues considering those challenges.

Describing Corporate Governance

1.4 The UK Corporate Governance Code defines corporate governance as the system by which organisations are directed and controlled.

1.5 While this definition remains relevant today, the Independent Commission on Good Governance in Public Services emphasised that effective governance also leads to good management, good performance, good stewardship of public money, good public engagement and ultimately good outcomes.

1.6 The Commission also stated that weak or ineffective governance fosters low morale and adversarial relationships that lead to poor performance or even, ultimately, to dysfunctional organisations. Therefore, effective governance is essential in addressing the challenges the NHS faces in Scotland.

1.7 The purpose of corporate governance is to facilitate effective, innovative and prudent management that can deliver the long–term success of the organisation.

1.8 In the NHS corporate governance includes not only financial, staff and information governance but also clinical and care governance and the governance of clinical education and training.

1.9 Corporate governance is about what the Board does and should be distinguished from the day-to-day operational management of the organisation by the Executive Leadership Team. A good governance system helps individuals avoid the tension and conflict that can arise in an organisation where these boundaries are not clear.

1.10 Corporate governance involves setting strategic aims; holding the executive to account for the delivery of those aims; determining the level of risk the Board is willing to accept; influencing the organisation's culture; and reporting to stakeholders on their stewardship.

Leadership and Corporate Governance

1.11 When considering the importance of good governance, and the place of the Board in achieving this, it is important to acknowledge that securing high quality, effective and efficient organisational performance also relies on the leadership skills of Board Members and members of the Executive Team.

1.12 If the NHS is to achieve the ambitions of the Scottish Government, then work on developing leadership capability and capacity must be carried out in parallel to work on enhancing governance. This work is being taken forward by NHS Education Scotland and includes initiatives on Board leadership, executive leadership and clinical leadership.

2. The Corporate Governance Blueprint

Constructing the Blueprint

2.1 To construct a blueprint that clearly defines an effective corporate governance system, the review team considered multiple sources of evidence, including governance frameworks, models and codes of conduct, such as that of the Care Inspectorate, CIPFA and the UK Corporate Governance Code.

2.2 The NHS Chairs Group's Quality Portfolio Committee's work and publications on improving Board effectiveness were also considered in the construction of the blueprint. As was the Scottish Parliament Health and Sport Committee's review of the governance of the NHS in Scotland.

2.3 The review team also systematically sourced academic literature and grey literature, for example, Parliamentary Audit Committee Reports from both the UK and Scottish Parliaments and other governance codes. A list of the research material examined by the review team is included as **Appendix One**.

2.4 Finally, the team also looked at other lessons learned from positive governance initiatives and failures across the UK public sector.

Using the Blueprint

2.5 By creating a corporate governance blueprint for NHS Scotland, the review team expect to not only create a shared vision of what a good governance system looks like but also to support the following activities:

- Setting standards for corporate governance in NHS Scotland by defining the functions, enablers and support required of an effective governance system.

- Contributing to the development of the policies and processes required by the Scottish Government's Public Appointments Team by describing the skills, experience and diversity required by NHS Board Members to deliver the corporate governance functions.

- Improving the induction training, targeted education and the development activities available to Board Members by highlighting the skills required to deliver their roles and responsibilities.

- Supporting the Board in holding the NHS executive leadership to account by providing a template for the design of assurance information systems.

- Ensuring administration arrangements effectively support the operation of the governance system by describing the Board's expectations of the Board Administrator and their support team.

- Facilitating the performance appraisal of Board Members by clearly describing their roles and responsibilities and the values and standard of behaviours expected of them, individually and collectively.

Ownership of the Blueprint

2.6 Ownership of the corporate governance blueprint rests with the Cabinet Secretary for Health & Sport, the Scottish Government and the NHS Scotland Chairs Group. To discharge this responsibility, a forum is required to provide the necessary leadership, support and guidance to the development of NHS Scotland's approach to corporate governance. The terms of reference and membership of this steering group have still to be finalised but they should include the following remit:

- To set the standards for corporate governance in NHS Scotland by approving the framework and blueprint to be applied across all 22 NHS Boards. The blueprint will define the functions, enablers and support required of an effective governance system.

- To input to the development of the policies and processes required by the Scottish Government's Public Appointments Team to ensure NHS Boards have the appropriate skills, experience and diversity to deliver their functions.

- To commission and approve the induction and skills training and the development activities required to support Board Members in delivering their roles and responsibilities.

- To commission and approve an appropriate assurance information system to support Boards in holding the NHS executive leadership to account. This to include introducing national systems to report on service delivery, human resources, finance and risk.

- To oversee the arrangements for the procurement, delivery and evaluation of the Internal and External Audit services being delivered to NHS Boards.

- To commission and approve effective administration arrangements for NHS Boards, including templates for Standing Instructions, Schemes of Delegation, Sub-Committee Terms of Reference, etc.

- To agree the Non-Executive resources required to deliver the governance functions and recommend the appropriate level of remuneration for the variety of Non-Executive roles across NHS Scotland.

- To determine and roll out an effective performance appraisal system for Board Members that reflects the functions and roles described in the governance blueprint.

- To determine and roll out an appropriate system for reviewing Board effectiveness, including annual self-assessments by Boards and external validation of these assessments at regular intervals.

- To commission and approve written guidance on corporate governance arrangements in NHS Scotland.

- To advise and support NHS Scotland colleagues in discussions with COSLA concerning the development of more effective governance arrangements for the integrated health and social care system in Scotland.

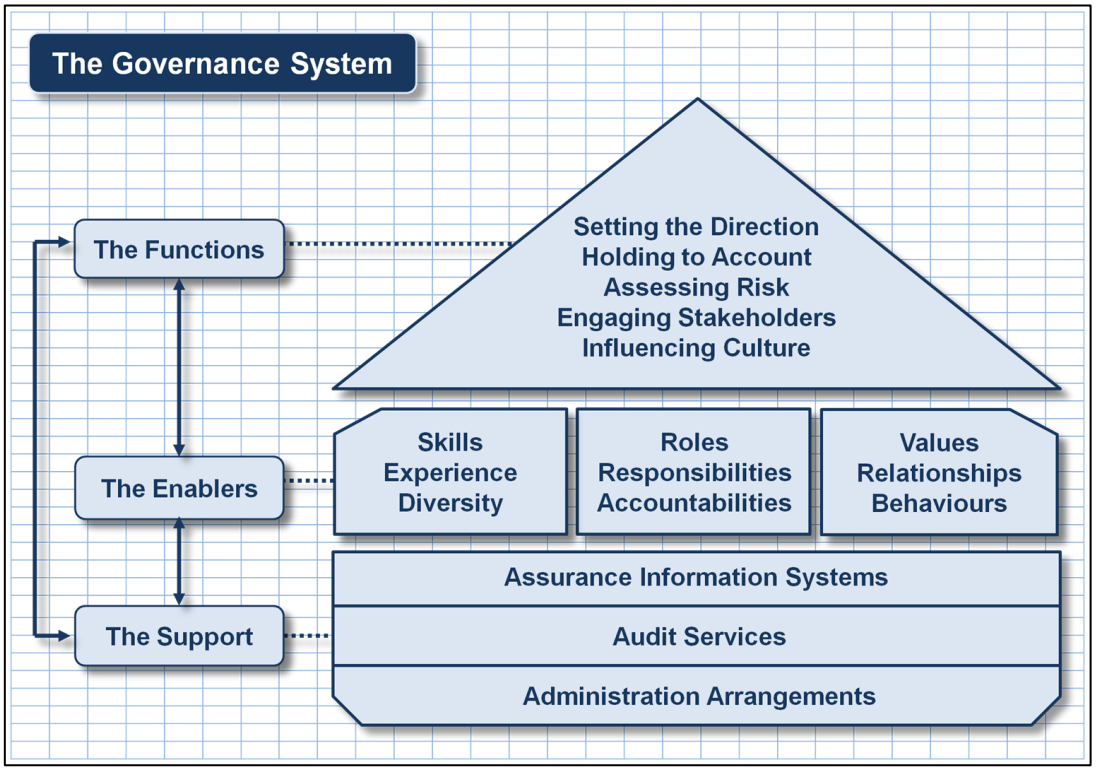
- To oversee the conduct of any external, ad-hoc reviews of NHS Boards; ensuring lessons learned are shared across other Boards as appropriate.

- To engage with key stakeholders to ensure that NHS Scotland arrangements continuously improve and reflect best practice in corporate governance in the public sector.

- To promote and share the NHS Scotland approach to colleagues in other parts of the public sector.

The Model

2.7 The corporate governance blueprint developed by the review team describes a three-tiered model that defines the functions of a governance system, the enablers and the support required to effectively deliver those functions.



2.8 What distinguishes this model from other governance models is its clear acknowledgement of the importance of how the Board approaches the achievement of its strategic aims and objectives as well as its focus on performance and outcomes. Although the model is presented as three distinct sections, they are in reality inter-dependent.

2.9 As the values, attitudes and behaviours that individuals demonstrate through their work as Board Members and Executive Team members play a major part in influencing the organisation's culture and ethos, we contend that having positive values, attitudes and behaviours underpin Board success.

The Functions

2.10 The detailed version of the blueprint defines the functions of a corporate governance system as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the Executive Leadership Team to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

The Enablers

2.11 The enablers identified in the blueprint are:

- Acquiring and retaining the necessary skills, experience and diversity at Board level.
- Defining clear roles, responsibilities and accountabilities for the Board Members and the Executive Leadership Team.
- Creating relationships and conducting business in line with agreed values and standards of behaviour.

The Support

2.12 The blueprint also identifies three categories of the support required for effective governance:

- Assurance information systems that help the Board to hold the Executive Leadership Team to account.
- Audit services that provide the Board with independent assurance.
- Administration arrangements that ensure the smooth operation of the Board and its sub-committees.

3. Delivering the Functions

Setting the Direction

3.1 To set the direction the NHS Board should:

- Provide leadership, support and guidance to the organisation, including determining the organisation's purpose and ambition.
- Approve the strategies and plans to deliver the policies and priorities of the Cabinet Secretary for Health and Sport and the Scottish Government.
- Allocate the budgets and approve the capital investments required to deliver strategic and operational plans.
- Agree aims, objectives, standards and targets for service delivery in line with the Scottish Government's priorities.

Holding to Account

3.2 In order to hold the Executive Leadership Team to account the Board should:

- Monitor, scrutinise, challenge and then, if satisfied, support the Executive Leadership Team's management of the organisation's activities in order to ensure that the organisation's aims, objectives, performance standards and targets are met.
- Safeguard and account for public money to ensure resources are used in accordance with Best Value principles.
- Ensure compliance with the requirements of relevant regulations or regulators.
- Ensure the application and implementation of fair and equitable systems of pay and performance management for the Executive Leadership Team.
- Ensure continuous improvement is embedded in all aspects of service delivery, identifying system failures and receiving assurances of remediation action.

Assessing Risk

3.3 Assessing risk requires that the Board should:

- Agree the organisation's risk appetite.
- Approve risk management strategies and ensure they are communicated to the organisation's staff.

- Identify current and future corporate, clinical, legislative, financial and reputational risks.

- Oversee an effective risk management system that assesses level of risk, identifies mitigation and provides assurance that risk is being effectively treated, tolerated or eliminated.

Engaging Stakeholders

3.4 To effectively engage with its stakeholders the Board should:

- Involve stakeholders in the development of policies and the setting of priorities.

- Take into account the views of stakeholders when designing services.

- Ensure priorities are clear, well communicated and understood by all stakeholders, including staff, service users and the general public.

- Establish and maintain public confidence in the organisation as a public body.

- Report on stewardship and performance and publish an Annual Report and Accounts.

- Contribute to the development of Scottish Government policies.

Influencing Culture

3.5 To influence the organisation's culture the Board should:

- Determine and promote shared values that underpin policy and behaviours throughout the organisation.

- Demonstrate the organisation's values and exemplify effective governance through Board Members' individual behaviours.

- Develop a cultural blueprint consistent with the organisation's purpose and ambition that describes an organisation where:

    - People are treated fairly, with respect and valued for their individual differences.

    - People are clear about their objectives and are sufficiently challenged.

    - People have an input to how they deliver their responsibilities and are involved in relevant decisions that affect their work.

- People are well informed and get the right information, at the right time, delivered in the right way.
- People receive the right training at the right time.

- Encourage a leadership approach where:
  - Leaders are sufficiently visible and give a clear sense of purpose and ambition.
  - Leaders help people understand how they contribute to achieving the Board's purpose and ambition.
  - Leaders recognise good performance and deal with poor performance.
  - Leaders encourage people to challenge and look for ways to improve performance.
  - Leaders help people identify and make best use of development and career opportunities.

4. Describing the Enablers

Skills, Experience and Diversity

4.1 Research has shown that Boards require a common set of competences and experience in order to discharge the minimum level of their responsibilities. Clearly having a highly skilled and diverse Board membership, with rich life and work experience would be preferable and beneficial; however, not every member of the Board will require every skill or experience. It is the responsibility of the Chair to ensure across the Board, all necessary skills, experience and diversity are present. This includes determining the Board's requirements during recruitment and the on-going development of the skills of existing Board Members.

4.2 The principles and personal attributes that individuals bring to the Board are as important as their skills and knowledge. These qualities enable Board Members to use their skills and knowledge to function well as part of a team and to make an active contribution to effective governance. The personal attributes that are required to ensure Board Members add value to the Board include being:

- **Committed** - able to devote the required time and energy to the role and being ambitious to achieve best possible outcomes for patients and service users.

- **Confident** - demonstrating an independence of mind, be able to lead and contribute to constructive conversations, to express their opinion and to play an active role on the Board.

- **Critical** - valuing their role as critical friend which enables challenge and support, self-reflection and the pursuit of learning and development opportunities to improve their own and whole Board effectiveness.

- **Creative** - able to challenge conventional wisdom and be open-minded about new approaches to problem-solving; recognising the value of innovation and creative thinking to organisational development and success.

Skills

4.3 To effectively operate an effective governance system Board Members should have the following skills:

- The insight into the organisation and an awareness of its operating environment.

- The capacity to question and challenge constructively.

- The ability to analyse and review complex issues, weighing up conflicting opinions and making evidence-based, well-informed and risk-assessed decisions.

- The interpersonal skills to communicate and engage with a wide range of organisations and individuals.

- The confidence and self-awareness to Chair, or participate as a member of, key committees that support corporate governance.

Board Membership should collectively cover all of these areas and where there are gaps these should be filled by alternative means.

Experience

4.4 Board Members should have experience gained in the public, private, third or voluntary sectors of some of the following:

- Leadership
- Strategic planning
- Change management
- Operations management
- Financial management
- Risk management
- Patient/service user experience
- Procurement
- Capital investment
- Human Resources management
- Customer relationship management
- Digital/Information Technology
- Media and communications
- Legal issues
- Equality and diversity issues

Diversity

4.5 Whilst Board Members do not represent any particular group, it is advantageous to secure a diverse range of people to join Boards. Diversity has been demonstrated as bringing many benefits to Boards. Boards should therefore actively pursue widening access and inclusion initiatives to bring greater diversity to their membership and encourage applications from a wide range of talented people irrespective of their religion or belief, gender, age, gender identity, disability, sexual orientation, ethnic origin, political belief, relationship status or caring responsibilities.

4.6 Applications should be particularly welcomed from groups currently under-represented on Scotland's public bodies, such as women, disabled people, those from minority ethnic communities, and people aged under 50. Boards should also be mindful of the Gender Representation on Public Boards (Scotland) Act 2018 which describes the 'gender representation objective' for a public board as having 50% of Non-Executive members who are women.

Roles, Responsibilities and Accountabilities

4.7 There should be clarity and a common understanding of the roles and responsibilities and accountability of the groups and individuals involved in the corporate governance system, namely:

The Chair

4.8 The Chair is personally responsible for:

- Leadership of the Board, ensuring that it effectively delivers its functions in accordance with the organisation's corporate governance arrangements.
- Appointing Board Members to Standing Committees, Integration Joint Boards and other roles within the NHS Board and partner organisations.
- Keeping the organisation's governance arrangements and the Board's effectiveness under review.
- Setting the agenda, format and tone of Board activities to promote effective decision making and constructive debate.
- Developing the capability and capacity of the Board by advising on the appointment of Board Members; appraisal and reporting on their performance; identifying appropriate training and development opportunities; and ensuring effective succession planning is in place.
- Providing performance management and development opportunities for the Chief Executive.
- Representing the organisation in links with Ministers, the Scottish Parliament and other key stakeholders. (Dual responsibility with the Chief Executive.)

The Vice Chair

4.9 In addition to that of a normal Board Member, the role of the Vice Chair to:

- Deputise for the Chair as required in any of his/her duties.
- Chair key Committees.
- Provide support and assistance to the Chair in carrying out his/her responsibilities.
- Act as a 'sounding board' and 'critical friend' to the Chair, Board Members and members of the Executive Team.
- Provide an alternative route for other Board Members to raise issues or concerns if they are unable to do so with the Chair. This is an important part of the checks and balances within governance and accountability and is analogous to the role of Senior Independent Governor recommended in the UK Code of Corporate Governance.

The Board Members

4.10 Board Members are personally responsible for:

- Ensuring the Board keeps focus on developing and maintaining its strategic direction in order to deliver the Scottish Government's policies and priorities.
- Providing effective scrutiny, challenge, support and advice to the Executive Leadership Team on the delivery of the organisation's aims, objectives, standards and targets.
- Contributing to the identification and management of strategic and operational risks.
- Bringing independence, external perspectives and impartial judgement to the business of the Board to support evidence-based, well-informed and risk-assessed decision making at Board meetings.
- Upholding the highest standards of integrity and probity and acting in accordance with the principle of collective and corporate responsibility for Board decisions. (No member is appointed on a representative basis for any body or group.)
- Undertaking ongoing personal development activities.
- Understanding and promoting diversity and equality.
- Engaging with stakeholders, including service users, the public, managers and staff.

In addition to discharging the above responsibilities, Board Members may also be required to support the business of the Board by chairing committees and meetings.

These responsibilities apply to all Board Members, including Non-Executive, Executive and Stakeholder Members.

The Chief Executive

4.11 In addition to their responsibilities as a Board Member, the Chief Executive is personally responsible for:

- Developing the policies, strategies and plans required to deliver the organisation's purpose and ambition.

- Building the organisational capability and capacity necessary to deliver the agreed outcomes and objectives.

- Leadership of change where required to improve services, including development of joint working with other organisation involved in the delivery of health and social care on a local, regional and national basis.

- Leadership and day-to-day management of the organisation and its staff, ensuring the Board's decisions are implemented and the organisation's aims, objectives, standards and targets are met.

- Proper management of public funds and for ensuring the regularity, propriety and value for money in the management of the organisation. Accountability for this function is directly to the Scottish Parliament under Section 15 of the Public Finance and Accountability (Scotland) Act 2000.

- Introducing an appropriate management structure and recruiting, training and developing an Executive Leadership Team that will deliver an appropriate and effective leadership and management approach for the organisation.

- Representing the organisation in links with Ministers, the Scottish Parliament and other key stakeholders. (Dual responsibility with the Chair.)

The Executive Leadership Team

4.12 Members of the Executive Leadership Team are personally responsible for:

- Providing advice and support to the Board to assist in the development of strategies and policies to deliver the Scottish Government's priorities.

- Developing strategic and operational delivery plans and processes to implement the Board's decisions.

- Monitoring progress towards aims, objectives, performance standards and targets for service delivery and providing the Board with appropriate information on performance, expenditure, issues, risks and successes.

- Developing the organisation's capability and capacity to meet the Board's current and future expectations.

The Board Secretary

4.13 The Board Secretary is personally responsible for:

- Leading the continuous development and implementation of the Board's corporate governance system, providing expert advice and support to the Chair, Chief Executive, Board Members and other stakeholders on governance matters as required.

- Providing advice and guidance to ensure the Board acts within its legal authority and statutory powers and that its Members comply with the Ethical Standards in Public Life (Scotland) Act (2000) and the Model Code of Conduct for Members of Devolved Public Bodies (2014).

- Ensuring that Board business is conducted in a spirit of openness and transparency.

- Managing the administrative and secretarial support to the Board and other appropriate governance Committees to deliver effective administration support to Board business.

- Providing personal support and guidance to the Chair and Chief Executive and managing the business of their private office, including the handling of Parliamentary Questions and enquiries from Ministers and other elected representatives.

Values, Relationships and Behaviours

4.14 Board Members should consider what is expected of them individually and collectively in terms of demonstrating the values, conducting the relationships and demonstrating the behaviours expected of a NHS Board.

Values

4.15 Board Members are expected to demonstrate and uphold the core values of NHS Scotland, as published in the 2020 Workforce Vision Everyone Matters in June 2013. These values are:

- Care and compassion.

- Dignity and respect.

- Openness, honesty and responsibility.
- Quality and teamwork.

Behaviours

4.16 The standards of behaviour expected from Board Members are laid down in the Model Code of Conduct for Members of Devolved Public Bodies (2014). This document describes the key principles underpinning public life in Scotland as:

- Duty.
- Selflessness.
- Integrity.
- Objectivity.
- Accountability and stewardship.
- Openness.
- Honesty.
- Leadership.
- Respect.

4.17 Board Members must also comply with the Board's rules regarding remuneration; allowances; expenses; gifts and hospitality; lobbying; registration of interests; and the confidentiality of information.

Relationships

4.18 Board Members should apply the values of NHS Scotland and the principles of the Model Code of Conduct for Members of Devolved Public Bodies to their dealings with fellow members of the Board, its employees and other stakeholders.

4.19 Board Members should also observe the principles of this Model Code in dealings with the public when performing duties as a member of the Board.

4.20 Board Members must respect the Chair, colleagues and management and staff in meetings and comply with rulings from the Chair in the conduct of the business of Board meetings.

5. Providing the Support

5.1 To support the Board in delivering good governance, the organisation needs to provide suitable assurance information systems, effective audit services and efficient administrative arrangements.

Assurance Information Systems

5.2 The Board should commission assurance information systems that deliver the necessary information to assist them in obtaining assurance on the delivery of the organisation's strategic, operational and financial plans.

5.3 The assurance information systems should be designed to provide frequent and informative performance and financial reports to assure the Board that it is delivering safe, accessible, quality, affordable and sustainable services. These systems should deliver relevant, accurate and timely information on:

- Performance Management.
- Quality Management.
- Financial Management.
- Human Resource Management.
- Change Management.
- Risk Management.
- Information Management.

5.4 The assurance information systems should also measure the organisation's performance by benchmarking results against those of similar organisations.

Audit Services

5.5 The corporate governance system includes the audit services required to provide the Board and key stakeholders with assurance that the system of internal controls is functioning as intended.

Internal Audit

5.6 The role of the internal audit team should include:

- Reviewing accounting and internal control systems.
- Reviewing the economy efficiency and effectiveness of operations.
- Assisting with the identification of significant risks.

- Examining financial and operating information.

- Special investigations.

- Reviewing compliance with legislation and other external regulations.

To ensure that internal audit is an independent objective assurance activity, the Board should ensure that the internal auditors are independent of executive management and should not have any involvement in the operations or systems they audit. The Head of Internal Audit should report directly to the Audit Committee and the Chief Executive, but also have direct access to the Board Chair.

External Audit

5.7 Boards employ external auditors primarily to give an independent opinion on the annual report and accounts. The role of the external auditors also includes reviewing and reporting on the arrangements within NHS Boards to manage their performance, regularity and use of resources such as money, staff and assets. In doing this, external auditors add value by supporting improvement and accountability

Audit Committee

5.8 The Board's Audit Committee has a key role in ensuring the effectiveness of the internal audit functions including:

- Overseeing the selection process for new internal auditors.

- Reviewing and agreeing the annual internal audit work plan.

- Ensuring recommendations are actioned by the Executive Leadership Team.

- Disseminating audit reports to the relevant Board Committees.

- Encouraging the use of audit reports as improvement tools.

- Monitoring and assessing the effectiveness of the audit team.

- Approving the appointment and termination of the Head of Internal Audit.

The Audit Committee is also responsible for oversight of the Board's relations with the external auditors, including reviewing the scope of the annual audit plan.

Administration Arrangements

5.9 The administration arrangements required to support the Boards consist of:

- Development of a strategic planning cycle that clearly indicates where the Board is involved in considering options, debating risk, giving approval and thereafter in monitoring delivery of the Board's strategic plans.

- An integrated annual work programme and coordinated timetable for Board meetings, Board seminars and Committee meetings. This programme should not only ensure that strategic planning is co-ordinated and the appropriate level of scrutiny is delivered, but also that decisions are taken in a logical sequence.

- A standard template and guidance on writing papers and reports, including setting the requirements for financial assessment and risk assessment of the impact of options presented to the Board.

- Secretariat support for meetings.

6. Assessing Effectiveness

6.1 In order to assess the effectiveness of a corporate governance system and report appropriately, it is important to have a consistent and systematic approach to assessing the Board's current arrangements.

6.2 Using the corporate governance blueprint to support the systematic audit of the current status of the functions, enablers and systems that make up the governance system will ensure that the criteria against which an assessment is being made is valid, reliable and transparent and that it represents best practice in corporate governance.

Self-assessment

6.3 The Board should annually assess the effectiveness of the corporate governance system, conducting a self-assessment to review progress with the development plan and identify any new and emerging issues or concerns.

6.4 Therefore the self-assessment questionnaire used by NHS Boards should be drafted to include questions on the delivery of the functions, enablers and support described in the corporate governance blueprint.

Independent Reviews

6.5 The self-assessment should be validated and enhanced by the Board commissioning a tri-annual independent review of their corporate governance system.

6.6 The approach recommended for independent reviews involves using the governance blueprint to structure and facilitate the external review, is qualitative in nature and involves three strands:

- Initial desk research exercise to consider relevant NHS Board documents.

- Face-to-face interviews with Board Members and members of the Executive Leadership Team using a semi-structured interview technique based on the corporate governance blueprint described above. These interviews should be conducted under Chatham House Rules and ensure all aspects of the governance system are discussed whilst still allowing interviewees to contribute their personal insights into the effectiveness of corporate governance.

- Observation of Board and Standing Committee meetings.

6.7 This approach not only allows the external review to triangulate data and strengthen the validity of findings but also is designed to not place undue pressures on busy NHS Boards and Executive Leadership Teams, nor require duplication of activity with other assurance frameworks.

6.8 Once all the evidence gathering and assessment stages have been completed, any recommendations for improvement in the delivery of the governance functions can then be described in terms of developments to the enablers and systems in the governance blueprint. A development plan can then be agreed to prioritise and deliver any actions necessary to meet these development needs, with scheduled reporting on progress to the NHS Board and the Scottish Government.

6.9 Recognising that governance is a system which extends beyond the immediate corporate Board, the views of key stakeholders (including the Scottish Government) should also be gathered by the review team.

6.10 Self-evaluation and tri-annual independent review should be supported by ad hoc thematic reviews of areas identified by the Board, for example, where governance issues have been identified in other sectors.

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NHS SCOTLAND

The Healthcare Quality Strategy for NHSScotland

The Scottish Government, May 2010

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healthier scotland
SCOTTISH GOVERNMENT

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1. Foreword

The ultimate aim of our Quality Strategy is to deliver the highest quality healthcare services to people in Scotland and through this to ensure that NHSScotland is recognised by the people of Scotland as amongst the best in the world. We want to achieve this aim in a way this is recognisable and meaningful to everybody. This is ambitious, but it is achievable and we are well placed to deliver. The aim is set at a high level, but the means to achieving it will be built from the ground up. What will make Scotland a world leader will be the combined effect of millions of individual care encounters that are consistently person-centred, clinically effective and safe, for every person, all the time.

People in Scotland have told us that they need and want the following things from the NHS and we have built this strategy around these priorities:

- **Caring** and **compassionate** staff and services;
- Clear **communication** and explanation about conditions and treatment;
- Effective **collaboration** between clinicians, patients and others;
- A **clean** and safe care environment;
- **Continuity** of care; and
- **Clinical** excellence.

We also know that everybody delivering healthcare services in Scotland is motivated above all by the quality of service they provide in partnership with their colleagues, with patients and their families. Delivering compassionate care is at the very heart of clinical values and it is the cornerstone of the mutual NHS that we first described in *Better Health, Better Care* (2007).

'...millions of individual care encounters that are consistently person-centred, clinically effective and safe, for every person, all the time.'

We want the implementation of the Quality Strategy to strengthen confidence and pride in our NHS. We want confidence for patients that their NHS is amongst the best in the world – safe, effective and responsive to their needs, every time and all of the time. We want confidence for people working in and with NHSScotland that they are doing what they came into the NHS to do, are valued and are key in delivering the ambition to make NHSScotland a world leader. We want a shared national pride in our NHS and a recognition that it is the very best it can be.

Implementing the Quality Strategy will build upon the integrated approach to service planning and delivery we have already established across NHSScotland. It will involve a range of actions by individuals, teams,

NHS Boards and the Scottish Government. Through taking these actions, we will expect to see measurable improvements in the key indicators of healthcare quality.

Success will mean that, for the first time, people in Scotland will have:

- the opportunity to comment systematically on their experience of healthcare and its impact on their quality of life;
- an assurance that NHSScotland services will be further improved in the light of what people tell us about their experiences and outcomes;
- support to engage in shared decision-making about their care;
- the whole of the NHS committed to patient safety and, in particular, to avoiding infection and harm, using consistent and reliable improvement methods;
- personalised care plans for those people with the most complex care needs; and
- a guarantee that their NHS Board will prioritise quality in its agenda, including the use of a new early warning system.

'NHSScotland has a long and strong tradition of providing high quality healthcare.'

NHSScotland has a long and strong tradition of providing high quality healthcare to the population. For example, we have a history of excellence in professional education and clinical audit, the use of patient records to improve outcomes, the creation of the SIGN[1] guideline system, the development of Managed Clinical Networks, the introduction of statutory systems of clinical governance and risk management and the world's first national Patient Safety Programme.

1 SIGN - Scottish Intercollegiate Guidelines Network

'The Quality Strategy provides the basis for us all to focus our combined efforts on what is required.'

We are all aware of the challenges in delivering reliable and responsive high quality healthcare, and in improving people's health. These include increased public expectations, changes in lifestyles, demographic change, an ageing population, new opportunities from developments in technology and information, and the current economic climate which brings with it significant financial constraints. The Quality Strategy provides the basis for us all to focus our combined efforts on what is required to address these current and future challenges, and to ensure high quality healthcare for ourselves and for generations to come.

By establishing a shared understanding of quality, and a commitment to place it at the heart of everything we do, the Quality Strategy represents a unique and important opportunity for all of us to work together to our mutual benefit to make our NHS even better, for everyone, now and into the future.

2. Executive Summary

What is the Quality Strategy?

'putting people at the heart of our NHS'

In December 2007, the *Better Health, Better Care Action Plan* (2007) made a series of commitments to improve the health of everyone in Scotland and to improve the quality of healthcare and healthcare experience. The related programmes and initiatives have already enhanced the quality of healthcare within NHSScotland. The Quality Strategy is a development of *Better Health, Better Care* which builds on the significant achievements of the last few years such as the further improvements we have made in waiting times, our approach to tackling Healthcare Associated Infection and improvements we have made to ensure the safety of patients in our hospitals. It has been informed by a wide range of discussions involving people working in NHSScotland, patients and carers and by a series of events in early 2010 involving independent primary care contractors.

The Healthcare Quality Strategy will ensure that we maximise the contribution of NHSScotland to the wider Purpose of the Scottish Government to create sustainable economic growth and opportunities for everyone in Scotland to flourish. The Quality Strategy will have a direct and positive impact on these goals through the improvements it will make in supporting everyone in Scotland to live longer healthier lives and to participate more productively both economically and socially. Increased effectiveness, efficiency and productivity of the health sector in Scotland will make a significant and direct contribution to economic growth.

In *Better Health, Better Care* we set out our proposal to create a mutual NHS in Scotland where staff, patients and carers fully understand their rights and responsibilities, and what they should expect from their NHS. A mutual NHS is an underpinning requirement of person-centred healthcare, so we will continue to pursue this as part of this Quality Strategy.

The Quality Strategy builds on these foundations and is about three things:

- It is about putting people at the heart of our NHS. It will mean that our NHS will listen to peoples' views, gather information about their perceptions and personal experience of care and use that information to further improve care.

'best possible care compassionately and reliably'

- It is about building on the values of the people working in and with NHSScotland and their commitment to providing the best possible care and advice compassionately and reliably by making the right thing easier to do for every person, every time.
- It is about making measurable improvement in the aspects of quality of care that patients, their families and carers and those providing healthcare services see as really important.

Firstly, we start with what people have told us are their priorities:

'making the right thing easier to do'

- **Caring** and **compassionate** staff and services;
- Clear **communication** and explanation about conditions and treatment;
- Effective **collaboration** between clinicians, patients and others;
- A **clean** and safe care environment;
- **Continuity** of care; and
- **Clinical** excellence.

'measurable improvement'

Secondly, the Quality Strategy makes explicit connection between these patient priorities and the values of the people working for and with NHSScotland.

Staff have long shared the vision of high quality healthcare services in Scotland. Indeed for many the drive to make a difference; caring for, supporting and enabling others is what motivated them to work in health and is completely aligned with their professional values and aspirations. Capturing and sustaining this enthusiasm and commitment is what underpins quality healthcare in effective organisations and enables the culture of quality to thrive. We already know from extensive research about the links between staff engagement and enhanced organisational performance. We also know about the correlation between staff experience and staff wellness with the patient experience and patient outcomes. It will be important therefore to balance our drive for quality, productivity and efficiency, with the support and development for staff to feel engaged, valued and empowered in leading and driving quality in their communities, services, wards and departments.

'we also know about the correlation between staff experience and staff wellness with the patient experience and patient outcomes'

Thirdly, we identify in the Quality Strategy the actions most likely to lead to improvements in these priority areas. We have built these improvement interventions from three healthcare Quality Ambitions.

'...commitment to equality of experience and outcomes...'

The Quality Ambitions
Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

These three Quality Ambitions will provide the focus for all our activity to support our aim of delivering the best quality healthcare to the people of Scotland and through this making NHSScotland a world leader in healthcare quality. They explicitly reflect the things people have told us they want and need and are based on the internationally recognised six dimensions of healthcare quality (Institute of Medicine):

- Person-centred;
- Safe;
- Effective;
- Efficient;
- Equitable; and
- Timely.

Our shared pursuit of the three Quality Ambitions will make significant and positive impacts on efficiency and productivity. Through this we will sustain the unprecedented improvements we have made in waiting times and in access to primary, secondary and emergency healthcare services. We will also strive to ensure that the high quality health services we deliver are provided on the basis of our ongoing commitment to equality of experience and outcomes - to everyone in Scotland, no matter who they are, or where they live.

Implementation of this Quality Strategy will be the means by which we ensure that the longer-term transformational challenges are addressed. In the short term the NHSScotland Efficiency and Productivity Strategic Oversight Group will support Boards to identify

'The Quality Strategy builds on a firm foundation'

'...need to do some new things, to do some things differently...'

immediate opportunities for achieving efficiencies based on the *Delivery Framework* which was published in June 2009 that are consistent with, and in the context of, the Quality Strategy.

How will we make it happen?

The Quality Strategy builds on a firm foundation as many of the things we are already doing across NHSScotland in primary care, in health improvement, in hospitals and in other healthcare environments are the right things. However, we also need to do some **new** things, to do some things **differently**, to stop wasteful activity, and to focus on evidence-based activities which yield the maximum benefit. We will have to reduce unjustified variation to minimise the potential for harm. We will have to involve the people of Scotland to a greater extent in the 'co-production' of health and healthcare. We also need to reflect the changing cultures, expectations, needs and context for healthcare service delivery so that future generations can also enjoy high quality healthcare services that are responsive to their needs and expectations.

In order to pave the way for implementation there are a number of underpinning things we will do. These include the following:

Commitments

- We will build on NHSScotland's integrated delivery arrangements, encouraging whole system improvement through mutually beneficial partnerships between clinical teams and the people in their care.

- We will continue to pursue the health improving activities NHSScotland is already undertaking in partnership with other bodies through the implementation of our health improvement and public health strategies, including *Equally Well* and pursuing a *Health Promoting Health Service*.

- We will review the alignment and contribution of the work we are doing across the range of other strategies and initiatives, reinforcing and joining-up those which clearly support the Quality Strategy aims, and re-positioning or indeed, scaling down or stopping those which do not.

- We will ensure that we create the necessary governance, measures and delivery structures across NHSScotland so that the interventions we pursue are clearly and appropriately integrated, aligned and managed. This will include the clear alignment of the set of national targets for NHSScotland (HEAT[2]) with the ambitions of the Quality Strategy.

- We will involve everyone in Scotland, by communicating the messages of our shared vision for healthcare quality so that everyone can play their part in making it happen.

- We will support Boards to share and spread their exemplars of high quality healthcare, and pursue their local commitments to take new action to improve quality.

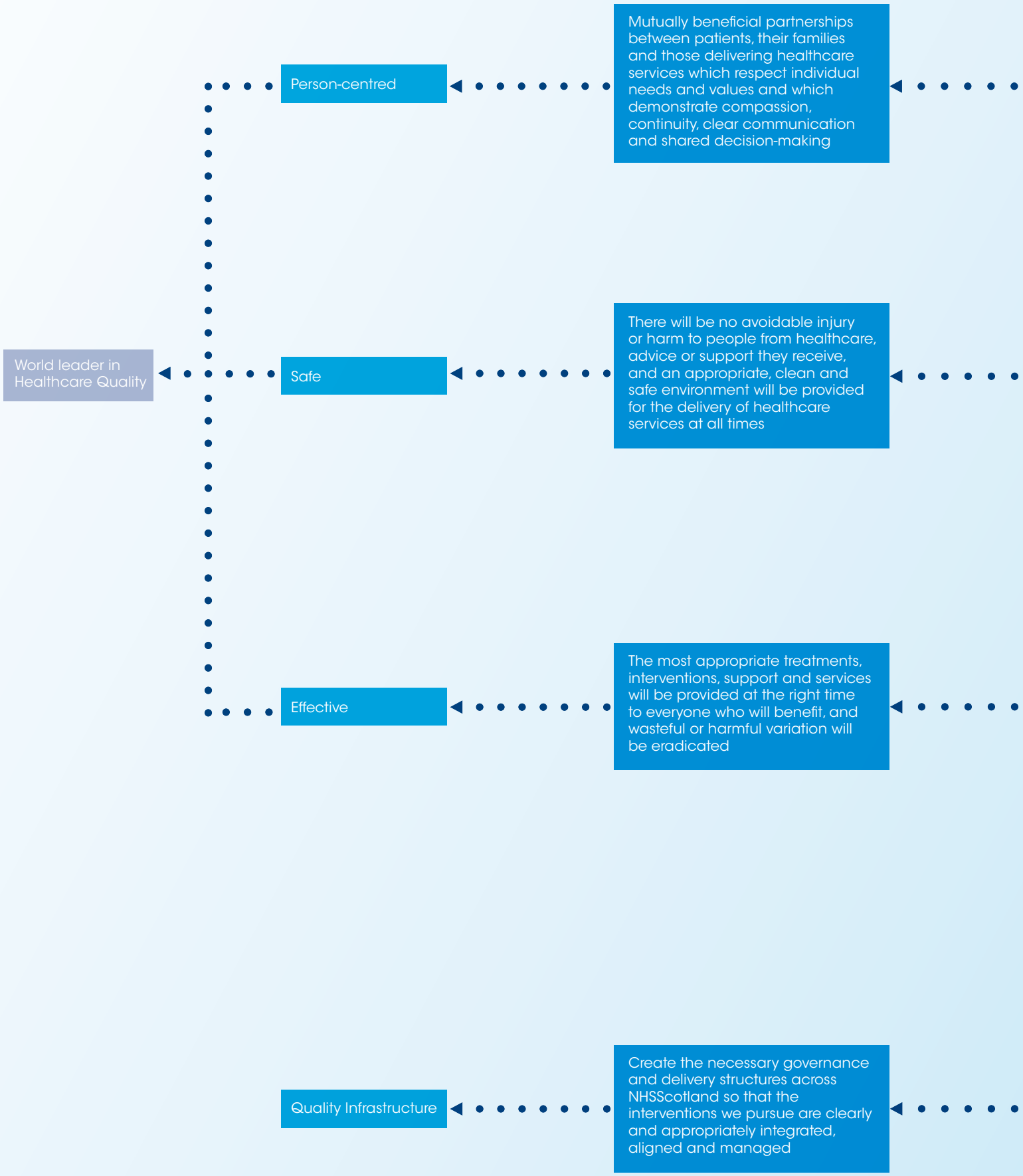
- We will set out our Quality Ambitions and related priority areas for national action and will produce a regular report on progress.

- We will work with and through people - our most valuable asset - our leaders, service users, health professionals and support staff to create and sustain a culture where quality can thrive and the contribution of every individual to quality is recognised and valued.

The Quality Strategy Driver Diagram (overleaf) sets out the priority areas for action and the specific improvement interventions we will focus on to enable us to achieve our three Quality Ambitions.

2 HEAT – 'H' Health Improvement, 'E' Efficiency and Resources, 'A' Access, 'T' Treatment

THE QUALITY STRATEGY DRIVER DIAGRAM



PRIORITY AREAS FOR ACTION	IMPROVEMENT INTERVENTIONS
1. Improve and embed patient-reported outcomes and experience across all NHSScotland services 2. Support staff, patients and carers to create parternships which result in shared decision-making 3. Inform and support people to manage and maintain ther health, and to manage ill-health	• Implementation of the new self management strategy; • Implementation of the Patient Rights (Scotland) Bill in 2011; • Action in response to the first results of the Better Together Patient Experience surveys; • Collection of appropriate data to measure patient reported outcomes (PROMS); • Shared decision-making defined, supported and measured; • Implement action of the CARE approach in primary and community care; • Building on the principles of QOF to maximise quality in the other contractor areas; • Enhanced management of falls, pressure area prevention and nutrition; • Improve resources to support better health literacy; • Develop evidenced interventions for support improved person-centredness; • Develop a programme of action to ensure that peoples' equality needs are gathered, shared and responded to across health services by Summer 2011; and • Introduce interventions to improve staff experience.
1. Secure the improvements which have been delivered through the success of the Scottish Patient Safety Programme, and roll out across other areas of NHSScotland activity 2. Support integrated programme of action to reduce occurrence of Healthcare Associated Infection (HAI)	• Accelerate roll out of the Scottish Patient Safety Programme in acute care, reducing hospital mortality and harm; • Implement patient safety programmes for primary care and mental health; • Accelerate medicines reconciliation across all transitions of care; • Ensure synergy with the work of the HAI taskforce to secure further reductions in infection; and • Extend the Electronic Care Summary and make widely available.
1. Ensure continuity in all care pathways through implementation of long-term conditions action plan and other key opportunities 2. Apply information from quality data to drive consistently better care across NHSScotland 3. Increase focus on preventative and anticipatory care and intervention	• Preventative and anticipatory approaches, building on and extending initiatives such as Keep Well/Well North, alcohol brief interventions and smoking cessation; • Implement the Long-term Conditions Action Plan; • Initiating a process of refreshing the suite of care pathways in close collaboration between secondary and primary care prioritisation; • Introduce and share Anticipatory Care Plans for 5 per cent of the population most at risk of hospital admission; • Implement the major national strategies; Better Cancer Care, Mental Health Primary Care, Heart Disease and Stroke, Dementia and Living and Dying Well; • Establish the appropriate healthcare skills and roles required to deliver high quality healthcare, and, through the use of the NHSScotland Career Framework and local/national workforce planning, establish plans to reshape the workforce accordingly; • Ensure all our GP enhanced services are fit for the purposes of this strategy; • Implement the Strategic Options framework for emergency response in remote and rural areas; • Leading Better Care implemented across all Boards by December 2010; • Implement the Releasing Time to Care approach across acute and community teams in all Boards; and • Ensure high-impact Efficiency and Productivity approaches are implemented reliably – (e.g. disinvestment, reduce harmful and wasteful variation (GP referrals, hospital length of stay, prescribing etc)).
1. Develop Quality Measures Framework (QMF) to drive and monitor progress 2. Develop information to provide rapid feedback for NHS Boards to identify and tackle risk. Boards to consider Quality at every meeting 3.Establish appropriate governance arrangements	• Establish Quality Ambitions by May 2010; • 2011/12 HEAT targets aligned with Quality Strategy by October 2010; • Quality Measurement Framework underpinning Quality Ambitions with related high-level outcome indicators agreed by October 2010 – including `early alert' Quality scorecard; • Establish governance responsibilities and procedures to support quality, and minimise risks; • Ensure that national and local audit programmes support the development of appropriate indicators of quality, rigorous peer review and local action to address inappropriate variations in care; • Develop, support and make best use of the skills, knowledge accountability and professional leadership of our staff to provide assurance of care quality at all levels; and • Develop the Quality Improvement Hub, reflecting a new partnership for improvement between NHS National Services Scotland (NSS), NHS Quality Improvement Scotland (QIS), NHS Heath Scotland, NHS National Education for Scotland (NES), and the Scottish Government Health Directorates Improvement and Support Team (IST).

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How will we measure and report progress?

A Quality Alliance will be formed, which will report progress on a regular basis with reference to a small set of high-level Quality Outcome Measures, selected to monitor progress towards the Quality Ambitions, and with reference to progress in implementing the improvement interventions.

The suite of 12 national Quality Outcome Measures proposed in this Quality Strategy requires further detailed development and definition through consultation across NHSScotland, and is as follows:

- healthcare experience;
- staff experience;
- staff attendance;
- Healthcare Assoicated Infection (HAI);
- emergency admissions;
- adverse events;
- Hospital Standardised Mortality Rate (HSMR);
- proportion of people who live beyond 75 years;
- patient reported outcomes;
- patient experience of access;
- self assessed general health; and
- percentage of last 12 months of life spent in preferred place of care.

'...NHSScotland national HEAT targets will be aligned with the Quality Strategy.'

The NHSScotland national HEAT targets[3] will be aligned with the Quality Strategy, and will set out the national targets which have been planned and agreed with NHSScotland as the priority areas for progress each year. Performance against the HEAT targets will therefore provide shorter term measures of progress toward the Quality Ambitions. In 2011/12, the HEAT targets will include a small number of new targets agreed with NHSScotland to provide greater alignment with the Quality Strategy. These will replace targets which have been met in 2010/11, hence ensuring that there will be no increase in the total number of national NHSScotland targets. There is a clear short-term commitment to reduce the overall number of HEAT targets.

3 HEAT – 'H' Health Improvement, 'E' Efficiency and Resources, 'A' Access, 'T' Treatment

3. Introduction – The Challenges

're-focusing alignment and integration'

'...a change in culture across Scotland in the way that we deliver, and engage in our healthcare.'

'...accelerate, join-up, re-position or indeed wind up...'

This document sets out the details of the new Quality Strategy for our NHS in Scotland. The Quality Strategy is about more than renewing policies and approaches to planning and delivering healthcare. It is about a change in culture across Scotland in the way that we deliver, and engage in our healthcare. It weaves through everything we are already doing, and will be supported by the re-focusing, alignment and integration of much of our existing work.

The strategy is based on our knowledge about what works well in Scotland, and builds on the range of excellent progress and work already underway at local, regional and national levels. It has been developed through wide-ranging discussions with the people working in NHSScotland, with patients and with carers, through opportunities such as the *Patient Rights (Scotland) Bill* consultation and the *Big Cancer Conversation*, and a range of events and discussions with NHSScotland, third sector and other public sector partners which took place during winter 2009/10. It also reflects some of the output of a series of events held around Scotland with primary care contractors. The strategy refers to the leading international thinking and is our key response to the future challenges we will face in delivering high quality and sustainable health services now, and into the future.

When the Scottish Government set out its plans for improving Scotland's health and healthcare in its action plan *Better Health, Better Care* (2007), it made a commitment to:

- improve the health for the whole Scottish population and reduce health inequalities;
- improve the quality of healthcare and healthcare experience, and develop a mutual NHS – offering the people of Scotland new rights and a stronger voice;
- maximise the value of our investment in health services in Scotland; and
- integrate health, care and other related services.

Considerable progress has already been made over the last two years through the range of programmes developed through *Better Health, Better Care*. As part of the implementation of the Quality Strategy, we need to assess the contribution of these and other programmes to the new Quality aims. Then we will need to accelerate, join-up or re-position these programmes or indeed wind them up where they have delivered their aims.

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The NHSScotland Chief Executive's Annual Report for 2008/09, published in December 2009[4] set out an overview of the progress which has been made in addressing the priorities for action set out in *Better Health, Better Care*. This progress has been made through the successful pursuit of national targets (HEAT) and through a range of achievements, many supported by the work streams established to implement the *Better Health, Better Care Action Plan*.

To improve health and reduce inequalities across the Scottish population, a number of national approaches are in place to tackle some of the underlying causes of poor health in Scotland. Some of the key programmes are as follows:

- extending targeted health checks through *Keep Well* and *Well North;*
- implementation of *Equally Well* and the *Early Years Framework;*
- screening programmes;
- smoking cessation and prevention;
- promoting healthy living and preventing overweight and obesity;
- alcohol brief intervention and treatment support services;
- breastfeeding programmes;
- reintroducing school-based preventative dental services; and
- implementing of national immunisation programmes, e.g. to combat cervical cancer.

In acute care, waiting times are at their lowest ever levels. We are implementing strategies to ensure that people with cancer, dementia, heart disease, stroke and other long-term conditions and comorbidities are getting better quality and quicker care than ever before. The Scottish Patient Safety Programme is delivering major improvements in care in our hospitals.

We have also recently been leading the world in our collaborative approach to minimise the impact of the AH1N1 strain of flu. This is an excellent example of what our NHSScotland, working with contractors, the public and with public services across Scotland, can achieve. It illustrates how focused and effective NHS effort can achieve impact and global recognition.

4 (http://www.scotland.gov.uk/Publications/2009/12/03133143/0)

The work we have done in recent years on improving patient safety is an excellent example of how well Scotland is placed to embrace new and effective ways of improving the quality of our healthcare services. Don Berwick (Institute of Healthcare Improvement), a recognised international expert on patient safety, has said, "*NHSScotland has undertaken a bold, comprehensive, and scientifically grounded programme to improve patient safety. The dedication of NHS leadership at all levels to this endeavour is clear, and bodes well for success. In its scale and ambition, the Scottish Patient Safety Programme marks Scotland as leader – second to no nation on earth – in its commitment to reducing harm to patients dramatically and continually.*" This confirms that we start from a real position of strength in developing and implementing a new quality strategy.

'…patient safety is an excellent example of how well Scotland is placed to embrace new and effective ways of improving quality…'

We are continuing to build the basis for our mutual NHS through pioneering work such as the *Patient Rights (Scotland) Bill*, the *Patient Experience Programme*, the development of a *Carers Strategy* and the improvements in support for the self-management of long-term conditions and for people at high risk of developing these. Through this mutual approach our NHS will continue to learn from, and improve on, what is most important to the people of Scotland, taking account of the needs of our diverse population – this approach will permeate all our programmes of work. In the Quality Strategy, we seek to embed the mutual approach of shared rights and responsibilities into every interaction between patients, their families and those providing healthcare services.

The publication of *A Force for Improvement* in January 2009 has already provided the foundations for agreeing the actions required to ensure that the NHS workforce is supported, developed and equipped to respond to the challenges of the future. We will ensure that this action is aligned with the priorities and commitments agreed in our Quality Strategy.

'...challenging ourselves, sharing the pursuit of our ambitions with every person in Scotland, focusing our efforts and raising the bar.'

This is not about pulling the plant up by the roots and starting again, it is about challenging ourselves, sharing the pursuit of our ambitions with every person in Scotland, focusing our efforts and raising the bar. To do this will require leadership, urgency, and a fundamental shift in culture focused on the delivery of effective, safe, person-centred care.

Future Challenges

For many years we have been well aware of the range of drivers of change which will create very real challenges in the delivery of high quality healthcare services:

- The next 20 years will see an ageing population, a continuing shift in the pattern of disease towards long-term conditions, and growing numbers of older people with multiple conditions and complex needs and the impact of this on them and their immediate carers. There will be more older family carers - many of whom will have their own health needs. These demographic changes and associated shifts in the pattern of ill-health will increase the demands on the whole healthcare system;
- Continuing public health challenges such as the rise in overweight and obesity, physical inactivity, harmful use of alcohol, Hepatitis C and the ongoing need to reduce smoking rates;
- Workforce pressures and sustainability will be critical in determining how we are able to respond to these changes in demand;
- Developments in technology and in information and communications technology in particular, will give us the tools to fundamentally reshape how healthcare is delivered; and
- Increased public awareness, diversity and intelligence creating different expectations and requirements around treatments, equipment, access, drugs and therapies.

'...tightening financial resources available to respond to the increasing demands...'

Added to these drivers are the new challenges we face in the current economic climate with tightening financial resources available to respond to the increasing demands suggested by these demographic, cultural and technological changes.

Implementation of the Quality Strategy will be the means by which we ensure that these longer-term transformational challenges are addressed. In the short term, the NHSScotland Efficiency and Productivity Strategic Oversight Group will support Boards to identify immediate opportunities for achieving efficiencies, based on the *Delivery Framework* which was published in June 2009, with action and decisions which are consistent with, and in the context of the Quality Strategy.

'...the Quality Strategy will be the means by which we ensure that these longer-term transformational challenges are addressed.'

Example of possible short-term national efficiency and productivity high-impact change:

Reviewing the use of bank and agency nurses/locum doctors, and establishing a more efficient approach which does not reduce the quality of care.

Examples of potential medium/long-term quality approaches which will reduce costs:

Disinvestment in drugs/treatments for which there is new evidence of low value added in terms of cost versus benefit to patients.

Investment in telecare/telehealth to support more people at home achieving better outcomes at less cost.

4. Our Response

'...the quality of healthcare services delivered by NHSScotland is recognised by the people of Scotland as amongst the best in the world.'

'...mutually beneficial partnerships with their families and carers and those delivering healthcare services.'

The Aim

The ultimate aim of our Quality Strategy is to deliver the highest quailty healthcare services to people in Scotland, and through this to ensure that NHSScotland is recognised by the people of Scotland as amongst the best in the world.

This aim will be achieved by working from the bottom up, and will build on:

- A single and shared understanding and definition of what we mean by high quality healthcare;
- Scotland's reputation for professionalism, clinical excellence and leadership – for example, pioneering the use of quality guidelines through SIGN, Best Practice Statements, knowledge exchange and leading in the development of the use of clinical data;
- The early success of the Scottish Patient Safety Programme which has marked Scotland as a world leader in developing a national patient safety programme;
- Increasing value being placed on the quality of the experiences of the people who use healthcare services;
- The opportunity for strong leadership and delivery which our integrated NHS system provides;
- A whole system anticipatory approach to delaying or preventing, and slowing the progression and impact of, ill-health;
- Cross-system quality improvement led by engaged clinicians working collaboratively across disciplines for example in Managed Clinical Networks;
- Staff ownership and enthusiasm for improving quality and safety;
- Public sector partnership working;
- High quality partners in the independent and voluntary sectors;
- Patients' motivation to be involved in mutually beneficial partnerships with their families and carers and those delivering healthcare services;
- Scotland's focus on collaboration and professional values;
- The range of existing national and local initiatives and programmes already in place; and
- A focus on each individual's wider needs, to achieve the best possible outcomes, by working with them to help them manage their own health.

We will need action at all levels if we are to succeed. We will need a clear line of sight from national strategies through to individual behaviours. In order to achieve this, our approach will be designed to be:

- Patient-based: reflecting the uniqueness of the individual, their experience of their health, illness and healthcare, and enabling them to share in decision-making about their care, to manage their own health, and illness though support and access to advice and information for them, their families and carers;
- Staff-based: enabling people working in and with NHSScotland to use their skills, further improving staff experience, staff engagement, building capacity, providing support and making the right thing the easiest thing to do;
- Systems-based: simplifying the policy/delivery landscape, aligning and re-enforcing our shared priorities, and providing the appropriate balance between performance management and continuous improvement; and
- Partnership-based: NHSScotland working with public and third sector partners, staff, independent contractors, patients and carers.

The Quality Ambitions

In order to be recognised as having world-leading healthcare services, we need to set out a clear set of ambitions with related measurable and achievable objectives (interventions) on which we can report progress.

Better Health, Better Care was based on the Institute of Medicine's six dimensions of quality. These six dimensions will remain central to our approach to systems-based healthcare quality improvement:

- ***Person-centred:*** providing care that is responsive to individual personal preferences, needs and values and assuring that patient values guide all clinical decisions;
- ***Safe:*** avoiding injuries to patients from healthcare that is intended to help them;
- ***Effective:*** providing services based on scientific knowledge;
- ***Efficient:*** avoiding waste, including waste of equipment, supplies, ideas, and energy;

- ***Equitable:*** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location or socio-economic status; and
- ***Timely:*** reducing waits and sometimes harmful delays for both those who receive care and those who give care.

We have a clear and shared vision for high quality healthcare services in Scotland which is derived from what people have told us they want and need:

- **Caring** and **compassionate** staff and services;
- Clear **communication** and explanation about conditions and treatment;
- Effective **collaboration** between clinicians, patients and others;
- A **clean** and safe care environment;
- **Continuity** of care; and
- **Clinical** excellence.

By focusing on what really matters to people, and through our approach to systems-based healthcare improvement based on the Institute of Medicine's six dimensions of quality, we will raise the quality of healthcare from the current high standards to world-leading by concentrating our priority action on achieving the following ambitions.

'...By focusing on what really matters to people... we will raise the quality of healthcare from the current high standards to world-leading...'

The Quality Ambitions

Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

Our Commitment to Equality

'...recognising and valuing diversity...'

NHSScotland is committed to understanding the needs of different communities, eliminating discrimination, reducing inequality, protecting human rights and building good relations by breaking down barriers that may be preventing people from accessing the care and services that they need, as well as meeting the legal duties in relation to age, race, disability and gender. It aims to address inequalities by recognising and valuing diversity, promoting a person-centred approach and involving people in the design and delivery of healthcare.

There are strong linkages between some of the key actions required and being taken forward to address health inequalities in Scotland, and proposed drivers of our quality strategy. In particular the person-centred and clinical effective drivers (specifically through long-term conditions) have the potential to address the health problems of many of those who carry a disproportionate burden of ill-health in our communities. Each of the aligned and integrated national programmes, intiatives and interventions pursued in support of achieving the three Quality Ambitions will require to be fully assessed in terms of their impact on equalities through a Health Inequalities Impact Assessment (HIIA), which includes mandatory Equalities Impact Assessment (EQIA). Through this we will ensure that the Quality Strategy optimises its impact on reducing inequality across Scotland.

The Improvement Interventions

Person-centred

We have a number of programmes and pilots in operation at present which are aimed at putting people at the centre of care and at supporting the development of relationships between NHSScotland staff, patients and carers which result in shared decision-making, better experiences and outcomes for patients and carers, and greater job satisfaction for staff. For example, there is the *Patient Experience Programme (Better Together)* (currently focusing on inpatients, general practice and long-term conditions), the *Self Management Strategy*, *Keep Well* and *Well North*, *Living and Dying Well*, the *Delivering Patient-centred Care Programme* underpinned by '*Curam*', the carer information strategies, *Scotland Cares* and the other work streams underway to develop further the caring and enabling aspects of the Nursing, Midwifery and Allied Health Professions. There is also the work to enhance the performance of NHSScotland as a Health Promoting Health Service, using every patient encounter as an opportunity to improve health.

'...every patient encounter as an opportunity to improve health.'

This strategy sets out how this and other work will be brought together more coherently, visibly and consistently and integrated with new developments such as the work on supporting 'relationship-based care', and shared decision making tools (for which there is strong evidence of improved patient choice, better experience and lower utilisation of expensive interventions). We will also ensure that our investment in our capital infrastructure provides the appropriate environment to support high quality healthcare experience and outcomes.

'...this and other work will be brought together more coherently, visibly and consistently and integrated with new developments...'

We will implement a generic and appropriate approach for measuring individual patients own assessments of the quality of the outcome of their healthcare episode, whether in primary, secondary or emergency care, so that a patient-based measure of health outcomes and experience can also be used to drive improvement in the quality of healthcare services.

In order to capture patients' assessment of their relationship with the healthcare professional supporting them, in such a way that it can be used to inform improvement, a measurement technique known as the *Consultation and Relational Empathy (CARE)* measure has been developed in Scotland. The *CARE* measure has been well validated with doctors, both with GPs in primary care and consultants in secondary care. We will pursue the introduction of the use of the *CARE* measure in all clinical appraisals and with other healthcare professionals. We will be able to use these measures to highlight action needed to ensure equity in terms of health outcomes and experience. Other tools to support staff, patients and carers in achieving the mutually beneficial partnerships we want will be developed, where appropriate, including outcomes approaches such as *Talking Points*.

Our initial improvement interventions will be:

- *Implementation of the new Self-Management Strategy*
- *Implementation of the Patient Rights (Scotland) Bill in 2011;*
- *Action in response to the first results of the Better Together Patient Experience surveys;*
- *Collection of appropriate data to measure patient reported outcomes (PROMS);*
- *Shared decision-making defined, supported and measured;*
- *Implementation of the CARE approach in primary and community care;*
- *Building on the principles of the Quality and Outcomes Framework (QOF) to maximise quality in the other contractor areas;*
- *Enhanced management of falls, pressure area prevention and nutrition;*
- *Improve resources to support better health literacy;*
- *Develop evidenced interventions to support improved person-centredness;*
- *Develop a programme of action to ensure that peoples' equality needs are gathered, shared and responded to across health services by Summer 2011; and*
- *Introduce interventions to improve staff experience.*

Making It Real – Lothian Community Nursing and long-term conditions

Before
Patient/person – Older people with chronic obstructive pulmonary disease at home and having difficulty in identifying signs and how to manage their symptoms. Often housebound.
Staff – aware that these older people need access to specialist nurses.

Actions
Touch screen technology is installed in the homes of people with chronic obstructive pulmonary disease.

After
Patient/person – Older people have found the equipment easy to use and feel supported in self management of their condition.
Staff – The nurses assess and coach people, monitor trends, refer when appropriate and enourage self management.
System – Technology enables vital sign collection and prompts. Enables video conferencing connecting people to specialist nurses who monitor their care remotely.

'We will roll out the successful focus on patient safety into a range of other care environments...'

Safe

The Scottish Patient Safety Programme is now making a significant impact across the NHS in Scotland. It represents an ambitious effort to make substantial safety improvements for the benefit of patients across a health system, and has gained significant ownership and buy-in from NHS staff. It aims to implement a set of key evidence-based interventions uniformly across all acute hospitals in Scotland, and to deliver significant reductions in premature mortality and in adverse events. We will roll out the successful focus on patient safety into a range of other care environments, and will develop appropriate approaches to improving safety in primary care and in mental health involving the contribution of both patients and staff.

NHSScotland's eHealth Strategy launched in June 2008 is focused on using information to improve quality. Good progress is being made in developing information technology and improving the business processes necessary to ensure that we get benefit from our investment in eHealth. The aim is to build a 'virtual patient record' that will contribute towards safety, continuity of care and collaborative decision making. With additional investment planned for 2010/11, key eHealth contributions to better quality care will include:

- Development of the Emergency Care Summary (ECS) and the Emergency Palliative Care Summary to enable, for example, their use in planned care as well as emergency care and extend as the Electronic Care Summary;
- Implementation of the 'clinical portal' programme to enable better sharing of patient information;
- Continued development of the 'patient portal' to allow patients access to information about their health; and
- Work on ways to bring clinical data to frontline staff.

Finally, we will ensure that the *Scottish Patient Safety Programme*, combined with our comprehensive HAI agenda, delivers change on the ground, so frontline staff can deliver a higher level of service to patients.

Our initial improvement interventions will be:

- *Accelerate roll out of the Scottish Patient Safety Programme in acute care, reducing hospital mortality and harm;*
- *Implement patient safety programmes for primary care and mental health;*
- *Accelerate medicines reconciliation across all transitions of care;*
- *Ensure synergy with the work of the HAI taskforce to secure further reductions in infection; and*
- *Extend the Electronic Care Summary and make widely available.*

Making It Real – Anaesthesia and intensive care, Glasgow Royal Infirmary

Before
Patients and public – All adverse events in Intensive Care Unit (ICU) increase duration of ICU stay.

Actions
Implementation of Scottish Intensive Care Society Ventilator Associated Pneumonia Prevention Bundle using real time data to measure improvement, and improvement in delivering interventions that are known to be effective.

After
Patients and public – reduction in ventilator associated pneumonia and other infections, a reduction in average length of stay in intensive care by a day and a half.
System – more efficient use of highly specialised intensive care facilities and improved reliability at delivery of effective interventions and reduced variation.

Effective

We will continue to focus on primary prevention of health problems, shifting the balance of care to prevention and early intervention. We will identify and reduce inappropriate variation in clinical practice, and in provision of care packages and treatments across all healthcare pathways so that the best care is consistently provided by the right person in the appropriate place at the right time. We will also implement our proposals to improve standards of care for long-term conditions and acute care in hospital, in the community and through supported self-management. Through these measures we will ensure that clear and challenging quality outcomes and success indicators are established for services for older people, and people with long-term conditions, and that there is leadership and capacity to support improvement. Much of the work required to improve quality and ensure sustainability of services for people with long-term conditions will involve primary and community care services, and supporting the drive to shift the balance of care away from hospital services towards the community.

Shifting the balance of care and enhancing prevention and anticipatory approaches has the potential to make services more efficient and sustainable by avoiding the development of disease and unnecessary hospital admissions, reducing avoidable days in hospital and improving patient experience. However, where hospital admission is required, we will ensure that patients receive high quality, evidence-based healthcare from well trained and empowered staff. We will support those with the most complex needs by ensuring that each of them has an integrated and shared *Anticipatory Care Plan* in place. Making this aspiration a reality will require a firm commitment to excellent cooperation and communication throughout the different stages in the care journey.

'...enhancing prevention and anticipatory approaches has the potential to make services more efficient and sustainable by avoiding the development of disease and unnecessary hospital admissions...'

We will continue to deliver our policy of reshaping the medical workforce so that the medical contribution is delivered predominantly by trained doctors, rather than doctors in training, and in collaboration with the extended multi-professional clinical team with the appropriate skill mix and capability.

We will also ensure that NHSScotland staff are properly supported, through new development packages where necessary, to provide anticipatory health and healthcare advice and support to people and their carers, tailored to the social, psychological and economic circumstances of their lives.

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'...a step change in health literacy across the whole population...'

We will support a step change in health literacy across the whole population, taking full advantage of existing and new approaches to communications, technology and resources to ensure that everybody has access to the information and advice they need, when they need it, to support them to maintain their health and wellbeing, manage ill-health and have the confidence to participate fully in shared decision-making.

With NHSScotland assets currently valued at approximately £5bn it is important that these assets are effectively managed to ensure the availability of appropriate, clean and safe healthcare environments which are central to the delivery of high quality healthcare. We will ensure that the *NHSScotland Property and Asset Management Policy* establishes an aligned approach to arrangements required by Boards for the safe and effective operation of their assets including premises, medical equipment vehicles and IT.

Our initial improvement interventions will be:

- *Preventative and anticipatory approaches, building on and extending initiatives such as Keep Well/ Well North, alcohol brief interventions and smoking cessation;*
- *Implement the Long-term Conditions Action Plan;*
- *Initiating a process of refreshing the suite of care pathways in close collaboration between secondary and primary care with clear prioritisation;*
- *Introduce and share Anticipatory Care Plans for 5 per cent of the population most at risk of hospital admission;*
- *Implement the major national strategies; Better Cancer Care, Mental Health Primary Care, Heart Disease and Stroke, Dementia and Living and Dying Well;*
- *Establish the appropriate healthcare skills and roles required to deliver high quality healthcare, and, through the use of the NHSScotland Career Framework and local/national workforce planning, establish plans to reshape the workforce accordingly;*
- *Ensure all our GP enhanced services are fit for the purposes of this strategy;*
- *Implement the Strategic Options framework for emergency response in remote and rural areas;*

- *Leading Better Care implemented across all Boards by December 2010;*
- *Implement the Releasing Time to Care approach across acute and community teams in all Boards; and*
- *Ensure high impact Efficiency and Productivity approaches are implemented reliably – (e.g. disinvestment, reduce harmful and wasteful variation (GP referrals, hospital length of stay, prescribing etc)).*

Making It Real – Clinical Quality Indicators

Before
Patients and public – variation in experience, care and outcomes around nutrition, pressure areas and falls.
Staff – no reliable local or national measure of the impact of nursing and midwifery care on quality.

Actions
A core set of evidence-based Clinical Quality Indicators (CQIs) were developed for nursing to support the measurement of the quality, safety and reliability of care. The initial focus was on CQIs applicable to inpatients, in a variety of specialties, on: food, fluid and nutrition; falls; and pressure area care.

After
Patients and public – evidence, for example in one NHS Board, that food, fluid and nutrition compliance is up from 50 per cent to 95 per cent, pressure area care from 60 per cent to 80 per cent, and falls compliance from 64 per cent to 66 per cent, and average compliance for all three CQIs has risen from 70 per cent to 90 per cent – real improvements for patients.
Staff – Better evidence, owned and used by ward staff to identify and support improvement actions, leading to better job satisfaction.

'…identify and remove any hurdles and barriers…'

Quality Infrastructure

A key requirement to realise our Quality Ambitions is for our systems and actions to be integrated and aligned across the whole NHS system. We need to identify and remove any hurdles and barriers presented by the current approaches to policy development and delivery across Scottish Government and NHSScotland. Responsibility for taking this action lies ultimately with NHSScotland Senior Management and with Scottish Government Ministers and senior officials.

'…Quality Alliance to involve all key stakeholders and oversee the implementation of the Quality Strategy…'

We will establish a new Quality Alliance to involve all key stakeholders and oversee the implementation of the Quality Strategy, and to ensure whole-system integration and alignment. The initial actions required include a simplification of the policy and delivery landscape with the introduction of a new approach to ensure that

existing and new initiatives are appropriately aligned with the Quality Strategy Ambitions, and that their impact on these ambitions is transparently communicated and properly measured and monitored. There will be a more robust review of HEAT, ensuring that we have a set of national targets which is clearly aligned and evidence-based in support of the Quality Ambitions.

We propose that the new Quality Strategy will extend to cover the activities of NHSScotland which are primarily focused on preventative and anticipatory care and are in pursuit of reducing health inequalities and in improving health. It will form the basis for our relationship with independent contractors.

We further propose that the Quality Strategy provides a basis for NHSScotland to work with community planning partners and the third sector in securing progress towards the Quality Ambitions and the outcomes agreed locally and nationally through the Single Outcome Agreements and the National Performance Framework.

'...ambitious leadership and strong professional values...'

The central purpose of the NHSScotland Quality Strategy is to create high quality, person-centred, clinically effective and safe healthcare services. Delivering this purpose requires ambitious leadership and strong professional values, supported by a robust and effective governance framework.

Strong and well developed governance arrangements will provide a framework of leadership, assurance and measurement in order to ensure transparency. This will mean NHS Boards need to ensure that governance activity at corporate level (including staff, financial and clinical governance) provides assurance that the organisation has a focus on quality; and that frontline staff, through a care governance approach, deliver care which aligns with our ambitions.

'...NHS Boards need to ensure that governance activity... provides assurance that the organisation has a focus on quality...'

Professional leadership, clinical engagement and the collective energy of all staff will be vital to Care Governance. Together we can cement the connection between improving our performance in all dimensions of quality with, and through, the clinical practice and individual contribution of every health professional in NHSScotland. Care Governance will explore how this

dynamic process can be strengthened and provide mechanisms for robust assurance on healthcare quality from 'point of care' to Board.

Our initial improvement interventions will be:

- *Establish Quality Ambitions by May 2010;*
- *2011/12 HEAT targets aligned with Quality Strategy by October 2010;*
- *Quality Measurement Framework underpinning Quality Ambitions with related high-level outcome indicators agreed by October 2010 – including 'early alert' Quality Scorecard;*
- *Establish governance responsibilities and procedures to support quality, and minimise risks;*
- *Ensure that national and local audit programmes support the development of appropriate indicators of quality, rigorous peer review and local action to address inappropriate variations in care;*
- *Develop, support and make best use of the skills, knowledge accountability and professional leadership of our staff to provide assurance of care quality at all levels; and*
- *Develop the Quality Improvement Hub, reflecting a new partnership for improvement between NHS National Services Scotland (NSS), NHS Quality improvement Scotland (QIS), NHS Heath Scotland, NHS National Education for Scotland (NES), and the Scottish Government Health Directorates Improvement and Support Team (IST).*

The Quality Measurement Framework

'Measurement is an important tool for driving large-scale improvement.'

Measurement is an important tool for driving large-scale improvement. This requires the use of appropriate measures for various purposes (e.g. improvement activity, performance management and tracking progress on outcomes). We are committed, through the Quality Strategy, to simplify and streamline the range of measures we use across NHSScotland to ensure that we achieve maximum value from our investment in data collection and measurement. Ensuring that there is a shared understanding of the types of measures involved, and how they relate to the achievement of the Quality Strategy's Ambitions, is critical.

We therefore propose to develop a Quality Measurement Framework that supports our shared vision of healthcare quality as described by the three healthcare Quality Ambitions. These clearly underpin the Scottish Government's Purpose and National Outcomes.

'...simplify and streamline the range of measures we use across NHSScotland to ensure that we achieve maximum value from our investment in data collection and measurement.'

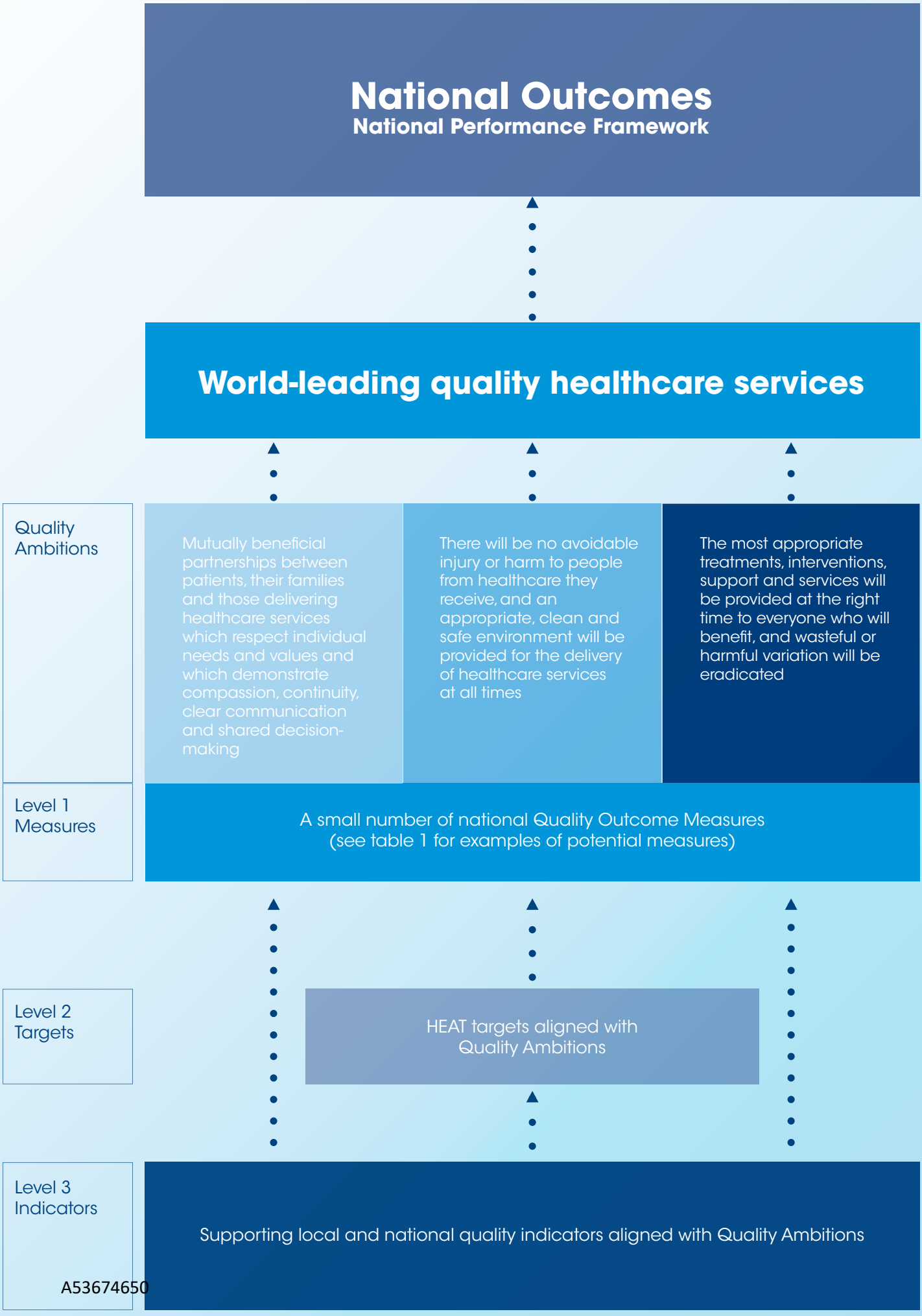
It is proposed that progress towards the three Quality Ambitions will be assessed nationally by reference to 12 Quality Outcome Measures. These measures will be based on a combination of patient and staff reported experiences and outcomes as well as measures of patient safety and clinical effectiveness. The detail of the measures is yet to be developed and agreed, but table 1 provides some examples of measures that will be considered. The Quality Outcome Measures will also contribute to the Quality Scorecard, a key tool for the NHS Boards to use to assess quality of care, and to provide an early warning of any potential quality issues.

The national targets for NHSScotland (HEAT targets) will be aligned to the Quality Ambitions, and will set out our agreed areas for specific accelerated improvement each year.

The Quality Measurement Framework also allows for supplementary local and national indicators that will underpin progress towards our Quality Ambitions, for example, the measures contained in the patient safety extranet.

By setting out the Quality Measurement Framework and ensuring a common understanding of healthcare quality we will be able to make sure that all of our measurement, performance and reporting systems

Proposed Quality Measurement Framework



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converge and align. It is intended that this will include the National Performance Framework, Single Outcome Agreements, HEAT and national data systems (held by ISD), as well as systems which Boards use in their own local areas (e.g. local governance, improvement and performance indicators).

Quality Outcome Measures

The Quality Outcome Measures:

- will reflect national progress towards the three Quality Ambitions, but will not be subject to specific targets;
- include a combination of patient-based, staff-based and system-based measures to cover the three main levers for change;
- are being derived in close collaboration with colleagues across NHSScotland; and
- provide a line of sight to the National Outcomes and the National Performance Framework.

Table 1 introduces the 12 potential national Quality Outcome Measures. Further analysis and consultation will take place with a view to agreeing them by October 2010 for implementation alongside the related set of HEAT targets for 2011/12. Some measures are likely to require development over the longer term.

Table 1: Potential National Quality Outcome Measures

Potential measure	Rationale	Patient/ staff/ system measure
● Healthcare experience	People's experience of our services is important. This is also an indicator in the National Performance Framework for which methodology has still to be developed. Ideally, this measure would include feedback from both patients and carers. Patient experience of various aspects of quality can be assessed from current surveys. Further consideration around how to capture the experience of carers will be required and existing information sources will be explored.	Patient
● Staff experience	Staff survey results provide another angle on the person-centredness of the NHS. Survey questions relate to several of the quality dimensions. Again, these could be separate measures or combined into one measure.	Staff
● Staff attendance	This indicator supports several dimensions, including efficiency and person-centredness. In addition, a reduction of staff absence could be expected to contribute to improved safety, timeliness and effectiveness.	System
● Healthcare Associated Infections	Key priority within the strategy. Indicates a cleaner environment and reduction in avoidable harm. Infections can result in longer stays in hospital, reducing clinical effectiveness, efficiency and affecting timeliness.	System
● Emergency admissions	This outcome indicator should represent a shift in the balance of care. It could demonstrate effectiveness of anticipatory and planned care. Patients are supported to remain at home where safe and appropriate. This measure should, therefore, reflect improved partnership working with social care, carers and the voluntary sector.	System
● Adverse events	This directly contributes towards the aim of no avoidable injury or harm. Adverse events result in poorer clinical outcomes and less effective use of resources. Therefore, this measure supports effectiveness and efficiency as well as safety.	Staff
● Hospital Standarised Mortality Rate (HSMR)	National reduction in HSMR should reflect work in individual hospitals to review mortality under the Scottish Patient Safety Programme and reflect reduction in serious adverse events and infections	System
● Proportion of people who live beyond 75 years	This outcome is intended to reflect the range of improvements right through the healthcare system from prevention to treatment.	System

Potential measure	Rationale	Patient/ staff/ system measure
● Patient Reported Outcomes	Indicates whether interventions have been effective from the point of view of patients. It is proposed that there is potential for, through time, an aggregated measure of PROMS based on local feedback to be developed. A project is being initiated by NHS QIS, working in partnership with the Universities of Stirling and Dundee & The Alliance of Self Care, to develop a national toolkit for this. As part of this project, the potential for this type of measure will be investigated. This is therefore a longer-term aim.	Patient
● Patient experience of access	Shows the patient point of view as to whether they have been able to access the care they needed, when they needed it.	Patient
● Self Assessed General Health	Self-assessed health will be a longer-term measure that will allow us to assess the effectiveness of a wide range of initiatives. Will reflect all quality outcomes including person-centred, timeliness, efficient, clinical effectiveness and safe.	Person
● Percentage of last 12 months of life spent in preferred place of care	Captures the outcomes of *Living and Dying Well* (a national action plan for palliative and end of life care in Scotland) i.e. use of tools to identify and assess people with palliative and end of life care needs; delivery and coordination of care across care settings to address those needs by consistent access to, and review of, anticipatory care plans (including palliative care summary and Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR).	System

5. Making it Happen

'Real improvement and consistent quality will come from the efforts and actions of health professionals and both clinical and non-clinical NHS staff at all levels.'

'...important changes in culture and approach will be required to ensure that staff are equipped and supported...'

The Quality Strategy will need to be owned by everyone in Scotland with a recognition that quality is at the heart of everything we do. It will require senior leaders in the NHS and other service providers to be focused on and be inspired by the aim of world-leading healthcare quality. Real improvement and consistent quality will come from the efforts and actions of health professionals and both clinical and non-clinical NHS staff at all levels, and most importantly those delivering direct care to patients and their families. This will mean that we need to work more effectively in partnership with professional groups, colleges and staff representatives to implement this strategy by ensuring that we set out the ambitions in a way which provides the basis for an alignment of individual, team, system and organisational goals.

Achieving change of this scale requires:

- Leadership at all levels;
- Shared ownership - winning hearts and minds;
- Partnership with staff, involvement of patients and carers;
- Embedding quality in day-to-day work;
- Creating the right infrastructure - people, IT;
- Energy and commitment - tying it all together;
- Focusing on the right outcomes and targets; and
- Developing meaningful measures, evidence and analysis.

The people delivering healthcare services across NHSScotland have already confirmed their commitment to making the changes needed to share a focus on our Quality Ambitions. Clinical leads, senior doctors and nurses, AHPs, senior managers, and many other healthcare and supporting staff have attended a series of events throughout 2009/10 providing input to this strategy, and demonstrating their individual and collective commitment. Throughout these discussions, we know that we are starting from a very strong foundation (for example our approach to establishing Managed Clinical Networks) but we equally recognise that important changes in culture and approach will be required to ensure that staff are equipped and supported to provide the high quality healthcare to which we aspire, all the time. To support this we will ensure that the *Knowledge and Skills Framework* is aligned to the Quality Ambitions, and that contracts, job descriptions and annual appraisals are used flexibly and more explicitly to support staff in pursuing improvements in healthcare quality.

'...compelling to, and shared by, partners in the rest of the public sector, and in the third sector.'

Our approach to implementing the Quality Strategy will recognise the different, and sometimes multiple roles that individuals have in implementing the actions required to achieve our aims. We will communicate the vision of a high quality NHS to the people in Scotland in a number of ways to ensure that it is compelling to all. We will do this in a way which makes it clear that every person in Scotland, no matter who they are, or where they are, has an important role to play to ensure our healthcare services are the best they can be now, and for generations to come. The vision also needs to be compelling to, and shared by, partners in the rest of the public sector, and in the third sector.

We will therefore take a partnership approach to communication and implementation which is simultaneously:

- Person-based;
- Staff-based; and
- System-based.

Person-based

Our communication approach will set out the vision for high quality Scottish healthcare services. It will explain what this means for every individual, in terms of their rights and expectations, and the responsibilities they will have for learning, taking action to maintain their own health, managing their ill-health, collaborating in respectful partnerships with healthcare staff, and feeding back their experiences and outcomes to support a continuous cycle of improvement.

Staff-based

We will continue to work with and through all staff working in and with NHSScotland to develop and implement quality improvement interventions we can use to drive person-centredness, clinical effectiveness and patient safety. To support this approach we will also explore training and skills development approaches they will need to support their practice – such as *The Effective Practitioner*, a NES online learning programme in development.

Our staff are our greatest resource and we must ensure that they can use their knowledge and skills to best

effect for service users and carers. There is evidence to suggest that effective clinical teams and effective management practices can both have a direct impact in reducing mortality. In addition, measures to enhance staff health and wellbeing have been shown to improve the patient experience and outcomes, reduce absenteeism, increase productivity and organisational efficiency. We will therefore continue to invest in developing clinical leaders, supporting best practice in managing staff in order to enhance the employee experience and the delivery of high quality care.

We shall also continue to pursue with primary care contractors the process we have begun to ensure that their energy, creativity and dedication are released for the benefit of patients.

System-based

In order to support staff, patients and carers to implement the inventions that will support the actions required to deliver the vision for health and healthcare services in Scotland, we need to identify and remove any hurdles and barriers presented by the current approaches to policy development and delivery. Responsibility for taking this action lies primarily with NHS senior management and with Scottish Government Ministers and officials. However, feedback from staff, patients and carers will inform the continuous cycle of improvement required to ensure that the wider system continues to support and facilitate the delivery of high quality health and healthcare services in Scotland.

'...staff health and wellbeing have been shown to improve the patient experience and outcomes...'

The initial actions required at the system level involve a clear and unambiguous reinforcement of the policy priorities for health and healthcare in Scotland. These will include a commitment to improving health and healthcare services quality improvement, embedding the concept of mutuality in pursuit of improved quality, achieving best value in everything we do, and through ensuring maximum integration and continuity of services. We shall also explore with primary care contractors the conditions which would have to be met - and the benefits which would accrue - if we were to move increasingly to a high trust/low bureaucracy culture. They also include a simplification of the policy and delivery landscape with the introduction of a new approach to ensure that existing and new initiatives are appropriately

'...a clear and unambiguous reinforcement of the policy priorities for health and healthcare in Scotland. '

aligned with the Quality Strategy aims, and that their impact on these aims is transparently communicated and properly measured and monitored. There will be a more robust review of HEAT, ensuring that we have a set of national targets which is evidence based and clearly aligned with the quality aims.

'...ensure that existing and new initiatives are appropriately aligned with the Quality Strategy...'

System-based changes will reinforce the commitments set out in *Better Health, Better Care*, focusing on the shift required from top-down approaches to bottom-up, the appropriate balance between performance management and continuous improvement and the focus required on getting it right for every person, every time by reducing inappropriate and unnecessary variation.

'...public sector partners and the third sector have a major role to play...'

There will be a refreshed commitment to working closely with community planning partners in the delivery of the Quality Strategy vision and the wider Local and National Outcomes, recognising that public sector partners and the third sector have a major role to play in supporting people across Scotland in making the changes required to achieve the world-leading health and healthcare services to which we aspire.

Working in partnership

This Quality Strategy will underpin all that we do. We propose that it will extend to cover the activities of NHSScotland which are primarily focused on preventative and anticipatory care and are in pursuit of reducing health inequalities and in improving health. It will form the basis for our relationship with independent contractors.

We further propose that this strategy provides a basis for NHSScotland to work with partners through Community Planning Partnerships and in the third sector in securing progress towards the Quality Ambitions, and the higher level outcomes agreed locally and nationally through the Single Outcome Agreements and the National Performance Framework. An example of this is the support required from other public sector partners in establishing the *Keep Well* health checks through providing follow-up activities to promote wellbeing and healthier lifestyles. *Reshaping Care for Older People* is a major programme that is being designed, developed and delivered as a partnership across NHSScotland and local government with active engagement from the third sector and community and patient/carer interests.

6. Implementation

The Quality Alliance

Following the launch of the Quality Strategy, we need to establish the arrangements through which action will be taken to implement the key interventions, ensure integration and alignment and to oversee progress on the wider commitments and changes required to take forward this Quality Strategy.

'...the Quality Alliance will... develop and maintain a robust high-level shared ownership and responsibility for implementing the Quality Strategy.'

To help us achieve this, the Quality Alliance will be created, which will include senior representatives from all of the stakeholder bodies. We will work with primary care contractors to ensure that the right forums are in place to ensure effective primary care input. The key role of the Quality Alliance will be to develop and maintain a robust high-level shared ownership and responsibility for implementing the Quality Strategy. It will be supported by a dedicated resource which will provide central leadership, coordination, intelligence and the day-to-day support required. The Scottish Government will liaise with NHS Boards, with particular reference to the opportunities for QIS and NES to play a major role in establishing this central resource. The Quality Alliance will lead a more detailed consideration and secure agreement on the areas for action and the related improvement interventions with those who will deliver the Quality Ambitions.

Data for Improvement

In this document we have set out a proposed framework for the development of measures to support the implementation of the Quality Strategy. These measures will be needed to define a shared understanding of healthcare quality, and to establish baselines from which to monitor improvement. We also make a commitment to reviewing the relationship of these measures with the HEAT targets – making necessary changes to HEAT for 2011/12 to ensure alignment and to reflect the role of performance management in achieving our aim.

'...measures will be needed to define a shared understanding of healthcare quality...'

The first steps will be for a range of lead partners, including QIS, NSS Information Services Division (ISD) and the Scottish Government, to work together to develop proposed definitions and methodologies for deriving the measures, and to consult widely to secure agreement, before developing the initial baseline measures. Following the launch of the 2010/11 Local Delivery Plans (LDPs) and HEAT targets in November 2009, the Scottish Government will consult on the action needed to align HEAT with the Quality Ambitions for 2011/12 and beyond.

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'...a major driver to motivate and inspire...'

Communication

Communication is a key component of the Quality Strategy, not just in terms of raising awareness about the ambitions for NHSScotland, but as a major driver to motivate and inspire everyone across Scotland to take appropriate action to make their contribution to achieving the shared vision for NHSScotland. The key aims of communication are therefore to:

1. Raise awareness both internally and externally, of the Scottish Government's vision for NHSScotland to ensure that the quality of healthcare services delivered by NHSScotland is recognised by the people of Scotland as amongst the best in the world;
2. Inspire staff and the public to appreciate and understand the role they play in delivering the Quality Strategy's vision; and
3. Highlight national and local programmes/services which are helping deliver quality healthcare.

In order to achieve these communication aims, we will:

- Position and frame the Quality Strategy's purpose and vision in a more accessible way which gives meaning and understanding to the public;
- Use all available approaches (events, publications, campaigns and digital communication) to engage with all stakeholders throughout Scotland at a national and local level (i.e. the public, NHS staff, Scottish Government, third sector etc.) informing them of the vision for NHSScotland and what it means for them;
- Promote and inform people working within NHSScotland and the public of existing and new services which are delivering the vision for NHSScotland at a national and local level;
- Equip and support the people working in and with NHSScotland with information about what they can do to help NHSScotland become a world leader in delivering quality healthcare; and
- Inspire and motivate staff and public to play an active role in achieving the vision for NHSScotland.

Conclusion

The Quality Strategy is about people. It is for all of us. It aims to provide everyone with the care and compassion they want and need by enabling their voice to be heard and then designing services with them that are amongst the safest, most effective and best in the world. The strategy aims to ensure that in our NHS this is provided reliably to every person, every time.

The Quality Strategy is about both continuity and change. Continuity comes from the Strategy's clear links with the founding principles of the NHS, the shared ownership of the NHS, and through building on the significant progress and improvements which have been made in recent years. Change will come from the stronger focus on the Scottish people's priorities, from greater involvement of people in the design and delivery of their care and from the quickening pace of the improvements we will make.

We are confident that by establishing this shared understanding of quality, and a commitment to place it at the heart of everything we do, our Quality Strategy represents a unique and important opportunity for all of us to work together to our mutual benefit to make our NHS even better, for everyone, now and into the future.



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The Blueprint for Good Governance in NHS Scotland

Second Edition
November 2022

Foreword

In 2018 the Scottish Government recognised the need to ensure that the governance arrangements in NHS Scotland were fit for purpose and keeping pace with the changing policy and financial environment. In response to this challenge, the Director General for Health and Social Care commissioned a review of best practice in healthcare governance. The outcome of the review was a blueprint for an effective governance system that could be adopted across NHS Scotland. The first edition of the Blueprint for Good Governance was published in January 2019 and since then NHS Boards have been adapting this model to meet the needs of their organisation and respond to the challenges faced by the NHS, including the impact of the Coronavirus pandemic.

As NHS Boards look forward to recovering and renewing the health and care system it is important that good governance remains in place to stabilise service delivery while continuing to support the longer term ambitions of service design and reform as part of the Care and Wellbeing Portfolio. To assist Boards in achieving that goal, the NHS Scotland Corporate Governance Steering Group commissioned additional guidance on delivering the approach described in the original Blueprint for Good Governance. The purpose of this document is to share the latest thinking on healthcare governance by publishing a revised version of the Blueprint that will support the NHS as it moves from response to recover and renew.

This second edition of the Blueprint for Good Governance now includes a definition of what is meant by 'good', placing more emphasis on the delivery mechanisms and the need to apply a continuous improvement approach to healthcare governance arrangements. Consideration of the approach to the governance of change now features more prominently in the design of the governance arrangements. The updated guidance also highlights the need for NHS Boards to adopt both active and collaborative approaches to governance.

I would like to thank all those in the Scottish Government, NHS Scotland and the other public and private sector organisations who have contributed to the development of the revised Blueprint for Good Governance. I am particularly grateful to the members of the NHS Scotland Corporate Governance Steering Group for their insight, advice and contribution to the final version of this guide to delivering good governance in healthcare.



Professor John Brown CBE
November 2022

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1. Introduction

1.1 The purpose of this document is to provide guidance on how to deliver and sustain good corporate governance. While this approach can be adapted and applied to other areas of the public sector, it has been customised for healthcare in Scotland.

1.2 Throughout the document the term healthcare is used in its broadest sense to mean not only the delivery of clinical interventions in response to a known healthcare need but also to cover the much wider, more proactive approach required to address population health improvement and promote health more broadly.

1.3 While the primary audience for this guide is the Board Members and Executive Leadership Teams working across NHS Scotland, it will also be of interest to the UK and Scottish Governments, local authorities, integration authorities, independent (primary care) contractors, and an extensive range of public sector organisations who all have an influence on the health of individuals and communities across Scotland.

1.4 Throughout this guide references to "NHS Boards" should be considered as including the fourteen territorial Health Boards, the six special Health Boards, Health Improvement Scotland and NHS National Services Scotland.

1.5 The guidance reflects the latest thinking and best practice in healthcare governance. It presents a Blueprint for Good Governance that describes the functions, the enablers, the assurance framework, the integrated system and the operating guidance that need to be in place to support good governance. The guidance also aims to improve the effectiveness of governance in the NHS by requiring that the Boards' governance arrangements are subject to continuous review and development.

1.6 The Blueprint provides NHS Education for Scotland and other training providers with a foundation for developing training and development products. It can also be used for providing awareness and information on healthcare governance for a wider community that includes clinicians, managers and other people with an interest in health and social care.

1.7 It is important to acknowledge the requirement that governance arrangements should reflect the needs of the organisation and the environment in which it operates, and NHS Boards should adopt a flexible approach, recognising that their governance systems must take into account the individual circumstances and the specific challenges faced by their organisation.

1.8 Therefore, while it is expected that all NHS Boards adopt the principles, underpinning models and frameworks described in this guide, these should not be seen as prescriptive and Boards are expected to be flexible and adapt them to ensure they have a governance system in place that is at all times appropriate and proportionate for their organisation. This includes introducing temporary changes to governance arrangements that may be required to provide a suitable response to emergency situations, such as those experienced during the Coronavirus pandemic.

1.9 For NHS Scotland to be successful in delivering quality healthcare, good governance is necessary but not sufficient if NHS Boards are to meet or exceed the expectations of their principal stakeholders. To do that, the organisation must also excel at the day-to-day management of operations and the implementation of change.

1.10 Therefore, the guidance provided in this document should be considered in conjunction with the various workstreams and initiatives across NHS Scotland that are focused on managing current operations, recovering from the public health emergency created by the Coronavirus pandemic and redesigning the NHS to meet the demands of the post-pandemic world.

1.11 The guidance begins by highlighting some of the challenges faced by the NHS and '**why**' having good governance is necessary to successfully respond to those challenges. It then goes on to define '**what**' good governance means in relation to healthcare before describing the blueprint for **'how**' this can be delivered, including '**who**' is accountable and responsible for ensuring good governance across NHS Scotland.

2. The Importance of Good Governance

2.1 In common with healthcare providers across the globe, NHS Scotland finds itself operating in an increasingly demanding environment. The impact of demographic change and the growth in long term health conditions at a time of financial constraint meant that the healthcare system was already under significant pressure prior to the Coronavirus pandemic.

2.2 The need to respond effectively to the impact of the public health emergency has added even greater and unprecedented challenges for the NHS. This includes developing the role of the NHS Boards as key 'anchor institutions' in the local and national economy and finding new and innovative approaches to delivering health and social care.

2.3 If the NHS is to address the challenges it faces in improving health at population level and creating a healthcare system that meets the present and future needs of the people of Scotland, the importance of good governance should not be underestimated.

2.4 The **Independent Commission on Good Governance in Public Services**[1] emphasised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and ultimately good outcomes. The Commission also highlighted that weak or ineffective governance fosters low morale and adversarial relationships that lead to poor performance or even, ultimately, to dysfunctional organisations.

2.5 Therefore, it is critical that NHS Boards ensure that robust, accountable and transparent governance arrangements are in place throughout the healthcare system.

2.6 NHS Boards need to be able to demonstrate that their governance arrangements respect and pursue the rights and interests of all their stakeholders, and enable Board Members to hold their Executive Leadership Teams to account for improving population health and addressing health inequalities, while delivering safe, effective and high quality healthcare services.

2.7 Having established why good governance is essential in addressing the challenges the NHS faces in Scotland - but before describing in detail the Blueprint for implementing that approach - it is necessary to have a shared understanding of what is meant by '**good governance**' in healthcare.

[1] www.cipfa.org/policy-and-guidance/reports/good-governance-standard-for-public-services

3. The Definition of Good Governance

3.1 A description of good governance that underpins the revised Blueprint has been developed that brings together an updated definition of the '**governance**' of healthcare with a list of the underlying principles that support the delivery of '**good**' governance.

3.2 This description of what is meant by '**good governance**' is further enhanced by explanations of the terms '**active**' and '**collaborative**' in the context of good governance.

The Governance of Healthcare

3.3 The publication of the **NHS Scotland Blueprint for Good Governance**[2] in 2019 described governance as "The system by which organisations are directed and controlled". While this statement was useful in clarifying what was meant by 'governance' in general, it is less helpful when considering what is specifically required to deliver good governance in a healthcare setting in 2022 and beyond.

3.4 Therefore, a more up to date and relevant definition of governance has been developed and approved by the NHS Scotland Corporate Governance Steering Group. The following paragraphs describe the thinking behind the development of this revised definition of 'governance'.

3.5 The **UK Corporate Governance Code**[3] also defines governance as "The system by which organisations are directed and controlled". It expands on that statement by adding that "Governance is about what the board does and how it sets the values of the organisation and is to be distinguished from executive director led day-to-day operational management". This recognises that a good governance system can also help individuals avoid the tension and conflict that can arise in an organisation where the boundaries between roles are not clear.

3.6 **The World Health Organisation and the Royal College of Physicians of Edinburgh's Quality Governance Collaborative**[4] have developed a joint working definition that provides further insight into what excellence in governance means in a healthcare organisation. They describe governance as "The means by which all institutions and organisations involved in the design and delivery of healthcare translate health policy into clinical practice and management in order to improve the quality and efficiency of healthcare. It is the ability to ask the right questions and to implement the right

[2] www.sehd.scot.nhs.uk/dl/DL(2019)02.pdf
[3] www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0-d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.pdf
[4] www.rcpe.ac.uk/college/QGC

mechanisms to ensure the organisation discharges its duties in line with its purpose and with focus on good clinical practice". This approach focuses on the governance of clinical practice and emphasises that good governance does not just rely on having systems in place. How well Boards use these systems is a critical factor in the delivery of good governance.

3.7 By bringing these two relevant and helpful definitions together a revised definition of governance in healthcare has been developed for use by NHS Scotland. This definition is expressed as:

> "Governance is the means by which NHS Boards direct and control the healthcare system to deliver Scottish Government policies and strategies and ensure the long term success of the organisation. It is the ability to ask questions and make decisions to improve population health and address health inequalities, while delivering safe, effective and high quality healthcare services. It is to be distinguished from executive-led operational management."

3.8 Governance arrangements in the NHS should include service delivery, change management, workforce, finance, information and asset management. These arrangements must have a clear focus on clinical and care governance, including the governance of clinical research. Particular attention should also be given to educational governance and the governance of the professional standards expected of the clinicians employed by the organisation. (Further advice on educational governance can be found on **NHS Education for Scotland's**[5] website.) All these categories of governance should be considered when NHS Boards determine their arrangements and systems for delivering good governance.

3.9 Having defined what is meant by 'governance' and what should be included in the NHS Boards' governance arrangements, it is helpful to consider next what 'good' looks like in relation to the governance of healthcare.

The Principles of Good Governance

3.10 To reflect and describe the latest thinking and best practice in governance in the public sector, ten principles of good governance have been identified. These principles underpin the design of the Blueprint for Good Governance.

[5] www.nes.scot.nhs.uk

3.11 **The Principles of Good Governance can be viewed as an executive summary of what is required to deliver good governance. They are as follows:**

i. Good governance requires the Board to set strategic direction, hold executives to account for delivery, manage risk, engage stakeholders and influence organisational culture.

ii. Good governance requires a Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships.

iii. Good governance requires that roles, responsibilities and accountabilities at Board and executive level are clearly defined and widely communicated.

iv. Good governance requires an assurance framework that aligns strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities.

v. Good governance requires an integrated governance system that co-ordinates and links the delivery of strategic planning and commissioning, risk management, assurance information flows, audit and sponsor oversight.

vi. Good governance requires an integrated governance system that co-ordinates and links the delivery of strategic planning and commissioning, risk management, assurance information flows, audit and sponsor oversight.

vii. Good governance requires operating guidance that is agreed, documented, widely-communicated and reviewed by the Board on a regular basis.

viii. Good governance requires regular evaluation of governance arrangements to ensure it is proportionate, flexible and subject to continuous improvement.

ix. Good governance requires an active approach that anticipates and responds to risks and opportunities which could have a significant impact on the delivery of corporate objectives, the Board's relationships with stakeholders and the management of the organisation's reputation.

x. Good governance requires a collaborative approach that ensures the organisation's systems are integrated or aligned with the governance arrangements of key external stakeholders.

xi. Good governance requires governance arrangements that are incorporated in the organisation's approach to the management of day-to-day operations and the implementation of change.

3.12 To assist NHS Boards in adopting the Principles of Good Governance, the following paragraphs explain what is meant by an active approach and a collaborative approach in relation to governance in healthcare.

The Active Approach

3.13 Put simply, the active approach to delivering good governance requires Board Members to focus on the right things, consider the right evidence and respond in the right way.

3.14 A more comprehensive description of the active approach to governance has been defined as:

> "Active governance exists when the appropriate issues are considered by the right people, the relevant information is reviewed in the most useful format at the right time, and the level of scrutiny produces rigorous challenge and an effective response."

3.15 This approach should not only ensure that Boards can make timely, well-informed, evidence-based and risk-assessed decisions, it will also ensure Board Members can rapidly identify, escalate and manage issues which otherwise might not be seen or understood.

3.16 While an active approach is required to deliver good governance in healthcare, it should be recognised that the NHS is only one of a range of organisations that impacts on the health of the population. Therefore, NHS Boards must also consider how they can influence and interact with the other bodies that have an impact on the delivery of quality healthcare.

The Collaborative Approach

3.17 The NHS works closely with national and local government, integration authorities, independent (primary care) contractors, the private sector, the third sector, charities, academia, communities and citizens to deliver healthcare in a joined up, person-centred manner.

3.18 Consequently, the governance of the organisations that interact with the NHS have a direct impact on population health and the delivery of healthcare services and this must be recognised when designing the governance approach for NHS Boards.

3.19 To assist in the promotion of this approach, the following definition of what collaborative means in relation to governance has been developed:

> "Collaborative governance exists when all parties who have an influence in the delivery of healthcare outcomes recognise, understand and respect the needs of each other and work together to integrate or align their arrangements for the governance of the delivery of services and products within the healthcare environment."

3.20 While fully integrating governance can be challenging, it is critical that a collaborative approach to governance is adopted by the key players in the healthcare system to ensure that the end-to- end governance arrangements are understood and aligned in order to achieve the best outcomes for the population and ensure best value in the use of public funds.

3.21 The introduction of the Principles of Good Governance will assist in delivering this approach and the development and communication of a Blueprint for Good Governance that describes the NHS approach to governance arrangements in more detail will further enable the collaborative approach.

4. The Blueprint for Good Governance

4.1 The primary purpose of the Blueprint for Good Governance is to provide guidance on how to deliver and sustain good governance in healthcare.

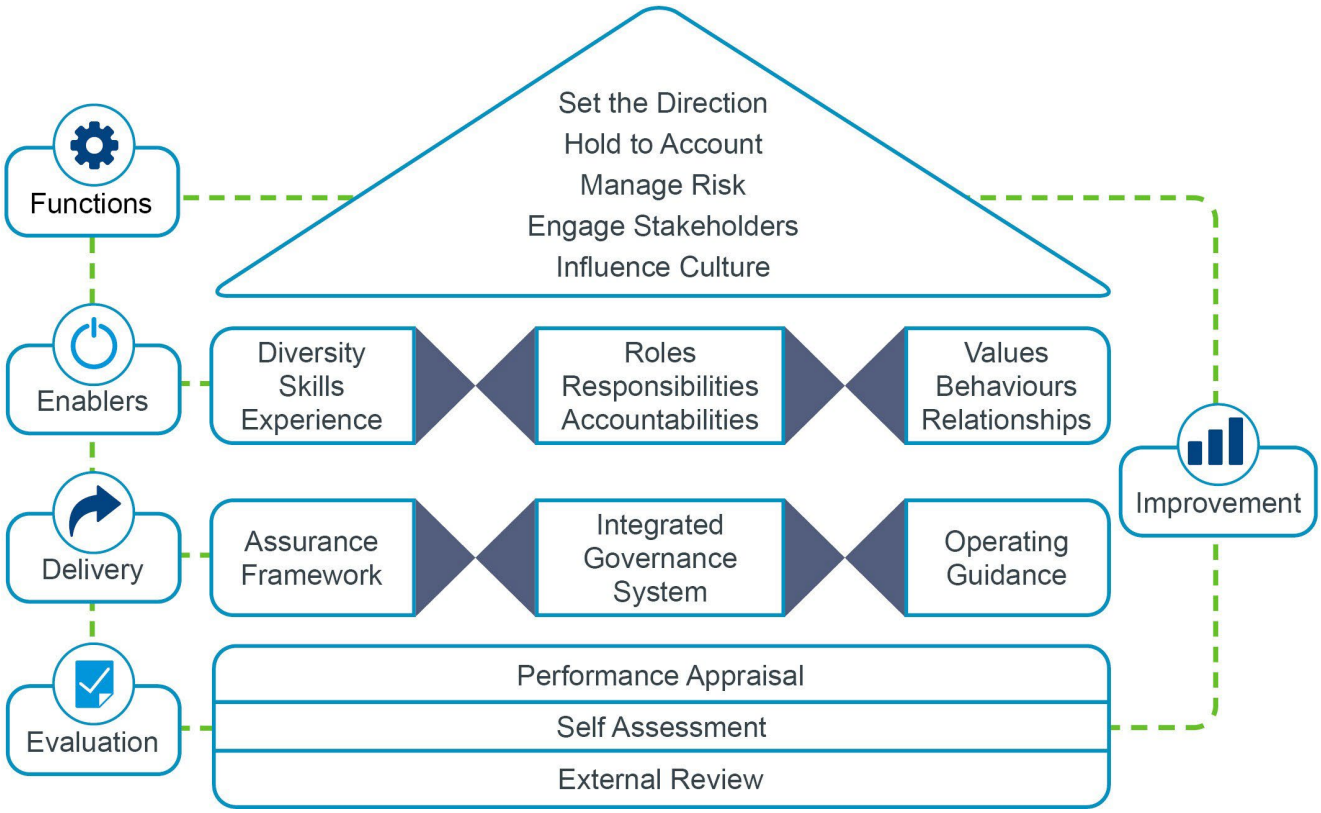
4.2 This model builds on the Principles of Good Governance that describe what good governance looks like and provides more detailed guidance to NHS Boards on the functions and the enablers of good governance. It provides definitions of the assurance framework, the integrated governance system and the operating guidance that also need to be in place to support good governance.

4.3 Adopting the Blueprint also commits NHS Boards to improving the effectiveness of governance in healthcare by requiring that Boards' governance arrangements are subject to regular evaluation and ongoing improvement activity.

4.4 The latest version of the governance Blueprint describes a four-tiered model where each component should be viewed as interdependent and subject to continuous improvement.

The Model

Figure One – The Blueprint for Good Governance



4.5 Ownership of the NHS Scotland bespoke version of the Blueprint for Good Governance rests with the Scottish Government, and accountability for reviewing and refreshing the healthcare model sits with the Director of Health Finance and Governance.

4.6 The following sections of the guide describe the component parts of the Blueprint in more detail, starting with the functions of good governance.

The Functions

4.7 **The Blueprint for Good Governance begins with a definition of the five primary functions of governance. These are described as:**

i. **Setting the direction**, including clarifying priorities and defining change and transformational expectations

ii. **Holding the Executive Leadership Team to account** by seeking assurance that the organisation is being effectively managed and change is being successfully delivered

iii. **Managing risks** to the quality, delivery and sustainability of services

iv. **Engaging with key stakeholders**, as and when appropriate

v. **Influencing** the Board's and the wider organisational culture.

4.8 The following paragraphs define the functions that need to be delivered to ensure good governance is in place.

Setting the Direction

4.9 Board Members are responsible and accountable for setting the overall strategy and direction of the organisation. They are also responsible for encouraging and facilitating innovation, driving change and transforming service delivery to better meet the expectations and needs of their key stakeholders.

4.10 To set the direction the NHS Board should provide advice, support and guidance to the Executive Leadership Team by:

- Determining the organisation's purpose, aims, values and corporate objectives
- Approving the corporate strategic and commissioning plans required to deliver the policies and priorities of the Scottish Government
- Setting the operational priorities for the organisation and agreeing the targets for service delivery with the Scottish Government and the Executive Leadership Team
- Allocating the budgets and approving the capital investments required to deliver strategic and operational plans.

4.11 Delivering this aspect of governance is explored further in the supplementary guidance that describes the strategic planning and commissioning component of the integrated governance system.

Holding to Account

4.12 In order to hold the Executive Leadership Team to account the NHS Board requires a clear and accurate picture of current and past delivery of services. This understanding of performance over time is necessary to assist Board Members in identifying systemic change which requires further investigation and be assured that appropriate action plans are in place to address any ongoing performance issues.

4.13 To be assured about the organisation's performance, Board Members must regularly monitor performance, scrutinise results and challenge outcomes. They are required to scrutinise evidence that describes the extent to which:

- The organisation's purpose, aims, values, corporate objectives, operational priorities and targets are being delivered to an acceptable level
- Public money is being safeguarded and appropriately accounted and resources are being used to secure 'best value' as set out in the **Scottish Public Finance Manual**[6]
- The requirements of relevant regulations or regulators are being complied with to the necessary standard
- Fair and equitable systems of pay and performance management (as determined by the Scottish Government) are being applied to the reward and recognition of the workforce, including the Executive Leadership Team
- Innovation and transformational change are being delivered and benefits realised
- Continuous improvement and quality management approaches are embedded in all aspects of service delivery and system failures are identified and remediated
- Best practices are shared across the organisation with a learning culture being promoted and nurtured.

4.14 Board Members should aim to be assured rather than reassured about the organisation's performance. This requires Board Members to consider reliable sources of information before being satisfied with the pace and progress in the delivery of outcomes, rather than being advised by others that performance or actions are acceptable.

4.15 Therefore, Board Members must have easy and early access to evidence from a wide range of sources. This requires an effective flow of data, information and feedback at a frequency and in a format that enables Board Members to develop early awareness and understanding of the current situation and the risks and opportunities in the operating environment.

4.16 Delivering this aspect of governance is explored further in the supplementary guidance that describes the assurance information system component of the integrated governance system.

4.17 Effectively holding the Executive Leadership to account not only requires that Board Members have access to the relevant data in the most useful format, an active approach to governance necessitates that data is subject to the right level of scrutiny.

[6] www.gov.scot/publications/scottish-public-finance-manual

4.18 To effectively challenge and prompt a worthwhile response it is important that Board Members give due consideration to the tone and manner in which they question the Executive Leadership Team. This includes recognising it is better to ask an open-ended question and to give the respondent time to answer with the appropriate level of detail and nuance.

Managing Risk

4.19 Board Members must have regard to the wider strategic and policy context in which they operate when considering the risks which could have a significant impact on the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This also applies to managing the risks to the Board's relationships with key stakeholders and risks to their reputation as a public body.

4.20 Exercising vigilance and managing risk is a key component of the active approach to governance and requires Board Members to be constantly looking forward, as well as looking backwards to hold the Executive Leadership Team to account for service delivery.

4.21 Effective risk management requires that the Board should:

- Agree the organisation's risk appetite
- Approve risk management strategies and ensure they are communicated to the organisation's workforce
- Consider current and emerging risks for all categories of healthcare governance
- Oversee an effective risk management system that assesses the level of risk, identifies the mitigation required and provides assurance that risk is being effectively treated, tolerated or eliminated.

4.22 Focusing on risk will not only assist Board Members to make timely, well-informed strategic decisions that affect the long term future of the organisation, it will also ensure Boards can rapidly identify, escalate and manage issues which otherwise might not be identified or understood.

4.23 Delivering this aspect of governance is explored further in the supplementary guidance that describes the risk management component of the integrated governance system.

Engaging Stakeholders

4.24 To deliver good governance NHS Boards also need to respect and pursue the rights and interests of all the stakeholders in the healthcare system and effective stakeholder engagement is required to establish and maintain public confidence in the organisation as a public body.

4.25 There is a wide range of diverse individuals and communities who can be considered as stakeholders in the NHS. Many of these stakeholders have a keen interest and a major influence in the governance arrangements that exist in the healthcare system. These key stakeholders include:

- The people of Scotland, including their elected representative at the Scottish Parliament, the Scottish Local Authorities and the UK Parliament
- The people who receive the care provided by the NHS, including patients, service users and their families
- The people who are responsible for delivering healthcare, including the Executive Leadership Teams, the workforce employed by the NHS Boards and their Trade Unions and Professional Bodies
- The organisations who are accountable for delivering good governance, including the Scottish Government, the NHS Boards and the Integration Authorities
- The public bodies, private sector, third sector and charitable organisations that interact with and support the NHS, including delivery partners, other health and social care providers and suppliers of services to NHS Boards
- The regulatory bodies such as the Health & Safety Executive, UK and Scottish Information Commissioners, Scottish Fire & Rescue Service, and the Medicines and Healthcare Products Regulatory Agency
- The media who inform and influence public opinion by reporting and commenting on the services provided and the changes proposed to the delivery of healthcare.

4.26 To ensure meaningful engagement with their stakeholders, NHS Boards should ensure that:

- Key stakeholders are identified and the approach to engagement adopted takes into account the stakeholders' interest and influence on the work of the NHS Board
- Appropriate stakeholders are involved in the development of the Board's strategic and commissioning plans, policies and the setting of corporate objectives and operational priorities
- The organisation's purpose, aims, values, corporate objectives, operational priorities and targets are clear, well communicated and understood by all stakeholders, including patients, service users, the public, managers and staff
- The views of the relevant stakeholders are taken into account when designing services and patient pathways.

4.27 Engagement that takes place routinely helps to develop trust between communities and public bodies, fosters mutual understanding and makes it easier to identify sustainable service improvements. Effective stakeholder engagement also assists Boards to create and exploit opportunities to contribute to the Scottish Government's policies on healthcare.

4.28 The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland. **The Charter of Patient Rights and Responsibilities**[7] summarises what people are entitled to when they use NHS services and receive NHS care in Scotland, and what they can do if they feel their rights have not been respected.

4.29 The Scottish Health Council, which operates as **Healthcare Improvement Scotland -**

[7] https://www.gov.scot/publications/charter-patient-rights-responsibilities-2/documents/

Community Engagement[8], has a key role in supporting NHS Boards and Integration Authorities to meaningfully engage with people and communities to shape national policies and health and social care services. NHS Boards should make use of the resources available to the Community Engagement Directorate to provide assurance that people and communities have been involved in any major service change.

4.30 Therefore, NHS Boards are required to collaborate with Community Engagement to ensure appropriate engagement with local communities throughout changes to services. This is a statutory duty that includes reviewing existing services and planning new services and patient pathways. Guidance on the planning and commissioning of health and social care services is included in the **Planning with People**[9] document published by the Scottish Government and the Convention of Scottish Local Authorities.

4.31 The criticality and potential of community planning in Scotland should be recognised by all NHS Boards. Scotland's community planning mechanisms are particularly relevant to the NHS's wider ambitions to address population health and the underlying causes of inequalities. For this reason, all Boards should take steps to seek assurance that the strongest possible contribution is consistently made to local community planning activities.

4.32 When engaging in community planning activities NHS Boards must also consider their role in promoting community empowerment. In Scotland public service reform and legislation has underpinned community empowerment. **The Community Empowerment (Scotland) Act 2015**[10] included measures which strengthened community planning and community right-to-buy arrangements, and introduced participation requests and asset transfer requests. In July 2019 Audit Scotland published a briefing on **Principles of Community Empowerment**[11]. Empowering communities remains a national priority for the Scottish Government, and all public bodies should be continually developing their systems to facilitate community empowerment. Therefore, NHS Boards should consider how their systems of governance enable and provide assurance on the effectiveness of their approach to community empowerment.

4.33 Delivering this aspect of governance is explored further in the supplementary guidance on strategic planning and commissioning.

Influencing Culture

4.34 An organisation's culture comprises its shared values, norms, beliefs, emotions and assumptions about "**how things are and should be done around here**". These 'things' include how decisions are made, how people interact and how work is carried out.

[8] www.hisengage.scot
[9] www.gov.scot/publications/planning-people
[10] www.legislation.gov.uk/asp/2015/6/contents/enacted
[11] www.audit-scotland.gov.uk/publications/principles-for-community-empowerment

4.35 NHS Boards have a critical role in shaping and influencing organisational culture in healthcare settings. To do this the Board should determine and promote shared values that underpin policy and behaviours throughout the organisation. Board Members must demonstrate the organisation's values and exemplify good governance through their individual behaviours.

4.36 **To ensure the delivery of the organisation's values the Board should encourage and support an organisational culture that reflects the NHS Scotland Staff Governance Standard[12]. These apply to all staff employed by NHS Boards and the Standard requires NHS Boards to demonstrate that staff are:**

i. Well informed
ii. Appropriately trained and developed
iii. Involved in decisions
iv. Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued
v. Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

4.37 **The Staff Governance Standard also requires all NHS staff**

i. Keep themselves up to date with developments relevant to their job within the organisation
ii. Commit to continuous personal and professional development
iii. Adhere to the standards set by their regulatory bodies
iv. Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation
v. Treat all staff and patients with dignity and respect while valuing diversity
vi. Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

4.38 The Staff Governance Standard should influence and feature in the design and application of all policies and procedures for the management of people by NHS Boards. The ethos of the Staff Governance Standard should also be reflected in the arrangements with private and independent contractors and partner agencies working with the NHS.

[12] www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard

4.39 Boards must also ensure that the organisation successfully adopts all policies and other best practice in human resource management that is require by the Scottish Government. This includes initiatives such as the **iMatter**[13] staff experience continuous improvement tool and the **National Whistleblowing Standards**[14].

4.40 The Scottish Public Services Ombudsman has taken up the role of the Independent National Whistleblowing Officer. The aim of the role is to make sure everyone delivering NHS services in Scotland is able to speak out to raise concerns, ultimately contributing to ensuring that the NHS in Scotland is as well run as possible. The Independent National Whistleblowing Officer is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland.

4.41 To support the delivery of this organisational culture, the leadership of the organisation has to be seen as competent and credible, act in the best interest of stakeholders, act at all times with integrity and are reliable in their decisions and actions, in other words they are trustworthy.

4.42 **Therefore the Board must play its part in creating this outcome by recruiting a Chief Executive and Executive Leadership Team who have the ability, ambition, insight and values to deliver a leadership approach that delivers the Staff Governance Standard. This includes ensuring that:**

i. Leaders at all levels are sufficiently visible and give a clear sense of purpose and ambition for the organisation
ii. Leaders help people understand how they contribute to achieving the Board's purpose, aims, values, corporate objectives, operational priorities and targets
iii. Leaders set standards, recognise good performance and deal with poor performance when it arises
iv. Leaders encourage people to challenge and look for ways to improve performance and the quality of the services provided
v. Leaders help people identify and make best use of development and career opportunities.

4.43 Having this organisational culture will ensure that NHS Scotland is widely recognised as a great place to work and will generate high level of employee engagement. This will ensure the workforce is focussed on delivering high quality services that are subject to continuous improvement and quality management.

4.44 The next section of the guide considers the enablers to the successful delivery of the functions of good governance.

[13] www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/imatter
[14] www.inwo.spso.org.uk/national-whistleblowing-standards

The Enablers

4.45 **To facilitate the delivery of the five governance functions, the Blueprint defines the three key enablers for good governance as:**

i. **Acquiring and retaining the necessary diversity, skills and experience** at Board level

ii. **Defining clear roles, responsibilities and accountabilities** for the principal groups and individuals that participate in the governance of healthcare

iii. **Creating relationships** and conducting business in line with agreed values and standards of behaviour.

4.46 The following paragraphs describe each of the enablers in more detail.

Diversity, Skills and Experience

4.47 The Blueprint for Good Governance highlights the importance of diversity and a range of skills and experience at Board level.

4.48 It is the responsibility of the Scottish Government, working with the NHS Board Chair, to ensure the necessary diversity, skills and experience are present across the Board. This includes determining the Board's requirements during the recruitment of new Members and the on-going development of the skills of existing Board Members.

4.49 The recruitment and appointment process is managed by the **Scottish Government Public Appointment Team**[15] who oversee the regulated public appointments process for Ministers.

4.50 The Public Appointments Team follow the Ethical Standards Commissioner's **Code of Practice for Ministerial Appointments to Public Bodies in Scotland**[16]. The Ethical Standards Commissioner and staff have a remit to encourage fairness, good conduct and transparency in public life in Scotland. The Commissioner regulates and monitors the system used to appoint Board Members and their staff play a key role in assuring that appointments are made on merit, using methods that are fair and open and reflect the diversity of Scottish society.

Diversity

4.51 Diversity is a core value at the heart of the day-to-day business of NHS Scotland. NHS Boards are required to hold their organisation to account for the inclusion and diversity strategies that must form part of their staff governance strategy. It is imperative that Boards demonstrate leadership and engagement to support anti-racist work across their organisation, ensuring improvements to equality, diversity and inclusion are continually monitored and challenged.

[15] www.gov.scot/collections/public-appointments
[16] www.ethicalstandards.org.uk/publication/revised-code-practice-ministerial-appointments-public-bodies-scotland

4.52 To ensure the Board reflects the diversity of their community NHS Boards should support the appointment process by implementing an appropriate attraction strategy which enables the recruitment of a diverse group of Board Members with the skills and experience required to deliver good governance. This includes taking targeted action where appropriate, encouraging and supporting applications from people with protected characteristics that are underrepresented on the Boards of Public Bodies.

4.53 **The Equality Act 2010**[17] defines protected characteristics and the recruitment process must also take into account the **Gender Representation on Public Boards (Scotland) Act 2018**[18] which describes the gender representation objective for a public board as having 50% of non-executive members who are women.

4.54 In addition to reflecting the diversity of the communities they serve, Boards require diversity of thought not only to improve decision-making but also to avoid 'group think', enabling alternative views to be debated and evaluated. If a diverse Board can demonstrate the benefits that come from its expanded knowledge, experience and insight, this should ultimately lead to an improved organisational culture and increased public confidence and trust in the NHS.

4.55 Therefore, whilst it is important to recognise that Board Members are not appointed to represent any particular body or group, there is a clear and welcomed ambition in NHS Scotland to recruit a broad and diverse representation of the population on NHS Boards.

Skills

4.56 NHS Boards require a minimum core set of skills and experience in order to discharge their responsibilities. However, while collectively NHS Boards require certain skills and experience, not every member of the NHS Board will require every skill or experience and Members will bring different levels of skill to the Board.

4.57 The recruitment, training and development of Board Members needs to be focused and built around the skills and experience they require to make an effective contribution to the governance of the organisation.

4.58 In addition to acquiring insight into the organisation and an awareness of its operating environment, Board Members need to be able to deploy a variety of skills that include:

- The capacity to question, challenge constructively and influence decision making
- The capability to recognise, listen to and respect different perspectives
- The ability to analyse and review complex issues, weighing up conflicting opinions and making timely, evidence-based, well-informed and risk-assessed decisions
- The interpersonal skills to communicate and engage with a wide range of organisations and individuals, building relationships, influencing and working collaboratively
- The confidence and self-awareness to chair, or participate as a member of, key committees that support good governance.

[17] www.legislation.gov.uk/ukpga/2010/15/contents
[18] www.legislation.gov.uk/asp/2018/4/contents

4.59 This definition of the skills required by NHS Boards assists NHS Education for Scotland to develop the induction training, targeted education and development activities required by Boards Members.

Experience

4.60 Board Members also bring a wide range of specialist experience and knowledge to the Board from the public, private, third or voluntary sectors. This can include lived experience of the services provided by the NHS as either a service user or provider. Experience gained in other settings or organisations can equally be of value to the delivery of good governance.

4.61 In addition to any previous experience in a governance role, the list of experience that Board Members can use to support the work of the Board is extensive and can include strategic planning, change management and operations management. Experience and training in financial management and risk management are also relevant to the governance of the NHS, as is human resource management and stakeholder management.

4.62 Board Members' experience also adds to the collective knowledge and understanding at Board level, and this is particularly welcomed around equality, diversity and inclusion, research and innovation, digital and information technology, media and communications, governance and legal issues.

4.63 Consideration should also be given to the extent to which clinicians are represented on the NHS Board. It is critical that Boards have appropriate skills and experience of clinical matters in order to be assured of the safety and quality of healthcare being delivered in both primary and secondary care settings. Having non-executive Board Members from a clinical background can assist in achieving that goal.

4.64 Given the integration of health and social care services in Scotland and the need for collaborative governance, it is also important that some experience of social care is available at Board level in the NHS.

4.65 To support succession planning and the deployment of Board Members to standing committees and other roles NHS Boards should maintain a record of the diversity, skills and experience present in the current Board. Any gaps in the diversity, skills, and experience of the Board should be reflected in the Board's succession planning, highlighted to the Cabinet Secretary when recruiting new Board Members and inform the promotion and advertising of vacancies. Boards may choose to have a Succession Planning Committee to oversee and support this activity.

4.66 The next section of the guide provides more information on '**who**' is responsible and accountable for ensuring good governance by describing the various roles, involved in the governance arrangements for NHS Scotland.

Roles, Responsibilities and Accountabilities

4.67 To support and deliver the functions described in the Blueprint for Good Governance it is essential that there is a common understanding of the roles, responsibilities and accountabilities of the principal groups and individuals that participate in the governance of healthcare.

4.68 Therefore the definitions of roles, responsibilities and accountabilities included in the Blueprint are intended to help the Scottish Government, the NHS Board Members, the Executive Directors and the Board Secretaries identify and deliver their respective functions within healthcare governance.

4.69 Together with the descriptions of the values and standard of behaviours expected of Board members, the definitions of their roles facilitates the performance appraisal of Board Members.

Scottish Government

4.70 The Scottish Parliament is responsible for the legislation that governs the delivery of healthcare in Scotland. The Cabinet Secretary for Health and Social Care has ministerial responsibility in the Scottish Government for the NHS in Scotland.

4.71 The **National Health Service (Scotland) Act 1978**[19] places a duty on the Cabinet Secretary to promote a comprehensive and integrated health service, designed to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis and treatment of illness. The Cabinet Secretary may do anything which they consider is likely to assist in discharging that duty

4.72 The Scottish Government Directorates for Health and Social Care have responsibility for health policy, the administration of the NHS, social care and public health. This includes setting the standards for governance in NHS Scotland and monitoring the adequacy and effectiveness of the governance arrangements throughout health and social care.

4.73 The Director General for Health and Social Care (who is also the Chief Executive of the NHS) leads the Directorates. With regard to the **Public Finance and Accountability (Scotland) Act 2000**[20] and the **Scottish Public Finance Manual**[21], the Director General is the designated Portfolio Accountable Officer for the Health and Social Care Directorates.

4.74 The Director of Health Finance and Governance has the responsibility for the oversight, development and support of governance arrangements across NHS Scotland and has approved the guidance contained in this document.

[19] www.legislation.gov.uk/ukpga/1978/29/contents
[20] www.legislation.gov.uk/asp/2000/1/contents
[21] www.legislation.gov.uk/asp/2000/1/contents

4.75 The Scottish Government Directorates for Health and Social Care are responsible for various activities within the overall system of governance for health and social care. This includes:

- Developing and implementing law which determines the shape of the public sector and defines the responsibilities and duties of the Scottish Government, public bodies and others for health and social care
- Developing and implementing national strategies and policies and providing support and information to maximise the likelihood of achieving whole-system success
- Recruiting, selecting, appointing and setting the level of remuneration for all members of NHS Boards
- Appointing individuals as Accountable Officers for their organisation (normally the Chief Executive) under the **Public Finance and Accountability (Scotland) Act 2000**[22]
- Developing and implementing a Code of Conduct for Board Members under the **Ethical Standard in Public Life etc. (Scotland) Act 2000**[23] and approving the Code which each body uses
- Developing and promoting good governance practice throughout the system of health and social care. This includes working with NHS Education for Scotland and others to develop and share good practice and provide support and advice on governance matters
- Developing and implementing the performance management framework for health and social care. This involves monitoring and overseeing the performance of public bodies which report directly to the Scottish Government and putting in place a framework of support to those bodies when required to improve and sustainably deliver the required outcomes
- Discharging the Scottish Government's responsibilities as set out in the **Scottish Public Finance Manual**[24]. This includes putting a framework document in place with each public body which sets out its sponsorship relationship with the body and its Accountable Officer.

NHS Boards

4.76 The NHS Boards are legal entities established by the **National Health Service (Scotland) Act 1978**[25] and are required by this legislation to promote the improvement of the physical and mental health and the prevention, diagnosis and treatment of illness of the people of Scotland. To ensure the delivery of this NHS Boards are delegated responsibilities by the Cabinet Secretary to plan, commission and deliver healthcare services and take overall responsibility for the health and wellbeing of the populations they serve.

4.77 To discharge their responsibilities under the 1978 Act, and deliver the Scottish Government policies and strategies for the provision of healthcare, NHS Boards must deliver the functions described in the Blueprint for Good Governance to the standards set by the Scottish Government.

[22] www.legislation.gov.uk/asp/2000/1/contents
[23] www.legislation.gov.uk/asp/2000/7/contents
[24] www.gov.scot/publications/scottish-public-finance-manual
[25] www.legislation.gov.uk/ukpga/1978/29/contents

4.78 Therefore, NHS Boards are primarily responsible and accountable for setting strategic direction, holding executives to account for delivery, managing risk, engaging with stakeholders and influencing organisational culture.

4.79 NHS Boards are also held to account by the Scottish Government for:

- Encouraging innovation, driving change and transforming service delivery to better meet the expectations and needs of their key stakeholders
- Adopting an active approach to governance that anticipates and identifies the risks and opportunities facing the organisation, escalating significant issues to the Scottish Government when and where appropriate
- Encouraging a collaborative approach to governance by the key stakeholders in the healthcare system.

4.80 NHS Boards are also expected to actively seek and create opportunities to inform and contribute to the development of Scottish Government policies and strategies for healthcare in Scotland.

4.81 In recognition of the whole-system nature of Scotland's population health challenges, Public Health Scotland is jointly sponsored and has dual accountability lines to both the Scottish Government and to local government via the Convention of Scottish Local Authorities. This is a unique feature for a Scottish public body and requires a commitment to shared decision making, planning and performance management in relation to the work of Public Health Scotland.

4.82 It is important that the Board clearly differentiates its role from that of the Executive Leadership Team. The Chief Executive and Senior Leadership Team should be protected from individual Board Members becoming involved in operational matters. This separation of governance from day-to-day operational management is explored further in the section of the guide on the role, responsibilities and accountabilities of Board Members.

Standing Committees

4.83 To support the work of the NHS Boards a framework of appropriate standing committees should be put in place to support the delivery of good governance.

4.84 Standing committees are established on a permanent basis. They are responsible for the scrutiny of functions, services and matters delegated to them by the NHS Board, making decisions, recommendations and escalating issues to the Board, as appropriate. The standing committees make a significant contribution to the monitoring and evaluation of the progress towards achieving the Board's purpose, aims, values, corporate objectives, operational priorities and targets by providing the time, space and expertise to effectively scrutinise performance across the healthcare system.

4.85 The Board's framework of standing committees must include an Audit and Risk Committee, a Remuneration Committee and a Staff Governance Committee. The territorial Boards and some special Boards are also required to have a Clinical Governance Committee and a Research Ethics Committee. To provide the necessary governance around the regulatory framework for the award of licences for new pharmaceutical premises, territorial Boards must also have a Pharmacy Practices Committee.

4.86 In addition to these mandatory committees Boards may decide to set up additional standing committees to oversee other aspects of the organisation's operations, e.g. Acute Services, Finance and Performance and Population Health and Wellbeing Committees.

4.87 Membership of the standing committees can include non-executive and executive Board Members but the committee must be chaired by a non-executive and have a majority of non-executive members.

4.88 The agenda for the standing committees should be agreed by the committee chair and the lead executive for the committee. The agenda should include standing items to facilitate the work of the committee, including minutes and action logs, regular items as set out in the committee's Annual Cycle of business, e.g., performance and financial reports, risk registers and ad-hoc items that require attention by Board Members.

4.89 Items should be referred to a standing committee if they require input on an issue or risk that has been delegated to that committee. The standing committee members should be encouraged to add value by providing a different perspective on the issues, risks or opportunities faced by the organisation.

4.90 In addition to submitting minutes of their meetings to the NHS Board, the standing committee chairs should highlight to the Board any areas of concern or risks that require escalation to the Board for their further consideration or decision. Standing committees should also provide an annual report of their activity to the Board.

Advisory Committees

4.91 In addition to the standing committees, NHS Boards can also be supported by advisory committees to ensure that Board Members are well-informed on the issues, risks and opportunities facing the organisation.

4.92 To ensure that the views of the workforce are properly and fully considered by the NHS Board, an Area Partnership Forum must be put in place to inform and influence the Board and the Executive Leadership Team's thinking and decision-making on issues affecting the workforce. Membership of the Area Partnership Forum should include representatives of recognised Trade Unions and managers that represent the range of services provided by the organisation.

4.93 In order to harness the knowledge, skills and commitment of the clinical community across NHS Scotland and ensure that appropriate professional advice is available to NHS Boards and encourage clinicians to contribute to the planning and delivery of services, the territorial Boards must also have in place an Area Clinical Forum.

4.94 The Area Clinical Forum should be supported by a range of clinical professional advisory committees, i.e. an area medical committee, dental committee, nursing and midwifery committee, pharmaceutical committee and optical committee. The special Health Boards, Health Improvement Scotland and NHS National Services should develop appropriate arrangements for clinical engagement in accordance with the circumstances of their organisation.

4.95 To provide the NHS Board with advice on issues affecting clinical practice and employee relations the role of the advisory committees should include:

- Engaging with the Executive Leadership Team to provide insight, support and advice on the delivery of services and the implementation of change
- Supporting and advising the NHS Board in their governance of the organisation, including advice on the impact of any proposed changes that effect the employment of staff
- Identifying opportunities for the improvement of services and the wellbeing of the workforce.

4.96 Advisory committees, including the Area Partnership Forum and the Area Clinical Forum, can also play an important role in supporting the NHS Board in discussions with key stakeholders.

4.97 NHS Boards may also decide to set up additional advisory committees to focus on other aspects of the Board's business, such as equality, diversity and inclusion, or climate change and sustainability, where these issues are not already included in the remit of existing standing committees.

Networks

4.98 The NHS makes extensive use of networking to support the delivery and continuous improvement of services and the introduction of innovation and new ways of working. These also help to improve the flow of information across the NHS and establish closer working relationships between key members of the organisation.

4.99 The same approach is applied to the governance of healthcare and in addition to the Board standing committees and the advisory committees, the governance system in NHS Scotland is supported by a range of informal networks.

4.100 These networks provide regular opportunities for the leadership of the NHS to meet informally and consider any issues or risks that may be of concern, including those still to surface through the existing reporting systems. This is a valuable addition to the delivery of good governance through the formal governance arrangements.

4.101 Although the networks are separate from the decision-making bodies and the formal governance system, the benefits of networking to provide peer support, work collaboratively, share best practice, influence stakeholders and improve engagement and communications across the healthcare system is recognised, encouraged and supported by the Scottish Government.

4.102 Within NHS Scotland there are a number of such governance networks, notably the NHS Board Chairs Group and the NHS Chief Executives Group. A Vice Chairs Group, a Whistleblowing Champions Network and an Audit and Risk Committee Chairs Network have also been set up to support healthcare governance across Scotland.

4.103 A similar arrangement has been put in place for the Integration Joint Board Chairs and Vice Chairs. Introducing this network has provided an opportunity to brief and support the Integration Joint Board Members and encourage and facilitate collaborative leadership and the sharing of best practice across the Health and Social Care Partnerships. This has created another space where NHS Board Members can consider the wider context in which we operate and identify cross- system risks to the successful delivery of our services.

4.104 To promote the benefits of networking and improve the wider understanding of the purpose and remit of the networks, it is important that they publish their terms of reference. This helps communicate the work of the network and encourage other stakeholders to engage with them.

Board Chairs

4.105 The Chair of the NHS Board is responsible for:

- Leadership of the Board, ensuring that it effectively delivers its functions in accordance with the organisation's governance arrangements
- Keeping the organisation's governance arrangements and the Board's effectiveness under review
- Setting the agenda, format and tone of Board activities to promote effective decision making and constructive debate
- In the absence of a Succession Planning Committee, nominating Board Members to standing committees, Integration Joint Boards and other roles within the NHS Board and partner organisations. The allocation of roles to Board Members, including the Chair of standing committees, should be formally approved by the full Board
- Developing the capability and capacity of the Board by contributing to the appointment of Board Members; appraisal and reporting on their performance; identifying appropriate training and development opportunities; and ensuring effective succession planning is in place
- Providing performance management and identifying development opportunities for the Chief Executive
- Representing the organisation in discussions with Ministers, the Scottish Parliament, the Scottish Government, Local Authorities and other key stakeholders. This is a responsibility shared with the Chief Executive.

4.106 The Chair is appointed by the Cabinet Secretary following a recruitment exercise undertaken by the Scottish Government Public Appointments Team.

4.107 This description of the role of the Board Chair should be seen as indicative of the role and responsibilities of the Chairs of the standing committees.

Board Vice Chairs

4.108 In addition to that of a NHS Board Member, the role of the Vice Chair includes:

- Deputising for the Chair as required in any of their duties, including representing the NHS Board in engaging with internal and external stakeholders
- Taking the lead on specific areas of the work on behalf of the Board Chair e.g. governance projects or reviews
- Providing advice, support and assistance to the Board Chair in carrying out their responsibilities
- Acting as a 'sounding board' and 'critical friend' to the Chair and the other Board Members.

4.109 The Vice Chair also provides an alternative route for Board Members to raise issues or concerns if they feel unable to do so with the Chair. This is an important part of the checks and balances within governance and accountability. If mediation by the Vice Chair does not resolve the situation, the issue or concern should be escalated to the Scottish Government.

4.110 Following an open selection process and confirmation of their suitability by the Cabinet Secretary, the appointment of the Vice Chair is made by the Board from the publicly appointed Board Members. The Board's Whistleblowing Champion and Board Members who are also employees of the organisation are excluded from this arrangement.

Board Members

4.111 All NHS Board Members are appointed by the Cabinet Secretary for Health and Social Care and the Cabinet Secretary has the authority to terminate their appointment if it is consider not in the interest of the health service that a member of a Board hold continue to hold that office.

4.112 The Board membership consists of non-executive and executive members. There are two broad categories of non-executive Board members: those appointed through the public appointment process after an open recruitment exercise, and those whom the Board's principal stakeholders have nominated for appointment by the Cabinet Secretary.

4.113 The stakeholder members are the Employee Director and, for territorial Boards, the Chair of the Area Clinical Forum and a representative from each of the Local Authorities in the area covered by the NHS Board.

4.114 NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian and NHS Tayside also have a stakeholder member to represent the medical school of the Universities of Aberdeen, Glasgow, Edinburgh and Dundee. This reflects the contribution these Boards make to NHS Scotland as the principal teaching Boards in Scotland.

4.115 The executive members for territorial Boards are the Chief Executive, Director of Finance, Nurse Director, Medical Director, and the Director of Public Health. For the special Boards, Health Improvement Scotland and NHS National Services for Scotland the executive membership of the Board can vary to meet their particular circumstances.

4.116 Publicly appointed members can serve a maximum of eight years on the Board. This limitation also applies to the appointment of the Chair and Vice Chair. Stakeholder members are also appointed for specific time periods but can be re-appointed provided the stakeholder body continues to nominate them. Executive members are appointed for the duration of their role.

4.117 NHS Board Members are responsible for:

- Ensuring the Board focuses on developing and maintaining a strategic direction designed to deliver the Scottish Government's policies and priorities
- Providing effective scrutiny, challenge, support and advice to the Executive Leadership Team on the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets
- Contributing to the identification and management of strategic and operational risks
- Bringing independence, external perspectives and impartial judgement to the business of the NHS Board to support timely, well-informed, evidence-based and risk-assessed decision making at Board level
- Upholding the highest standards of integrity and probity and acting in accordance with the principle of collective and corporate responsibility for Board decisions
- Understanding and promoting diversity, equality and inclusion
- Engaging with stakeholders, including patients, service users, the public, managers and staff
- Undertaking ongoing personal development activities.

4.118 Irrespective of the basis of their appointment, their letter of appointment from the Cabinet Secretary advises that, "No Member of the Board is appointed on a representative basis for any body or group."

4.119 While Board members must be ready to offer constructive challenge, they must also share collective responsibility for decisions taken by the Board as a whole. If they fundamentally disagree with the decision taken by the Board, they have the option of recording their concerns in the minutes. However, ultimately, they must either accept and support the collective decision of the Board – or resign. Board decisions should always comply with statute, Ministerial directions (where this is provided for in statute), Ministerial guidance and the objectives of the Scottish Government's Health & Social Care Directorates.[26]

[26] On Board: a guide for members of statutory boards - gov.scot (www.gov.scot)

4.120 To help them discharge their responsibilities, the Standards Commission for Scotland has issued a range of **Advice Notes**[27]. This includes guidance on a wide range of topics including:

- Use of social media
- Distinguishing between strategic and operational matters
- Bullying and harassment
- Declaration of interests
- Gifts and hospitality.

4.121 The role of Board Members is to provide governance, i.e., setting the direction for the organisation and overseeing the delivery of services. This primarily involves agreeing strategy and policy and holding the Executive Leadership Team to account for the delivery of the Board's purpose, aims, values, corporate objectives, operational priorities and targets. It includes managing risk, engaging with stakeholders and influencing the organisation's culture.

4.122 By comparison, the Executive Leadership Team has the primary responsibility for the implementation of change and the day-to-day management of operations. This involves the design and implementation of new ways of working that exploit research and innovation, and the planning, organising and execution involved in day to day activities and service delivery.

4.123 The line between strategic and operational matters is not always distinct, as strategic objective setting and policy setting is underpinned by operational work. In addition, some operational matters will have strategic ramifications for an organisation in terms of service delivery and risk management.

4.124 Therefore, if in doubt, Board Members should refer to the Standards Commission's advice to avoid becoming inappropriately involved in operational matters. The Board Chair should be consulted if the issue cannot be resolved following a Board Member's review of the Standards Commission's Advice Note.

4.125 It is also important to note that clinical decision making and the medical treatment of specific patients do not fall within the ambit of Board Members' governance duties.

4.126 In addition to discharging the above responsibilities, non-executive Board Members may also be required to support the business of the Board by chairing standing committees and other meetings relevant to the business of the NHS Board.

4.127 Publicly appointed members may also be appointed by the Board to represent the NHS as a voting member of the Integration Joint Boards. If it is not possible to fill the NHS positions from the publicly appointed members, Boards can nominate other members to act as voting members of the Integration Joint Boards. Stakeholder members who are councillors are excluded from this arrangement.

[27] www.standardscommissionscotland.org.uk/education-and-resources/professional-briefings

4.128 Many non-executive Board Members also play a part in supporting the Executive Leadership Team's management of the organisation that goes beyond their roles as standing committee members. This can include supporting HR appeals and whistleblowing investigations. Board members may also be asked to act as Chairs for other groups where the NHS is a member.

Board Champions

4.129 The members of the NHS Board and Standing Committees can be supported in their work by a variety of colleagues acting as 'Champions' for a wide range of issues and communities. This could include equality, diversity and inclusion, mental health, whistleblowing, sustainability, global citizenship, smoking cessation, organ donation, healthy working lives and veterans.

4.130 With the exception of the Whistleblowing Champions who are appointed by the Cabinet Secretary to that role, the Champions are appointed by the Board from the non-executive membership of the NHS Board.

4.131 The principal responsibility of the Champion is to take a lead in advocating the NHS Board's commitment to being a learning organisation that focuses on improvement and the implementation of best practice in their particular area of interest. This includes raising the profile of particular issues and supporting the Executive Leadership Team in the development of appropriate policies, strategies and action plans prior to consideration by the Board.

4.132 The Champions are also available to offer a Board Member's perspective to staff networks and management teams, using this as an opportunity to share information and communicate back to the Board.

4.133 The Champions are not responsible for making operational decisions on specific issues or cases. Neither are they expected to lobby the Board for specific outcomes, but rather to ensure that relevant issues are brought to the Board's attention.

4.134 The standing committee Chairs also act as 'Champions' for the remit and functions of their committees and it is important to note that all Board Members should have an interest in the issues being considered by Champions. For example, ensuring that equality, diversity and inclusion are reflected in the Board's thinking and decision making is the responsibility of all Board Members, not just those who have a role as Equality and Diversity Champions.

Chief Executives

4.135 The description of the role and responsibilities of the Chief Executive and the one that follows for the Executive Directors, are based on work commissioned by the Scottish Government to develop a Leadership Success Profile to support recruitment and succession planning at that level of NHS Scotland.

4.136 In addition to their responsibilities as a Board Member, the NHS Chief Executive is also responsible for:

- Overseeing the development of an integrated set of policies, strategies and plans that are designed to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This includes focusing globally and strategically on developments that will impact upon the provision of health and social care across Scotland, and working collaboratively with Ministers, the Scottish Parliament, the Scottish Government, Local Authorities, Health and Social Care Partnerships, and other key stakeholders to increase alignment and cohesion between government policy and the delivery of health and social care services to local communities.
- Acting as the Accountable Officer for the proper management of public funds and for ensuring the regularity, propriety and value for money in the management of the organisation. Accountability for this function is directly to the Scottish Parliament under **Section 15 of the Public Finance and Accountability (Scotland) Act 2000**[28].
- Providing leadership and day-to-day management of the organisation and its workforce, shaping desired cultural attributes within the NHS, and ensuring the organisation's policies, strategies and plans are delivered on time and within budgets. This includes building strategic and operational capability and accountability amongst the Executive Leadership Team, ensuring collective responsibility for delivering the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.
- Contributing to the delivery of multiple system-wide interventions at regional and national levels, whilst overseeing local delivery of change initiatives by the Executive Leadership Team. This includes encouraging and supporting research and innovation into new ways of delivering healthcare.
- Managing relationships with NHS Board Members, Scottish Government Ministers, the Director General for Health and Social Care, Senior Civil Servants and other key stakeholders involved in the delivery of health and social care. This includes establishing and enabling inclusive and effective networks at local and national level, expanding these beyond NHS Scotland and a purely healthcare focus. This is a responsibility shared with the Board Chair.

Executive Directors

4.137 The NHS Executive Directors are responsible for:

- Providing professional and expert advice and support to the NHS Board and the Chief Executive to assist in the development of the policies, strategies and plans required to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This includes ensuring local policies, plans and strategies are aligned to national and regional priorities for healthcare by gathering insights and information from local, regional and national systems and keeping the NHS Board, executive colleagues and their directorate teams up to date with priorities and developments in the delivery of health and social care.

[28] www.legislation.gov.uk/asp/2000/1/section/15

- Managing the integrated and collaborative delivery of services and the implementation of the organisation's plans, projects, programmes and processes within their own leadership teams and across the organisation, enabling leaders at all levels to take responsibility for delivering operational goals and performance. This includes providing collective leadership with executive colleagues for developing and sustaining the optimum culture throughout the organisation, and collaborating with system partners to empower, support and enable integrated frontline teams to operate flexibly towards the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.
- Monitoring progress towards corporate objectives, operational priorities and targets for service delivery and managing their relationship with other key stakeholders by providing appropriate information and assurance on performance, expenditure, issues, risks and successes.
- Overseeing the delivery of multiple, interconnected and organisation-wide change interventions. This includes supporting the transformation of services at national, regional and local levels by forging relationships and supporting networks, and by engaging key stakeholders in the long term and mutual benefits of system transformation.
- Supporting the wellbeing of the workforce by providing the necessary support, training, development, and management approach required to deliver the **NHS Scotland Staff Governance Standard**[29].

4.138 Where Executive Directors are also appointed to the Board they have the same accountabilities and responsibilities as the non-executive Board Members. The same level of training and support is available to executive Board Members as is provided for the non-executive Members.

Board Secretaries

4.139 The term 'Board Secretary' is commonly used across NHS Scotland but in some NHS Boards other job titles such as 'Head of Corporate Governance' has been adopted to better describe this role. The following guidance is intended to cover the post, irrespective of the job title.

4.140 The Board Secretary has the lead role in supporting the NHS Board's approach to delivering good governance. They have the primary responsibility for ensuring the smooth operation of the governance arrangements required by the NHS Board.

4.141 The Board Secretary is responsible for:

- Leading the continuous development and implementation of the Board's governance arrangements, including the facilitation of an integrated approach to the delivery of the governance systems and the provision of the operating guidance required to effectively manage these systems
- Providing expert advice and support to the Chair, Chief Executive, Board Members and other stakeholders on governance related issues
- Providing guidance to assist the Board in acting within its legal authority and statutory

[29] www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard

powers and its Members in complying with the Ethical Standards in Public Life etc. (Scotland) Act (2000) and the Code of Conduct for Members of Health Boards. This aspect of governance is explored further in the section of the guide on the behaviours expected of Board Members
- Ensuring that Board business is conducted in a spirit of openness and transparency and in accordance with any agreed Board protocol
- Communicating details of the Board's governance arrangements to ensure they are widely understood and effectively delivered by all the key players in the governance system.

4.142 Board Secretaries may also be responsible for managing the administrative and secretarial support to the Board and other governance and advisory committees.

4.143 The Board Secretaries have an informal network that facilitates the sharing of best practice and provides support to the creation and maintenance of the operating guidance for the Board and the standing committees.

Values, Behaviours and Relationships

4.144 All the members of the NHS Board should consider what is expected of them individually and collectively in terms of demonstrating the NHS Scotland values and displaying the behaviours expected of a Board Member of a public body. This includes conducting their relationships in a manner that reflects these standards.

Values

4.145 While everyone in NHS Scotland is expected to demonstrate these values, Board Members have an additional responsibility to act as role models for the rest of the workforce.

4.146 **Board Members are expected to demonstrate and uphold the core values of NHS Scotland, as published in the 2020 Workforce Vision 'Everyone Matters'[30]. These are defined as:**

i. Care and compassion
ii. Dignity and respect
iii. Openness, honesty and responsibility
iv. Quality and teamwork.

Behaviours

4.147 NHS Boards must act morally, ethically and fairly if they are to deliver good governance in healthcare. In common with all public bodies in Scotland, Boards are required to have in place a Code of Conduct that sets out the standards of behaviours expected of their Board Members.

[30] www.gov.scot/publications/everyone-matters-2020-workforce-vision/

4.148 To support the delivery of the requirements set out in the **Ethical Standards in Public Life etc. (Scotland) Act (2000)**[31], the Scottish Government's Public Bodies Unit has developed a Code of Conduct specifically designed for Members of Health Boards. This not only sets out how the provisions of the Code should be interpreted and applied in practice, it also gives guidance on the rules regarding remuneration, allowances, expenses, gifts and hospitality, lobbying, registration of interests and the confidentiality of information.

4.149 **The Code of Conduct for NHS Board Members is based on the Model Code of Conduct for Members of Devolved Public Bodies**[32] **approved by the Scottish Parliament on 7 December 2021. This has been developed in line with the Principles of Public Life in Scotland. These are:**

i. **Duty** – Members have a duty to uphold the law and act in accordance with the law and the public trust placed in them. They have a duty to act in the interests of the public body of which they are a member and in accordance with the core tasks of that body.
ii. **Selflessness** – Members have a duty to take decisions solely in terms of public interest. They must not act in order to gain financial or other material benefit for themselves, family or friends.
iii. **Integrity** – Members must not place themselves under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence them in the performance of their duties.
iv. **Objectivity** – Members must make decisions solely on merit when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.
v. **Accountability and Stewardship** – Members are accountable for their decisions and actions to the public. They have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.
vi. **Openness** – Members have a duty to be as open as possible about their decisions and actions, giving reasons for their decisions and restricting information only when the wider public interest clearly demands.
vii. **Honesty** – Members have a duty to act honestly. They must declare any private interests relating to their public duties and take steps to resolve any conflicts arising in a way that protects the public interest.
viii. **Leadership** – Members have a duty to promote and support the Principles of Public Life in Scotland by leadership and example, to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.
ix. **Respect** – Members must respect fellow members of their public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly they must respect members of the public when performing duties as a member of your public body.

[31] www.legislation.gov.uk/asp/2000/7/contents
[32] www.standardscommissionscotland.org.uk/codes-of-conduct/members-model-code-of-conduct

4.150 The Standards Commission has produced **Guidance on the Code of Conduct**[33] to help Board Members interpret and adhere to the provisions in the Code and to attain the highest possible standards of conduct.

4.151 NHS Boards must adopt the Code of Conduct, having first obtained Scottish Government's approval for any amendments to the draft proposed by the Public Bodies Unit. The Board should then formally record their acceptance of the Code of Conduct for Members of their Board. This should then be reflected in the Standing Orders required to support their governance arrangements.

Relationships

4.152 Building and maintaining effective working relationships are critical to the delivery of good governance. Board Members should consider and constantly review their own and the NHS Board's relationships with the other stakeholders in the health and social care system.

4.153 Board Members must apply the values of NHS Scotland and the principles of the Code of Conduct for Members of Health Boards in their dealings with fellow members of the Board, its employees and other stakeholders. The Board Chair has a responsibility to ensure that Members receive the necessary support to act in the appropriate manner at all times.

4.154 To support collaborative working relationships and assist in the conduct of Board business a Board Protocol may be introduced to ensure that best use is made of the time and the contribution of the Board Members. Highlighting the rules or etiquette for the conduct of meetings can assist Chairs to ensure the views of Members are heard and meetings are conducted in a manner consistent with the NHS Scotland values and the Code of Conduct for NHS Board Members.

4.155 The introduction of a Board Protocol should also help Members to make enquiry and challenge the executives in an appropriate manner, ensuring a healthy relationship exists between Board Members and the Executive Leadership Team.

4.156 Defining the functions and enablers of the governance approach is not enough to ensure good governance. To embed the Principles of Good Governance, NHS Boards must also implement, maintain and continuously improve cohesive governance arrangements that are specifically designed to deliver this approach at Board level. The following sections of the guide describe how NHS Boards should go about delivering those aspects of the Blueprint for Good Governance.

The Delivery Approach

4.157 To support the delivery of good governance NHS Boards should construct an assurance framework and implement an integrated governance system that brings together the organisation's strategic planning, risk management and assurance information systems.

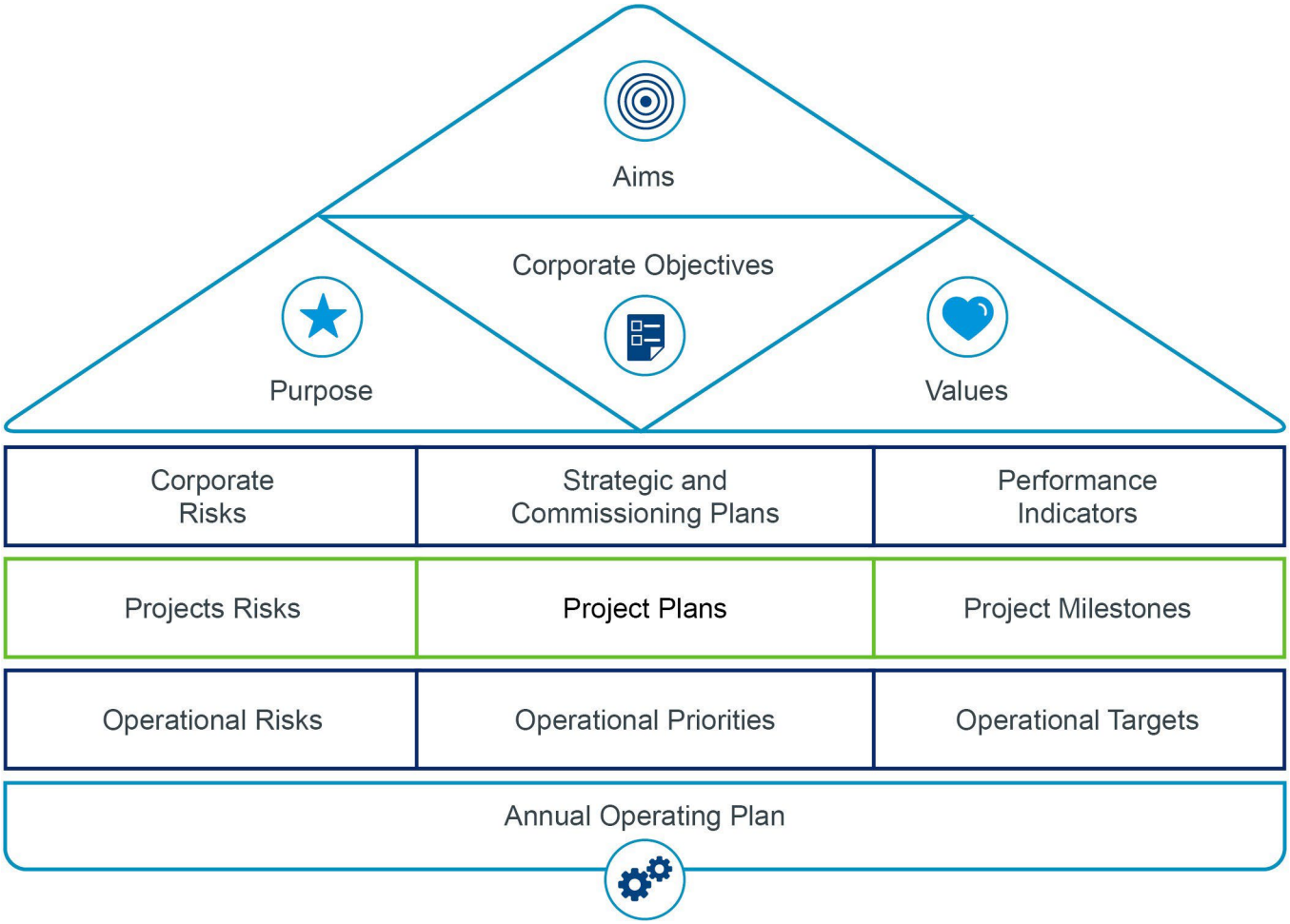
[33] www.standardscommissionscotland.org.uk/guidance/guidance-notes

4.158 The assurance framework and integrated governance system must be supported by a suite of operating guidance and it is critical to the delivery of good governance that these arrangements are widely communicated across the organisation.

The Assurance Framework

4.159 Promoting and delivering good governance starts with the development of an assurance framework. This simple model brings together the organisation's purpose, aims, values, corporate objectives and risks with the strategic plans, change projects and operating plans necessary to deliver the desired outcomes.

Figure Two – The Assurance Framework



4.160 The assurance framework is primarily used to identify and resolve any gaps in control and assurance and helps identify any areas where assurance is not present, insufficient or disproportionate in relation to the delivery of the NHS Board's corporate objectives or operational priorities.

4.161 The construction of the assurance framework also ensures the systems introduced for strategic planning and commissioning, implementing change, managing risk and providing assurance information are all aligned and focused on the corporate objectives and operational priorities.

4.162 The assurance framework also describes the performance indicators, change project milestones and targets linked to each of the corporate objectives and forms the foundations for the assurance information system that provides the accountability reports to the NHS Board and standing committees.

4.163 Once completed, the framework provides a clear picture of the links between the outcomes expected by the Board and the strategic plans, transformational change projects and operational plans developed by the Executive Leadership Team to deliver those outcomes. It describes which objectives and what risks are delegated (in the Scheme of Delegation) to each of the standing committees. This ensures that both the delivery of strategic and transformational change and the current operational outputs and outcomes are subject to appropriate scrutiny, at the appropriate level and in the appropriate place within the governance system.

4.164 In practice, the application of the assurance framework means that longer-term strategic issues and risks are considered in a holistic fashion by the Board, with the standing committees focusing on the delivery of delegated, specific corporate objectives, operational priorities and the more immediate annual operating plans.

4.165 To further enhance this approach and support collaborative governance, it is important that the territorial Boards also take account of the strategic and commissioning plans and the annual accountability reports produced by the local Integration Authorities when developing their assurance frameworks.

4.166 Introducing an assurance framework also helps executives, managers and staff better understand how the organisation is governed and their role and accountabilities within the governance system. It emphasises the division of responsibilities between the Board and the Executive Leadership Team.

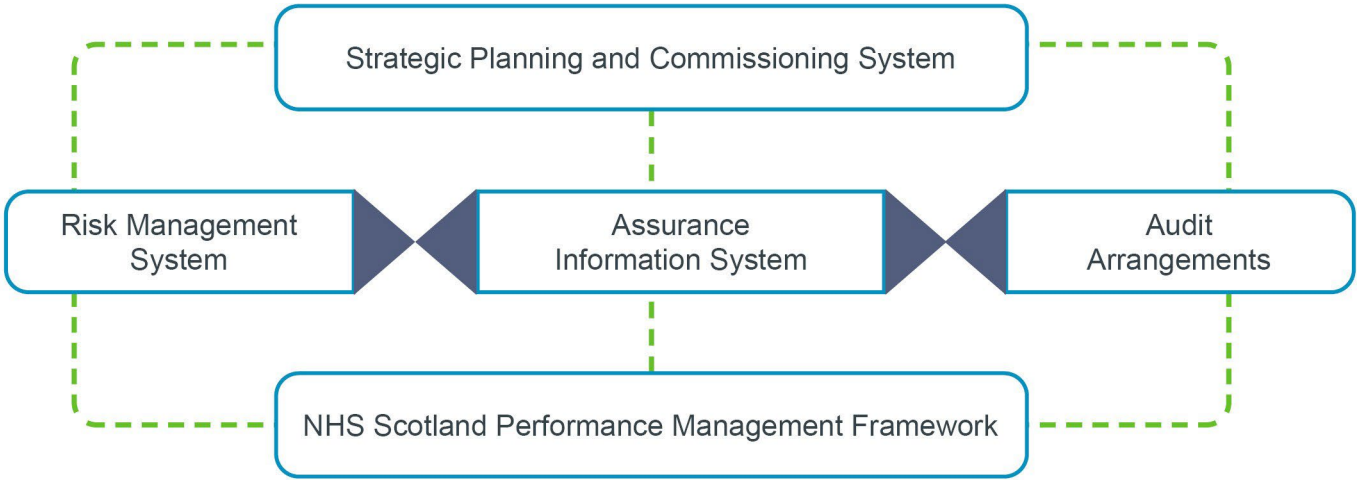
4.167 NHS Boards should go beyond simply constructing an assurance framework to deliver good governance. The framework has to be implemented effectively for it to be of value. This is explored further in the next sections of the guide that relates to the integrated governance system.

The Integrated Governance System

4.168 Integrated governance requires an all-encompassing approach to the delivery of the services provided by the organisation. It brings together the distinct governance systems required to direct and control the management of operations and the leadership of change, and the effective integration of these systems is critical to the delivery of the active and collaborative approaches to governance.

4.169 In NHS Scotland there are five discrete but linked assurance systems that can be considered as the integrated governance system that supports the delivery of good governance.

Figure Three – The Integrated Governance System



4.170 These systems primarily assist the NHS Board in setting the direction, holding the Executive Leadership Team to account and managing risk. They can also play an important part in delivering the assurance required in relation to the stakeholder engagement and influencing culture functions of the Board.

4.171 The Board shares ownership of the strategic planning and commissioning system with the Integration Authorities and has accountability for the risk management system, the assurance information system and the audit arrangements. The Scottish Government owns the NHS Scotland Performance Management System.

4.172 Collectively, these systems provide the Scottish Government, the NHS Board, the standing committees and the Integration Authorities with important information that helps them to be assured that good governance is in place across the healthcare system.

4.173 A more in-depth description of the component parts of the integrated governance system is included in the supplementary guidance attached as an appendix to the guide.

4.174 While the introduction of an assurance framework and the development of an integrated governance system will contribute significantly to the delivery of the active and collaborative approaches to governance, the delivery of good governance also relies on efficient operating arrangements being implemented throughout the organisation. How NHS Boards should achieve this outcome is described in a suite of documents described in the Blueprint for Good Governance as operating guidance.

The Operating Guidance

4.175 The detailed description of the NHS Board's governance arrangements and the guidance on implementing these arrangements are contained in a portfolio of documents that is developed, maintained and communicated by the Board Secretary. It includes Standing Orders, Standing Financial Instructions and the Schemes of Delegation that provide the senior leadership and management of the NHS with their principal operating guidance.

Figure Four – The Operating Guidance



4.176 Additional guidance is available from the Board Secretaries Group to support the efficient delivery of the NHS Board's proceedings and business, including terms of reference for committees and templates for agendas and minutes of meetings.

4.177 Board Secretaries can also provide guidance on how Boards should develop their Annual Cycle of Business for the Board and the standing committees that delivers an integrated work programme and coordinated timetable for Board meetings, Board seminars and standing committee meetings.

4.178 Guidance on the drafting of papers and reports, including security classification and setting the requirements for financial, risk and equality assessments of the impact of options presented to the Board is also required to ensure the smooth operation of Board and committee meetings.

4.179 To supplement the guidance in the Code of Conduct for NHS Board Members, the suite of operating instructions available to Board Members may also include a locally agreed Board Protocol for the chairing, conduct and reporting of meetings.

4.180 In the territorial Boards the operating requirements for those functions delegated to the Integration Authorities are described in the Integration Schemes agreed between the NHS Boards and the Local Authorities. This document also provides Board Members with guidance on the delivery of the collaborative governance arrangements for the healthcare functions delegated to the Integration Joint Board. As such, they should be seen as an important component of the NHS Board's operating guidance.

4.181 With the exception of the Integration Scheme(s), the documents that make up the Operating Guidance should be reviewed annually by the Boards to coincide with the preparation of governance statement that forms part of the Annual Report.

4.182 **The Public Bodies (Joint Working) (Scotland) Act 2014**[34] requires Local Authorities and Health Boards to review their Integration Schemes before the expiry date, which is five years after the scheme was approved in the Scottish Parliament. The Scottish Government is responsible for facilitating parliamentary approval of any revisions to the Integration Schemes.

4.183 In addition to the standard portfolio of operating guidance described above, some Boards may also have other material that describes how the system of governance works within their particular organisation. Board Members should be aware of these local instructions and take them into account when carrying out their role.

4.184 Further information on best practice in healthcare governance can be found at the websites provided by **NHS Scotland**[35] and **NHS Education for Scotland**[36].

4.185 Having considered what needs to be done to ensure good governance, it is important to consider how the NHS Boards and the Scottish Government will determine whether or not this approach has been successful. Therefore, the next section of the guide describes the evaluation process for the governance of NHS Scotland.

The Evaluation Approach

4.186 In order to assess the effectiveness of the healthcare governance system and whether or not it is continuously improving, it is important to have a consistent and systematic approach to assessing and evaluating the NHS Boards' governance arrangements against the Principles of Good Governance.

4.187 The approach to evaluation must provide assurance to the Board, the Scottish Government and the other stakeholders in healthcare that good governance is being delivered across all the categories of governance in healthcare.

[34] www.legislation.gov.uk/asp/2014/9/contents
[35] www.nhs.scot
[36] www.nes.scot.nhs.uk

4.188 For NHS Scotland the preferred approach to evaluation involves three levels of assessment:

- Appraisal of the Board Members' individual performance
- Self-assessment of the Board's effectiveness
- External review of the organisation's governance arrangements.

These activities should be viewed as a means of supporting personal and Board development, rather than a punitive process.

4.189 The following paragraphs describe each level of the evaluation approach and how they are brought together to inform and drive a programme of improvement activities.

Individual Performance Appraisal

4.190 The Scottish Government is responsible for developing and implementing the performance appraisal system for Chairs and other NHS Board Members.

4.191 The Director General for Health and Social Care carries out the appraisal of NHS Board Chairs on behalf of the Cabinet Secretary. This process includes a self-assessment by the Chair and a 360 degree feedback exercise involving Board Members, executives and other stakeholders.

4.192 The Board Chair reports to the Scottish Government on the contribution made to the work of the Board by its Members. The format of these reports is set by the Government and includes discussions on personal development opportunities that might be used to enhance the individual's effectiveness as a Board Member.

4.193 The NHS Board Chair should consider how any weaknesses in the governance arrangements identified through the individual performance appraisal systems can be addressed by the Board.

Board Self-Assessment

4.194 NHS Boards should regularly review their governance arrangements and annually conduct a structured self-assessment to review their effectiveness, identifying any new and emerging issues or concerns.

4.195 The Principles of Good Governance form the basis of the Board's self-assessment and this exercise should provide a view of the extent to which the Blueprint for Good Governance has been implemented across the organisation. This should include an evaluation of the current status of the systems that support the organisation's governance arrangements.

4.196 To ensure that the criteria against which the Board's assessment is valid, reliable and transparent and reflects best practice in governance, the Scottish Government provide NHS Boards with advice and guidance on how to conduct the self-assessment exercise.

4.197 After critically examining the findings of the self-assessment exercise, the Board should use this information as the baseline and driver for its improvement and development activities.

External Review

4.198 To enhance and validate the Boards' self-assessments, a systematic evaluation of the governance arrangements across the NHS Boards should be undertaken by an external specialist in governance.

4.199 The Scottish Government are responsible for commissioning and managing a programme of structured governance reviews that includes a work plan to evaluate the NHS Boards' governance arrangements at least every three years.

4.200 In undertaking these reviews the external specialist will bring together a range of evidence from a number of sources and include benchmarking the NHS Board's governance with comparative healthcare organisations and the latest thinking on best practice in governance.

4.201 NHS Boards and the Scottish Government can also commission ad hoc thematic reviews of specific areas of governance, e.g., clinical governance or risk management.

4.202 The Board should compare the findings of the external reviews, with the output of the Board's self-assessment exercise and the view of the governance arrangements gained from the individual performance reviews. This combination of information should then be used to inform and support the continuous improvement approach to governance described in the final section of the guide.

The Improvement Approach

4.203 For the governance of healthcare to continuously improve, the approach adopted by NHS Scotland has to be an evolving, iterative and integrated process that is widely understood and adopted by the NHS Boards.

4.204 The following paragraphs describe the quality improvement approach required by the NHS Boards, NHS Education for Scotland and the Scottish Government to ensure that the governance arrangements in NHS Scotland remain relevant and continue to be fit for purpose as the health and social care system evolves over time.

NHS Boards

4.205 Having assessed the effectiveness of the organisations governance arrangements by triangulating information from individual performance reviews, the Board self-assessment and external reviews, the NHS Boards must design and implement a bespoke programme of activities to address the issues and concerns raised by the evaluation process.

4.206 The activities included in the Board's improvement programme should focus on the delivery of the Principles of Good Governance and be described in terms of enhancements to the enablers and delivery systems in the Blueprint for Good Governance.

4.207 The improvement programme must include actions to address any shortcomings in the recruitment, induction, training and development of Board Members that surfaced at individual performance reviews. It must respond to the findings of the self-assessment of Board effectiveness by including work to overcome any weaknesses identified by the Board Members. Any recommendations for improvement in the governance arrangements from external reviews or other sources should also be added to the programme plan.

4.208 The Board's improvement programme plan should be published and details of the progress made to implement the actions outlined in the plan should be regularly reported to the NHS Board and discussed at the NHS Board's Annual Review with the Scottish Government.

NHS Education for Scotland

4.209 NHS Education for Scotland has a significant role in improving the delivery of good governance in the NHS by supporting NHS Boards to respond positively to the findings of the internal and external evaluation of their governance arrangements.

4.210 This support is primarily delivered through a comprehensive programme of development activities that includes a range of support material, training courses, seminars and workshops designed to support NHS Boards in improving their governance arrangements. This includes induction training and broader development opportunities tailored to individual Boards and Board Members' needs, a mentoring scheme for Board members and a development programme for aspiring Chairs and Vice Chairs.

4.211 The training and development material offered by NHS Education for Scotland is regularly updated to reflect best practice in healthcare governance and is supported by a digital portal which offers practical resources to support Board Members' continuous personal development. This is accessed through the TURAS Learn system on the **NHS Scotland Board Development**[37] website and all Board Members are expected to register on the TURAS Learn system and take advantage of the opportunities for developing their skills as Board Members.

4.212 The support provided by NHS Education for Scotland to NHS Boards and individual Board Members is a valuable resource and should be incorporated as appropriate into the Board's improvement programme.

[37] https://learn.nes.nhs.scot/17367/board-development

Scottish Government

4.213 To ensure that good governance is being delivered across NHS Scotland in a consistent manner, the Directorate for Finance and Governance works with NHS Boards to achieve continuous improvement in their governance arrangements. This includes commissioning and approving the national induction and the other training and development material on governance in healthcare that is delivered by NHS Education for Scotland and other training providers.

4.214 The Scottish Government also supports the continuous improvement approach by providing advice and guidance to NHS Boards on specific governance issues and its website contains valuable information to support Board Members in delivering their roles and responsibilities.

4.215 To guide and support the improvement of governance in NHS Scotland, the Director of Health Finance and Governance has put in place a Healthcare Governance Advisory Board. This replaces the NHS Scotland Corporate Governance Steering Group.

4.216 The purpose of the Healthcare Governance Advisory Board is to provide leadership, support and guidance to key stakeholders by advising on the development and implementation of the delivery of good governance in healthcare across NHS Scotland. The remit of the Advisory Board includes providing input to the development of the policies and initiatives required to ensure a continuous improvement approach is adopted to governance in NHS Scotland.

4.217 The Advisory Board reports to the Director of Health Finance and Governance and its membership includes a Chair appointed by the Scottish Government and representatives from the key stakeholders in healthcare governance. This may include independent advisors to bring an external perspective to the work of the Board and other members of NHS Scotland may be invited to join as and when specific expertise is required on the Advisory Board.

4.218 The description of the support for a continuous improvement approach to governance in healthcare in the previous paragraphs completes the guide to the Blueprint for Good Governance.

4.219 The publication of this document should ensure that Board Members, Executive Leadership Teams and other stakeholders in the governance of NHS Scotland have a shared understanding of the importance and definition of good governance and appreciate the role that active, collaborative and continuous improvement approaches play in the delivery of the Blueprint.

4.220 Although the guide describes the functions, enablers, delivery, evaluation and improvement approaches that make up the Blueprint for Good Governance, supplementary guidance has been appended to this document to provide further, more detailed guidance on the delivery of the Integrated Governance System require to implement and sustain good governance across the NHS.

Supplementary Guidance

A. The Strategic Planning and Commissioning System

A.1 In setting the direction for the healthcare system, strategic and commissioning plans should clearly set out the drivers for change, the consultation and engagement undertaken, and the vision of the future that should result from implementing the strategies and services described in the plans.

A.2 Strategic and commissioning plans must be aligned to the NHS Board's purpose, aims and values. The corporate objectives being supported and the outcomes expected from the delivery of these plans should be clearly stated.

A.3 The development of strategies and changes to service delivery models should include appropriate stakeholder engagement, particularly when a proposed service change will have a major impact. NHS Boards must ensure that when necessary, stakeholder engagement is carried out at the outset of the planning and commissioning process and this engagement is inclusive, proportionate and robust. Advice from **Healthcare Improvement Scotland Community Engagement**[38] is available to NHS Boards to ensure that they have met the national standards for engagement.

A.4 In addition to describing the need for change and the expected outcomes, strategic and commissioning plans should also include details of the business case behind this approach. A cost- benefit analysis of proposed changes gives Board Members one of the key pieces of information required to approve the plans.

A.5 Board Members also require assurance around the implementation of the strategic and commissioning plans. As these will usually require a degree of transformational change, Boards should ensure that the organisation has the capability and capacity to support the delivery of the change projects and programmes. This is necessary to not only deliver the planned changes, but also to ensure the realisation of the benefits expected from the strategic and commissioning plans.

A.6 The Board should seek assurance that implementation plans and change projects and programmes include comprehensive risk assessments, equality impact assessments and communication plans that will support the delivery of strategic plans and change projects and programmes.

[38] www.hisengage.scot

A.7 The implementation plans should also be clear about how success will be measured and the governance arrangements for oversight of delivery, including details of the information flows to the Board Members on the progress being made with implementation. This should include any arrangements for evaluation of the effectiveness of new approaches during and at the end of the period covered by the plan.

A.8 It is also important that Board Members consider the extent to which corporate strategies and change projects and programmes take advantage of research and innovation in science and technology.

A.9 Who has the overall accountability for the delivery of the strategy and who are the individuals responsible for delivering specific change projects and programmes should also be considered by Board Members. It will be important that the Board is assured that the organisation has the personnel in place with both the capability and the capacity to meet these requirements.

A.10 NHS Boards should put in place a strategic planning cycle that clearly indicates where and when the Board is involved in considering options, debating risk, giving approval and thereafter in monitoring delivery of the Board's strategic plans. To facilitate this approach, a strategic planning framework should be maintained.

A.11 For each of the strategic and commissioning plans, the strategic planning framework should describe the period covered and the corporate objectives addressed by the plan. It should also identify the stakeholders consulted, the author, the approver and the date approved. Details of the reporting arrangements and the expected date of the next review by Board Members should also form part of the framework.

A.12 Given the close relationship between healthcare and social care services and the integrated approach to delivering these services required by NHS Boards and Local Authorities in Scotland, it is critical to the effective planning and commissioning of primary and secondary healthcare that the plans developed by the Integration Authorities align with the strategic plans approved by the NHS Board.

A.13 **The Public Bodies (Joint Working) (Scotland) Act 2014**[39] introduced a statutory duty for NHS Boards and Local Authorities to integrate the planning and delivery of delegated health and social care functions across Scotland. Therefore, it is essential that NHS Boards play their part in the development of the Integration Authorities strategic commissioning plans as set out in the 2014 Act. This requires Integration Authorities to establish a Strategic Planning Group, and the NHS Board must nominate a minimum of one person to join that group. That requirement should feature in the Integration Scheme agreed between the NHS Board and the Local Authority.

A.14 The NHS Boards should include details of the Integration Authorities strategic commissioning planning process in their strategic planning framework. This should highlight the dependencies between plans that need to be managed by the NHS Chief Executive and the Health and Social Care Partnership's Chief Officer(s).

[39] www.legislation.gov.uk/asp/2014/9/contents

A.15 NHS Boards also have responsibilities under the **Community Empowerment (Scotland) Act 2015**[40] for working together with local communities to plan and deliver better services that make a real difference to people's lives.

A.16 The NHS Boards' involvement in the Community Planning Partnerships across Scotland is intended to ensure that service planning is co-ordinated at a local level. Therefore, Boards should take into account the views, ambitions and priorities of the Community Planning Partnership when developing their strategic and commissioning plans.

A.17 This inclusive and collaborative approach to designing and maintaining an overview of strategic planning and commissioning should ensure that the NHS Board can be assured that the organisation's aims are being pursued and the full range of corporate objectives are being addressed by those responsible for the delivery of healthcare in their area.

A.18 The NHS Board's strategic and commissioning plans should be aligned with any relevant operational policies in place to support the delivery of healthcare services. Boards should ensure that operational policies are subject to approval and regular review by the Board and the standing committees. To manage this in a co-ordinated manner a policy framework should be established and maintained for all significant healthcare policies. The policy framework should provide Board Members with the same information on policy development that the strategic planning framework does on strategic and commissioning plans.

A.19 Effective strategic planning and policy development must include assessment of the risks existing in the healthcare system and the next section of the supplementary guidance focuses on that aspect of the integrated governance system.

[40] www.legislation.gov.uk/asp/2015/6/contents

B. The Risk Management System

B.1 Risk management is an integral part of the active and collaborative approaches to delivering good governance. It enhances strategic planning and prioritisation, assists in achieving corporate objectives and strengthens the Board's ability to be agile in response to the challenges faced by the NHS.

B.2 NHS Boards cannot be entirely risk averse, and having an effective and meaningful risk management system that systematically anticipates and prepares successful responses to the uncertainties faced by NHS Boards is critical to delivering the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.

B.3 When considering their approach to risk management, NHS Boards should recognise that it is often not possible to manage all risks at any point in time to the desirable tolerance level. Very often it is also not possible, and not financially affordable, to fully remove uncertainty from decisions. Therefore, Boards should encourage and support a risk culture that embraces openness, supports transparency, welcomes constructive challenge and promotes collaboration, consultation and co-operation.

B.4 The principles and concepts that support effective risk management are outlined in **HM Government's Orange Book**[41] and the **Scottish Public Finance Manual**[42] provides guidance on best practice for risk management in the Scottish public sector.

B.5 Almost all processes, procedures and activities carried out by the NHS carry with them a degree of risk. So, it is necessary for the NHS Board to agree the level of risk with which it aims to operate, based on what it considers to be justifiable and proportionate to the impact on patients, service users, the public, the workforce and the Board. Consequently, understanding and communicating the Board's risk appetite is the first step in constructing an effective risk management system.

B.6 Guidance on the development and use of a risk appetite statement is contained in **HM Government's Risk Appetite Guidance Notes**[43]. Having agreed their risk appetite, NHS Boards must then develop, maintain and continuously improve a risk management system that supports the achievement of the Board's corporate objectives and operational priorities while remaining within its risk appetite.

B.7 The risk management approach adopted by the organisation must include activities and processes that facilitate the identification of corporate and operational risks and supports the assessment, mitigation, monitoring and reporting of these risks.

[41] www.gov.uk/government/publications/orange-book
[42] www.gov.scot/publications/scottish-public-finance-manual
[43] assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012891/20210805_-_Risk_Appetite_Guidance_Note_v2.0.pdf

B.8 The risk management system should be utilised in a way that assists the NHS Board and the Executive Leadership Team to prioritise available resources to minimise risk to best effect and to provide assurance that progress is being made. This must include the maintenance of a tiered set of operational and corporate risk registers to quantify and prioritise risks which threaten the achievement of the organisation's objectives and priorities.

B.9 The purpose of the risk registers is to achieve greater visibility of exposure to risk across the categories identified in the risk appetite statement and as a result reduce the likelihood that risks will occur or evoke an effective response when risks occur. Therefore, it is important that the risk registers are constantly updated to reflect the dynamic nature of delivering healthcare.

B.10 For the risk registers to be an effective tool for the management of risk it is important that they include an articulation of the risk event itself, details of the underlying causes (including internal and external factors), and the range of consequences should the risk event occur.

B.11 The risk registers should include an assessment of the combination of the consequences of the event (impact) and its probability (likelihood). The impact should be the estimated effect of the risk on the objectives in question. This assessment is focused on scale, scope and resource implications. Likelihood is the estimated chance of the risk occurring. This is focussed on probability.

B.12 Having assessed the risk, the response should be to either treat, tolerate, or terminate the risk. The mitigation actions already taken or proposed to respond to the risks to be treated, should also be described in the registers. This should include the owner of the action, the timescales involved and where the oversight and scrutiny of the delivery and outcome of the mitigation sits within the organisation's hierarchy.

B.13 To highlight the expected changes to the impact and likelihood of the risk materialising, the assessment scores should be included pre and post the mitigation actions.

B.14 The development of business continuity plans are often used to mitigate some corporate risks, including those around the loss of IT systems, disruption to water, gas and electricity supplies, and other failures in the physical infrastructure. These plans are designed to ensure that the organisation can continue to operate and recover should a significant risk materialise. They aim to increase resilience across the healthcare system by responding to identified risks with an impact assessment and contingency plans that have been implemented and tested across the organisation.

B.15 Therefore, NHS Boards must ensure that appropriate business continuity plans are in place, regularly tested and reviewed, and widely communicated with the appropriate stakeholders.

B.16 Where the delivery of services provided by organisations outside of the NHS Board can introduce risk to the delivery of healthcare, it is important that the NHS approach to risk management and business continuity planning recognises this and responds appropriately. This is particularly important in the delivery of integrated health and social care systems and requires Board Members who also sit on the Integration Joint Boards to pay particular attention to the impact mitigating healthcare risks can have on social care services and vice versa.

B.17 The information presented in the risk registers and the business continuity plans should improve decision making and assist the NHS Board to assess whether or not management controls and resources deployed are adequate to effectively manage corporate and operational risks in healthcare.

B.18 Responsibility and accountability for the operation and the oversight of the risk management system should be clearly defined and responsibility for contributing to the management of risks should be included in the job descriptions of staff, the terms of reference of the governance committees and the Board's Scheme of Delegation.

B.19 Not only do NHS Boards require assurance on the effectiveness of their approach to strategic planning and risk management, they need to commission an assurance information system that provides them with the necessary information to give Board Members assurance on the progress being made towards the delivery of the organisation's strategic, operational and financial plans.

C. The Assurance Information System

C.1 The assurance information system should be designed to provide frequent and informative performance and financial reports to assure the Board that it is delivering safe, effective, patient- centred, affordable and sustainable services. This system should deliver relevant, accurate and timely information on a wide range of activities, including:

- Service delivery
- Safety and quality standards
- Innovation and transformational change
- Workforce
- Education, training and development
- Finance.

C.2 NHS Boards should agree with the NHS Chief Executive the contents of the assurance information system required by the Board and the standing committees. This should include information on both the management of current operations and the progress being made to deliver change across the healthcare system.

C.3 How data should be presented in order to assist those preparing papers for Board Members' scrutiny should also be agreed with the NHS Chief Executive and in the case of territorial NHS Boards, with the Health and Social Care Partnership's Chief Officer(s).

C.4 Board papers should show data in a clear, consistent and effective way to ensure that Board Members are able to understand and interpret its significance and receive the level of assurance required. Best practice in presenting data includes:

- Presenting statistical information in charts or tables, rather than in a narrative format
- Including actual numbers rather than percentages, although there will be times where both are appropriate
- Limiting the volume of information shown as charts and tables that have too much information can mean that key messages are lost or difficult to see
- Ensuring units of time are consistent for comparative purposes, e.g., months have variable number of days but weeks always have the same number of days
- Using line charts to measure change or performance over time and if variation is a potential concern, add a target line or convert to a control chart
- Favouring control charts to show if variation is within normal limits and therefore not necessarily a concern
- Describing a position at a point in time by allocating RAG status but these should be used with caution as RAG charts could focus attention on lower priorities
- Benchmarking results using pareto charts which are preferable to pie charts
- Comparing results using funnel charts helps to identify special cause variation, i.e. one not typically expected

- Compiling a whole system view by presenting a series of charts showing different aspects of performance within the same area, giving a more comprehensive and thorough overview
- Including forecasts in tables and charts to describe what results are predicted with the resources available and in the circumstances expected
- Adding trajectories when a changing level of performance over time is required, often by the body commissioning the work.

C.5 Further guidance on the presentation of data to Board Members can be obtained from NHS Education for Scotland's material on the implementation of the active approach to delivering good governance.

C.6 While data and management information provides Board Members with a particular view of the organisation, to deliver good governance this has to be triangulated with other reports and the more qualitative information available on service delivery.

C.7 Therefore, the assurance information system should incorporate other regular internal reports on the operation of the healthcare system, particularly those that reflect patient, service user and staff experience. Examples of this category of assurance information sources would include the following:

- Healthcare Acquired Infection Report
- Complaints Report
- Duty of Candour Annual Report
- Public Health Screening Programme Annual Report
- Vaccination Programme Annual Report
- Child Poverty Action Plans Progress Report
- Research and Development Annual Report
- iMatter Reports
- Whistleblowing Annual Report.

C.8 It is important that this list is seen as simply an example and the majority of reports included are relevant to territorial Boards. Consideration of these reports by the Board or the appropriate standing committee should form part of the Annual Cycle of Business or in the case of the ad hoc reports, be reviewed at the earliest opportunity.

C.9 The Assurance Information System should also incorporate the wide range of external reports available to Boards. These include one-off Audit Scotland reports on various aspects of the health and social care system, Health Improvement Scotland reviews, Care Opinion feedback, Mental Welfare Commission reports, Scottish Public Services Ombudsman's reports, NHS Education for Scotland Deanery Reports and the General Medical Council's reports on the training of junior doctors.

C.10 Board Members should be aware that the specific issues raised in these reports may signal wider concerns. For example, GMC reports on the training of junior doctors can potentially highlight wider issues concerning patient safety and the standard of care, thus providing an opportunity for early intervention and remedial action.

C.11 NHS Boards should also closely scrutinise the reports prepared for the Board's Annual and Mid- Year Reviews with the Scottish Government and pay particular attention to the Annual Reports submitted to the Scottish Government by the Health and Social Care Partnerships. These documents combine to give a comprehensive account of the progress made by the organisation across both Primary and Secondary Care and should provide Board Members with assurance on the progress being made to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.

C.12 In additional to scrutiny of internal and external reports NHS Boards should also pay attention to the feedback to NHS Boards from the **Sharing Intelligence for Health and Care Group**[44]. This group is responsible for supporting improvement in the quality of care provided for the people of Scotland and its main objective is to ensure that any potentially serious concerns about a care system are shared and acted upon appropriately. The feedback from the group also highlights examples of where things are working well.

C.13 Feedback from a structured visiting programme by Board Members to frontline services and online discussions with patients, service users and staff should also feature in the assurance information system, enabling the quantitative data and the external perspective to be considered against the Board Members' impression of the patient and staff's views of the organisation.

C.14 In addition to having effective strategic planning, risk management and flows of assurance information to the NHS Board, an integrated approach to delivering good governance also relies on having effective internal and external audit arrangements.

[44] www.healthcareimprovementscotland.org/our_work/governance_and_assurance/sharing_intelligence.aspx

D. The Audit Arrangements

D.1 The integrated governance system includes the audit arrangements required to provide the Board and key stakeholders with assurance that the system of internal controls is functioning as intended.

D.2 The main contributors to the audit arrangements are the NHS Board, the Internal Auditors, the External Auditors and the Audit and Risk Committee.

D.3 NHS Boards have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity. This includes ensuring that accurate accounting records are maintained and financial statements are prepared that give a true and fair view.

D.4 **The Code of Audit Practice (2021)**[45] prepared by Audit Scotland sets out the respective functions and responsibilities of the internal and external auditors.

D.5 Internal audit is a function of management and it operates under the **Public Sector Internal Audit Standards**[46]. This defines internal auditing as an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. To deliver these outcomes the role the internal audit team should include:

- Reviewing accounting and internal control systems
- Reviewing the economy efficiency and effectiveness of operations
- Assisting with the identification of significant risks
- Examining financial and operating information
- Special investigations
- Reviewing compliance with legislation and other external regulations.

D.6 To ensure that internal audit is an independent and objective assurance activity, the Board should seek assurance that the internal auditors are independent of executive management and should not have any involvement in the operations or systems they audit. The Head of Internal Audit should report to the Chief Executive or one of their direct reports. They also should report functionally to the audit committee and have right of access to the Chair of the Audit and Risk Committee, the Chief Executive and the NHS Board Chair. These arrangements should be clearly set out in the Board's Standing Financial Instructions and the terms of reference for its Audit and Risk Committee.

[45] www.audit-scotland.gov.uk/publications/code-of-audit-practice-2021 f
[46] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

D.7 External audit provides independent challenge and assurance on the Board's annual accounts and provide a view on matters relating to regularity, propriety, performance and the use of resources. NHS Boards are assigned external auditors by the Auditor General for Scotland who is a Crown appointment and is independent of Government. The responsibilities of independent auditors are established by the **Public Finance and Accountability (Scotland) Act 2000**[47] and the **Code of Audit Practice**[48] and their work is guided by the **Financial Reporting Council's Ethical Standard**[49].

D.8 The key responsibilities of the external auditors can be summarised as follows:

- To give an independent opinion on the financial statements and other information within the annual report and accounts
- To review and report on the arrangements within the audited body to manage its performance, regularity and use of resources
- To support improvement and accountability.

D.9 To deliver the internal and external audit functions, an annual audit programme should be put in place to deliver a comprehensive portfolio of system audits that ensures the main contributors are all able to meet their statutory responsibilities and the NHS Board and the Scottish Government can be assured on the effectiveness of the management, leadership and governance of the organisation.

D.10 The audit plans included in the programme should document how the internal and external auditors intend to meet their responsibilities and it is important that these plans are joined-up, effective and proportionate. They should be linked to the delivery of corporate objectives and operational priorities and should focus on the areas identified as corporate and operational risks.

D.11 The Board's Audit and Risk Committee has a key role in ensuring the effectiveness of the internal audit functions including:

- Overseeing the selection process for new internal auditors
- Reviewing and agreeing the annual internal audit work plan
- Ensuring recommendations are actioned by the Executive Leadership Team
- Disseminating audit reports to the relevant Board committees
- Encouraging the use of audit reports as improvement tools
- Monitoring and assessing the effectiveness of the audit team
- Making recommendations to the Board for the award of the internal audit contract and the appointment and termination of the Head of Internal Audit
- Overseeing the Board's relations with the external auditors, including reviewing the scope of their annual audit plan.

D.12 Guidance on the principles and best practice for the organisation and delivery of Audit and Risk Committees is available in the **Audit and Assurance Committee Handbook**[50] published by the Scottish Government.

[47] www.legislation.gov.uk/asp/2000/1/contents
[48] www.nao.org.uk/code-audit-practice
[49] www.frc.org.uk/getattachment/0bd6ee4e-075c-4b55-a4ad-b8e5037b56c6/Revised-Ethical-Standard-2016-UK.pdf
[50] www.gov.scot/publications/audit-assurance-committee-handbook

D.13 It is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable.

D.14 The final component of the integrated governance system is the NHS Scotland Performance Management Framework. The following section of the supplementary guidance describes this arrangement in more detail.

E. The NHS Scotland Performance Management Framework

E.1 As the sponsor of the NHS Boards, the Director General for Health and Social Care has put in place a performance management framework to assist the Scottish Government in ensuring that the NHS Boards are delivering services and targets to the required standards, within budgets and with the appropriate governance.

E.2 The NHS Scotland Performance Management Framework provides five stages of a Ladder of Escalation that provides a model for intervention by the Scottish Government when there are concerns about a NHS Board's ability to deliver the expected standards, targets and governance.

E.3 The model not only describes the stages of performance but also the level of support that would be provided by the Scottish Government Directorates for Health and Social Care at each stage.

Stage	Description	Response
1	Steady state 'on-plan' and normal reporting	Surveillance through published statistics and scheduled engagement of Annual Review and Mid-Year Reviews.
2	Some variation from plan; possible delivery risk if no action.	Local Recovery Plan – advice and support tailored if necessary. Increased surveillance and monitoring by Scottish Government. SG Directors aware.
3	Significant variation from plan; risks materialising; tailored support required.	Formal Recovery Plan agreed with Scottish Government. Milestones and responsibilities clear. External expert support. Relevant SG Directors engaged with CEO and top team. DG aware.
4	Significant risks to delivery, quality, financial performance or safety; senior level external support required.	Transformation team reporting to Director General and CEO NHS Scotland.
5	Organisational structure/ configuration unable to deliver effective care.	Ministerial powers of Intervention.

E.4 The Ladder of Escalation's use is not limited to specific performance measures and may be triggered by concerns about specific services or broader organisational issues.

E.5 The Performance Management Framework is overseen by the National Planning and Performance Oversight Group, a sub-group of the Health and Social Care Management Board. The Oversight Group considers various forms of intelligence and makes subsequent recommendations to the Health and Social Care Management Board on escalation, de-escalation and/or the provision of enhanced support for NHS Boards.

The Blueprint for Good Governance

Second Edition

A53674650

November 2022

Glasgow health chief reassures parents over hospital infection fears

1 December 2019



NHSGGC chief executive Jane Grant apologises to parents and insists a hospital is safe

The head of Scotland's largest health board has moved to reassure parents as it emerged a child died last week after contracting a hospital infection.

NHS Greater Glasgow and Clyde insists the Queen Elizabeth University Hospital in Glasgow is safe. It said the death was not related to any previous cases.

Chief executive Jane Grant said the hospital was committed to the safety and quality of care for children.

She said infection rates were currently in line with other paediatric units.

The **Herald newspaper reported** on Sunday that the child, who died on [redacted] had a hospital-acquired infection and had been moved between wards at the site.

NHGGC confirmed that a child had died, saying the issue was being appropriately managed and Health Protection Scotland had been informed.

Warning of 'high risk' to water supply at Glasgow hospital

Glasgow health board placed in 'special measures'

Timeline: The trials of Scotland's super hospital

The development follows growing concern in recent weeks about the number of infections and the death of a [redacted] at the £842m "super hospital" complex which potentially could be linked to problems with contaminated water supplies.

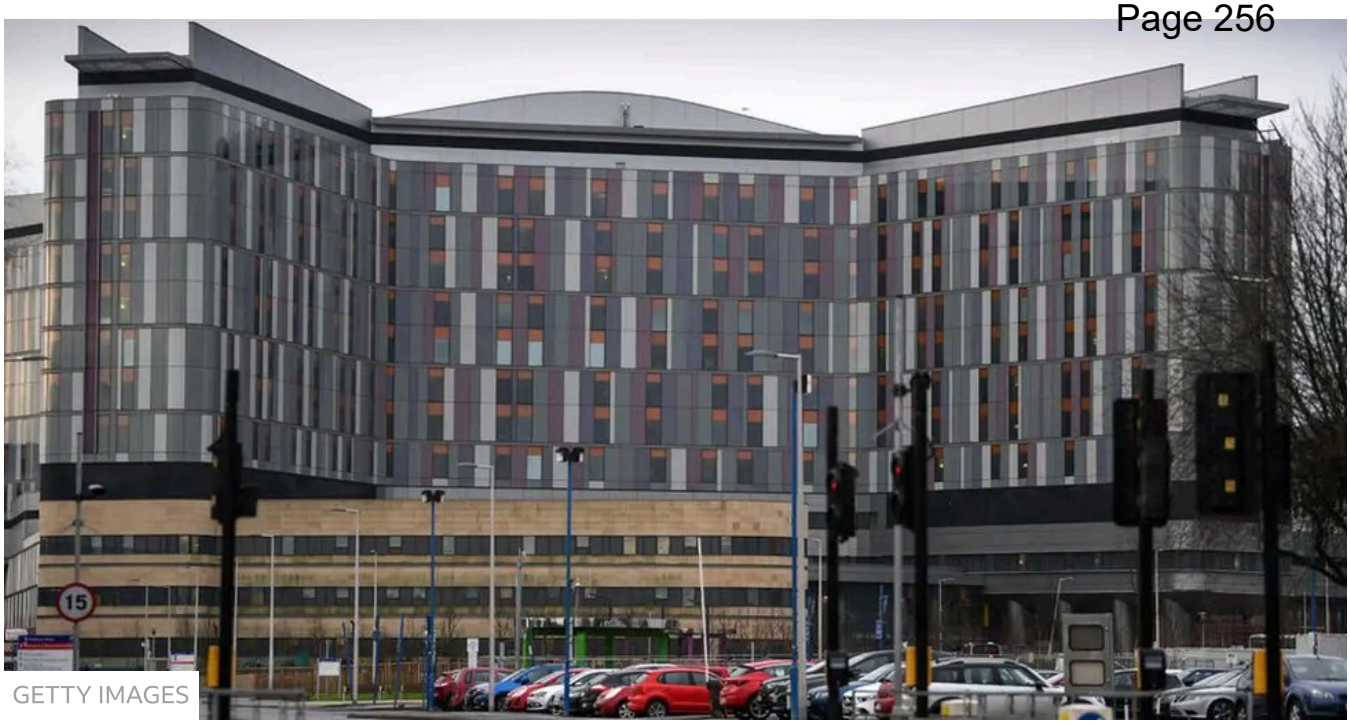
Responding to the reports Ms Grant said that she was "absolutely committed" to working internally and externally and also with the new oversight board the Scottish government has established to rebuild the confidence of the public.

She said: "We have at all times tried to work with patients and families and we recognise there is much to do there.

"The chairman and I have met with families over recent weeks and they have given us their views on areas where we should improve. We are working on now because we recognise it is absolutely critical parents and their families are supported properly.

"It is difficult for parents in this circumstance and we regret and are sorry for the distress and concern that has been added to a difficult time for families."

Which wards are affected?



GETTY IMAGES

The Queen Elizabeth University Hospital campus was opened to patients in 2015

September 2018: A spike in infections led to interventions over water contamination and the closure of wards 2A and 2B in the Royal Hospital for Children. NHSGGC said extensive work was carried out on the taps in the wards. Six new cases were reported and an incident management team was appointed. Children were moved to wards 6A and 4B of the adjoining adult hospital, the QEUH.

February 2019: An investigation into the water supply at the QEUH found "widespread contamination". A report by Health Protection Scotland said contamination was found in taps and drains at both hospitals.

4 August 2019: Ward 6A was closed to new admissions at the QEUH after three young patients contracted infections. Work started on its water supply and air quality systems. NHSGGC said there was "nothing to link the infections" to practices or the environment of the QEUH ward.

November 2019: Ward 6A reopens where child cancer patients are now being treated.

It comes a day after parents of children being treated at the QEUH said they had "no confidence" in NHS Greater Glasgow and Clyde.

A group of 15 parents met at the constituency office of Glasgow MSP Anas Sarwar who has been highlighting concerns at Holyrood over the hospital.

Charmaine Lacock, acting as spokeswoman for the parents, said on Sunday that Ms Grant should be suspended until there was a clearer picture.

She said: "If you don't give parents honest answers, how do you expect them to trust you?

"The parents fear that with her there, with the health board in place, an ongoing investigation will just be another cover-up, another whitewash.



On Thursday, **a leaked inspection report into Glasgow's Queen Elizabeth University Hospital (QEUH)** revealed "high risks" had been identified in 2015, soon after the hospital opened.

Kimberly Darroch, the mother of [redacted], who developed a fatal infection while recovering from leukaemia treatment, **said her daughter would be still alive** had those concerns about water contamination risks been addressed in time.

NHSGGC was placed into special measures by Health Secretary Jeane Freeman on 22 November, just days after an independent review into the hospital was ordered. An oversight board is being chaired by chief nursing officer Prof Fiona McQueen.

'Immediate steps'

Jane Grant said that infection control levels had returned to a normal level.

She said: "Since the move to Ward 6A and 4B in September 2018, infection rates have been similar to other Scottish paediatric units.

"We have fully tested the water supply and ward surfaces in Ward 6A and also reviewed individual infections and found no links between individual infections and no source of infections in the ward.

"Families should be reassured that infection rates at present are within expected levels and the hospital is safe."



NHSGGC

NHSGGC chief executive Jane Grant has insisted the Queen Elizabeth University Hospital is safe

She also said that the technical reports on the quality of the water supplies at the QEUH Campus mentioned by Mr Sarwar in the Scottish Parliament were not brought to the hospital's senior leadership team's attention until 2018.

She said: "Issues with the water were first raised with us in 2018 and immediately, a proper infection management process was put in place.

"A number of hypotheses were suggested in the beginning, They were all worked through in the normal routine infection control process. As soon as we were made aware of those things, action was taken."

She added: "I have inherited a set of difficult circumstances, a set of circumstances which have clearly gone back a number of years. The public inquiry will focus on how that occurred and we will work with them. Going forward we are committed to delivering high quality services."

'Cover-up'

Glasgow MSP Anas Sarwar, who has called for the current health board leadership to be removed, said the chief executive was "ultimately responsible for the rotten culture of fear and intimidation at this hospital".

He said: "It should never have taken brave whistleblowers to come forward for this scandal to emerge. Without them, parents would still be in the dark.

"While senior managers remain in place there is a risk the investigation will be compromised, which is why they should be moved aside - as would surely have happened in a criminal investigation if this was in the private sector.

"With another tragic death at the hospital reported in recent days, parents, patients and the public deserve urgent answers about what has gone so catastrophically wrong at the QEUH."

He also called for the health secretary to give an urgent update at Holyrood on Tuesday.

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2 December 2019



Parents demand answers over troubled hospital

30 November 2019



[redacted]would be here' had hospital followed advice

29 November 2019



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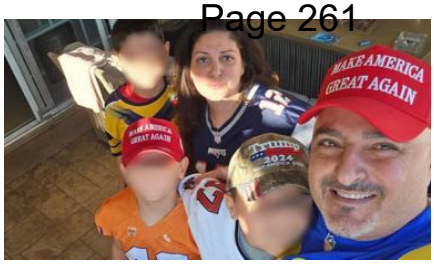
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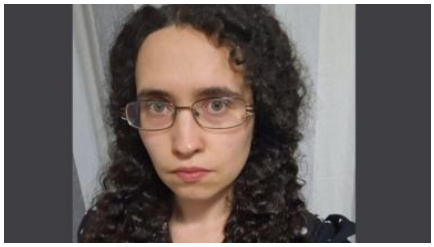
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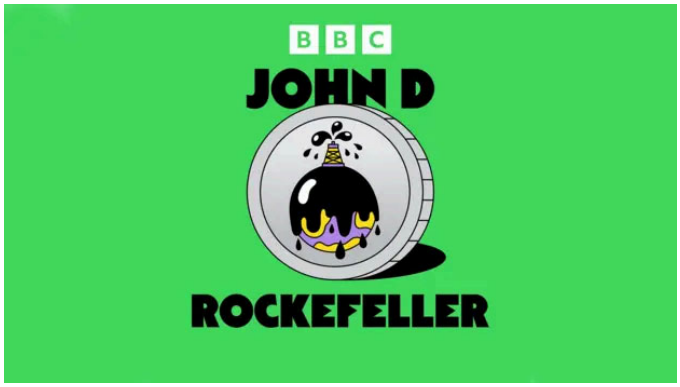
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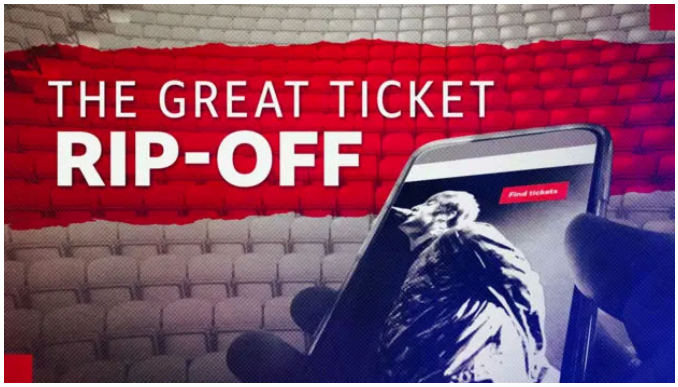
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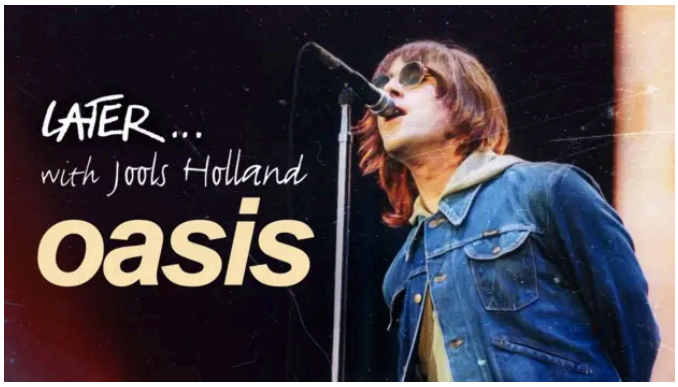
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Transcript of video clip in "Glasgow health chief reassures parents over hospital infection fears" - 01 December 2019 < www.bbc.co.uk/news/uk-scotland-glasgow-west-50621401> accessed 09 July 2025

We have at all times tried to work with patients and families. We recognise that there is much to do there. We have met, the chairman and I have met with a number of families in recent weeks and they have given us their views on areas where we should improve and we're working on that just now. Because we do recognise it is absolutely critical that parents and their families, patients and their families are supported properly. It is difficult for parents in this circumstance and what I would say is we regret and are sorry for the distress and concern that has been added at the difficult time for families. Well undoubtedly we, I have inherited a set of difficult circumstances and what I would say is I am absolutely committed to working internally and externally and with the new Oversight Board that the Scottish Government has established to ensure that everything possible both from our internal sources but also, as importantly, externally and with families to ensure that we rebuild the confidence of the public.

NewsBank inc.

December 3, 2019 | Times, The/Sunday Times, The: Web Edition Articles (London, England) | Charlie Parker

The head of Glasgow's health board who is being called on to resign has blamed **previous leadership** at the city's Queen Elizabeth University **Hospital for** its handling of water supply safety.

Jane Grant, **chief** executive of NHS Greater Glasgow & Clyde, has said she was made aware of reports highlighting a high risk of **infection** in areas of the **hospital** only last year.

In [redacted], who was [redacted] and recovering from leukaemia, died in the Royal **Hospital for** Children, which is part of the Queen Elizabeth campus, after contracting an **infection** linked to contaminated water.

A report given by a whistleblower to the Labour MSP Anas Sarwar has indicated that the board was warned about potential water contamination before the **hospital** opened in 2015. Two other documents, also handed to Mr Sarwar, suggested that there were still problem t at Queen Elizabeth University **Hospital** (QEUH) in 2017 and last year.

Ms Grant has said she had inherited challenges from the **previous** administration when she took over in April 2017 after moving from NHS Forth Valley. She has been accused by Mr Sarwar of being "complicit in a cover-up" and urged to stand down so that the outbreak can be investigated independently. She said: "I want to assure the families involved at that time that there was no attempt to ignore these reports once they were brought to my attention.

"The technical reports on the quality of the water supplies at the QEUH campus mentioned by Mr Sarwar in the Scottish parliament were not brought to the senior **leadership** team's attention until 2018."

Ms Grant said that once she had been made aware of the reports she had ensured that immediate action was taken to give assurance about the water supply. "I would, therefore, hope the families who have called **for** changes at the top of the organisation can accept that the current**leadership** team have made significant efforts to address the situation," she said.

"This has not been easy given the challenges we inherited from the **previous leadership** team, and we accept communications with the families could have been better, but I remain convinced we have the right people to take the Royal **Hospital for** Children forward so that it fulfils its potential to be one of the leading children's hospitals in the UK."

Ms Grant's predecessor was Robert Calderwood, who retired in January 2017 after eight years in charge. He said last night that there had been no significant changes in the health board's senior **leadership** since 2015 other than Ms Grant's appointment. He said: "[The reports] certainly did fall under the time I was **chief** executive. I haven't seen any of the reports. But there's been no change of the management of **infection** control of late."

He said that if the **hospital** had ordered an external report it would have been received by the people who commissioned it. "And you would expect action to be taken if it did indeed highlight any deficiency," he said.

Last night Mr Sarwar said of Ms Grant: "She's decided to speak out publicly **for** the first time in some three weeks if not longer. This is all an attempt, I believe, to save her job. What we don't need now is a **chief** executive worried about saving their job."

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Health chiefs 'ignored the - Herald, The: Web Edition Articles (Glasgow, Scotland) - December 8, 2019 - page 1
December 8, 2019 | Herald, The: Web Edition Articles (Glasgow, Scotland) | Hannah Rodger

HEALTH chiefs ignored legal guidelines by failing to report the death of a [redacted] linked to contaminated water to the Crown Office.

NHS Greater Glasgow and Clyde (NHSGGC) has still not contacted the procurator fiscal to report [redacted] death, despite details emerging about the tragedy's alleged links to an infection from dirty water at the Royal Hospital for Children (RHC).

[redacted] died on [redacted], 2017, having contracted Stenotrophomonas in her line used to administer medicines.

A whistleblower said the bacteria had been in water at the RHC, and a report from 2018 said the same bacteria was associated with more than a dozen water-related infections in children.

Her family were not told at the time that the bacterial infection was linked to contaminated water at the hospital, or that it was a cause of her death.

They only discovered later by looking at [redacted] death certificate, following the series of infection scandals which have emerged about the RHC and Queen Elizabeth University Hospital (QEUH).

[redacted] mother Kimberley Darroch said she was "very surprised" that her daughter's death had not been reported to prosecutors after being informed by The Herald on Sunday.

She said: "Nobody explained to us the possible cause of [redacted] death at the time.

"It has been incredibly hard reliving the pain of [redacted] death in recent weeks, but we are very grateful to the whistleblowers and others who have come forward and would like to thank everyone for their support.

"I believe [redacted] would still be alive today if hospital managers had listened to all the warnings of infection risk when the building first opened.

"As a family we will consider all options so that we can get answers about [redacted] death, and so that no family has to go through this ordeal again. We can't wait for a public inquiry.

"I have no faith in this health board and its leadership. We will only have a truly independent inquiry if they are moved aside."

According to the prosecutor's protocols, any death should be reported by medics in charge of the patient if it raises issues of public safety.

A report by clinicians in 2017, detailed by a newspaper two weeks ago, revealed that there were 26 cases of infections potentially linked to contaminated water on the same ward as where [redacted] was being treated.

Crucially, guidelines clearly state that "where, at any time, a death certificate has been issued and a complaint is later received ... which suggests that an act or omission by medical staff caused or contributed to the death" that death should be reported to the procurator fiscal.

A death can also be reported when "the circumstances might indicate fault or neglect on the part of medical staff or where medical staff have concerns regarding the circumstances of death".

Other health boards' own policy documents state that any death where the person had a hospital-acquired infection must be reported.

Sources working at the QEUH said they were aware that [redacted] death had not been reported, but say that "it categorically should have been".

One senior figure said: "Another boy who passed away ... his death was reported, and he was on the same ward. I do not understand why [redacted] death wasn't. It continues to look as if the board covered this up.

"The family wouldn't have complained at the time as they didn't even know that their child's death was linked to the water. They weren't told."

Anas Sarwar, the Glasgow Labour MSP, has been working with Ms Darroch on her case.

He said: "If the procurator fiscal wasn't informed at the time of [redacted] death, that raises serious fresh questions.

"Health board chiefs kept [redacted] parents in the dark, and that is totally unforgivable.

"It took a brave whistleblower to come forward to reveal what happened, and if health board managers had their way then this would still be covered up.

"I will stand by [redacted] family with whatever decision they take – they deserve answers and they deserve justice, as does every family affected."

His colleague Monica Lennon, Labour's health spokeswoman, said that NHSGGC had been "too secretive" about infections at the site.

She said: "Scottish Labour contacted the Crown Office and Procurator Fiscal Service earlier this year with questions about hospital-acquired deaths, because of our concerns over transparency at NHS Greater Glasgow and Clyde.

"The health board has been too secretive about infections and unexpected deaths at the hospital but the law is very clear on what should be reported.

"Unfortunately, families and patients no longer trust what the health board is saying, and grieving families have been treated appallingly.

"It beggars belief that the leadership team hasn't been moved aside. The Health Secretary has been too soft for too long and the public fears an infections cover-up at the QEUH.

"We need a categoric assurance

from Jeane Freeman that NHSGCC and all health boards in Scotland are complying with the law.

"There can be no exceptions. All health boards should be following the correct reporting procedures in relation to hospital deaths."

NHS Greater Glasgow and Clyde said that they followed protocols and a spokeswoman added: "The procurator fiscal sets out clear advice to medical practitioners on the circumstances when a death should be reported and these were followed in this case.

"In doing so, we took into account that the family had no concerns or complaints about the treatment or care provided to [redacted] at the time."

The spokeswoman added: "The death of any child is a tragedy and we continue to offer our sympathies to [redacted] family for their loss.

"We have written to [redacted] mother this week to answer a number of her questions.

"We have also updated her on the significant amount of work under way to review [redacted] case."

Jane Grant, chief executive of NHSGGC, has been facing calls to resign over the scandals at the £842 million superhospital campus and subsequent lack of communication with the public and families involved.

Last week, she said that it "had not been easy given the challenges we inherited from the previous leadership team" – a claim which her predecessor Bob Calderwood dismissed, saying the majority of top staff at the health board had remained unchanged.

Grant said: "I am truly sorry for the distress and pain being caused to [redacted] family by the uncertainty that has surrounded questions about the water supply and whether it was the source of [redacted] infection.

"[redacted] family deserves answers. We owe it them to thoroughly and fully re-examine the investigations that took place.

"We want to do anything we can to answer her questions. We have written to her this week and remain keen to meet Ms Darroch to discuss these results in more detail with her."

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From: Baxter M (Mike) (Health)
To: DG Health; Matheson J (John); Sheriff C (Carmel)
Subject: FW: Project Update
Date: 29 May 2009 13:54:00
Attachments: PRG 19-5 New South Glasgow Hospitals - PRG paper May 2009 final (2).DOC

Dear colleague

Please find attached an update on progress with the New southern Hospitals Project in Glasgow for your information.

Mike Baxter
Deputy Director (Capital Planning and Asset Management)
Scottish Government Health Directorates
[redacted]

From: Frew, Shiona [redacted]
Sent: 28 May 2009 16:35
To: Baxter M (Mike) (Health); Kinnear N (Norman)
Cc: Walker L (Leigh)
Subject: Project Update

Hi Mike/Norman

I have been asked to send you the attached paper as Alan's 3 monthly report to yourself. This paper was presented to the Board's Performance Review Group on the 19th May 2009.

Regards

Shiona

Shiona Frew
PA to Project Director
New South Glasgow Hospitals Project
St Andrew's House
80 Queen Elizabeth Avenue
Hillington
Glasgow
G52 4NQ
[redacted]

****

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From: Kinnear N (Norman)
Sent: 09 June 2009 15:25
To: Cabinet Secretary for Health and Wellbeing
Cc: Cabinet Secretary for Finance and Sustainable Growth; Minister for Public Health and Sport; Minister for Housing and Communities; DGHealth [redacted] Dolan N (Noel); Matheson J (John); Stafford A (Alyson); Brown AM (Alistair); Baxter M (Mike) (Health); Sheriff C (Carmel)
Subject: Glasgow briefing for Cabinet Secretary

Follow Up Flag: Follow up
Flag Status: Flagged

I attach a minute from Mike Baxter.



Glasgow briefing for Cabinet S...

Cabinet Secretary for Health and Wellbeing

NHS GREATER GLASGOW AND CLYDE – NEW SOUTH GLASGOW HOSPITALS AND LABORATORY PROJECT – UPDATE ON PROGRESS

Purpose

1. To provide the Cabinet Secretary with an update on progress with the project.

Priority

2. Routine.

Current position

3. The project has successfully undertaken the Gateway Review 2 process and has initiated the procurement for the construction of the new adult and children's hospitals and laboratory facility on the Southern General Hospital Site. This paper sets out the work undertaken since then, the current status and the next steps.

4. A design team was appointed in March 2009 for the laboratory facility which will be constructed as an advanced works contract to the main hospital contract. The Design team will complete the detailed design to enable a firm tender to be submitted in September 2009.

5. The Board issued a Pre Qualification Questionnaire (PQQ) which was published on 10th February 2009. The PQQ assesses the economic and financial standing and technical ability of organisations wishing to express an interest in bidding. At the same time, the Board also issued a Memorandum of Information (MOI) providing further information about the Board's Acute Services Strategy and the Project.

6. The Board received five expressions of interest and has undertaken an evaluation of each according to pre-defined criteria, to determine their:

    - Technical Ability (in terms of experience, working practices and structure);
    - Capacity (in terms of expertise and availability) and
    - Financial and Economic standing.

7. The evaluation panel was made up of Board personnel and Technical, Legal and Financial Advisers. The evaluation process was overseen by the Board's Head of Procurement.

8. The evaluation panel recommended, and a joint meeting of the New South Glasgow Executive Board and the Procurement & Finance Group approved, that the following parties be shortlisted to proceed to the Invitation to Participate in Dialogue (ITPD) stage:

    - Balfour Beatty Group Limited;
    - Brookfield Europe LP;
    - Laing O'Rourke Construction Limited;

9. The tender documentation i.e. the Invitation To Participate in Dialogue (ITPD) is critical to ensure the Board achieves its objectives to deliver the new Hospital Development. As such the New South Glasgow Executive Board requested that a peer review of the documentation and the competitive dialogue process with the Bidders be undertaken. A local company, Atkins, which has a high level of experience providing professional technical advice in this field to their clients, was commissioned to do this.

10. Atkins remit was to carry out a high level review to test the readiness to proceed to issue the ITPD by reviewing:

    - The structure and completeness of the ITPD document;
    - The documents are suitable for Bidders to allow Bidders to respond;
    - That there is auditability; and
    - That the evaluation process demonstrates VFM.

11. Atkins made a number of recommendations which have now been completed by the Project Team. The Invitation to Participate in Dialogue (ITPD) documentation has now been issued

Governance

12. The Gateway Review 2 report recommended that the Project Board should consider a more integrated project structure. In considering how best to take this forward, it has been agreed that the new South Glasgow Hospitals and Laboratory Project Executive Board and the Procurement and Finance Group should merge to become one group – the new South Glasgow Hospitals and Laboratory Project Executive Board. SGHD will be represented by Mike Baxter, Assistant Director of Health Finance. James Stewart, Chief Executive of Partnerships UK is also a member.

Next steps

13. The next stage of the procurement process is to carryout the competitive dialogue meetings with each of the bidders. There are four work-streams to be taken forward and these are:

- Design;
- Logistics;
- Laboratories;
- Commercial.

14. After the Competitive Dialogue has been completed the bidders will compile and submit their tender response on the 11th September 2009. During a six week period up to the 23rd October 2009 the tenders will be evaluated and a recommendation from the evaluation panel submitted to the Performance Review Group on 3rd November. The recommendation will ask Board members to consider and approve the following:

    - The Laboratories Full Business Case (as this is an Advanced-works contract);
    - The detailed design development for the new Hospitals;
    - The contract agreement to build the new Hospitals.

15. If the PRG/Board approves the above, then the Full Business Case for the Laboratories will require to be submitted to the Scottish Government Capital Investment Group (SGCIG) for approval as it will be over the Board's delegated limit of £10m.

Recommendation

16. The Cabinet Secretary is asked to note the current position.

Mike Baxter
Deputy Director
Capital Planning and Asset Management
[redacted]
9th June, 2009

Copy List:	For Action	For Comments	For Information		
			Portfolio Interest	Constit Interest	General Awareness
Cabinet Secretary for Finance and Sustainable Growth			x		
Minister for Public Health and Sport					x
Minister for Housing and Communities					x
DG for Health & Wellbeing DG Finance Noel Dolan John Matheson Alyson Stafford Alistair Brown Norman Kinnear Carmel Sherrif					

CAPITAL INVESTMENT GROUP MEETING, TUESDAY 9TH NOVEMBER 2010 AT 9.30AM, CONFERENCE ROOM A & B, ST ANDREW'S HOUSE

AGENDA

1. Apologies

2. Minutes from 28th September 2010 meeting

3. Action Points from 28th September 2010 meeting **Paper 28/10**

4. Business Case timetable **Paper 29/10**

5. Gateway Review Update – Health Sector **Paper 30/10**

6. NHS Fife **Paper 31/10**
   - The Redevelopment of Glenwood Health Centre – Outline Business Case

7. NHS Tayside **Paper 32/10**
   - Mental Health Project – Full Business Case Addendum

8. NHS Greater Glasgow and Clyde **Paper 33/10**
   - New South Glasgow Hospitals – Full Business Case

9. Any other Business

Board: ***NHS Greater Glasgow and Clyde***

Project: **New South Glasgow Hospitals Project**

Status: **Full Business Case**

Value: **£842m capital; £23.3m revenue offset by service and site savings of £43.6m resulting in Recurring Net Cost Savings after Depreciation on Enabling Costs of £18.251m**

Background: -

The purpose of this Full Business Case is to present the proposals for a new children's hospital and new adults' hospital (The New South Glasgow Hospital) on the site of the current Southern General Hospital and to confirm the proposals set out in the document are fully in line with the phased construction contract signed between NHS Greater Glasgow and Clyde and Brookfield Construction UK Limited in December 2009.

The proposals represent the largest investment in health services undertaken in Scotland and will transform the experience of healthcare for patients and staff alike with Glasgow becoming the home to one of the largest, most advanced NHS developments in the UK.

The proposals for a new adult and children's hospitals, new laboratory, facilities management (FM) and new 33KV electrical sub-station were previously presented to the Scottish Government in an Outline Business Case (OBC) which was approved in May 2008.

The need for change :-

In 2002 Greater Glasgow Health Board described the case for change, which identified that the status quo was not an option, as there were significant challenges to the sustainability of the configuration of services across Glasgow and to the ability to improve patient pathways and create more efficient and effective care pathways. All of the factors identified in 2002 remain relevant today with additional challenges and pressures resulting in even greater need to reduce hospital sites and duplication of services.

The Acute Services Review (ASR) identified a programme of change last 8 years following approval of the proposals by the then, Minister for Health to address NHS

GG&C's business needs and this has been implemented over the and Community Care in 2002.

The ASR programme sees the reduction in the number of adult inpatient sites from the current six hospital sites to three. Two sites, Glasgow Royal Infirmary and the new South Glasgow hospitals, will have A&E and trauma facilities. The third inpatient hospital for Glasgow will be Gartnavel General Hospital. These acute sites will be supported by the two new build Ambulatory Care Hospitals.

NHS GG&C is currently carrying out an accelerated ASR with the redesign of services for the north and east of the city to transfer inpatient services from Stobhill Hospital to Glasgow Royal Infirmary in 2011; the recent rationalisation of urology services to 2 sites and the centralisation of vascular surgery and renal services to the Western Infirmary by the end of 2010 - in preparation for achieving a single site model within the New South Glasgow Hospitals. The proposals for the new South Glasgow Hospitals on the Southern GeneralHospital campus form the second phase of this Acute Strategy and are pivotal in achieving the transformation of services provided by NHS GG&C into a modern, fit for purpose 21st century healthcare system.

On completion in 2015, NHS GG&C will be able to enact the following:

- inpatient services in the Victoria Infirmary to transfer to the new South Glasgow Hospitals
- inpatient services at the Mansion House Unit (MHU) to transfer to the new South Glasgow Hospitals allowing closure of the MHU
- inpatient services housed in outdated buildings on the Southern General Hospital and Western Infirmary sites to be relocated to the new South Glasgow Hospitals .
- transfer of A&E services and associated beds from the Victoria Infirmary,
- the Western Infirmary and the Southern General Hospital to the new South Glasgow Hospitals

Following these transfers closure can take place of the Western & Victoria Infirmary sites and of older parts of the Southern General Hospital. This means that by 2015 the plans for the 3 site inpatient configuration of adult services in Glasgow will be achieved.

Options: -

The summary of the short listed options are illustrated in the table below. -

Option	Description
Greenfield Option	A new build whole site solution for all facilities currently provided Acute and Children's Hospitals, plus related facilities. Land for a at the Southern General site, together with new Adult Greenfield site would be required under this option.
Option 1	This option represents an entire new build solution on the current Southern General site for the Adult Acute and Children's Hospitals, plus new build Laboratories, and other related services.
Option 1A	A new build provision on the Southern General site for the Adult Acute and Children's Hospitals, plus the refurbishment of some existing facilities on the Southern General site to provide Laboratories and other related services. This option allows for the retention of Neurosciences, Maternity, the Spinal Unit and the Langlands buildings currently on site.

Option 1A remains the preferred option

Capital Costs & Revenue Consequences: -

The total capital cost of the new hospitals is £842m. The recurring revenue costs for the project are £23.3m offset by service and site savings of £43.6m resulting in Recurring Net Cost Savings after Depreciation on Enabling Costs of £18.251m.

The capital and revenue requirements of the project have been fully reviewed in order to confirm that the preferred solution continues to be affordable in both capital and revenue This review concluded that the capital costs, including provision for Value terms. Added Tax at the increased rate of 20% from January 2011, remains affordable. In addition, by proceeding with the project, the Board will achieve net overall recurring savings in excess of £18.2m through enhanced efficiencies. Consequently the construction of the New Adult and Children's Hospitals is deemed to be affordable in both capital and revenue terms.

Timescale

Estimated key milestones for the project have been identified as follows:

Event	Milestone
Stage 2 completion, Full Business Case (FBC) approval by Health Board	26 October 2010
FBC considered by Scottish Government Capital Investment group	November 2010
Stage 3 (Construction of adult and children's hospital programmed to commence	November 2010
Stage 1 Completion (Construction) - laboratory facilities	March 2012
Stage 3 Completion (Construction) – adult and children's hospital	January 2015
Operational Date – adult and children's hospital complete service transfers.	**Summer 2015**
Stage 3a completion, demolition of surgical block and completion of landscaping	Summer 2016

Additional information

The Business Case is presented for discussion only as there are outstanding issues still to be resolved.

Recommendations

It is recommended that the FBC be considered via expedited procedures when outstanding issues have been resolved.

Mike Baxter
Deputy Director
Capital Planning and Asset Management Division
November 2010

From: Kinnear N (Norman)
Sent: 09 December 2010 15:16
To: Minister for Public Health and Sport
Cc: Cabinet Secretary for Health and Wellbeing; Cabinet Secretary for Finance and Sustainable Growth; DG Health; DG Finance and Corporate Services; Matheson J (John); Stafford A (Alyson); Baxter M (Mike) (Health); McLaughlin C (Christine); Sheriff C (Carmel); Dolan N (Noel); Communications Health and Wellbeing; Communications Finance and Sustainable Growth; MacKay MJ (Marion)
Subject: New South Glasgow submission (2).doc

Importance: High
Sensitivity: Confidential

Follow Up Flag: Follow up
Flag Status: Flagged

I attach a submission for the Minister.

Norman Kinnear

Major Capital Projects Advisor
Scottish Government
Health Finance Directorate
Capital Planning and Asset Management
Basement Rear
St Andrew's House
Regent Road
Edinburgh

[redacted]

norman.kinnear[redacted] (email)
www.pfcu.scot.nhs.uk (website)

New South Glasgow submis...

From: Norman Kinnear
Health Finance – Capital Planning &
Asset Management
9 December 2010

Minister for Public Health

NEW SOUTH GLASGOW HOSPITALS PROJECT

Purpose

1. As this is a constituency matter for the Cabinet Secretary for Health and Wellbeing this paper seeks approval of the Capital Investment Group's approval of the NHS Greater Glasgow & Clyde Health Board's Full Business Case which will enable the issue of a letter from Derek Feeley, Acting Director-General Health – Chief Executive, NHS Scotland and full implementation of the projects construction.

Priority

2. Urgent

Background

3. On 8 April 2008, Cabinet gave its approval to the Outline Business case for an integrated Children's and Adult Hospital and a new laboratory on the site of the current Southern General Hospital, Glasgow and that the NHS Board proceed to procurement. It also agreed the provision of capital resources. For ease of reference the paper approved is attached at Annex A. The Health Board continued with its development work and procurement and submitted a Full Business case for consideration by the Capital Investment Group on 9 November 2010. As a number of queries were outstanding at that time further consideration was addressed using expedited procedures. The paper considered by CIG on 9 November is attached at Annex B. This process was brought to a satisfactory conclusion on 2 December 2010. The project was recently given priority for capital funding despite the change in allocation to the Scottish Government hence the project is affordable.

4. Attached at Annex C is a draft of the letter from Derek Feeley to Robert Calderwood, Chief Executive.

Recommendation

5. Agreement of the decision to approve the Full Business Case and of the draft letter to be issued.

Norman Kinnear
Health Finance – Capital Planning & Asset Management
[redacted] 9 December 2010

Copy List:	For Action	For Comments	For Information		
			Portfolio Interest	Constit Interest	General Awareness
Cabinet Secretary Health and Wellbeing Cabinet Secretary Finance & Sustainable Growth			X X	X	

DG Health
DG Finance & Sustainable Growth
Allyson Stafford
John Matheson
Mike Baxter
Christine McLaughlin
Carmel Sheriff
Ian Waugh
Noel Dolan
Communications Health
Marion Mackay
Communications Finance & Sustainable Growth

ANNEX A

FOR DECISION **Paper number:**

SCOTTISH CABINET

NEW SOUTHERN AND CHILDREN'S HOSPITAL PROJECT, GLASGOW

PAPER BY THE MINISTER FOR PUBLIC HEALTH

Purpose

1. This paper invites Cabinet:
- to agree to the approval of the Outline Business Case for an integrated Children's and Adult Hospital and a new laboratory on the site of the current Southern General Hospital, Glasgow and that the NHS Board proceed to procurement; and
- to agree to the provision of required additional capital resources totalling £108m over 6 years; and
- to note the presentational arrangements.

Timing

2. This paper is provisionally scheduled to be discussed at Cabinet on 8 April. A decision is required now to approve the Outline Business Case and enable the Project to proceed to procurement. Key stakeholders are aware that this matter is being considered by the Government and are anxious to know, following consideration by the NHS Board on 19th February, whether the Government is to support the project going forward. In financial terms, given the projected total capital cost of £842m, a delay of a month in delivery equates to an additional cost of £5-6m simply through construction inflation.

Background – Factual Information and Analysis

3. NHS Greater Glasgow and Clyde had their Acute and Related Services Review approved in 2002 by the then Minister for Health and Community Care. Since that time the NHS Board have been progressing plans to reconfigure the nature of services. The first phase involved three major capital developments. These were the new West of Scotland Cancer Centre at Gartnaval Hospital which opened in 2007 and the two new Ambulatory Care Hospitals at Stobhill and Victoria which are currently in construction and due to open in summer/ autumn 2009 respectively.

4. The New Southern Hospitals project being considered is pivotal to the delivery of the overall strategy and will completely redevelop the Southern General

Hospital and also provide a new state of the art Children's Hospital for the West of Scotland.

5. **At a capital cost of £842m, the New Southern Hospitals Project represents the biggest building project in the history of NHSScotland**. **It is vital that the development is deliverable, affordable, sustainable and represents best value for money for the taxpayer.**

Advice to Ministers

6. Following identification of the preferred service option (consistent with the Service strategy agreed in 2002 and subsequent recommendations of the Calder Group on Children's and Maternity Services) through an option appraisal process the options for delivering the project have been appraised.

7. A rigorous value for money and affordability analysis was conducted comparing a public capital option against a Non Profit Distributing (NPD) PPP model. The results of this analysis showed a negligible margin between the two routes and therefore, in value for money terms, either funding route could be justified.

8. In affordability terms however, given the impact of resource accounting and budgeting, the impact of the two routes is markedly different with the additional revenue costs of the public capital option £53.8m per annum against the impact of £76m per annum for the NPD route. In other words use of the NPD route would require an additional £22m of service savings to be achieved with no additional value for money benefit.

9. A publicly funded capital route offers the potential to deliver an affordable solution within the context of the Board's financial plan for the 10 year period to 2017/18. The funding implications of this are considered at paragraphs 13 – 19 below.

10. In delivering the project the Scottish Government will wish to be assured that NHS Greater Glasgow and Clyde are managing the risks associated with the project and that the project is delivered on time and on budget. The Board are currently assessing the options for a detailed procurement strategy. It has already been recognised that there is a need to embed the disciplines associated with a PPP procurement on delivery whilst using a public capital funding solution.

11. As part of both the Gateway Review process and the Health Directorate's Capital Investment Group consideration it is recognised that there is a clear need for external challenge within the governance arrangements for the project. It is proposed to make such external representation on the Project Board a condition of approval for the project.

Legal Considerations

12. The proposals in this paper raise no legal implications.

Financial Implications

13. The project has an implication for the overall capital requirement for the Health and Wellbeing portfolio over the period 2011-12 to 2013-14. The project is being developed and delivered on a revenue neutral basis. The phasing of expenditure and the relevant contributions is shown in the Table 1 below:

Table 1 Phasing and Funding Requirements for New Southern Hospitals Project (£m's)

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	TOTAL
NHS GG&C capital and receipts	10	40	50	55	48	48	19	**270**
Endowments			10	10				**20**
Scottish Government	18	101	176	170	95	11	(19)	**552**
TOTAL	**28**	**141**	**236**	**235**	**143**	**59**	**-**	**842**

14. Of the total requirement of £842m NHS Greater Glasgow and Clyde have identified £135m from within their own formula based capital resources and £135m generated through capital receipts. A further £20m will also be provided through local endowment funding. The balance of funding required is therefore £552m The previous Administration had already committed £130m towards the cost of the New Children's Hospital leaving a net additional funding requirement of £422m.

15. The required capital contributions from Scottish Government and NHS Greater Glasgow and Clyde to cover the initial planning and first stages of construction in 2009-10 and 2010-11 are contained within the agreed SR07 Health and Wellbeing capital baseline. The bulk of the capital spend as shown above falls in the following spending review period from 2011-12 to 2013-14. To assess the impact of this project on the Health and Wellbeing capital budget, the 2010-11 Health Net Capital Budget of £597.7m has been used as a baseline.

16. Factoring in the level of Scottish Government support required (shown in Table 1) together with existing commitments to NHS Lanarkshire (£100m), NHS Ayrshire and Arran (£30m), projected funding requirements for the main phases of the redevelopment of Aberdeen Royal Infirmary and Dumfries and

Galloway Royal Infirmary the total capital requirement for Health over the 2011-12 to 2013-14 period is £730m/ £745m/£670m.

17. This is an additional £351m over the 2010-11 baseline for a three year period. To offset this additional requirement in the SR10 period it is proposed to reduce the Health capital requirement in the SR13 period to £550m/£500m/£501m. This is equivalent to a reduction of £243m on a recurrent baseline of £598m for three years.

18. The net additional capital requirement over 6 years is therefore £108m. Table 2 below demonstrates the overall phasing of required capital resources:

	2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**
Total Health Capital Requirement	£730m	£745m	£670m	£550m	£500m	£501m
Difference from 2010-11 Capital Baseline (£598m)	+£132m	+£147m	+£72m	-£48m	-£98m	-£97m

19. In testing the affordability of a new service commitment of this scale, the Board has required to prepare a 10 year forward financial plan which examines the movements in both funding and expenditure which it is likely to face over this time period. In doing so, it has identified and assessed the key areas of risk which could impact on its financial projections, and reviewed its capacity for mitigating these through management action. On the basis of this analysis, the Board is able to conclude that the proposal which is contained within this OBC is affordable.

Parliament

20. It is intended to announce the approval of the Outline Business Case by means of an Inspired PQ. Given the project is within the constituency of the Cabinet Secretary for Health and Wellbeing, the answer will be provided by the Minister for Public Health.

Presentation

21. It is proposed to make the announcement through an Arranged PQ. This will allow greater flexibility regarding the time and date of release. We would propose that this is done early in the chosen week, Monday or Tuesday. A news release will be issued following the publication of the PQ, and the timing of the PQ could coincide with a visit by the Minister/ Ministers to the proposed site.

Publication

22. In accordance with extant guidance a copy of the Outline Business Case will require to be lodged with SPICe within one month of approval. At this stage some financial data will be redacted in order to protect NHS Greater Glasgow and Clyde's commercial position entering procurement. An full version of the OBC will be released following conclusion of negotiations.

Timetable

23. The timetable we shall be working to is set out below.

Description	**Target Date**
Outline Planning Approval	January 2008
Gateway Review	January 2008
Final OBC to NHS Greater Glasgow & Clyde Board	19th February 2008
Final OBC considered by Scottish Government Capital Investment Group	14th March 2008
Submit OBC to Cabinet	8th April 2008
Notification of OBC Approval	By end April 2008
Full Business Case Submission	2nd quarter 2010
Construction Starts	2nd quarter 2010
Completion – Children's Hospital	1st quarter 2013
Completion – Acute Hospital	2nd quarter 2014

Consultation

24. [I have consulted the Cabinet Secretary for Finance and Sustainable Growth, Cabinet Secretary for Justice, Cabinet Secretary for Rural Affairs and Environment and Cabinet Secretary for Education and Lifelong Learning and comments received have now been taken into account in the version of the Plan which accompanies this paper.]

Conclusion

25. Cabinet is invited to:

a. agree to provide the required net additional capital funding of £108m over 6 years to support the project (paragraph 18) ; and

b. agree that approval be given to NHS Greater Glasgow and Clyde to proceed to procurement; and

c. agree the proposals regarding presentation of the decision (paragraph 21).

SR
APRIL 2008

ANNEX A

NHS GREATER GLASGOW AND CLYDE OUTLINE BUSINESS CASE EXTRACT

1. EXECUTIVE SUMMARY

1.1 INTRODUCTION

The purpose of this Outline Business Case (OBC) is to present proposals for the development of an integrated Children's and Adult Hospital and a new laboratory build on the site of the current Southern General Hospital.

The proposals represent the largest investment in health services undertaken in Scotland and form a major part of NHS Greater Glasgow and Clyde's Acute Services Strategy to modernise health services.

This investment will transform the experience of healthcare for patients and staff alike with Glasgow becoming the home to the largest, most advanced single NHS development delivering gold standard hospitals on the Southern campus.

A jewel in the crown of NHS Scotland, the new hospital campus will provide maternity, paediatric and adult acute services together on the one site. This will ensure immediate access to specialist services of all kinds and therefore the highest quality and safety standards for adults, children and babies alike.

The construction of the new hospitals will give opportunity to redesign radically the way in which health services are delivered and reappraise the skills and profile of the workforce tailoring delivery of modern health services in keeping with the 21st century.

The entire campus will have excellent transport links. Plans under discussion may include a Fastlink public transport system from the city to Braehead – which will take staff and visitors to and from all the main entrances within the hospital complex. New car parks will create more spaces bringing the total number of spaces from the current 1400 to around 3500.

As one of the largest single investments in the south of the city the development has the potential to regenerate and breath new life into Govan and the wider area. Liaison is taking place with Scottish Enterprise and a number of other external organisations to establish a New Hospitals Engagement Forum to realise this potential and bring added value to the new hospitals project.

The Health Board has been engaging with the Scottish Government to agree the format and content of the Outline Business Case, the outcome is reflected within this document.

1.2 THE CASE FOR CHANGE

NHS Greater Glasgow & Clyde recognise the need to ensure that patients who require access to hospital care can be seen, fully investigated and treated as quickly as possible within the appropriate facilities. For patients presenting as an emergency there should be access to specialised care of the highest quality, with access to state of the art investigations and treatment facilities on a 24 hour /7days a week basis. For elective care, patients should be seen, investigated and leave the hospital with a diagnosis and treatment plan wherever possible on the first visit. Underpinning this should be effective information and computer systems which allow GPs, Specialists and patient access to all relevant information needed to deliver high quality and effective patient care.

In 2002 Greater Glasgow Health Board described the case for change, which identified that the status quo was not an option, as there was significant challenge to the sustainability of the configuration of services and to the ability to improve patient pathways and create more efficient and effective care pathways. All of the factors identified remain relevant today with additional challenges and pressures resulting in even greater need to reduce hospital sites and duplication of services. In brief the issues are:

- The need to achieve the objectives of the guidance in 'Better Health, Better Care' and other key national policies. These policies drive reductions in waiting times; fast track access to rapid diagnosis and treatment; provision of services designed around the needs of the patient; modernisation of healthcare through better use of technology and improved integration with primary and social care reducing inequalities in health. To achieve these objectives a major programme of investment in buildings, information technology and redesign of services is required.
- Fragmented services, there is a requirement for patients to move within and around sites and different buildings with an inevitable loss of continuity of patient care, important co-locations of services are not possible and difficulties arise in transferring information between services.
- Increasing sub-specialisation in medicine and surgery and an increasing need to move towards larger teams to ensure all patients can access the appropriate Specialist on a 24hours a day and 7 days a week basis.
- Pressures on staff in sustaining appropriate staffing levels, for example Modernising Medical Careers and the European Working Time Directive impact upon the availability of medical staff and therefore on the sustainability of multiple rotas.
- Outdated buildings unsuitable and unfit for modern healthcare offering a poor patient environment with unsuitable facilities for modernising services, restricting capacity and creating bottlenecks and delays in treatment.

1.3 ACUTE SERVICES REVIEW (ASR)

The health services in Glasgow have entered a period of dramatic and exciting change. Following a decade of planning and public consultation, proposals to modernise the acute health services in Glasgow were approved in 2002 by Malcolm Chisholm, Minister for Health and Community Care.

The components of the acute service strategy are as follows:

- A new Beatson West of Scotland Cancer Centre at the Gartnavel General site (2008).

- Two Ambulatory Care and Diagnostic Hospitals on the Stobhill site and on a site adjacent to the Victoria Infirmary site, this will support the future reduction from 6 to 3 adult inpatient sites.
- A reduction in Maternity services from three sites to two, those being the Princess Royal Maternity Hospital at Glasgow Royal site and the redeveloped maternity facility on the new southern campus.
- In North Glasgow, acute in-patient services will be provided from Glasgow Royal Infirmary and Gartnavel General Hospital.
- In South Glasgow, acute in-patient services will be provided from a major new development at the Southern General Hospital.
- Full A&E services will be provided from two sites, located at Glasgow Royal Infirmary and the Southern General Hospital.
- Trauma and Orthopaedic in-patient services will be provided from the two full A&E sites. Orthopaedic out-patient and day case services to be provided from all five adult sites (Gartnavel, Stobhill, GRI, Victoria and Southern General).
- Minor Injury Units will be provided from all five adult sites.

In 2004 the Minister for Health and Community Care announced that the Scottish Government would provide £100 million to enable a new children's hospital to be built on a site which would support the "triple co-location of services". The Royal Hospital for Sick Children is currently co-located with the Queen Mothers Hospital (QMH). The planned closure of the QMH, and the transfer of its activity and services to the Southern and Glasgow Royal sites, will leave the Royal Hospital for Sick Children (RHSC) isolated. Following an option appraisal in 2005, of potential locations for the new children's hospital, the Southern General site was identified as the only location to offer both co-location with maternity and adult services and appropriate vacant land for building. This process was undertaken in collaboration with a Ministerial Advisory Group chaired by Professor Andrew Calder. The report of that Group, published in March 2006, affirmed the selection of the Southern General site as the location for the new children's hospital. This recommendation was accepted by the Minister for Health and Community Care in 2006 following a period of consultation.

A review of laboratory services was carried out to identify the optimal configuration of laboratory services in Glasgow to support the Acute Services Strategy. The preferred option involves: centralising the majority of laboratory services into two main sites at Glasgow Royal and the Southern site; consolidating immunology, tissue typing, stem cell lab work and all other laboratory services associated with leukaemia research and Haemato-oncology onto the Gartnavel site co-location with the West of Scotland Cancer Centre; and finally centralising pathology and genetics services onto a single site near the Southern Campus.

The process to transform acute hospital services across the city is well underway with the opening of the new West of Scotland Cancer Centre in 2007 and construction of two, state of the art, Ambulatory Care Hospitals (ACH) at the Victoria and Stobhill sites. The ACH's will be commissioned over the period late 2007 to summer 2009, which will result in not only significant modernisation of Glasgow's healthcare facilities and creation of single centres of excellence but will also result in 4 of Glasgow's major adult hospital sites operating below capacity.

This document describes the scheme which forms the second phase of the Acute Strategy, this involves the development of the new South Glasgow Hospital campus which not only sees the single biggest phase of modernisation and rationalisation of our adult clinical

services, but incorporates the creation of a new Children's Hospital for the Greater Glasgow and West of Scotland populations and the completion of the modernisation of Glasgow's Maternity Services.

On completion of the development of the new adult hospital in 2014, the Board will be able to enact the following:

- inpatient services in the Victoria Infirmary to transfer to the new development thus vacating the Victoria Infirmary site;
- inpatient services at the Mansion House Unit (MHU) to transfer allowing closure of the MHU;
- inpatient services housed in outdated buildings on the southern site to be relocated;
- transfer of Accident and Emergency services and associated beds at the Western Infirmary enabling closure of the Western Infirmary.

By 2014, following some major refurbishment and new build works within existing estate at Glasgow Royal Infirmary and Gartnavel General Hospital, sufficient capacity will be created, following the opening of the new South Glasgow Hospital, to allow the 3 site inpatient configuration of adult services to be implemented, therefore also allowing the rationalisation of the inpatient services from Stobhill to Glasgow Royal Infirmary by no later than 2014.

Phase 3 of the Acute Services Strategy sees the major redevelopment and modernisation of the Glasgow Royal Infirmary campus and this work will be developed with a view to being brought forward for funding consideration in the period beyond 2015 followed by the final phase, which would see the redevelopment and modernisation of the retained adult inpatient services required on the Gartnavel General Hospital campus undertaken.

1.4 PROPOSED FUTURE SERVICES

1.4.1 Adult and Children's Services

Adult New Build

A 1,109 bedded adult new build acute hospital is planned. This will provide A&E services and acute specialist in-patient care, a small volume of medical day cases and out-patient clinics serving the local population. No day surgery will be undertaken as this will be provided by the New Victoria Hospital.

New Children's Hospital

The proposed new 240 bedded children's hospital will provide A&E services and a comprehensive range of inpatient and day case specialist medical and surgical paediatric services on a local, regional and national basis. The new development will also have outpatient facilities. The Health Board's strategy is that all Glasgow's Children's Services (up to the age of 16 and up to 18 years where appropriate) will be provided at the New Children's Hospital.

The planned number of beds for the adult and children's hospitals are shown below:

Adult Hospital	
Specialty	***Beds***

Children's Hospital	
Specialty	***Beds***

General Medicine (including MHDU)	407
Haematology	14
Dermatology	18
Nephrology (incl surgery)	80
Geriatric Medicine	93
CCU	18
ITU	20
SHDU	23
General Surgery & Vascular	169
Urology	51
Orthopaedic & Ortho Rehab	141
ENT	37
Clyde Beds *	38
Total In-patient Beds	1,109

In-patient (including critical care areas)	193
Short-stay (emergency receiving)	20
Day Care/Day Investigation	27
Total	240

* Clyde Beds
In line with the South of the River Strategy for Clyde, consulted and agreed on during 2006/07, the in-patient bed requirements for the following services have been included within the bed model for the new South Glasgow Adult Hospital – Vascular Surgery, ENT, Dermatology and Haematology.

1.4.2 New Laboratory Build

The proposed New Laboratory build will provide biochemistry, haematology blood transfusion and mortuary services.

5.1.1 1.4.3 Retained Services

The Southern site will retain approximately 630 beds within the Institute of Neurological Services, Maternity, Spinal Injuries and Langlands buildings. The Langlands facility provides older people's services and also services for the young physically disabled.

1.4.4 Future Service Changes

At the time of undertaking the latest bed modelling exercise for the ASR it was recognised that there might be future changes to bed numbers as the result of changes to regional services provision such as neurosciences, oral-maxillofacial services, renal services, gynae-oncology services. With the exception of renal services, which has already been factored into the new South Glasgow Adult Hospital's bed model other potential changes to requirements in relation to beds do not affect the new South Glasgow Adult Hospital's current proposals.

1.5 EXPECTED BENEFITS OF THE PROJECT

It is anticipated that the proposals set out in this business case will deliver a range of benefits for patients. These are as follows:

- Provision of high quality services which are timely, accessible and consistently available by providing local access to core medical and surgical services and consolidating specialist and tertiary services on fewer sites within the city.
- Investment in high tech equipment and Information Technology
- Attention to design and landscaping to improve the patients overall care
- Fully accessible to all and DDA compliant (Disability Discrimination Act.)
- Reduced waiting times for treatment through the provision of more efficient services increasing clinical capacity by investment in Information Technology (IT), the concentration of clinical teams onto fewer sites, optimising departmental and functional relationships and improving access to diagnostic services such as laboratory services.
- Access to highly specialised steams provided by skilled staff facilitated through the centralisation of services.
- Rapid, one stop services through high volume processing of diagnostic tests and an extended working day to fit in with new models of care.
- Protection of elective workload from disruption by emergencies thereby improving the efficiency of the service and reducing the number of cancellations.
- Enhanced staff skills and knowledge through improved retention and recruitment due to a radically better working environment
- Modern, fit for purpose facilities which meet the needs of patients, visitors and staff

- Enhanced University links through co-location of an academic centre with the new hospitals on the Southern General Campus. This will enhance teaching, and research and play a significant role in attracting and retaining high quality staff in all disciplines.

It is also recognised that the proposed new builds on the Southern site could contribute substantially to the local Govan economy and the wider area.

A social economic benefits analysis was carried out by SQW Consultants, funded by NHS Greater Glasgow NHS in partnership with a number of other contributors including Scottish Enterprise and Glasgow City Council.

The analysis looked at the potential impact on the immediate area around the Southern General site, the wider city of Glasgow and the Glasgow Metropolitan City Region. The

analysis identified potential benefits within the following categories: economic, human and social, knowledge (e.g. research and development) and place.

In brief SQW has estimated that the future service configurations on the Southern General site will have a combined direct, indirect and induced economic impact of between £30 and £40 million on the South West Glasgow economy; between £110 and £140 million on the city economy and between £240 and £290 million on Glasgow city region by 2012/13. The new builds will also contribute to opportunities for training and employment and the development has the potential to support collaboration between academic, public and private sector partners to realise opportunities in research and development, bio-medical and life sciences.

In conclusion, the Southern General development is seen as a catalyst for wider social and regeneration activity contributing to the creation of higher aspirations for the physical development of the local area.

1.6 OPTION APPRAISAL – SITE AND DESIGN OF NEW SOUTH GLASGOW AND NEW CHILDREN'S HOSPITALS

1.6.1 Greenfield Option

For purposes of comparison for the Outline Business Case the option of building the new hospitals on a Greenfield site was revisited. This confirmed the outcome of the 2002 review, during which this option was first explored and dismissed because of high cost.

1.6.2 New Southern General Campus Options

Site

In thinking about the optimum site on the Southern General Campus for the New South Glasgow and New Children's Hospitals a key criterion has been the need to physically link the new hospitals to the Maternity and Neurosciences buildings. This will allow ready access to a range of paediatric services for foetus in utero or new born babies and mothers access to critical care and other acute services. An area which lies between the Maternity and Neurosciences buildings has therefore been designated for the construction of the new Hospital to allow these links.

Separate or Integrated Hospital Builds

In comparing options to build the new hospitals separately or together as an integrated build, the latter, an integrated build, was considered to offer more benefits, less risk, increased deliverability and lower cost. A further option appraisal took place involving NHS stakeholder input to identify the optimum design solution for the integrated build. An exemplar design was then developed involving input from a wide range of users.

Supporting/Associated Developments and Works

In addition to the new Adult and Children's Hospitals and Laboratory facility there are series of associated developments and works. For the purposes of the Outline Business case two options around the Southern General site have been developed, these are option 1 with a higher percentage of new build associated developments and option 1a utilising more of the existing estate.

1.6.3 Benefits Appraisal

A benefits appraisal exercise was undertaken looking at the Greenfield site, Option 1 and Option 1a. The benefits criteria were derived from the project objectives. The criteria were

weighted and scored against each of the options. The appraisal of the options produced scores within a very tight band, those options involving an increased percentage of new build producing slightly higher scoring.

1.7 LABORATORY SERVICES

A Glasgow wide review of laboratory services identified centralisation of the majority of laboratory services on the Southern General site and Glasgow Royal site as the optimum configuration to support the Acute Services Strategy.

A new build laboratory facility is planned for the Southern General site housing haematology, biochemistry and mortuary services. The laboratory will be located alongside the new hospitals linked via an underground tunnel.

The new build will support the New Adult and Children's Hospitals and other services south of the city. The planned model for the new laboratory development will be one of high volume processing of tests with use of automation and up-to-date integrated IT systems with extended day and 24/7 working to reflect the new patient care models.

1.8 FINANCIAL ANALYSIS

The capital cost of the proposal to provide New Adult and Children's Hospitals on the Southern General site is forecast to be £841.7m (Option 1a, 100% single rooms).

It is proposed to fund this following a public capital procurement route, combining £270m of capital resources sourced from the Board's general allocation of capital funds and from capital receipts generated from the disposal of sites which become surplus, together with £20m from its endowment funds, leaving £551.7m to be provided by SGHD in the form of a specific allocation of capital funding to the Board. This represents the level of capital funding which the Board requires to deliver the proposal contained within this Outline Business Case, and which is the subject of the Outline Business Case.

The Board has tested alternative procurement routes for delivering the new Adult and Children's Hospitals, assessing each of these in terms of their capacity to deliver Value for Money and Affordability. The outcome of this assessment confirms that there is little to differentiate the alternative procurement routes in terms of their capacity to deliver Value for Money, however a publicly funded capital route offers the potential to deliver an affordable solution within the context of the Board's financial plan for the 10 year period to 2017/18.

In testing the affordability of a new service commitment of this scale, the Board has required to prepare a 10 year forward financial plan which examines the movements in both funding and expenditure which it is likely to face over this time period. In doing so, it has identified and assessed the key areas of risk which could impact on its financial projections, and reviewed its capacity for mitigating these through management action. On the basis of this analysis, the Board is able to conclude that the proposal which is contained within this OBC is affordable.

1.9 ASSOCIATED CAPITAL WORKS

As described, there are a series of smaller capital works and developments associated with the new hospitals, these being: clearance of the build site, development of multi-storey car parks, a clinical support facility and a 22 bedded rehabilitation facility.

The capital cost of these associated works is identified and will be funded from within the Board's Capital Allocation provided through separate business cases. Those projects above

the Board's delegated authority will be subject to Capital Investment Group, Scottish Government approval.

It is proposed that all of the above projects and the new adult and children's hospital will be planned and co-ordinated through a Site Programme Co-ordinating Group, ensuring that all potential risks that may occur in delivering a multi-construction project environment are appropriately managed.

1.10 PLANNING PERMISSION

The Outline Planning Application was submitted to Glasgow City Council on 13th April 2007. The application was considered at the Glasgow Planning Committee meeting held on 16th January 2008 and received approval subject to specific conditions and the Section 75 legal agreements.

1.11 UNIVERSITY – WORKING WITH ACADEMIC PARTNERS

Glasgow University is intending to support the development of the Southern General campus by building an academic centre on the site. This will provide a modern academic facility to support teaching and research. An area of land on the Southern Campus has been identified by the Health Board for this purpose.

A new multidisciplinary Skills and Education Centre is also proposed. Partners in this include the Royal College of Physicians and Surgeons of Glasgow, the University of Glasgow and NHS Education for Scotland. A site adjacent to the new hospitals has been identified as a possible location.

1.12 FACILITIES, TECHNOLOGY, WORKFORCE

The reconfiguration of services across Glasgow will have a major impact upon the workforce and the requirements for information technology and facilities.

The Health Board's intention is to provide all hard and soft FM services from within NHS Greater Glasgow and Clyde's facilities pool and to explore the most effective methods of service delivery through benchmarking to achieve value for money and efficiency for these services. The FM services for the PFI Langlands Building in the south of the southern campus will remain with the present contractor and will not form part of this exercise.

There is a need to invest in significant Information Technology (IT) infrastructure with appropriate functionality to support the reconfiguration of services and emerging models of care, which will be crucial to the successful implementation of modern efficient healthcare systems.

As the largest NHS employer in Scotland, NHS Greater Glasgow and Clyde will continue to undertake effective workforce planning linked to issues of service delivery and redesign. This will allow any future workforce gaps to be identified as well as to set in motion a range of solution based action plans.

The proposal to develop the South Glasgow Hospital site will consolidate a range of services which will require the transfer of staff from a number of existing sites across the city. The opportunities for redesign offered by the new investment in facilities and the consolidation of workforce onto fewer sites will allow for significant re-profiling of the workforce.

In determining the potential workforce implications of change, workforce planning methodologies have been developed in conjunction with input from Service Directors and

Professional Leads. This has involved analysing a range of policy and legislative drivers for change and a review of the subsequent knock-on effect for future workforce requirements.

1.13 REDESIGN OF SERVICES

Another important aspect in the success of the project will be a proactive programme of redesign of services to:

a) ensure efficient services which:

- meet patient needs;
- offer one-stop services;
- offer quick access to diagnostic services;
- reduce the amount of time patients are in hospital;
- provide a balance of care and treatment in the community.

b) provide a high quality streamlined service within the projected bed complement;

c) influence the optimal building layout and design.

An important aspect of the redesign work will be the interface with the Community Health (and Care) Partnerships to ensure, where appropriate, services for patients are provided outside of hospital settings.

A programme of redesign work is underway to address the models of care associated with the Ambulatory Care Hospitals. The programme is closely linked to the planned changes in regional workforce planning and the development and implementation of the information Management and Technology Strategy.

The methodology and templates being put into place to take this work forward will be applied to the New South Glasgow Hospital ensuring consistency in care models and a streamlined flow of service provision within Glasgow.

1.14 PROJECT MANAGEMENT ARRANGEMENTS

Robust Project Management arrangements are in place to ensure that the project, and the individual elements within it, meet the expected time, cost and quality criteria.

1.15 PARTNERSHIP WORKING

The Board is committed to partnership working. There is an open and inclusive approach to staff side communication and the Board. The project management arrangements incorporate partnership working and staff side input with staff side membership on the two key project groups Project Executive Group and the Acute Services Review Programme Board.

1.16 COMMUNITY ENGAGEMENT

NHS Greater Glasgow and Clyde established a Community Engagement team in 2002 to inform and involve patients and the public in the acute services strategy. Dedicated staff have been allocated to the new hospitals and an extensive programme of consultation with patients, carers, families is ongoing. Detailed work involving communities in Greater Govan and South West of Glasgow is also occurring. The team are working in partnership with both

local and national organisations, such as Scottish Enterprise, to develop the full potential of the project for regenerating the wider area.

1.17 GATEWAY REVIEW

The New South Glasgow Hospitals project is subject to an Office of Government and Commerce (OGC) Gateway Review.

The review is an independent assessment confirming that the business case is robust to meet the business need, is affordable, achievable with appropriate options explored and likely to achieve value for money.

In doing this, the review outcome highlights whether aspects of the project are red, amber or green (traffic light system). Red means that the project cannot proceed to the next milestone until the issues identified as red are addressed. Amber means that the recommendations identified must be completed before the next Gateway Review stage. Green means that the programme or project is in good shape but may benefit from uptake of any green recommendations to enhance the project.

The project completed a Gateway Review Stage 1 assessment in January 2008. The outcome of the Gateway Review was that there were no red recommendations hence the project may proceed to the Board and Scottish Capital Investment Group with the Outline Business Case.

There were five amber and one green recommendations and these will be addressed before the Gateway 2 Review.

ANNEX B

Board: **NHS Greater Glasgow and Clyde**

Project: **New South Glasgow Hospitals Project**

Status: **Full Business Case**

Value: **£842m capital; £23.3m revenue offset by service and site savings of £43.6m resulting in Recurring Net Cost Savings after Depreciation on Enabling Costs of £18.251m**

Background: -

The purpose of this Full Business Case is to present the proposals for a new children's hospital and new adults' hospital (The New South Glasgow Hospital) on the site of the current Southern General Hospital and to confirm the proposals set out in the document are fully in line with the phased construction contract signed between NHS Greater Glasgow and Clyde and Brookfield Construction UK Limited in December 2009.

The proposals represent the largest investment in health services undertaken in Scotland and will transform the experience of healthcare for patients and staff alike with Glasgow becoming the home to one of the largest, most advanced NHS developments in the UK.

The proposals for a new adult and children's hospitals, new laboratory, facilities management (FM) and new 33KV electrical sub-station were previously presented to the Scottish Government in an Outline Business Case (OBC) which was approved in May 2008.

The need for change :-

In 2002 Greater Glasgow Health Board described the case for change, which identified that the status quo was not an option, as there were significant challenges to the sustainability of the configuration of services across Glasgow and to the ability to improve patient pathways and create more efficient and effective care pathways. All of the factors identified in 2002 remain relevant today with additional challenges and pressures resulting in even greater need to reduce hospital sites and duplication of services.

The Acute Services Review (ASR) identified a programme of change last 8 years following approval of the proposals by the then, Minister for Health to address NHS GG&C's business needs and this has been implemented over the and Community Care in 2002.

The ASR programme sees the reduction in the number of adult inpatient sites from the current six hospital sites to three. Two sites, Glasgow Royal Infirmary and the new South Glasgow hospitals, will have A&E and trauma facilities. The third inpatient hospital for Glasgow will be Gartnavel General Hospital. These acute sites will be supported by the two new build Ambulatory Care Hospitals.

NHS GG&C is currently carrying out an accelerated ASR with the redesign of services for the north and east of the city to transfer inpatient services from Stobhill Hospital to

Glasgow Royal Infirmary in 2011; the recent rationalisation of urology services to 2 sites and the centralisation of vascular surgery and renal services to the Western Infirmary by the end of 2010 - in preparation for achieving a single site model within the New South Glasgow Hospitals. The proposals for the new South Glasgow Hospitals on the Southern GeneralHospital campus form the second phase of this Acute Strategy and are pivotal in achieving the transformation of services provided by NHS GG&C into a modern, fit for purpose 21st century healthcare system.

On completion in 2015, NHS GG&C will be able to enact the following:

- inpatient services in the Victoria Infirmary to transfer to the new South Glasgow Hospitals
- inpatient services at the Mansion House Unit (MHU) to transfer to the new South Glasgow Hospitals allowing closure of the MHU
- inpatient services housed in outdated buildings on the Southern General Hospital and Western Infirmary sites to be relocated to the new South Glasgow Hospitals .
- transfer of A&E services and associated beds from the Victoria Infirmary,
- the Western Infirmary and the Southern General Hospital to the new South Glasgow Hospitals

Following these transfers closure can take place of the Western & Victoria Infirmary sites and of older parts of the Southern General Hospital. This means that by 2015 the plans for the 3 site inpatient configuration of adult services in Glasgow will be achieved.

Options: -

The summary of the short listed options are illustrated in the table below. -

Option	Description
Greenfield Option	A new build whole site solution for all facilities currently provided Acute and Children's Hospitals, plus related facilities. Land for a at the Southern General site, together with new Adult Greenfield site would be required under this option.
Option 1	This option represents an entire new build solution on the current Southern General site for the Adult Acute and Children's Hospitals, plus new build Laboratories, and other related services.
Option 1A	A new build provision on the Southern General site for the Adult Acute and Children's Hospitals, plus the refurbishment of some existing facilities on the Southern General site to provide Laboratories and other related services. This option allows for the retention of Neurosciences, Maternity, the Spinal Unit and the Langlands buildings currently on site.

Option 1A remains the preferred option

Capital Costs & Revenue Consequences: -

The total capital cost of the new hospitals is £842m. The recurring revenue costs for the project are £23.3m offset by service and site savings of £43.6m resulting in Recurring Net Cost Savings after Depreciation on Enabling Costs of £18.251m.

The capital and revenue requirements of the project have been fully reviewed in order to confirm that the preferred solution continues to be affordable in both capital and revenue This review concluded that the capital costs, including provision for Value terms. Added Tax at the increased rate of 20% from January 2011, remains affordable. In addition, by proceeding with the project, the Board will achieve net overall recurring savings in excess of £18.2m through enhanced efficiencies. Consequently the construction of the New Adult and Children's Hospitals is deemed to be affordable in both capital and revenue terms.

Timescale

Estimated key milestones for the project have been identified as follows:

Event	**Milestone**
Stage 2 completion, Full Business Case (FBC) approval by Health Board	26 October 2010
FBC considered by Scottish Government Capital Investment group	November 2010
Stage 3 (Construction of adult and children's hospital programmed to commence	November 2010
Stage 1 Completion (Construction) - laboratory facilities	March 2012
Stage 3 Completion (Construction) – adult and children's hospital	January 2015
Operational Date – adult and children's hospital complete service transfers.	**Summer 2015**
Stage 3a completion, demolition of surgical block and completion of landscaping	Summer 2016

Additional information

The Business Case is presented for discussion only as there are outstanding issues still to be resolved.

Recommendations

It is recommended that the FBC be considered via expedited procedures when outstanding issues have been resolved.

Mike Baxter
Deputy Director
Capital Planning and Asset Management Division
November 2010

ANNEX C

Acting Director-General Health and Chief Executive NHS Scotland
Derek Feeley

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The Scottish Government

Mr Robert Calderwood
Chief Executive
NHS Greater Glasgow and Clyde
JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Our ref: F3450124
December 2010

Dear Robert

NHS GREATER GLASGOW AND CLYDE – NEW SOUTH GLASGOW HOSPITALS – FULL BUSINESS CASE

Following consideration and a recommendation of approval of the above Full Business Case (FBC) by the Health Directorate's Capital Investment Group (CIG) this investment in healthcare infrastructure was considered and supported by the Cabinet of the Scottish Government. I am pleased therefore to formally confirm approval of the FBC and invite your Board to proceed to implementation.

Please note that in accordance with the Revised SCIM Guidance, which replaces earlier guidance contained in NHS HDL(2005)19 issued on 22 April 2005, www.scim.scot.nhs.uk/Approvals/Pub_BC_C.htm, all business cases/ addendums in excess of £5m are required to be placed within the Scottish Parliament Library (SPICe) within one month of receiving approval. Therefore, I would be grateful if you could forward a public version of the Full Business Case to Glenda Roy at the above address within one month of receiving this approval letter.

If you have any queries regarding the above please contact Mike Baxter on [redacted] or e-mail Mike.Baxter[redacted]

Finally I would like to take this opportunity to commend you and your team for the quality of the business case submitted and the development work undertaken with the contractor you have appointed.

Yours sincerely
DEREK FEELEY

Unique CCP Ref No	Description of Change	Impact of Change (Programme/Capital /Revenue)	Authorised by Director	Date	Deadline Date for Authorisation by COO	Decision/Action to be taken	Date Authorised by COO
NSG 001	Reduce number of haemo-dialysis stations in the Renal Dialysis Unit (Level 2) by 8, from 30 stations to 22 stations. To be achieved by removing 1x8 station bay leaving 2 x 8 station bays and 6 single rooms. No other changes to adjacencies required	None	Jonathan Best	12/02/2010	8th March 2010	Not agreed. No change to be instigated	10/03/2010
NSG 002	Reprofile Haemato-oncology area from 14 inpatient rooms and 4 day treatment rooms to 10 inpatient rooms and 0 day treatment beds. Requirementd for remaining rooms/facilities are as per agreed schedule of accommodation discussed on 04 Feb 2010	None	Jonathan Best	12/02/2010	5th March 2010	Change agreed and contractor notified on 12/03/2010	10/03/2010
NSG 003	Proposed to change in Dermatology to reducing inpatient beds by 4.	None	Grant Archibald	11/03/2010	11th March 2010	Not agreed. Bed Spaces to remain	11/03/2010
NSG 004	Relocation of Main Kitchen from 3rd Floor location to basement as it is logistically preferable due to reducing patient meal transfer distance and jounrey time to the wards on the retained estate.	Capital = £57k (may reduce - awaiting detailed costs from BCL)	Alex McIntyre	25/05/2010	28th June 2010	Change agreed and contractor notified on 06/07/2010	06/07/2010
NCH 001	NCH Medical Day unit. Proposal to change trolley configuration to bed configuration. Infection Control advise that if bed configuration then bed space must be 3.6m. However, Directorate now advise that trolley configuration is acceptable. Infection Control still requiring 3.6m space between trolleys.	Under consideration	Rosslyn Crocket		24th March 2010	Not agreed. Bed spaces to be 2.7m	18/03/2010
LAB 001	Mortuary X-Ray Room – the signed off room is 17sqm and was designed for the use of a portable DR machine as used by the Fiscal Service. The proposal is to increase the floor area to 24.5 sqm to provide space for a larger ceiling mounted imaging machine with CR capability. A review of existing DR equipment across the Directorate was undertaken and a piece of kit that would serve the same function was identified, currently in use at Stobhill, but due to be decommissioned December 2010. It was agreed that this would meet the mortuary requirements and would be stored until March 2012 when the room in the Lab Build is ready.	Under consideration	Aileen MacLennan	20/05/2010	27th May 2010	Change agreed and contractor notified 31st May 2010	28/05/2010

Time
Revenue
Capital
None
Time, Revenue
Time, Capital
Time, Revenue, Capital
Revenue, Capital

Director-General Health & Social Care and
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John Brown, Chairman
Jane Grant, Chief Executive
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22 November 2019

Dear John and Jane

Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC)

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC and the associated communication and public engagement issues, I have concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of our performance framework. This stage is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.'
The intention of the escalation would ensure appropriate governance is in place to increase public confidence and strengthen current approaches that are in place to mitigate avoidable harms.

As a result, an Oversight Board will be put in place, chaired by Professor Fiona McQueen, Chief Nursing Officer. Professor Craig White will continue to lead and direct the work required to improve the provision of responses, information and support to patients and their families and to support improvements in the delivery of effective clinical governance and assurance within the Directorates identified through the work carried out to date. This will be augmented with specific support for Infection Prevention & Control, communications and engagement.

Yours sincerely

[redacted]

Malcolm Wright
Director General for Health & Social Care and Chief Executive of NHSScotland

INVESTOR IN PEOPLE

POSITIVE ABOUT DISABLED PEOPLE

A9367455

OFFICIAL:SENSITIVE
Yes

Paper no: HSCMB/85/2019
Meeting date: 10 July 2019
Agenda item: 5

Standing items and Updates

Title:	NHS Board Performance Escalation Framework - NHS Lothian

Background and Key Issues:	Recent identification of issues around the new Royal Hospital for Children and Young People are considered in the context of wider performance and other issues related to NHS Lothian. This paper provides an overview of external support that the health board has received / is receiving around unscheduled and scheduled care. It also provides an update on recent issues relating to mental health and the Royal Edinburgh Hospital.

Action(s) Required:	HSCMB is asked to take account of the issues identified in the paper in deciding whether: a) NHS Lothian should be formally escalated to Stage 3 or above within the NHS Board Performance Escalation Framework; b) what, if any, additional action or support is required as a consequence of that decision.

Author: Yvonne Summers/Tracy Slater **Date: 9 July 2019**	**Director: John Connaghan** **Date: 9 July 2019**

What are the current challenges?

Edinburgh Children's Hospital

On June 28 the Board Medical Director, Nurse Director and Finance Director attended a meeting at the new hospital to discuss progress and process around theatre ventilation as part of the pre-hospital opening sign-off. On Monday afternoon (4.30) 1 July, a further teleconference took place regarding the theatre progress and at this point an issue relating to paediatric critical care ventilation was raised. The Medical Director who was in attendance escalated this to the Chief Executive, by email, for his return from leave on 2 July.

The Chief Executive picked the escalation up on Tuesday 2 July and on the same day informed the Board Chairman and the Director General for Health & Social Care. As a result, the Cabinet Secretary took the decision to halt the planned move of the Edinburgh Children's Hospital and the Department of Clinical Neurosciences for the time being. It is expected that it will take at least six months for the problem to be resolved, but further work is required to test and validate the proposed solution and estimated timeline.

In the meantime, the Cabinet Secretary has asked that an external series of checks is undertaken, led by Health Facilities Scotland and Health Protection Scotland, to ensure that all the relevant technical specifications and standards applicable to the new Edinburgh Children's Hospital are being followed and implemented.

The Cabinet Secretary has also commissioned follow up work to audit the full decision and build process to identify how and where this ventilation problem initiated and why it has not been identified until this week.

What is the ask of Management Board? (box will expand as you type)

Management Board is asked to take account of the issues identified above and to:

a) Take a view on whether NHS Lothian should be formally escalated to Stage 3 or above within the NHS Board Performance Escalation Framework (see Annex 1);

b) Identify what, if any, additional action or support is required as a consequence of that decision.

ANNEX 1

NHS Board Performance Escalation Framework

Stage	Description	Response
Stage 1	Steady state "on-plan" and normal reporting	Surveillance through published statistics and scheduled engagement of ARs/MYRs
Stage 2	Some variation from plan; possible delivery risk if no action	Local Recovery Plan – advice and support tailored if necessary. Increased surveillance and monitoring Scottish Government. SG Directors aware.
Stage 3	Significant variation from plan; risks materialising; tailored support required	Formal Recovery Plan agreed with Scottish Government. Milestones and responsibilities clear. External expert support. Relevant SG Directors engaged with CEO and top team. DG aware.
Stage 4	Significant risks to delivery, quality, financial performance or safety; senior level external support required	Transformation team reporting to Director General and CEO NHS Scotland.
Stage 5	Organisational structure / configuration unable to deliver effective care.	Ministerial powers of Intervention.

ANNEX 2

NHS LOTHIAN ANNUAL REVIEW 2017/18

MAIN ACTION POINTS

The Board must:

- Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safety
- Keep the Health & Social Care Directorates informed on progress towards achieving all access targets in line with agreed improvement trajectories, including the outpatient target, cancer targets and mental health access targets
- Continue to implement the actions agreed as a result of the Academy of Medical Royal Colleges report; improving and maintaining performance in relation to unscheduled care performance
- Continue to work with planning partners on the critical health and social integration agenda, including effectively addressing the delayed discharge challenge
- Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection
- Continue to achieve financial management targets
- Agree a new remit for the Area Clinical Forum and ensure that there is provision for appropriate attendance at, and regular meetings of, the Forum.
- Keep the Health & Social Care Directorates informed of progress with its significant local health improvement activity, including against the smoking cessation target
- Keep the Health & Social Care Directorates informed of progress with local service redesign plans, in line with the national policy
- Provide a written update to the Scottish Government on progress against the above actions by 30 June 2019

PARLIAMENTARY STATEMENT:
QUEEN ELIZABETH UNIVERSITY HOSPITAL UPDATE

Presiding Officer, the people served by NHS Greater Glasgow and Clyde deserve to have confidence that their local health board is improving its performance.

The staff of our health service deserve the assurance that should they have concerns about the care of patients, they will be listened to and supported.

And the families of children who have been treated at the Queen Elizabeth Hospital campus deserve to have answers to their questions, and as safe an environment as possible for the care of their children.

The actions I have taken in recent times in NHS Greater Glasgow and Clyde aim to deliver on these concerns.

Escalation to Level 4

Last week I escalated the board to level 4 for all aspects of it performance. This includes bringing in an operational turnaround director working directly to resolve issues in a number of areas, including out of hours services and waiting times.

But today I will focus on actions taken since I updated Parliament in December in relation to the board's increase to level 4 for infection control and family engagement around the QEUH.

Chief Nurse Prof Fiona McQueen is chairing an oversight board that has identified the steps needed.

- First, a review of the care of children who had blood stream infections from 2015 to date;
- Second, improving the quality of governance of infection prevention and control;
- Third, establishing a technical group to ensure associated building works, water and ventilation are being progressed; and,
- Fourth, sustaining far better communication and engagement with patients and families.

Case review – numbers, approach, timescale

I have a clear priority to make sure families are given the answers they need about their children's time in the hospital. Particularly about infections that may have caused harm, or – in the worst cases – may have been the cause of death.

A review of patients is looking at relevant cases in the paediatric haemato-oncology ward since the hospital opened in 2015.

Since December, a team of Scottish experts from outside GGC has been assembled to undertake the review, led by Prof Marion Bain, who I have appointed to take over responsibility for infection prevention and control.

To ensure rigour and robustness the case reviews will utilise two approaches:

An epidemiological review which is validated by microbiologists and epidemiologists and uses international infection definitions to identify gram negative infections in the selected group. The epidemiology review will define the frequency of infections and their distribution by person, place, and time. Health Protection Scotland will lead this part of the review; and,

The Paediatric Trigger Tool Review - an internationally-validated approach that will help clinicians understand the effect infection may have had on children and will also help assess wider quality of care.

Infection prevention and control measures, their use and effectiveness will also be assessed in relation to the outputs of the case reviews.

Dr Peter Lachman, Paediatrician and Chief Executive of The International Society for Quality in Health Care, and one of the authors of the Paediatric Trigger Tool, has provided guidance on the use of the Tool for this purpose and the augmentation required for these patients.

As this review covers a significant time period and a number of cases and complexities, a segmented approach will be taken.

The first group of reviews will concentrate on patients who received care in 2017. I think that's only appropriate given the long period of worry and distress that these families have endured.

The first set of reviews will be completed during February. The review team considers that there are likely to be around 80 cases to be examined, but they will continue to keep this assessment under review.

This whole approach will be discussed with the parent representatives working with us. The review must also answer questions posed by parents - and Prof Craig White will liaise with parents to ensure that this happens and they are kept informed of progress.

As reviews are completed families will be offered an individual, face to face report, by one of the reviewing clinicians.

I consider it imperative to the restoration of confidence that no one in this process will be in the business of 'marking their own homework'. Not NHS Greater Glasgow and Clyde, not NHS Scotland. All must be subject to expert, independent and external scrutiny.

The work of the review team will be advised and subject to scrutiny by experts from outside Scotland.

Prof Mike Stevens, Emeritus Professor of Haemato-oncology from the University of Bristol; and, Gaynor Evans, Clinical Lead for the Gram-negative Bloodstream Infection Programme at NHS Improvement England, will advise the review team and report directly to the Chief Nursing Officer.

Wards 2A and 2B – timetable for reopening

Presiding Officer, the Parliament will recall that in 2018 NHSGGC considered it necessary to close wards 2A and 2B at the Children's Hospital, and relocate patients to ward 6A in the Queen Elizabeth.

This move was both worrying and unsettling for children and their families and the length of time has been longer than expected.

Changes have been made in ward 6A to make available space for parents to have a rest and some time to themselves, extra measures have been taken to enhance air filtering, alongside thorough and regular cleaning and additional steps taken to bring aspects play and therapeutic environment of 2A/2B to 6A.

Welcome those these enhancements are, what is obviously necessary is for children to return to wards specifically designed for them.

Wards 2A and 2B are being refurbished, to make good the problems identified in 2018 and to bring them up to the highest standards.

I am informed by GGC that their plan now is for work to be completed in the summer of this year and progress towards reopening is being monitored by the Oversight Board's technical sub group.

Patients will move back to 2A and 2B when these wards are fully ready and meet all required standards.

Infection prevention and control

Presiding Officer, Prof Marion Bain is now in post in GGC. Prof Bain is leading the case review that I have described already.

Working with the staff who have raised concerns, and making sure their insight and experience is woven into the ongoing work of infection prevention and control in GGC, she is reviewing, all aspects of working practice and governance, including how the Board assesses, reports and manages incidents and outbreaks.

The policies of GGC are being considered, but so too is the detail of spikes in infection experienced in the hospital, and how the Board responded both in its operations and corporately.

I expect the Oversight Board to receive a report from the sub group about these matters by the time of the Easter recess.

Alongside this, the Chief Nursing Officer has instructed a peer review of how the Infection Prevention and Control team approach and escalate infection incidents.

This will report during February to Prof Bain.

Communication with families

Prof Craig White is following up on feedback received from parents through surveys and meetings, and this is informing the work of the communications sub group of the Oversight Board and I am grateful to the parent representatives who are working with us on this.

GGC's website now has an improved section offering answers to questions that parents have asked about the hospital and the safety and care of their children.

We will ensure that families are involved in preparations to reopen wards 2A and 2B, with the questions they have answered, and taking into account ideas that they have for the operation of the wards.

Public Inquiry

Lastly, Presiding Officer, I want to update the Chamber on progress with the establishment of the Public Inquiry, which I announced in September last year.

The remit and terms of reference are at an advanced stage of drafting and are being considered by Lord Brodie.

Lord Brodie and I are committed to ensuring that the Inquiry addresses the concerns of patients and families and to offering them an opportunity to comment on the terms of reference before they are finalised. I expect that the remit and the terms of reference will be shared with families during February and thereafter I will meet with party spokespeople as I have committed to do.

Conclusion

Presiding Officer, significant work is under way to address the legitimate concerns that have been raised by members on behalf of families and staff.

The work is ongoing under the scrutiny of external experts, it is detailed and will take time. But families and children and staff deserve it to be done properly and thoroughly. I will update Parliament further as progress is made.

From: Finnigan C (Carole) on behalf of DG Health & Social Care
Sent: 22 November 2019 15:06
To: DG Health & Social Care
Subject: Corresp - MW - NHS GG&C - escalation - 22 November 2019

Follow Up Flag: Follow up
Flag Status: Completed


RE_ HSCMB Paper - NHSGGC escal...


HSCMB_NHS GGC_escalation_...


Letter from Malcolm Wright...


Letters to HS & PAPLS Committ...


RE_ Letters to HS & PAPLS Comm...


RE_ Letters to HS & PAPLS Comm...


RE_ NEWS RELEASE TO CLE...

Regards

Carole

Carole Finnigan |Private Secretary to Malcolm Wright|DG Health and Social Care and Chief Executive NHS Scotland
Scottish Government | St Andrews House | Regent Road | Edinburgh | EH1 3DG
☎ [redacted] dghsc@gov.scot

Scottish Government
Riaghaltas na h-Alba
gov.scot

A53674650

From: Finnigan C (Carole) on behalf of DG Health & Social Care
Sent: 22 November 2019 15:05
To: Mitchell E (Elinor); McQueen F (Fiona); Chief Medical Officer; McLaughlin C (Christine); Rogers S (Shirley); DG Health & Social Care; Foggo R (Richard); Leitch J (Jason); Ives J (Josephine); Wright M (Malcolm); Director of Population Health; Bell D (Donna); Connaghan J (John) (Health); McCallum R (Richard); Colvin I (Iona); Calderwood C (Catherine); Chalmers MJ (Michael) (DCAF); Smith G (Gregor); Kirkwood R (Robert)
Cc: Dunk R (Rachael); Shepherd L (Lesley); Morris K (Keith); Burgess E (Elizabeth); White C (Craig); Birch J (Jason); Allan L (Lara)
Subject: RE: HSCMB Paper - NHSGGC escalation

Hi all

Attaching the final HSCMB paper and letters which have now issued.

HSCMB

HSCMB_NHS GGC_escalation_...

Letter to Chair & Chief Executive

Letter - Malcolm Wright - NHS ...

Letters to Health & Sport, PAPLS and Auditor General.

u418806_22-11-... u418806_22-11-... FW_ Letter from Malcolm Wright...

Regards

Carole

Carole Finnigan |Private Secretary to Malcolm Wright |DG Health and Social Care and Chief Executive NHS Scotland|Rm 1E.16 |SAH
☎ [redacted] dghsc@gov.scot

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
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Lewis Macdonald MSP
Convener
Health and Sport Committee

By Email.

22 November 2019

Dear Lewis

Queen Elizabeth University Hospital Ward Closures

I am writing to you following my statement to Parliament on Wednesday 20 November on the recent issues relating to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC).

As I said in my statement, we had triggered the process that considers the escalation of a Board. That process has now concluded.

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC and the associated communication and public engagement issues, I have concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of our performance framework. This stage is defined as 'significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.'

The intention of the escalation would ensure appropriate governance is in place to increase public confidence and strengthen current approaches that are in place to mitigate avoidable harms.

As a result, an Oversight Board will be put in place, chaired by Professor Fiona McQueen, Chief Nursing Officer. Professor Craig White will continue to lead and direct the work required to improve the provision of responses, information and support to patients and their families and to now also to explicitly support improvements in the delivery of effective clinical governance and assurance within the Directorates identified through the work carried out to date. This will be augmented with specific support for Infection Prevention & Control, communications and engagement.

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I will keep Parliament updated on the role of the Oversight Board and the actions that it is taking, as the work progresses.

I have attached a copy of the letter to the board and I have copied this letter to each of the Party spokespeople on health and to Mr Sarwar given his particular interests and engagement on this matter.

Kind regards

[redacted]

JEANE FREEMAN

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

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From: pqt[redacted]
Sent: 22 January 2019 15:37
To: Goodfellow M (Melanie)
Subject: TOPICAL PQ Answers
Attachments: s5t-01442.docx; s5t-01442_backgroundnote.docx

Please find attached, the answers to the TOPICAL PQs processed on 22/01/2019:-
S5T-01442

SCOTTISH PARLIAMENT

TOPICAL ANSWER

22 January 2019

Index Heading: Health and Social Care

Monica Lennon (Central Scotland) (Scottish Labour): To ask the Scottish Government what its response is to reports that two patients have died at the Queen Elizabeth University Hospital after contracting a fungal infection, and what advice has been issued to NHS boards on this matter.

S5T-01442

Jeane Freeman: In November the bacteria cryptococcus was identified in one patient. That patient was discharged for palliative care and sadly subsequently died in [redacted], but crytococcus was not a contributory factor in their death.

In December, a post mortem of a [redacted] who had passed away confirmed that cryptococcus was both present and a contributory factor in their death. I know I speak for the whole chamber when I say for both families our thoughts and sympathies go to them.

The identification of 2 cases acts as the trigger for further infection control action by the Board. This includes the provision of prophylaxis anti-fungal medication to the relevant group of vulnerable patients and the provision of additional HEPA filter machines to ensure clean and clear air and air monitoring.

In visiting QEUH this morning I had detailed briefing and the opportunity to speak directly with the medical director, senior nurse, senior board members and a family.

From this, from the external advice the Board has sought, including from Health protection Scotland and from the clinical advice available directly to me I am confident the Board have taken all the steps they should have to ensure patient safety. To provide further independent assurance I have also asked HEI to fully review this incident and to make recommendations on any further steps that should be taken.

BACKGROUND NOTE FOR S5T-01442

Water related

Can you provide an update on the water incident?

Officials have now received the final version of the summary report of the contamination of the water and drainage system within the RHC. The recommendations in this report will be used to share the lessons learned and make improvements across NHSScotland. Since January 2018 the confirmed number of cases is 23. The majority of these (17) were affected before infection prevention control measures were put in place by NHS GGC.

A temporary decant of the affected wards (2A/2B) took place in September 2018 to allow the Board's Estates and Facilities Team to carry out extensive investigations. NHS GGC has assured Officials that all appropriate steps had been taken to ensure the decant wards were safe. HPS and HFS continue to support NHS GGC to manage this incident and the associated remedial works. This includes dosing of the water system and the replacement of taps, sinks and drains within RHC. NHS GGC has advised Officials that work will continue into 2019 and patients will only return to the wards when it is considered to be safe.

As yet, the source of this outbreak has not been identified. HPS have advised that it is possible that the source may never be identified, which is not unusual for this type of incident.

Is this most recent incident related to the water?

This infection is not related to or transmitted by water. It is being investigated by the Board as a separate incident.

When will we see the water incident report?

I have received the water report and in light of that and this most recent incident I have asked my Officials to instigate an external independent review of the QUEH and RCH sites at NHSGGC.

I announced this earlier today and will provide the Chamber with details of this review and independent chair. As our national expert bodies this will involve Health Protection Scotland and Health Facilities Scotland, but I want an independent Chair who will be able to draw on knowledge from a range of experts.

What is the timescale for this latest review and what will it cover?

I will provide further details to the Chamber in due course.

Is the hospital safe?

I have sought assurance from the Board today that the hospital is safe. The Chair and Chief Executive have provided me with that assurance.

Why haven't you contacted other Health Boards to find out if they have similar problems?

We already have clear, well tested, reporting lines for outbreaks and incidents in place. NHS Boards are expected to inform Health Protection Scotland of any incidents and outbreaks. Health Protection Scotland offer the Board external independent advice on incident and outbreak management. They also provide my officials with updates on incidents and outbreaks across Scotland, who in turn advise me. My officials have contacted Health Protection Scotland who have confirmed there are no other hospitals who have a similar problem.

On 28 November 2018 Health Facilities Scotland brought together NHS Directors of Estates to share the learning from the water incident at NHS GGC and there is ongoing dialogue through regular meetings of the NHS Strategic Facilities Group.

Additionally, later today the Director General for Health and Social Care is arranging a call with NHS Chief Executives and Directors of Estates to provide him with appropriate assurance that ventilation and water systems are safe across NHS Scotland

Are the pigeons still in the hospital?

The Board have put a number of anti-pigeon measures in place to manage this.

When did we get alerted to this pigeon incident?

My Officials were advised of the incident on 21 December 2018.

What action did the Health Board take?

The Board put in place a range of control measures including: establishment of an Incident Management Team, providing anti-fungal prophylaxis to other at risk patients [immediately], installing HEPA filters in high risk areas [in January], enhanced cleaning regimes and cleaning of areas where pigeon excrement was visible.

What are the issues with the new hospital?

I am aware of a number of issues in relation to the building which is why I have instigated the external review.

Were any patients affected by the drain/water issues or the Cowlairs shut down also been affected by this incident?

No patients have had an infection associated with both the water incident and the fungal incident. The patient who sadly died was one of the patients moved from wards 2A/2B (the area affected by the water incident) to ward 6A.

There are no patients involved in the water or fungal infection incidents who had treatments cancelled due to the Cowlairs shut down.

Has the current incident affected admission or treatment commencement for any patient?

Patient safety has been the Boards concern throughout this incident and decisions on individuals care is a matter for the clinical team.

If pressed:

The Board have advised me that the current treatment for their haemato-oncology patients is as follows:

Bone Marrow Transplant (BMT) patients continue to be treated in Ward 4B (adult BMT) at QEUH. They are being cared for in a discrete area on the adult ward.

The majority of paediatric (non-BMT) patients cared for on Ward 6A QEUH have been transferred to Royal Hospital for Children (RHC) on Saturday (19 January 2019) to a number of rooms fitted with PPVL (Positive Pressure Ventilation).

Following a meeting of the senior clinical and management team on evening of 22 January 2019 it was agreed to transfer the 4 remaining inpatients to RHC. These moves are being undertaken today.

This will result in the ward being empty of patients and will enable a full programme of remedial works to be completed. Air testing and sampling will be undertaken with a plan to return the paediatric patients to return within 4 weeks.

This patient cohort were initially transferred from RHC to QEUH in September to enable water and drainage issues to be addressed. This work is now complete.

How much money does the Board spend on maintaining their property and functional use of buildings?

The Board have advised me that this year they will spend [redacted] on revenue and [redacted] on capital to maintain their property and the functional use of buildings.

Is the Scottish Government giving any money to the Board to resolve this issue?

It is the Boards responsibility to ensure they allocate revenue and capital to ensure their property is maintained.

What else will you do to ensure this doesn't happen again?

In addition to any recommendations established by the external review I have asked Fiona McQueen, our Chief Nursing Officer to review the roles and responsibilities of Infection Control Teams and to consider how to strengthen the role of facilities teams in Infection control issues.

Answers to previous PQs on the water incident:

S5W-18941 (Miles Briggs, September 2018): To ask the Scottish Government, further to the answer to the fifth supplementary to question S5F-02602 by Nicola Sturgeon on 20 September 2018 (Official Report, c. 16), how many patients have had their chemotherapy treatment delayed due to issues concerning the safety of the water supply at the Royal Hospital for Children in Glasgow in each year since June 2015.

The information in relation to delayed chemotherapy treatments is not collected or held centrally. However on 26 September 2018, NHS Greater Glasgow and Clyde confirmed since January 2018 16 patients at the Royal Hospital for Children have had their chemotherapy treatment delayed.

S5W-19030 (Anas Sarwar, September 2018): To ask the Scottish Government which bacteria was identified during the incidents that were reported at the Royal Hospital for Sick Children in Glasgow in March 2018, and whether it is the same bacteria that was identified during similar incidents in November 2015.

On 20 March 2018 the then Cabinet Secretary, Shona Robison MSP, announced to Parliament that she had asked Health Protection Scotland (HPS) to undertake a thorough investigation of this incident. This investigation is on-going and once it has concluded a report will be provided. This report will address the incident in full and the outcomes will be used to inform learning for NHSScotland.

Regarding the incident in 2015, NHS Greater Glasgow and Clyde has confirmed that HPS conducted a thorough investigation of the incident and concluded that it was not related to bacteria in the water.

S5W-19033 (Anas Sarwar, September 2018): To ask the Scottish Government, in light of the incidents at the Royal Hospital for Sick Children in Glasgow that were reported in 2015, what the consequences were for patients of the incidents of bacteria in the water; how many were prescribed prophylactic antibiotics; whether the water is now clear of bacteria in the areas that were affected; how long the water was contaminated for; whether the ward is a safe environment for patients; who was responsible for ensuring that the water was safe before the hospital opened, and who has been responsible for this since.

NHS Greater Glasgow and Clyde have confirmed that 18 patients were affected by the incident in the Neonatal Intensive Care Unit (NICU) at the Queen Elizabeth University Hospital in 2015. One of these patients, a very premature infant with complex medical problems, developed a blood stream infection and died as a result.

A further 2 patients died of causes unrelated to the incident and the remaining 15 patients were discharged home. The Scottish Government do not hold information centrally on the number of patients who were prescribed prophylactic antibiotics.

The Health Protection Scotland investigation concluded that this incident did not relate to bacteria in the water and the NICU was safe for patents and their families.

Prior to the hospital opening, the Project Director and Project Team were responsible for ensuring water safety. Decisions were based on reports and advice from the appointed commissioning engineers. The Director of Properties, Procurement and Facilities Management is now responsible for water safety.

S5W-19032 (Anas Sarwar, September 2018): To ask the Scottish Government how many patients were affected by the incidents of bacteria in the water at the Royal Hospital for Sick Children in Glasgow that were reported in 2015, broken down by the ward they were on and its speciality.

The incident reported by the Board in 2015 affected 18 patients, all of whom were in the Neonatal Intensive Care Unit (NICU). This unit cares for both medical and surgical neonates.

Health Protection Scotland conducted a thorough investigation, which concluded that this incident did not relate to bacteria in the water.

S5W-19031 (Anas Sarwar, September 2018): To ask the Scottish Government, in light of the incidents at the Royal Hospital for Sick Children in Glasgow that were reported in March 2018, how the bacteria got into the water, and which areas of the hospital were affected.

On 20 March 2018 the then Cabinet Secretary, Shona Robison MSP, announced to Parliament that she had asked Health Protection Scotland (HPS) to undertake a thorough investigation of this incident. The investigation into the source of the outbreak is on-going, however there have been no patient cases since 14 September 2018.

A report will be provided to Parliament in due course which will address the incident in full and the outcomes will be used to inform learning for NHSScotland.

Wards 2A and 2B, the haemato-oncology unit in the Royal Hospital for Children, have been affected by this incident.

Contact Name: [Jason Birch]
Ext: [redacted]

From: Downie J (Jack) on behalf of Cabinet Secretary for Health and Sport
Sent: 01 February 2019 11:09
To: monica.lennon.msp[redacted]
Cc: Cabinet Secretary for Health and Sport
Subject: Letter from the Cabinet Secretary for Health & Sport
Attachments: Ltr to Monica Lennon 010219 QEUH.pdf

Good Morning,

Please find attached a letter from the Cabinet Secretary for Health & Sport.

I would be grateful for receipt of this email.

Kind Regards,
Jack

Jack Downie
The Scottish Government
Health & Sport Ministerial Private Office
St Andrews House, Edinburgh

Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@gov.scot

Monica Lennon MSP
The Scottish Parliament

By Email.

1 February 2019

Dear Monica,

CORRECTION TO OFFICIAL REPORT:
TUESDAY 22 JANUARY 2019 – Cryptococcus Infection (Queen Elizabeth University Hospital)

In response to your topical question on Tuesday 22 January 2019 I made a statement to Parliament on the Cryptococcus infection at the Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde. (S5T-01442). Officials have drawn to my attention that the information provided by them for use in my statement about the date of death of one patient and reference to the word bacteria were inaccurate. I have therefore written to the Presiding Officer to request that the following correction is made to the Official Report.

What has been recorded in the Official Report

"In November, the bacteria Cryptococcus was identified in one patient. That patient was discharged for palliative care and, sadly, subsequently died in [redacted], but Cryptococcus was not a contributory factor in their death."

Correction requested

"In November, Cryptococcus was identified in one patient. That patient sadly, subsequently died in [redacted], but we were advised that Cryptococcus was not a contributory factor in their death."

The Director General for Health and Social Care has given me his personal apology for the provision of incorrect information and has asked me to make you and the Presiding Officer aware of that. I also want to offer you my apology for this error.

Kind Regards,

[redacted]

JEANE FREEMAN

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See
www.lobbying.scot

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Paul

Fiona just mentioned the 2 patients as they were mentioned twice, so she removed one – but still no dates, so will omit both defences as per your version.

She says SITREP is fine.

Billy

Billy Renfrew
Health Resilience Unit | Scottish Government | Tel: [redacted] | Email: billy.renfrew@[redacted] | Unit email address: SGHRU@gov.scot

For reporting incidents out-of-hours contact the SG Health Resilience Duty Officer via pager: 07623 909 981
Follow SG Health on twitter: @scotgovhealth
For more information: SG Health Resilience
Preparedness, Resilience and Response

From: McQueen F (Fiona) [redacted]
Sent: 01 February 2019 19:30
To: Renfrew W (Billy) [redacted]
Subject:

Billy – apologies – I needed to trawl a lot of info to get why patients were transferred.

It was due to Cryptococcus so I have altered the slides and taken the two patients off the water slide.

The sit rep is fine.
F

#hello my name is...
Fiona McQueen | Chief Nursing Officer |
Chief Nursing Officer's Directorate | Scottish Government | 1E.14 St Andrew's House |
Regent Road | Edinburgh | EH1 3DG | ☎ [redacted] | [redacted]
✉fiona.mcqueen[redacted]

follow me on twitter @FionaCMcQueen

CRIP

NHS: Infection Control & Estates

COMMONLY RECOGNISED INFORMATION PICTURE (CRIP)

CRIP 3

NEW INFORMATION SHOWN IN RED

Information correct as of 1 February 2019

- **Issue: QEUH: Water Contamination**
- **Background**
  - QEUH: SG informed of Water Contamination incident on 1 March 2018. Total 23 cases between Jan-Sept 2018
    - No deaths
    - All cases were related to water borne contamination
    - Patients have been transferred from 2A/2B to 6A and 4C.
    - Wards 2A/2B are being refurbished, water dosing units installed.
    - There were treatment delays associated with this.
    - National support framework invoked by CNO on 20 March, HPS report received Dec 2018
- **Current Position**
    - 30 January 2019:
    - Cabinet Secretary, CNO discussed water contamination report by HPS on 30 January
    - At the meeting, it was agreed that a further briefing on the handling of the HPS report will be provided to the Cabinet Secretary by early next week.
- **Communications**
  - This has been mentioned by the media in the context of the Cryptococcus infections but has not received significant attention this week.

- **Issue: Cryptococcus neoformans**
- **Background**
  - On 21 December 2018, 2 cases of Cryptococcus neoformans were reported to SG – one [redacted] and one [redacted].
  - Both patients have died. The [redacted] patient died on [redacted] and the [redacted] patient on [redacted].
  - There have been no further cases reported.
- **Current Position**
  - Both deaths are being investigated by the Procurator Fiscal.
  - Healthcare Environment Inspectorate are undertaking an inspection of QEUH from 29 January which was initially expected to conclude on 31 January but is now being extended until Friday, with further documentation sought.
  - Initial findings will no longer be reported to the Board on Friday 1 February. Feedback is expected next week and we will update as soon as we know. [**not in the public domain]**
  - The board have implemented control measures, including portable HEPA filters, prophylaxis anti-fungal medication to other most at risk patients.
  - Patients and families have been spoken to by GGC staff.
  - NHS GGC continue to treat all existing patients and for external reviews done on a case by case basis.
  - Ward 2A has been opened again as a Clinical Decision Unit (acute admission). Wards 2B and 6A are still closed. Ward 4B is open for paediatric bone marrow transplant and high risk patients.
  - NHS GGC confirmed that 2 patients have been transferred to Edinburgh for treatment.
- **Communications**
  - Significant media and political interest but no new enquiries on Cryptococcus to SG on 30/1 and 31/1 as the focus has been on the Princess Royal Maternity cases

- **Issue: PRMH Neonatal Unit: Staphylococcus aureus infection**
- NHSGGC reported to SG on 25 January **three** cases of *Staphylococcus aureus* in blood cultures (**two** confirmed on 25 January and **one** confirmed on 30 January) in the Neonatal Intensive care Unit (NICU), Princess Royal Maternity Unit,
- Current position
  - Case 1 remains in the NICU, isolated in a single room and is in a stable condition.
  - Case 2 died on [redacted]. Post mortem results are awaited.
  - Case 3 died on [redacted]. *Staphylococcus aureus* bacteraemia was confirmed on Part 1A of the death certificate for case 3.
- Control measures
  - Terminal clean of the unit was completed 17 January 2019. All five neonatal occupants in the NICU were screened for Staphylococcus aureus on 24 January 2019 and will be screened weekly for the next four weeks.
  - Additional terminal cleans of communal parent areas are scheduled. Environmental swabbing was carried out on 24 January. Enhanced routine cleaning (twice daily) commenced on 25 January. Reviews of device insertion practices, cot spacing and hand hygiene are under way. Next IMT planned for Tuesday 5th February at 4pm; unless the situation changes before this date.
- Support requested by Board: On 29 January, NHS GGC have proactively sought the formal support of Health Protection Scotland through the National Support Framework, and have asked them to investigate this incident and provide a report to the policy unit.
- **Communications**
  - The board has been in contact with the affected families, as well as other families of babies in the unit, to advise them of the incident and the action they are taking. The board issued a press statement on 30 January.
  - HIIAT de-escalated to Amber (severity of illness – moderate, impact on services – minor, risk of transmission – moderate, public anxiety – moderate).

From: Ritchie Lisa (NATIONAL SERVICES SCOTLAND)
Sent: 25 November 2015 16:56
To: Ahmed Syed (NATIONAL SERVICES SCOTLAND)
Cc: Reilly Jacqui (NATIONAL SERVICES SCOTLAND); Harley Kate (NATIONAL SERVICES SCOTLAND)
Subject: FW: SBAR NHSGG&C NNU Serratia marcescens
Attachments: SBAR NHSGGC 18 Nov 2015 V1.0.docx

Importance: High

Dear Syed,

Please see below the email sent from the HAI Policy Unit following receipt of the SBAR: HPS Outbreak support visits to NICU, Neonatal Unit, Royal Children's Hospital, NHSGG&C for 5th and 12th November 2015 (attached).

There has been no response from NHSGG&C to HPS as requested by the HAI Policy Unit.

There is an OCT meeting scheduled for tomorrow at 4pm at the QEUH site.

I have and will continue to offer support to NHSGG&C ICT.

Kind regards,
Lisa

Lisa Ritchie
Nurse Consultant Infection Control
Infection Control Team / HAI Group
Health Protection Scotland

NHS National Services Scotland
4th Floor Meridian Court
5 Cadogan Street
Glasgow G2 6QE
T: [redacted]

From: Abigail.Mullings@[redacted]
Sent: 19 November 2015 14:43
To: Ritchie Lisa (NATIONAL SERVICES SCOTLAND); Reilly Jacqui (NATIONAL SERVICES SCOTLAND); Walsh Thomas (NHS GREATER GLASGOW & CLYDE); Williams Craig (NHS GREATER GLASGOW & CLYDE); Armstrong Jennifer (NHS GREATER GLASGOW & CLYDE); margaret.mcguire[redacted]
Cc: Fiona.McQueen[redacted] Rachael.Dunk[redacted] Guy.Fey[redacted] George.Galanopoulos[redacted] alistair.leanord[redacted]; allison.wood[redacted] Young Stephen (SCOTTISH GOVERNMENT HEALTH & SOCIAL CARE DIRECTORATE)
Subject: RE: SBAR NHSGG&C NNU Serratia marcescens
Importance: High

Dear Lisa and colleagues,

Many thanks for this comprehensive update.

We are concerned to note in this GG&C update that there was a fatal Pseudomonas bacteraemia in [redacted] 2015 as this was not reported as per the Scottish Government (SG) mandatory requirement.

With regards to this patient death, in order for us to brief the Cabinet Secretary as per our SG protocol, we request that GG&C complete the necessary HAI ORT template and communicate this as per the mandatory CNO Algorithm (2015)2 to HPS by Wednesday 25th of November. We also request details of actions taken following this unfortunate HAI related death in addition to an explanation as to why this has not been formally reported by GG&C.

Additionally, we would like to request a meeting with GG&C (with HPS HAI leads in attendance) to discuss the GG&C management and reporting of HAI outbreaks and incidents in relation to our Scottish Government mandatory requirements.

My colleague, Stephen Young (cc'd) will be in touch to arrange this meeting which will be held in St Andrew's House.

Kind regards,

Abigail (on behalf of the HAI Policy Unit)

Abigail Mullings I HAI Professional Advisor I Scottish Government
St Andrew's House I Regent Road Edinburgh EH1 3DG
[redacted]

From: Ritchie Lisa (NATIONAL SERVICES SCOTLAND) [redacted]
Sent: 18 November 2015 11:10
To: Mullings A (Abigail); Leanord A (Alistair); Wood A (Allison); Galanopoulos G (George); Fey G (Guy); HPSInfectionControl (NATIONAL SERVICES SCOTLAND); Lockhart Michael (NATIONAL SERVICES SCOTLAND); Dunk R (Rachael); Reilly Jacqui (NATIONAL SERVICES SCOTLAND)
Cc: Williams Craig (NHS GREATER GLASGOW & CLYDE); Mcnamee Sandra (NHS GREATER GLASGOW & CLYDE); 'Pamela Joannidis (ICN, IPS)'; Walsh Thomas (NHS GREATER GLASGOW & CLYDE); Reilly Jacqui (NATIONAL SERVICES SCOTLAND); Lockhart Michael (NATIONAL SERVICES SCOTLAND)
Subject: SBAR NHSGG&C NNU Serratia marcescens

Dear Abigail,

In response to SGHSCD formally invoking the National Support Framework CNO (2015), please find attached

SBAR: HPS Outbreak support visits to NICU, Neonatal Unit, Royal Children's Hospital, NHSGG&C for 5th and 12th

November 2015.

This SBAR has been shared with colleagues in NHSGG&C ICT.

Kind regards,
Lisa

Lisa Ritchie
Nurse Consultant Infection Control
Infection Control Team / HAI Group
Health Protection Scotland

NHS National Services Scotland
4th Floor Meridian Court
5 Cadogan Street
Glasgow G2 6QE
T: [redacted]

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Dh’fhaodadh gum bi teachdaireachd sam bith bho Riaghaltas na h-Alba air a chlàradh neo air a sgrùdadh airson dearbhadh gu bheil an siostam ag obair gu h-èifeachdach neo airson adhbhar laghail eile. Dh’fhaodadh nach eil beachdan anns a’ phost-d seo co-ionann ri beachdan Riaghaltas na h-Alba.
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From: Ritchie Lisa (NATIONAL SERVICES SCOTLAND)
Sent: 10 November 2015 10:11
To: Abigail Mullings; Alistair Leanord; Allison Wood; Brown Claire (NATIONAL SERVICES SCOTLAND); George Galanopoulos; Guy Fey; HPSInfectionControl (NATIONAL SERVICES SCOTLAND); Kane Hayley (NATIONAL SERVICES SCOTLAND); Imrie Laura (NATIONAL SERVICES SCOTLAND); Lockhart Michael (NATIONAL SERVICES SCOTLAND); McIntyre Jackie (NATIONAL SERVICES SCOTLAND); Rachael Dunk; Rankin Annette (NATIONAL SERVICES SCOTLAND); Reilly Jacqui (NATIONAL SERVICES SCOTLAND); Ritchie Lisa (NATIONAL SERVICES SCOTLAND); Sharon Mooney; Wallace Heather (NATIONAL SERVICES SCOTLAND); Wiuff Camilla (NATIONAL SERVICES SCOTLAND)
Cc: Williams Craig (NHS GREATER GLASGOW & CLYDE); Mcnamee Sandra (NHS GREATER GLASGOW & CLYDE); 'Pamela Joannidis (ICN, IPS)'
Subject: HAIORT NHSGG&C Serratia
Attachments: HAIORT 09 11 15.docx

Importance: High

Dear Abigail,

Please find the attached update to the HAIORT following yesterday's 4pm OCT meeting at RHC. In summary:

Patient cases:

- The three babies reported in the update on Friday 6th November remain in the Unit; none of these babies are reported to be giving cause for concern.
- There have been no other babies identified with positive colonisation or infection with S.marcescens since the 26th October 2015.

Microbiological tying of patient screens:

- Three strain types were reported at the OCT meeting; eight babies colonised with the same strain.
- NHSGG&C ICT have agreed to undertake a review, with HPS, of the S. marcescens data and the other Gram-negative Organism (GNO) data colonising and infecting babies within this Unit over the last 6 months as previously requested by the HAI Policy Unit. This should be complete by the end of this week.

Environmental screening:

- The condensate from the humidifiers of the ventilator circuits sampled was reported to have GNOs present, none definitive. Repeat samples to be taken.
- Swabs from breast pumps all reported negative.

Control measures:

- An extensive action plan of control measures remains in place.

HIIAT Assessment at 9th November 2015: GREEN Impact on patients:
Minor Impact on services: Minor Impact on public: Minor Impact on public anxiety: Moderate

Next expected update following OCT Meeting scheduled for Thursday 12th November 2015 at 4pm, unless the situation changes. In the meantime the Microbiology Laboratory data on GNOs will be reviewed by NHSGG&C and HPS.

Kind regards,
Lisa

Craig, Sandra, Pamela, please advise any errors or omissions to the above.

Kind regards,
Lisa

Lisa Ritchie
Nurse Consultant Infection Control
Infection Control Team / HAI Group
Health Protection Scotland

NHS National Services Scotland
4th Floor Meridian Court
5 Cadogan Street
Glasgow G2 6QE
T: [redacted]

support phone 0141 300 1100 and ask to speak to the HPS On-Call Consultant.

Please consider the environment before printing this e-mail.

NHS National Services Scotland is the common name for the Common Services Agency for the Scottish Health Service. www.nhsnss.org

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Dh'fhaodadh gum bi teachdaireachd sam bith bho Riaghaltas na h-Alba air a chlàradh neo air a sgrùdadh airson dearbhadh gu bheil an siostam ag obair gu h-èifeachdach neo airson adhbhar laghail eile. Dh'fhaodadh nach eil beachdan anns a' phost-d seo co-ionann ri beachdan Riaghaltas na h-Alba.
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A New Incident Form			
NHS Board		Greater Glasgow and Clyde	
Date and time of reporting		02/11/2015 12md	
Person Reporting incident		Craig Williams Pamela Joannidis,	
Designation of above		Lead ICD NCIPC/Lead IPCN for Paediatric Services	
Contact phone number		[redacted]	
email		Pamela.joannidis[redacted] Craig.williams[redacted]	
Where is the incident / outbreak occurring?			
Healthcare facility / hospital (including type)		Royal Hospital for Children	
Name of clinical area		NICU	
What patient services does this area care for		Neonatal services	
How many beds in this area		30	
What type of incident			
Category of incident	Outbreak: Increased incidence of colonisation / infection confirmed		
Name of organism	*Serratia marcescens*		
Infection Category	Other state: all patients colonisation; 1 patient blood stream infection		
Case definition (Preliminary)	Any patient with: Serratia marcescens in NICU/RHC/NHS GGC from 27/07/15		
Decontamination incident (where no persons are currently ill at present)			
What is the incident?			
Number of patients exposed		Number of staff exposed	
Outbreak – Total number of cases (patient) 13	Asymptomatic colonised 12	Symptomatic but not lab confirmed NA	Symptomatic and lab confirmed 1
Number of cases (staff) None		Date first case colonised 20/07/15 Baby 1: Deceased baby first colonised 26/10/15 Died [redacted]	
Of the above **patients**, are any giving cause for concern as a consequence of this infection / incident?		None	
Have any **patients died** as a consequence of this incident?		1 patient	
Has the organism been cited as a cause of death on a **death certificate (**if yes, which part of the certificate**)**		Part1 Septicaemia Part 2 Major peri-ventricular haemorrhage and ventricular dilatation	
Additional info on cases		Extreme prematurity and multiple complex co-morbidities	
Is the clinical area closed to admissions / transfers		N	
Hospital Infection Incident Assessment Tool (link to tool)			
Impact on patients	Minor Moderate Major	Major	
Impact on services	Minor Moderate Major	Minor	
Impact on public health	Minor Moderate Major	Minor	
Impact on public anxiety	Minor Moderate Major	Moderate	
HIIAT Score	Red Amber Green	RED	
What control measures are in place?			
Outbreak specific control measures in place	Action plan in place since August 2015. Reviewed daily and at IMTs. HPS ICT reviewed and commented. Action plan available.		
Other Control Measures			
What actions have and will take place			
Involved ICM	Y / N	Ongoing	
Involved CPHM	Y / N	02/11/15	

Patients / Relatives informed	Y / N	02/11/15
Formal OCT meeting held	Y Date	02/11/15
Press statement	Release	03/11/15
Next meeting to be held	Y / N Date	03/11/15
Other information:		
Planned next update		Date 03/11/15

Date	03/11/15	04/11/15	05/11/15	09/11/15		
Incidence						
New patients since last report who are symptomatic and are confirmed	No	No	No	No		
New patients who are symptomatic but not yet confirmed	No	No	No	No		
New patients asymptomatic but colonised	No	No	No	No		
New patients giving cause for concern	No	No	No	No		
New deaths as a consequence of the incident	No	No	No	No		
Prevalence						
Total number of new and existing cases (who have or have had symptoms and are confirmed)?	13	13	13	13		
Total number of cases who have or have had symptoms but are not lab confirmed?	0	0	0	0		
Total number of asymptomatic colonised?	12	12	12	12		
Of the new and existing confirmed cases how many still have symptoms today?	0	0	0	0		
Patients currently giving cause for concern	0	0	0	0		
Total deaths as a consequence If yes what part of certificate	1	1	1	1		
Service Impact						
Is the ward /services still closed	No	No	No	No		
Is a service still restricted	No	No	No	No		
Changes to HIIAT or Control Measures						
HIIAT	Green (manage as amber)	Green (manage as amber)	Green (manage as amber)	Green (manage as amber)		
Control measures unchanged	Yes	Yes	Yes	Yes		

Narrative update	Comment
Date: 03/11/15	No new patients identified today. Action plan remains in place. 4 colonised patients remain in-patients, none of whom are giving cause for concern
Date: 04/11/15	No new patients identified today. 4 colonised patients remain in-patients, none of whom are giving cause for concern Action plan remains in place
Date: 05/11/15	In reviewing the timeline today, 1 baby who was colonised, was noted to have died 22.10.15 Death certificate: Part 1: Chronic Lung Disease; Part 2: Extreme prematurity. 3 colonised patients remain in-patients, none of whom are giving cause for concern Action plan remains in place
Date: 09/11/15	No new patients identified today. Action plan remains in place. 3 colonised patients remain as in-patients. Next IMT on 12/11/15
Date:	
Date:	

THE WATT GROUP REPORT

A review of the outbreak of salmonella at the Victoria Infirmary, Glasgow, between December 2001 and January 2002 and lessons that may be learned by both the Victoria Infirmary and the wider NHS family in Scotland.

SCOTTISH EXECUTIVE
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4 ANTECEDENTS

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PREFACE

The outbreak of Salmonella infection in the Victoria Infirmary was a tragic episode for the patients who died and their relatives. It also had an impact on the Hospital and its staff. It is, therefore, particularly important to ensure that appropriate lessons are learned for the future both in the Hospital itself and in the wider NHS.

The Review identified a series of shortcomings at all levels. Some of these shortcomings were specific to the organisation concerned but many we believe could have been replicated throughout Scotland.

Some, but not all, of the failures and shortcomings that we detail have already been identified and remedial actions put in place. These are in addition to the recent initiatives relating to all aspects of hospital acquired infection (HAI) which will have important benefits in reducing HAI in the future.

The Review, and this Report, were team efforts. I would like to thank the members of the Review Group for their hard work, their professionalism and their support. If our recommendations help to reduce the risks of HAI and to improve the management of outbreaks in the future, some good will have come out of this sad episode.

BRIAN WATT

SUMMARY OF RECOMMENDATIONS

1. ***That Trusts should put in place structured audits of hand washing for all groups of staff, including medical, bank, agency and night staff.***

2. ***That the cleaning specification in wards and departments should be set by the senior nurse responsible for the area and each ward/departmental manager in collaboration with the relevant Infection Control Team and Domestic Services Manager. Cleaning against this specification should be subject to rigorous monitoring and action to correct deficiencies. Failure to meet the specification should be subject to formal audit and review within each hospital and be subject to public disclosure.***

3. ***That the ward/departmental manager should have unambiguous responsibility and be held accountable for all aspects of hygiene in their area. They must have commensurate authority, skills and resources (time and money) to discharge this responsibility.***

4. ***That Audit Scotland reports are reviewed carefully by the management of Trusts, and that appropriate action is taken to respond to them.***

5. ***That the Clinical Standards Board for Scotland ensures that there are reliable mechanisms in place to monitor compliance with its cleaning services standards.***

6. ***That exposure of staff to faeces should be documented through the Incident Reporting Procedure as thoroughly as exposure to any other biological (body) fluids.***

7. ***That specific guidelines and facilities (washing, showering, cleaning uniforms) should be available in every hospital for the decontamination of staff who become grossly contaminated from body fluids (blood, urine, faeces and so on).***

8. ***That every Trust should have a staff uniform policy that ensures that:***

   (a) ***all staff uniforms are laundered by, or under the auspices of, the NHS;***

   (b) ***the widespread practice of staff travelling to and from work in (potentially contaminated) uniforms ceases; and***

   (c) ***adequate staff changing and decontamination facilities are provided.***

9. ***That nursing notes/care plans should clearly reflect the need for enteric precautions in individuals suffering from loose stools /diarrhoea.***

10. ***That nursing documentation should be improved so that key information and advice relating to infection control measures can be communicated to all relevant staff.***

11. ***That clear infection control guidance to all staff on how to nurse a patient with loose stools/diarrhoea should be provided within the infection control manual.***

12. ***That there should be careful consideration nationally on reducing the movement of patients between wards in hospitals so that the likelihood of outbreaks occurring is minimised and when they do occur they are contained within as defined a location as possible.***

13. ***That a scientific meeting be organised at which experience and ideas relating to the specific infection control challenges of old buildings be shared and that following this the SEHD should issue guidance on the upgrading and maintenance of such buildings.***

14. ***That Trusts ensure that levels of basic ward equipment (e.g., hoist slings, commodes) are sufficient to reduce the communal use of such equipment and reduce the risk of cross-contamination due to inadequate decontamination.***

15. ***That Trusts develop policies which clearly identify the accountabilities of nursing and domestic staff in the cleaning of ward furniture and apparatus, including baths, food trolleys and "clinical" equipment and that clearly identify who has overall responsibility.***

16. ***(a)*** ***That the Scottish Executive Health Department should reinforce the good practice contained within the Scottish Health Facilities Note 30, "Infection Control in the built environment - design and planning," January 2002.***

(b) ***That the NHS in Scotland develops, as a matter of urgency, standards relating to new builds and refurbishment projects incorporating, where necessary, the Scottish Health Facilities Note 30 guidance as best practice and requires Trusts to produce action plans for compliance with Note 30.***

17. ***That control of an outbreak must include restriction of staff movement between wards and departments. When patients require infection control precautions to be implemented the nurses providing the care should, where possible, be the 'named nurse'. This should minimise the number of contacts of both the patient and the nurse. This may have implications for staffing of the ward but this will be temporary and not a high recurring cost.***

18. ***That the Agency/Bank/Locum induction checklist should include explicit mention of Infection Control precautions in place.***

19. ***That all Trusts should put in place assessments of the competencies of nursing staff in Infection Control and ensure that structured training programmes are established and the SEHD should consider with the Nursing Agency proprietors how competencies in Infection Control can be similarly assessed and delivered for Agency nurses. Similar training programmes should be put in place for medical and professions allied to medicine (PAM) staff.***

20. ***That all staff at ward or department level who handle food should receive training in food hygiene commensurate with their duties and in compliance with the Food Safety (General Food Hygiene) Regulations 1995.***

21. ***That appliances used for storing or preparing food (whether in the ward or elsewhere) should be subject to appropriate inspection and the results recorded.***

22. ***(a)*** ***That contacts with, and advice given by, any member of the ICT should be documented by both the individuals providing and receiving the advice. This is in addition to infection control care plans.***

(b) ***That nursing documentation should be improved so that key instructions relating to infection control measures can be communicated to all relevant staff.***

23. ***(a)*** ***That an OCT should always be chaired by someone with competence and authority in health care associated infection. The local Consultant in Public Health Medicine (CPHM) should chair OCTs for major outbreaks (see Appendix E for definition). This demonstrates that the Team is led by an individual external to the Trust, who has close links with the local NHS Board and with community surveillance. In the case of other hospital outbreaks the CPHM should be consulted regarding chairmanship of the team. In practice, this will usually be the ICD.***

(b) ***That there should be clear role definitions for the members of the OCT, with clear responsibilities documented.***

(c) ***That a clear Outbreak Control Plan should be agreed and implemented.***

24. ***That senior management (Executive Director level) of the Trust should be fully engaged from an early stage in managing outbreaks either as full and active members of the OCT or as a separate support team to the OCT. Senior management support should include a senior communications manager who can ensure that staff, relatives and the public are timeously informed of the outbreak and are given appropriate public health messages.***

25. ***That all OCT reports should provide sufficient details of key factors in the spread of infection to allow proper audit.***

26. ***That recommendation 10.22(a) and 10.22(b) of the Pennington Group Report (page 37) be extended to cover all outbreaks:***

(a) ***"On completion of investigations, it should be the responsibility of the CPHM to provide SCIEH with a minimum data set (in the form of a standard proforma) "***

(b) ***"For large (or otherwise significant) outbreaks a full written report should be completed and consideration given to its publication. Copies of written reports should be forwarded to SCIEH."***

27. ***That an expert group be set up to give clear Scottish guidance on the role of staff screening in outbreaks of infection, so that such guidance can be used by OCTs in the future.***

28. ***That in the case of an outbreak where non-invasive screening of relevant staff is deemed appropriate, Trusts should place a duty on all such staff to comply.***

29. ***That Trusts take measures to improve the quality of clinical information on laboratory request forms.***

30. ***That a classification system for infection outbreaks/episodes be drawn up and used by all key players as "common currency" in deciding the actions and communications required in a given infection incident (A framework (Infection Control Risk Matrix) is set out in detail in Appendix E) and that clear policies are developed, using this system, which identify all the key individuals involved in communications about outbreaks of different severity.***

31. ***That in any outbreak that is considered at any stage to be foodborne, the Scottish Executive is informed in addition to the Food Standards Agency.***

32. ***That Trusts and Boards ensure that there are sufficient resources to appoint adequate levels of communication professionals, but that "Press Office to Press Office" communication is additional to, not a substitute for, professional communication.***

33. ***(a)*** ***That the Chief Executive of a Trust or Health Board (depending on whether the outbreak is primarily in the hospital or community respectively) should assume the unambiguous responsibility for ensuring effective internal and external communications, including the media, appropriate Government Departments and Agencies.***

(b) ***That within the SEHD consideration should be given to the nomination of an issue manager as soon as a serious outbreak occurs and irrespective of the route through which notification has come. Clear guidelines should also be in place on which Division/Unit within the SEHD should be responsible for actions and briefing associated with an outbreak.***

34. ***That resources are in place to ensure that each Trust has a designated and trained ICD, who will normally lead the Trust ICT. This will usually, but not invariably, be a consultant microbiologist who will have designated sessions and a clearly defined job description for this component of their work. In the case of Trusts without laboratory facilities (e.g., Primary Care Trusts) they should formalise arrangements with a suitably trained and appropriately resourced individual.***

35. ***That resources are in place to ensure that each Trust has sufficient ICN establishment to:***

(a) ***have daily contact with wards or other health care premises;***

(b) ***visit each facility at least weekly;***

(c) ***provide advice to ward and departmental nursing staff on the nursing care of patients who are at risk of , or who have, infection;***

(d) be responsible for a systematic competency programme in infection control for all health care workers at their place of work (including medical, agency and bank staff);

(e) undertake systematic hand washing audits, including audits involving night and weekend health care workers; and

(f) provide an on-call service to advise on infection control matters on a 24-hour basis.

.

36. That there should be a lead Infection Control Nurse (ICN) in each Trust.

37. That infection control champions at ward level can complement, but not replace, the roles of the Infection Control Team. They should not be used as substitutes for ICNs but:

(a) They should assist in the delivery of a comprehensive infection control service and be integral members of an enlarged Infection Control Team; and

(b) Have clearly defined roles, dedicated time for infection control duties and be appropriately trained and supervised. The extra responsibilities and training should attract enhancement of salaries.

38. That each Health Board should have an appropriately constituted Standing Infection Control Team (ICT) which:

(a) takes the lead in strategic aspects of infection control in their area;

(b) formulates and agrees infection control policies;

(c) co-ordinates the management of all outbreaks where the Major Outbreak Plan is invoked;

(d) has a designated leader;

(e) links effectively with Risk Management Committees and Clinical Governance Committees; and

(f) provides assistance and advice to Trust ICTs when requested and/or when appropriate.

39. That large Trusts should have an appropriately constituted Standing Infection Control Team (ICT) which:

(a) prevents and manages healthcare associated infection within their Trust;

(b) implements agreed Board and Trust policies in infection control;

(c) has a designated leader;

(d) links effectively with Risk Management Committees and Clinical Governance Committees; and

(e) liaises closely with, co-operates with, and provides membership for the Health Board ICT.

40. That CPHMs (CD/EH) should be trained in the management of HAI and play a more prominent role in HAI surveillance and hospital outbreak management. They should normally lead all infection outbreaks within their Board where the Board's Major Outbreak Plan is invoked.

41. That each Health Board holds regular (possibly every 2 years) simulated outbreak exercises, with adequate debriefing afterward, and that documentation of such exercises be provided to the Clinical Standards Board at the time of their inspections.

42. (a) That all relevant parts of the NHS operate to a consistent set of criteria that is linked to a risk management classification that describes infection outbreaks/episodes.

(b) That the level of outbreak/episode risk category determines both the level of action(s) required and the level of communications.

43. That Trusts link infection control to risk management structures as a matter of urgency.

44. That at both local and Scottish Executive level more strenuous efforts are made to tap the potential of the media to improve the public understanding of infection control issues. This will require a more open relationship to be developed between the NHS and the media based on mutual trust. There should be presumption of early disclosure to the public and the media of outbreaks of infection.

45. That internal communications within and between the Scottish Executive and NHS organisations are improved and clarified so as to reflect the openness culture and this is emulated in communications with relevant agencies (e.g., The Food Standards Agency, Scottish Water, Scottish Environmental Protection Agency (SEPA).

46. (a) That NHS Scotland should adopt a programme budgeting approach to Infection Control and that each Trust and each Board be required to provide details of the resources devoted to Infection Control.

(b) That such details are supplied as part of the documentation provided to the Clinical Standards Board for Scotland at the time of individual Trust reviews.

47. That the Scottish Executive should convene a Working Group to develop methods of tracking and calculating the costs of HAI and its control in Scotland.

CHAPTER 1

INTRODUCTION

Following the outbreak of salmonella in the Victoria Infirmary, Glasgow, a Group under the chairmanship of Dr Brian Watt was set up by the Scottish Executive to review the outbreak, with a remit to:

(a) "Review the circumstances surrounding the onset of the outbreak of salmonella infection at the Victoria Infirmary, Glasgow, in December 2001 and January 2002 and identify the likely causal factors;

(b) Assess the management of the outbreak and its effectiveness in reducing further exposure to the organism involved;

(c) Assess how the NHS Trust managed the overall situation, including communications with other relevant organisations and the public; and

(d) Draw conclusions and make recommendations to help reduce the risks of future outbreaks of infections of this kind in hospitals and help improve both outbreak and overall management."

The Group convened during May 2002 and met a wide range of individuals from all of the relevant organisations involved. As far as possible, the Group as a whole interviewed each individual. The Group also interviewed staff from the Scottish Executive; in these latter interviews no secretariat was present and members of the Group took notes. Membership of the Group is given in Appendix A and a list of individuals interviewed is given in Appendix B.

Where opinions are expressed on various issues covered in this report these are based on: interviews; professional opinion; the relevant guidance listed in Appendix D; and the review of a large series of relevant documents, some confidential. A full list of the non-confidential documents is given in Appendix C. Access to these documents can be obtained by contacting: **Mr John Brunton, the Scottish Executive Health Department, St Andrew's House, Regent Road, Edinburgh EH1 3DG, Tel: 0131 244 2868.**

Fatal Accident Inquiry/Investigations by Health and Safety Executive

At the time of writing the Report, decisions on whether to proceed to a Fatal Accident Inquiry had not been made. Also, an investigation by the Health and Safety Executive was continuing. The Group was given permission by the Procurator Fiscal to proceed with their review, and to receive a confidential briefing from the Health and Safety Executive to assist in their work. This briefing also informed the opinions of the Group.

The Group's Approach to the Review

From the beginning the Group worked on the basis of 3 principles:

(1) The purpose of the Review was not to apportion individual blame, but to identify systematic shortcomings and to make recommendations;

(2) The Review would not be a "white-wash"; where shortcomings were identified, these would be clearly outlined, irrespective of where they occurred; and

(3) All comments made to the Group during the interviews would be non-attributable.

These principles were explained to each individual before their interviews.

The Group preserved patient confidentiality; the patients involved were known to the Group, and are referred to in this Report, by letters only.

At the request of the Group, the Trust wrote to the relatives of the bereaved patients giving them the opportunity to meet the Group if they wished.

Acknowledgements

We are very grateful to all of those who took part in interviews. We are especially grateful to Dr Giles Edwards and Mrs Emily Simpson (Information Librarian, Royal College of Physicians, Edinburgh) for help with literature reviews.

We are very grateful to our Secretary, Mr John Brunton, for his clear minuting of the interviews, collation of documents and organisation of the administrative arrangements.

CHAPTER 2

THE SALMONELLA OUTBREAK IN THE VICTORIA INFIRMARY

Summary and Chronology

The Group, having read the Report of the Outbreak Control Team (OCT) agrees with the detailed facts of the outbreak given therein. These can be summarised as follows:

Salmonella species was isolated from Patient A (who had been admitted with diarrhoea on 27th December 2001) on 30th December 2001. This patient had been transferred to a medical ward before being transferred to a specialist unit in another hospital on that day.

Salmonella species was also isolated on 2nd January 2002 from Patient B, who had been in the same medical ward since 21st November 2001. This patient developed diarrhoea from 31st December 2001 and a faecal sample had been taken on that date.

Patient C, being nursed in the same ward in a bed next to Patient B, had had diarrhoea since admission on 16th November 2001 but became increasingly unwell. A stored faecal sample taken on 27th December 2001 tested for Salmonella spp. and reported positive on 3rd January 2002. A faecal sample taken on 10th December 2001 was negative.

3rd January 2002 - at this stage 3 patients from the same ward had been confirmed as having Salmonella spp.

On 7th January 2002, Salmonella species was isolated from Patient E, who had been a patient in the same ward since 27th December 2001 and had diarrhoea from 5th January 2002. [Stool samples from another patient, Patient D, who had been nursed next to Patients B and C but who was asymptomatic, were negative and this patient was not considered part of the outbreak.].

By 8th January 2002, the Salmonella Reference Laboratory reported as follows:

Patient A - Salmonella enteritidis phage type 4.

Patient B - Salmonella enteritidis phage type 21.

Patient C - Salmonella enteritidis phage type 21.

[Thus Patient A was not part of the outbreak.]

At this time, the laboratory reported that they had received a report from the Reference Laboratory on 7th January 2002 that another patient, Patient F, who had been in the same ward from 21-23 December 2001, had Salmonella enteritidis phage type 21 present.

On [redacted] Patients B and C died.

On 10th January 2002, the Salmonella species isolated from Patient E was also confirmed as Salmonella enteritidis phage type 21.

On [redacted] Patient E died.

Salmonella species were isolated from a further 2 patients: from Patient G (faecal sample on 11th January 2002) and from Patient H (faecal sample on 18th January 2002). The organism was identified as Salmonella enteritidis phage type 21 on 15th January 2002 (Patient G) and 21st January 2002 (Patient H). Neither patient had been in the ward in which the other cases had occurred.

At this stage (23rd January 2002) the Outbreak Control Team (OCT) implemented faecal screening of staff. Two health care workers were found to have Salmonella enteritidis phage type 21.

After this time there were no further patients or staff identified with Salmonella enteritidis phage type 21.

Epidemiological Conclusions

The views of the OCT are set out in their OCT Report and can be summarised as follows:

- Patient F was the likely source, having acquired Salmonella enteritidis in the community before admission to hospital.

- There was no evidence that hospital food caused the outbreak (one of the patients was being fed by tube only and there was no evidence of unusual levels of diarrhoea in patients or staff).

- Patients B, C and E acquired their infections by inadvertent transmission of the organism in the medical ward.

- There was no link between Patients G and H or with the other patients. Food histories from these patients indicated possible acquisition of the organism in the community. This was considered by the OCT to be the likeliest explanation on the balance of probabilities.

- The two health care workers identified as having Salmonella enteritidis phage type 21 on screening were not considered to be responsible for cross-infection but rather to have acquired the organism as a result of exposure to it in the course of their duties on the medical ward.

- The exact route(s) of cross-infection could not be identified.

The Review Group generally agrees with these conclusions, based as they are on the best evidence available and, where more than one possibility existed, on the balance of probability. However, the Group considers that person-to-person spread within another of the Hospital wards cannot be excluded as a factor in the latter two patients (G and H).

CHAPTER 3

NOSOCOMIAL OUTBREAKS OF SALMONELLA – BACKGROUND

This chapter is intended to provide background to the factors that contributed to the outbreak; it is not an extensive scientific review.

Salmonella species causing gastrointestinal infection in man are often derived from cattle or poultry in which they may be found as commensals in faeces. For infection to occur, the organisms must be ingested, usually through the faecal-oral route. In the main, infection is foodborne and occurs by ingestion of meat or animal products contaminated with these faecal salmonella. In a smaller proportion of outbreaks infection may occur due to person-to-person contact, either directly or indirectly via contamination of equipment or of a surface, which is then handled by a second person and the organism transferred to their mouth.

Ingestion of Salmonella spp. may produce:

- No effects (i.e. organisms destroyed by the digestive system);
- Replication within the gut and consequent faecal excretion without clinical symptoms (asymptomatic carriage);
- Replication within the gut and clinical (usually gastrointestinal) symptoms.

Both asymptomatic carriers and symptomatic patients can be a potential source of infection to others.

Salmonella spp. cause symptoms 6-72 hours (usually 12-36 hours) after ingestion.[1] The incubation period may be as long as 7 days. The illness is usually self limiting and short-lived but in a proportion of patients (usually at the extremes of life) the illness can be life threatening.[2]

Although it had long been assumed, on the basis of volunteer studies, that it was necessary to ingest large numbers of salmonella organisms to produce infection, a review of the subject [3] concluded both that such studies had their limitations (e.g., few tested low challenge doses) and that, in those foodborne outbreaks where the challenge dose had been calculated, the numbers of organisms could be as low as 10^3 or less. There also appears to be a clear dose-response relationship; ingested dose appears to be an important determinant of incubation period, symptoms and severity of disease.[4,5] All of these studies relate to foodborne infections; but it is reasonable to assume that these conclusions are also valid for person-to-person spread. There needs to be more detailed studies of non-foodborne nosocomial outbreaks of Salmonella infection to establish how person to person spread occurs and whether non-contact routes (e.g., aerosolisation of organisms) play any or a significant part. Such studies would be assisted by comprehensive surveillance of nosocomial outbreaks.

Salmonella spp. are grouped into serotypes (sometimes still referred to as species). The commonest serotypes are S.enteritidis and S.typhimurium. Although there has been a year-on-year reduction in the number of laboratory isolates of salmonella, S.enteritidis accounts for the majority of human isolates (see OCT report).

Strains of S.enteritidis and S.typhimurium can be subtyped by their susceptibility to a range of bacteriophages. The organism involved in this outbreak was Salmonella enteritidis phage

type 21, an uncommon phage type in Scotland (49 of 1,349 isolates in 1998), although, as in the rest of the UK, there has been a recent increase in frequency of isolation.[2]

Strains can be further subtyped using molecular techniques such as pulsed field gel electrophoresis (PFGE) and plasmid profiling, as well as antibiotic susceptibility testing. These methods may have considerable use in the investigation of outbreaks.

Salmonella spp. can cause outbreaks of infection in the community and in healthcare premises such as hospitals. Exact information on the role of salmonella in the community and in hospitals is difficult to obtain; laboratory based surveillance is believed to detect only a small proportion of cases in the community.[6] In any case most laboratory reports refer to individual patient isolates, rather than outbreaks.[7]

In a review of outbreaks of salmonella in hospitals in England and Wales over a 10 year period, Joseph and Palmer[8] showed that of 248 outbreaks, foodborne infection accounted for 57 (24%) outbreaks and presumed person-to-person spread for 70 (30%). No information was available for 107 (46%) of the outbreaks.

A more recent review[9] concluded that of 22 outbreaks in which Salmonella spp. were implicated, person-to-person spread accounted for 12, foodborne infection for 8 and in the other 2 the route of infection was unknown. Frequently person-to-person transmission is established by the exclusion of foodborne infection.

Although it is sometimes possible to establish the source of person-to-person spread in nosocomial salmonella outbreaks[10] in most outbreaks the exact source(s) cannot be determined. For example, careful investigation of a nosocomial outbreak due to S.enteritidis phage type 4, including the use of PFGE[11] established that person-to-person spread was the most likely cause, but failed to establish the source. The authors concluded that admission of a patient with an unrecognised community-acquired infection was the most likely source.

This was probably the case in an outbreak of nosocomial S.typhimurium infection in a Scottish hospital, which resulted in transmission of infection to 2 patients, 13 health care workers and a relative of one of the health care workers. The causative organism carried two independent drug resistance plasmids, which the authors concluded might have contributed to the virulence and transmissibility of the organism.[12]

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CHAPTER 4

ANTECEDENTS

The Victoria Infirmary, built in 1893, is no longer fit for purpose as a busy general hospital. It has suffered from a prolonged period of uncertainty about its future with consequent planning blight and serious under-investment in the fabric of the building. The Hospital has faced a long-standing series of difficulties, well publicised in often hostile media coverage.

The above factors have had 2 consequences:

(a) Difficulties in recruitment (30% shortfall of the nursing establishment in the medical unit where the outbreak occurred) with reliance on bank and agency staff to fill the gaps;

(b) Lowering of morale and the development of a "siege" mentality in some Trust staff.

We recognise the wide array of competing pressures on the time, energy and focus of individuals, managers and on the resources of an NHS Trust, and also recognise the dedication of hard-pressed staff working in difficult conditions.

Causal and Associated Factors

The exact route(s) of transmission within the ward cannot be established with certainty, but could be one or more of the following:

(1) Patient-to-patient contact, either directly or via the environment or via staff;

(2) Through inadequately decontaminated equipment and environment;

(3) By contamination of food at ward level and subsequent storage at unsatisfactory temperatures.

Hand Washing

There is evidence that before the outbreak there were insufficient hand washing facilities in the wards concerned and no audit evidence of compliance with hand washing guidelines. Compliance with hand washing guidelines is a problem throughout the NHS. The Group considers that there needs to be a "culture change" so that it is as unacceptable for health care workers not to comply with hand washing guidelines as it is for a surgeon to commence an operation without scrubbing up, or without using sterile instruments. Trusts should recognise the central importance of hand washing.

Recommendation

1. That Trusts should put in place structured audits of hand washing for all groups of staff, including medical, bank, agency and night staff.

Cleaning

The layout of the ward, especially the space between beds; the surface finishes; and state of the fabric, will have made it a challenge to clean effectively.

It is clear that there were widespread concerns about the quality and frequency of ward cleaning in the Victoria Infirmary before, during and after the outbreak. The contract specification is inadequate and ward staff have long complained about this. The contract is now the subject of renegotiation by the management of the Trust and the contractor.

There was a lack of clarity about who was responsible for the cleanliness of ward areas and a lack of regular audits. Although regular monitoring occurred, improvements were not effected.

The Group was concerned that in spite of these issues and of the recent Health and Safety Executive Report on the hospital, which expressed major concerns in relation to cleanliness, we were led to believe by the Trust that there were no serious issues arising from the recent assessment by Audit Scotland of the Trust's compliance with the Clinical Standards Board for Scotland's Healthcare Associated Infection (HAI) and Cleaning Services standards, and "A Clean Bill of Health: a review of domestic services in Scottish hospitals" published in April 2000.[13]

Recommendations

2. ***That the cleaning specification in wards and departments should be set by the senior nurse responsible for the area and each ward/departmental manager in collaboration with the relevant Infection Control Team and Domestic Services Manager. Cleaning against this specification should be subject to rigorous monitoring and action to correct deficiencies. Failure to meet the specification should be subject to formal audit and review within each hospital and be subject to public disclosure.***

3. ***That the ward/departmental manager should have unambiguous responsibility and be held accountable for all aspects of hygiene in their area. They must have commensurate authority, skills and resources (time and money) to discharge this responsibility.***

4. ***That Audit Scotland reports are reviewed carefully by the management of Trusts, and that appropriate action is taken to respond to them.***

5. ***That the Clinical Standards Board for Scotland ensures that there are reliable mechanisms in place to monitor compliance with its cleaning services standards.***

[13] Auditor General for Scotland. 'A Clean Bill of Health', a review of domestic services in Scottish hospitals, April 2000. (Audit Scotland)

Decontamination of Staff/Changing Facilities

Although faecal contamination of staff was believed to have resulted in occupationally acquired salmonella infection, the Group was not provided with evidence that these incidents had been clearly documented and investigated. Also, there did not appear to be clear guidelines for decontamination of staff, nor for the treatment and laundering of soiled uniforms. It was clear that staff travelled to and from work in uniform and that many laundered their uniforms at home. The Trust's uniform policy was more of a dress code guideline. It did not give guidance as to how uniforms should be laundered, or whether a spare should be brought to work in case of a contamination incident, nor how uniforms should be treated in the event of such an incident. Staff changing facilities were inadequate and there was evidence of staff changing into clinical uniforms in the sluice room (classed as a "dirty" utility room) or domestic services room. Travelling to work in uniform and changing as described above are not positive symbols of good hygiene and will undermine public confidence.

Recommendations

6. That exposure of staff to faeces should be documented through the Incident Reporting Procedure as thoroughly as exposure to any other biological (body) fluids.

7. That specific guidelines and facilities (washing, showering, cleaning uniforms) should be available in every hospital for the decontamination of staff who become grossly contaminated from body fluids (blood, urine, faeces and so on).

8. That every Trust should have a staff uniform policy that ensures that:

(a) all staff uniforms are laundered by, or under the auspices of, the NHS;

(b) the widespread practice of staff travelling to and from work in (potentially contaminated) uniforms ceases; and

(c) adequate staff changing and decontamination facilities are provided.

Nursing Documentation

There was insufficient information about the excretions of patients so that it was unclear whether certain patients had diarrhoea at the time of admission or subsequently developed it. Guidance given to nursing staff by the Infection Control Staff was not readily documented within the nursing notes and there was no clear written guidance to all staff members that specific patients suffering from diarrhoea were to have enteric precautions implemented. There was failure to clearly document individuals having loose stools; the number of stools passed; and their consistency in the nursing notes. The first visible sign of enteric precaution documentation followed the diagnosis of Salmonella infection.

Recommendations

9. That nursing notes/care plans should clearly reflect the need for enteric precautions in individuals suffering from loose stools /diarrhoea.

10. That nursing documentation should be improved so that key information and advice relating to infection control measures can be communicated to all relevant staff.

11. That clear infection control guidance to all staff on how to nurse a patient with loose stools/diarrhoea should be provided within the infection control manual.

Patient Movement

The Hospital was extremely busy before and during the outbreak with considerable patient movement. It is a common practice in the NHS for patients to be moved from bed area to bed area and from ward to ward. Sometimes there are clinical reasons for this but it has also been actively pursued to increase efficiency in the throughput of patients: e.g., it is routine for patients to be admitted to an assessment ward, then to a specialty ward and to be moved again if beds are unavailable. They may also be transferred to a discharge lounge, another form of ward, before they eventually leave hospital. Although probably not relating directly to the patients concerned in the outbreak, the Group considers that this practice does carry serious disadvantages - it confuses patients and they feel there is no one person who is in full possession of the facts of their case; it increases workload and puts an extra burden on communication between patient and staff and between staff and staff. Crucially, it also places an added burden on the control of infection - greater cleaning and decontamination is required and facts about patients such as their bowel movements may be lost or misinterpreted.

Recommendation

12. That there should be careful consideration nationally on reducing the movement of patients between wards in hospitals so that the likelihood of outbreaks occurring is minimised and when they do occur they are contained within as defined a location as possible.

Ward Environment

The layout of the ward, cramped conditions, insufficient single rooms for isolation, paucity of storage facilities and the state of the fabric, were not conducive to compliance with Infection Control Guidelines. They were not, however, in themselves a reason for non-compliance; many hospitals in Scotland pose similar challenges.

Recommendation

13. That a scientific meeting be organised at which experience and ideas relating to the specific infection control challenges of old buildings be shared and that following this the SEHD should issue guidance on the upgrading and maintenance of such buildings.

Ward Equipment

The demarcation of nursing and domestic staff roles in cleaning ward equipment was not clearly understood by nursing or domestic staff. At interviews, there was a lack of clarity as

to who had overall responsibility. Also, the level of basic ward equipment, especially hoist slings and commodes in the ward concerned, was insufficient. This must have led to considerable communal sharing, putting greater strain on the decontamination process.

Recommendations

14. That Trusts ensure that levels of basic ward equipment (e.g., hoist slings, commodes) are sufficient to reduce the communal use of such equipment and reduce the risk of cross-contamination due to inadequate decontamination.

15. That Trusts develop policies which clearly identify the accountabilities of nursing and domestic staff in the cleaning of ward furniture and apparatus, including baths, food trolleys and "clinical" equipment and that clearly identify who has overall responsibility.

Space Considerations

Valiant attempts had been made to improve the Victorian layout of some wards (e.g., to give greater privacy and patient amenity) by changing their internal configuration. This applied to the wards affected by the outbreak. In doing so, however, it would appear that the distances between beds were reduced and patients were therefore in closer contact with one another than had applied previously. In addition, there was inadequate ancillary accommodation: clean and dirty utility rooms, staff changing rooms, domestic services areas and staff bases.

Overcrowding is a recognised factor in the causation of healthcare associated infections. Standards of ward accommodation (to reduce the likelihood of outbreaks of cross infection and to maximise their containment if they do occur) should be set nationally and be effected by a specific funding programme. These standards should include, amongst other things, sufficient hand washing facilities, en-suite toilet accommodation and clean preparation areas, segregation of domestic cleaning rooms and clean storage from dirty utility rooms.

The Scottish Health Facilities Note 30[14] should be used as a first point of reference on Infection Control on new builds and refurbishment projects. The Group fully supports this as a guide for best practice.

Recommendation

16. (a) That the Scottish Executive Health Department should reinforce the good practice contained within the Scottish Health Facilities Note 30, "Infection Control in the built environment - design and planning," January 2002.

(b) That the NHS in Scotland develops, as a matter of urgency, standards relating to new builds and refurbishment projects incorporating, where necessary, the Scottish Health Facilities Note 30 guidance as best practice and requires Trusts to produce action plans for compliance with Note 30.

[14] Scottish Health Facilities Note 30, 'Infection control in the built environment – design and planning' January 2002, page 10. (Scottish Executive)

Vacancies and Agency/Bank Nursing Staff

Nursing staff vacancies within the medical unit in which the outbreak took place were quoted to be 30% and it appears they were at this level before and during the outbreak. These vacancies were covered by agency and bank staff. This added to the numbers of staff passing through the wards. The Group is concerned both that infection control training of Agency staff may have been insufficient and that by increasing 'throughput' of staff there could have been an increased risk of cross infection.

There was also insufficient Infection Control Nurse cover, especially over the festive holiday period.

Recommendations

17. That control of an outbreak must include restriction of staff movement between wards and departments. When patients require infection control precautions to be implemented the nurses providing the care should, where possible, be the 'named nurse'. This should minimise the number of contacts of both the patient and the nurse. This may have implications for staffing of the ward but this will be temporary and not a high recurring cost.

18. That the Agency/Bank/Locum induction checklist should include explicit mention of Infection Control precautions in place.

19. That all Trusts should put in place assessments of the competencies of nursing staff in Infection Control and ensure that structured training programmes are established and the SEHD should consider with the Nursing Agency proprietors how competencies in Infection Control can be similarly assessed and delivered for Agency nurses. Similar training programmes should be put in place for medical and professions allied to medicine (PAM) staff.

Handling of Food at Ward Level

Although there was no clear evidence of this being a factor in the outbreak, the Group was concerned that:

(a) The ward refrigerator was not kept at the correct temperature;

(b) Ward staff received no formal training in food handling.

Recommendations

20. That all staff at ward or department level who handle food should receive training in food hygiene commensurate with their duties and in compliance with the Food Safety (General Food Hygiene) Regulations 1995.

21. That appliances used for storing or preparing food (whether in the ward or elsewhere) should be subject to appropriate inspection and the results recorded.

Clinical Waste Disposal

The Health and Safety Executive commented in detail in their report about concerns relating to clinical waste disposal. We endorse their findings and comments.

CHAPTER 5

MANAGEMENT OF THE OUTBREAK

Initial Response

The cases occurred over a festive holiday period and initial actions were undertaken by the Infection Control Doctor (ICD). However, it was not clear to the Review Group that these actions/instructions had been properly documented at ward level or carried out.

Recommendation

22. (a) That contacts with, and advice given by, any member of the ICT should be documented by both the individuals providing and receiving the advice. This is in addition to infection control care plans.

(b) That nursing documentation should be improved so that key instructions relating to infection control measures can be communicated to all relevant staff.

Infection Control Doctor

The Group considered that while the individual performed well as Infection Control Doctor (ICD) during the outbreak, the role and accountability of the ICD in the Victoria Infirmary was poorly defined and no clear sessional commitments for this role were agreed or documented.

Outbreak Control Team (OCT)

Although three cases of salmonella infection had been identified in patients from the same ward by 3rd January 2002, an outbreak was not declared and the OCT was not established until 8th January 2002. Thereafter the OCT met regularly, but attendances were inconsistent, roles and responsibilities were not clearly defined and the OCT was chaired by three different individuals. To some extent this reflected the impact of media coverage and of the developing SRSV outbreak. Nevertheless there was a lack of clarity about who was responsible for the overall management of the Salmonella outbreak. The line of executive actions (taking decisions, committing resources, ensuring that actions were carried out) was also unclear. It appeared that management at Executive Director level within the Greater Glasgow NHS system were not fully engaged until late in the outbreak.

The Group believes that Infection Control needs to command a much higher order in the priorities of senior managers.

Recommendations

23. (a) An OCT should always be chaired by someone with competence and authority in health care associated infection. The local Consultant in Public Health Medicine (CPHM) should chair OCTs for major outbreaks (see Appendix E for definition). This demonstrates that the Team is led by an individual external to the Trust, who has close links with the local NHS

Board and with community surveillance. In the case of other hospital outbreaks the CPHM should be consulted regarding chairmanship of the team. In practice, this will usually be the ICD.

(b) That there should be clear role definitions for the members of the OCT, with clear responsibilities documented.

(c) That a clear Outbreak Control Plan should be agreed and implemented.

24. That senior management (Executive Director level) of the Trust should be fully engaged from an early stage in managing outbreaks either as full and active members of the OCT or as a separate support team to the OCT. Senior management support should include a senior communications manager who can ensure that staff, relatives and the public are timeously informed of the outbreak and are given appropriate public health messages. **[See Chapter 6]**

OCT Report

The report was well written and provided a clear account of the epidemiological, microbiological and environmental investigations and conclusions, as well as succinctly describing the management of the outbreak. It was in a format suitable for public dissemination. However, the Report did not document the fundamental aspects of the likely spread of infection, nor give details of key infection control issues relevant to the outbreak (e.g., hand washing, cleanliness, decontamination). As there was no "lessons learnt" section in the Report, this could prevent proper audit of remedial actions and lead to a belief amongst staff that there were few, if any, lessons to be learnt. There was some evidence of this belief from our interviews.

Recommendations

25. That all OCT reports should provide sufficient details of key factors in the spread of infection to allow proper audit.

26. That recommendation 10.22(a) and 10.22(b) of the Pennington Group Report[15] (page 37) be extended to cover all outbreaks:

(a) ***"On completion of investigations, it should be the responsibility of the CPHM to provide SCIEH with a minimum data set (in the form of a standard proforma) "***

(b) ***"For large (or otherwise significant) outbreaks a full written report should be completed and consideration given to its publication. Copies of written reports should be forwarded to SCIEH."***

[15] Pennington Group Report – 'Report on the circumstances leading to the 1996 outbreak of infection with E.coli 0157 in Central Scotland, the implications for food safety and the lessons to be learned.' (The Scottish Office, 1997)

Staff Screening

The OCT changed its policy on staff screening in the middle of the outbreak, due to the further development of new cases, from one of no screening to one of screening of relevant staff. When screening commenced, it was on a voluntary basis and it was clear that a significant proportion of staff did not submit samples.

The Group was aware of the confusion surrounding guidelines on staff screening (and of the benefits of hindsight) but considered that earlier screening of staff might have defined the extent of the outbreak more clearly.

Recommendations

27. That an expert group be set up to give clear Scottish guidance on the role of staff screening in outbreaks of infection, so that such guidance can be used by OCTs in the future.

28. That in the case of an outbreak where non-invasive screening of relevant staff is deemed appropriate, Trusts should place a duty on all such staff to comply.

Major Outbreak Plan

At no point was the outbreak managed as a major or critical incident. There was little clarity about which guidance was followed by the OCT; initially local guidelines were followed and only very late in the outbreak did Greater Glasgow NHS Board guidelines come to the fore. The Review Team also heard evidence that although the NHS Board's Infection Control Guidelines (including an Outbreak Control Plan) were available, some Trusts in Greater Glasgow had developed their own guidelines without reference to those of the Board. **This issue is covered in more detail in Chapter 6 and our recommendations are set out there.**

Infection Control Nurse (ICN) Support

Although we recognise that the Trust subsequently increased the number of ICNs to 4 WTEs, shared between the two major sites (Southern General Hospital and Victoria Infirmary) there was insufficient ICN support in the period leading up to the outbreak. The fact that there was only one WTE in post at the Trust at the time of the outbreak did not allow for delivery of a comprehensive, fully integrated, infection control service and proper monitoring of compliance with infection control guidelines.

Telephone guidance was available from 4th January 2002, and in person from 8th January 2002, but the Group found evidence that Infection Control advice was not properly documented in the nursing notes. The Group found no evidence of guidelines relating to the management of patients admitted with diarrhoea and vomiting.

The Group was concerned that, although ICN support has been increased since the outbreak, there was still no clarity about which individual was designated to provide ICN leadership and no clear evidence of plans for the future development of the service.

The Group believes that the present 9.00am to 5.00pm, 5 days a week, ICN service (with no telephone cover or public holiday cover) that exists in Scottish hospitals is inadequate to

provide a comprehensive infection control nursing service. **This is addressed in detail in Chapter 6.**

Microbiological Support

The microbiology laboratory provided good support during the outbreak. However, it is unfortunate that the possible role of patient F in the outbreak was not considered until 8th January 2002 when delayed phage typing results from the Reference Laboratory became available, although a faecal sample was taken from the patient on 23rd December 2001.

The amount of clinical information given on several of the request forms was inadequate or absent; mention of changes in bowel habit might have alerted laboratory staff to the need for more extensive testing.

Inadequate clinical information on laboratory request forms is a common problem. Medical and nursing staff must be aware of the need for relevant and up-to-date clinical information.

Recommendation

29. That Trusts take measures to improve the quality of clinical information on laboratory request forms.

CHAPTER 6

WIDER MANAGEMENT CONSIDERATIONS, INCLUDING COMMUNICATIONS AND OTHER KEY ISSUES

As has already been mentioned in Chapter 5, the Group considered that management at Executive Director level within the Greater Glasgow NHS system had not been fully engaged in the outbreak until shortly before the issue appeared in the media. A decision had been taken not to issue a press statement (although one had been prepared). The public was not informed of the circumstances and issues surrounding the outbreak until the relatives of one patient took their concerns to the media. An important means of communication and of transmission of a public health message was therefore lost. When the story broke, the Trust's perception of a hostile media became self-fulfilling.

Internally, communication with staff appeared to rely mainly on a verbal briefing system from 3rd January 2002 and regular ward visits by ICNs from 8th January onwards. There is some doubt, based on interviews, as to whether all staff would have received a full briefing on the progress of the outbreak or control measures to be implemented. The Group believes that one of the responsibilities of the OCT must be to ensure prompt and clear internal communication with all relevant staff.

The Group found that a series of communications failures had occurred at various stages between the OCT and the Scottish Executive, as well as within the Scottish Executive itself. These can be summarised as follows:

(1) Although the Trust informed the Public Health Department on 3rd January, there appeared to be a delay in informing senior management of the Greater Glasgow NHS Board.

(2) Delay and lack of clarity within Greater Glasgow NHS Board with no formalised policy for early warning of the Chief Executive and Director of Public Health by Consultants in Public Health Medicine. This resulted in the Chief Executive not being engaged in the outbreak until a week had elapsed.

(3) Failure of the Trust OCT to inform the Scottish Executive although the SCIEH representative on the OCT had informed the Food Standards Agency; eventually information was requested from the Trust by the Scottish Executive when they learned of the press interest (neither SCIEH nor the FSA informed the SEHD).

(4) Greater Glasgow NHS Board did not inform the Scottish Executive about the outbreak until information was requested of them.

(5) The Scottish Executive only learned of the outbreak on 15th January 2002 when a copy of a press statement from the Trust (prepared in response to media enquiries) was sent to the Press Office at Greater Glasgow NHS Board. This was read over the phone to Press Health at the Scottish Executive. Later that day the Trust informed Press Health directly, because the Trust knew that a Glasgow newspaper would run with the story. Up to that point there had

been no direct communication from those involved in the outbreak with the Scottish Executive.

(6) Although the Scottish Executive Press Office informed the Scottish Executive Public Health Division and Performance Management Division, no clear attribution of responsibilities existed.

(7) Initial follow-up action was taken on 15th January 2002 by the Scottish Executive Public Health Team who made enquiries direct of the Public Health Department at Greater Glasgow NHS Board. Details of the outbreak were then e-mailed from Glasgow to the Public Health Team. However, no further follow-up action occurred by the SEHD until late on 16th January 2002 and early on 17th January 2002. The Minister for Health and Community Care was not, therefore, briefed until lunchtime on 17th January 2002, 9 days after the OCT was convened and just before local and national media released the story.

The common characteristics of these shortcomings were:

(1) A lack of clarity about the circumstances in which details of an outbreak should be communicated to the Scottish Executive.

(2) A similar confusion about which individuals should take the lead for such communication.

(3) No clear internal communications policies within the organisations concerned.

(4) Confusion about which Division/Unit within the Scottish Executive Health Department (SEHD) should take the lead in briefing the Health Minister and take necessary further actions.

(5) A belief that "Press Office to Press Office" communication was a satisfactory and sufficient method of notifying key players about an outbreak of infection.

(6) Reluctance to communicate with the public until forced to do so by external media enquiries, so that media pressures drove events.

Recommendations

The Review Team were concerned about these communications and wider management failures. We recommend the following:

30. That a classification system for infection outbreaks/episodes be drawn up and used by all key players as "common currency" in deciding the actions and communications required in a given infection incident (A framework (Infection Control Risk Matrix) is set out in detail in Appendix E), and that clear policies are developed, using this system, which identify all the key individuals involved in communications about outbreaks of different severity.

31. That in any outbreak that is considered at any stage to be foodborne, the Scottish Executive is informed in addition to the Food Standards Agency.

32. That Trusts and Boards ensure that there are sufficient resources to appoint adequate levels of communication professionals, but that "Press Office to Press Office" communication is additional to, not a substitute for, professional communication.

33. (a) That the Chief Executive of a Trust or Health Board (depending on whether the outbreak is primarily in the hospital or community respectively) should assume the unambiguous responsibility for ensuring effective internal and external communications, including the media, appropriate Government Departments and Agencies.

(b) That within the SEHD consideration should be given to the nomination of an issue manager as soon as a serious outbreak occurs and irrespective of the route through which notification has come. Clear guidelines should also be in place on which Division/Unit within the SEHD should be responsible for actions and briefing associated with an outbreak.

Other Issues

In the course of the Review, the Group considered a series of other key issues that emerged as having wider implications for the control of HAI in Scotland. Recommendations to address these issues are given below.

Infection Control Doctor

The designated Infection Control Doctor (ICD) will be trained in and have a professional interest in infection control and management of HAI. They will have designated sessions for this work and would normally be appointed ICT leader at Trust level. They should agree and implement an infection control programme with all members of the ICT. They will normally chair OCTs at Trust level. They will report and be accountable for infection prevention and management through Trust Clinical Governance and Risk Management Committees. Training and resources will be required to bring this recommendation to fruition.

The Group believes that a more extensive level of ICD service is required if healthcare associated infection is to be kept to a minimum.

Recommendation

34. That resources are in place to ensure that each Trust has a designated and trained ICD, who will normally lead the Trust ICT. This will usually, but not invariably, be a consultant microbiologist who will have designated sessions and a clearly defined job description for this component of their work. In the case of Trusts without laboratory facilities (e.g., Primary Care Trusts) they should formalise arrangements with a suitably trained and appropriately resourced individual.

Infection Control Nursing

Infection control nurses (ICNs) are a key catalyst in preventing and managing infection in hospitals. At present, most Trusts have ICN support available on a 9am to 5pm, 5-day a week, basis that often excludes Public Holidays, as was the case in the Victoria Infirmary. Outwith these hours the ICD provides infection control clinical advice, usually by telephone.

By providing infection control training for all staff at induction and providing a systematic programme for all health care staff at place of work, ICNs can ensure that outbreaks are kept to the minimum. They should have daily contact with wards or other healthcare premises. They should visit each facility at least weekly. They should undertake the education of agency and bank staff as well as medical staff within a coherent programme of training and education. They should undertake, oversee and report on systematic audits of hand washing practice. They should have an on-call rota to advise on infection matters on a 24-hour basis. They will, along with the ICD, be central to management of outbreaks of infection.

Recommendations

35. That resources are in place to ensure that each Trust has sufficient ICN establishment to:

(a) have daily contact with wards or other health care premises;

(b) visit each facility at least weekly;

(c) provide advice to ward and departmental nursing staff on the nursing care of patients who are at risk of , or who have, infection;

(d) be responsible for a systematic competency programme in infection control for all health care workers at their place of work (including medical, agency and bank staff);

(e) undertake systematic hand washing audits, including audits involving night and weekend health care workers; and

(f) provide an on-call service to advise on infection control matters on a 24-hour basis.

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36. That there should be a lead Infection Control Nurse (ICN) in each Trust.

Infection Control Champions

The concept of infection control champions[16] announced by the Minister for Health and Community Care on 26 April 2002 is supported by the Group and should be developed.

[16] Scottish Executive Press Release – 26 April 2002

Recommendation

37. That infection control champions at ward level can complement, but not replace, the roles of the Infection Control Team. They should not be used as substitutes for ICNs but:

(a) They should assist in the delivery of a comprehensive infection control service and be integral members of an enlarged Infection Control Team; and

(b) Have clearly defined roles, dedicated time for infection control duties and be appropriately trained and supervised. The extra responsibilities and training should attract enhancement of salaries.

Role of NHS Boards in Infection Control

NHS Board Infection Control Team (ICT)

The Group believes that NHS Boards should take the lead in the strategic aspects of infection control within their areas, including the formulation of policies.

The Group recommends that each NHS Board should have a standing ICT to co-ordinate the strategic management of all outbreaks where the Major Outbreak Plan is implemented. It will advise the NHS Board and the relevant Trust where infection control resources are needed and where protocols and procedures need to be improved to comply with current standards and requirements.[17,18,19] It will monitor compliance with recommended national guidance at Trust level. It will ensure that clinical governance and risk management committees are made aware of this advice. The NHS Board ICT will provide direct assistance to the Trust ICT when requested to do so.

The NHS Board ICT will have a designated leader, who is trained in infection control and who has the necessary skills to ensure that clinical governance requirements and CSBS standards are met in the prevention and management of infection. The core membership of the Infection Control Team at NHS Board level should include:

- Infection Control Doctor;
- CPHM (CD/EH);
- ICN/Public Health Nurse(s);
- Communicable Disease Administrator and Secretarial Support staff.

The Head of Environmental Health should also be a core member of the NHS Board ICT if a food-borne source of infection is suspected. For smaller NHS Boards (e.g., Forth Valley,

[17] CSBS. Standards - Healthcare Associated Infection (HAI) Control, NHS Scotland, December 2001 (Clinical Standards Board)

[18] Scottish Office Department of Health Advisory Group on Infection. 'Scottish Infection Manual - guidance on core standards for the control of infection in hospitals, healthcare premises and at community interface.'1998.

[19] Food Standards Agency/Scottish Executive Health Department. 'Guidance on the investigation and control of foodborne disease in Scotland' (Cairns Smith Report) 2002. (Food Standards Agency).

Highland, Borders, Dumfries & Galloway, Island Boards) the NHS Board ICT may function as the Trust's ICT also. The core membership is consistent with that set out in the Cairns-Smith Report.[19]

Recommendation

38. That each Health Board should have an appropriately constituted Standing Infection Control Team (ICT) which:

(a) takes the lead in strategic aspects of infection control in their area;

(b) formulates and agrees infection control policies;

(c) co-ordinates the management of all outbreaks where the Major Outbreak Plan is invoked;

(d) has a designated leader;

(e) links effectively with Risk Management Committees and Clinical Governance Committees; and

(f) provides assistance and advice to Trust ICTs when requested and/or when appropriate.

A review of NHS Board and Trust functions in Scotland may necessitate some changes in infection control organisation and liaison in the future. The infrastructure suggested is, however, consistent with the Clinical Standards Board for Scotland recommendations and more recently the SCIEH commissioned report 'Model of Infection Control and Communicable Disease Control'.[20]

Trust Infection Control Teams

In larger NHS Boards, Trusts will assemble their own ICTs. Membership will include:

- Infection Control Doctor;
- CPHM (CD/EH);
- ICNs;
- HAI Surveillance Project Manager and Secretarial Support Staff.

The Trust ICT will be responsible for the prevention and management of healthcare acquired infection within their Trust and will be responsible for ensuring appropriate infection control audits are completed. The Trust ICT will manage outbreaks until the Major Outbreak Plan is invoked or until clear transfer of responsibility is effected to the relevant NHS Board ICT.

[19] Food Standards Agency/Scottish Executive Health Department. 'Guidance on the investigation and control of foodborne disease in Scotland' (Cairns Smith Report) 2002. (Food Standards Agency).

[20] Kennedy Business Development. Model of Infection Control and Communicable Disease Control (SCIEH/NHS Scotland, May 2002)

This transfer of responsibility should apply to complex or difficult outbreaks where the Major Outbreak Plan is not implemented. It should apply to outbreaks that cross two or more hospitals or Trusts. It should also apply when widespread transmission of infection to and from the community to hospital occurs.

The Trust ICT will appoint a team leader who is trained in and has a professional interest in infection control and who will agree to take responsibility for prevention and management of infection at Trust level. He/she will ensure that clinical governance requirements and Clinical Standards Board Scotland (CSBS) standards are met. The Team Leader would either be the Infection Control Doctor (ICD), or an Infection Control Nurse (ICN).

Comprehensive risk management arrangements will, however, have to be in place to ensure that advice and recommendations are appropriately considered and implemented by the Hospital and Trust management.

Recommendation

39. That large Trusts should have an appropriately constituted Standing Infection Control Team (ICT) which:

(a) prevents and manages healthcare associated infection within their Trust;

(b) implements agreed Board and Trust policies in infection control;

(c) has a designated leader;

(d) links effectively with Risk Management Committees and Clinical Governance Committees; and

(e) liaises closely with, co-operates with, and provides membership for the Health Board ICT.

Consultant in Public Health Medicine with Responsibility for Communicable Diseases [CPHM (CD/EH)]

The CPHM (CD/EH) will become much more closely involved in ICTs at Health Board and at Trust levels. He/she will normally lead the ICT at Board level. CPHMs (CD/EH) should now be trained in the management of HAI and play a much more prominent role in HAI surveillance and management of hospital outbreaks.

Recommendation

40. That CPHMs (CD/EH) should be trained in the management of HAI and play a more prominent role in HAI surveillance and hospital outbreak management. They should normally lead all infection outbreaks within their Board where the Board's Major Outbreak Plan is invoked.

Simulated Outbreaks

At present, although Trusts and Boards hold simulated emergency exercises, these do not include simulated outbreaks of infection. The Group considered that this situation is unsatisfactory.

Recommendation

41. That each Health Board holds regular (possibly every 2 years) simulated outbreak exercises, with adequate debriefing afterward, and that documentation of such exercises be provided to the Clinical Standards Board at the time of their inspections.

Classification of Outbreaks/Episodes and Linkage to Risk Management

At present there is much confusion as to what constitutes an outbreak/episode and when an outbreak/episode is deemed "minor" or "major". There is no consistency of approach so that different health service agencies may operate to different (unwritten) criteria. There is also, in many cases, no linkage of outbreaks to more general risk management structures.

This leads to some of the management and communication problems shown in this outbreak.

Recommendations

42. (a) That all relevant parts of the NHS operate to a consistent set of criteria that is linked to a risk management classification that describes infection outbreaks/episodes.

(b) That the level of outbreak/episode risk category determines both the level of action(s) required and the level of communications.

43. That Trusts link infection control to risk management structures as a matter of urgency.

An Infection Control Outbreak/Episode Risk Matrix is given in Appendix E. The Group recognises that outbreaks/episodes develop quickly and that situations change from day to day; this should lead to a constant re-appraisal of the risk category of any outbreak/episode with re-assignment to a higher level as soon as deemed appropriate.

Relations with the Media

There is a responsibility for the Scottish Executive and for the NHS to inform and educate the public about all aspects of health care infections. The media has a crucial role in this process. All too often this partnership fails; the media concentrates on raising concerns (and therefore raises public anxiety), there is poor internal communication between and within the organisations responsible for health care provision and externally with a perceived hostile media. The result, as in this case, is that there is both a lack of openness and a lack of context and balance in reporting. The public are made anxious about perceived secrecy relating to

infection incidents without receiving the necessary information to put these in context. Such negative media coverage may lead to:

(a) Important information being withheld from the public; and

(b) A "siege mentality", with lowering of staff morale, recruitment problems and eventually a self-fulfilling prophecy of deteriorating health care.

More involvement of the media in positive aspects of infection issues would allow:

(a) More openness; and

(b) Better public understanding of infection issues (e.g., the limitations of staff screening, the relative risks of HAI as compared to risks of not receiving health care treatment).

Recommendations

44. That at both local and Scottish Executive level more strenuous efforts are made to tap the potential of the media to improve the public understanding of infection control issues. This will require a more open relationship to be developed between the NHS and the media based on mutual trust. There should be presumption of early disclosure to the public and the media of outbreaks of infection.

45. That internal communications within and between the Scottish Executive and NHS organisations are improved and clarified so as to reflect the openness culture and this is emulated in communications with relevant agencies (e.g., The Food Standards Agency, Scottish Water, Scottish Environmental Protection Agency (SEPA).

Resource Issues

There is good evidence that resources put into infection control are cost effective in reducing the costs of HAI.[21,22] At present Trusts, as was the case in this outbreak, often do not have information on the costs of infection nor the costs of infection control.

It is important that infection control commands a much higher order in the resources devoted to it and that Trusts are adequately resourced for this. In the longer term, such resources should be related to the costs of HAI.

To ensure that properly staffed ICTs become a reality will require some resources for ICNs and ICDs. However, it is more important to ensure that there is a culture change within NHS Boards and Trusts to redesign current ways of working towards delivering the NHS Board and Trust agreed infection control programme. Training of staff for these new roles will be a *sine qua non* to implement these developments.

[21] National Audit Office. 'The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England', House of Commons, 2000 (HMSO, London).
[22] Plowman R, Graves N, Griffin M, Roberts JA, Swan A, Cookson B et al. The socio-economic burden of hospital acquired infection. PHLS, London, 2000.

Recommendations

46. (a) That NHS Scotland should adopt a programme budgeting approach to Infection Control and that each Trust and each Board be required to provide details of the resources devoted to Infection Control.

(b) That such details are supplied as part of the documentation provided to the Clinical Standards Board for Scotland at the time of individual Trust reviews.

47. That the Scottish Executive should convene a Working Group to develop methods of tracking and calculating the costs of HAI and its control in Scotland.

Health and Safety Executive

Health care associated infection is a patient and staff safety issue. We welcome the increasing profile of the HSE in this area, but would urge that inspections of health care premises are on a consistent basis. The Infection Incident Control Outbreak/Episode Risk Matrix should facilitate such a consistency of approach.

CONCLUSIONS

The Group recognises that hindsight bestows a wisdom that is difficult to achieve when taking day to day decisions in a hard-pressed service. The Group also recognises the wide array of competing pressures on the time, energy and focus of individual managers and on the resources of an NHS Trust that is subject to scrutiny from a wide range of organisations such as the Health & Safety Executive, the Clinical Standards Board for Scotland and the Scottish Health Advisory Service. Nevertheless, hospital acquired infection (HAI) and its control differs significantly from other issues because:

- Infection not only affects an individual but it can, and too frequently does, transmit to others who rightly have an expectation that they will be protected from cross infection;

- There is a distinct and immediate public health implication and the public have an expectation that coherent advice to them will be forthcoming; and

- Even quite small outbreaks of cross infection will have an impact on health service provision, because more resources will be required and also (and of further concern to the public) there is likely to be temporary closure of services such as wards or whole hospitals.

This Report looks at, and comments on, a range of infection control issues that are pertinent throughout the NHS in Scotland. It also makes recommendations on various ways in which the NHS can help to combat HAI in Scottish hospitals. The major themes running through the Report can be summarised within five key areas and include:

1) **A comprehensive implementation of Infection Control standards at ward/departmental level and the necessary resources to achieve this;**

2) **A properly developed and funded infection control infrastructure;**

3) **A culture change in hand washing, underpinned by hand washing audits for all staff;**

4) **Implementation of a suggested Infection Control Outbreak/Episode Risk Matrix to allow consistent responses and communications across Scotland (Appendix E); and**

5) **Proper emphasis on all aspects of communications in infection control and in outbreaks, including a culture of openness.**

The recommendations in this Report should help to ensure that the NHS in Scotland learns the lessons from the outbreak at the Victoria Infirmary and makes changes to minimise the chances of a similar episode occurring in the future. They should therefore be considered as a coherent whole and implemented as a whole.

APPENDIX A

REVIEW GROUP MEMBERSHIP

Dr Brian Watt, Chairman - recently retired Consultant Microbiologist

Mrs Deirdre Anderson, Senior Infection Control Adviser - Forth Valley Primary Care NHS Trust

Dr David Breen, Consultant in Public Health Medicine - Dumfries & Galloway NHS Board

Mr Paul Wilson, Director of Nursing - Lanarkshire Acute Hospitals NHS Trust

APPENDIX B

INTERVIEWEES

Dr S Ahmed, Consultant in Public Health Medicine, Greater Glasgow NHS Board

Mrs M Arnott, Clinical Nurse Manager - Medicine, Victoria Infirmary, Glasgow

Mr R Calderwood, Chief Executive, South Glasgow University Hospitals NHS Trust

Mrs F Clayton, Infection Control Nurse, the Victoria Infirmary, Glasgow

Dr B Cowan, Medical Director, South Glasgow University Hospitals NHS Trust

Dr J Cowden, SCIEH

Mr T Divers, Chief Executive, Greater Glasgow NHS Board

Dr G Edwards, Salmonella Reference Laboratory

Mrs A Gillespie, Deputy Director of Nursing, South Glasgow University Hospitals NHS Trust

Mr C Gillespie, Charge Nurse Ward 7, The Victoria Infirmary, Glasgow

Ms A Harkness, General Manager - Medical Services, The Victoria Infirmary, Glasgow

Mrs J Higgins, Infection Control Nurse, The Southern General Hospital, Glasgow

Mrs M Kyle, Ward Manager, Ward 10, The Victoria Infirmary, Glasgow

Mrs M McGuire, Public Health Nurse, Greater Glasgow NHS Board

Mr A McIntyre, General Manager, Support Services, South Glasgow University Hospitals NHS Trust

Dr J McMenamin, Consultant in Public Medicine, Greater Glasgow NHS Board

Mrs A Rankin, Infection Control Nurse, The Victoria Infirmary, Glasgow

Dr P Redding, Consultant Microbiologist and Infection Control Doctor, the Victoria Infirmary, Glasgow

Mr D Ross, Trust Press Officer, South Glasgow University Hospitals NHS Trust

Dr D Stewart, Chairman OCT and Associate Medical Director, South Glasgow University Hospitals NHS Trust

APPENDIX C

LIST OF ALL NON-CONFIDENTIAL DOCUMENTS THAT INFORMED THIS REPORT

NHS Greater Glasgow

Area Infection Control Committee - Infection Control Guidelines.

Communicable Diseases Within the Greater Glasgow Health Board Area: Outbreak Control Plan.

Report of Outbreak Control Team on the Outbreak of Salmonella Enteritidis Phage Type 21 in the Victoria Infirmary, Glasgow - January 2002.

South Glasgow University Hospitals NHS Trust

A CPD Strategy for Practice Development 2001-2004 - South Glasgow University Hospitals NHS Trust.

Directorate of Medicine for the Elderly - Preceptorship Programme for Registered Nurses.

South Glasgow University Hospitals NHS Trust - Nursing Auxiliary Competency Profile.

South Glasgow University Hospitals NHS Trust Formal Trust Management Group - Briefing Paper Re Nursing Manpower

South Glasgow University Hospitals NHS Trust - Nursing & Midwifery Strategy 1999-2002.

Southern General Hospital, Victoria Infirmary, Mansionhouse Unit, Mearnskirk House - Unqualified Staff Orientation Programme May 2002

The Victoria Infirmary

Scottish Health Management Efficiency Group - Domestic Services Part 1 - Victoria Infirmary - Bed and Day Room Areas.

Scottish Health Management Efficiency Group - Domestic Services Part 1: Victoria Infirmary - Laboratory and Pharmacy.

Victoria Infirmary - Care Plan for Possible/Confirmed Gastroenteritis.

Victoria Infirmary, Directorate of Medicine, Qualified Nurse Complimentary Orientation Directory.

Victoria Infirmary, Medical/Haematology - Ward A, Orientation Programme - Untrained Staff.

Victoria Infirmary -Ward 6/10, Acute Receiving Unit, General Orientation Information.

Victoria Infirmary - Ward A Orientation Package (Staff Nurse).

Victoria Infirmary High Dependency Unit - Staff Nurse Preceptorship/Education Programme.

Other NHS Board Areas

NHS Dumfries & Galloway Area Control of Infection Committee - Major Outbreak Plan.

Forth Valley Primary Care NHS Trust - Trust-Wide Incident Reporting and Investigation Guidance Document.

Forth Valley Primary Care NHS Trust - Trust-Wide Incident Reporting and Investigation Policy.

Scottish Centre for Infection and Environmental Health

Summary Information on General Outbreaks of Infectious Intestinal Disease Identified by SCIEH in 2001.

Clinical Standards Board Scotland

CSBS Healthcare Associated Infection - Cleaning Services - Self-Assessment Submission Forms.

APPENDIX D

LIST OF GUIDANCE THAT INFORMED THIS REPORT

Scottish Office Department of Health Advisory Group on Infection. 'Scottish Infection Manual - guidance on core standards for the control of infection in hospitals, healthcare premises and at community interface.'1998.

Food Standards Agency/Scottish Executive Health Department. 'Guidance on the investigation and control of foodborne disease in Scotland' (Cairns Smith Report) 2002. (Food Standards Agency).

Ayliffe, GAJ, Fraise, AP, Geddes, AM, Mitchell, K. 'Control of Hospital Infection - a practical handbook.' (Arnold, 4th Edition, 2000).

CSBS Standards – 'Healthcare Associated Infection (HAI) Control' - December 2001. (Clinical Standards Board).

CSBS Standards – 'Healthcare Associated Infection (HAI) – Cleaning Services' - June 2002. (Clinical Standards Board).

Auditor General for Scotland. 'A Clean Bill of Health', a review of domestic services in Scottish hospitals, April 2000. (Audit Scotland).

Scottish Health Facilities Note 30, 'Infection control in the built environment –design and planning' January 2002, page 10. (Scottish Executive)

Kennedy Business Development. 'Model of Infection Control and Communicable Disease Control.' (SCIEH/NHS Scotland, May 2002).

Food Safety (General Food Hygiene) Regulations 1995.

Pennington Group Report – 'Report on the circumstances leading to the 1996 outbreak of infection with E.coli 0157 in Central Scotland, the implications for food safety and the lessons to be learned.' (The Scottish Office, 1997).

National Audit Office. 'The Management and Control of Hospital Acquired Infection in Acute NHS Trusts in England' House of Commons, 2000 (HMSO, London).

INFECTION CONTROL OUTBREAK/EPISODE RISK MATRIX **APPENDIX E**

An infection outbreak/episode (e.g., single case of rabies, Legionellae, Dentist/Doctor with confirmed Hepatitis B undertaking exposure prone procedures etc.) is difficult to incorporate into the existing AS/NZS 4360:1999 Risk Management Standard because although consequences of recurrence can be established it can be difficult to ascertain the likelihood of recurrence. The Infection Control Team will quantify the infection control risk criteria and ascertain the associated risk, which will determine the appropriate action to be taken.

Four infection risk categories can be identified: **Red** - High Risk **Orange** - Moderate Risk **Yellow** - Low Risk **Green** - Very Low Risk

Criteria	Quantification Criteria	Risk Category	Action Required	Communications
3 or more met	Death and/or serious illness Major implications for public health Exceptional or unusual infection episode Major disruption of health and/or public services Major public anxiety and concern	Red - High Risk	Implement Area Major Outbreak Plan	**Full** (e.g., Trust, Health Board, SCIEH, FSA, SEHD) and others as appropriate (e.g., Local Authority, Water Authority, SEPA, HSE etc.)
1 or 2 met	Death and/or serious illness Major implications for public health Exceptional infection episode Major disruption of health and/or public services Major public anxiety and concern	Orange - Moderate Risk	Implement Trust Outbreak Plan - Full Outbreak Control Team	**Full** (e.g., Trust, Health Board, SCIEH, FSA, SEHD) and others as appropriate (e.g., local authority, water authority, SEPA, HSE etc.)
3 or more met	Serious illness and/or moderate infection episode and/or cases Moderate impact on public health Short-term disruption of health and/or public services Moderate public anxiety and concern	Yellow - Low Risk	Implement Trust Outbreak Plan - Infection Control Team	Trust and Health Board communications
All 4 met	Minimal infection episode and/or case Minimal impact on public health Minimal disruption of health and/or public services Minimal public anxiety and concern	Green - Very Low Risk	Implementation- Infection Control Team Investigation	Trust communications

N.B. Infection risk category coding may vary slightly from Trust to Trust. No more than four risk categories should apply to this infection control risk matrix.

Further copies of this Report are available from
the Performance Management Division of the
Scottish Executive Health Department, Tel: 0131 244 2868.
The Report can also be accessed on the internet at www.scotland.gov.uk.



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SCOTTISH EXECUTIVE

Health Department
Directorate of Performance Management and Finance

22nd November 2002

Addresses

For action

Chief Executives, NHS Trusts
Chief Executives, Health Boards
Chief Executive, NES
Chief Executive, PEF
General Manager, SCIEH
Chief Executive, CSBS
Chief Executive, State Hospital
Chief Executive, Scottish Ambulance Service

For information

Chief Executive, CSA
Chief Executive, HEBS
Executive Director, Scottish Council for Postgraduate Medical and Dental Education

Enquiries to:
Craig Gilbert
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St Andrew's House
EDINBURGH EH1 3DG
[redacted]

Dear Colleague

MINISTERIAL ACTION PLAN ON HEALTHCARE ASSOCIATED INFECTION, WATT GROUP REPORT ON THE OUTBREAK OF SALMONELLA INFECTION AT VICTORIA INFIRMARY AND HAI & PATIENT CARE ENVIRONMENT QUESTIONNAIRE

Introduction

Infection control is an important issue for NHSScotland, both in terms of the safety and well-being of patients and of the efficiency and effectiveness of the service. I attach copies of two documents with important recommendations for the management of healthcare associated infection. Ministers have accepted these recommendations. Also enclosed is a questionnaire intended to help identify the extent of infection and related risk posed by the patient care environment in NHS hospitals and the work required to address the issue.

The Watt Group Report includes 47 recommendations for action by NHS Trusts/Boards and other bodies, including the Scottish Executive, to improve the efficiency and effectiveness of infection control arrangements and of hospital cleaning services. The Ministerial Action Plan, which incorporates the conclusions of the Watt report and a number of recommendations from the HAI convention held in Edinburgh at the end of June, sets out proposals for action by Trusts and other bodies. The implementation arrangements proposed in the Action Plan, in particular the formation of a Task Force to be led by the Chief Medical Officer are an important means of progressing effective action against HAI and of implementing the Watt Group's recommendations.

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Conclusion

The first step is for you to take these reports to your Boards and assess how best to implement the recommendations that have been made. Full implementation will clearly take time and will involve action from the wide range of NHS bodies with an interest in HAI. The programme of work sketched out above and detailed in the Action Plan and the Watt Group report is clearly challenging and has implications for the commitment of NHS resources. But this is also an area which has to be tackled as a major and immediate priority. It is moreover an area where improvements in procedures cannot only benefit patients but can also reduce the cost burdens currently being borne by the NHS as a result of unnecessarily high levels of HAI.

Yours sincerely



JOHN ALDRIDGE
Director of Performance Management and Finance

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NHS Boards and Trusts

It is important that NHSScotland takes action on the recommendations now. There are a number of recommendations on which Boards and Trusts can act without delay. **I would therefore be grateful if chief executives would arrange for**:

- the recommendations in the Watt Group report to be considered by your Board as a matter of urgency, and

- the Board to develop a plan for implementing those recommendations to the fullest extent possible in the light of your operational and financial circumstances and with due regard to the need to manage resources efficiently, effectively and to secure best value.

In particular the plan should set out immediate arrangements to respond to the following Watt Group recommendations – 2, 4, 6, 7, 9, 11 and 18 which deal with better arrangements for cleaning and infection control and recommendations 23, 24, 25, 31 and 32 which relate to arrangements for managing outbreaks including communications. (Annex B sets out the text of these recommendations.)

NHS Boards and Trusts should also consider the HAI Action Plan and provide the Department with a short report indicating how they plan to deliver it. In particular, the report should indicate how the Board/Trust will contribute to the implementation Task Force which CMO will lead. It should also set out how the Board/Trust will ensure that its documented policies and procedures are aligned with the objectives of the Action Plan and supportive of the overall objective of managing down the level of HAI. **This report should reach the Department by 31.01.03.**

The questionnaire below deals with assessing the scale of risks of HAI posed by the patient care environment and how best to reduce these risks through appropriate management action. (The cost of management action should be met within the increased overall allocations made available to NHS Boards this year and within indicative allocations for future years.) These are important issues for NHSScotland and the Department. Given the priority which Ministers attach to the issue of infection control and the potential costs of effective action, I would expect chief executives to take personal responsibility for ensuring completion of the attached questionnaire.

Please note that we have arranged for a session at the chief executives' meeting on 28 November to discuss the results emerging from the survey. This will also provide an opportunity for chief executives to discuss more general HAI/infection control issues and in particular the Watt Group report and the Action Plan. The Minister will no doubt wish to cover similar issues at his meeting with NHS Chairs on 29 November.

NHS Boards and Trusts should develop a HAI leaflet and other information materials for patients informing them what their rights are in this respect and what information they can expect from NHS in Scotland about the risks to them from receiving a clinical procedure in a specific setting, with advice from HEBS and SCIEH as required.

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Other NHS bodies

Addressing HAI will require a co-ordinated response by NHSScotland including those bodies such as the Scottish Ambulance Service. While the Action Plan and questionnaire have been drafted in consideration of the issues within the hospital setting, the same fundamental principles apply in whatever environment in which patient care is being provided. Bodies such as the SAS are therefore asked to carry out an assessment of the scale of the specific problems faced and to develop plans for securing better arrangements for cleaning and infection control and to submit these to the same timetable as NHS Boards and Trusts. A number of NHS organisations are specifically being called on to play their part with regard to education and training, patient information, raising standards, developing guidance on the built environment and other issues. Action in these areas will benefit from some further discussion and co-operation amongst the bodies involved. Proposals for particular bodies are set out below.

HAI is also an important issue for

NHS Education for Scotland (NES)

As an integral component of mandatory induction, NES should contribute to the establishment of education on HAI and hygiene for all clinical and non-clinical staff with revalidation of knowledge and skills at appropriate intervals.

In addition to the educational initiative to prepare 'clinical champions' that is already underway, NES should also develop for NHS staff groups an educational framework on risk assessment and management which will inform:

- standardised educational packages on HAI for all clinical and non-clinical staff;
- an HAI website with links to all relevant guidance and training materials; and
- liaison with universities and colleges on ensuring all receiving undergraduate education in clinical disciplines receive appropriate HAI-related education.

CSBS and NES to review the scope for joint working in setting standards and methodologies for monitoring Trusts' education and training programmes on HAI and hygiene.

NHS Scotland Property and Environmental Forum

PEF should review the current guidance on upgrading the physical environment for healthcare in old buildings. This would be with a view to ensuring it's accessibility for general managers and to strengthen associated good practice guidance.

Following the patient care environment audit and the stakeholder conference, PEF should conduct a healthcare environment audit of standards and technical requirements related to infection control and the built environment including the provision of staff washing, decontamination and changing facilities to guide new builds and refurbishment projects.

SCIEH

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SCIEH should develop model infection control policies and procedures taking account of CSBS standards, including the management of outbreaks of HAI and guidance on staff screening during HAI outbreaks. SCIEH should also arrange to train public health and microbiology staff in the management of HAI outbreaks.

CSBS

CSBS should aim to work with NES to set standards and methodologies for monitoring Trusts' education and training programmes on HAI and hygiene.

CSBS should further develop their infection control standards particularly with regard to ensuring that Trusts have in place:

- systems for ensuring good practice in catheterisation and anti-microbial prescribing;
- infection control services, drawing on the SCIEH model on good practice as appropriate; and
- systems to monitor the level of resources invested in infection control .

Other Bodies

Arrangements are being made to carry forward recommendations applying to the Chief Scientist's Office (on research) to the Health Department (on communications) and on multi disciplinary prescribing teams in hospitals.

Background

The Scottish Health Plan, "Our National Health" made clear that tackling HAI was a major objective for the health service. As a result of the proposals set out there, the CSBS has developed standards for infection control and cleaning services which NHS Trusts are expected to meet. The CSBS and Audit Scotland will report on the performance of the health service against these standards in December this year. **Achieving the CSBS standards will continue to be the main yardstick by which the performance of the NHS will be judged in this context, and Trusts will be expected to address the areas for improvement identified in their individual reports.**

Since the last major HDL on HAI (Managing the risk of HAI in NHS Scotland HDL(2001)53) was issued in June 2001 there have been a number of developments including the holding of a Ministerial Convention on HAI, the commissioning of the Watt Group report and a higher profile for HSE's involvement in these issues. This has been accompanied by a generally increased concern about the quality of the patient care environment.

HAI Action Plan

The Minister hosted the HAI convention on 28 June. The intention, which was widely publicised, was to use the event as the basis for developing an action plan covering further measures to tackle HAI. This has been done. A report summarising the convention proceedings has been produced to provide a record of the material presented, the issues discussed and the recommendations made by those who attended. The report underpins but is distinct from the Action Plan. The Plan incorporates proposals generated at the convention, by the Watt Group recommendations and through policy development within the Department.

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The Action Plan focuses on making progress in three key areas and highlights the additional development activity required to tackle HAI more effectively. A summary of the Action Plan is set out in Annex C.

National Co-ordination

To take forward the Action Plan, SEHD will establish a multi-disciplinary Task Force led by the Chief Medical Officer with the remit to:

- co-ordinate the development and implementation of the HAI Action Plan;
- review progress across Scotland;
- monitor the levels of HAI and assess the impact of control measures;
- take forward amendments to the action plan and its component initiatives;
- report on progress to the Minister of Health and Community Care and annually through the CMO's report, to the public at large.

Phasing

Of the 17 initiatives listed in the Action Plan, the most important priorities are the development and implementation of:

- the Code of Practice for the local management of hygiene;
- mandatory hygiene and infection control induction training programmes and the other HAI related educational initiatives;
- technical requirements for cleaning processes.

These and the implementation of the 12 initiatives currently in train will form the core programmes of the HAI Action Plan in the first year of its operation. The HAI Task Force will decide the timing of other initiatives.

2. Watt Report

The Watt Group report was commissioned as a result of an outbreak of salmonella infection at the Victoria Infirmary, Glasgow, in December 2001 and January this year. The Watt Group was asked to draw conclusions and make recommendations to help reduce the risks of future outbreaks of infections of this kind and help improve management.

The report makes a large number of recommendations. Amongst its conclusions are that the following are required throughout the NHS In Scotland:

- A comprehensive implementation of Infection Control standards at ward/departmental level and the necessary resources to achieve this;
- A properly developed and funded infection control infrastructure:

- A culture change in hand washing, underpinned by hand washing audits for all staff;

- Implementation of a suggested Infection Control Outbreak/Episode Risk Matrix to allow consistent responses and communications across Scotland and

- Proper emphasis on all aspects of communications in infection control and in outbreaks, including a culture of openness.

The detailed recommendations of the group have been incorporated in the HAI Action Plan.

3. HAI & Patient Care Environment Questionnaire

Part of the solution to the problems posed by HAI lies in addressing the challenges of the patient care environment. Some of our hospitals are not ideally suited to delivering modern patient care while minimising risk of infection for patients, staff and visitors. The attached questionnaire has been drawn up to help assess the scale of the specific problems faced by the service and to help Trusts develop plans to address them. These plans should be realistic and reflect the resources available. The questionnaire has been prepared with the support of a NHS advisory group chaired by Richard Carey (chief executive Highland Acute Hospitals Trust). Its purpose is

- To allow each hospital site/Trust to rapidly assess its own situation in relation to the risks posed by the patient care environment and to identify potential action points; and
- To allow collation of information on the current situation across Scotland.

We are particularly interested in the position in high risk areas of hospitals. These have been identified as Intensive Care, High Dependency, neonatal wards, Special Care Baby Units, areas with patients with orthopaedic or surgical implants (including hip replacements, pins & plates, grafts), oncology/transplant units, haemodialysis units and burns units. The environmental issues we have identified relate to:

- handwashing facilities
- Sluice areas
- Patient handling equipment
- Furniture and fittings
- Storage of domestic services equipment
- Bed spacing
- Isolation facilities for infectious patients

There are also hospital wide issues which relate to:

- Staff changing facilities
- Staff washing/decontamination facilities
- Management of clinical waste

Information from this questionnaire will be used solely for the purposes of assessing the overall Scottish picture.

The questionnaire should be returned by **22 November 2002.** This will enable us to feed back initial results of the survey at the Chief Executives meeting on 28 November.

2. ***That the cleaning specification in wards and departments should be set by the senior nurse responsible for the area and each ward/departmental manager in collaboration with the relevant Infection Control Team and Domestic Services Manager. Cleaning against this specification should be subject to rigorous monitoring and action to correct deficiencies. Failure to meet the specification should be subject to formal audit and review within each hospital and be subject to public disclosure.***

4. ***That Audit Scotland reports are reviewed carefully by the management of Trusts, and that appropriate action is taken to respond to them.***

6. ***That exposure of staff to faeces should be documented through the Incident Reporting Procedure as thoroughly as exposure to any other biological (body) fluids.***

7. ***That specific guidelines and facilities (washing, showering, cleaning uniforms) should be available in every hospital for the decontamination of staff who become grossly contaminated from body fluids (blood, urine, faeces and so on).***

9. ***That nursing notes/care plans should clearly reflect the need for enteric precautions in individuals suffering from loose stools /diarrhoea.***

11. ***That clear infection control guidance to all staff on how to nurse a patient with loose stools/diarrhoea should be provided within the infection control manual.***

18. ***That the Agency/Bank/Locum induction checklist should include explicit mention of Infection Control precautions in place.***

23. ***(a)*** ***That an OCT should always be chaired by someone with competence and authority in health care associated infection. The local Consultant in Public Health Medicine (CPHM) should chair OCTs for major outbreaks (see Appendix E for definition). This demonstrates that the Team is led by an individual external to the Trust, who has close links with the local NHS Board and with community surveillance. In the case of other hospital outbreaks the CPHM should be consulted regarding chairmanship of the team. In practice, this will usually be the ICD.***

(b) ***That there should be clear role definitions for the members of the OCT, with clear responsibilities documented.***

(c) ***That a clear Outbreak Control Plan should be agreed and implemented.***

24. ***That senior management (Executive Director level) of the Trust should be fully engaged from an early stage in managing outbreaks either as full and active members of the OCT or as a separate support team to the OCT. Senior management support should include a senior communications manager who can ensure that staff, relatives and the public are timeously informed of the outbreak and are given appropriate public health messages.***

25. ***That all OCT reports should provide sufficient details of key factors in the spread of infection to allow proper audit.***

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31. That in any outbreak that is considered at any stage to be foodborne, the Scottish Executive is informed in addition to the Food Standards Agency.

32. That Trusts and Boards ensure that there are sufficient resources to appoint adequate levels of communication professionals, but that "Press Office to Press Office" communication is additional to, not a substitute for, professional communication.

HAI ACTION PLAN **ANNEX C**

The action plan covers three broad areas of activity.

(i) Promoting good infection control and hygiene practice in wards, other clinical settings and support services.

Good hygiene is an essential aspect of clinical care. The environments staff work in may not always be conducive to effective infection control but we need to ensure that their focus is always on hygiene. We shall encourage this by action under the following heads

The development and implementation of a **Scotland wide Code of Practice for the local management of hygiene** .

The Code will define local management powers and responsibilities for:

ensuring environmental and equipment standards are maintained;
informing patients about the risks of HAI and measures to reduce them;
managing inappropriate or over-frequent patient movement and overcrowding; and
ensuring compliance with hygiene and infection control standards especially hand hygiene.

It will include guidance on:

managing patients with loose stools;
setting requirements for basic equipment to reduce communal use especially in clinical settings ;
records on infection control measures and advice in patient notes and incidents of staff exposure to faeces or other body fluids;
decontaminating grossly contaminated staff;
policy and procedures on uniforms and changing;
training in hygiene and infection control, including food hygiene;
ensuring that agency nursing staff and other contracted non-NHS staff are competent in hygiene and infection control;
improving the quality of clinical information on laboratory request forms.

.

The establishment of **mandatory induction training on HAI and hygiene for all clinical and non-clinical staff** with appropriate revalidation arrangements.

The introduction of **an HAI leaflet and other information for patients** setting out their rights and explaining the information to expect from NHS in Scotland about the risks of clinical procedures in specific settings.

The introduction of **training packages on risk assessment and management** including;

- standardised packages in HAI for all clinical and non-clinical staff;
- an HAI website with links to guidance and training materials;
- arrangements to ensure undergraduate education in clinical disciplines includes an HAI-related element.

Holding a stakeholder conference to develop **guidance on upgrading the physical environment for healthcare in old buildings.**

Setting **technical requirements for cleaning processes and frequencies for service specifications for cleaning services**.

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To guide new builds and refurbishment projects, a detailed **review of standards and technical requirements related to infection control and the built environment** including the provision of staff washing, decontamination and changing facilities.

(ii) Management arrangements to ensure that good hygiene and infection control practice is in place throughout healthcare organisations.

Most NHS organisations in Scotland are upgrading their management systems related to infection control. To further develop management systems we shall:

review the **training and support arrangements for those engaged in media handling**

develop **model infection control policies and procedures, including the management of outbreaks**

develop **guidance on staff screening during HAI outbreaks**

develop **guidance on multidisciplinary prescribing teams** in all NHS hospitals and primary care services to ensure that education and training on anti-microbial use takes place and practice is audited and

introduce training of public health and microbiology staff in **the management of outbreaks of HAI.**

(iii) Ensuring that the performance of healthcare organisations in Scotland is of sufficient quality and effectiveness to reduce the incidence of HAI.

To strengthen policy, performance management and accountability at national level, we shall:

Develop, for incorporation in the overall Performance Assessment Framework, **performance indicators for the risk management of HAI** (based on HAI surveillance and CSBS data) designed to demonstrate progress with risk reduction.

Develop a **Code of Practice on disclosure of adverse events**, including HAI rates, outbreaks and compliance with standards.

Commission research into:

the use of HAI surveillance data to alert Trusts to the development of outbreaks and incidents;

the impact of HAI on bed usage and resources;

the cost-effectiveness of different interventions to reduce HAI;

the development of a methodology to track the on-going impact of HAI including the cost of its control .

Institute joint working to **set standards and methodologies for monitoring Trusts' education and training programmes on HAI and hygiene**.

Encourage further development of infection control standards particularly with regard to ensuring that Trusts have in place:

systems for ensuring good practice in catheterisation and anti-microbial prescribing;

infection control services which take account of the recommendations of the SCIEH model on good practice;

systems to monitor the level of resources invested in infection control.

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Review SEHD procedures for handling outbreaks, including streamlining arrangements for reporting and communications.

The full text of the guidance referred to below should be consulted for further details: copies should be available from the Property and Environment Forum if not available locally. The Property and Environment Forum has issued a helpful CD-ROM under the heading 'Decontamination Guidance' which contains details of guidance produced by PEF, the Scottish Executive, NHS Estates (England) the Medical Devices agency and others: it also covers topics such as ventilation in healthcare premises.

This audit questionnaire is being sent to all Acute Trusts, and should cover all hospital sites within the Trust. There are two purposes to this exercise:

- to allow each Trust to rapidly assess its own situation in relation to issues raised by the Victoria Infirmary investigations, and to identify potential action points; and
- to allow collation of summary information on the current situation across Scotland, and to feed back this summary information to Trusts.

There are a number of basic principles underlying the conduct of this survey and assessing its implications: it should be a learning opportunity which is risk-based, evidence based, practicable, affordable, predicated on impact on patient care, and built into systems which already exist. This particular survey relates only to current issues of specific concern, and forms part of the immediate activities outlined in the HAI Action Plan.

The questionnaire has two Sections, the first relating to specified high-risk areas and the second to the site in general. It may be easier (and more useful for Trusts) to complete a separate copy of the questionnaire for each ward, department or clinical area, and to collate the results within a single form for return to SEHD. If there are too many wards to cover by the return deadline, we suggest selection of sentinel or representative wards, with extrapolation of cost implications for the hospital. However, the exercise should be applied to all specified areas for the Trust's internal management purposes.

Where there are standards published by NHSScotland Property and Environment Forum, these are cited and briefly summarised in the Appendix. However, the complete documents should be referred to in the conduct of this exercise.

This questionnaire should be returned by 22nd November 2002 at the latest to allow collation of results by the end of November.

Information from this questionnaire will be used by the Department solely for the purposes of assessing the general situation in Scotland. However, we would expect that, where major deficiencies are detected, appropriate action is taken to remedy these.

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Audit questionnaire

Hospital……Trust…… ……

Date of completion……..

Person completing the questionnaire:……..

Designation and contact details:……...

……..

Information comes from: (tick)

Summary of survey of all appropriate wards ☐

Selected 'sentinel' wards only* ☐

** If incomplete results are submitted, please indicate that financial estimates have been extrapolate to cover implications for the whole hospital.*

Information from this questionnaire will be used solely for the purposes of assessing the general situation in Scotland, and individual Trusts or hospitals will **not** be identified in any reports or presentations.

Electronic copies of this form can be obtained from susan.roberts[redacted].

Please return completed forms, preferably by email, to the address below by 22nd November 2002

Bill.Sim[redacted] Fax [redacted]

W Sim
Performance Management Division
SEHD
St Andrews House
Edinburgh EH1 3DG

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SECTION 1: infection control high risk areas

Questions in this Section relate to Intensive Care, High Dependency, neonatal wards, Special Care Baby Units (SCBU), areas hosting patients with orthopaedic or surgical implants (e.g. total hip replacements, pins & plates, grafts), oncology/transplant units, haemodialysis units and burns units.

Example of answer to questions:

1.6 Bed centres

Standard: Minimum of 2.7 metres between bed centres (see Appendix)

Is provision in high risk areas adequate? YES / <u>NO</u> *if NO, please complete table below*

Where and in what respect is provision inadequate?	*25% of bed centres are under 2.7m*
What steps are needed to remedy the situation, and are there plans to do this?	**Increase space between beds, principally in orthopaedics** **Plan: increase spacing in areas where space can be recovered from moveable equipment and furniture**
Estimate of costs required to rectify	**Would require construction of new 20-bed ward and rearrangement of many facilities: of the order of £x,000**
What would be the implications for service delivery if implemented?	Implementation now would create 5% loss in bed capacity for the Trust; effects on patient throughput
Are there non-financial obstacles to remedial action, and what are they?	*Limited space for building new ward(s); staff recruitment; disruption to service delivery*

SECTION 1: infection control high risk areas

1.1 Provision of handwashing facilities

Standard: adequate numbers and types of facilities available (see Appendix A)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.2 Sluice areas

Suggested standard: Surfaces (floor, worktops, splashbacks) intact and easy to clean; adequate storage for essential equipment

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.3 Provision of patient handling equipment (hoists etc) **and commodes**

Suggested standard: sufficient equipment available to allow effective decontamination of fabric slings and/or non-removable surfaces between use for one patient and the next

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1. 4 Furniture and fittings in clinical areas and day areas

Suggested standard: all furniture & fittings are in good repair, fit for use and capable of being cleaned (e.g. chairs, tables, lockers, beds, mattresses)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.5 Storage of domestic services equipment

Suggested standard: Suitable storage space is available and is not used for other purposes (see Appendix B)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.6 Bed centres

Standard: Minimum of 2.7 metres between bed centres (see Appendix C)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 1: infection control high risk areas

1.7 Provision of side room facilities (e.g. for isolation of infectious patients)

Standard: Each ward should have, or have access to, single rooms with en suite toilets (see Appendix D)

Is provision in high risk areas adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 2: hospital-wide issues

Questions in this Section relate to **all areas** within the hospital.

2.1 Provision of (uniformed) ward staff changing facilities

Standard: Staff should have dedicated, clean and secure changing facilities (see Appendix E)

Is provision within the hospital adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 2: hospital-wide issues

Questions in this Section relate to **all areas** within the hospital.

2.2 Provision of staff washing/decontamination facilities

Standard: Staff should have access to facilities for washing and changing following incidents involving gross contamination with body fluids & faeces (see Appendix E)

Is provision within the hospital adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

SECTION 2: hospital-wide issues

Questions in this Section relate to all areas within the hospital.

2.3 Management of clinical waste

Suggested standard: There is a Trust policy for management of clinical waste which is effectively implemented (particularly re storage, accumulation and uplift of waste)

Is provision within the hospital adequate? YES / NO *if NO, please complete table below*

Where and in what respect is provision inadequate?	
What steps are needed to remedy the situation, and are there plans to do this?	
Estimate of costs required to rectify	
What would be the implications for service delivery if implemented?	
Are there non-financial obstacles to remedial action, and what are they?	

Comments:

APPENDIX

The full text of the guidance referred to below should be consulted for further details: copies should be available from the Property and Environment Forum if not available locally. The Property and Environment Forum has issued a helpful CD-ROM under the heading 'Decontamination Guidance' which contains details of guidance produced by PEF, the Scottish Executive, NHS Estates (England) the Medical Devices agency and others: it also covers topics such as ventilation in healthcare premises.

A. Standards for hand wash basins in the healthcare environment

References: SHPN 04 [In-patient accommodation: options for Choice]

SHPN 04 provides guidance on the planning and design of hospital accommodation for people with acute illness or immediately before or after an acute intervention. This document lists recommendations for the appropriate number of hand wash sinks in clinical areas as follows:-

- a minimum of one sink per single room and small ward areas [see also SHPN 35]
- one sink per six beds in a large multi-occupied room.

Other recommendations to encourage good practice include:-

- High dependency setting e.g. ITU – one sink between two patients [see also SHPN 27]
- Acute, elderly and long-term care settings – one sink between four patients
- Low dependency settings e.g. mental health units – one sink between six patients
- Primary care settings, where clinical procedures or examination of a patients/clients is undertaken – a sink must be close to the procedure. [see also SHPN 35]

The types of taps required are also specified. See also SHFN 30 [Infection Control in the built environment: Design and planning]

B. Storage of domestic services equipment

Reference: SHFN 30 [Infection control in the built environment January 2002] and SHPN 04 [In-patient Accommodation]

Domestic cleaning equipment, laundry and clinical waste all need to be stored in separate purpose-built areas to prevent cross-contamination. The domestic services/cleaners room is the base from which domestic staff provide the immediate day-to-day cleaning service. A clinical wash-hand basin should be provided. It should include storage for cleaning materials and equipment in daily use and facilities for the routine servicing and cleaning of equipment. The room should be well lit and ventilated so that equipment can dry quickly; mechanical ventilation may be required. Bulky equipment has to be moved in and out of the room and this should be taken into account in its location. Cleaning materials should be stored in a secure cupboard.

C. Standards for spaces between beds

Reference: SHFN 30 [Infection control in the built environment January 2002]

This document makes reference to SHPN 04 and its guidance for the size and space of in-patient accommodation. Specifically, the bed centre spacing of 2.7m is the standard currently adopted by

HSE. A planning checklist is included in this document, which can be used throughout the design and planning process to ensure areas with infection control implications are not missed. The list is as follows: -

- Sufficient space should be maintained between beds to allow for activities to take place and to avoid transmission of organisms either by air or by contact with blood /body fluids.
- The exact space required between beds will vary according to numbers and activity of staff, type of patient, and environmental factors such as ventilation, humidity and overcrowding
- Bed centres should be at least 2.7m apart.
- Bed groupings should contain the smallest possible number of beds
- Single rooms can be used for isolating patients with communicable infections.
- Provision of single room accommodation with ventilation will help prevent the spread of organisms, especially those transferred by the airborne route, or easily disseminated into the immediate patient environment
- There is currently no definitive guidance on size, ventilation or the equipping of single rooms.
- Healthcare facilities must provide enough sanitary facilities and shower/bathrooms to ensure easy access, convenience and independence where possible.
- All WCs must have provision for hand washing and HBN4 recommends that toilet facilities should be no more than 12m from the bed area or dayroom.
- Storage is required for bulky items of equipment as well as the smaller items used in the clinical setting to protect them dust or contamination and the need for sufficient storage should not be underestimated.

SHPN 27 [Intensive Care Unit] deals specifically with the requirements for space around beds in that environment. Recommendations include:

- A bed space should be large enough to permit all clinical interventions, accommodate multi-parameter monitoring and life support systems.
- Each bed space will now be required to accommodate patient hoists and mobile X-ray machines
- Staff access around each bed space is essential and staff must be able to access all four sides of the bed without having to move it away from the wall.
- Each bed space must also have enough space to allow a clinical team to deal with the 'worst case' scenario.

D. Standards for provision of single room facilities

Reference: SHFN 30 [Infection control in the built environment January 2002], also SHPN 04 and SHPN 27.

There is no definitive guidance on the size, ventilation or the equipping of single rooms used for patient isolation.

E. Standards for staff changing facilities

Reference: SHPN 04. Guidance is supplemented in individual departmental guidance in the relevant SHPNs.

The term ‘uniform’ includes protective clothing such as white coats for medical staff.

F. Management of clinical waste

The Action Plan ‘Waste Management in NHSScotland Trusts’ issued in May 2002 (HDL(2002)43) contains a number of specific actions in this area, notably the appointment of a Waste Management Officer who should be able to supply the required information for this audit. This Action Plan also covers compliance with the revised SHTN 3 (Management & Disposal of Clinical Waste).

Report to the Cabinet Secretary for Health and Sport

into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland

April 2019

John Sturrock QC

"There was never any physical violence. Only the fear. That nauseous feeling in my stomach. Hyper vigilance. It would start on a Tuesday and culminate on the Friday when we met. The intimidation was horrible. I would do everything I could to avoid it. I was blamed for leaving early. I never told anyone at the time. They, those in charge, must have known. But I felt powerless. Ashamed. As if it was my fault. It affected everything. I suspect it has had a huge impact on my life."

"I found it really hard being called a bully. It was shocking in fact but I couldn't admit it to anyone outside. I hadn't been trained to take on this role. I had tried my best. But there was huge pressure to conform, to do things a certain way. I knew I was hard to work for at times and would tend to be demanding. In reality, I was struggling. I couldn't show that or tell anyone. I didn't mean to cause harm. Sometimes, it felt like I was the one being bullied even though I was supposed to be in charge. Even now, I feel ill at the thought of it..."

(see Personal Note at paragraph 1.17)

"We can't solve problems by using the same kind of thinking we used when we created them".
(attributed to Albert Einstein)

"The key to doing well lies not in overcoming others, but in eliciting their co-operation."
(Robert Axelrod)

"We have far more in common than that which divides us"
(Jo Cox MP)

"There is no us and them, only us."
(Ken Cloke)

"When in doubt, do the kindest thing"
(unattributed)

"We are mirrored not by concepts, but by faces delighting in us—giving us the face we can't give to ourselves. It is "the face of the other" that finally creates us and, I am sorry to say, also destroys us. It is the gaze that does us in…."
(Richard Rohr)

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
(Maya Angelou)

Questions

"Everyone thinks of changing the world, but no one thinks of changing him or her self."
(adapted from words of Leo Tolstoy)

It is perhaps only by asking, and continuing to ask, ourselves and each other difficult questions that a constructive way forward will emerge.

Before you read this report, I invite you to ask yourself some questions:

- What am I hoping to find in this report?
- What assumptions have I made before I start?
- What do I hope to learn from reading this?
- How open am I to new perspectives?
- How willing am I to see another side of the story?

After reading the report, you might ask:

- What have I learned?
- What needs to change?
- Who do I now need to talk to?
- What else do I now need to do?
- What do I need to let go?
- How can I help to change things for the better?

If you are affected by what has happened in NHS Highland, I invite you to ask these further questions:

- What was my role in things which happened?
- What might I have done differently?
- What do I now regret doing or not doing?
- What do I need to acknowledge in myself or about others?
- What might it be like to be the person I dislike or fear most?
- How might others see me?

"O wad some Power the giftie gie us, to see oursels as ithers see us!"
(Robert Burns)

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Introduction and Summary

1. Introduction to the Report

1.1 On 23 November 2018, I was asked by the Cabinet Secretary for Health and Sport to undertake a fully independent external review into allegations of a bullying culture at NHS Highland.

Remit

1.2 The stated purpose of the review was to:

- Create a safe space for individual and/or collective concerns to be raised and discussed confidentially with an independent and impartial third party.
- Understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally.
- Identify proposals and recommendations for ways forward which help to ensure the culture within NHS Highland in the future is open and transparent and perceived by all concerned in this way.

Public Announcements

1.3 The press release announcing my appointment included these words from me:

"My primary role, therefore, is to provide a safe and confidential place for people to be heard and to explore with them what the underlying issues might be."

1.4 In publicising the review, I added that I hoped to make recommendations and proposals with a view to helping to improve culture and behaviours both now and in the future and restore the trust between the management of NHS Highland, the clinical community, and local staff-side representatives, in order to build and maintain a culture of cooperation and respect.

1.5 I note also that following a meeting hosted by Shirley Rogers, Director of Healthcare Workforce and Strategic Change in the Scottish Government, with union representatives on 19th November 2018, a statement was made by the Scottish Government that an externally led independent review into the allegations of bullying at NHS Highland *"will consider **all the circumstances** that have led to the allegations and make recommendations"* (my emphasis).

1.6 The Cabinet Secretary expressed the hope in the Scottish Parliament on 27 November 2018 that I would at least present her with interim recommendations in early 2019. That guided my conduct of the review. I submitted interim findings and recommendations on 5 February 2019.

Review and Report

1.7 This full report was submitted in draft form on 27 March 2019. I am conscious that this means that the review was conducted in approximately eighteen weeks (which included the Christmas break). I am mindful that such a relatively short period of time places some restrictions on the scope of the review but hope that this report does sufficient justice to what I have heard and read in that time to enable others to build on it.

1.8 I have been able to revise the report to take account of representations made since the first draft and I am also aware that, since I gathered information in late 2018 and early 2019, matters have moved on with a number of changes at senior levels.

1.9 I should also record, as I expand on later, that the number of responses I received greatly exceeded what had been anticipated when I was appointed and this has impacted on the management of time and resources. Nearly all respondents had serious contributions to make and concerns to express, and the majority requested meetings with me.

1.10 Against that background, this report is designed to enable the Cabinet Secretary to reach conclusions about the matters I have explored in connection with NHS Highland and, if she wishes to do so, to act on my proposals and invite others to do so. It is also written with a wider audience

in mind including those in NHS Highland who will need to take matters forward and all those interested in the circumstances which I have been asked to review.

1.11 This is by no means the final word. I fully appreciate that some of those with whom I met, and others with whom I have not met, will have views to express about the content of the report. That should be part of the continuing dialogue. I have sought to reflect what I have heard and how I have seen things. This report reflects a stage in a longer journey of consideration and discussion about these important issues.

Report Sections

1.12 To aid navigation through the report, it is presented in six broad sections:

(I) Introduction and Summary (from page 12)

(II) Context (from page 22)

(III) What the Review was Told (from page 49)

(IV) Understanding the Cultural Issues (from page 65)

(V) & (VI) Ways Forward for NHSH (in two parts, from pages 134 and 147)

1.13 Some readers may wish to skim through the Context section which contains a number of general observations not all of which, I acknowledge, will be of interest to every reader.

1.14 There are a number of chapters in each section. Inevitably topics and themes overlap and intersect.

1.15 For those who wish a quick overview, the Summary of the Report, which follows after this Introduction, provides that. Please do bear in mind, however, that the full explanation of, and context for, the points made there are found in the detail of the report. There is also a Quick Summary of Main Points and Proposals towards the end, in Chapter 37.

1.16 For ease, I refer in this report to NHS Highland as "NHSH".

Personal Note

1.17 I have some limited experience myself of what is called bullying. The two quotations on page 2 relate to my own life experience: at school in the early 1970s and some years ago as the founder of a small business. Bullying affects many of us in many ways.

Gratitude

1.18 I am grateful to my colleague Miriam Kennedy for all her hard work behind the scenes and to my colleagues Charlie Woods and Liz Rivers for bringing compassion, insight and wisdom to the process. Ainsley Francis also provided invaluable support in the presentation of this report.

1.19 However, my biggest thanks go to the 340 people who came forward, often reluctantly and with some trepidation, most of whom candidly shared their experiences and offered their views. While I have not been able to incorporate or reflect all that I heard, I hope they feel that this review does some justice to what they said.

A Reflection

1.20 We often wish that things had not happened in our time. But we have to deal with what we have been given. If challenges seem impossible and overwhelming, all we can do is look to the present and the future. We each have the choice to do something, to make our contribution, however small. In that way, *our sense of powerlessness can be converted into empowerment.*

1.21 It is often said that *"little things can make a big difference."* I hope that this report will empower many people in NHSH to choose to accept the challenge to make contributions, however small, to a better future for the organisation.

2. Summary of the Report

Overview

2.1 NHSH is and has been for many a great place to work. There are thousands of well-motivated, caring and supportive people providing excellent caring services to thousands of patients in the area served by NHSH, often sacrificially and well beyond the call of duty.

2.2 This has been a very hard time for many employees of NHSH and those connected with NHSH. It may be that focus on the primacy of patient care and safety in recent years, through quality and performance initiatives, has not been matched in all situations by care for those delivering the services.

2.3 Patients and others in the NHSH community need to be reassured that the day to day work of the organisation is designed and able to do the very best it can for all concerned.

2.4 The only way to optimise the use of limited fiscal resources is to draw upon and acknowledge the deep well of goodwill that exists in the NHSH workforce. That goodwill has been seriously tested in recent years for a number of those working in NHSH.

2.5 There is a great opportunity now to create an open, safe and inclusive organisation in all of its component parts, perhaps even to be a leading exemplar to other organisations. If real learning can be taken from what has happened, and if kindness and compassion can be restored in NHSH, there is a great opportunity to build a new kind of organisation.

2.6 There may be no greater leadership challenge in 2019 than to help people under pressure to feel valued and for everyone to appreciate the benefits which come from rebuilding strong relationships, bringing out the best in each other and enabling everyone to be more effective in every way.

2.7 It seems necessary, at a deep level, to explore and understand why individuals and organisations behave as they do, especially when under pressure, and to find enduring remedies, not transient sticking plasters. Current research into behavioural psychology and neuro-science provides an excellent resource to draw on.

2.8 This is an organisation with an £800 million budget funded by the taxpayer. The current situation merits serious analysis. This report reflects a stage in a longer journey of consideration and discussion about these important issues.

The Review

2.9 Of the 340 people who made contact, the review engaged directly with 282 respondents in face to face meetings and in written form. They came from a broad cross section of the staff employed by or associated with NHSH, from most departments, services and occupations, mostly current and some former.

2.10 In total, the review has enabled a total of 186 individuals to express their views personally on a one to one basis or in a group setting. This was not easy for many. Most people expressed satisfaction with the opportunity afforded to them.

2.11 Those coming forward in response offered a wide range of views, from those who wished to say that they are not aware of bullying in NHSH at all to those who provided details of their own and others' experiences of bullying behaviour, both individually and collectively.

What the Review was Told

2.12 The majority (66%) of those responding to this review wished to report experiences of what they described as bullying, in many instances significant, harmful and multi-layered, and in various parts, at all staffing levels, and in many geographic areas, disciplines and departments of NHSH.

2.13 There are issues common to the whole of NHSH, some which are particular to the Inverness area and Raigmore, and some which are particular to more rural areas and to Argyll and Bute. These affect wider communities too.

2.14 A significant minority of respondents expressed views with varying degrees of firmness to the effect that there is not a problem, or at least that there is no bullying culture as such, and that any conduct of concern is nothing other than what might be expected in any similar organisation with day to day pressures. They have been hurt and angered by the adverse impact of the allegations which have been made, on patients, staff and local communities.

2.15 A significant majority of those with whom the review engaged have, over a number of years suffered, or are currently suffering, fear, intimidation and inappropriate behaviour at work. The issues raised are also wider and more complex than "bullying", however that is defined. Bullying cannot be assessed in a binary way.

2.16 While it is not possible to conclude conclusively that there is or is not a bullying culture in NHSH, it may be possible to conclude that the majority of employees of NHSH have not experienced bullying as such. Having said that, extrapolating from the evidence available to this review, it seems equally possible that many hundreds have experienced behaviour which is inappropriate. That seems far too many.

2.17 The number of individual cases in which people have experienced inappropriate behaviour which falls within the broad definitions of bullying and harassment described earlier is a matter of the utmost concern. Many appear to have suffered significant and serious harm and trauma, feel angry and a sense of injustice and want to have their story heard.

2.18 A number of those against whom bullying allegations have been made are also, or have been, the subject of inappropriate behaviour themselves.

2.19 Many people have been afraid to take steps to address issues internally or to speak out, currently and over a period of many years. Many feel that no really effective, safe mechanism to do so has existed.

2.20 A significant number of employees, at all levels of seniority, have resigned, moved to other jobs or retired as a direct result of their experiences in NHSH and inability to achieve a satisfactory resolution, some to their financial detriment.

2.21 Themes emerged for staff who feel they are not valued, not respected, not supported in carrying out very stressful work and not listened to regarding patient safety concerns, with decisions made behind closed doors. They feel sidelined, criticised, victimised, undermined and ostracised for raising matters of concern. Many described a culture of fear and of protecting the organisation when issues are raised.

Understanding the Cultural Issues

2.22 The experiences of many NHSH staff are likely to be attributable to a number of factors which have built up over many years, a number of which have also created difficulty in raising and addressing matters locally.

2.23 Some factors could be described as cultural and are possibly unique to the specific local and geographic circumstances of NHSH and its employees. Other matters are relevant in general to the NHS in Scotland and to the provision of health care overall. There are other significant factors which will be common to all large organisations.

2.24 These are explored in detail in this Report.

Management and Leadership

2.25 Many of the difficulties experienced in recent years in NHSH are said to be attributable to a management style which has not been effective in the challenging circumstances of the modern NHS, and relate also to the effectiveness of the governing body to provide effective oversight.

2.26 A significant number of respondents expressed concerns about the role of senior management. The senior leadership of NHSH has seemed to many, though not all, to have been characterised over some years by what has been described as an autocratic, intimidating, closed, suppressing, defensive and centralising style, where challenge was not welcome and people felt unsupported.

2.27 A significant number of managers who engaged with the review reported operating

in circumstances in which they felt unable to manage effectively because of the uncertainties and pressures presented by the current situation. There is a real concern that allegations of bullying can be used to avoid or deflect appropriate management of performance and other difficult issues.

2.28 It appears that the intersection in decision-making between management and clinicians is not working well enough and is a cause of much frustration and sub-optimal performance.

2.29 Issues were raised about appointment, recruitment, promotion, training, diversity and relationships of managers.

2.30 Many who were concerned at director and senior management level and who themselves experienced bullying behaviour have left the organisation. Some people have been very damaged by the experience.

2.31 It is understandable that some have concluded that what was being experienced at the top of the organisation led to a situation in which identifying and addressing inappropriate behaviour was difficult.

Governance

2.32 For a number of reasons, including inadequate provision of information to the Board which was not conducive to effective and informed decision-making and a culture which tended to discourage challenge, it appears that the Board has not functioned optimally in its governance and oversight role leading to a situation where allegations apparently could not be raised and responded to, adequately, locally.

2.33 Over a period of time, concerns have been expressed about a style of management and type of behaviour which many contended was not acceptable in a large and complex organisation. It seems clear that people in leadership positions were or should have been sufficiently aware of the concerns expressed as late as mid-2017 and probably earlier.

2.34 Both the Board and the Scottish Government were, or should have been, sufficiently alerted by developments to act more decisively at an earlier stage.

2.35 In a public service with a budget of £800 million, new leadership should look seriously at the learning arising from what has occurred, especially in connection with holding to account. If this is done, it should be possible to assess and respond to allegations, such as those of bullying, more fully at an earlier stage.

2.36 The absence of a proper strategic vision with specific goals and timelines seems to be a contributor to the current sense of lack of direction.

2.37 The governance structure seems extensive and impenetrable to many. It does not seem conducive to open, transparent and effective operation.

2.38 The role, appointment, training and support of, and provision of information to, non-executive directors appears not adequate in practice to meet the needs of the Board of a large publicly funded organisation with an £800 million budget.

2.39 Unless people with the necessary skills, knowledge, expertise and experience (and ability to ask the right questions in the right way while understanding financial, risk and other management issues) are appointed to NHS boards, there is a danger that governance will not be effective and national policies will not be implemented effectively.

2.40 Many people expressed their concerns about the partnership agreement for staff involvement in decision-making and the role of trade unions and staff-side representation, which appears to many employees to have failed adequately to represent the interests of employees of NHSH in regard to bullying claims.

HR and Other Processes

2.41 It appears there has been, and continues to be, serious delay in addressing many of the issues of significant concern to members of staff in NHSH. This is often because of failures and delays in recording, reporting and investigating, and in grievance and other procedures and policies for dealing with complaints and other concerns (including the inconsistent and inappropriate use of suspension and capability assessments, breaches of confidentiality and perceived loss of impartiality).

2.42 While there is a lot of criticism of "HR", that may be a catch-all which conflates management roles and the HR function and does not fully acknowledge the wide-ranging nature of the dysfunction across management generally.

2.43 The view has been expressed that there is a strong need to improve diversity awareness and bring the NHSH culture into line with attitudes and practice in the rest of the UK.

2.44 It has become clear that mental health should be a major management issue for the NHS and NHSH in particular. A significant number of people employed in NHSH have suffered and some continue to suffer from significant mental health issues as a result of their experiences, many of which can be described as traumatic given their repetitive and intrusive nature in disruptive and damaging situations.

2.45 There are a number of more specific concerns which the report comments on in some detail.

Scottish Government

2.46 Senior officials in Scottish Government were aware of the dysfunctional situation with the Board and at senior leadership level for a considerable period of time prior to matters becoming more public in the autumn of 2017.

2.47 There is a tension for Scottish Government between intervening and encouraging organisations and individuals to deal with issues themselves. Government is often accused of over-involvement. Yet, when things go wrong, it is held responsible. Judging when and how to intervene is not easy.

2.48 The Scottish Government is an essential part of the system. How it acts and reacts also impacts on those in NHS boards and executive positions in local areas. Now seems like a good time to review this relationship.

Whistleblowers

2.49 Those involved as whistleblowers genuinely felt they had no option but to do what they did and that this was the only way to address matters, even with the costs which arose. None of this would have been necessary or would have developed as it did had the Board and management appeared to be open to a full exploration of the issues. The report's findings are not hugely influenced by the whistleblowers' allegations; they were ultimately a catalyst for others to come forward.

2.50 Many people have been hurt and feel misrepresented and offended by what has appeared to them to be a brutal step by the whistleblowers. Individual reputations in a close community have been adversely affected. There seems little doubt that certain assertions were too broad and without the support claimed.

2.51 The existing system for whistleblowing does not seem to have functioned as effectively as it needs to.

Ways Forward for NHSH

2.52 In NHSH, steps can be taken, both restorative and preventative, to reset the whole organisation and to promote an institution-wide healing and reconciliation initiative, supporting and liberating the workforce. This is likely to have a positive impact on patient care and outcomes too.

2.53 Better staff relationships will lead to better clinical outcomes, especially when the tasks are complex and interdependent. To achieve this, there is an urgent need to collaborate and work together rather than to compete, based on a deeper and wider understanding of the shared interests that allow people to cooperate more effectively and efficiently to find solutions.

2.54 This necessarily entails a move away from trying to control everything to a more distributed, multi-disciplinary or collective leadership and decision making.

People-Centred Culture

2.55 There needs to be an enabling culture from the top. Culture change needs to be owned by the leaders. That means leaders who are not afraid, who have high self-esteem and a great deal of humanity and compassion. Kindness is a critical component of the leadership which will be needed going forward.

2.56 A new style of people-centred leadership will be crucial, with a more effective and competent management team and board, and a more compassionate, honest, courageous, humble,

empowering culture, open to respectful challenge, communicative and accepting of the realities of operating in a very pressurised and financially challenging situation. Fear cannot be the driver.

Other Considerations

2.57 An honest conversation is needed more generally in the NHS, and with the general public and employees, about realistic expectations and the perhaps inevitable tensions between clinical delivery and financial reality.

2.58 Fault-finding and a culture of blame will not be a productive way forward. Wherever possible, NHSH will need to look forward constructively to the future.

2.59 Looking ahead, it will be necessary to find ways to acknowledge the circumstances of the past, to recognise the impact on individuals, processes and services, to demonstrate acceptance of some personal responsibility, to show that lessons have been learned, to reassure staff and indeed the general public that there is a genuine willingness to grasp the need for change and that things will be different in the future, to rebuild confidence, and to move forward with greater competence in the years ahead.

2.60 More attention should be paid to early intervention, when a difficulty or conflict is first identified. Nipping matters in the bud is critical. This can be addressed by education and training, by empowering those affected and bystanders to raise concerns early, and by introducing other different approaches which move away from adversarial or binary processes.

2.61 Many of the issues currently being addressed through conventional grievance and other procedures may be amenable to, and more effectively resolved by, early intervention through mediation and other facilitated conversations.

2.62 The time has come to place mediation firmly at the centre of a preventative strategy in the NHS in Scotland. That could start in NHSH.

2.63 Leaders and others will wish to reflect on and seek to align how things are done in NHSH with the National Performance Framework and its outcomes.

Leadership, Governance and Management

2.64 It seems essential for the new chief executive to exhibit an ability to engage with people at a personal level, to listen well and to seek to understand, to value contributions from all parts of the organisation and to be alert to the human effect of the inevitable tensions and constraints which funding limitations and other challenges bring.

2.65 He will benefit from the support of like-minded and like-acting colleagues who can help lead by example and demonstrate real empathy, insight, self-awareness and vision in practice. He will need the support of an appropriately qualified Board chair who has a similar mindset.

2.66 There is a real need for an authentic, meaningful acknowledgement and acceptance of how serious matters have been for many people in NHSH over a number of years, together with recognition of the impact on them of these circumstances and a reassurance that matters will be addressed now with rigour going forward.

2.67 At the same time, there should be recognition of the impact on those who have not experienced adverse behaviour but who have been affected by the fact that the allegations themselves have been made. Healing can only occur if the different experiences are recognised and acknowledged.

2.68 Whatever procedures and policies are available, they are unlikely to be effective unless people are civil to one another, especially when under pressure. This comes from the top and cascades through the whole organisation. Consideration might be given to adopting something akin to the Commitment to Respectful Dialogue of Collaborative Scotland.

2.69 The Board must be able to hold senior executives effectively to account, in the sense of supportively enabling and ensuring effective leadership rather than blaming or coercing. A review of governance structures, the committee network and culture will enable the kind of clear communication and taking of responsibility which this report commends. Allied to this, the Board will wish to oversee a review of the management structure also.

2.70 Other detailed proposals regarding governance should be acted on, particularly in connection with non-executive directors.

2.71 Reassessment of the relationship between and among clinicians, GPs and management seems to be an essential part of building a collaborative and mutually respectful and supportive culture. There should be reflection on the manner and benefits of clinical involvement in leadership.

2.72 Clearer management structures, a better understanding of the needs and motivations of both management and medical staff and a positive approach to the greater good, will all benefit staff and patients alike.

2.73 The role of trade unions and staffside representation, including the partnership agreement, merits review in order to ensure really effective representation of employees' interests.

2.74 By reason of its geographic and possibly other specific circumstances, a separate review in and about the functioning of management in Argyll and Bute should be commenced, conducted by a person or persons from outside that area.

2.75 In so far as staff have any specific concerns about patient safety, these should be referred to the chief executive or to a specified independent person if preferred.

Support for NHSH Employees

2.76 Support is needed, in a number of ways, for individual employees in NHSH (at all levels), who have experienced inappropriate behaviour and who have suffered distress, harm and other loss. This should include providing safe and independent spaces for many current and outstanding physical, emotional and psychological issues to be addressed fairly urgently.

2.77 It is likely that these initiatives will result in a need to address specific complaints, disciplinary matters and grievances, many of which appear to remain outstanding and/or unresolved. The cooperation of the unions, especially the GMB, will be important in this. A strategy to resolve the many outstanding cases as speedily as possible should be devised.

2.78 Other specific proposals are made in this Report.

Training and HR

2.79 Longer term, a carefully designed ongoing comprehensive training programme addressing appropriate behaviour (including a well communicated, simple and clear definition of what constitutes bullying and harassment, together with diversity and discrimination awareness) could have a profound impact.

2.80 There is a need to rebuild confidence in and of managers. A programme of action learning, training, review, coaching and support is essential at all management levels, including for those preparing for recruitment, induction or promotion into management positions.

2.81 Among a number of specific recommendations to build relationships and confidence, the introduction and/or enhancement of well facilitated team meetings on a regular basis, possibly across boundaries on an inter- and/or multi-disciplinary basis, with opportunities to express concerns, to brief and debrief safely, and review events and experiences in a supportive culture, could help greatly. Managers could be trained and encouraged to undertake and facilitate these.

2.82 There needs to be an organisation wide clarity about and understanding of the role of HR, and its limitations, and it and Occupational Health need full-time direction at the highest level. Appointment of a full-time HR Director is essential.

2.83 All HR and other policies and procedures should be reviewed, updated and simplified, in the context of national reviews – and properly publicised. Systems for accurate and robust recording of complaints about alleged bullying and harassment should be maintained so that understanding of the extent, nature and distribution of bullying and harassment in the organisation is improved.

2.84 Grievance and other formal procedures, when used as a last resort, must be redesigned to be speedy, transparent and fair to all.

2.85 It is suggested that all NHS staff should be educated about the effects of bullying, the trauma model, the Adverse Childhood Experiences study and how they can address

unprocessed trauma leading to consequences for the alleged victim and to themselves. Other steps to address dealing with trauma are recommended.

Whistleblowing

2.86 While one would hope that the steps above would minimise the need, and that "whistleblowing" would be very much a last resort, further steps should be taken to provide a properly functioning, clear, safe and respected wholly independent and confidential whistleblowing or, more helpfully, "speaking up" mechanism.

2.87 All staff should be aware of how to use this and in what circumstances its use is relevant so that individuals with concerns are able to express these confidently in the future.

2.88 Provision of an independent, confidential, trained "guardian" or guardians seems essential both for those who experience and wish to report inappropriate behaviour and for those against whom such behaviour is alleged.

Context

3. NHS Highland

A Place of Work

3.1 It has been an enormous privilege to conduct this review. NHSH is a central and vital part of the Highland community. It extends from Caithness to Campbeltown, from Kingussie to Portree and from Nairn to Tobermory. But, interestingly, not to Elgin or Stornoway, Kirkwall or Perth! It has its central focal point at Raigmore in Inverness. It is a large, diverse, complex and sometimes fragile organisation. NHSH is and has been for many a great place to work. The following observations by some of the respondents to the review emphasise this point.

> "I am immensely proud to work for the NHS and NHS Highland, I love my job and I think that the majority of people working within the NHS go above and beyond every day when they are at work."

> "My over-riding impression is that staff are trying their very hardest to provide the best standard of care for their patients."

> "My experience of working as a nurse in NHS Highland is a very positive one… Where ever I go and whoever I interact or work with I am filled with a great sense of pride to see such great staff delivering really excellent care."

> "Raigmore is the nicest, friendliest hospital I have ever worked in."

> "Generally speaking, it sometimes feels like the organisation is under siege. One of the things that keeps me going is how many good things one can see in the organisation. Being able to see that there are positive things happening."

The People who Work in NHSH

3.2 There are thousands of well-motivated, caring and supportive people providing excellent caring services to thousands of patients in the area served by NHSH, often sacrificially and well beyond the call of duty. I have met many very fine, high quality professional people, trying – and doing – their best in their jobs, which they love, in often really difficult circumstances. The public's expectations of them (and of the NHS as a whole) are huge. We must acknowledge that fact and its effects.

3.3 I have admired the professionalism and humanity of individuals whose primary role is either to provide care for others in the community at times of stress and pain or to support colleagues who do so. I am struck by the essential goodness of those employed by NHSH and also by the adverse impact on many of them of the allegations which have been made, including on those for whom the allegations came as a shock.

3.4 This has been a very hard time for many employees of NHSH and those connected with NHSH. It may be that focus on the primacy of patient care and safety in recent years, through quality and performance initiatives, has not been matched in all situations by care for those delivering the services. The two are of course inseparable.

3.5 Overall, I am sure that NHSH staff wish to do well for and to support each other and the patients and others they seek to serve. This can and should be the foundation going forward. Patients and others in the NHSH community need to be reassured that the day to day work of the organisation is designed and able to do the very best it can for all concerned.

Pressures and Priorities

3.6 I am aware that there are other pressures and priorities too, not least financially. The organisation is under huge financial pressure. While that is so, it seems really important that the people side is given full consideration. While cost constraints are a part of life in a publicly funded organisation, ultimately people must be the priority. Indeed *"People are the Priority"* might be a useful slogan for the year ahead. I am told that prioritising people is a central tenet of the Nursing and Midwifery Council Code.[1]

1 Nmc.org.uk. (n.d.). Read The Code online. [online] Available at https://www.nmc.org.uk/standards/code/read-the-code-online/#third [Accessed 8 Mar. 2019].

3.7 Financial targets will only work well if people are thriving. Human dignity is an infinite resource; public finance is not. Indeed, perhaps the only way to optimise the use of limited fiscal resources is to draw upon and acknowledge the deep well of goodwill that exists in the NHSH workforce. That goodwill has been seriously tested in recent years for a number of those working in NHSH. Ironically the damage to, and waste of, human resources surely adds to the financial cost.

3.8 If people, and achieving their full potential, become the priority, the converse is also likely to be true. Real compassion in and towards the workforce is an investment, an example perhaps of preventative spend.

3.9 The value of all this coming to the surface, as it now has, must be that it creates an opportunity to learn, to try to do things differently in the years ahead and to turn a crisis into a better future. At some point, a line will need to be drawn under the past and I hope that this report will play a modest part in enabling that to be done. There is a great opportunity now to create an open, safe and inclusive organisation in all of its component parts, perhaps even to be a leading exemplar to other organisations.

A Word about Patients

3.10 I am aware that it was hoped that allegations of bullying against patients would also be included in this review. However, given the time constraints, it was agreed at an early stage that these would not be included. Purely for the record, we received very few such allegations, even from the outset.

3.11 Everyone is agreed that patient safety is paramount. Patient safety is not something I can cover in detail in this report. However, a number of concerns have been expressed to me about the consequences for patients of unhappiness and poor relationships among staff and it seems inevitable, given the extent of dysfunctioning upon which I report below, that there will be issues to address, of which I was given some examples.

3.12 On the other hand, and in keeping with my earlier comments, the vast majority of patient care is likely to be of a very high standard. In so far as this whole situation has caused concerns for patients and their communities, confidence needs to be restored. I hope that this report, and the actions following it, will play a part in helping to do so.

4. My Approach to Conducting the Review

"Clear is kind. Unclear is unkind…Feeding people half-truths or b……t to make them feel better (which is almost always about making ourselves feel more comfortable) is unkind."[2]

General

4.1 It was made clear from the outset that the review could not specifically address individual complaints or concerns, whether resolved or unresolved. I emphasised that the review's objective was to explore matters more generally. Those responding understood that readily. Of course, individual matters are very important as they represent experiences and examples to take into account in considering the overall situation in NHSH. I refer to a number of these to exemplify the issues raised.

4.2 I am not an expert in the workings of the NHS nor in allegations of organisational bullying. I am better informed now but I am more of a generalist than a specialist. That needs to be borne in mind by the reader. In order to inform myself better about the context of my review, I have taken into account a number of other reports and reviews. Some are specific to NHSH and others are more general, such as the reports by Sir Robert Francis in England[3] and the Bowles Report on NHS Lothian[4]. I have also been aware of the BMA's recent expressions of concern about bullying more generally in the NHS in Scotland[5] and of other reports commenting on bullying elsewhere.

4.3 However, I have endeavoured not to be unduly influenced by the fact or content of reports relating to matters elsewhere and to focus my attention on what has been and is said to be occurring specifically in NHSH. It will be for others to discern a pattern or to draw comparisons, if any, with what is happening elsewhere or more generally.

4.4 In forming views, I have listened extensively and tried to assess and distil what I (and my colleagues) have heard and read. I have noted the sources of information, and the apparent veracity of what has been said. I have been interested when multiple strands of information have come together and disclosed a trend or a theme. I have endeavoured to assess the credibility of what I have been told. The wide-ranging nature of the review has given me a substantial body of material to draw on. When making a statement of fact, I do so when I am satisfied that what I have heard and/or read reasonably entitles me to do so. Generally, however, I am reflecting the views expressed to me by others and have not sought to check every statement made for its factual accuracy.

Content

4.5 In accepting this appointment, I made clear that I would not conduct a form of inquiry in which I would find fault or allocate blame. However, inevitably, my report contains commentary which implies criticism of individuals in some cases. I cannot do justice to the many views expressed and the experiences so many have shared with me without doing so. This is unfortunate but it is an inevitable consequence of such a review.

4.6 I have not recorded all of the detail with which I was provided. That would have filled an even larger tome. Necessarily I have tried to acknowledge what I have heard and to assess the bigger picture. That also means that others

2 Brown, B. (2018). *Dare to Lead*. 1st ed. Random House.

3 Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry and Francis, R. (2015). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS.

4 David J Bowles & Associates Ltd (2012). Investigation in to Management Culture in NHS Lothian.

5 Freeman, T. (2018). Bullying 'widespread' in NHS Scotland, claims BMA. *Holyrood*. [online] Available at https://www.holyrood.com/articles/news/bullying-%E2%80%98widespread%E2%80%99-nhs-scotland-claims-bma [Accessed 12 Jan. 2019].

will need to take forward and give effect, if they wish, to the specific proposals and suggestions which I make, and indeed develop these even more specifically.

4.7 There is a sense in which my review is more qualitative than quantitative, offering a broad analysis based on observations, meetings, and written submissions, without scrutinising every detail of every claim, situation or case brought to me nor placing precise numbers on all aspects. That provides a strong basis for initial understanding and insights and for a range of broad initial proposals.

4.8 As I mention above, the review is not forensic in the sense of testing every statement and assertion. More specific inquiry may be necessary in some areas and individual cases. Some of my suggestions may seem overly general, naïve or untested. Some proposals may already have been expressed or implemented elsewhere. So be it. Repetition may be useful. Reinforcement may be essential.

Confidentiality

4.9 There is a vast resource in the thoughtfulness and insights of NHSH staff. I am aware that I am privy to a very large amount of hugely helpful information about the workings of NHSH and I am concerned to try to ensure that the richness of what I have heard and read is not lost altogether when it might be useful to others. On the other hand, most of the information has been disclosed confidentially and I intend to respect that above all. In line with our undertaking to Scottish Government and our data protection responsibilities, data which we have gathered will be destroyed within two months of the publication of this report. I comment further on this in my proposals.

Getting Under the Surface

4.10 I have tried to approach this review with an open mind. I am very aware of the biases that affect us all (and I write more extensively about that later in the report), however careful we try to be. Many of these biases are unconscious and I need to accept that I cannot eliminate them wholly myself. I can only see through the glass darkly... and recognise that my own knowledge is imperfect. As has been said: *"In human affairs there is no certain truth and all our knowledge is but a woven web of guesses."*[6]

4.11 My own main bias may be that my life's work is to try to find ways to understand why conflict arises and remains unresolved in so many places in society - and to endeavour to help people find ways to overcome their differences and communicate effectively about what matters to them. In doing this, I may err on the side of trying to help or to fix things when my role is only to understand what is really going on and to make suggestions.

4.12 To take a possibly oversimplistic medical metaphor, I have been aware that there are many reported symptoms of a problem in NHSH which have been presented as bullying, and that one of my tasks, rather than merely accepting what appears on the surface, is to explore underneath and try to understand and diagnose the underlying causes of those symptoms.

4.13 In other words: *What is happening? Why is it happening? What lies under the surface? What is really going on? And why?* Only then can a general remedy or set of remedies be proposed for consideration and testing, after which it may be possible to prescribe a way forward in specific terms. This may be both restorative and preventative. *What can be done to make things better? How can that be achieved? Why might that work better?*

4.14 Even then, there may be a real need for trial and error until the best solution or solutions is found. It is unlikely that there will be easy fixes. Perseverance and patience will be required. To adopt a cliché, if the patient is really hurting, the application of a sticking plaster on the surface is unlikely to suffice.

4.15 Words from a report by the Organisation for Economic Co-operation and Development (OECD) resonate in NHSH:

"We're beyond quick fixes to address the discontent of people. There is no returning to the past. Too many things are not working for too many people. The only way forward is not to patch up ..., but to shake it up.

6 Xenophanes, Fragments as translated by Popper, K. (2002). *Conjectures and Refutations*. 2nd ed. London: Routledge.

We are confronting a similar foundational moment: one that demands decisive cures, rather than palliatives. These times require the same boldness, innovation, and above all, the long-awaited action to recreate, with our employees and stakeholders, a fair and prosperous future for all." [7]

Scotland's National Performance Framework

4.16 During my work on this review, I became aware of the details of the National Performance Framework (NPF). These are intended to guide public sector authorities in the conduct of their organisations. Social, economic and environmental indicators are designed to measure national wellbeing with a view to enabling all citizens to flourish. It is designed to be open, transparent and non-political and to encourage a shift from "business as usual". It draws attention to the complex interplay between the human stuff and the system stuff, illustrated as follows:

4.17 NPF recognises that we live in a VUCA world, one which is volatile, uncertain, complex and ambiguous:

THE VUCA WORLD

Volatility – The nature, speed, volume, magnitude, and dynamics of change

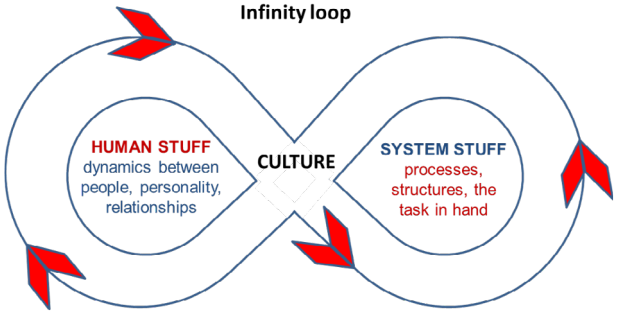
Uncertainty – the lack of predictability of issues and events

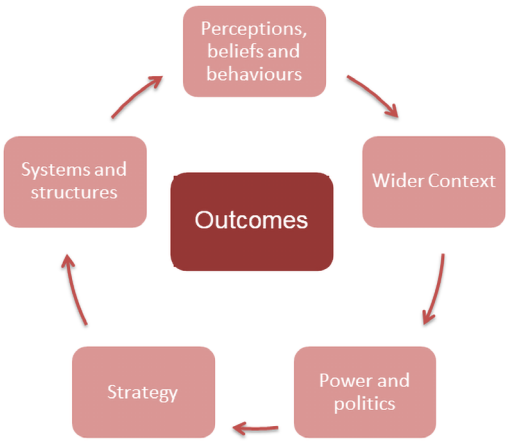
Complexity – The confounding of issues and the chaos that surrounds any organisation

Ambiguity – the haziness of reality and the mixed meanings of conditions

All of this is certainly true of the modern NHS and, as I have discovered, of NHSH.

4.18 The following further illustration shows the complexity of the world in which the NHS and other public bodies operate:





7 Gurría, A. (2017). Globalisation: Don't patch it up, shake it up - OECD Observer. [online] Oecdobserver.org. Available at http://www.oecd.org/newsroom/globalisation-do-not-patch-it-up-shake-it-up.htm [Accessed 28 Feb. 2019].

4.19 Among the values of the NPF are being a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way. Among the expectations about how the National Outcomes will be achieved (see below), one particularly caught my attention, as I noted in the list of quotations which opened this report: *"We grow up loved, safe and respected so that we realise our full potential"*. This should strike a chord as we explore what needs to happen in NHSH.

4.20 I have found all of this to be a helpful benchmark as I review what has happened in NHSH. It seems likely that NHSH will benefit from following the approach set out in the NPF as part of its leadership in the public sector in Scotland. The Purpose, Values and National Outcomes of the NPF are illustrated here:



Dignity

4.21 Above all, in conducting this review, I have been guided by the requirement to recognise that a sense of dignity is a fundamental need and right for all of us.

4.22 Donna Hicks has written eloquently ...

> *"All human beings are unique; there is only one copy of us around. Something so precious deserves to be treated as invaluable, priceless, and irreplaceable. Yet, not a day goes by when we don't experience some kind of violation to our dignity—a rude remark, a critical tone of voice, a dismissive gesture intended to make us feel small. We all know the crushing and intolerable feeling of being shamed.*
>
> *We human beings have an uncanny way of knowing how to psychologically hurt one another, and the attacks are always aimed at the most vulnerable aspect of our being—our dignity, our sense of worth. We share this vulnerability, just as we are all prone to physical attack and injury. Whether we are aware of it or not, when we inflict wounds on one another, they are meant to make us doubt the very core of who we are. They leave us with the question, "Am I good or am I bad?"*
>
> *The truth about wounds to our dignity is that they don't go away. They accumulate within us until we do something radical, like scream at someone, walk off a job, leave a marriage, or start a revolution."* [8]

4.23 I sense that these words will resonate with many of those in NHSH who engaged with this review - and with others too.

8 Hicks, D. (n.d.). Declare Dignity. [online] Declaredignity.com. Available at https://declaredignity.com/dignity-project/ [Accessed 28 Feb. 2019].

5. Creating a Safe Space for Confidential Discussions

Responses

5.1 In fulfilling the remit, in December 2018 and January 2019, this review has enabled a total of 186 individuals to express their views personally on a one to one basis or in a group setting.

5.2 In total, I met with 53 individuals on a one to one private and confidential basis and spoke to another 8 on the telephone, usually at some length. As the number of responses greatly exceeded that which was initially expected, two senior colleagues, Charlie Woods and Liz Rivers, assisted me by conducting further meetings. Between them, they conducted a further 27 private meetings with individuals and reported on each of these to me.

5.3 We also met a further 98 individuals in group settings, with groups ranging in size from 2 to 18.

5.4 In addition to the meetings discussed above, I also received 96 submissions in writing from people whom we did not meet, both in detail and simply by email correspondence. Many of those with whom we met also submitted detailed further written submissions.

5.5 In total, therefore, of the 340 approaches we received, my colleagues and I engaged with 282 respondents directly and in written form.

The Meetings Themselves

5.6 We conducted most of our meetings in a hotel in Inverness which provided an independent and discreet location, where we worked hard to avoid overlap or any embarrassment for those attending. I also conducted meetings at NHSH headquarters at Assynt House, at Raigmore Hospital, Inverness, and in a rural community.

5.7 I regret that, in the time available, I was not able to travel to other locations or to engage with more people at their places of work. However, most people wished to meet outside of their workplace in any event. Many travelled a distance to meet me. Given the number of meetings, and constraints on time, meeting in the way we did was the most efficient way to use time.

5.8 Our approach in meetings was to encourage people to speak candidly and frankly about their experiences - and to listen without judgment to what they wished to tell us. Each meeting lasted for about an hour, some taking a bit longer, others less. We asked questions to clarify certain matters and to understand more deeply what each person had experienced and was concerned about. Where it was relevant to do so, we asked about ways forward in the future. Again, where necessary, we carefully challenged conclusions or inferences drawn.

5.9 I was aware that, for many people, being able to tell their story to someone face to face was important to them and that having someone independent and impartial to listen was also very important. For some, it was cathartic. For others, there was a sense of obligation in trying to ensure that what had happened to them did not happen to others; for yet others, stepping forward now eased the pain of the guilt they felt about not having spoken up before. For some, it was an opportunity to make sure I heard all sides of the story.

5.10 I am aware of course that, for many people, speaking up and speaking out is not easy to do. Many of those who approached me have not spoken before and many were anxious about doing so. Indeed, I was struck by the level of fear that some respondents exhibited about participating (in any way) with the review and their perceptions of the possible adverse consequences of doing so. Taking part was all the more commendable.

5.11 Some of the meetings were difficult and emotional for the individuals concerned, for a variety of reasons. I am aware that many people confided in me in a way that they had not done with anyone else. For these reasons, I have only referred to specific examples when I have received specific permission to do so. Otherwise, and generally, I made clear that views expressed would be reflected in the report in an entirely non-attributable way.

5.12 The relief felt by many was expressed by one respondent in these words:

> "I feel I've told someone. I praise the bravery of the colleagues who made this an issue and opening the door for me to finally say how I felt. At least I feel less alone, thanks for hearing me out."

Feedback about Meetings

5.13 This response is mirrored in anonymous feedback which we obtained through a questionnaire sent out by email after the one to one meetings to all those with whom we met:

- 96% said they felt listened to in the meetings
- 89% found the meeting useful
- 97% found that the atmosphere was conducive to a frank conversation
- 91% felt able to express all concerns and points of view
- 76% said the meeting had given them confidence in the independent review process and
- 75% felt that the meeting itself had helped them process their experiences.

5.14 In the anonymous feedback for meetings of groups, 92% of those who attended group meetings expressed the view that the meetings had been useful while 100% said the atmosphere was conducive to a frank conversation, that they felt listened to and that they felt able to express all of their concerns and points of view.

5.15 I am sure that a mere electronic feedback process has limitations (and some respondents observed, for example, that confidence in the review could only come later) but these results offer some reassurance that the approach was worthwhile for many of those who participated.

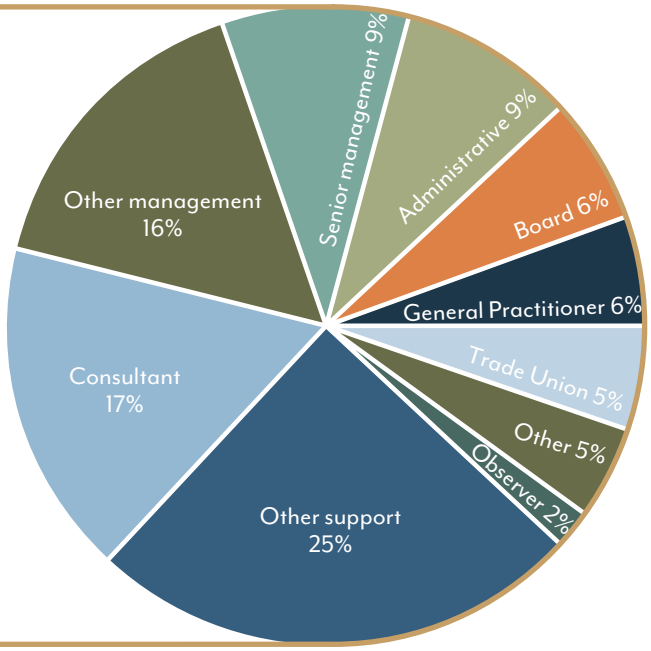
6. Adequacy of the Review

Extent of Response

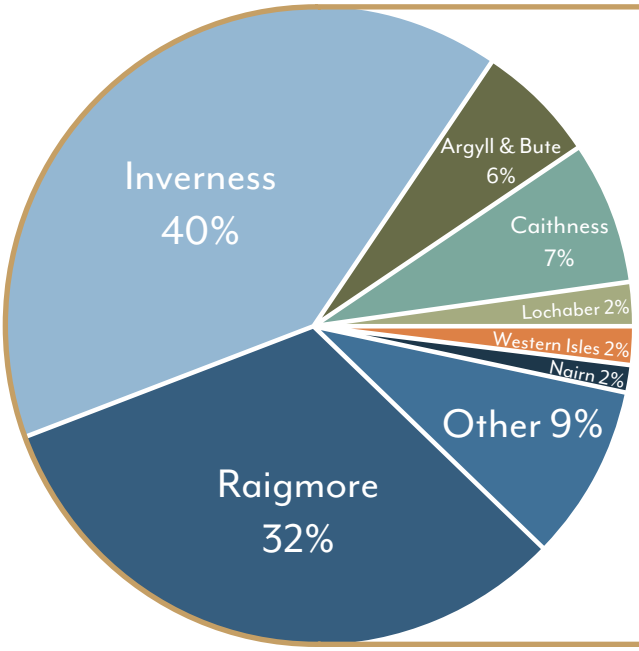
6.1 Overall, as noted above, a total of 340 people engaged with the review. They have come from a broad cross-section of the staff employed by or associated with NHSH, from most departments, services and occupations, mostly current and some former. To give me some context, I spoke to a few outside observers also.

6.2 Geographically, the respondents came from across the region covered by NHSH, including Argyll and Bute. As can be seen in the graphics below, they span support staff, doctors and nurses, GPs, senior and middle management, board level, allied health professionals and others.

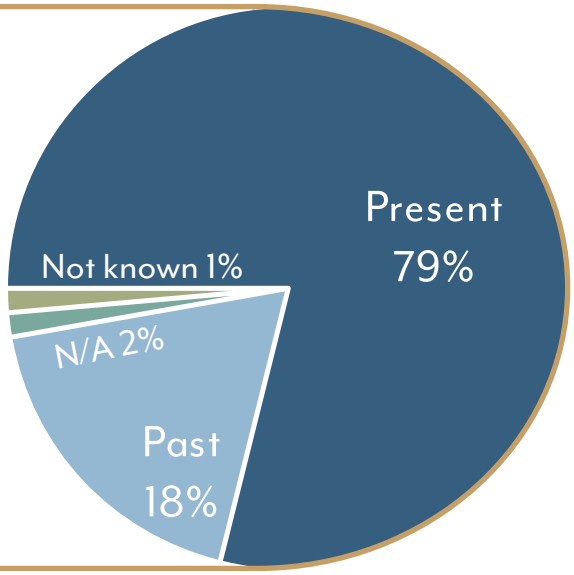
Respondent Role



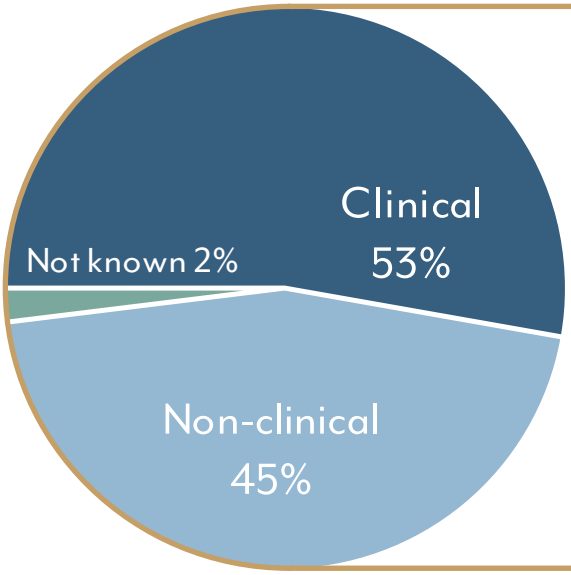
Place of Work



NHSH Employment Status



Clinical and Non-Clinical Staff Ratio



6.3 In total, again as noted above, my colleagues and I engaged with 282 of these respondents directly and in written form. Altogether, approximately 40 days were allocated to meeting and information gathering, together with substantial support and administrative time. Writing up the report has taken many additional days.

Publicity for the Review

6.4 An "all-user" email was circulated by NHSH publicising the review and advising of a dedicated email address to which to write to make contact with the review. Other interested parties were also informed by Scottish Government and they circulated details. People who wished to do so made contact with me using the email address. I responded personally by email to nearly every person who made contact with the review.

6.5 One group who may, at least to some extent, have been missed may be those employees who do not use or have access to email as they may not have received communication about the review. I refer to this in my proposals.

6.6 I am aware that there was a view in some quarters that more could have been done to publicise the review and that there was a danger of selection bias in that only those with a grievance to express would respond. However, after the first two or three weeks, it became clear that the response was significantly greater than anticipated and with a very broad range of views, as will be obvious later in the report.

Limitations

6.7 The response was such that, in the time and with the resources available, I could not meet with all those who had responded and who wished to meet, even with help from my colleagues. Therefore, I agreed with the Cabinet Secretary that I would write to those who had made contact after the initial communications and advise them that I would endeavour to provide an initial report in February. If individuals wished to comment on that, or if they still wished to meet and be heard by someone in private after its completion, provision could be made for a possible further stage of the review.

6.8 While the timescale has changed, it is very important that this is not lost sight of. Many NHSH employees have commented on promises being made and then not kept. This should not happen with this report, which I accept is much fuller than anticipated at an earlier stage. There may be others who I did not meet, seek out or hear from who may wish to comment on the report when they see its terms.

6.9 A number of those to whom that particular message was sent have made written submissions to me instead, often at my request. Throughout, people have been understanding of the potential (and actual) enormity of the task in the planned timescale and have sought to accommodate my requests for assistance in managing the volume of material. I am very grateful to everyone for their thoughtfulness.

MSPs

6.10 At their request, I also met with two local MSPs. I was aware that local politicians need to take care in how they characterise situations like these. There is an understandable frustration and a need and indeed duty to draw attention to perceived wrongs. However, where patient confidence is so important and matters so fragile, a degree of discernment and balance will always be necessary.

6.11 As one respondent put it, *"political grandstanding by MSPs or others and resolving disputes through the media"* is not conducive to a long-term solution. I hope discernment will continue to be applied in the aftermath of this report.

Criteria for Meetings

6.12 I am aware that concern has also been expressed about the criteria I applied when arranging to meet people. To be honest, I undertook to meet many of those who got in touch at an early stage before the size of the project became clear. I felt it fair to honour my commitment to them whenever I could and to fit in as many others as possible in the timescale. There were certain people with whom it seemed particularly important to meet. There was a judgment to exercise and also a certain randomness in the process which, paradoxically, has achieved a very wide spread of views and minimised the bias that trying to identify set criteria could have built in. In any event, as I make clear later, provision should still be made for those who feel that they still wish to be heard.

Spread of Views

6.13 As noted above, concern was expressed that, given my remit and its wording, I would only hear one point of view and that the other side of the story would not be heard. However, I am able to say that those coming forward in response offered a wide range of views, from those who wished to say that they are not aware of bullying in NHSH at all to those who provided details of their own and others' experiences of bullying behaviour, both individually and collectively.

6.14 One of the challenges is that experience was often mixed and, indeed, sometimes contradictory. As one respondent observed: *"It is possible to have two co-existing experiences".* Another commentator said: *"It slightly shocks me how thin the dividing line can be between one person's experience of someone as a robust manager who gets things done and another person's experience of them as a bully."*

6.15 There is much to wrestle with. In some ways, ambiguity can be useful: *"...in the intersection between [multiple] perspectives, real insight can be gleaned".*[9] It is hoped that real insights will be gleaned in this report.

6.16 Others speak of the *"coincidence of opposites."* The theologian Richard Rohr once said that holding contradictions and resolving them in ourselves and in our organisations are *"the only real agents of transformation, reconciliation, and newness"*. In any event, the fact remains that there is no one perspective on any of this. There is a variety of viewpoints.

Reasonable Cross-Section

6.17 While the number of respondents to the review is low relative to the overall number of employees in NHSH, I have taken the view that they represent a reasonable cross-section of the workforce.

6.18 Given the volume of information I have received, I am comfortable that I can form views which have general applicability. In any event, there should be an opportunity for those who disagree with my conclusions to do so. Others can decide whether, in an organisation of approximately 10,000 employees, the information here is sufficiently relevant and important to warrant action. I have formed the view that it is.

9 Heffernan, M. (2012). *Wilful blindness: Why we ignore the obvious at our peril*. London: Simon & Schuster.

7. Initial thoughts

Understanding

7.1 I accept that a report like this cannot meet everyone's expectations. Indeed, it should not try to do so. Some people have been so affected by events that they seek retribution or revenge. Others see no need for change. In all respects, we need to understand why that is and, in the review, I have been mindful of the need to try to understand at a deep level what happens when some individuals and groups experience trauma of some sort, especially when for some it seems to be embedded, to a degree at least, institutionally. As I have indicated earlier, there is both restorative and preventative work to be done.

7.2 Nicholas Janni writes:

> *"We understand the essential nature of trauma to be energy that could not be and has not been processed and therefore stays stuck as frozen layers within our personal and collective structures. By learning to work directly with these layers, we create together a journey of restoration, allowing large amounts of core life energy, intelligence and relational capacity to be released."* [10]

Process

7.3 Unpacking these words is a part of the process. It is unlikely that the value of this report can be measured by people's immediate reactions. There are some "quick wins" to be sought. However, a lot of thought will be required over a long period of time to produce meaningful longer-term benefits. As I mention above, there is no magic instant fix, or a binary right/wrong solution. The real value may lie in enabling thoughtful people - and a new leadership - to take responsibility for matters going forward in ways that they understand and can deliver.

Relationships

7.4 There may be no greater leadership challenge in 2019 than to help people under pressure to feel valued and for everyone to appreciate the benefits which come from rebuilding strong relationships, bringing out the best in each other and enabling everyone to be more effective in every way.

7.5 That probably means letting go, enabling people to thrive and for people to be given responsibility. In an infinitely complex world, not everything can be controlled or micro-managed from the top.

7.6 This is a journey. It will be better to focus on how to travel than on a hoped-for end point. The goal may simply need to be endeavouring to work more effectively together in tough times – and creating the environment for that to occur. If so, relationships will be a vital part of this. Ultimately it is usually all about people and relationships: why have they broken down and what can be done to restore them? Indeed, as I observe later, prioritising good relationships at all levels is likely to make the biggest difference. People will need to walk with - and care for - others, including those with whom they have fallen out in the past or by whom they feel undervalued.

7.7 People must feel valued in NHSH and that will only occur if it is done from all perspectives: from the leadership in NHS Scotland to those involved with the day to day intersection with the patients. This will need a lot of patience and tolerance. The future cannot be viewed as a series of one-off transactions but must be seen as a pattern of new behaviours and approaches, providing growth and healing as an antidote to the pain and loss which so many have experienced. This will take time.

10 Janni, N. (n.d.). Healing Personal, Ancestral & Collective Trauma. [online] Nicholasjanni.com. Available at https://www.nicholasjanni.com/societal-work/ [Accessed 28 Feb. 2019].

Change

7.8 Change is not easy. Growth cannot occur without pain. Healing can be a hard thing to achieve. Letting go of grievances and grudges may not be appropriate in all cases but it is likely to be necessary in many. Giving up that which has defined us or in which we have placed so much hope or expectation is a tough thing to do. We may fear many things, including loss of face and relevance, with a sense of emptiness and even hopelessness. To be open to our own shortcomings, as well as those we perceive in others, takes courage, especially if we have been or feel wounded.

7.9 A change of heart, as well as mind, will be the biggest challenge and yet that seems the only way to achieve release and a new way forward. This must be demonstrated by leadership from the top. Humility, authenticity, vulnerability, openness, courage, responsibility, accountability, self-discipline – these are all essential components and are likely to be important touchstones in the future.

7.10 A number of these, and other attributes, are apparently recognised as leadership qualities in the NHS Highland Senior Manager and Executive cohort annual appraisal. It is time for the words to be demonstrated in practice. I note that a top-selling book at the time of writing is *The Language of Kindness*[11], written by a nurse, Christie Watson. Kindness is what is needed in NHSH.

Learning

7.11 If real learning can be taken from what has happened, and if kindness and compassion can be restored in NHSH, there is a great opportunity to build a new kind of organisation, a beacon of hope in the NHS, in which good relationships, collaboration, fairness and a welcome for courageous conversations and constructive challenge, together with mutual respect and dignity for all, are experienced throughout. I explore this further later in the report.

7.12 As I mention above, I acknowledge that not everyone will recognise all of the findings or accept all of the proposals in this report. I am also aware that both the Board and management have begun to take steps to try to address some of these matters already, albeit it is probably necessary for them to have a much fuller understanding of the depth and breadth of the concerns in order to do so really well. Whatever is done should be undertaken in a way which brings, and by those who can bring, credibility, confidence, compassion and competence to the tasks.

7.13 I pick up on these themes towards the end of this report in the final chapters. In the next chapter, I set out some general observations about human nature. Some readers may prefer to pass over this but I include it and commend it as part of the context for what follows.

7.14 It seems important to understand the emotional, psychological and neuro-scientific aspects of what has happened – and to find compassionate ways to address the issues. As the University of Edinburgh Global Compassion Initiative reminds us: *"Developments in neuroscience and psychology are providing evidence-based insight into the importance of values and character building to health and well-being in an increasingly secular age. Compassion is a defining human ethic."*[12]

11 Watson, C. (2018). *The Language of Kindness*. Chatto & Windus.

12 The University of Edinburgh. (2018). Global Compassion Initiative. [online] Available at https://www.ed.ac.uk/global-health/global-compassion-initiative [Accessed 20 Mar. 2019].

8. A Few Words about Human Nature

"It's not our differences that divide us, but our judgments about each other."[13]

Introduction

8.1 In this chapter, I offer some general views on the underlying psychology which tends to fuel so much conflict. I believe that understanding some of this fast-growing area of science is helpful as context for what follows in the report.

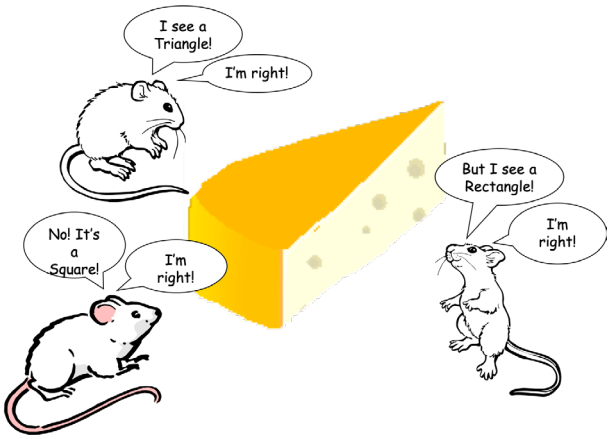
8.2 It seems necessary, at a deep level, to explore and understand why individuals and organisations behave as they do, especially when under pressure, and to find enduring remedies, not transient sticking plasters. Current research into behavioural psychology and neuro-science provides an excellent resource to draw on. This deeper work is, it seems to me, critical to a sustainable future.

Complexity

8.3 In this review, I have been struck by the reality that this is all much more complex and multi-layered than anyone might wish, or like it to be, and reflects the ambiguous, paradoxical and uncertain nature of so much of human life. Nothing is black and white. For me on each step of the way, another layer of the onion was revealed. There is no straight binary conclusion to be reached. The situation is better viewed along a continuum, with a spectrum of experiences and realities, often dependent on time, place and circumstance.

8.4 In my day-to-day role as a mediator and facilitator, I have a working assumption that nearly everyone is trying his or her (or their) best in the circumstances in which they find themselves, even if they struggle to do so. We are told that there is a positive intention behind most behaviour and that most people make the best choices they can given the information available to them at the time.

8.5 How many of those reading this report would not acknowledge that most of us are trying our best most of the time? I also find it useful to take the view that very few people are motivated entirely by ill will. Life is complex and there are usually several sides to a story. Much depends on where you start from, your perspective, as this rudimentary illustration shows:



13 Wheatley, M. (2002). *Turning to One Another: Simple Conversations to Restore Hope to the Future*. Berrett-Koehler Publishers. P36.

Fight, Flight or Freeze

8.6 People's perceptions become their reality. Perceptions, we know, are shaped by many factors. And what people say may not always be what they really believe, feel, mean or need. Modern neuro-science and behavioural psychology help us to understand well that we tend to be shaped by our experiences, our biases, our prejudices, our need for protection, our fear of loss of face and so forth.

8.7 Our survival instincts, fight, flight or freeze, override the rational mind very easily. Our self-preservation instincts are very strong. These may lead to covering up what is embarrassing, threatening or causes us to look bad. After all, looking bad, public exposure, can be among the most painful and humiliating of human experiences.

8.8 Under pressure, our default setting is to protect ourselves from external threat, whether physical, psychological or social. We seem to have no choice – our brains are wired that way (see, for example, Daniel Kahneman: *Thinking, Fast and Slow*[14]). This stems from the survival behaviour (located in the primitive part of our brains) inherited from our early ancestors who faced constant physical threats to their very existence. Fear is a strong force and triggers defence and/or aggression. We are complex creatures, each capable of acts of great kindness and also of acts of cruelty to others, often in close proximity to each other.

8.9 Though physical threats are less relevant now, we are still hardwired to feel shame and to fear blame when the threats are social and our dignity or sense of self is challenged. Our basic instinct for self-preservation, often by using force or dominating in other ways, can be stronger than our instinct to preserve a relationship.

8.10 Relationships may break down when the need for individual self-protection overrides our need for connection. We tend to denigrate, belittle and criticise others, who in turn may experience loss of esteem, misery and abandonment – and react accordingly. Colleagues are undermined. We avoid contact with those outside our group. We rush to judgment. Uncertainty prevails. Others around us are adversely affected.

Mixing People and the Problem

8.11 As the writer Ken Cloke has observed, *"it seems easier to turn each other's lives into a living hell than to apologize, rebuild trust and restore intimacy and collaboration in conflicted relationships."*[15]

8.12 Or as an NHSH staff member put it: *"I despair of the culture where a sincere apology is not even considered as a first option even in respect of just good manners. Rather fear of showing weakness and fear of comeback or litigation is the overriding reaction."*

8.13 So, we end up mixing up the people with the problem, when what we really need to do is to try to separate the individuals involved from the underlying issues, even if the individuals themselves appear to be the problem. Small matters can be quickly blown out of proportion. Our energy can easily focus on adopting our particular position and blaming or shaming others with whom we disagree. We become entrenched. Our anger may be directed towards the "enemy".

8.14 Behaviour can become – or be perceived to be – threatening, aggressive, intimidating, domineering and emotional. We all recognise how easily we use the scapegoat mechanism as a foundation for the formation of many social groups and cultures. We need another group to be against in order to form and sustain our own group, our tribe.

14 Kahneman, D. (2012). *Thinking, Fast and Slow*. New York: Penguin Books.

15 Cloke, K. (2018). *Politics, Dialogue and the Evolution of Democracy: How to Discuss Race, Abortion, Immigration, Gun Control, Climate Change, Same Sex Marriage and Other Hot Topics*. Goodmedia Press.

8.15 Scapegoating occurs too easily: We hate or blame others, projecting our pain elsewhere, rather than recognising our own weaknesses and negativity. *"She made me do it." "He is guilty." "He deserves it." "They are the problem." "They are evil."* We seldom consciously know that we are scapegoating or projecting. It's automatic, ingrained, and unconscious. Because of our wiring, people literally "do not know what they are doing".

8.16 Many readers will be familiar with the Drama Triangle[16] in which people can fall into, choose and rotate the roles of victim, rescuer or persecutor, perpetuating a crisis rather than breaking the cycle. So easily can the language of the persecuted in turn appear to others to be that of persecutors. Even describing someone as a "victim" brings with it inherent risk. Perhaps in the NHS, with its traditional role being one of seeking healing, matters are more complicated for "rescuers".

Assumptions, Perceptions and Biases

8.17 I suspect that the cognitive or unconscious biases (institutional and individual) operating in all of us have been at play in what has been happening and is alleged in NHSH. It is said that we jump quickly and intuitively to conclusions, assuming we are correct, based on our own incomplete knowledge of the world, our prior experiences, our prejudices, our expectations, our fears and hopes, our assumptions.

8.18 We can become wilfully blind to the bigger picture or to contradictory information as what is known as confirmation bias takes hold. Our seeing and hearing become selective. We acquiesce in inappropriate behaviour in order to avoid conflict.

8.19 To survive, we may simply not see or hear what should be obvious to us. Our responses to a situation are shaped by those prior assumptions and perceptions. Very often these are wrong but, if something is asserted often enough, we may come to believe it - even if it is not wholly or even partially true. We may then end up trying to persuade others of its truth and adopting measures to maintain the fiction.

8.20 On other occasions, we will subconsciously devalue what is said by people we dislike or by whom we feel shamed or threatened, while overvaluing the words of those we admire or who are part of our group or tribe. Our human tendency is to judge the behaviour of others with whom we disagree as a reflection of their character and ill will towards us; in contrast, we describe our own (and our tribe's) behaviour as acceptable, and attributable to the circumstances in which we find ourselves.

8.21 There is apparent safety in being with apparently like-minded people, especially if we feel under threat. Silos are built. It feels better to be part of the group than to be excluded, not to rock the boat or speak out, for fear of being ostracised. This is all entirely understandable. However, when the environment is not a safe one, these aspects of human nature can lead to disorder and dysfunction.

8.22 In an organisation where self-protection has come to dominate, it seems that relationships may inevitably breakdown. Alternatively, people may compromise their own dignity to try and preserve relationships. Consequently, as Ken Cloke puts it, we often elect to remain silent and suppress our true beliefs and feelings, or pretend to agree when we really don't, or even leave the organisation rather than risk a loss of intimacy and connection with people we care about - or challenge the thing we fear.[17]

8.23 It can all become cyclical and self-fulfilling. Relationships suffer, communication is poor (or non-existent), nobody seems to listen, information is concealed, concessions appear to be a sign of weakness, common interest and mutual respect is lost. And all of this is enormously costly in time, morale and money. It increases risk and is truly a zero-sum situation.

Why Does Any of This Matter?

8.24 Why are these points relevant to this review? Because it is likely that all of this is just as true for those involved in NHSH as elsewhere. It helps us to understand many of the situations described in this report. In particular, we should not underestimate the role of fear in much of what

16 Karpman, S. (1968). Fairy tales and script drama analysis. Transactional Analysis Bulletin, 7(26), 39-43

17 Cloke, K. (2018). *Politics, Dialogue and the Evolution of Democracy: How to Discuss Race, Abortion, Immigration, Gun Control, Climate Change, Same Sex Marriage and Other Hot Topics*. Goodmedia Press.

has occurred at many levels. More importantly, perhaps, it seems to me that we all need to understand these facets of human behaviour if the underlying issues are to be addressed and resolved with long term sustainability. One cannot separate this theory from the real world.

8.25 In this regard, I note an excellent book entitled *Embodied Conflict* by a mediator colleague from Oregon in the United States, Tim Hicks (no relation to Donna Hicks, quoted in paragraph 4.22). He writes*: "It's interesting to think about the violence we see in the world, whether at the level of interpersonal relationships or at the societal and global levels, as a public health issue."* [18] These words resonate particularly with this review.

Choices

8.26 We can choose to behave differently. To do so, we need to find and welcome ways to overcome the automatic, unconscious, easily triggered fight or flight instinct located in our reptilian/ limbic "old" brains and to engage the neo cortex, the "new" part of the brain, which helps us to think and act in a more measured, thoughtful way. We know that this takes conscious effort and is energy consuming. We need the right environment to do this. Creating that environment is the key to a successful modern workplace and to a successful NHSH.

8.27 We may think we know much of this already but it is not so easy to apply. It needs to be learned and understood. We have the capacity to be self-reflective and to change behaviour. We need to take responsibility to do so. What follows can be read with all of this in mind.

18 Hicks, T. (2018). *Embodied Conflict: The Neural Basis of Conflict and Communication*. Milton: Routledge.

9. Navigating the Substance of the Report

Symptoms, Diagnoses and Remedies

9.1 My approach to the substance of this review is to describe what I have heard and read and to try to identify the circumstances which have led to the allegations of bullying and harassment, and to add my observations about these. This includes what, in terms of my remit, I *"understand to be the cultural issues, if any, which have led to any bullying or harassment and [to a situation] where such allegations apparently cannot be raised and responded to locally."*

9.2 Thus, simplistically, I am dealing with symptoms and diagnosis in this report (noting that things will often be more complex and multi-faceted). These refer both to events in the past over several years and to current circumstances. I am conscious of the exhortation not to "overwrite" or "underwrite" in such a report. Given the quality and substantial nature of so much of what I have heard, if I have erred it will be to overwrite. I do so in an attempt to ensure that, wherever possible, people feel that they have been properly acknowledged and enabled to move on – and also to give the Board and management a clear indication of what people in NHSH are saying.

9.3 This is an organisation with an £800 million budget funded by the taxpayer. The current situation merits serious analysis. The review has received an enormous amount of information, all of which will be destroyed soon for reasons of confidentiality. This report, therefore, is a distillation, a summary and what will soon be the only record of what I have been told.

9.4 I also seek to *"identify proposals and recommendations for ways forward which will help to ensure the culture within NHS Highland in the future is open and transparent and perceived by all concerned in this way"*.

9.5 Thus, I seek to suggest possible remedies. As I have mentioned, these include both the restorative (seeking to address past and present issues) and the preventative (looking to the future and avoiding continuation or repetition of problems). These proposals are however merely signposts for others to follow in what needs to be an organisation-wide collaborative project of renewal.

Themes and Topics

9.6 Inevitably, what I have heard and read has caused me to consider the terms of my remit. I have taken the view that it would be helpful to take a broad rather than narrow interpretation of my remit, when I have heard and read so much which could help the organisation to learn and move forward.

9.7 Thus, to take words referred to in connection with remit, I *"will consider all the circumstances that have led to the allegations and make recommendations"*.

9.8 This leads me to address matters in this report according to themes and topics, following I hope some sort of logical order. I have quoted liberally from my meetings and from written submissions as these speak more eloquently than any words of mine. However, as agreed with respondents, remarks have been used in a way which is non-attributable unless I have specific agreement to the contrary. Where I have been concerned about any possible risk of attribution, I have sought to check with the authors. If any have slipped through the net, I apologise. I have endeavoured to correct typographical errors but have not corrected grammar, except where necessary to make sense of the words used.

9.9 I am aware that extracting excerpts from longer submissions may deprive words of their context and I acknowledge that this may occasionally be a cause for concern. I have done my best to try to understand and place contributions in their wider context. I take full responsibility for the way in which this report is presented.

A Note of Caution

9.10 Finally, again, I need to reinforce the important point that matters are complex and not amenable to binary, simplistic analysis. There are many sides to most stories. I was presented with many contradictions and inconsistencies. Care needs to be taken in reaching overall conclusions and making apparently universal statements. I am conscious that I shall have slipped into doing so myself on occasions where the circumstances are probably more nuanced. My report should be read with all that in mind.

9.11 I start with some general observations about bullying and culture before moving on to the symptoms experienced in NHSH.

10. Bullying and Harassment

Definition

10.1 It is alleged that there has been a culture of bullying and/or harassment in NHSH.

10.2 According to the Oxford Advanced Learner's Dictionary bullying is *"to frighten or hurt a weaker person"*[19] or group, and a bully *"uses her or his strength or power to frighten or hurt weaker people."*[20]

10.3 Other definitions refer to a persistent pattern of mistreatment from others that causes either physical or emotional harm and includes tactics such as verbal, nonverbal, psychological, physical abuse and humiliation. This can also, according to some definitions, include harassment which itself can include intimidation.

10.4 The Health & Safety Executive refers to a pattern of behaviour happening *"repeatedly and persistently over time."*[21]

10.5 While I note that there is a statutory definition of harassment in the Equality Act 2010, for the purposes of this report I do not find it necessary to distinguish between bullying and harassment. These words by themselves describe conclusions from primary facts, namely the actual behaviour which is likely to cause concern. The following excerpt (taken from the report by Dame Laura Cox into bullying and harassment in the House of Commons [22]) adequately describes that behaviour and I find her descriptions useful in this review:

> 98. "The terms "bullying" and "harassment" can mean different things to different people … it is important to bear in mind that it is not always possible or sensible to try and compartmentalise misconduct of this kind. Some of those contributing to this inquiry described behaviour which would fall within more than one category."
>
> 101. "There is obviously considerable overlap between the terms "bullying" and "harassment", and employment policies that address them often use the terms interchangeably."

10.6 She further reported:

> 106. "ACAS have described bullying and harassment together as "offensive, intimidating, malicious or insulting behaviour, an abuse or misuse of power through means intended to undermine, humiliate, denigrate or injure the recipient. Bullying or harassment may be by an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. It may be persistent or an isolated incident. It can also occur in written communications, by phone or through email, not just face to face. Whatever form it takes, it is unwarranted and unwelcome to the individual."

19 Oxford Advanced Learner's Dictionary. (n.d.). Bully (Verb). [online] Available at https://www.oxfordlearnersdictionaries.com/definition/english/bully_2 [Accessed 26 Mar. 2019]

20 Oxford Advanced Learner's Dictionary. (n.d.). Bully (Noun). [online] Available at https://www.oxfordlearnersdictionaries.com/definition/english/bully_1 [Accessed 26 Mar. 2019].

21 Health and Safety Executive Northern Ireland. (n.d.). Workplace bullying and harassment - Good Practice. [online] Available at https://www.hseni.gov.uk/articles/workplace-bullying-and-harassment-good-practice [Accessed 8 Mar. 2019].

22 Cox, L. (2018). The Bullying and Harassment of House of Commons Staff.

Dame Laura Cox Descriptions

10.7 For further useful guidance and as a reference point, I find it helpful and relevant to set out more fully some of what Dame Laura Cox has written, as so much of what she reports has relevance to what has occurred in NHSH, as subsequent sections describe:

> 102. "Under the Protection from Harassment Act 1997 it is unlawful for someone to pursue a "course of conduct" (thus involving two or more incidents), which they know or ought to know would be harassment. The term "harassment" is not defined in the Act since it can take so many different forms, but section 7(2) provides that it "includes alarming the person or causing the person distress," and "conduct" includes "speech." The actions complained of do not need to be violent. The courts have stated that "harassment" describes conduct targeted at an individual, which is calculated to cause alarm or distress, and that to be actionable it must cross "the boundary between unattractive or even unreasonable conduct and conduct which is oppressive and unacceptable" (Conn v Sunderland City Council [2007]CACiv1492)."
>
> 105. "The term "bullying" covers a wide spectrum of behaviours and a degree of flexibility is required when classifying such behaviour. In my view one of the most helpful descriptions of bullying at work is that formulated by the late Tim Field and those at the Andrea Adams Trust, who carried out much of the pioneering work in this field, namely that it is "behaviour that cannot be objectively justified by a reasonable code of conduct, and whose likely or actual cumulative effect is to threaten, undermine, constrain, humiliate or harm another person or their property, reputation, self-esteem, self-confidence or ability to perform."
>
> 107. "The typical features of bullying and harassment are therefore that the behaviour is unwarranted, unwelcome, intimidating, degrading, humiliating or offensive. The important question is whether the actions or words are viewed as detrimental and unacceptable to the target. It is the deed itself and its impact on the target that matters, not the intention of the perpetrator. And it is usually preferable to describe someone being bullied as a 'target,' rather than a 'victim.' The latter term tends to be associated with negative notions of someone unable to take responsibility for themselves, or needing to be 'rescued' from a situation. Bullies often respond to complaints about their behaviour by describing the target as having a "victim mentality," with all the negative imagery that phrase invokes."
>
> 108. "Bullying and harassment can affect anyone, in any career, at any time, at any level and within any workplace... Such behaviour can take the form of easily noticed, physically threatening or intimidatory conduct with immediate impact, or it can take place behind closed doors, or be much more subtle or camouflaged and difficult to identify, at least at first. It can start, for example, with what appear to be minor instances, such as routine 'nit-picking' or fault-finding with someone's performance, but which become cumulative or develop into more serious behaviour over time, enabling the perpetrator to isolate and control the person and eventually, on occasion, to apply conduct or capability proceedings inappropriately in order to bring about their dismissal."
>
> 109. "Some bullies lack insight into their behaviour and are unaware of how others perceive it. Others know exactly what they are doing and will continue to bully if they feel they are unlikely to be challenged. Bullying and harassment can sometimes be overlooked, as a result of common euphemisms being used by way of explanation or justification, referring to someone as having a "poor management style" or a "bad attitude," for example, or to the problem being due to a "personality clash." The information provided to this inquiry has demonstrated all these different features."

111. "In relation to the allegations of bullying made against House staff, a number of people referred to the need to distinguish between behaviour that is truly bullying and behaviour that is no more than "assertive" or "firm" management. They referred, similarly, to the need to distinguish between harassment and legitimate supervision. I agree that it is important to recognise these distinctions, although there can sometimes be a fine line and both managers and those whom they manage need to be trained to spot the difference."

112. "A good line manager can manage or supervise someone firmly and be assertive without bullying or harassing them... Firm management does not demand an overbearing or oppressive style. Firmness and resoluteness are not inconsistent with an open and inclusive style, encouraging direct communications with employees and regular feedback on performance, which are invariably more motivating."

113. "It is also important to distinguish between bullying behaviour and reasonable management responses to actual or perceived misconduct, or to poor performance by an employee. A few contributors described instances when managers who had instigated appropriate conduct or performance management proceedings found themselves on the receiving end of a grievance accusing them of bullying. This had immediately brought a halt to the proper management of the employee's conduct or performance. The original deficiencies were then lost during the months taken up in dealing with the grievance, expending precious resources, causing distress to the manager accused and inhibiting other managers from tackling poor performance. Sometimes there had been earlier failures to manage the employee effectively and they had simply been moved on to other departments, where the manager who eventually sought to address the poor performance was then unfairly accused." [23]

Sir Robert Francis Report

10.8 Sir Robert Francis in his report "Freedom to Speak Up", provides these examples offered by ACAS of bullying or harassment:

- spreading malicious rumours
- insulting someone by word or behaviour
- exclusion or victimisation
- unfair treatment
- overbearing supervision or other misuse of power or position
- making threats or comments about job security without foundation
- deliberately undermining a competent worker by overloading and constant criticism
- preventing individuals progressing by intentionally blocking promotion or training opportunities. [24]

10.9 I mention these examples as again they seem relevant, and to give context, to what has been experienced in NHSH as this report will outline. In other words, these are common experiences.

Language

10.10 Language and definitions are inevitably fraught with difficulty. Sir Robert Francis recognised that bullying is often "in the eye of the beholder" and that the term can be misapplied but also that *"To an extent, whether people's experiences meet an objective standard definition of bullying or not is beside the point. If someone believes they have been bullied or harassed and the perception of others around them is that they have suffered or will also suffer in a similar way as a result of speaking up, then they will be less likely to raise a concern in future."* As he observed: *"The perception of bullying can have the same detrimental effect as deliberate bullying conduct."* [25]

23 Cox, L. (2018). The Bullying and Harassment of House of Commons Staff.

24 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.4.

25 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.5-5.5.8

10.11 For the purposes of this review, I use the expression "bullying" to describe behaviour which has been experienced by staff that may fall within the terms "bullying" and/or "harassment". I have on occasions preferred the term "inappropriate behaviour" to describe what people have experienced.

10.12 I noted this comment about the very use of the word "bullying" by one of the senior figures in NHSH:

> "If people could measure us now, they'd get a detectable change in us when you say the word. It's a violent-impact word. As a communicator, if I choose to use that word, I know it's a dart and will not land well. So I choose not to use it."

This seems a useful reminder which readers should bear in mind whenever the term "bullying" appears in this report.

10.13 Another observer commented:

> "… there may be people who are generally unhappy with people who do not enjoy the work. Things have changed. They don't feel in control or their voice is being heard. But they haven't been bullied or intimidated. It's teasing out these different things and having an understanding of why people feel the way they have, in a situation that has caused them distress."

10.14 One respondent to the review observed how difficult it is to identify bullying:

> "B&H is difficult to deal with generally. It's a very personal thing. Harassment is easier as it can be obvious. Bullying can be an undercurrent – can make people feel in a certain way and takes them time to even come to the conclusion that they feel or are bullied. It's not just managers and employees, but as an organisation we're not necessarily clear about respectful behaviours."

10.15 Another respondent put it in the context of NHSH:

> "There are various definitions of what is meant by the phrase "bullying and harassment", but none are well-known to the wider workforce. Most people will be unaware of the standards of behaviour to which their employer will hold them."

10.16 This seems to be an important point. NHSH has its own policies on bullying and harassment; there are descriptions of what is included and what action can and should be taken. If these are not known and/or have not been followed, it seems essential to explore why not.

Why Bullying is Bad

10.17 Sir Robert Francis stated the obvious perhaps but, under the heading "Why Bullying is Bad", he commented:

> 5.5.9 "The impact of bullying on individuals, on teams and on organisations as a whole are well known. Examples include:
>
> - avoidable stress and resulting illness
> - increase in sickness absence leading to stretched teams and/or increased spend on temporary staff
> - poor morale and difficult staff relations
> - loss of respect for managers and leaders
> - difficulties in staff retention
> - reputational damage
> - patients suffering harm or receiving less than optimal care."

10.18 For him, the *"most important consequence is the fact that workers who are bullied, or who see others bullied, are much less likely to raise the safety concerns which any well-led organisation needs to know about and act on."* [26]

Again, this has resonance in the experiences in NHSH.

26 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.9-10.

11. Culture

Definition

11.1 While I have toyed with an extensive analysis of what we mean by culture, a short definition is *"a combination of behaviours which are repeated"*. Boxall and Purcell describe organisational culture as: *"... a system of shared values and beliefs about what is important, what behaviours are important and about feelings and relationships internally and externally."*[27]

11.2 An article in the BMJ[28] was drawn to my attention which seeks to tease out what culture means and how this relates to service performance, quality, safety and improvement. Its key messages remind us that:

- Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations.
- Healthcare organisations are best viewed as comprising multiple subcultures, which may be driving forces for change or may undermine quality improvement initiatives
- A growing body of evidence links cultures and quality, but we need a more nuanced and sophisticated understanding of cultural dynamics
- Although culture is often identified as the primary culprit in healthcare scandals, with cultural reform required to remedy failings, such simplistic diagnoses and prescriptions can lack depth and specificity

Many Different Cultures

11.3 Sir Robert Francis notes that:

"There can also be various cultures within the same organisation. Different teams, different departments, and different hospital sites can all 'feel' different. A whistleblower interviewee described the contrast between teams in the same organisation, where one had good leadership that allowed people to address mistakes directly and question one another, and the other had a command and control style with 'an individualistic dynamic and a blame culture'."[29]

11.4 In his discussion of the definition and exploration of culture in a healthcare context in the Mid Staffordshire NHS Foundation Trust Public Inquiry Report, Sir Robert reports that:

> 20.5: "Professor Charles Vincent sums up culture as meaning "how we do things round here", "here" being anything from a small group or team, to a whole organisation, a profession or a health system..."
>
> 20.6: "As Professor Vincent points out, an organisation may aspire to a common culture throughout, but in practice, in anything as complex and large as the NHS, culture can vary from organisation to organisation and from department to department." [30]

11.5 Again, this analysis has a strong resonance with the findings in this review, especially the idea that many different cultures may exist in one organisation, as this respondent told us from a rural area:

"I do also acknowledge that the size of the NHS makes it an unwieldy organisation and there is no doubt in my mind a pack/gang mentality can be easily formed in any department, staff grouping, committee etc. and that is what I felt I was up against."

27 Boxall, P and Purcell, J. (2003). *Strategic Human Resource Management*, Palgrave Macmillan, Basingstoke

28 Mannion, R. and Davies, H. (2018). Understanding organisational culture for healthcare quality improvement. BMJ, p.k4907.

29 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.1.3

30 Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Vol.3, p1358

11.6 Of course, there can be cultures that contribute to or create a set of circumstances (positive or negative) and cultures which address or fail to address these circumstances. It is multi-faceted.

An Iceberg?

11.7 Sir Robert refers to this observation:

> *"There exists a culture of bullying within the organisation that was largely covered up. For every case that comes to light, there is an iceberg of events that are simply not reported."*[31]

11.8 It is possible that what is reported in this report is the tip of a larger iceberg in NHSH. Only further exploration will elicit whether that is so.

31 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.5.10

What the Review was Told

12. A Culture of Bullying and Harassment?

General

12.1 In this chapter, I provide an overview of what I heard about allegations of bullying in NHSH, describing both the minority and majority views expressed, the range of views, and commenting on whether a "culture of bullying" existed.

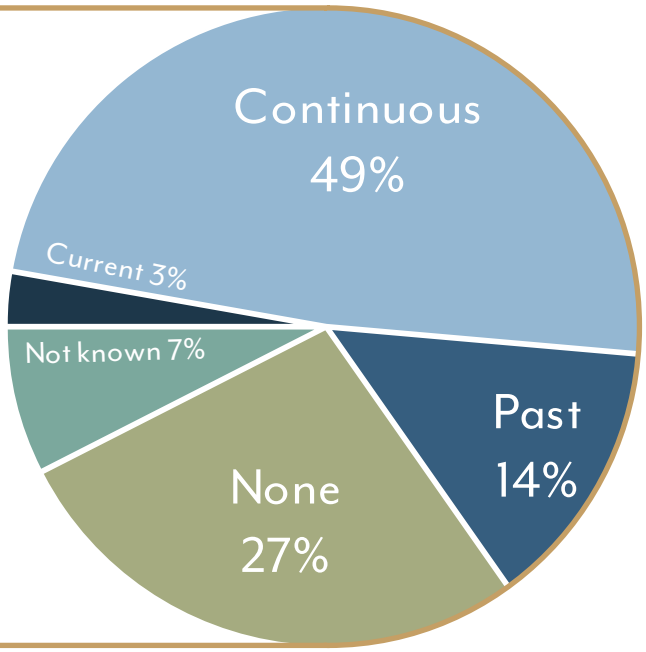
12.2 The majority (66%) of those responding to this review wished to report experiences of what they described as bullying, in many instances significant, harmful and multi-layered, and in various parts, at all staffing levels, and in many geographic areas, disciplines and departments of NHSH. There are issues common to the whole of NHSH, some which are particular to the Inverness area and Raigmore, and some which are particular to more rural areas and to Argyll and Bute. These affect wider communities too.

12.3 As illustrated below (in a pie chart which should be taken as illustrative only and not definitive), these are a combination of very recent experiences, experiences over years and experiences from the past. Some people sense recent improvement compared to the past, while others believe that matters remain unsatisfactory.

12.4 Many experiences have not been adequately addressed at the time and the lack of closure continues to dominate some people's lives. I am satisfied that the number of examples given to me is sufficient to warrant real concern. The issues raised are also wider and more complex than "bullying", however that is defined. There are many issues to be addressed, understood and avoided in the future. I explore these further later.

The Minority View

12.5 However, it is very important to record that a significant minority of respondents expressed views with varying degrees of firmness to the effect that there is not a problem, or at least that there is no bullying culture as such, and that any conduct of concern is nothing other than what might be expected in any similar organisation with day to day pressures.



Respondents' Descriptions of a Bullying Culture

12.6 Many people, from many different and diverse vantage points within NHSH, report that they are not affected by any such concerns and feel fully supported by the organisation. Indeed, they have been more affected by the allegations made by the whistleblowers that they do not understand and have not themselves experienced. They have been hurt and angered by the adverse impact of the allegations which have been made, on patients, staff and local communities. For many of these people, reading this report may be shocking.

12.7 In order that these views are well represented, what follows is illustrative of some of what I have been told:

"I am disappointed and upset at the way NHS Highland has been portrayed in the media over recent months. I feel that the actions taken by a small number of individuals will have damaged the reputation of and public confidence in the organisation."

"These individuals are not speaking for me."

"I do not recognise that there is a culture of bullying in Highland."

"I was absolutely shocked by the press statement about a bullying culture in NHSH. I experienced years of bullying myself by a GP colleague so I am fully aware of the effect bullying can have on health and morale but, when things came to a head in my own situation, senior management in NHSH were exceptionally supportive and helpful and I don't feel I would have got through it without them. I haven't always agreed with decisions and plans over the years but have, equally, always felt able to express my views and have felt that my voice has been heard. I have never witnessed bullying in any of the clinical situations I have worked in, which was why I was so surprised and shocked by the allegations made about NHSH."

"We have never at any time experienced anything other than courtesy and professionalism from the myriad managers we have worked closely with, over the years."

"Yes, we are working in pressured and busy environments but I have not, in all my time, been part of a bullying culture. In fact, I would say the quite opposite, I have worked and continue to work with dedicated and supportive health professionals, managers and directors whose ultimate goal is that we deliver quality patient care to the population of Highland, as they deserve nothing less. I am realistic that in an organisation of this size there will be bullies and I have come across one or two but these are rare and isolated cases. Of course, it is completely unacceptable that anyone is bullied but it really concerns me is that NHS Highland has been portrayed as having a bullying culture. In my view, NHS Highland is one of the best Boards in Scotland to work in (and I have worked in and link closely with a number of Boards in my current role) and it concerns me that potentially will be forever associated and tarnished with this bullying story."

"...nothing worse than I would expect from an intensely pressured healthcare environment operated by imperfect human beings."

"... just because a person describes this process (of being questioned about their performance or working pattern), as victimisation or bullying, does not **necessarily** mean it is."

"I do not perceive the culture here to be one of sustained and systemic bullying, however there may be one of benign/not so benign neglect, lack focus on core service delivery and lack of values and reflective based practice."

"The main point I wanted to make is that while I know that bullying goes on in NHS Highland, I don't believe that there is an orchestrated culture of bullying as was suggested by the clinicians who initially contacted the press."

"I'm in no doubt that in an organisation of 10 000 individuals there will be instances of individual bullying and harassment. There may also be small pockets in some services or localities. I have not seen anything that suggests it is endemic across NHS Highland."

"I have also managed staff in NHS Highland, and am managed by more senior managers and what is being described is not something I have seen any evidence of. On the contrary, where there are staff who can be more difficult to manage, or who are not particularly good at undertaking their job, the ultimate full support is given to them, I would say to the detriment of NHS Highland. I have been involved in managing some staff who in all honesty I felt were trying to play a game and trying to avoid having to do a day's work, but we as managers are bound by our policies to support these staff who are usually the ones to involve their Unions. All the evidence I see in my role is NHS Highland support their staff to high levels which would not, I believe, happen in the private sector. I have huge concerns these allegations have empowered some staff inappropriately who see this as an opportunity to blemish our organisation."

Other Similar Views

12.8 A group of consultants from one specialty wrote to me as follows confirming what they had told me in a meeting, namely that they were surprised to hear of the allegations:

"Cumulatively, we have over 70 years of experience in NHS Highland, through various service changes and management arrangements. We have experienced disagreements and conflicts, but our overwhelming experience is of dedicated staff working together to deliver care to the best of their abilities. We accept that some staff have had different experiences, but we have not personally experienced or witnessed bullying. We have found NHS Highland a friendly and supportive environment in which to work."

12.9 The diversity of experience and viewpoints is marked with these comments from the South and Mid Division Senior Leadership team. They told me that *"in the senior management team, we have spoken about the allegations that were made. The feel from this team was complete shock and disbelief. What we have struggled with is the whole view of a culture of bullying and harassment that we just do not recognise."*

12.10 Similarly, a group of senior nurses at Raigmore Hospital expressed the collective view that, *"while there may be isolated incidents and communication issues, there is not a culture of bullying."*

12.11 Frustrations allied to general contentment was summed up by one clinician in this way:

"I have been very happy working in Raigmore and have lots of positives to say about Raigmore which include team working, good colleagues, good relationships with other teams in the hospital, opportunities in developing personal interests. There are frustrations about working in NHS Highland but I imagine this is not unique to Highland given the financial constraints. I feel management do not always listen to concerns raised... and that there is a lack of information coming down from senior management. There are many decisions I do not agree with; however I do not see this as a bullying culture."

Confusion

12.12 The state of general confusion and impotence in which a number of employees found themselves is reflected in this:

"I am unaware of the detail of the concerns that have been raised, I have not been party to any NHS Highland Board or senior executive level discussions. I have been in an uncomfortable position with a complete lack of information available to me. I have as a result been unable to fully understand what the issues are other than hearing snippets from medical staff who have clearly been having much discussion through WhatsApp. One Consultant advised me that there was talk of a need for organisational cleansing – quite what that involves I am not clear but it felt threatening! For myself as an individual I feel I have been severely undermined and disrespected, and I have been completely unable to support the staff that report to me effectively with regards to the current situation."

A Spectrum?

12.13 In reality, given the range of responses and experiences, there is probably for many people a continuum or spectrum. For them, the existence (or not) of bullying cannot be assessed in a binary way. As noted earlier, it is likely that pockets exist. Other observations support this:

"I've observed people with supreme experience handling very difficult situations in an exemplary way. I've seen the complete opposite as well."

"My experience working within NHS Highland is that there is not a bullying culture. There are bullies and there are incidents of bullying. There are also those who seem susceptible to bullying. I personally do not see it on an everyday basis which means I don't think it is endemic.

It may be that the specific instances where I think conflict has become bullying will be repeated to you time and again and this may represent focal pockets attributable within certain departments, certain individuals or when certain stresses hit the system. There are also people throughout the clinical, support services and management of the organisation who are excellent people with great skills and attitudes who do a fantastic job day in day out."

12.14 Interestingly, in our meeting, the clinician who expressed the latter views spoke of a number of instances of behaviour that were not acceptable and we agreed that there may be two ways of

seeing the same thing and that, in fact, when one thought about it and pieced together different events, a broader picture of unsatisfactory behaviour emerged. This was not necessarily systematic or deliberately commissioned but the result of a culture which was replicated and adopted because (a) it achieved certain financial and other targets and (b) it was the way others behaved and was a safe way to protect oneself.

12.15 Other respondents also modified their views upon reflection and in discussion, especially as they reflected on their own experiences. This represents an often-expressed emerging acceptance:

"At the time that the press release went out about a bullying culture I felt that this was wrong without consultation and that it might do more harm than good. I am glad though that this is being investigated in this way and will be interested in the outcome of the report."

12.16 Another, who had challenged the allegations about bullying because of their source and at whom they were apparently directed, came to the view that he himself had actually experienced what would be described as bullying but from a different angle.

"I feel very bruised by the four. But something has been released in the organisation, so it served its purpose."

12.17 A nursing member of staff acknowledged that many people had not spoken up:

"I feel let down by a system that didn't care until it felt the pressure to atone after being publicly shamed in the press. My experience is that there are a wealth of good people in the organisation who have stood by and done nothing, because that's easier than speaking out."

The Majority View

12.18 Further along the continuum, this summary of the behaviours which have caused so much concern comes from a senior member in an important supporting role:

"Over the past ten years, I have supported [a number of] Senior Managers in NHS Highland, who reported being bullied and intimidated in their work, some to the point of tears and sickness through stress and most of them having now left the organisation. I have also supported many more in middle management who reported the same kind of bullying happening to them.

It became apparent to me that models of bullying behaviour at the highest levels of the organisation, were being copied throughout. These included ignoring people, belittling them, treating their ideas with contempt and talking about them negatively to other members of staff. Often when staff have spoken out against this, or against what they perceive to be poor decisions, they are taken aside and interviewed by two or more Senior Managers and cautioned or threatened with disciplinary action. I have seen the abuse of 'suspension processes' and trite or trumped up charges being levelled at staff in order to take them through protracted disciplinary processes, during which time they are off work and instructed not to speak to their colleagues. In my mind, there is no doubt whatsoever that there is a culture of bullying in the organisation, and not just isolated incidents."

12.19 This, which bears a striking similarity to definitions provided in chapter 10, is a perspective shared by many of those who responded and who welcome the review, as the following comment from another senior and recently retired member of staff reveals:

"... I am in no doubt that NHSH has operated under a veil of fear and intimidation for many, many years. Anecdotal evidence indicates behaviours in keeping with this to be at the highest level of the organisation. Sadly, I have had confidential discussions with many colleagues who have had similar experiences to my own and have been left with no adequate resolution to their concerns and in some instances have chosen to leave the organisation. Early retirement sadly, is a very popular option...

There are many, many dedicated, highly professional and committed people working for NHSH. This review does offer a real and important opportunity to get to the bottom of why things have gone so badly wrong, make recommendations to ensure that the organisation can move forward positively and effectively enabling a happy, confident and stable workforce. This is the essence of ensuring patients receive excellent clinical, holistic, person-centred and compassionate care."

12.20 The final paragraph above summarises the value many NHSH employees place on the decision to carry out this review.

A Bullying Culture?

12.21 While, as I noted at the start of this section, the view that there is no bullying culture is represented by a minority of respondents to this review, it may be possible to conclude that the majority of employees of NHSH have not experienced bullying as such. Having said that, extrapolating from the evidence available to this review, it seems equally possible that many hundreds have experienced behaviour which is inappropriate. That seems far too many. I explore examples of this more fully in the following sections.

12.22 If it was within my remit to do so, it would not be possible to conclude conclusively that there is or is not a bullying culture in NHSH. Everything depends on context and circumstances. It depends on where and who you are. As Sir Robert Francis and others have pointed out (and as noted in the remarks on culture in an earlier section of this report), there may be pockets, sub-cultures and hotspots; one department could be perfectly satisfactory while, next door, the situation could be unbearable.

12.23 However, as noted earlier, in terms of my remit, I need to explore what, if any *cultural issues* have led to any bullying, or harassment, and a *culture* where such allegations apparently cannot be raised and responded to locally, and identify proposals and recommendations for ways forward which help to ensure *the culture* within NHS Highland in the future is open and transparent and perceived by all concerned in this way. I do so later in this Report.

The Gallanders Report

12.24 In passing, it is fair to note that, in November 2018, an Independent HR Consultant, Sandy Gallanders, reported to the Board.[32]

12.25 The Draft Report stated that:

> 60. "The prevalence of bullying and harassment in NHS Highland is not significantly different to that in other NHS organisations or elsewhere in the economy. The problem is growing across organisations and it is something that all employers will have to address."

12.26 The report concluded that:

> 19. "Whilst 28 respondents expressed concerns regarding having witnessed or experienced bullying, the overall number of respondents was small and the evidence, whilst a useful indicator of further analysis being required, is insufficient in itself to warrant a conclusion that there is systemic bullying/harassment within the organisation."

12.27 The Report noted:

> 23. "A review undertaken by the Clinical Governance Team found that in the great majority of cases there was a proactive approach from the handler/ manager to address the incident and concluded that there was no indication of specific trends for concern. This conclusion is considered reasonable on the basis of the evidence available. It is also consistent with the relatively low number of cases which are in process under the "Preventing Bullying and Harassment" policy."

32 Gallanders, S. (2018). Allegations of Bullying and Harassment in NHS Highland.

12.28 In reviewing an "iMatter" Survey (an online process), the report observed that:

> 37. "The high level iMatter responses are encouraging. There are no "red flags" which would suggest the presence of systemic bullying and/or harassment. However, only lower level team based data would show if potential problems exist at a more localised level. This would require a higher survey completion and measures to encourage this for future surveys should be considered."

12.29 In connection with a Dignity at Work Survey, it was said:

> 43. "On the balance of the information available, the reported overall prevalence of bullying and harassment in NHSH reported in the DAW Survey, whilst obviously of concern and warranting more detailed examination and intervention, does not appear out of the ordinary."

The Gallanders Report in Context

12.30 There are a number of criticisms of the report. The GMB union expressed the view that the surveys cited fail to give an accurate picture of experiences on the ground, with most of the statistics coming from iMatters *"which has a notoriously low staff response rate, so their numbers are skewed from the start".*

12.31 The GMB also commented: *"The survey is done electronically and the questions do not allow you to report, for example, incidents of bullying by saying there is a management issue, so it is skewed in that way too."* It was not a proper reflection, was limited in its scope, *"not representative, too quick, too easy."* According to another respondent, it did not reach *"an operational level where the bullying and harassment has impacted".* I am told that it did not involve any discussions with individuals or seek to look at any underlying relationship or cultural issues.

12.32 I mention all of this not to criticise Mr Gallanders or his report but to help gain an understanding of why that piece of work did not uncover the issues which this review has uncovered. More generally, it is helpful to note that the gathering of information about allegations of bullying needs careful thought and insight. Mr Gallanders recognised this himself quite explicitly:

> 65. "The desktop analysis of survey and other data considered earlier in this report does not provide the qualitative information which lays behind some of the headline figures for NHSH. It is important that this information is mined. This will inevitably mean engaging directly with people rather than sending them another survey form. It is important to do this for two main reasons – firstly to get a better understanding of what the issues are where they are occurring and what the common themes are. This will provide a much richer source of diagnostic information to inform future planning and targeting. Secondly, engaging people is the right thing to do – a direct face to face interaction with an employee or group of employees will both provide information to the organisation to help improve things and help that employee or group feel that they are valued and cared about by the organisation."

Use of the Gallanders' Report

12.33 For completeness and because Mr Gallanders' report is full of useful suggestions which could easily be lost in the headlines about it, I have included, in Appendix 2, some more of his findings which seem to me to be helpful. I also commend the Report's list of short, medium and longer term tasks and priorities. They contain much which is of importance and utility. I pick this up in my own proposals later in this report.

13. Experiences of Inappropriate Behaviour

A Matter of Concern

13.1 A significant majority of those with whom the review engaged have, over a number of years suffered, or are currently suffering, fear, intimidation and inappropriate behaviour at work. In this chapter, I set out what I have been learned from many sources.

13.2 The number of individual cases in which people have experienced inappropriate behaviour which falls within the broad definitions of bullying and harassment described earlier is a matter of the utmost concern. Many appear to have suffered significant and serious harm and trauma, feel angry and a sense of injustice and want to have their story heard. There are, it appears, serious concerns about the mental and physical wellbeing of a significant number of members of staff. There are, I am told, links to anxiety, depression, withdrawal, alcoholism, drug abuse, suicidal thoughts and other serious consequences.

13.3 A number of those against whom bullying allegations have been made are also, or have been, the subject of inappropriate behaviour themselves. Bullying can be both upwards and downwards – or both. Many people have been afraid to take steps to address issues internally or to speak out, currently and over a period of many years. Many feel that no really effective, safe, mechanism to do so has existed.

13.4 One comment offered was that:

> "Many individuals have come to serious harm over these years in addition to the destruction of a highly motivated staff base at what used to be a fantastic hospital."

13.5 A clinician told me:

> "I've seen scores of people who have worked for the organisation who have said their distress is such that they have enacted or considered self harm to deal with the pressure. These are people who work for the organisation who have cut themselves or seriously attempted to take their own life by overdosing. Over the years this has not been an uncommon occurrence. Bullying has a really corrosive effect on a person's life, not just at work, but on how they feel about themselves, and on how they interact with their families. Feeling oppressed, under the scrutiny of a manager, this really affects people. Perfectly able, intelligent people can become unable to cope. Over the years I have met many people who describe experiencing those sorts of emotions. It's not just within NHSH, although I think NHSH is the largest employer in the area, so it's not surprising I see this as often as I do."

13.6 A significant number of employees, at all levels of seniority, have resigned, moved to other jobs or retired as a direct result of their experiences in NHSH and inability to achieve satisfactory resolution, some to their financial detriment. Many of these situations and their direct relationship to the work situation at NHSH are, I am told, vouched by independent medical reports and other evidence. The following remarks sum up the situation experienced by many:

> "My decision was not taken lightly. Although I loved my job I felt it was impossible to return to this unhealthy, toxic environment and with an extremely heavy heart (I cry now as I type this), I asked if I could take early retirement from service."

13.7 One member of staff who felt compelled to depart described how she had felt and the indignity which she experienced:

> "Yesterday was a dreadful day in the office and I feel that managers were avoiding any contact with me whatsoever! I was dreadfully upset and I decided at that point that I could not continue to work under this veil of indifference. I had hoped to leave the organisation with some degree of dignity and recognition of my dedication to NHS Highland."

13.8 Another member of staff in a rural location described the impact on herself and colleagues:

> "The main issue was the process in which it was managed and how [a number] of us ended up being left with no outcome, no apology. We felt

completely overwhelmed by it all and definitely under appreciated by an organisation to which we have given a collective work life of [over 60] years ([and many more] years to the NHS)."

Range and Scale

13.9 After the whistleblowing occurred in September 2018, there were apparently 90 calls to a trade union support line in two weeks. That union advised me early in my review that it had nearly 150 cases, many of which were unresolved. One union official told me: *"Over 20 years of working for a trade union, I have never seen the reaction we got when this went public."*

13.10 I cannot reflect the full range and scale of concerns expressed but I do wish to acknowledge the candour and clarity with which people wrote and spoke to me. The volume and specificity could leave no one in any doubt about the seriousness of the problems, many of which remain outstanding. As mentioned earlier, a significant number of these cases arise in rural areas and local departments as well as in the major centres.

13.11 Themes emerged for staff who feel they are not valued, not respected, not supported in carrying out very stressful work and not listened to regarding patient safety concerns, with decisions made behind closed doors. They feel sidelined, criticised, victimised, undermined and ostracised for raising matters of concern. Other respondents cited a clique or pack mentality, being kept out of the loop, abuse by email, leaking of sensitive information and being briefed against. Many described a culture of fear and of protecting the organisation when issues are raised.

Views Expressed

13.12 In this section of the report, the words of a few individuals, suitably anonymised, speak for themselves. These are not random remarks. I have selected them because they express views I heard repeatedly. I have formed the view that it is important for these voices to be heard (a) to make clear how serious the problem has been and continues for many to be and (b) in the hope that by bringing this out now NHSH can begin the journey to a better place. Further views are expressed in other sections of the report. As I have said repeatedly, they are not offered for their wholesale factual accuracy but to enable the reader to build a picture of the depth and extent of how people have felt. I have not attempted to investigate responses to all of these views.

13.13 I am aware that, for many, this degree of specificity is painful and frightening. It creates a situation where individuals are fearful that what is recorded is directed at them, rightly or wrongly. Responses to bullying can themselves seem or feel intimidating and inappropriate. I am also aware that for some of those who feel they have suffered inappropriately, reading all of this may also be traumatic. Therefore, in recording these views, I ask readers to be sensitive to the impact of what follows on individuals. And to remember, throughout this report, that there will often be several sides to a story.

A Rural Practice

13.14 For me, much of what I heard was encapsulated in a meeting I held with fifteen members of staff in a rural medical practice. My anonymised record of the comments made at the time summarises what I have heard about how many people feel at work generally in NHSH.

"We've put up with it for so long"

"Our manager has made our life hell for years"

"He shows no respect, it's his way or no way"

"He intimidates us, speaks to us like children"

"It's one rule for us, and one for him"

"He owns us like slaves"

"Higher up management backs him up – it goes all the way up"

"His line manager knows – he is scared of him"

"They all know, they've heard it all before"

"It's an abuse of power, it's all about control"

"He gets away with it"

"What's the point in taking it up?"

"HR held a meeting with us but there was no proper follow up"

"HR cc'd the person I was complaining about!"

"I wrote to his line manager confidentially but my letter was passed on to him and I had to meet with him; Datix is the same"

"I got no response to my letter"

"iMatter is a paper exercise, a tick box; he takes the meeting and decides what we discuss"

"We don't take it up because we fear recrimination"

"There are inconsistencies in how they apply the policies"

"They are manipulating the outcomes of application of policies"

"Policies are not followed; instead they apply local interpretations in an arbitrary and discriminatory way – it's unfair"

"If we stand up, we get shot down"

"There's nothing we can do"

"This is management style of 30 years ago – bossing us around"

"We have lost many staff over the years as a result"

"Senior management needs to support the staff not the line managers when legitimate complaints are made"

"They keep cancelling meetings they promised us"

"They don't seem to care about us"

"Senior managers need to understand their role – many are in the wrong job; they need training or to change job"

"Those appointed to management need to have the necessary skills as facilitators"

"We would like adult conversations and to be treated with respect"

This last remark perfectly captures what many respondents feel has been missing in NHSH.

An Individual View

13.15 Another individual described experiences over many years:

- "Throughout my career (spanning over 20 years) I have been subjected to bullying and harassment by a colleague
- I have on several occasions addressed and escalated this with senior management, this did resolve issues temporarily
- Formal mediation was agreed and sought, no follow through on this, colleague avoided and not followed up by HR.
- Felt excluded, disrespected and inadequate, and in some cases still do.
- Professional lead role not respected or at times included within decision making processes.
- Have had to work hard to remain at work, high stress levels but have utilised coaching (external) to support.
- Experienced humiliation at times from senior management when presenting or contributing to meetings."

Historic Concerns

13.16 That this situation has prevailed for a number of years seems fairly clear. The following was brought to my attention as examples taken from a survey carried out in 2014:

- "Although concerns are expressed they are dismissed, staff feel unsupported.
- Unsupportive management focus only on negatives and problems, there is no recognition of good work. There is a total lack of inclusion or consultation in any proposed changes.
- Anyone who attempts to raise legitimate concerns is victimised and targeted
- I was shouted at by the trainer, witnesses were shocked by this and managers heard about it and did nothing (3 other people made similar comments)
- Anyone who tries to raise concerns regarding management is subjected to unfair treatment and things are made difficult
- Please, please listen and act on our concerns
- Team spirit and cohesiveness has been destroyed by negative management. Morale is very low and no-one is sure who they can trust
- There is a bullying culture here that has never been eradicated. Genuine concerns should be addressed rather than swept aside
- Unrealistic expectations from senior management and treatment by managers with an autocratic style is really stressful.
- Staff are too scared to raise a grievance, a concern or even report something that is clearly wrong. We've seen what happens to those that do
- I don't know why I'm bothering to fill this in, other than I was told to! But nothing ever happens anyway, it all gets covered up."

A Former Employee

13.17 A former employee who had felt unable to continue with NHSH summarised what she told me in a meeting in these words:

> "Previous history of allegations made by the two individual nurses in the team, which had led to the suspension of the previous Senior Nurse, who later retired as she was unable to continue working in the service due to her traumatic experiences.
>
> Perpetual bullying by the Nurse who was redeployed stating that he would 'have my job', directing the nurses to follow a particular practice pathway in the absence of professional/ team discussion, taking on tasks that were not appropriate and undermining my professional status and role.
>
> Professional disrespect and lack of understanding of roles and responsibilities. This created significant barriers between, for example, Nurses and [clinicians] in the service. There was an attitude that prevailed of superiority and inferiority and working together across disciplines was particularly difficult for some.
>
> Oppressing certain professionals, the Service Manager undermining and making derogatory or negative remarks in front of other team members without justification, about certain colleagues, who were competent in their work, usually those who challenged others (seen as a threat). An experienced [clinician] was transferred out of the service, following her allegations about 'bullying' as she was seen as 'problematic and divisive'.
>
> A culture based on fear and intimidation, blame, mistrust, covert practice, 'cliques', defensiveness and indiscreet recrimination, without an actual evidence base."

Other Experiences

13.18 Another nurse put it this way in our meeting:

> "A wee group including charge nurses, other nurses, auxiliaries etc. treated [me] badly, talking behind [my] back, being unkind, using harsh tone, questioning [me] in front of patients, not made to feel part of the group etc. Felt intimidated, undermined, disregarded, ill informed and that [I] was a scapegoat for all the ward's ills."

13.19 One of my colleagues reported to me the experience of a bank auxiliary nurse who described consistently being treated in a derogatory manner by ward nurses:

> "They speak to him in a brusque and patronising manner and do not value his expertise and experience. He estimates this happens more than 50% of the time. He thinks the belittling is driven by stress due to time pressure and the failure to make full use of him is driven by a hierarchical mindset that devalues auxiliary nurses. He recognises the nurses in turn are probably experiencing this treatment from doctors and managers. When he raises the derogatory behaviour with more senior nurses they tend to excuse it as being down to stress and do not tackle it robustly. He thinks that a team culture is needed."

13.20 A hospital worker told me:

> "The degree of low-level and at times almost direct intimidation and bullying was very marked, with a pervasive feeling of fear and being unsettled in the job. What we as practitioners did each day was brought into question, with more and more constraints, and if we tried to explain how impracticable a new dictate was we were met with disregard, and an increase in feeling of being singled out, with her raising increasing "concerns" against individuals. Grievances were taken out against the manager, and although no evidence was found to back up the manager's "concerns" regarding practice, these were still upheld and our grievances against her given little credence, but the line taken was not to worry about it. My concern is that even when going through the official routes, if it is a manager a concern is raised against, it feels almost as if there is a closing of ranks, and even the unions did little to fight against this."

13.21 A junior member of staff described in detail her concerns in one unit:

> "This has created a very fragmented and divisive culture across the unit. Junior [staff] are being blamed/scapegoated for mistakes they were not involved with and errors being made by senior [staff] are being covered up and collusion is occurring to blame junior [staff] for these errors."

13.22 A former employee had this to say:

> "... in the NHS Highlands they burdened me with an excessive workload, made unilateral decisions without discussion, treated me like a robot rather than a human being, isolated staff (divide and conquer), emotionally blackmailed staff, put targets over patient care and safety, did not treat me with respect or appreciate me and severely affected my health and well being and ultimately made me seek employment elsewhere."

13.23 A laboratory assistant told me:

> "I have never seen any workplace managed in the manner that this laboratory is now, it thrives on bullying at all levels as well as favouritism and gossip. There is no adequate staff training at all and I have been set up to fail on so many occasions."

13.24 A little vignette sums up the feelings of many who experienced a kind of cognitive dissonance:

> "NHSH invested in promoting dignity at work policies. They organised this dignity at work workshop/meeting. I went to it, they paid all of this money out on mugs etc. then there was a presentation from two people at HR. At one point, one of the speakers was not confident – what are we doing next? And the other snapped saying "well I don't know, it's your bit!" It was right before my eyes."

13.25 An administrator described her experience in one department as being *"kept out of decisions made by senior managers and then expected to communicate and defend unpopular decisions to staff"*, who would see her as the problem. She experienced bullying both from managers and from staff she was trying to manage. *"I kept being handed a loaded gun"*. If she tried to tackle underperformance she was not backed up by management and then was criticised by staff for letting underperformers get away with it. She expressed concern that HR offered little support when she asked for help with bullying – options were either to live with it or raise a grievance, which would take a long time. In any formal meeting *"HR only support the manager, so the staff member gets no support. Also, HR isn't confidential"*.

13.26 The damaging impact was described by another administrator who told me:

> "I now find myself in complete limbo with no specific job role,... I am excluded from all staff meetings and have no contact with the actual local dept ...The support staff still will not speak with me or acknowledge me in any way. I am struggling with immense feelings of rejection and isolation."

13.27 A former senior manager vividly described a series of experiences of what is known as "gaslighting" perpetrated by an even more senior manager. I am told that gaslighting is a form of *"psychological manipulation that seeks to sow seeds of doubt in a targeted individual or in members of a targeted group, making them question their own memory, perception, and sanity. Using persistent denial, misdirection, contradiction, and lying, it attempts to destabilise the victim and delegitimize the victim's belief."* Gaslighting was a word I became more familiar with during my review as respondents described their experiences.

13.28 This sort of unpleasant experience was corroborated by a former support manager:

> "A number of staff complained about [a particular event], including myself, and this is when I started to be managed out of the business. Within a relatively short period of time my self-belief had been undermined so comprehensively that I would never have employed myself and was eventually signed off with stress (this is common in this department). When I was under treatment by my GP (none of those who signed the letter in the press) they were entirely unsurprised by my experience and said that stories like my own were common from NHS workers."

13.29 The experiences seem to be widespread across NHSH; this example comes from a rural community:

> "It is widely felt by staff that there is an institutionalised culture of bullying management on [this island] but nothing can be done about it."

An Experience of the Board

13.30 I conclude this section with a completely different situation to those described above, in which a senior clinician describes an experience with "the Board" (which is used as a collective term here and may not refer to all members or an actual Board meeting). I do not offer this for its

factual accuracy (as ever, perceptions will vary in a very pressurised situation) but record it as an indication of how dysfunctional things appear to have been and the resulting impact:

"What we experienced on that afternoon was both eye-opening and frightening. We were looking into the dark soul of the NHS organisation. Our team was shocked by this. Senior clinicians – three of them – moved to tears during the meeting. A lot of anger expressed about the way we were treated. The body language of board members was very unpleasant. There was an attempt to undermine us, make us look foolish. The behaviour was threatening. They left, we agreed to nothing. We agreed to meet the next day to discuss further. All shell-shocked. One colleague left during the meeting. Another tried to leave but was told to sit down. What took place was well beyond our collective scope of experience, and as such it was powerfully disorientating. I had never witnessed anything like it. In this way the Board broke the collegiate will of our clinical team. They left behind a fragmented, confused and angry remnant. In ways we found difficult to discuss I think we all felt ashamed of ourselves. Many of us were traumatised and remain so. Most of us felt that we had failed to defend the interests of our service and our patients. The methods of ambush, intimidation, isolation and undermining reflect the themes raised by those who requested an investigation into "bullying" at NHS Highland. It demonstrated a Board that is not listening to the concerns of its staff, driven by its own agenda and believing itself to be above the law. At a subsequent meeting arranged at my request, the Board Chairman asked me a very direct question: "did you feel bullied?", to which I answered "yes". That meeting ...was never acknowledged, and to my knowledge no steps were taken to investigate the issue of high level bullying that the Chairman and chief executive had identified. What I perceived as formulated organisational subjugation allowed inconvenient truths to be concealed. As seen in other instances within the NHS, this kind of behaviour presents a risk to patient safety and to the long term reputation of the service. My concern is that that behaviour, which they probably don't recognise as being bullying, has a very significant influence on the safety of our service. Has allowed us to brush under the carpet the opinions of senior clinicians and very significant risks across NHSH."

Managers' Concerns

13.31 The allegations of bullying go both ways. Managers are also said to be the recipients of inappropriate behaviour from members of staff. This from an island community:

"My experiences are actually of NHS Highland Managers being bullied not the other way around. I have seen a very concerning increase in 'bad behaviour' from my colleagues over the past 3 years. I have been shouted at, screamed at, sworn at, lied about, accused of being unprofessional and uncaring too many times to keep track off. I feel as an organisation NHS Highland have lost their way a bit by not being assertive enough when managing services, the public and staff."

13.32 Similarly:

"I have had instances of managers being bullied by their nurses. This manager was accommodating the nurse's availability only and then scheduling everyone else around that one nurse. When I asked her if she felt bullied, she burst into tears and left."

13.33 This from a manager in a middle management situation expresses clearly the difficulty for someone in that position:

"During my employment as a Manager I found myself managing an unprecedented situation involving a member of staff I line managed. I found HR to be completely ineffective, my senior managers showed little interest. The end result of this ghastly situation was finding myself at the centre of grievance by the member of staff – unfounded accusations were made against me. I was made aware of this way of a phone call on a Friday evening from a very senior manager. Although I continued to work, I was under investigation which took many months to resolve. The outcome was 'no case to answer'; the situation was not dealt with appropriately. My experiences are not in isolation within NHSH....

I have also found myself being accused of bullying & harassment by a member of staff I lined managed. I took my role as a manager extremely serious and ensured I followed due process ...I have evidence of this. The staff member involved did not want to be managed, had been used to 'doing her own thing' due to lack of structure within the area of responsibility. I viewed her as a risk, had significant concerns re her capability including clinical competence. She

chose to accuse me of bullying her – again lack of support from HR was evident and the outcome was unsatisfactory. Again this not unusual in NHSH – people do not want to be managed, nobody takes responsibility contributing to compromising patient safety."

13.34 This comes from a long-serving senior manager who feels vulnerable at work:

"This has been a distressing time for me and I don't feel that there has been support for me as a (wrongly accused) manager within the organisation. I know the truth will out so to speak though so I just have to hang in there until it does. Fortunately my immediate line management know that the accusations are untrue and there is evidence to substantiate this however it concerns me that people can just make up stories on the bullying bandwagonand because NHS Highland is currently in the position it is in, the stance feels along the lines that managers must be at fault and need to improve as opposed to supporting managers who find themselves wrongly accused. I feel that I am a very vulnerable position and this unresolved situation has the risks of impact on my ability to continue to manage effectively without fear of accusations."

13.35 One manager described the impact on him of the recent accusations as a form of bullying itself:

"There has been an overwhelming feeling by myself and managerial colleagues that we have been labelled as bullies. Various individuals have had open access to mainstream media, social media and other avenues to express their allegations of bullying and labelling all levels of NHS Highland structure as bullies, including [one MSP] in open questioning at the Scottish Government. To me this could be considered as indirect intimidation and bullying without the right to reply. I have had to personally defend myself against various comments and assumptions outwith work as a result of the allegations made which includes my ex line manager. This may seem "par for the course" considering the serious nature of the allegations but unacceptable as an individual where I have no control of how the allegations were made to the press."

13.36 These views are clearly of great importance and reflect both the multifaceted nature of the situation and concerns about the way matters have been handled, together with the implications, on which I comment elsewhere.

14. Unwillingness to Raise Concerns

Introduction

14.1 It is relevant and important to discuss why people felt unable to report their experiences and the adverse effects if and when they did.

14.2 It is said that, in general, the main barriers to reporting allegations of bullying or other inappropriate behaviour are the perception that nothing will change, not wishing to be seen as a troublemaker, the seniority of the bully, the fear that bullying will get worse, and the fear or real risk of being dismissed or side-lined. The legal and other remedies are not easy to pursue, often leaving a choice between leaving the job (with all that entails) or continuing to suffer.

14.3 Sir Robert Francis identified a number of factors which may lead to fear of speaking up as being:

- blamed or made a scapegoat
- discriminated against
- disbelieved
- seen as disloyal
- seen as disrespectful in a hierarchical system
- bullied
- fear of wider consequences for a career.[33]

14.4 As noted already, these have been the experience in NHSH. In this short chapter, I offer some more illustrations of reasons for people feeling unable to raise their concerns.

Themes

14.5 A consultant told me of a variety of impediments:

> "Potential repercussions – need to keep my job, pay my bills. I've watched what happens to others who challenge. People's careers sabotaged – cannot work again- will never work again – no pension…If I were to go and make a complaint – who would I go to? I don't have an answer – I won't turn up at the new CEO's door…"

14.6 This is a recurring theme:

> "People are unwilling to step forward and say this is a problem. I've spoken to a number of colleagues who, when I told them I was coming, they said, "good for you" and when I asked if they thought about it, the majority of responses were "I've got a mortgage, I've got children.""

14.7 A senior staff member wrote in these terms:

> "Those who have gone to formal grievance have come away feeling like they are in the wrong, that this manager is having to deal with them and their faults. This tends to give the message to others that going down this route puts them at risk of being deemed as either a trouble maker, not coping with their work and therefore at fault themselves. Until this bullying behaviour is acknowledged, staff supported, and communication improved I can see many experienced staff leaving if they can't hold out till x retires. This is not my impression of a supportive forward-thinking organisation who cares for the wellbeing of their staff…
>
> That really summed up how I feel about Bullying within NHS Highland and in particular in the [x] department. Before putting in my grievance I had been warned that "management stick together so don't expect your grievance to have a very good outcome" and I have unfortunately found this to be my experience."

14.8 A former local MSP told me:

> "I had many cases of NHS bullying over the years. The one conclusion that I reached was that there was a common denominator in the vast majority of cases. Generally speaking, most of the staff who had been bullied had 'dared' to raise concerns regarding patient care or suggest ways to improve patient care. They tended to be well qualified, experienced and conscientious in their professional capacity. Having raised an issue, they were often redeployed to a

33 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.3.19

post with lesser responsibilities or taken from specialised posts to general work. It was not only bullying that was involved, but a fair amount of humiliation was also used, often in front of patients and particularly with other staff present."

14.9 These views echo the observation of Sir Robert Francis that workers who are bullied, or who see others bullied, are much less likely to raise their concerns (see paragraph 10.18), as the following passages underscore.

14.10 A former manager in a support role told me:

"What NHS Highland fails to recognise is that most people who are bullied will not report it and perhaps don't even realise that they are being bullied until they have left that situation. If someone does eventually raise a complaint… they will quickly realise that a record has been kept of things that you've done and said that can be skewed to seem negative and, as you haven't kept an equivalent record (not knowing that you needed to), you can't counter the negativity."

14.11 From a care worker in Argyll and Bute:

"My case is not isolated, I have met many people who have raised a concern and been shunted from post to demoted post until they leave. There is a fundamental lack of understanding by NHS Highland of the nature of bullying, it is generally secretive and there is little evidence. People who witness bullying will rarely corroborate a complaint for fear that they will be the next target. When people see what happens to someone who raises a complaint it is little wonder that bullying goes unchallenged. Senior and Middle management close ranks and say there is no issue."

14.12 The feelings of a number of those who came forward are summed up here:

"It is common knowledge that this particular manager openly boasts in the staff dining room about the number of grievances against them and has said that it doesn't matter because "nothing ever happens about them". Staff … feel that this manager is "untouchable" and are afraid to complain further due to the poor outcomes of previous complaints & the open victimisation of those who have previously complained. Several members of staff have actually resigned their posts as they felt unable to continue working under these conditions."

14.13 There seems to be a strong theme around victimisation, a fear that, if someone raises an issue, the person complained of will use their power to harm the person raising the issue further. Staff fear reprisals.

14.14 I was asked to note that doctors are less likely than other staff to report incidents of bullying and harassment; trainee doctors are among the least likely to speak up. They fear repercussions if they do. They believe that nothing will change by raising concerns. There is also a mistaken perception that doctors do not suffer bullying. They are often seen as powerful, successful and self-confident people, and therefore somehow immune. I was told that this is not the case.

Understanding the Cultural Issues

15. Possible Causes: Health Sector Generally

Introduction

15.1 There are undoubtedly multiple causes of the symptoms described in this report. Finding a simple reason is not always possible. An observer commented: *"There is often no explanation or reason one person subjects another to the type of behaviour defined by ACAS..."* as bullying.

15.2 Diagnostically, the experiences of many NHSH staff are likely to be attributable to a number of factors which have built up over many years, a number of which have also created difficulty in raising and addressing them locally.

15.3 Some would say these have created a perfect storm in NHSH. Many of the features described in a "VUCA World" (see paragraph 4.17) and referred to in my chapter on human nature are manifest in NHSH. A number are outside the control of an organisation such as NHSH. We should not underestimate the effects in recent years of the general sense of isolation and alienation felt in some parts of society.

15.4 Some factors could be described as cultural and are possibly unique to the specific local and geographic circumstances of NHSH and its employees. I am mindful of emphasis on the importance of "place" in recent years. These factors play an important role. Other matters are relevant in general to the NHS in Scotland and to the provision of health care overall. There are other significant factors which will, I expect, be common to all large organisations. Yet others have to do with a management style which, it is perceived, has been prevalent in NHSH in the past several years and relate also to the effectiveness of the governing body to provide effective oversight.

15.5 I seek to address these and other possible reasons in this and the following chapters of the report. This chapter seeks to cover more general issues. The next chapter discusses matters related to NHSH itself. The succeeding chapters cover further topics which are relevant, including management, governance, HR issues, the role of trade unions and the Scottish Government and other topics.

15.6 In some of this, there is an inevitable amount of conjecture on my part, allied to the views of well-informed respondents, upon whose words I have again placed considerable reliance as authentic and authoritative sources upon which I can legitimately draw. However, this analysis will inevitably throw up questions and comments by those who understand the organisation intimately. If so, that is a good thing. There are matters which deserve to be wrestled with as NHSH seeks to move forward.

Changes in Expectations and Behaviour

15.7 As Mr Gallanders noted in his report, what is or should be tolerated as acceptable behaviour has changed in recent years[34]. It is likely that, more generally, society is experiencing a lower tolerance of behaviour which is perceived to be intimidatory, disrespectful and hierarchical, as we have seen in other areas of public life. There is growing evidence of increased levels of awareness of workplace bullying generally – either because more is happening in fact or because attitudes are changing and mounting evidence reveals more of its existence.

15.8 Workplace bullying is not exclusive to the NHS or to the public sector. We know from recent examples that it occurs in the private and charity sectors, affecting productivity and increasing absenteeism in all organisations. The increased power of social media with no apparent parameters or checks is, I was told, another significant factor:

"Emails and social media have been fatal. People have a glass of wine and then write it all down. I have seen in the past two years, my staff's behaviour change and deteriorate quite dramatically."

"Social media spreads like a disease."

34 Gallanders, S. (2018). Allegations of Bullying and Harassment in NHS Highland. Para 61.

15.9 Further, health care provision across the developed world is increasingly complex and expectations of improved services in the NHS continue to be high among patients, the media and society generally, alongside medical and technological advances. One commentator said:

> "Some policies have undoubtedly contributed to the NHS pressures, most recently around patients "rights" to have drugs even when extremely expensive ie rationing/control is now very difficult precisely at a time when extremely expensive drugs are being made available."

Medicine and Hierarchies

15.10 In any event, it seems that the culture in the medical world has probably historically been rather hierarchical and power-based, with a sense of entitlement and status and a corresponding element of bullying behaviour, aspects of which still remain. Lack of respect among and by clinicians still seems to be the norm in some places. A culture of deference may be an associated feature. Changing circumstances can feel like a challenge to ego and authority. The move from the autonomous, heroic "clinician with power" model to a more complicated and shared power / teamwork approach is not easy.

15.11 The perceived rise of managerialism and the clash with clinical leadership is a significant feature I am told. Younger doctors may be more at ease with a changing culture but this can itself lead to internal tension. One senior manager described it in this way:

> "I've described it as being ante-diluvian. It's being in James Robertson Justice's Carry-On Doctor. Not everybody, but some consultants who are longer in the tooth. I think that's coming from a place of stress."

15.12 As one senior person put it:

> "In terms of structures, I think sometimes some doctors have got an unrealistic idea of the extent of their autonomy and entitlement to do as they wish. Some people can be pretty inflexible and resist what the manager is trying to do. I wouldn't characterise the whole organisation like that, but I think part of it is the doctor's disinclination to step up. It's the model of being an advocate for individual patients being the primary concern, fitting in with traditional medical autonomy. But it doesn't fit into modern view – medicine is now a team game in delivery for care. Constrained resources. Someone has to make decisions about prioritisation. Our doctors sometimes don't step up into that more modern role. If put under pressure, can retreat into that traditional role."

15.13 A former board member told me:

> "I found the hierarchy and clinical domination, and in particular deference to medics, noteworthy when I joined NHS Highland. There are tensions and conflict around how individual clinicians and teams manage 'their' patients whereas the board and senior manager's responsibilities span across all services as they apply to the entire population." An HR staff member commented: "There is a superiority thing that informs how people behave. There is a lot of emphasis on patients being important – "I'm saving lives today, what are you doing?" The staff feel that they don't matter..."

15.14 One senior manager commented:

> "We have a culture in the NHS which lapses into categorisation of people by their profession, grade, job title or background. It's far from straight forward, however, because senior clinicians (of all backgrounds) have also described how virtually overnight they went from being respected and valued to one of abject disrespect when they moved into management roles."
>
> "I have seen great progress in this regard since joining NHS Highland but medical dominance (in particular) still prevails throughout the NHS. Of course in many ways this is positive but there is a balance to be struck to ensure a healthy culture, where everyone is valued, particularly based on their contribution. Doctors don't always know best, and can and should be respectfully challenged, in the same way as other colleagues would expect to be."

15.15 Power is an important driver. Another former manager told me:

> "I've worked in lots of organisations and there are pockets of people who are on the edge. ...But in NHSH, there was nobody catching it. It was the behaviour that was wanted. It's what people wanted to see. There weren't isolated incidents, but an underlying current of it all the time. ... I was told to just "manage it". But it was bigger than me, I need help to manage it. We

had a good clinical manager and we took a lot of abuse. But ultimately, the power wasn't with us and nobody was willing to help wrestle that power away."

15.16 Issues about education, training and selection may arise which are beyond the scope of this review and which I understand bodies such as the Royal College of Surgeons consider actively. It was pointed out that the NHS was based on a post-World War 2 model of command and control based on a military template, with "officers", divisions, uniforms, hierarchies, unquestioning deference and other attributes, many of which may have seemed valid then and which still remain. (Ironically, some respondents pointed to changes in the way the military handle bullying as a model for NHSH to follow as a necessary stage in its evolution in the 21st century).

15.17 In a later chapter, I address the tension between clinicians and managers and indeed those clinicians who have become managers. It is a complex situation.

Resistance to Change

15.18 It is fair to note that one experienced former director pointed to the difficulty of introducing change in the medical world:

"I mean the unenviable task for managers in managing these disparate groups, but more importantly managing a group of staff who earn salaries far in excess of that of their line manager. This produces a dynamic and power base that is not always conducive to change and can indeed thwart progress. The challenges in recruitment and retention across some staff groups may enhance that power base at times strengthening resistance. In my time in NHSH I have witnessed many managers struggling with budgets, increasing demand for services and expectations in relation to new interventions or medications. Not all staff understand or support these struggles and may wrongly interpret firm and fair management as a result. I believe ... that NHSH has a culture of continuous improvement and that resistance to change is a natural consequence of this. NHSH has always had processes in place to support those who resist change and I believe the organisation has always aimed to be open and transparent in implementing these processes."

15.19 A professional lead put it his way:

"You'll get people who can be aggressive in actually saying "you haven't discussed that with me" when we have through consultations. But because the outcome is not what they wanted, they plead ignorance. They become aggressive and then try to undermine you in other ways. I see myself as an isolated voice although there are other ways. People are afraid to put their head above the parapet. Any change is fearful. In the change model, the status quo is the place they know even though they don't like it."

15.20 Again, system inertia is a well-recognised feature of an organisation and affects individuals under strain and who are fearful of the consequences of change. One observer reflected on the result:

"Organisational inertia, which is linked to many things. People get used to nothing happening and get frustrated or give up. This leads to some of the behaviours, whether by those managing or those seeking change or explanation."

Government Targets

15.21 It is perceived that there is significant and increased pressure to perform and meet targets throughout the organisation. This, perhaps underscored by a fight or flight response, has probably often taken precedence over people issues. It was argued that Scottish Government policies such as treatment time guarantees and waiting list targets press NHS Boards to deliver without enough regard for affordability and other resource issues. Unrealistic or unachievable expectations can lead managerial staff to pressurise clinical and other staff to improve performance.

15.22 Thus, these policies may have an adverse impact on the people charged with delivering them, leading to dysfunction and loss of morale which can tend to cascade down through the system. By their nature, they may emphasise a more transactional approach, to the detriment of relationships. Rather than criticising the targets themselves, there may be an absence of the necessary skills to implement them – or realistic conversations about them.

15.23 The emphasis on targets seems to be one reason for tension between management and clinicians. As I mentioned at an earlier point, there may be an inevitable, perhaps irreconcilable, tension between clinical obligations to patients and

the management need to cut costs and/or increase efficiency. I am told that this is further exacerbated by the gathering and collation of data for reporting to the Board, which is used to assess targets and measure waiting times rather than shared operationally to enable those on the ground to adapt services.

15.24 One clinician observed:

"Targets are useful, but if all one is doing is working to the target, everything else becomes secondary. Particularly when the directors, CEOs and the like are managed against that target." And that creates problems for others: "People tasked with implementing the approach/regime are not necessarily knowledgeable or skilled enough to do this. Culture of training someone to do something and immediately assuming expertise. That cannot be easy. A large part of our role is to justify the role of management and administration to produce figures for them."

"Management, from the very top down, remain fixated with targets, both for delivery of services (e.g. waiting times) and financial. They have retreated to the lowest common denominator, leading to poor clinical standards, acceptance of poor behaviours and lack of candour. Clinicians have become the tool of management, we exist to allow them to produce reports to demonstrate they are meeting targets. This has led, in some places, to a culture of bullying, often as a response to fear, this is top down. Morale is very low, highly skilled and experienced people are leaving the NHS."

15.25 An employee representative commented on the political pressures and impact:

"But we have also to acknowledge the external pressure on all NHS Boards which comes from above/outside. Political discourse in Scotland around the NHS is largely centred around the meeting/breaching of targets, and success (or otherwise) in delivering a premium service within limited budgets. Government and opposition alike use this as the default for discussion and for measuring success, and that context is mirrored in media reporting. If the workplace culture in the NHS is to change, the effect of this wider context needs to be recognised for the impact it has."

15.26 One GP summarised the effect: *"You see the management firefighting all the time. Their reaction under pressure is a bullying one."* Firefighting is a description that arose several times.

15.27 Overall, there was a feeling of NHS boards under pressure:

"It is right that the Scottish Government (not just the current administration) places high expectations on Boards to deliver – Governments are after all answerable to the people that elect them. Equally it appears to me that the current administration is not willing to have the difficult conversations with the public over what can be expected from a resource limited public health care system – I see this daily with medicines where I feel we could get better value from investing our resources in other therapies/care. It has provided little constructive leadership and left the Board exposed when making difficult decisions."

15.28 One director expressed the frustration felt by many:

"It's the most unrewarding organisation I have ever worked for. How do you measure success? You're here to deliver care – how do you measure the care? I can tell you how many people are in a queue – how many we have failed. A good day is when you don't fail as much as a bad day."

15.29 The impact on NHSH may be more acute:

"I think the government target driven health service in an under-capacity NHS causes major issues and I have seen this for years with ill feeling and upset. It may work better in central belt with private hospitals with separate managers/nurses and secretaries but in Raigmore it distracts from the capacity we have."

15.30 A senior consultant commented on measurement as against clinical outcomes:

"Financial stringency brings with it challenging issues and the need to make difficult decisions. The way that targets have been achieved has not always been acceptable. There has been a preoccupation with the measurable whilst ignoring clinical important issues. Eg the push to meet cancer targets results in funding for facilitators and clerical staff who monitor performance and chivvy clinicians. Sometimes this can be to the detriment of more clinically pressing cases that do not attract targets and associated funding. Improved funding for staff performing the work might be better for patients in the long term."

15.31 He also said: *"Financial stringency has had a major effect on the NHS but it should be possible to run a patient centred and staff friendly organisation even in the face of limited budgets."* That is surely the challenge for the NHS generally and NHSH in particular.

Economic and Resource Factors

15.32 To all this can be added more general economic circumstances: over the past ten years, in times of austerity, with budget restrictions and reduced spending, financial constraints can often lead to people feeling overwhelmed at work, with too much to do, and not enough time or resource. This is likely to cause stress and may lead to behaviour which is inappropriate.

15.33 I have heard a number of examples of this, with senior (and other) employees at breaking point. Where there is significant and increased pressure to perform throughout the organisation, this may have taken precedence over people issues.

> "Austerity has been a major factor. The NHS was used to solutions made out of additional investment from Government. When this became no longer possible the pressure within the entire NHS system increased."

> "These are coming with cuts being made to resources, staff being asked to do more beyond their accountability, experienced staff leaving, newer staff not realising that being stressed at your work was not always a feature, managers becoming process led..."

15.34 The impact on staff morale and the lack of acknowledgment was recorded in these terms:

> "I perceive a lack of interest and understanding on behalf of the health board in the day to day experience of staff and patients. I hear many staff expressing the view that their work is not appreciated by the organisation; the organisation does not understand the pressures they are under and does not recognise the impact on patient care. I see good people trying their hardest to provide high quality care in very difficult circumstances with ever fewer resources. We all recognise that resources are very limited and there is no spare money but given the reduction in resource which I have experienced in my own specialty and is mirrored in many other areas, the pressure from the organisation to not only continue with the same level of service, but to increase service provision creates a sense of inevitable failure. Never being able to achieve the standard of care aspired to, leads to low morale and this is manifest in the increasing levels of staff stress and sickness."

15.35 Ironically, the resulting breakdown in relationships may well lead to behaviour which is experienced as bullying:

> "There are also the inevitable financial pressures. Currently we are several members of staff down due to problems with recruitment. The perception is that senior management are only interested in saving money and are happy to let the remaining staff pick up the work. This again leads to a general perception that this is not a caring and supportive organisation. In this atmosphere unpopular decisions or inability to progress can be viewed as uncaring and bullying."

15.36 The resulting disconnect was further highlighted in this observation about the impact on front line staff from a team leader who emphasised his understanding of the need for tough decisions and innovative thinking to produce a sustainable and cost-effective service:

> "Within NHS Highland and particularly in Argyll and Bute the message coming from senior management has changed as the financial savings targets have increased. The message of changing services to save money but maintaining quality has subtly changed over the past few years so that frontline staff now hear only 'save money' with decisions made arbitrarily and opportunistically which clearly do not fit with the Highland Quality Approach - wholesale cuts to services for more vulnerable patient groups such as mental health are becoming more common. Concerns raised about such cuts are deflected with assurances that services have simply been 'redesigned'. The lack of openness and denial that services have been cut without significant consultation or risk assessment is contributing to the disconnect between staff and senior managers and leaving the staff feeling that cost saving is the only priority of the Health and Social Care Partnership in Argyll and Bute. This disconnect has been highlighted in iMatters staff questionnaires over the past two years."

15.37 He goes on to capture the impact of all of this on perceptions of the leadership and loss of compassion and understanding:

> "Overall, morale among frontline staff is pretty low and although not a typical picture of 'bullying' there seems to be a drift towards an oppressive approach to management as the financial savings appear more and more unachievable. Recent managers job descriptions have included phrases like 'manage conflict with assertive responses' and 'assert self in contentious issues' which seems to support the idea that leadership only involves showing strength, excluding compassion and understanding as important aspects of leadership."

15.38 A consultant wrote to me in these terms about the impact on service managers who are caught in the middle:

> "The most vulnerable amongst us, as a group, are our service managers. The … department where I have worked now for [a number of] years has had [a number of] service managers, most of them bearing a load of multiple services to manage and being buffeted by our clinical demands from below and financial pressures from above. In my mind, the demand to balance books while ensuring quality comes from the government and is the driver of this bullying culture. Whilst the government may not mean to do so, this is how it comes across."

15.39 A senior consultant reflected a more general frustration with indecision and a poor leadership model:

> "…there are frustrations whenever new funding is required. There appears to be a culture amongst some decision makers that they neither say no this is not possible or yes we can achieve this. Instead you find indecision as a way of managing budgets. This means you continue to work up ideas and chase funding over and over again without much luck. This is at best frustrating and can create a deep sense of frustration.
>
> I know there are areas where we are wasting money but nobody really wants to release time to make significant change happen, certainly not at a medical level. Instead unappealing clinical leadership jobs are designed where failure, or at least limited achievement, is almost guaranteed. This is particularly in the medical directorate, there are individuals who work hard and have achieved a lot but I'm certain that this is due to their individual resourcefulness and not driven by structured clinical leadership model."

15.40 Of course, all of these factors can contribute to behaviour which becomes generally unacceptable, especially when in combination or accumulative. One director observed:

> "As a senior leader I have felt bullied and harassed by the organisation, by the Scottish Government. What I do believe is that in the NHS now people are feeling so pressurised. It's a horrible environment. It's targets. It's finance. It's political. Populist policies but don't have the resources to fill them. NHSH is just one health board of many that are suffering."

Clinical Governance and Quality Improvement

15.41 It has been suggested to me that there is something to be said about clinical governance and quality improvement when these are carried out as technical skill sets rather than as an adaptive leadership activity. An example would be the way incidents are recorded and episodes of care – or deaths – are investigated with the aim of learning and improvement. If there is a focus on criticising people rather than on the systems that give rise to individual actions, there can be an unsafe outcome. That may occur if clarity of accountability and psychological safety is neglected and activities are perceived to have a blame culture at their centre. This is perhaps another example of the transactional trumping the relational.

15.42 A consultant put it this way:

> "There is a need for NHS Highland to shift from a person-centred approach to a systems based approach to risk… Recent thinking[35] (Reason 2000) highlights that 'patient safety cannot be improved by focussing only on the 'person approach' with 'active failures' of the individual practitioner such as forgetfulness, inattention, carelessness and focussing on reducing variability in human behaviour through

35 Reason, J. Human error: models and management. BMJ. 2000; 768-70.

fear, disciplinary measures, threat of litigation, naming blaming and shaming. By focussing on only persons, the unsafe act of the individual is uncoupled from the systems context."

Other General Factors

15.43 There are other regional and national influences mentioned to me which are beyond scope of this report, such as the no redundancy policy and the number of, and variation in, health boards and support services and the variable degrees of collaboration among them. Concerns were expressed about the amount of time and money invested in the supporting infrastructure.

16. Possible Causes: NHSH and the Highlands

Geography and Scale

16.1 As I mention above, there are also factors which are likely to be unique or specific to NHSH. I explore some of these in this chapter, starting with geography. The area covered by NHSH is a vast one and very diverse (41% of the land mass of Scotland; possibly the largest area covered by any health body in the UK?).

16.2 A senior employee commented on "a service under pressure":

> "There is no doubt that NHS Highland feels like a Board under great pressure to achieve a balance between acceptable quality, performance and financial outcomes across a large area. It is neither a large but geographically contained Board nor a small island Board and is a difficult challenge to achieve satisfactory outcomes for all populations across all three of those domains. It is my view that as a consequence staff, patients and the public are left feeling dissatisfied with what is achieved/not achieved. That is expressed by the public in their dissatisfaction and mistrust with the way services could be restructured for the better eg in Skye and Caithness. Inevitably this has an impact on staff in both remote and central services."

16.3 To this he added observations about "a workforce under pressure":

> "Trying to keep up with larger boards whilst operating across the geography of a rural Board is a significant challenge. The economies of scale available in a large Board to do work do not exist, which when added to travel across distance places significant pressure on staff/services both clinically and managerially. That said NHSH has a dedicated and innovative workforce that in my view is committed to providing the best service it can for each and every patient."

16.4 The national and political context in which NHSH sits is reflected here:

> "Any actions by NHS Highland Management have to be seen in the context of the national picture, with huge pressures on both primary and secondary care, some the result of fiscal pressures but many resulting from workforce shortages. All Boards face these pressures but it is clear that the further north the Board, the more significant the workforce pressures become. Over time, these pressures have increased. In NHS Highland, the pressures of sustaining the service to remote geographical locations have not been helped by party political pressures as well as the pressures from politicians who have remote constituencies. There is an impression that these pressures, and what some might describe as a bullying culture, start in Edinburgh and perhaps the way that chief executives are treated by their superiors gives some of them a comfort zone in dealing with their subordinates in a similar manner."

16.5 A team lead in a more rural setting said this about the adverse effect of location:

> "At the highest level we have a government which is advocating financial prudence and value for money and rightly so; however there is no allowance made to rural health and social care boards for the higher cost per person in delivering these services. This immediately places a relatively greater financial burden on rural health boards and their senior management team. Rural areas are also struggling to attract clinical staff adding additional costs to already stretched budgets. I do realise that city and urban health services are struggling too but wanted to highlight the additional burden NHS Highland has in comparison."

16.6 The effect on communication may be marked:

> "However, perhaps NHS Highland faces additional challenges with staff spread across such a large area counting against face to face communication and visibility, certainly at board level."

The Highlands

16.7 The following further factors have been suggested to me:

- NHSH is the largest employer in the region
- the relative insularity of the organisation geographically and culturally as distinct from other organisations

- there is no alternative NHS body in the area to which disaffected or unhappy employees can transfer – *"leaving is not an option"; "being a monopoly employer in the area prevents staff finding easy employment elsewhere"*

- there is little opportunity for career progression, so people are very protective of their position and tend to hang on to their jobs for a long time: as a result, norms develop which can allow 'the unacceptable to become idiosyncratic'

- lots of promotions are due to reorganisation and posts are not advertised externally where better candidates could possibly be found

- it may not be so easy to attract staff from elsewhere; there is a smaller pool of potential staff and some may be over-promoted

- lack of leadership development and management training means it is "dead man's shoes" – even if they have aspirations, *"people are sitting and hitting their head off a brick wall. Little things become more important and have more currency, as does history."*

- staff are often related to one another and conflicts of interest can arise

- people tend to live and work in the area (and even one department) for many years and are committed to it culturally, socially and economically so that the workplace can assume great importance as a community

- preservation of jobs, livelihoods and status in the community is very important at many levels

- communities are smaller and more tightly knit, people know each other, memories linger, trust may be harder to build; conversely, the fact that everyone knows everyone can be a positive – bringing more closeness and understanding rather than anonymity

- NHSH staff, especially doctors, are very visible in communities and influential in how they represent NHSH: a "goldfish bowl" as it has been described

- there is a *"culture of silence"*; in the Highlands, folk are more reticent about coming forward; ironically, it's also *"very gossipy and if you don't join in you are seen as an outsider"*

- there are stronger religious affiliations than in other parts of Scotland

- there may be tensions between those who stay and those who leave - and those who are perceived as "incomers" with a different view of the NHS from those who are local

- NHSH can be viewed by some as a modern institution, different from "the Highland way"

- there have been big population changes in recent years: Inverness is apparently one of the fastest growing cities in Europe

- Raigmore is a disproportionately large, somewhat anonymous, even oppressive, facility and attracts news stories

16.8 One person summed it up as follows:

"There's a thing about Highland, it's not like the Central Belt. When people get good jobs, they tend to stay in them for a long time. There are a lot of individuals who have been in roles for a long time. Our recruitment process is that we can't replace people. There's a worldwide shortage. When you're competing with the Central Belt and the opportunities there, it's difficult. People come here for a lifestyle choice. They see potential in our HQA and links to the university. But I think that whole dynamic is an issue."

Many Positives

16.9 At the same time, I am told that high-quality people are attracted to NHSH and often come to the Highlands because they want to live and work there. I understand that Inverness has been ranked very highly for its quality of life and has been described as the happiest place in Scotland.

"When friends and family ask me what is it like working in the Highlands? I invariably reply – "It's like being on holiday but going to work through the day". I really like living and working here."

16.10 For some, uniqueness works well:

"Across NHS Highland, notwithstanding some of the complexities I have described, the vast majority of working relationships are really positive. My experience is there is much mutual goodwill, respect and commitment across the whole board area, and would suggest there is much that is uniquely positive in NHS Highland."

16.11 As ever, there is a need for balance and an encouraging view comes from another senior consultant:

"I would like to highlight some of the others positives of working here. Since August we have been working on NHS Highland based senior medical training, this is mushrooming with many trainees keen to stay in Inverness due to the clinical experience, teaching experience and opportunities here in Highland. We have increasing strengths in research and development and the introduction of new undergraduate curriculums all of which have been positively received."

Insiders and Outsiders?

16.12 Diversity of origin seems to be an issue:

"Differences even between Scottish staff, eg Highlanders and Lowlanders, East coast and West coast. Inherent nature of Highlanders (to feel put upon, taken advantage of good nature and gentle ways) ousted by others (Highland clearances and now 'incomers' buying up property, changing the community dynamics). The sense of being 'taken over', 'outsiders can do it better'."

"Been thought of as slow and stupid." "Lack of respect for the locals."

"These issues are not being raised for fear of being seen as racist, prejudiced, unwelcoming. 'Need to be careful when you ask where someone is from'."

16.13 These remarks capture the impact of behaviour regarding "out of area" staff:

"Although the publicity so far appears to concentrate on bullying coming from senior staff one must also be aware that there is another form of bullying which has a detrimental knock on effect right across the Organisation. Although there are many good and kind staff working within NHS Highland they are afraid to speak up against a small portion of staff who were not only resistant to change but disliked/ resented any staff who came in from out-with the area particularly if placed in a more senior role. If their behaviour was challenged they became offensive, intimidating or made claims of bullying, therefore creating a situation in which the person they accused would lack credibility if they tried to defend themselves or made their own complaints."

16.14 Some of this has to do with language:

"Misunderstandings in language, the way people talk, phraseology, terminology, manners. Misconstrued as being 'bossy' or arrogant just by different mannerisms and ways of speaking."

'Lots of different accents', 'hard to find someone local'. 'Quite a few 'foreigners' from different cultures and religions'.

"Communication issues, misunderstandings in ways people speak, their delivery might sound angry or rude, but is just the way they talk. Highlanders tend to be soft spoken, polite, sometimes speak slowly, can sound laidback."

Communication

16.15 As ever, many issues come down to communication within and throughout NHSH. As one member of staff observed:

"Communication with staff tends to be on a need to know basis. Changes made tend to be done with little consultation and an expectation that they will not be questioned even if problems are experienced by staff or patients with the changes. It appears that questioning decisions even if it's just to gain information is seen as disrespectful and reacted to badly. Simple things like changes to tone of voice, a certain way of answering etc gives the impression to staff that they are being scolded and there is a definite treatment of staff that mimics a parent child type relationship. This authoritarian way of dealing with people is certainly not the way most adults want to be treated at work."

16.16 As one respondent suggested, NHSH would benefit from having a clear direction and momentum, strong clinical engagement and financial realism which comes from more effective organisation-wide communication. I am told by others that communications systems are not "fit for purpose"; that all user emails do not reach (some) GPs, electronic communications and newsletters are not read and digested appropriately and "verbal cascade is patchy".

16.17 A senior nurse observed:

"Senior management wouldn't be known by my staff if they tripped over them in the corridor. They are not physically present. Things being done to you and not with you. That's what I mean by communication issue."

Rural Communities

16.18 As noted above, the geographic element has its impact in rural areas. Generally, I heard a number of reports of people in small rural communities being affected by the behaviours of management both locally and centrally. There is a feeling that communities themselves have felt bullied because of promises made and not kept, giving a feeling of being lied to and deceived. Although the evidence is variable, there is a tangible sense that some rural communities feel undervalued and let down by "the centre".

16.19 Poor communication and lack of appreciation/ awareness by the centre, in this case "those folk in Inverness", seems to be a theme. One senior manager commented: *"There's quite a distance. And we're only five minute's walk away. How must it feel for someone living in Ullapool who must feel very disconnected."* It was pointed out that urban health care solutions may not work in rural locations.

16.20 The divergence between Inverness and the surrounding area and the more distant rural communities can seem marked:

> "Inverness and the Inner Moray Firth have been transformed in the last twenty years while the outer remoter geographies remain the more vulnerable due to loss of industry, vulnerable rural economies and a changing demography. This can make the design and delivery of services uniquely challenging, particularly when we take the importance of place to the communities we provide services to."

16.21 This from one very rural GP reflects a view I heard on a number of occasions from people who feel on the periphery:

> "I am afraid that after the false promises and time that has passed, I do not trust NHS Highland management." "The truth has been twisted throughout this time and I have been badly treated by NHS Highland. I feel as though I have been led on by NHSH management, but ultimately they have turned round and kicked me in the teeth."

16.22 Another GP practice in a remote area (salaried PMS) spoke of a letter informing them of a large cut in budget coming *"with no warning, no personable covering letter and made no allowance for our circumstances"*. They were told to submit a practice plan of how this would be achieved, which they did but subsequently some seven months later, they eventually

> "received a copy of a rather meaningless letter ...which basically said that we didn't need to bother after all that! We did not even get a letter addressed to us. This second-hand response in no way acknowledged the stress, worry and work that the original letter had caused us and by not even writing to us directly is treating us with contempt. We feel that this was intimidation on the part of NHSH trying to squeeze money from our Practice as a soft and easy target. There was no discussion with us but a complete lack of understanding of our situation and a woeful lack of sensible or respectful communication or indeed any communication to our original plan that we had submitted."

16.23 It is well known in the Highlands that communities far removed from Inverness can feel isolated. It takes hard work to acknowledge that fact and provide the necessary recognition and reassurance.

Social Care

16.24 I note also the effect of the integration of social care which is unique to NHSH. It appears that the integration of social care has been a particular factor of concern.

16.25 One respondent opined:

> "Adult social care was a glass bowl from Highland Council to NHS. It shattered, we cannot pick up the pieces...I would say the bowl being smashed has put an enormous burden on an already overburdened system."

16.26 Whatever metaphor is used, it certainly seems to be the case that integration has placed significant strains on an already stretched organisation and at a time of reducing resources.

16.27 There seems to have been and may still be significant misalignment between expectations within NHSH and Highland Council over social care, at least in some areas.

> *"Being managed by someone that does not know or understand job role, comes from a different background. Most obvious when Social care and Health care joined forces." "This profession has*

had a bit of a hard time with managers put in due to integration, who do not understand the profession."

This aspect is beyond the scope of this review but may be important to address.

Importation of Ideas from Virginia Mason Hospital in Seattle

16.28 I heard comments about the appropriateness, effectiveness and transferability of management ideas from the United States. I am not able to comment specifically but wonder to what extent the importation of ideas from one culture to another may have had an impact on NHSH's ability to deal with some of its local issues.

16.29 The impact may be marked: one senior consultant commented:

"NHSH has followed the ethos of the Virginia Mason unit in the USA. Our managers have visited Seattle many times, as recently as November 2018 at significant cost to NHSH. Forming a large part of the Highland Quality Approach, success in Seattle followed confrontation with clinical staff and the active reduction in engagement of clinical staff in hospital management. NHSH has followed this trend and reduced the influence of working clinicians in decision making. Individuals with an alternative viewpoint are marginalised and ostracised and have no recourse to the decision-making apparatus. This has been a management tactic ..."

16.30 It is easy for the enthusiasm for a new idea to prevail over the discernment needed to apply it in a way which takes account of local conditions and of changing priorities and pressures. Indeed, having committed to it, with substantial sums of money having been spent and with saving face a possible issue for the proponents, there may have been resistance to challenge on, and review of, these matters. If so, and in any event, it may place in context some at least of what has occurred.

Highland Quality Improvement

16.31 Related to this, it seems that those responsible for programmes to enhance staff and team performance experienced the cognitive dissonance of promoting values and beliefs which were not being implemented in practice by the very people who were supposed to be leading on them. I was told there was emphasis on implementing policies but without empathy, honesty or openness.

16.32 It has been pointed out that there may have been over-reliance on the technical aspects of improvement without the focus on creating the culture and conditions for quality and safety to flourish at the frontline. Quality improvement would be seen as a method that can be used at board level rather than as a method that required distributed leadership and clinical/managerial engagement in owning the services.

16.33 This is reinforced in this comment:

"There was no time for leadership from senior staff, who were too busy with day-to-day staffing and admin issues, strategic planning and meetings, and did not work with or understand the Band 5 staff's individual roles. Consequently initiatives such as QI were poorly understood on the floor, people, morale was low, and the stronger personalities were allowed to ignore processes that they did not like."

16.34 I was told that:

"The rhetoric within the Highland Quality Approach was merely that - we ticked boxes and encouraged a chosen few to pursue ambitions which often left them burnt out because of too great expectations placed on them."

16.35 A director expressed this view:

"Over-emphasis in past 5 years on financial targets dressed up as quality improvement. This message hasn't worked and has in fact created distrust."

16.36 That said, there are mixed views (*"Some love it, some hate it"*) and perhaps there is still real potential under thoughtful leadership.

Collective Trauma?

16.37 I was interested to note that, during my review, the media reported on a research paper which was published by NHSH which apparently attributed some health problems in the area to the inter-generational impact of the Highland Clearances. Whether that is a factor which would be relevant to this review is beyond its scope, but the very existence of such a view does

highlight the fact that there are unique aspects to this part of the world, some of which are not easy to speak about. Indeed, as I conducted my review, I became aware of the importance of research on epigenetic, transgenerational implications of trauma and its aftermath. I explore the issue of trauma further later in this report.

Some Specific Observations about NHSH

16.38 That NHSH is marked out as different is underscored in the following remarks, which tend to corroborate and expand upon some of the factors above, from a member of staff who has experience of working elsewhere in the NHS. Again, this reflects views which appear to be fairly widely held among those who engaged with the review. This employee feels that *"there are some stark differences in NHS Highland and the culture, specifically with regards to the management of staff."* In outline, these are as follows:

- "NHS Highland has a very insular feeling to it. Everyone knows everyone else, they have a history or are friends. This is made clear to staff. This means that should you have a problem or worry about a situation with your manager then you feel like there is no one else to go to. If you speak to someone senior, then this would be raised with the manager and discussed in what I would call an 'unprofessional manner'. By this I mean it becomes a personal attack on the person rather than a professional discussion about an issue.
- This leads me to my next issue, a lack of confidentiality between managers and staff. I will use an example I have witnessed to explain. The individual had applied for a job and informed his/her manager as per the usual process when looking at changing positions. However, the individual was the congratulated on getting the 'new job' by another member of staff the same day, interviews had not even taken place. It was a case of this individual's situation being discussed outside their confidential meeting with someone else. Though not related to bullying this has now created the feeling that information shared with managers is not confidential. This has broken the trust between staff and managers and made individuals feel as though they cannot speak openly to their manager for fear of who else this may be shared with. This creates isolation and leads to people keeping quiet about many things for fear of how this will be handled.
- Gossip – I have heard managers gossiping about other staff, passing what I would call derogatory comments and making their feeling of dislike for the staff quite clear. I also relate this to the point above, staff's private situations and discussed with other staff members who are their 'friends'. A level of gossip and chatter amongst staff, especially junior staff is common, and when working in close quarters you are inevitably going to overhear things you would rather not or shouldn't hear. However, when these come from managers and staff are seeing managers gossiping, it creates a culture that this is unacceptable.
- Discrimination - I feel that processes/ policies are implemented for certain staff when they feel the need, but this is not uniform across all staff. I have witnessed in certain situations staff are asked to take annual leave whereas others are offered compassionate or special leave, sickness policy implemented with some staff and not others despite these staff having significant sickness. This inequality between staff leads to low morale and bad feeling between staff. This feeds into the gossiping and that circle is continued.
- Lack of support – generally my feeling is that there is a lack of support for staff. There often seems to be a lack of management in office, a lot of staff complain about a lack of induction and this creates problems going forward, it also makes staff feel 'neglected' and unsupported. Staff needs in terms of supervision is limited and supporting staff development and growth is not a focus of management. There is a lack of career development and minimal support for staff in seeking these opportunities.
- Communication is poor at all levels. Concerns that are raised never seem to be fully appraised and what I would call 'placating emails' are sent to try keep staff happy for the interim. This makes challenging issues difficult as you have followed process and nothing has changed or been actioned, a dead end is reached."

16.39 A well-informed respondent offered these views about some of the causes:

- "There is a clear disconnect between the top of the organisation and the service delivery parts of the organisation.
- Lack of clear direction for departments, with lack of clarity about budgets and resource constraints

- There is no clinical strategy. This translates further down the organisation as a lack of clarity about what NHS Highland should or shouldn't do, will or won't provide.
- There is a weak clinical voice at the top of the organisation.
- Reactive approach to issues is commoner than pro-active; this starts at the top and is replicated down through all of the organisation
- Crisis management causes an increase in likelihood of interpersonal conflict or bullying.
- Lack of ownership at department level of issues/ problems/challenges.
- Ineffective or under-effective organisational meetings structures, and people attending them do not properly represent or participate, people attend unprepared and uninformed.
- Behaviours. Many people do not behave well in meetings. This applies across the board. The underlying cause of this is a mix of personal conduct, poor chairing and a lack of defined proper behaviours.
- Managers are given responsibility for department performance even though it is invariably clinical outcomes which are being measured.
- Learned helplessness of clinicians at all levels but most importantly at senior level.
- Incomplete leadership structures in hospital plus vacant management posts, high manager turnover, eclectic/odd management portfolios."

Contrasts with Other NHS Bodies

16.40 Finally, the view that the experience in NHSH is different from elsewhere is reinforced by others:

"Appalling, environment toxic, people could do what they wanted, disjointed, so unlike other NHS bodies, much worse, no collaboration..."

"I now work for [another NHS body in Scotland]. I am confident that if these behaviours occurred there they would be called out for what they are and would be managed."

"I have observed the management culture within Highland and contributed to quality management reviews in Boards throughout Scotland... This experience tells me that while NHS Highland may not be alone in having problems of morale, the gulf between management and clinicians within the Board is deeper and wider than I have seen elsewhere in Scotland."

"I have faced stressed/upset/angry/depressed colleagues throughout my career, both as a registrar and in my current post amongst more senior physicians. But in the Highlands, and only there, did I see many of them slowly change over the years. Their posture changed and they developed this shell shocked, wide-eyed look about them and clearly didn't know which way to turn anymore."

16.41 The problem was summed up by one NHSH employee in a rural area with personal experience both of bullying and unsatisfactory treatment for a family member:

"With all the bullying allegations, recruitment problems, stress and pressure on staff within NHS Highland one has to wonder if the shortage of staff and ridiculous waiting times within some departments are a consequence of these long term problems within NHS Highland and is due to the style of management and an inadequate board who are unwilling to listen or adapt. Potential new staff will not apply or accept a post within a region with a poor reputation and bad treatment of staff. Word of mouth is very powerful in more rural areas."

16.42 A full time official for one of the Trade Unions wrote to me about his experiences of NHSH:

"On a general point I do sigh when I hear that a member has a problem within NHS Highland as I know it will be a long tortuous process. There is clear evidence of unnecessary delays in any investigation process and with issues around bullying and harassment it means that, regardless of any outcome, the professional working relationship is beyond repair. Highland does have a raft of policies the same as any other Health Board, however it is a continuous fight with management and HR to actually follow these policies. In particular timescales are drawn out whereby investigations take place 9 months after allegations of bullying have been submitted in writing, no one is trained on a particular policy (Gender based Violence), members do not hear about a complaint that has been lodged

> 4 months prior, contact with managers and HR are ignored and often members and myself are passed from one person to another and even then the answer that comes back is inconclusive. This always leads to an escalation and lack of faith in the Board to deal with anything....

He concludes:

> "In my role, I cover the whole of Scotland for the last 17 years, I have had to deal with more allegations of bullying and harassment in NHS Highland than all the other health boards put together."

16.43 I pick up the themes of the management, board and HR in subsequent chapters.

Last Word?

16.44 On the peculiarities of NHSH, this was offered as a summing up:

> "I love living in the Highlands and have enjoyed working for NHS Highland, however it is struggling both financially and staffing wise. In all areas, ageing staff are retiring, recruitment is difficult and remaining staff are struggling to deliver a service with fewer resources. People become stressed and frustrated so it's easy to see why these allegations come about."

16.45 For those who wish to look forward and rejuvenate the organisation and enable its staff to flourish, these words should not be a conclusion but a challenge to change things for the better.

17. NHSH as a Dysfunctioning Family

17.1 One senior member of staff described the situation eloquently with a family allegory which I am authorised to share:

"I would describe the current leadership crisis in NHS Highland to that of a dysfunctional and distressed family. The adults (Executive team) over the years were often distracted by the acquisition of wealth (operational area/budget/staff or professional group represented) and status (Highland Quality Approach). The parenting style is in the main, chaotic disinterested in the children (staff) and authoritarian as required. The extended family of aunts and uncles (non-executives) are variously concerned and troubled by the behaviours of the parents but lack the confidence to challenge, it is easier to acquiesce, recalling what happened to some who previously raised concerns and who chose to leave.

The various children (staff) serve a purpose when they meet the needs of the parents, particularly when they do this without challenge, even if this involves ignoring the dysfunction and power play. While the older children (senior managers) are left to manage the day to day of the little ones and if they do harm no one is really that interested, just so long as the needs of the parents are met. Sibling (staff) pressures and relationship challenges are not well understood or well managed. The more vulnerable or smaller children have been known to come to harm. No one is really that interested, as long as no one outside the family gets involved. No one looks for this, as there are likely to be consequences. A child every so often might be picked for special attention, particularly if they are attractive in some way to the parents. They might be given special opportunities and privileges, unless they cross the parents in which case they can fall from favour. This can be a very unpleasant and isolating experience. Some leave, others find a place to work at a distance from the parents, out of sight and mind.

The parents at times, can overstep the mark with inappropriate parenting styles that can leave some of the children in day to day contact with them really quite vulnerable (administrative and clerical staff). No one takes action to address these indiscretions and those affected have small voices and no power. Some manage to get away, others stay and somehow get by, but at a cost to their wellbeing. Few seem to notice or care about this.

No one is really interested in naming or addressing these issues. Even when there are family meetings that children are fearful or anxious about attending, because they do not want to be ritually humiliated, or left exposed by the parents if they have not met their needs in the moment: too complex and risky because some of the parents will not allow or tolerate dissent. Somehere / somehow, the parents with less influence are distracted and caught up with meeting the more important needs of the more powerful. They can be vulnerable and needy, even tearful at times, especially when the pressures of parenting a large family become too much.

The wider family (Scottish Government) might, or might not, be aware of some of the difficulties/ challenges in the family. They might have tried to intervene, offer some relationship support, however they have found it is easier and safer to appease rather than follow through with more formal measures. The consequences of following through are seen to be too risky and too great for the wider reputation of the family at large. Some personality/relationship dynamics do not lend themselves to mediation, which requires a willingness, capacity and a mutual desire to understand and redress harms done. For some, this is just too threatening or exposing to entertain and those involved are made subtly, or not so, aware that if this is required there will be a price to pay."

17.2 Again, the challenge is to change the setting, the relationships and the responses so that the family begins to function again in a psychologically and otherwise mature and safe way. Some of the issues which arise are covered in the next chapter on management roles and behaviours.

18. Management Roles and Behaviours

Introduction

18.1 I have found this and the following chapters among the most difficult to write as so much of what I heard in my review focussed on perceptions of inadequacies in management throughout the organisation. I am sure that there are many sides to this and, while I seek to capture some of these here, I am equally sure that those better informed than I am will be able to identify other aspects to this and indeed point to misunderstandings on my part. So be it. This is a contribution to be built on.

18.2 I have sought to identify specific areas in connection with which concerns have been expressed and where many managers and others have felt unable confidently to carry out their duties. The views expressed here also help to explain why the concerns about bullying have become so prevalent.

18.3 At the outset, I am concerned that many of the difficulties experienced in recent years in NHSH are said to be attributable to a management style which has not been effective in the challenging circumstances of the modern NHS. This poignant summary captures much of what I have heard about the management of NHSH:

> "I've just left a meeting where a colleague I hold in considerable regard has effectively collapsed as the ineffective organisation and culture in the … management team leaves him vulnerable to a colleague who can only 'react out' rather than face their weaknesses. This person already has an unresolved staff issue with a team member off work … because of ineffective systems to manage them out of the service. He now faces another charge of bullying that is unlikely to stand scrutiny.
>
> This is what plays out in real time when systems… are managed by people who lack the insight and perspective to manage well. In effect, a collective failure of both leadership and management. Where individuals who are unable to deliver the tasks required of their role are chronically undermanaged because they create fear and confusion for their managers. They perpetuate harm on others as the only way they can stay 'safe' is to 'kick back.' It becomes a tangled mess of chaotic if not bullying behaviour, culture and practice with judgements of Solomon required to make sense of it.
>
> I do not think it unreasonable for civil servants, senior managers and directors to be able to demonstrate such awareness, skill and competence in managing these scenarios.
>
> It bothers me to watch these situations play out in full sight with an organisational culture of inertia as to how to respond. Something needs to fundamentally shift for NHS Highland to move on. We diminish service delivery and perpetuate harm on the majority when a minority in positions of power and limited awareness (insight, integrity, perspective, compassion, empathy) hold sway."

These are telling words. I explore aspects of this "fundamental shift" in a chapter on leadership in the final section of this report. Meantime, I explore further perceptions of the current situation in this chapter.

18.4 More simply, perhaps, one specialist in Raigmore Hospital emphasised that poor management rather than bullying itself may be a significant cause of the present situation:

> "The greatest issues which have been expressed to me by colleagues in medicine in Raigmore Hospital…is of poor management of bullying, and staff not being listened to. I think the consequences of poor management may well outweigh the distress caused by the initial bad behaviour….staff feel they have concerns and these are not registered or understood. This could be because the options which they wish to follow are not achievable or are unrealistic, but without documented reason, and/or registering of the decision, individuals seem to feel disempowered and undervalued. This then affects teamwork and morale. I do not think this is an intentional policy, but may to some degree be a cultural or historical issue."

Concern about Senior Management

18.5 I need to record that a significant number of respondents expressed concerns about the role of senior management and its ability to recognise and address the issues which have arisen in connection with inappropriate behaviour in recent years. Some senior managers are viewed with suspicion and resentment. I have had concerns expressed to me about a number of the director level executives and their ability to function coherently, individually and collectively.

18.6 I do not go into detail but I am told that many people feel that, unless there are changes at that level, much of what has been occurring will continue. That may be associated with a view that executives *"are not visible, rarely at the coal face. Who are they? Disconnect, not understand, done to not with".* "Done to, not with" is a telling remark. It signifies the feelings of a large number of those who responded to the review.

18.7 A commonly held view is expressed thus:

"Many believe the senior medical leadership are complicit in the development and maintenance of the ongoing issue of bullying within NHS Highland and it is perhaps inappropriate for them to be leading on the restorative work that will be so very necessary going forward."

18.8 I comment further on this in my proposals for the future. Clearly, a demonstrable change in leadership is necessary and has, of course, already begun.

18.9 An employee in a rural community commented on the perception that this is a pervasive tendency:

"NHS Highland management were more than aware of multiple policy failures and continual breaches of them. They allowed for multiple staff member(s) to repeat the same as the staff member(s) before. NHS Highland management themselves became bullies and harassers by isolating me and by covering up the bullying and harassment that I was subjected to for so long. They have tried to cover everything that had happened up and tried to encourage me to just forget all about it. This was not limited to just the .. original bullies/harassers named in grievance one, but by all the management involved, right up to senior management; I was passed around from pillar to post, told conflicting and contradicting information each and every time. It has all been a horrific nightmare and sadly I don't believe I am the only staff member in which has been subjected to this kind of behaviour."

To be clear, I offer this view not for its factual accuracy but for the perception it expresses, in the hope that doing so will help in the healing process going forward.

18.10 Describing intimidation, fear and reprisal against NHSH staff in a number of settings, a GP told me (prior to recent senior changes):

"I fear that unless those few individuals in Senior management are called to task over their behaviour and leave their posts that nothing will change. The fact that until recently they denied there even was a problem but are now wanting to meet together to improve things fills me with despair that by pretending to work together to solve the problem they will be seen in a different light."

18.11 Perception is so important as I discussed earlier in this report. Making a few superficial changes is unlikely to be sufficient to restore confidence.

18.12 One director astutely summarised the position:

"If I managed people the way I'm managed then we'd be in a lot of trouble."

18.13 An experienced team leader wrote in these terms:

"Within the HSCP we have a few senior managers who have what could be described as an autocratic approach to management, I have personally been in meetings where there has been an audible gasp from the room when someone has challenged ideas put forward by certain senior managers. Some seem to revel in their public image as cold and ruthless managers which negates any 'open door' policy they may profess to have. There also seems to be a lack of clear strategic planning with many decisions being made hastily in response to the latest reports of potential quick fix solutions. As a result, the overall image of senior management from the clinical staff is one of ruthless determination to make saving at any cost."

18.14 Autocratic, fearful to challenge, ruthlessness, lack of strategy, undue haste: these are all powerful images which reappear in later chapters. Further concerns and the effects are captured in the following paragraphs.

18.15 An occupational therapist described the situation in this way:

"Although I do not feel bullied as an individual, I do have to engage with processes and systems which I find uncomfortable both ethically and professionally. Many systems and processes are being introduced which are not effective and have a detrimental effect on clients, service and staff. I personally feel that it is incompetent senior management and the lip service which is given to consultation and feedback from front line staff which is the problem. Senior management seem to devise systems which as well as not being effective, waste resources and staff retention and recruitment are a major issue."

18.16 A long-standing clinician said:

"… you should be aware that these issues have had a very significant detrimental effect on patient care and in my case have also impacted on my own health and personal life. I think there are two main problems at play here

1. Dysfunctional management structure, with very limited clinical input to board level.
2. Behaviour and attitude of senior management.

I think this combination has resulted in a disconnect between the front line staff and senior management leading to the former feeling disenfranchised and powerless at best. I have been a consultant here [for many years] and can honestly say how saddened I am by the current state of affairs."

18.17 Another long-standing observer, this time a GP, described experiences and observations of mishandling of complaints in this way:

"Perhaps the institutionalised incompetence and arrogance has led to a rise in bullying. As I said – I have never seen it. However, I have seen a progressive deterioration in what was once a great Board to work for, to a Board that does not care about its staff."

These words capture the underlying nature of many of the concerns about a deterioration in management and governance which many have experienced.

18.18 This from a now-departed consultant bears upon the bullying allegations:

"To conclude, I believe that NHS Highland has a leadership culture which does not wish to hear views which differ from its own. It gives privileges to those who say what they want to hear and it is willing to allow people with hierarchical privilege to abuse their position. Lastly, the managers of NHS Highland do not know how to recognise or to address bullying when it occurs in the institution."

18.19 The impact can be serious and the implications resonate with the findings in this review:

"It is very hierarchical and senior management (above grade 8B) are always believed and supported. This leads junior staff to feel too scared to raise concerns. Any concerns are dealt with through a formal process of investigation, when a more informal conversation or approach could foster better relationships.

There is reluctance to challenge or deal with people like x because it will take so much time, cause major disruption to senior management and would perhaps encourage more staff to make complaints, taking more time.

This leads to people behaving like bystanders, almost glad that it's not them or hoping that the situation will resolve itself."

18.20 Some of these concerns are picked up elsewhere in this report; I am mindful for example that these points could equally arise in the earlier chapter addressing why people feel unable to raise concerns.

18.21 The problems with the management culture are summarised here:

"I've worked for the NHS for [many] years now… Over the last 10 years, I've seen significant changes in the behaviour of senior management, some of the attitudes towards staff has been of a bullying nature. This 'top down' attitude has become more prevalent since HSCPs were established legally, I fully appreciate the financial pressure however that does not, nor should be an excuse for treating staff so appallingly. It's almost become an accepted organisational culture, primarily because staff do not feel able or willing to challenge it.

Staff morale everywhere is the lowest I've ever witnessed. I am aware of a few individual

members of staff who have spoken privately about being subject of inappropriate behaviour. Some have been close to submitting formal grievances however they have been worried about the ramifications of doing so to the extent they have either sought employment elsewhere or they just learn to tolerate it which does little to encourage people to perform effectively or indeed support their health & wellbeing. In one instance, a member of staff felt 'leaned on' to prevent a grievance being submitted.

This was quite a common tactic used by NHS management: they isolated one person to discuss an unpopular decision and then went silent until everyone involved simply gave up."

18.22 It is difficult not to conclude that a new "management culture" is essential if NHSH is to thrive and the behaviours and effects experienced by many are to change.

The Medical Director

18.23 The role of Medical Director is clearly a pivotal one. As one respondent put it: *"...a Medical Director is a highest link and connecting position between medical colleagues and the Board."* It is a role which requires sensitivity, confidence and real leadership, and a combination of skills and aptitudes which are not necessarily easy to exhibit. It is necessary for me to say that a number of specific concerns were expressed by a number of respondents about the way in which the Medical Director has handled matters over a number of years. These were summed up by one respondent:

"If I had concerns, I could not take them to the Medical Director."

18.24 The role has not necessarily been an easy one; as ever there are differing views:

"He's extremely well motivated. He finds it very tough. He's been wilfully misrepresented. Deliberate traps set for him."

18.25 The Medical Director has intimated his intention to retire and I judge it unnecessary to go into these matters in further detail. Suffice it to say that, in later sections in this report on the future and leadership, I describe the attributes of openness, engagement, listening, empathy and support that seem essential in the key management roles to take NHSH forward into the future.

Middle Management

18.26 Just as the workings of senior management are a matter of regular commentary by those with whom I engaged, there was awareness of the challenges for those in middle management roles.

"I've always had the sense that something wasn't quite right. This comes through in comments made, awareness of staff turnover. Sense that middle management are given tasks to implement without any sense they can be listened to. Command and control approach."

18.27 A retired consultant said:

"Hospital managers have a difficult task. Several competent and conscientious managers have been forced out over the last 15 years. Medical staff often don't hear the details until much later. One technique employed in NHSH is to create another tier of management and to hold the manager below you to account for failing to meet targets and so create a scapegoat."

18.28 One consultant, with many years working elsewhere in the NHS and who recognises issues in NHSH to an extent that he has not previously experienced, told me:

"Middle-management (clinical and service) are not empowered to effect changes and defer to senior management on the majority of issues. When combined with a lack of senior management presence (clinical and service) this leads to a lack of transparency and a feeling of not being heard amongst consultant staff. Service Managers continue to be given unrealistically high workload and only have time for fire-fighting. Service manager illness rates appear to be high with the knock on effect of covering for missing colleagues significantly impacting the remaining managers' workload."

18.29 From a rural GP practice, the impression of top down, command and control is reinforced:

"Our experience over that last 15 years has been of a good deal of incompetence, and a great deal of lack of engagement from NHS managers

with us as a practice. We have not found that management see their role as enablers of clinical practice, but of reducing budgets and meeting targets. This has produced a very negative culture in which it has been difficult to thrive.

It is my opinion that the middle management of the NHS in Highland are in general underqualified for the work that they do, and that although in the main good people they lack the experience in management to provide effective support to clinical staff. This means that decision making is often deferred, that lines of communication are indistinct and that the organisation is very "upward looking" rather than responsive to the opinions of front line staff. There is a "top down, centrally driven" culture."

18.30 The difficulties for local and middle managers were captured in this way by a director reflecting on a particular situation to illustrate a point:

"What respect does the clinician have for the local manager? They see them as administrators rather than managers. That poor local manager, who's trying to do the best they can, has a group of staff they have little influence over. The dynamic we have is that now is that every manager who has been trying to manage doctors thinks "oh hell, I have no chance now". Those middle-managers now feel completely disempowered. Anything they try to "force through" will be perceived as bullying.".

18.31 Another respondent was concerned that I should make clear that the voice of these managers needs to be heard in the current discussions. This further comment reinforces that point:

"That group of people – service managers – not senior people but do an important job to keep things together and making it all happen. Some of the hardest working people in the organisation who are asked to put up with a lot. They don't have a voice."

Vulnerability of Managers

18.32 This leads on to the issue that a significant number of managers who engaged with the review reported operating in circumstances in which they feel unable to manage effectively because of the uncertainties and pressures presented by the current situation. There is a real concern that allegations of bullying can be used to avoid or deflect appropriate management of performance and other difficult issues.

18.33 I mentioned earlier that many managers feel that the situation places them in a vulnerable position as exemplified by these remarks:

"Because NHS Highland is currently in the position it is in, the stance feels along the lines that managers must be at fault and need to improve as opposed to supporting managers who find themselves wrongly accused. I feel that I am a very vulnerable position."

18.34 Two senior managers expressed the anxiety of many managers that allegations of bullying serve to disempower them from carrying out their roles effectively:

"Managers and clinical/service leads within the NHS have a designated responsibility to keep others accountable for their work. If poor performance exists then one must address this as part of Clinical Governance. This would also apply to situations where there might be a lack of transparency about what a person is doing in their work – the leader or manager may need to ask questions to ascertain whether the working practices of that person need to be changed in some way."

18.35 However:

"I am concerned that I and others will now be limited or defensive in the difficult and challenging context for [this department] in particular and health services generally in having appropriately assertive, adult and honest communication for fear of being accused of bullying."

A Very Real Concern

18.36 Loss of confidence, disempowerment and distrust underline the linkage between cause and effect:

"I feel a significant amount of damage has been done and for those that are expected to provide leadership, support and application of organisational policies, there will I feel be a lack of confidence in the support that will be provided by the organisation where managers are applying policies and doing their best to manage difficult situations.

The biggest issue we are possibly left with as a result of the way in which this has been raised and handled is to rebuild a trusting and safe environment for staff to both work and manage in. We have significant risk and there has been a significant disempowering and shattering of confidence at senior manager and senior HR level in the organisation. This may add to the

current feeling of lack of direction which I think has caused the current situation."

18.37 A senior management representative captured the vulnerability of, and danger for, senior managers in the exposure which is now occurring:

"My concern about the complaints made against senior managers at NHS Highland is that they are public, would appear to be designed to name and shame the senior managers, to stigmatise them publicly, cause division, and encourage blame. There is no opportunity for the employees both those named and those associated to take the issues levelled against them and discuss and resolve them in a fair, open and adult manner.

There are very many excellent dedicated senior managers within NHS Highland, past and present yet they have been attacked without chance to defend themselves. This behaviour is profoundly unfair and I would hope if you are able to make recommendations about the importance of following NHS Highland policies and raise concerns with dignity, integrity and a degree of confidentiality in the first instance. We are concerned that there has been a tendency to use the media to attack colleagues in public. Staff side and management agree policies to enable better communication and manage expectations between one another and it is fairer to all if these are used. A future public shaming must be avoided. If employees feel they are not listened to by their employer then it is best to agree a secondary link with the Scottish Government where concerns can be escalated and acted on. The print and broadcast media is not the best environment for this at all."

18.38 It is important to recognise the significance of this contribution among all the comments and criticisms which I have been bound to record. The thrust of these comments probably provides the only sensible way forward.

The Future

18.39 Looking ahead, however, it will be necessary to find a way to address these complex issues. The serious issues raised in this report will need to be faced openly, directly and clearly. I discuss some of this in later chapters.

18.40 I was interested to hear the point of view of those who have operated within the current structure. The forward-looking approach of the following remarks is helpful to note and is indicative of the type of radical thinking that is perceived to be needed to create meaningful change. A consultant told me:

"There is a continuous thread of management inefficiency, bullishness and a culture of not listening and giving in to narrow tribal considerations. Only a root and branch reform of the management structure would be able to move this organisation from a 'blame the individual' to a 'just culture' where people can work with confidence and deliver the best healthcare possible to the local population."

18.41 A former director made a number of apparently useful suggestions to address suboptimal performance:

"The present deployment of the Medical Directorate is suboptimal in terms of cohesive working, clinical-strategy development and interchangeability of roles. Addressing these issues would strengthen the team and in turn bring greater robustness to bear in leading... At both territorial board level and at national level this network is currently functioning sub-optimally, due in part to inadequate or poorly timed engagement over issues of substance relating to strategy and delivery.

Furthermore, adequate investment in administrative support and communication could enable clinical staff to feel a greater sense of ownership of decisions made by their organisation and could be a vehicle for

reporting dysfunctional or adverse culture and/or behaviour which was not being satisfactorily dealt with by other (eg HR) routes and thus would provide an additional safety-net.

All along the health service continuum, from Parliament/Government right through to every clinician, one of the major factors which increases stress levels (in turn potentially increasing dysfunctional behaviour) is real or perceived inadequacy of time to perform tasks or deliver outcomes properly or satisfactorily. If NHS cultural values are taken seriously then there should be an onus to share or co-operate over the delegation of new work and tasks at all levels in order to establish how the additional capacity for implementation will be found. Such additional capacity can be found by either relinquishing another task, working differently or allocating more staff hours to the new task.

Establishing this as the **normal** modus operandi will reduce stress at all levels."

19. Management and Clinicians

Introduction

19.1 Linked to previous chapters, I am aware that the relationship between managers and clinicians is a critical one. It appears that the intersection in decision-making between management and clinicians is not working well enough and is a cause of much frustration and sub-optimal performance. Of course, many managers are clinicians who are promoted to the management role, perhaps without requisite training.

19.2 I do not feel that I have got fully to the bottom of how this affects service delivery and impacts upon behaviours but I have gathered the views of a number of respondents in this chapter in the hope that, by drawing these out now, something can be done to change the mood, tone and relationships for the better.

19.3 Generally, I heard from some clinicians who felt they were not valued, not respected, not supported in carrying out very stressful work, not listened to regarding patient safety concerns, that funding issues affected performance, that decisions were made behind closed doors and that they were undermined when managing staff issues. As we have seen already, and is further developed in this chapter, many managers are also under immense pressure.

Observations

19.4 The sensitive interaction of management and clinicians is captured here:

> "There are departments where clinicians have been under huge clinical pressure and have reacted in ways, which while not the most constructive, are understandable. They have been labelled as being difficult. Instead of acknowledging that these problems are structural national problems and not the fault of any group of clinicians, they have been rewarded by being managed, not by the most able managers available, but by the weakest. These difficult problems have now become critical."

19.5 A highly respected senior clinician told me that matters are exacerbated in NHSH:

> "At times I have found working in NHS Highland extremely frustrating and stressful, not because of the clinical work but because of the dysfunctionality of the interface between clinicians and managers and because of the lack of senior decision making and lack of clarity of decision making. One might argue that this is a common theme across the NHS in the UK but in NHS Highland there has been very poor leadership and lack of decision making when implementing possible solutions that would relieve some of this pressure."

19.6 Another clinician, who reported not being sure he had ever been directly bullied but had *"been ignored, side-lined and forced to work in a consistently negative working environment"*, went on *"....the combination of staff marginalisation in decision making, the lack of a clear clinical plan for NHS Highland and the 'head in the sand' approach to managing the clinical risks .... has gone on too long and I have found it tiresome and demoralising."*

19.7 From another consultant:

> "The bullying appeared to represent a top-down culture with a consistent approach to clinicians raising clinical concerns: isolating, marginalising and discrediting individuals coupled with reprisal actions. There were several examples of this leading to sickness absence followed by resignation.
>
> Managers used jargon like 'golden thread' and 'catch ball'. When they came to speak to us about the HQA and told us that 'patients are at the centre' it was one of the most demeaning things I have ever been told by a manager – why do they think we became doctors?"

19.8 Once again, the tensions created between clinicians and managers are highlighted in this contribution:

> "These [local area] managers are in a position where they have little decision-making power but are the link between clinical staff and the senior managers who can make decisions regarding services. It is become clear that many are choosing to filter information from clinical staff to avoid delivering 'bad news' and are

instead tending to report only good news. The result of this is that clinical staff are being told to implement 'top down' directives for service change and when it is clear that those directives cannot be implemented or made to work there is a reluctance to report potential failure and instead increased pressure is applied to clinical staff to 'make things work' often without the appropriate resources to deliver. In some instances resources have been promised to support service change and then been withheld with the clinical staff being berated for failure to deliver despite not having the resources made available."

19.9 This captures some of the broader issues already mentioned elsewhere:

"The pressure on Raigmore management to stay within a budget that some might say was always set too low, in the face of increases in activity year on year, has eroded the morale of both the clinicians and the middle managers. It has also resulted in a relatively rapid turnover in the individuals at the top of the management structure in Raigmore, many of whom have been able and hardworking people who have subsequently gone on to success in other jobs, inside or outside the NHS."

19.10 From one clinical department comes commentary about the increase in manager numbers, changes in structure, and destabilising impact:

"There was over 100% increase in managers during my time in Raigmore, decisions were becoming remote from clinical departments and managerial decisions were being taking without a working knowledge of the services provided or any detailed analysis to back up changes. I have and always will be an advocate for patients; I was regularly reprimanded for using the word and advised that the term was clients.

Over that period of time there was a regular series of poor leadership decisions, leading to negative service impact. It started to become clear that some of these changes were also having a financial impact. During this time the management structure was regularly changing: this caused, across all staff groups, a level of unease as decisions and directions were regularly being changed on an ad hoc basis ultimately destabilising the whole structure in many departments. Many of these changes had a clinical impact on patients."

19.11 A professional lead told me about lack of trust and integration:

"When I came in, they were on the offensive – senior managers and other professionals. I sit between the senior managers and everyone else. It's a difficult point – managers want to cost cut but want to increase efficacy with less resources, and the people on the ground dealing with that. Because there was so much distrust, which seems to have been repeated in other areas around Highland. Because of the geography, you can't help but have some fragmentation, but they have not learned to work in an integrated way despite locations. They have done a good job with what they have, but they got caught up in this."

19.12 A change in attitude is perceived; the language of enmity expressed in the following remarks reinforces the strength of feeling:

"For my own perspective, there's been a change in attitude towards the people working on the ground. Working on budgets. At some point, the staff become the enemy. The dialogue between staff and managers changed. It used to be about listening to what we thought – that's gone...They've stopped listening to us as professionals. If I have a professional judgment and it's not what wanted to be heard, it's closed off and you feel that you've done something wrong...Partnership working between senior management and nurses is gone. I don't trust them. It's not just me. It's about the way they try to manage me – I think I need to be empowered. I don't need to be micromanaged or feel intimidated by into doing what they want me to do. I'm quite a strong person – but it's what they do to my teams. By not developing them, by driving them into the ground. These are good, caring [members of staff]. They deserve better than to be run into the ground, retire, be on the sick. We need someone to work with us and not against us. We're not the enemy, we're their solution."

19.13 There is sympathy for managers placed in difficult positions:

"I recognise that the behaviour I was subjected to is in part related to the individual in question, but also acknowledge that he would be under pressure to maintain a service. For several years our consultant group have raised concerns to management about inadequate staffing to maintain a safe service. Inevitably, if rotas are

always stretched, then there is no resilience for unforeseen events such as prolonged ill health of a colleague and the impact on a department, without support from managers, may drive unsupportive or bullying behaviour."

19.14 Looking ahead, a senior manager expressed the views of a number of people in saying that:

"We still need to secure more clinical engagement and leadership. We are still challenged by increasing demand, limited capacity & difficulties in recruitment to key areas that are vital to the function of an acute service eg diagnostics. I remain positive this is a good place to work, with significant challenges but at the risk of being idealistic it is a time to come together not be divisive and critical of each other. Many of the clinical and management colleagues I work with are dismayed about the current situation, fearful of the future impact on attracting people to work here and worried about the impact of patient and the public's confidence in our services."

19.15 A consultant described problems in smaller departments and the need for better long-term planning:

"I feel that in the past there have not necessarily been adequate systems in place to ensure that any allegations of bullying are taken seriously and I think it will be important that this is the case in the future. From my perspective I feel that consultants working in smaller departments need to be given more of a voice to bring about change. In view of the recent lack of medical managers I have not really known whom to turn to help bring about improvements and in particular to raise concerns around patient safety issues. Time pressures mean that these issues are often not addressed in a timely fashion. The fast change over in personal of the service managers has at times perpetuated this problem as it can take time for them to understand the workings of the department. Financial pressures are often blamed for not being able to bring about change, but I feel better long-term planning is needed."

19.16 This probably provides a good reminder that systems, time pressure, lack of understanding, the financial situation and the desirability of strategic planning are recurring themes.

Addendum

19.17 I record here the views of one consultant on how matters might be improved; this may simply serve as a useful provocation of new ways of thinking:

- "Move to a GP practice model: give a department a budget and autonomy on how they spend it. Let clinicians make decisions and give them a good departmental administrator implement them. This allows those who are close to the needs to make decisions
- Get senior managers to attend departmental meetings rather than expecting service leads to go to the senior management to ask for something.
- Senior managers to bring an accountant to those meetings so there can be clarity about what is in the budget.
- Invite clinical leads to attend board meetings and speak to management directly rather than being filtered by another manager. It's easier for a clinical lead to speak up as they have tenure whereas a manager will be looking for promotion.
- With accountants and good departmental administrators, could probably do away with most middle managers who create extra layers of bureaucracy by reviewing clinical decisions where they have nothing to add.
- Treat departments consistently. Don't reward overspend and take away from departments that manage themselves better.
- Create job plans (time budgets for standard tasks) and use this as a planning tool across the hospital.
- Do away with … quality initiatives such as Highland quality approach and rapid performance improvement….. Replace with good departmental administrators.
- CEO to thank and appreciate staff as well as addressing problems. The job is getting harder and staff need support.
- CEO to visit the hospital.
- Consider the tone of CEO communications."

20. Some Broad Management Issues

Introduction

20.1 As one considers further the details of what is happening in a management context, the following extensive observations come from someone working as a departmental secretary. I repeat them here as this summarises many views I have heard and raises issues about job creation and protection, appropriate placing, redeployment, funding, overstaffing and bullying:

> "The main management tone is generally divide and conquer, belittle and undermine your staff so that they are too scared to trust anyone with their issues. You are made to feel that you are the only one with an issue.
>
> There has been a huge explosion in management, so much so that the people who end up in the managerial posts are often staff who don't know how to manage/don't know the job as they have come from outwith the NHS or are staff that another directorate is trying to offload (because as we know in the NHS if you are not fit for a job they create another one for you and move you along, more than likely with a pay rise to sweeten the deal). This means that once you are in a post and you can't cope with it or are just bad at it you can be redeployed or indeed request redeployment into any position that is equal in pay-band or below, you will be on a protected salary. This also means that someone who was bullied in one department can redeploy to a higher band as a line manager and then become the perpetrator and keep the higher banding.
>
> Jobs appear to be created out of thin air, to the curiosity of lower banded staff who have to struggle on due to lack of money to get the staff that are needed on the lower pay grades, only to discover that staff have been taken on elsewhere either in management roles that have no problem getting funding or on the back of Government funding, the problem with this is that when the funding runs out what do you do with the staff? They can't go back to the job they had as it has been backfilled. They are redeployed more often than not into a position that has been created, quite often managerial and not in the discipline they are trained for.
>
> If you count in all the "time saving departments" and their managers, there is a vast amount of overstaffing. Every manager is managing on a dog eat dog basis and protecting themselves and a job that either they are incapable of doing and should have gone from long ago should not even have as it was a created post as they couldn't be sacked.
>
> There is a mentality of protect their job at all costs and this is where the bullying comes in. It is their way or the highway. There is no listening to staff who are in post and try to make things easier for everyone. I am sure that a lot of the pressure is coming from higher up than my administrator and service manager and sideways from the peer groups who are also trying to cover themselves, which is where the link to the board and what has already been made public is."
>
> Bullying in NHS Highland is in the managerial DNA, there is constant pressure on bands 4 and below to get targets met, targets that are actually not of our making and can only be solved by paying consultants or other hospitals to treat the patients. These are actually to the benefit of the managers as they are paid bonuses for getting them met.
>
> At the end of the day it is the patients that suffer the consequence of this. NHS Scotland needs a roots and branches clearout of managers and the money saved diverted to where it is needed.. patient care."

There is much to consider and review just in these few paragraphs.

Appointment and Recruitment

20.2 I have been told repeatedly that there are significant deficits in the appointment, promotion, support for and training of managers at many levels, resulting in many unhappy relationships (for managers and those being managed), poor communication and unsatisfactory decision-making, which is likely to be costly in both staffing and financial terms. It is also likely to be the source of inappropriate behaviours which are experienced as bullying.

20.3 Recruitment to management is a recurring issue. This view from a mental health practitioner reflects the views of many who engaged with the review:

"Generally, I feel that management is poor in some areas, with people being recruited/ promoted into posts that they do not have the skills for. This has a direct effect on the service delivery to our patients but also to staff morale and sickness levels within services. It is difficult to recruit to some of the more remote and rural areas. Staff development is not a priority. This is one of the factors that affect our ability to recruit and retain people within NHS Highland."

20.4 The issues pertaining to appointment processes to senior positions arose on a number of occasions: According to a senior consultant:

"A number of senior medical posts within NHS Highland do not appear to be advertised to relevant staff. There is evidence that some of these posts may be created to favour key individuals in favour with senior management; those individuals are appointed to them without open competition. Together with the release of research monies this behaviour looks like patronage, and may be expected to buy favour or silence opposition."

20.5 As we have seen earlier in this report, favouritism is an issue of concern. This from a nurse:

"The lack of equal support for [Clinical Nurse Specialists] is profound. There is definitely a culture of apportioning blame, and career progression blocking for the least favourite staff.

It worries me, as I can see that junior staff nurses, or even senior staff nurses do not want to enter into specialist roles as there is too much responsibility put on these CNSs with little or no recognition. The lack of forward planning and future workforce planning to invest in staff is debilitating to the service, and I believe that there is a complete lack of awareness, from those who could make these changes, that changes need to be made."

20.6 If nothing else the perception of favouritism is harmful. Another nurse referred to staff and friends of a Service Manager being *"given upgrades irrespective of their ability and privileges (office space, desks, equipment), whilst the Senior Nurse was informed that there was no money for the promised upgrade and the Nursing budget was also threatened in relation to the number of posts and overall workforce".*

Promotion and Training

20.7 As noted above, the promotion process for managers was raised on numerous occasions: it seems that management training for those who are promoted is perceived to be inadequate and that this, understandably, could lead to mis-handling of difficult employment issues. Another related concern is the promotion to manager of people without relevant experience in or understanding of the discipline they are being asked to manage. The "grow our own" policy was the subject of criticism.

20.8 The following comments capture the concerns expressed by a number of respondents:

"Throughout NHSH it is common practice for staff to be promoted into supervisory/managerial positions with absolutely no grounding in people skills, managing people skills, etc. It seems that once one reaches a certain banding, perhaps Band 7, they become autonomous and non-accountable. For example, sending out totally inappropriate letters to staff."

"How do applicants get an interview for a post they aren't fit to do? It horrifies me that a Band 6 gets promoted to a Band 8A. How can we be sure that it is safe to employ these people if they haven't got the knowledge and understanding. That's a concern."

"Let's be honest for what skills we are looking for in our managers and if it is line management, then recruit them for that."

""Growing our own" and advertising lower grade posts so that higher up staff get promoted does not work if those promoted are not competent"

"...a lot of service managers are promoted into posts that they don't have the skills to do that work. They fall into dictatorial techniques. It doesn't lead to getting the workforce on board. When I was recruiting new people, I was being pressurised to move people up the scale and advertise for the lower post. "Grow our own". That's great but doesn't matter if they're not ready to do the job. Need new people in post with different thinking."

"There is a theme of "growing our own" in NHSH – they get slotted into posts they are not ready

for and don't have the experience for. They need more management training and beyond their specific qualifications. Nurses go into managing roles, but they don't have the management training."

Lack of Diversity

20.9 One manager offered this view which is self-explanatory:

"There is very little diversity in the senior managers, mostly white, middle class, 50-60s and in last job before retirement. They have old fashioned, dictatorial management styles and do not listen, know what's happening on the ground, trust staff or know how to engage them in decisions."

Friendship and Family Ties

20.10 As anticipated in the chapter on causes which may be particular to NHSH, I am told that many managers are friendly with colleagues (often people they manage) outside of work and that this can get in the way of holding colleagues to account for their behaviour. Training about how to manage multiple roles and relationships (and confidentiality) appears lacking. There are also criticisms of conflicts arising when family members are employed in sensitive positions, as characterised here:

"NHS Highland is a small environment with many staff being related to senior staff, which resulted in other staff being afraid of repercussions if they spoke up about inappropriate behaviour."

21. The Board and Governance

Introduction

21.1 My remit invites me to try to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally. In that context, I have been told that what has happened at NHS Highland is a failure in staff governance which should be treated as seriously as a failure in financial or clinical governance. If this is not done, *"it sends out the wrong message in terms of the way staff are regarded, both in NHS Highland and in NHS Scotland".*

21.2 By way of preface, I recognise that, in what follows, there is inevitably adverse comment about some of what has occurred in the recent past. I do wish to emphasise that these remarks are intended to help explain the situation in which NHSH has found itself and to enable it to move on. I am sure that those in leadership and governance roles have generally tried their best in relation to the serious issues raised. Future progress will come from a healthy recognition of things that have not worked as well as they should in the past. And I recognise that the benefit of hindsight was not afforded to members of a Board under a lot of pressure.

21.3 Concern has been expressed that this report may conflate concerns about "the system" generally and individual or collective actions by Board members. I refer to my earlier remarks that this is not an exercise in finding fault or allocating blame but an attempt to ascertain what can be learned from the past and what might be done differently. I hope that a thoughtful Board will accept this commentary in the spirit in which it is offered and build on it, not through guilt but with a sense of leadership responsibility.

21.4 It is important going forward that the Board is held in high regard by patients, staff and the wider community. What follows bears on the general situation and not any specific case. I have drawn on what I have been told and readily recognise that there will be nuances and other perspectives of which I am not aware.

21.5 For a number of reasons, including inadequate provision of information to the Board which was not conducive to effective and informed decision-making and a culture which tended to discourage challenge, it appears that the Board has not functioned optimally in its governance and oversight role leading to a situation where allegations apparently could not be raised and responded to, adequately, locally. I address some of the issues which arise in this and the following two chapters.

21.6 This review prompts a question: given what has now come to light and the concerns expressed by so many people, why were steps not taken to address this earlier? The Board's response to the public announcement by the whistleblowers in September 2018 recognised that there were issues (for completeness, I append this as a note at the end of this chapter). The question has been asked why it took so long to do so and whether this response was an adequate one in the circumstances.

21.7 A former board member described:

> "....an organisational culture that was not open and supportive but was one in which bullying had become institutionalised to a point where it was unrecognisable as an issue. Now with the benefit of hindsight I believe we almost all conformed to it in our daily relations with other members of the organisation complicit in the belief that these were the behaviours expected of us operating at such a level. It was however not only at board level: my role took me to all parts and places within the organisation and all too often I witnessed behaviours which did not support and encourage input and discussion from staff, rather the reverse.
>
> The impact of such a culture had two important consequences:- bullying of individuals who felt unable to voice their concerns other than in strict confidence to me and a very poor system of governance and accountability at board level. It is both that led to an institutional culture of intimidation and individual bullying and are therefore inseparable in terms of an analysis as to how we ended up in such a position."

I note that in theory at least "the system of governance and accountability at Board level" in NHSH is the same as in other health boards in Scotland.

21.8 Another observed:

"How much of this about bullying, how much is about governance? There is a culture of suppression - if you're not the right person, it won't happen. Or being labelled as a trouble maker. That leads to bullying."

A Failure of Governance?

21.9 I heard that, over a period of time, concerns have been expressed about a style of management and type of behaviour which many contended was not acceptable in a large and complex organisation. It seems clear that people in leadership positions were or should have been sufficiently aware of the concerns expressed as late as mid-2017 and probably earlier. At times, it appears that opportunities have arisen to address these and that steps which could and should have been taken were not taken.

21.10 One must remember, as I note again below, that this is an organisation with a budget of £800 million of public money. There will be very few Scottish businesses or organisations with budgets of that scale and with the complexity this entails.

21.11 A non-executive director told me:

"The issue of a bullying culture was first raised with the auditors, Audit Chair and Board Chair in late 2016. SG knew about it. Nothing was done. NEDs advised SG in August 2017: "We feel the culture and leadership is a risk to our stated values and objectives." When John Brown[36] came in, he did a verbal report to us that was dynamite. He said it as it is. "Your board do not trust you or have any confidence in you". In essence, we knew about it, we tried to do something about it. But in the meantime, the bullying was going on."

21.12 I suspect that some senior executives and some board members (though not all) have suffered from a degree of unconscious blindness. While it might have been obvious that something was wrong, for a variety of reasons they have not seen it or have been unable to act on it. It is likely that many of the cognitive biases and other influences mentioned in chapter 8 have been at play and that may be understandable in the circumstances. I believe there are other reasons and I explore some here.

21.13 When asked *"What one step would make a difference?"* a non-executive board member told me:

"The truth needs to come out. The NEDs were aware of it eighteen months ago. We have been working through the process of telling SG." "...as a board we have missed a lot." "There have been some big misses by this board. We have a lot of reflecting to do."

21.14 A senior executive told me:

"That's the other thing that worries me about the situation. There is so much that has come up to the surface that we're not aware of. That is awful. It worries me more than anything else."

21.15 A very senior figure commented:

"They (the Board) have been paralysed by fear of doing the wrong thing."

21.16 A former non-executive director described the situation as seen by that person at that time (a view not held by all nor necessarily applicable now):

"Board operation prevented the CEO from being held to account in a forum where in depth examination of issues could be undertaken [of] evidence of institutionalised intimidation and its supporting committees were held in much the same way and allowed inappropriate behaviours between people. Intimidation was the norm.

... relations within the Board between executives and non-executives were confrontational and often made "personal" or at worst non-executives were deemed to be wasting the time of executives by their questions and/or requests. Non-executives received little or no support for their role. I coached informally several members or lay members about their role as they felt inadequate or foolish as a result of their treatment at the Board. The number of

36 Brown, J. and Walsh, S. (2018). Corporate Governance in NHS Highland.

resignations should have caused questions to be raised by government."

"I raised issues discreetly with the Chair and within the Remuneration Committee under "our duty of care to our staff" but got nowhere."

21.17 A central reason behind the resignation of at least one non-executive director was the lack of proper governance. To that person, the Board appeared peripheral and a rubber stamp, with decisions being taken by the chief executive and the Chair. Presentation of information to the Board was not conducive to effective and informed decision-making. Some board members played little part in discussions. It seemed that there was little opportunity for or encouragement of challenge. There was general concern about poor communication.

21.18 I understand that various non-executive directors have expressed concern about governance in recent years and the Brown and Polley reviews (referred to elsewhere) took place. One of the curiosities of the situation is that a number of non-executive directors have resigned but there seems to be a lack of transparency regarding the reasons for their doing so. It is arguable that both the Board (and, indeed, the Scottish Government) were, or should have been, sufficiently alerted by these developments alone to act more decisively at an earlier stage. It appears that resignation letters were not shared by the Scottish Government, even with the Chair. I understand that some board members feel that they did all they could. I sense that red lights should have been flashing by 2017 at the latest although some concerns about governance were apparently raised by Audit Scotland in 2015.

21.19 A director observed:

"We have had at least three or four NEDs leave. I don't know how many need to leave before someone wakes up to the fact we have a problem." "They haven't pulled their punches either. They wrote to the government and said the Chair cannot keep the CEO in check. We've had so many, a governance review. No trust in the CEO and no confidence in the chair. You'd think something would happen from that."

21.20 Concerns were expressed by a number of respondents about the Chair's ability to hold the chief executive fully to account. A now retired director expressed this concern about accountability:

"My experience tells me that power rested with one individual in the organisation and they acted as the gatekeeper of opinion and advice to the Board and other senior officers. There was not the ability to safely challenge or express alternatives...In my opinion, the very necessary separation of powers held by the Executive (the chief executive), the Chairman, Non-Executives and Staff Director completely broke down... An organisation where there is responsibility without accountability results in turn in an extremely unstable organisation."

21.21 This seems especially relevant to events in and around August 2017. While hindsight is a great thing, the concerns raised then were, I sense, not as well handled by the then Chair as they could have been. I acknowledge that he would be in a difficult position and that Scottish Government was also involved at that time. Decisive action at that stage to address concerns, amid board resignations and a difficult situation regarding radiology, might have made a big difference.

21.22 I believe that the Chair recognised that there was a problem in that people may have lacked confidence in the systems for raising their concerns and engaging in a conversation about their concerns directly with the Board. I acknowledge that external reviews have been commissioned and other steps taken to address the situation which has now arisen and that the Board is also awaiting this report.

21.23 While the question arises whether his relationship with the chief executive was sufficiently robust and frank, I acknowledge that the Chair was in a difficult position and would be trying his best in the circumstances in which he found himself. He has since resigned. However, in a public service with a budget of £800 million, new leadership should look seriously at all of these matters and the learning arising from what has occurred, especially in connection with holding to account. If this is done, it should be possible to assess and respond to allegations, such as those of bullying, more fully at an earlier stage.

Accountability and Competence

21.24 Overall, in trying to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally, it seems reasonable to conclude that the Board has not functioned as well as it could. There appears not to have been a culture of sufficient openness and one which welcomes challenge.

21.25 One non-executive director told me:

"I think we need to change our approach to how people can raise things. Talking with the whistleblowers, they have tried to raise things for a while. So have NEDs. We didn't know. As a board, we need to work on ourselves and how we lead. We have new members who we don't know that well, so difficult to trust. Exec board colleagues, still don't have that much contact with them outwith board meetings."

21.26 I note that the Scottish Government published a guide for board members of public bodies in 2015. This summary on roles and responsibilities is helpful:

"The four main functions of the Board of a public body are: to ensure that the body delivers its functions in accordance with Ministers' policies and priorities; to provide strategic leadership; to ensure financial stewardship; and to hold the chief executive and senior management team to account." [37]

21.27 NHSH has its own clear guidance about the role of the Board and its members, including non-executive members. It appears that the problem here is not lack of information but lack of implementation.

21.28 It is possible that concerns about the functioning of the Board went deeper. One former board member told me:

"Competence is another contributor. Some of the players were a level beyond their competence... The body was not competent enough to know what they wanted."

21.29 I note that the fit and proper person regulation (FPPR) requirements[38] which came into force for all NHS trusts and foundation trusts in England in November 2014 require NHS trusts to seek the necessary assurance that all executive and non-executive directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role.

21.30 In order to meet compliance with these requirements, all NHS trusts must ensure they have robust processes in place to assess the suitability of directors at the point of recruitment and throughout their ongoing employment. They are also required to have effective arrangements in place to tackle issues should any concerns be raised about a director's ongoing fitness and suitability to carry out any such role.

21.31 Although not applicable in Scotland, these illustrate what might be expected of a board functioning well and of an appointment and review system which is itself fit for purpose.

Governance Structure

21.32 None of this is helped by what seems like an extraordinary governance structure. As I believe Audit Scotland commented over three years ago, the governance model seems extensive and impenetrable to many. It does not seem conducive to open, transparent and effective operation. I confess that I found the maps of the governance structure complicated and very difficult to navigate. I found nobody who was able to explain to me how all the many and extensive committees operate in connection with each other. There appears to be no comprehensive organisational diagram or other presentation of the governance relationships. I understand that executive and non executive directors have raised this and been told that legislation or government guidance is needed for many aspects.

21.33 Incidentally, the same appears to apply to the multi-layered management structures. A very senior director manager was unable to describe this either and another commented on a lack of integration operationally.

37 The Scottish Government (2015). On Board: A Guide for Board Members of Public Bodies in Scotland. p.24.

38 www.nhsemployers.org. (2018). Fit and proper persons requirement for directors. [online] Available at https://www.nhsemployers.org/your-workforce/recruit/employment-checks/criminal-record-check/fit-and-proper-persons-requirement-for-directors [Accessed 18 Mar. 2019].

21.34 I have the impression that attempts have been made to examine and reform governance but progress seems to be slower than may be necessary. The Brown and Walsh report in May 2018[39] covered all of this in some detail. Again, there must be a simpler way of managing the organisation without, as one person suggested, tearing down the whole governance structure and starting again.

The Jan Polley Review

21.35 Simply by way of illustrating that there may be nothing new in much of what I comment on here, I note that the Jan Polley review which reported in February 2016 included the following recommendations:

"A deeper understanding of the respective roles of non-executive board members and executive board members in order to build confidence in and share appreciation of how they work as a team, adding greater value to each other;

A review of the remits of the governance committees to minimise duplication of papers and discussions and clarify the roles of and relationships between the Board and its committees;

A strengthening of the corporate governance support given to the board and its non-executive members in order to reinforce governance processes, including the training and development opportunities available to board members." [40]

Strategic Plan

21.36 I should add that, while generally outside my remit, the absence of a proper strategic plan with specific goals and timelines seems to be a contributor to the current sense of lack of direction. The report by John Brown made recommendations in this regard as it did on holding to account, roles and responsibilities and other matters referred to in this report. Executive Directors have pointed out that NHS Highland has a 'NHS Highland Strategic Quality and Sustainability Plan', which was approved by the Board in 2017. Work was apparently also undertaken in 2018 on a simplified info-graphic summary, which was discussed with executive and non-executive directors but has not been finalised, due to changes in staff.

Board Meetings

21.37 In passing, I note one other issue which seems germane to the effective functioning of a board seeking to hold senior executives to account. That is the holding of board meetings in public.

"The other dynamic that is a constant... the theatre of the board meeting itself in public. What gets discussed in private versus public. There is a real issue - quite a tricky thing - to raise issues that need to be discussed at an open board meeting that will not impede the executives. The public nature is an ongoing problem. Not many people turn up, but it is webcast so in theory... and the press are there, in a small community. It's in the paper the next day."

21.38 I asked myself the question: how useful is subjecting health boards in this way to open public meetings and intense media scrutiny? On balance, does it assist or hinder? Does it fulfil an effective audit purpose? Might this be done differently? There must be an argument that the public nature of the meeting inhibits the kind of scrutiny which is essential. If board members are competent and have been transparently appointed, perhaps they should be trusted to get on with it, with specific open public fora once or twice a year.

Finally

21.39 This has been a lengthy chapter but effective governance is critical to the future of the organisation. As one senior clinician commented:

"Moving forward, the chief executive has left the organisation but there now needs to be a fundamental change in the relationships between clinicians and the corporate team, if the present situation is to improve. The individuals who have raised the issue did so in a manner that I do not support or condone. I can, however, see

39 Brown, J. and Walsh, S. (2018). Corporate Governance in NHS Highland.

40 Polley, J. (2016). NHS Highland Governance Review 2015-16. p2.

why they felt they had to do it in that way, having taken an issue to the CMO and attempted to bring the culture of Board officers to the attention of the Board.

The way that members of staff have been dealt with and the resignations of Non-Executive Directors of the Board certainly gave the strong impression that the clinical governance of the Board did not come up to the standards you would expect from a public institution. Whether the actions of the Board and the Executive team are labelled as bullying or simply poor management is less important than the need to move forward for the benefit of the service in general and the wellbeing of patients and staff alike."

These words aptly sum up the need for a change of direction at board level.

Note

21.40 Board statement issued in October 2018, agreed by all board members present[41]:

"We all joined the Board of NHS Highland because we care very much about the NHS and the services we provide for the people of the Highlands. It feels like NHS Highland is being publicly torn apart, with little right of reply.

"For the sake of all of our staff and the people we serve we feel this cannot continue in this way. Our offer to meet the four clinicians remains open and we hope others will speak up and we urge that to happen as a matter of urgency.

"For the four doctors to make a public claim that 'a thread of cruelty has purposefully been spun throughout NHS Highland' simply cannot go unchallenged.

"We feel sure that everyone who cares about the NHS will share the view that our patients, staff and public deserve better and we are calling on everyone to make their voice heard."

21.41 The statement went on to say:

"We recognise the utmost seriousness of the situation and are prepared to leave no stone unturned to get to the truth. There is clearly an issue of some sort which needs to be understood. We are of the firm opinion that it is surely in everyone's interest for any allegations to be addressed as a matter of urgency.

"Therefore, we unanimously express our ongoing frustration that we are being denied any substance to the accusations and also that the opportunity to have a mature, responsible and respectful dialogue continues to stall."

Board members heard from Dawne Bloodworth, NHS Highland's interim director of HR, that all the internal evidence to date paints a very different picture from what is being publicly alleged.

She said: "There is no evidence that I have seen to date that indicates that the four doctors represent the views of all GPs and Consultants. Indeed some clinicians have raised concerns to this effect.

"In common with all parts of the NHS there are certainly pressures in the system and as a board we acknowledge that. Sadly we also know there are some incidents of bullying, past and present. We are unanimous as a board, however, that to claim there is a systemic culture of bullying is not a true representation of the facts and opinions that we are currently aware of including feed-back from staff."

She went on to stress: "That should not in any way, shape or form underplay any incidents of bullying. We have a duty of care to anyone who has been bullied and we are truly sorry that it can happen. We also have a duty or care to anyone accused of bullying to make sure they are also not unfairly treated.

"As a board we have mechanisms, policies and procedures in place to manage this. We have also invited external HR scrutiny to see what more we can do to bring the highest level of confidence possible."

41 BBC News (2018). Claim 100 NHS Highland staff 'bullied'. [online] Available at https://www.bbc.co.uk/news/uk-scotland-highlands-islands-45952210 [Accessed 25 Mar. 2019].

She added: “I believe the action that we have taken so far has been immediate to actively encourage staff to express their concerns and views through a wide range of routes. We continue to welcome feed-back from staff who we know have a range of views. Somehow we need to encourage everyone to work together and in all good faith I really hope that something positive can come from this.”

22. Role of Non-Executive Directors (NEDs)

22.1 In trying to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally, it seems important to address in some detail the role of the NEDs. In setting matters out as I do, I do not intend to be critical of individual NEDs who are well-motivated people trying to do their best in difficult circumstances. However, a number of matters have arisen about the way in which NEDs have functioned in NHSH and I discuss these in this chapter.

Information

22.2 Firstly, as one NED put it *"it is vital for a NED to know what is going on – and wherever possible to see or hear independent views. There is a real danger of group-think"*. A number of NEDs at NHSH tried to make a difference while others may have been simply intimidated or wholly frustrated. Access to key documents and other meeting information needs to be good. However, reporting and discussion seems to have been conducted in such a way as to reduce their active and appropriate participation. There has been no clear strategy to provide them with adequate information. They could not do their job effectively.

22.3 On lack of governance specifically, I was told by a former NED that

> "there existed no system by which the Board could set a clear strategy for delivery. We never received costed options and alternative proposals on which to base decisions. So never were strategic decisions converted into clear delivery plans containing clear goals, milestones, risks etc by which the Board could direct a robust system of risk management and accountability and through which it could hold the CEO to account within a forum of mutual support and understanding."

22.4 Another had said in his resignation letter:

> "I am resigning as I feel that I cannot make a meaningful contribution to the outcomes from the Board. Too many strategic policy issues are taken, outwith the Board process, as being "operational". I have requested,in vain, that the NHSH Board or a Committee discusses key issues including the impact of Brexit on our workforce, the new GP contract and its negative implications for remote rural GPs in the H&I, the consultant led Radiology Service, funding for the Voluntary Sector, the continuation of small rural residential Care Homes etc. There needs to be a much more forensic approach to financial scrutiny. We rarely receive an options appraisal on an issue, simply a recommendation. Constructive criticism is not welcomed."

22.5 Another NED expressed the view that challenge or expressing a different point of view has not been particularly welcomed and rarely has it made any difference to an issue; there is an inability to carry out the role of holding the organisation to account without the information to do so; often they are receiving only reassurance rather than assurance, leading to ineffectiveness as a non-executive director.

22.6 On the theme of information to the Board, a very senior clinician observed:

> "There was and, I think remains, no clear ability for clinical advice to get to the Board other than through the Executive Team... The Board did not and does not meet "rank and file" clinicians to inform themselves directly without the filter applied by the Executive team."

This theme was repeated a number of times.

22.7 This diminishing of the input of NEDs is underscored by a senior executive director:

> "In the private conversations in senior leadership teams, the NEDs would sometimes seem as nuisances that needed to be won round. Or people that didn't really understand and we needed to manipulate them. I think references to some people, in their absence, could be quite dismissive.
>
> There might be a criticism that they didn't make that many decisions. A lot of stuff was airbrushed. Out of hours review was useless. If you look at the audit trail, board members feel that they haven't all agreed to the final product. Decisions get made at the top. Decision making structure is opaque and labyrinthine, which

has developed over time. It's convenient to the management style…

I think if you look at the board papers, they are far too long and drowning the NEDs in information so that they were hard pressed to make a real decision. Need clear executive summaries, recommendations etc so the reader can assimilate the information properly."

22.8 I happened to see one set of Board papers from 2017. They were overwhelming. I cannot imagine what it must feel like to receive and try to digest these, far less ask intelligent questions. This is something which needs serious consideration to enable Board members to perform their function properly. The unnecessary use of jargon is an example of where barriers can be created, deliberately or inadvertently.

22.9 Overall, the sense that the Board (in the form of the non-executives) were disabled is summed up in these words from one observer:

"Everything to do with the Board was orchestrated. …We would have dress rehearsals before the meeting. This is what will be said, this is what will be done. The Board weren't allowed to know exactly how bad it was."

Appointment and Training

22.10 The evidence suggests that the role, appointment, training and support of NEDs appears, in any event (whatever the theory), not adequate in practice to meet the needs of the board of a large publicly funded organisation with an £800 million budget. I note that some NEDs have asked for training in specific areas. I understand that developmental support for NEDs is a Scottish Government function.

22.11 I note that it appears that some NEDs may not be as clear or realistic about the extent and limits of their roles as they need to be. There may be some naivety about the role. There is need to pass on experience from outgoing to incoming NEDs. The lack of experience and knowledge of new appointees is a concern to a number of people with board experience. *"There is very little corporate memory,"* is how it was put. Consideration of an overhaul of how the Board is appointed, trained and sustained appears necessary.

22.12 The view has been expressed more generally that neither NEDs nor the Scottish Government fully understand the important role that NEDs should play. Be that as it may, Government guidance states: *"Public bodies ..... allow the public sector to benefit from the skills, knowledge, expertise, experience, perspectives and commitment of the members who sit on their Boards and focus in depth on clear and specific functions and purposes."*[42]

22.13 Unless people with the necessary skills, knowledge, expertise and experience (and ability to ask the right questions in the right way while understanding financial, risk and other management issues) are appointed to NHS boards, there is a danger that governance will not be effective and national policies will not be implemented effectively. There may be a difficulty in finding people with the requisite competence and skills. If so, that should be faced up to, with clear criteria and honesty if they cannot be met. I am told that Board appointments have seemed to some to place too much power in too limited a selection process, leading to perceptions of favouritism.

22.14 I was interested in these comments about the need for external input:

"Within NHS Highland and more generally within NHS Scotland there is an introspective approach to organisational development and an 'internalisation' of responses to whistleblowing, bullying and harassment and grievances, and generally to governance. [x] advised me that the governance review framework he was using was developed by the NHS Board Chairs. This leads to 'group think' and behaviours. There would be benefit in establishing an external, independent source of advice for Boards and Board members on these and other governance issues. My experience is that NHS Scotland and particularly NHS Highland does not recognise the validity of advice and practice from private sector businesses to themselves, citing the NHS as too complex and different."

22.15 This was also said:

"Over recent years there has been an increase in appointment of Local Authority councillors and staff, and ex-politicians to Boards, particularly Chairs, which has introduced a more political way of working, with both a small and large 'p',

42 The Scottish Government (2015). On Board: A Guide for Board Members of Public Bodies in Scotland. p.2

and changed the dynamic of Boards. My view is that this has contributed to a dilution of the role of the NHS Board and compromised the role of the non-executive director."

22.16 A concern was expressed that NEDs who are also councillors may be inclined to bring their own issues and agendas to meetings. I sense that this may not be confined to councillors.

22.17 I was also told that the imperative of inclusivity can lead to large boards, which seek to accommodate many interests, but that this may come with a cost to board effectiveness.

22.18 I did not explore the role of the Audit Committee but its effective functioning is clearly crucial.

Looking Ahead

22.19 One experienced NED offered this view which I record in full as a helpful guide for the future:

"There is minimal investment in development of non-executives in the skills required for the role and the 'training' for board members is quite basic. Also NHS Highland did not utilize the checklist tools[43] for Board Members provided by the Auditor General in many of her reports.

A more business-like approach is required. Improvements would be:

- Base recruitment of non-executives on their skills and abilities to do the job rather than their specific knowledge of sectors, issues, interests.
- Clarify the role of the non-executive as a governance role, providing independent judgement on issues of strategy, performance and resources. As per the Cadbury Report, their independence brings a degree of objectivity to the Board's deliberations and a valuable role in monitoring executive management.
- Provide induction for executives and non-executives on their roles, the role of the Board, the Chair, Vice Chair and Committee Chairs.
- Establish the role of the Senior Independent Director to act as a sounding board for the chair and an intermediary for other directors if they have concerns. They would also hold annual meetings, and other meetings as necessary, with non-executive directors, without the chair, to appraise the performance of the chair.
- Confirm and provide training for Committee Chairs on their role as well as how to chair meetings.
- Provide regular (at least annual) governance training for Boards framed in their specific environments to identify any issues, developments etc required and discuss solutions and improvements. Training to include such as what is assurance? How to look for assurance, what dimensions to consider in decision making.
- Record/codify/formalize Board conventions and procedures alongside Standing Orders (across NHS Scotland) and include in induction and training. Eg Board decision making re brokerage; Board members right to dissent, how it should be recorded.

All of these to be developed with external independent experts in governance."

22.20 I have been made aware of some really helpful initiatives for NEDs in other NHS boards, such as Lothian, where there are well developed resources and an induction programme, alongside good support from executives and administrators, and structured shadowing with clinicians, with six board development sessions per year. There is a structure for sharing of concerns and a "buddying" system for new NEDs. I am sure NEDs in NHSH would gain much from the support of, and the kind of initiatives available to, their colleagues elsewhere.

Remuneration

22.21 Finally, the rate of remuneration of a NED (£8,000 per annum) is, I understand, for a time commitment of one day per week. However, the actual time commitment (and responsibility) is considerably higher than this; I am told that *"many will be responding to something on every day during the working week"*. I understand that the Scottish Government is currently considering the remuneration of NEDs as part of a programme of work to review the system of corporate governance in NHS Scotland and do not comment further on this.

43 Auditor General (2018). NHS in Scotland 2018: Checklist for NHS non-executive directors. Supplement 1.

23. Senior Leadership

Concerns Expressed

23.1 In trying to understand what, if any, cultural issues have led to any bullying, or harassment, and a culture where such allegations apparently cannot be raised and responded to locally, I note that the senior leadership of NHSH has seemed to many with whom the review engaged, though not all, to have been characterised over some years by what has been variously described as an autocratic, intimidating, closed, suppressing, defensive and centralising style. It appears, at least to some, that challenge was not welcome.

23.2 It is said that there was pressure on senior management to conform even if individuals felt uneasy. Perhaps understandably, self-protection seems to have been the norm for some senior managers. People felt unsupported. I was told that attempts to change things failed and people lost jobs.

23.3 I was told this may have resulted in an unwillingness to speak frankly and that people felt helpless, trapped, unhappy and, at times, scared at work. I was told that power and control appear to have been concentrated in a very small group and exercised in a particular way, with limited sharing of information. I recall the words of Professor Charles Vincent, mentioned in an earlier chapter, summing up "culture" as meaning ""how we do things round here", "here" being anything from a small group or team, to a whole organisation..."

23.4 Associated with this view, sadly, one of the more significant issues of concern brought to my attention has been how some respondents have viewed the apparent influence over a period of time of the recently departed chief executive. Given that departure, it is not useful to report in detail on the specific examples I was given from a variety of backgrounds in the organisation but it is important to seek to learn from this. Indeed, with the passage of time since my appointment and gathering of information, the organisation has to some extent already begun to move on. I am conscious of not wishing to impede that momentum.

23.5 I am also conscious that I have mentioned more than once in my report that one should assume that people are trying their best in the circumstances in which they find themselves. I am also aware that I am reporting on views expressed which have not been tested forensically. I remind the reader of the caveats set out earlier in this report.

23.6 However, I feel I would not be fulfilling my remit if I do not mention this leadership issue, as acknowledgement to those who came forward and for those who told me of their experiences and who expressed the view that this cannot be allowed to happen again. That, I suggest, is the key point and I also cover aspects of this in my sections on governance and management.

23.7 A former non-executive director commented that:

"I feel that unless one addresses the culture, it'll all fall off again. I think the culture element is that the culture is set at the top. What they don't tolerate/promote. Unless one changes those values, we will not change the way in which this organisation is run."

Other Perspectives

23.8 It is important for me to acknowledge that the former chief executive feels that she has been unfairly treated and that the actions of others have been very damaging to her and the organisation and that she herself feels she was the subject of bullying. I also acknowledge the view that some of the issues raised in this report may have been evident before she came into post. One senior management representative said that they did *"not believe that the management culture at NHS Highland has been created by one person or that it emerged under the recent and current leadership"*.

23.9 I note the view of one board member:

"I don't think there is any way that [the chief executive] as one person can set a culture that applies to everyone. The culture is something that grows and develops itself."

23.10 Another senior manager told me:

> "I don't think of it as possible or credible that one or two individuals of an organisation like the NHS could have that degree of influence. I don't think so. Cannot pin the reputation of an organisation of this size on a very small number."

23.11 A former senior manager noted:

> "I believe the Leadership team has shown considerable strength and commitment in its drive to improve quality and safety. I understand that in taking forward such significant change, there will be some who remain unconvinced of the direction of travel and may even feel aggrieved by it. However I firmly believe that the organisation has followed due process in relation to any concerns raised."

23.12 And a more nuanced view from a board member:

> "The board is perceived as an omnipotent top of the pyramid, but it's not like that. It's much more collegiate. That's really challenging to do. I think [the chief executive] has her faults, as we all do. I think she's incredibly committed. She's a driven person who can see a way forward and make change. Very focused on the needs of people, the political pressures, budget. Very complicated to deal with. I think that might lead to perceptions that she just drives ahead regardless and if you don't agree you better get out of the way. There might be that type of perception/feeling."

Inability to Speak Up

23.13 I reported at an earlier stage that a feature of the general situation in the organisation was unwillingness to speak up. It also seems that some people in senior management positions did not feel able to speak up, even collectively. I put this down to a perhaps understandable culture of learned behaviour – a degree of self-protection.

23.14 "Learned helplessness" is a recognised symptom of simply staying where you are when you have no control over your situation. It is important to note that it appears that those who sought to resist or challenge the situation as they perceived it felt side-lined, marginalised, undermined or intimidated.

> "People in senior positions knew what was happening but there was nowhere to go."

> "I could see that senior managers disappeared or moved sideways. I would ask where they went. It feels like it you're not part of it… you're either in or you're out."

> "…if you rock the boat you are a marked man and you wouldn't do it twice"

> "who did I think would say no…? It would be career suicide."

> "Victims of bullying are often made to feel that they are the problem, or have a problem. I feared that I would be undermined."

23.15 Many who were concerned at director and senior management level and themselves experienced bullying behaviour have left the organisation. I was also told that some people have been very damaged by the experience. Others, allegedly bullied, adopted bullying behaviour themselves. One senior manager who was herself the subject of specific allegations of bullying behaviour, reported that she had also experienced fairly horrific behaviour directed at her. The pressure to perform, conform and survive seems likely to have produced a vicious cycle. *"If the best way to manage is to yell and threaten that may percolate to all levels,"* as one put it.

23.16 I am aware that some now regret their inaction, experiencing what is described as bystander shame or guilt: *"I find that so sad because if we don't care about people, we're finished. Why didn't I put my hand up?" "I thought I was the only one."*

23.17 A person close to senior positions told me:

> "I saw many bullies go unchallenged. I feel the culture of NHS highland supports bullying behaviour and treats it as normal and acceptable. The culture is toxic and is harmful to staff and I am sure this in turn is harmful to patients. I am ashamed I did not play a part in bringing this to a close."

23.18 One said:

> "I feel disgusted that bullying of this level can be allowed to go on when so many people at the top are aware of it." Another described helplessness: "despite it being common knowledge no one helped."

23.19 All of this, of course, reflects the themes highlighted by Dame Laura Cox and Sir Robert Francis in their reports referred to earlier. And, as NHSH moves on to a new stage, this needs to be learned from and then left behind. I refer to my final chapters.

Leading by Example

23.20 The relationship between behaviour at a senior level and behaviour more generally was commented on by one senior manager:

> "It's contaminated through senior management this aggression that was never there before. It's an aggression – a feeling of people don't matter, results matter. It's evidenced by the number of members of staff who have become patients. People talking about their fear and literally shaking when they have to have meetings ..."

23.21 Overall, in assessing what, if any, culture exists where allegations apparently cannot be raised or responded to locally, from what I have heard and with the important caveats already referred to, I understand why some have concluded that what was being experienced at the top of the organisation led to a situation in which identifying and addressing inappropriate behaviour was difficult.

23.22 In seeking to discern to what extent the way in which leaders behave influences an organisation, I note the Bowles report into NHS Lothian[44] at paragraph 3.2:

> *"Complex organisations have many sub-cultures, depending on a range of factors such as geography, sector, values and mission. In the NHS there will be very different cultures particularly in relation to healthcare professionals who have their own ethical standards and codes with which they need to comply. Nevertheless there will be an over-arching culture which is predominantly created and shaped by the Chief Executive and the senior leadership team."*

23.23 I note that Sir Robert Francis expressed the same view that *"culture starts at the top... and filters down through all levels of leadership and management to the front line..."*[45] and that willingness to speak up is influenced *"not only by what is said by the leadership team, but also what they do and the signals they give."*

23.24 The Bowles Report goes on:

> "**The role of leaders in setting or undermining avowed cultures**
>
> Leaders of organisations have a pivotal role in setting the tone and style of the over-arching organisational culture. From EMT downward through the management hierarchy, employees look to their managers to role model the espoused values of the organisation, and to guide them on the path to understanding and interpreting the culture so that they do things in the right way.
>
> In any organisation where the behaviours and leadership styles of any of the leadership team are at odds with the avowed values of the organisation, it can cause a cultural disconnect, with layers of disaffection, poor engagement patterns and inappropriate behaviour throughout the workforce. The old adage... 'Don't do what I do, do what I say'... if in evidence and repeated throughout the management hierarchy can cause personal and organisational tension in terms of lost output, poor morale, stress, sickness absence and retention issues."[46]

23.25 From what I have been told, I have formed the view that this analysis is relevant in NHSH also.

Learning?

23.26 Generally, for future appointments and to address these issues, it seems important to consider in general terms what drives leadership

44 David J Bowles & Associates Ltd (2012). Investigation in to Management Culture in NHS Lothian.

45 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 5.1.4

46 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. Paragraph 3.3

behaviour. Some of it may be personal and personality-driven; indeed often fear will be a factor. It is possible for example that sub-optimal outcomes of a programme such as quality improvement, and the need to make it appear that everything is working well, could be an influence.

23.27 Reputation, fear of loss of face, or appearing not competent in a job may well play its part for so many under pressure in senior roles. A need to be (or at least to be seen to be) in control is another recognisable feature.

23.28 It must also be recognised that inappropriate behaviour can be attributable to a number of external factors including the pressure of the serious financial situation and fairly constant, and perhaps understandable, interventions from government. As a senior executive observed: *"The relationship with Scottish Government is one of command and control."*

23.29 A senior consultant put it this way:

"The bullying seems to start at the top with the SG giving CEs an impossible job. It is not just about the lack of money. We have too many hospitals in NHSH and yet the politicians have been unsupportive at attempts to rationalise and close hospitals that need to close. The problem has been that our local NHSH management has been insufficiently strong to challenge this, but I appreciate how difficult / impossible it might be to do so."

23.30 It is a complex, multi-layered situation. While one can only speculate, and some of the factors outlined here may help to explain, the real value lies in seeking to ensure a different approach and outcome in the future.

23.31 The new chief executive will wish to take NHSH to a different place in terms of relationships and behaviours. I comment on this in my later chapters covering leadership and in my proposals.

23.32 As a senior director put it,

"We need new leadership and a new culture to be adopted. We'll need a very capable CEO in terms of their people skills, their leadership. That's critical. I think that we need to change how we engage with our staff (we haven't done that properly or well)."

A Note of Caution

23.33 I am alert to one of the dangers I mentioned at the outset, that of scapegoating. In the comments above, I have tried to be respectful of the views expressed to me and to ensure that these are acknowledged. However, these words of a senior staff representative bear repetition:

"Scapegoating individuals will not resolve many issues. It is important for every employee to take personal responsibility for her/his own behaviour, to be the best version of her/himself, to be able to apologise if s/he has had a bad day which may have resulted in less than desired behaviour, for the apology to be accepted and for everyone to move on. It is important that employees feel safe to identify behaviours – their own and others - they would like to discuss and resolve in a positive, balanced and adult manner, to know that such a request is welcome and discussion is possible. The ability to self initiate the words 'I'm sorry' is powerful, especially when the person offering them is already aware that words will be accepted and respected. It brings greater peace of mind, trust and security. The worry of a grievance being lodged is stressful and can lead to ill health and time away from the workplace.

There are undoubtedly bullying behaviours evident within NHS Highland over a long period of time. HR practices and processes have often required challenge by members with our support. Rather than the responsibility of an individual employee, workplace cultures of bullying are an organisational wide issue and change requires an organisational intervention – it cannot be left to individual employees to challenge decisions and change the culture on their own. That said, every employee has responsibility to avoid it

> as a chosen behaviour for the workplace, to challenge unfairness, bullying and harassment when it occurs and have this fairly resolved. It is important that when employees raise concerns that they are not ignored, unfairly removed from post, blamed for someone else's perception or told that the behaviour they are experiencing is not happening, the phenomenon known as gaslighting."

23.34 The challenge now is to create an environment in which these laudable aspirations can actually be met.

24. Role of Staff Representatives and Unions

Introduction

24.1 In trying to understand cultural issues, many people expressed their concerns to me about the role of trade unions and staff-side representation which appears to many employees to have failed adequately to represent the interests of employees of NHSH in regard to bullying claims.

24.2 This narrative sums up views I have heard:

> "With respect to the input of a trade union, x is a member of Unite. Her representative's key advice throughout was that only by accepting redeployment could he guarantee that she would keep a job. He stated that his experience of NHS Highland was that the managers would gang up to ensure that she had no chance of winning her case. He may well have been correct in the last point, but it is a sad reflection of how a union should operate. It suggests that something is amiss within the checks and balances between union and management generally. At the outset, the same representative, having reviewed her evidence, had advised x that she had nothing to worry about. As noted previously, it is only now, with the involvement and support of GMB together with external influences, that x feels comfortable enough to take matters further within the organisation."

The Partnership Model

24.3 The partnership arrangement for staff involvement in decision-making and the role of staffside representatives on the Board is a matter of concern to a number of those with whom the review engaged and appears not adequately to be addressing serious issues for employees in NHSH.

24.4 This has raised questions about the role and effectiveness of the trade unions in the context of the partnership agreement model operated in the NHS in Scotland, which many have suggested is not appropriate or at least is not operating in NHSH in the interests of the staff.

> "The Staff Governance and partnership arrangements in NHS Scotland are probably now out of date. They have clearly failed staff in NHS Highland. Originally set up to provide a constructive way of working between the Unions and Management, they may now be too cosy and unrepresentative. In NHS Highland the Staff Governance Committee was ineffective and its meetings were sterile. [For example] challenge about indicators of staff experience were turned into a positive presentation of engagement rather than a question about why people choose not to engage. The organisations around the table represented about 50% of staff."

24.5 Observers contend that there is an inherent conflict in being a funded full-time employee representative and also an advocate for the staff side. This makes it difficult to challenge the Board and to retain appropriate independence and objectivity. It reduces the checks and balances. This can result in the employee director being perceived as ineffective or too close to management and unable to function in the interests of the employee side. At least, there is a blurring of boundaries. I suspect that the current staffside representative might concede that this could be possible.

24.6 I am sure that the current employee director is well motivated and does a huge amount in the full-time role as it is presently conceived. He works hard to function in the environment in which he operates and with which he is very familiar. However, he appears to be in serious danger of being sidelined and to have lost credibility by being associated directly with board and management actions which appear to have diminished the concerns about the allegations of bullying. His appointment alongside the Medical Director to chair a working group has tended, for some, to reinforce this perception.

The Role of the GMB

24.7 The GMB union has become involved in NHSH following the transfer of adult social care to NHSH from Highland Council. Their model and approach is perceived to be more confrontational and actively to use the more time consuming grievance procedures as a tool to help employees and challenge NHSH. I am told that employees are going to GMB because they feel that other unions are not able to address

the situation adequately and many respondents reported that only GMB has really supported them, citing examples, as noted above, of failures by other unions.

"People wanted to speak up, but they couldn't. They were afraid. So they would be willing to confidentially give their statement to GMB, a chance to be heard."

24.8 Concern has been expressed that GMB, being outside the Partnership Agreement, have acted in ways which themselves are not acceptable and constitute intimidation. There are accusations of using bullying behaviour in emails, the press and meetings. I have had some fairly unpleasant behaviours described to me and ascribed to one or more GMB representatives. I cannot comment on the accuracy of these but it is again one of the ironies that those helping to expose what they see as bullying are perceived by some to exhibit similar behaviours.

24.9 I wholly understand why the GMB has taken the approach it has so far to seek to focus issues and raise awareness but I sense that, if the changes proposed following this review can be adopted, GMB will have much to contribute if they can find a way to engage fully with NHSH going forward. Providing information in response to requests to do so and engaging fully is ultimately likely to be helpful to their members in the longer term. As one informed observer said: *"I can't help but think if the GMB would work with us we would achieve more than in the papers. It's going to lead to polarisation."*

24.10 The same applies of course to other staff representative bodies who all need to be very thoughtful about their role in supporting NHSH and its employees.

25. Human Resources Procedures, Policies, Processes and Related Issues

Introduction

25.1 The number of specific issues which were raised with the review covering what I would describe as "process" is enormous. I can only provide a summary here and expect that, as part of a new approach, matters like these will be taken up by others.

25.2 From what I have been told, there has been and continues to be serious delay in addressing many of the issues of significant concern to members of staff in NHSH. This is often because of failures and delays in recording, reporting and investigating and in grievance and other procedures and policies for dealing with complaints and other concerns (including the inconsistent and inappropriate use of suspension and capability assessments, breaches of confidentiality and loss of impartiality). I have heard that this leads to polarisation, tension, stress, unhappiness, sickness and other detriment in individual departments. A key feature is said to be the lack of a willingness to follow process and properly investigate.

25.3 One respondent summarised matters in this way:

> "I feel there was/is no confidence in the processes we have for dealing with issues such as bullying and harassment (nor the qualified people or appropriate training) and it will be an important part of your review to examine these and hopefully recommend improvements."

25.4 While there is a lot of criticism of "HR", that may be a catch-all which conflates management roles and the HR function and does not fully acknowledge the wide-ranging nature of the dysfunction across management generally. I acknowledge that the HR team's morale has been affected by the allegations made and that there may be misunderstandings about the limits of the HR role. They tell me that they have also themselves been the subject of inappropriate behaviour on occasions.

25.5 I was impressed by the openness and candour of those I met from HR. In reality, it seems that Human Resources (and Occupational Health) have not, for a number of reasons, been able to cope with the enormity of the situation.

Resources

25.6 I note that there is a widely held (but not universal) view that resources within HR are not adequate (*"we end up firefighting"*), not least in the employment of a part-time HR director. It is fairly clear that such a role is not sufficient, as the present part-time Director of HR acknowledges. The view was also expressed that if HR could focus on preventative strategies, rather than simply handling a barrage of case work, they could be more proactive.

25.7 This view sums up what I heard from a number of respondents:

> "...while I had good HR support for some aspects of the work, I do not think NHS Highland has anything like enough HR staff to provide the support needed to work through some of the very tortuous HR policies. This means that situations that can both cause and contribute to stress within departments are not dealt with in a timely manner. I'm thinking mainly of capability and attendance issues which can go on for several years without any resolution. This increases pressures on other members of staff."

25.8 One respondent described the overarching issues as seen by that person:

- "Inexperienced HR personnel/advisors
- Poor advice from HR
- Lack of consistency
- Not following guidance/PIN Policies etc.
- Lack of moral/ethical compass
- Difficult/complex issues filed on 'too hard' shelf"

25.9 It was suggested that HR difficulties may, in part, be a throwback to the inclusion of a large number of council employees (approximately

1500) when care services were transferred, especially as there were significant cultural differences between the two organisations. It seems unlikely that adequate HR resources were planned for at that time.

25.10 Much of this chapter takes the form of narratives of what I was told, which I feel speak for themselves. In a sense, it is the overall picture which emerges which merits consideration, demonstrating as it does extensive dissatisfaction with processes in NHSH. I recall the remarks about NHSH made by a full time union official, recorded at paragraph 16.42 above.

Lack of Implementation

25.11 It is said that policies are not implemented or interpreted consistently by managers, with serious results:

"Furthermore, when my case was addressed by Senior Management the resultant actions, were not consistent with NHS Highland policies and were not based on any proper investigation of the case. NHS Highland has used policies, practices and threats to marginalise, isolate and bully in an attempt to pressure me into accepting a career ending change. My reputation and indeed personal confidence have been damaged as a result. The impact of the above has been traumatic adversely affecting my Health and Welfare with consequential impacts on my family generally."

25.12 There is general concern about the application of policies and standards as these contributions show:

"Throughout my experience in the last 3 years I have directly experienced breaches in the staff governance standard, breaches in NHS Highland policies, breaches in Health and Safety legislation and breaches in guidelines from ACAS in carrying out investigations. As evidenced by lack of adherence to policies, procedures and law it is clear that staff are unsupported, poorly trained, ill-informed and are effectively "making it up as they go along"."

"The NHS Highland Policy "Preventing & Dealing with Bullying & Harassment" states that "It is crucial that organisations treat seriously any form of intimidating behaviour". From my own experience, my perception is that NHS Highland does not take such allegations seriously preferring to sweep the issue under the carpet which in my view is questionable in terms of the Law, it certainly goes against Policy.

The "Dealing with Employee Grievances" policy clearly states that "employees are encouraged to raise grievances without fear of penalty or victimisation, and that NHS Highland has a clear commitment to operate in an open, consistent and fair manner with the aim of creating a no-blame culture". Unfortunately, I believe I am being penalised. I have received no feedback from discussions that were supposed to take place between the Chief Officer & my line manager about her behaviour which leads me to believe my grievance is not being taken seriously, leave it long enough & it might go away."

Other Specific Concerns

25.13 Specific concerns about the HR function were expressed by many respondents:

"...after many weeks I was informed that [Senior HR] would be carrying out the review instead. After more delays [her] review came back not upheld and the recommendation of alternative employment for me was still the only conclusion and recommendation. I cannot get my head around why there were so many reviews carried out when the reviewers had no intention of investigating my case properly. Were they told not to? .... [she] advised in her report that she would be assisting me going forward in my redeployment and that she would arrange a meeting with another member of management. However I never did hear from [her] ever again and no such meeting was ever arranged." I resigned from my post.., as it was clear that management were not going to fix or attempt to do anything to help my situation. I had been left with no job, thus no wages; my career has been destroyed by the negligence of NHS Highland Management. Someone has to be answerable to the destruction of my life."

"A couple of years ago a Give Respect/ Get Respect meeting held locally after a questionnaires being completed and returned by staff. This meeting was attended by an HR representative... and members of staff. Many members of staff spoke up about instances that had happened to them at..., the way they were treated or spoken to. This took a lot of courage for these woman to speak up, they decided to raise their issues as it seemed that NHS wanted to make changes and improve relationships

with staff. Consequently nothing has happened regarding issues raised, it has been swept under the carpet and some issues regarding ... management passed off as relating to another member of staff no longer at..."

"Overall she has lost faith in HR and management - feels they are underhand, all stick together and watch each other's backs, feels blocked at every turn, feels she has been lied to on occasion - the official escalation route has not worked"

"Disciplinary hearings: NHS are prosecutor, judge, jury, executor – not impartial"

"Senior managers are not trained to handle complaints"

"NHSH does not have a robust or effective system for mediation and does not have enough experienced or unbiased staff to carry out investigations."

"Moreover, no member of Management or Personnel Department responded or held accountable for the handling of the process. [Senior HR] was not even challenged after he sent in error all the documents relating to my investigation to someone who had given evidence against me. The handling of my Investigation process was reviewed by a member of staff who was subordinate to the people involved. How would such a person be able to criticise his senior colleagues?"

25.14 The following remarks by another staff member capture many of the concerns about process:

- "NHSH did not adhere to and showed poor knowledge of their own policies.
- Chose to use policies which suited the organisation rather than the victim to the detriment of fair process and unnecessarily (possibly deliberately) elongated time scales to the detriment of processes and resulting in the victim being timed out of other options.
- They did not allow the victims witnesses to be called or interviewed unless they were current employees of NHSH – this seriously impacted on the victim`s case.
- NHSH did not apply reasonable care or common sense to look after the victim and ensure her safety in the work place.
- There was no named/confidential contact made available...
- The perpetrator effectively remained the manager of the victim and made decisions about her every day working etc. This allowed him to conduct a discrediting campaign, maximise her isolation and make her working environment intolerable.
- His manager was complicit with this and was at lengths to point out that the perpetrator`s rights were to be upheld and as a manager his work was more important than the victim`s.
- Grievances brought forward by the victim about this treatment were not progressed to completion.
- OH reports were not acted on and a crucial one was retained by HR and not shared with a new manager.
- The Perpetrator remains in the organisation, the victim has had to leave due to impossible working environment and the unwillingness of NHSH to put in place robust measures to protect her.
- The same manager and HR person were assigned to both the perpetrator and the victim. The manager was his immediate line manager who he worked closely with.
- NHSH used `the pay out offer` just before the Tribunal which as they knew triggered the funding from the victim`s union to be withdrawn thus effectively stopping the Tribunal and keeping knowledge of the assault out of public domain. This also stopped the opportunity for other victims to come forward.
- The internal investigation findings of `not proven` changed at ET1 response by NHSH to not guilty and supporting the perpetrator. This without any further information from the victim.
- The process from making complaint to NHSH, to the victim leaving the organisation, took 19 months.
- On leaving the organisation I sought to meet with [a very senior manager] to tell her of the problems with processes etc in the hope that the organisation could learn from my experience and no one else would have to go through the same experience as me.

- She did not acknowledge my several emails even though they were copied to her secretary.

- I was continually told by HR and managers that my case was unique, I cannot believe this is the case and feel it is more likely that others distrust the NHSH processes and therefore do not report incidents."

  It is this general conclusion which reinforces so much of what I have heard from others. This needs to be addressed.

The Grievance Process

25.15 Many people have expressed frustration that their complaints are not dealt with adequately:

> "The reason for adding my voice to my colleagues now is my dismay and frustration at NHS Highlands Bullying grievance process. Having plucked up the courage to go ahead, x was allowed to put in a counter-grievance against me, which incidentally was remarkably similar to the one x put in against one of my colleagues when x also raised a complaint. X's grievance was treated to equal billing with mine and the whole process seemed to be aimed at causing the least amount of headache for HR and NHS management as possible. The sole aim seemed to be to get the 2 of us to be able to work together - not to look into my allegations of long-term bullying as I had hoped."

25.16 That these are long standing issues is reflected in this commentary on "Lessons Learnt from NHS Highland Grievance Process" provided by an existing employee who experienced difficulties a few years ago:

- "The system for raising a grievance in theory should work, but it is flawed on every level. As I discovered even senior managers do not adhere to the process and timeframe, but the complainant is expected to.

- In its current format, it is biased in favour of management and personnel staff. Union representatives may well be acquainted with the various policies, but my experience showed them to be more inclined to keep in with managers and to belittle the nature of the grievance.

- My grievance while more than valid need never have reached a formal grievance process. There should be an independent reviewer to validate whether a grievance should progress or just an apology given.

- Persons independent of the area in which the grievance is raised should deal with it. They should have no prior knowledge or involvement with the staff involved. I.e. the Line Manager of the friend of the Manager being investigated should not be the Investigating Manager for obvious reasons of possible bias.

- Personnel and Managers should be fully cognisant of policies and their content in order to apply them effectively and in the right context. It should also be made clear on every policy that it applies to every NHS employee regardless of roles, so that managers and personnel are not exempt.

- The so-called 'No Blame Policy' is the only policy that managers adopt for and between themselves. It does not actually exist on paper. I was told to my face by a group of managers that they would never ask another manager to apologise for their actions or the way they manage. Instead the organisation (a faceless concept) could apologise on their behalf, if necessary.

- The personnel people involved in the debacle were never brought to account for their incompetence in the way things were handled. They were rude, unprofessional and extremely unhelpful. This gives the impression they are untouchable and separate from the workforce.

- The grievance process is made to be difficult for the person who has the temerity to be raising a grievance. Why else would [Senior HR] try to dissuade by telling you how stressful it will be. It should not be a stressful process especially for a complainant raising concerns about the stress being caused to them, and more especially so if it is an issue of bullying and harassment.

- The person raising the grievance or any concerns for that matter should not be made to feel like a villain or that they are in the wrong. It should be recognised that to reach a grievance stage, it is a last resort, a corner into which the complainant has been pushed.

- The grievance process as it stands only serves to heighten the perception of 'them and us. It shows that there is no parity between managers and staff, or between staff and personnel. It is a side-taking exercise that allows managers

to take cover behind the lines of the spurious and dubious implementation of policies by personnel staff and to some extent even Union representatives.

- There should be a system in place, a framework with options that allows any member of staff, be it a cleaner or a manager, to raise concerns in several ways, before it might ultimately end up a grievance. It needs to be a neutral, fair process, with absolutely no possibility of bias. In some ways there is a case to be argued for this to be run by a department independent of the organisation.

- My experience showed that in an organisation that purports to be representative of the gamut of the caring professions, it became instead a coldly, defensive, uncompassionate machine that eventually, after everything I'd had to go through, proffered what can only be termed as an automated 'apology from the organisation' a truly faceless concept.

- Finally, having been through the grievance process as the complainant, not only did I have to singularly defend and speak for myself, despite providing masses of written 'evidence' beforehand and having gone to a Stage 2, before my grievance was finally upheld. I have absolutely no doubt that my personal file will have me marked as 'trouble' and that's the price you pay for 'raising concerns or whistleblowing'."

25.17 Other concerns were expressed about a seemingly disjointed and impartial process where interviews of witnesses and "perpetrators" took place before any formally submitted complaint or allegation, with a perceived lack of independence by those conducting the investigation and failure to take account of independent evidence and other clinical concerns.

Delay

25.18 Passage of time and lengthy delay came up repeatedly in my discussions and in written responses, as these examples illustrate:

"... that whole process takes far too long. The effect of this is two or three-fold. You, as the complainant, have to have a difficult working relationship with your manager while it's being investigated. Sometimes the delay means that one or both the complainant and respondent will go off on sick. Sometimes the investigation makes things more polarised. By the time the investigation concludes, it's too difficult to make it positive for either party, neither wants to work with each other. It's a corrosive process. It doesn't need to be systemic, you just need to multiply individual experiences to make a big problem."

"I would like to report that I put in a complaint regarding bullying and undermining behaviour regarding my clinical line manager in January of this year, and discussed the complaint with the service manager at that time. By late September when I had not heard anything further, I contacted members of the Board including the interim director of HR, board medical director and chair of the Board. Aside from an acknowledgement of my email from HR I heard nothing and after a further 5 weeks contacted the above individuals again in November. Again I received only an acknowledgement from HR. On both occasions the chair of the board has not responded at all. In frustration, I chose to write a separate email to the board medical director to express my distress and disillusionment at the situation. In response to this he advised me that on discussion with the director of HR it was acknowledged that my complaint had not been progressed, but at no point have I received any direct communication from HR to inform me of the status of my complaint. Since the external enquiry has been announced I have now received an invitation to an informal meeting with medical managers, but with no indication of process or progress. The behaviour I experienced was extremely distressing but the lack of any response over a 10 month period has left me completely disillusioned with my employer and considering leaving the specialty that I have trained in, in order to avoid further confrontation and distress."

"The processes took too long to happen - things dragged on for too long and by the time meetings were made between union/ employer and HR, details were forgotten and the energy to take it forward was lost. By the end, my union rep wanted me to take it further, but I had lost the will and just needed to get a salary again."

(For completeness, the Medical Director has advised that he took immediate action on receipt of the communication on both occasions.)

25.19 Another concern is a change in approach after much delay, as this contribution illustrates:

> "A second meeting was then held on [date] where I was advised that NHS Highland had decided my formal grievance would now be dealt with by the alternative 'bullying and harassment policy'. My grievance had been accepted since [10 months ago] and dealt with under the Grievance Policy. My [union] rep and I have formally objected to the abrupt and unnecessary change and are highlighting this to you as a further example of attempting to delay and intimidate me during the grievance process."

25.20 It seems that there are a number of reasons for delays, not least the volume of case work and the impact of that, for example, on the availability of union representatives to handle these. Overall, however, for (at least) scores of people in NHSH, the lapse in time is unacceptable and deeply affects relationships for all concerned.

Perceptions of Lack of Confidentiality and Bias

25.21 As we have seen already, lack of confidentiality and perceptions of bias are a repeated concern. Respondents reported that staff do not wish to raise formal concerns because of the damaging effect this will have on them both personally and professionally.

25.22 I was told of an instance where:

> "… cases are heard by managers who are line managed by the very people (senior managers) the grievances are about. This seems fundamentally flawed and open to bias and inappropriate influence. I had similar issues with Union representation who was also a Board member and again feel this created a conflict of interest and influenced how the process was managed."

Suspension, Capability and Redeployment

25.23 There is particular concern regarding the apparently peremptory, inappropriate and inconsistent use of suspension as a disciplinary tool without full explanation and with long waiting times for information. The use and excessive length of suspensions can result in these becoming punitive in nature.

> "This investigation turned into an unjustifiably long process. I was suspended from work and banned from entering any NHS Highland premises and told not to contact any member of staff, even those who were my friends. This process lasted for 2 years. I understand this practice of long-term suspension was a regular occurrence and staff often left in the process. Not only is this a cruel and unfair process it is also a complete waste of valuable skills and tax payers money. During this time not only was I deskilling, I was isolated in a rural area with my health and wellbeing suffering greatly."

25.24 Similarly, concerns have been expressed about the (mis-) use of "capability" assessments – with no reasons given, long duration, and unsatisfactory outcomes.

> "The whole process was treated more like punishment."

> "On a professional level, to be told that I was to be assessed through the capability procedures was devastating to me. The so called support plan was insulting in the extreme and had very little substance."

25.25 I heard that Supported Improvement Plans should be used genuinely for improvement, not as *"a device to get rid of people"*.

25.26 I am told that the use of redeployment often fails to address the real issue:

> "Then you get people who are redeployed, they don't want it, but they are too scared to leave and lose the post."

25.27 I am told that redeployment is also used as a threat. More tellingly:

> "I was subjected to bullying and harassment by my team leader and two of my other nurse colleagues. There was a series of incidents; I was harassed and intimated, sworn at, belittled on so many occasions. I was being set up to fail by my colleagues and team leader often…Management turned the whole situation around on me, as if I was the problem. I was encouraged not to raise a grievance but to follow the redeployment process and procedures. The reality of redeployment did not hit me at that time, as I was under so much stress and anxiety with everything that had been

happening over the time. Management were not interested in trying to rectify the situation and they only made my extremely difficult situation even more horrendous."

25.28 On general governance issues there was a concern that management more often than not moved problems and people rather than addressing them. There is a concern that the alleged victim is often required to move, rather than the alleged bully. It is suggested that moving or suspending both the alleged bully and the alleged victim during investigation would be logical and fair and would put pressure on managers to get resolution within the time required by the regulations.

25.29 The use of temporary and short-term contracts is also viewed as intimidatory.

25.30 Concerns also related to the use of Partnership Information Netowrk (PIN) policies. It is said that *"the NHS Scotland Pin Policy – Managing Employee Conduct – is not fit for purpose"*. I have heard claims that they can be misused as an intimidatory threat. I do not offer further views except to recommend that these are looked at afresh.

Diversity and Discrimination

25.31 I was told by a colleague that the picture painted is of a culture that is 30 years behind the times when it comes to diversity awareness. The view has been expressed that there is a strong need to improve this and bring the NHSH culture into line with attitudes and practice in the rest of the UK.

25.32 Cultural and discrimination issues arise:

"I'm left feeling victimised and discriminated by several NHS Raigmore staff for having a disability and doing my very best to remain in employment. I have never put anyone at risk as I know my own limitation and have friends that drive me home if required. The allegations are not a true reflection of my caring personality. NHS staff will pretend they care about you to obtain personal information then use it against you. It deeply upsets me that I have so many discrepancies and very sensitive information on my NHS personal file."

25.33 One member of staff expressed this to me:

"I'm left feeling victimised and discriminated by several NHS Raigmore staff for having a disability and doing my very best to remain in employment."

25.34 One member of the portering staff described graphically the discrimination and disdain he experienced because of his accent and origins. He advised me that he was told it would be easier just to leave his job.

25.35 I have also been made aware by some respondents of significant and, for those involved, distressing instances of homophobia and racial discrimination.

Failure to Join Up Events

25.36 There is concern that the implications of the reporting of a number of comparable events, themes and patterns are not identified.

"Not joining up the dots, lack of system to do so (eg number of similar cases, departures from one dept etc – why not analyse human resource loss like would do with physical resources eg scanners)"

25.37 As a former support manager told me:

"One of my final points would be that the department had double digit staff turnover every year that I was there - if my memory is correct one year it was approximately 25%. I strongly believe that any department that has a double digit staff turnover rate should be investigated and managerial responses of 'they decided they didn't like it', 'too much like hard work', etc should not be accepted at face value."

25.38 I heard about a situation where there were at least three other reported cases against an individual in the previous five years and *"where no links have been made between these grievances, by HR or senior management, or if links are made there is no desire to do anything about it."*

25.39 In another example, *"I was told by an Occupational Health doctor that this manager's name was one he was familiar with when dealing with staff experiencing stress and depression; I asked why he hadn't raised this, he claimed he had "no role" in intervening in such matters."*

25.40 I am advised that steps were taken at board level to monitor trends relating to sickness absence and suspensions.

Occupational Health

25.41 There are concerns about the ineffectiveness of Occupational Health in collating and reporting on matters to do with bullying. I am told that *"Occupational health is drowning"*, often dealing with matters on the telephone when a proper interview would be required in order to assess the situation adequately, especially if mental health issues arise.

Loss of Earnings

25.42 I have been asked to note the continuing financial loss that some individuals have suffered and /or will suffer. For those staff who have been forced to leave or those who have had to retire early because, as one put it, *"they really couldn't take any more"*, there is concern that they have lost or will lose out on pensions, wages, references and other benefits.

25.43 This is just one example of many given to me:

"One important point I wanted to make is the significant financial loss as a consequence of raising concerns regarding patient safety, and protocols/policy resulting in my ill health both mental and physical. The stress and anxiety and depression that led to a loss of earnings resulting in half pay, with the second episode of sickness pay being stopped after 4 months."

Datix

25.44 Concerns were expressed that the use of this online reporting system is not as effective as it should be. This is beyond the scope of my report but I recommend a review so that employees not only understand how it works but can use it confidently and be confident in its results, especially when reporting incidents about the behaviour of colleagues in confidence.

iMatter Survey

25.45 I am advised that the 'iMatter staff surveys' seem to have superseded other forms of survey or staff consultation. However, it is said that because they are conducted for teams there is a feeling that any comments made are then traceable. I was told that these surveys are now viewed by some as "I Don't Matter". Generally, there *"have been various staff engagement exercises such as iMatters. These do not seem to pick up the feeling of many staff who I know have expressed concern with this management style. Nor do HR seem to tie these episodes together and take a closer look at the impact on staff. If they are aware, there is no reassurance to staff that things are being dealt with and that their wellbeing is being taken in to account."*

The Need for a Different Approach

25.46 A member of staff with personal experience discussed the need to find a different way of doing things:

"...generally the evidence is very difficult to obtain, and often is between 2 individuals with no witnesses. Most often even if no evidence is found or the complaint is withdrawn (which is very unusual) the relationships have broken down so far that staff cannot work together again and this means at least one of the staff is redeployed into another area. Staff can feel punished for having spoken up, as the whole process is very difficult. On the other side of things, I can very much appreciate the need for evidence to be present before formal action can be taken against staff who are behaving inappropriately. My own view is that the policy should more adequately support staff to raise and deal with issues at the informal stage, to prevent issues escalating. Managers should be properly trained to enable 'difficult' conversations with staff and to challenge inappropriate behaviours (without fear of being told they are bullying the staff by setting standards)".

25.47 A senior staff member wrote to me in these terms:

"There needs to be better training for those dealing with grievance procedures, mediation and follow up when these processes are finished to ensure agreed changes are ongoing.

My hope is that processes in dealing with these issues are improved. There is better training for management who deal with these processes. The cases and picture gained through things like mediation are tied together and managers or other staff who do not behave professionally are given support to improve and the staff experiencing bullying are treated with respect and supported fully."

HR Views

25.48 I am extremely grateful to senior members of the HR team for spending time with me and for providing me with their analysis following our meeting. I repeat this in full in Appendix 3 for three reasons: (a) it provides a useful acknowledgement of many of the points made above; (b) it provides a sense of balance from those within NHSH who have a far better understanding of many of these issues than I do; and (c) it provides a number of forward-looking proposals which deserve to be fully supported.

Confidentiality

25.49 I have been asked to note that there are significant constraints on the ability of an organisation to identify patterns of alleged bullying owing to the NHS policy of maintaining confidentiality in regard to individual cases. This could contribute to lack of knowledge at board and other levels.

26. Trauma and Mental Health

A Significant Issue?

26.1 It has become clear to me that mental health should be a major management issue for the NHS and NHSH in particular. I am not an expert in trauma but I have spoken to people who are. I am persuaded that a significant number of people employed in NHSH have suffered and some continue to suffer from significant mental health issues as a result of their experiences, many of which can be described as traumatic given their repetitive and intrusive nature in disruptive and damaging situations. Trauma appears to be a more common experience than might be thought. I am told that some employees have the symptoms of Post Traumatic Stress Disorder (PTSD). It is important to have the ability to diagnose and deal with PTSD appropriately.

26.2 As one former employee told me:

"A person with developing mental health illness is not well enough or confident to stand up for themselves...The long-term effects - like PTSD - should not be underestimated and has daily impact e.g. dealing with emails, phone, challenging conversations, sleep patterns. There was no neutral counsellor/ advocate to speak to early enough until the unions made themselves involved after nearly a year off sick. Discussion with colleagues only reinforced negative issues, and there was nowhere to take issues."

26.3 One well informed member of staff advised me that, in his view:

"NHS Highland does not take PTSD seriously, as they would an overtly physical illness. They should ask why a person has developed this condition and act to mitigate distress. This applies even to Occupational Health, at senior staff level."

26.4 He expressed concern that:

"When these people go to interview with a manager who will put them back to work in proximity to where they were abused, they won't be able to think and will be drawn back into the trauma memories. They will experience dissociation from the here and now, and will relive (for example) being trapped, with someone looming over them and shouting with an angry face. They may be silent, but that does not indicate acceptance. They are not participating. They won't remember what is said. They are unable to represent themselves."

26.5 I am told there is thus an issue about by whom and how they are looked after. This requires a different approach to the standard investigation and advocacy in say a grievance setting.

26.6 Another well informed employee told me:

"The legacy effects of working in an emotionally unsafe system, and the culpability that can come from an uncomfortable awareness of having been involved and complicit in something inherently wrong, but where there was no voice, can be traumatic in itself. There will be advantages, if not a need, for people most affected, to have time and space make sense of, heal and recover even as the organisation moves ahead. If there were a way to achieve this, we might take the learning and wisdom into the future."

26.7 More generally, this is a leadership issue. Trauma-informed organisations recognise that trauma is widespread in the lives of individuals, families and communities and that trauma can be perpetuated in organisational culture and practice. This may well be the situation for some of those affected in NHSH.

26.8 I note that the Scottish Government commissioned NHS Education for Scotland to develop a framework for Transforming Psychological Trauma[47]. In that regard, I also note that:

"When an individual or a team struggles or cannot evidence insight and perspective on the impact of their distress or behaviour that can be traumatising to others, the wider system needs to step in and up. Senior leaders need to be able to actively visibly demonstrate competencies and teams around them have a duty to the wider organisation where a leader is known to be struggling."

Confidentiality

26.9 I am told that the business process means that all administrative staff have access to mental health records and that this breaches confidentiality. There can be conflicts of interest for staff working in occupational health who are handling records and cases from departments where they have relatives.

47 NHS Education for Scotland (2017). Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce. NES in partnership with Scottish Government. [online]. Available at https://www.nes.scot.nhs.uk/media/3971582/nationaltraumatrainingframework.pdf

27. Other Concerns about Behaviour

Introduction

27.1 Some specific concerns were raised in connection with a number of departments, disciplines and services. I raise these here, along with some commentary and observations about what may be needed. Again, I wish to reinforce that I have not tested these matters forensically but include them as they are indicative of what can be worked on to set NHSH on a different path in the future.

Concerns Regarding GPs

27.2 I was made aware of a number of difficulties in relationships between some GP practices and management/central services and concerns about how some GPs are perceived to behave. It seems that the relationship between many GPs, as independent contractors, and the organisation itself at senior management level and through support systems, is often rather strained. These comments capture the concerns expressed:

"Whilst the majority of GPs are excellent to work with, there are some that prove to be more challenging, disrespectful and on several occasions I find intimidating and passive aggressive. The only intimidation I have ever experienced has come from certain GPs."

"What I do recognise and have experience of, both personally and directed towards people in my own team, is a culture of disrespect and intimidation from some GPs and some GP practice employed staff towards NHS managed service staff. I believe that some GPs have no recognition that the way they speak to and treat staff can be intimidating, threatening and bullying."

"Some GPs appear to have no respect for the roles and professional responsibilities of other professions and have an attitude that, as GPs, they should be in a position to command and control what other professionals will and won't do and to dictate demands to us. This is far from the collaborative and multi-disciplinary approach to patient centred care that many of us strive to achieve. I have seen and heard many examples where staff have been made to feel humiliate and belittled by GPs."

"As well as individual GPs having no recognition that they behave in such a manner there is also no accountability for them to improve their behaviours. As independent contractors, the Dignity at Work Policy does not apply to them and, in any case, they do not recognise the concept of dignity at work. Until recently I would also say that there has been a reluctance in NHS Highland to recognise and to try and address some of these issues. When I/we have raised such incidents with managers, I perceive there has been an approach that, because it is GPs, there is little that can be done and that we just have to live with these unacceptable behaviours. I do not think this should be the case. When we have challenged individual GP's behaviour it often does improve in the short term but then reverts back."

"Unless the culture amongst some GPs changes, I am very concerned that we see some very experienced and highly valued staff members leave, directly as a result of how they are being treated."

27.3 The impact of this on some senior managers is reflected here:

"This behaviour has not been dealt with, not because there is a culture of bullying but because as an organisation (and as senior managers in this organisation) we are afraid to do anything that would upset these individuals or would make the situation worse. There is an imbalance of power in favour of those who display this behaviour (particularly when they are clinicians such as GPs and consultants) which also creates a climate of fear."

27.4 A different perspective comes from one manager who understands the tensions:

"I still have tough conversations with GPs. One meeting where they were bordering on disrespectful. But for me, that's part of the process. They need to push the boundaries to get across their point. I can understand why people could believe there was a culture of bullying, I

personally don't think there is, but I could see why they feel that way."

27.5 On the other hand. I heard from a GP that he perceived an anti-GP ethos and felt picked on by management:

"They'll pick that up and infer you're a trouble maker if you keep challenging what they're trying to implement, like effectively withdrawing the district nursing practice in my area."

27.6 There is a perception about management interference, for example in prescribing practices, in order to reduce cost. Another GP expressed concerns about a bullying approach by NHSH managers towards GPs. Yet another GP described experiences she has had which have left her *"feeling ever less valued and in tears (over years) despite a tremendous work ethic and a recognised loyalty to patients and their care."*

27.7 As ever, contradictions abound. Issues around the new GP contract and its impact in the Highlands add a further layer of complexity.

27.8 An astute observer posed this question:

"When we work for an organisation like that health service, we care for one another and care for those in lead. There is a recognition that we must nurture each other to keep doing what we do. We do have a corporate sense of responsibility. I've spoken about subcultures. I don't always get that sense of corporate responsibility from general practice. It's the way that the service is set up, it's a microcosm focussing on their own enterprise in that area. GPs are good clinicians but... I wonder if the action of my four colleagues: is it about their lack of access to leadership and support? If we are better at interdisciplinary working and access to leadership and support services, would we have got to the position we are in?"

27.9 What is clearly needed is a new and open set of relationships with a new and collaborative approach to leadership and negotiation about use of limited resources. This will require people-centred skills and attitudes on all sides.

Nairn GP Practice

27.10 One GP practice, Nairn, featured significantly in this review. It is clear that there have been serious issues between Nairn and the Board and managers for a number of years. I heard concerns expressed on both sides. However, again, the way of dealing with this is said to have been through implied or direct threats and intimidation. This is not sustainable.

27.11 Nairn is, I am told, innovative and different. It may not necessarily fit the expectations of some decision-makers. That issue could be faced up to directly and respectfully. I was encouraged to think that a quantitative analysis of clinical effectiveness would help to achieve an objective way forward.

27.12 In any event, urgent work seems to be needed to achieve a deep understanding and common ground between the Board and Managers and the practice. I believe that skilled independent mediation would offer a start.

Radiology

27.13 I was made aware of serious concerns regarding this important department. It has not been functioning as it should over the years. There have been tensions between senior radiologists and management and within the department.

27.14 There has been concern about locum provision and risk to radiology services, especially interventional. I was told of an apparent unwillingness on the part of the Board/chair/senior management to listen to concerns over a number of years. I was told that dealings with the senior management team and the Board have been frustrating and that the severe problems around recruitment of senior medical staff to Radiology have been essentially ignored until latterly. I also heard that this has fuelled discontent so far as Radiology is concerned.

27.15 However, it seems clear that there are many sides to this story and indeed I heard of real difficulties experienced by some senior clinicians who provided the interface between the service and management. Senior managers have also expressed concern about disruptive behaviour by some senior radiologists. *"The Radiologists never embraced change willingly or took a lead on this... The culture in the department was difficult with a huge amount of undermining and disrespectful behaviour on-going."*

27.16 This whole situation has been unhealthy and would benefit from an urgent rigorous independent assessment and review (and

possibly mediation) which takes account of all points of view and not only the strongest voices. Indeed, I would suggest an overall review of the future of Radiology to ensure confidence in the vital working relationships and decision-making the department needs to ensure the delivery of safe, effective and high-quality services to their patients in the Highlands. Could it be recalibrated and become a world-class centre of excellence?

27.17 Whatever the outcome, this could be an excellent example of where having an overall clinical strategy at Board level would be really constructive and beneficial for the future. And where deeper understanding of the real underlying issues from all perspectives might build a foundation for a more effectively functioning service.

Chaplaincy

27.18 I have been made aware, from a number of sources, of internal leadership issues, including allegations of bullying, connected with the chaplaincy service which, it is recognised by a number of people, does much good work and could do more in the counselling area. I am told that staff have sought to raise awareness over many years but feel that little has changed in managing concerns.

27.19 Again, this seems to exemplify what many employees of NHSH are saying. As one observer put it: *"A more robust approach in dealing with concerns raised could have stamped this out 10 years ago."*

27.20 I suggest that a review of the leadership of the chaplaincy function may be necessary.

Mental Health and Other Departments

27.21 I heard a number of concerns expressed about management in various areas of mental health including neurology, neuropsychology, psychology, psychotherapy and psychiatry, especially an apparent lack of respect for clinical judgment and needs: in one context, a consultant told me:

> "Many acts of overt and covert attempts to destabilise and deconstruct the department, with direct impact upon individuals including myself; unprofessional and inaccurate, displaying a fundamental lack of both knowledge about what we do, but also lack of concern about stating that we as a professional group are not cost effective."

27.22 Another concern expressed was that a service lead for mental health banned the phrase "clinical governance"; *"however, clinical governance is the cornerstone to robust lines of accountability and appropriate practice. The Francis report clearly identified failings in clinical governance that led to multiple deaths and a very top down, blaming culture."*

27.23 These views are replicated by others with concerns about intimidating behaviour, harassment, belittling of services, avoidance of key issues, failure to address bullying by a head of department over many years, inappropriate management, poor clinical governance, loss of staff and failure by the union to act appropriately.

27.24 I also mention paediatrics, orthopaedics, dentistry and maternity as areas where specific concerns about bullying have been raised. I cannot go into further detail in this report for reasons of confidentiality.

Belford Hospital, Fort William

27.25 I have the sense that a review at Belford would be useful. There are concerns about its isolated nature, burnout/longevity of senior staff, the relationship with other hospitals in NHSH and some inappropriate behaviours. I suspect that these will be well known to senior management.

Argyll and Bute

27.26 A number of respondents came from Argyll and Bute (A&B). There is no doubt that the geographic spread of NHSH creates unusual situations. It was put to me that *"A&B within the context of NHSH, in many respects 'manages its own smoke', although there is clearly a corporate link with the 'north'. A&B is a different place to 'north' NHSH, as all secondary care referrals go to Glasgow, and so there is no 'clinical link' with 'north' NHSH which includes Raigmore Hospital."*

27.27 Initially it seemed that the circumstances in Argyll & Bute were such that many of the concerns in the north might not apply there. But, as evidence came in, similar concerns were

raised, especially about management behaviour and inconsistency, and inadequacy in training of managers, appointment and application of policies and systems.

27.28 In the time available, I was not able to conduct as full a review of Argyll & Bute as of the north Highlands. Thus, I fell into the position which is often the subject of criticism by those in the west and south, with justification, of not seeming to be as interested in that part of the organisation as elsewhere. I fully appreciate that there will be much more to learn.

27.29 However, I was concerned to hear from a number of sources about particular problems in some of the island communities and of a management culture located in Lochgilphead and Oban which seems to have created significant tensions and resulted in poor relations between managers and frontline staff.

27.30 This is one example:

> "Thank you for listening to my concerns. When a working environment becomes toxic over a period of time, what is non acceptable behaviour becomes normal and suddenly it's embedded. For staff on the frontline in Argyll and Bute defensive and intimidating behaviour is normal practice that we endure on a daily basis, it corrodes confidence and lowers morale but we keep on caring for people and their families. The calibre of frontline staff is immense and they are a credit. The solution to financial pressures is within them if senior management stop and listen properly and start to work with senior nurses and staff instead of treating us like the enemy. You save money by helping people to work more efficiently through workable IT and systems not by cutting nurses, services and beds."

27.31 The key areas of concern were described by one respondent as:

- Intimidating behaviour individually and as a team by [certain senior managers]
- Aggressive body language and facial expressions.
- Making negative or derogatory comments.
- Changes in decision making leaving people on the back foot and ill prepared.
- Making decisions affecting individuals without consulting them and announcing them widely.

Other respondents described unacceptable treatment in a small community including ostracisation, victimisation, harassment, humiliation and rumour-spreading.

27.32 This observation summed up concerns: *"A culture of undermining, intimidating and pressurising operational managers has developed within the A&B HSCP."* I am persuaded that a specific review of management practices in Argyll and Bute is necessary and, because the nature of some of the allegations implicate management at a very senior level, consideration should be given to this being conducted by someone from outside the area who is viewed as wholly independent. Consideration should also be given to greater integration with North Highlands.

27.33 I am aware that there is new director level leadership and I hope this will help in the process of resetting matters in this part of NHSH.

28. The Role of Scottish Government

Tension and Balance

28.1 I acknowledge that it must be hard to be an official in the Scottish Government trying to deliver all of the policies and targets of the government of the day and knowing, by implication or explicitly, that there are all sorts of issues at local as well as regional and national levels which are difficult to manage.

28.2 The tension of balancing possibly competing political, policy, financial and human needs must seem acute on a daily basis. The need to achieve particular goals must place real pressure on all concerned. The same, I suspect, will apply to a minister or a Cabinet Secretary.

28.3 There is also the tension between intervening and encouraging organisations and individuals to deal with issues themselves. Government is often accused of over-involvement. Yet, when things go wrong, it is held responsible. Judging when and how to intervene is not easy. I mention this as it may help to explain the Scottish Government's response to its own knowledge about events in NHSH.

Awareness of Situation in NHSH

28.4 Officials were made aware in autumn 2017 about concerns expressed by NHSH non-executive directors. It seems likely that more active intervention at that time would have avoided such a public and arguably more damaging process now. Indeed, I am satisfied that senior people in Scottish Government were aware of the dysfunctioning situation with the Board and at senior leadership level for a considerable period of time prior to matters becoming more public in the autumn of 2017.

28.5 In particular, the resignation of a number of non-executive directors and other events and information provided to the Government over a period of time ought to have signalled the seriousness of matters and could have prompted more decisive action at an earlier stage. The question of whether the Scottish Government could and should have acted is for others to consider.

28.6 A few observations from senior people in NHSH sum up what I have heard in this connection:

"The main point there, SG have known that there are things going on."

"We were told that "we're trying to deal with this internally" which gave me the clue that the Cab Sec wouldn't know".

"I can't feel the government in any of this. I don't know where they were, what role they were playing. They've almost been watching the board self-destruct. Watching to see whether we succeeded."

"I expected an exit-interview with government in which I could voice my concerns but this never happened. I subsequently attempted to raise my concerns with [a very senior official] on several occasions soon after leaving, prompted usually by another confidential call from a senior member of staff asking for my advice. I also offered to participate in the governance review conducted approx a year ago now.... but although given assurances by the civil servants that I would be contacted, I never was."

"Scottish Government was made aware of a number of the above issues and its action was to instigate a quiet 6 month review of Board governance rather than to take a more direct or more visible action."

"The overall message, yes I believe there was a serious problem. It related directly to the CEO. I believe that, for whatever reason, Chairs were afraid to do anything about it. There was also the dynamic of government civil service and politicians. I've had conversations with everyone including [senior civil servant] about it. The reaction from civil servants are "don't put it in an email please".

"I told him [senior Scottish Government official] my story and about the whistleblowing line being a waste of time. I told him there was a list of people to speak to them. I said if they can't speak to you, what should I tell them? He said, "tell them message received, loud and clear". But then nothing happened. So, SG was of no use."

Relationships

28.7 I have gained an impression that the Scottish Government is sometimes viewed as being less respectful and less coherent in its engagement with boards and their leaders than it may perceive from its perspective. Certainly, the same points about a collective and enabling approach to leadership which I mention in later chapters should also apply at the top of NHS Scotland.

28.8 There are no doubt lessons to be learned about when and how to act. Perhaps what is needed is the setting of clear benchmarks against which to assess whether, how and when to intervene. The Scottish Government is an essential part of the system. How it acts and reacts also impacts on those in NHS boards and executive positions in local areas. Now seems like a good time to review this relationship.

29. The Whistleblowers

Introduction

29.1 Some insight into the complex nature of bringing allegations about bullying and harassment to the fore in NHSH can be gleaned from a consideration of the actings of, and responses to, the whistleblowing event of September 2018.

29.2 On 26th September 2018, a letter to The Herald was published in these terms:

"The culture of bullying at NHS Highland must change

AS senior clinicians at NHS Highland, we wish to make clear our serious concerns around the long-standing bullying culture that exists within the health board where we work.

It is our belief that, for at least a decade, this practice of suppressing criticism, which emanates from the very top of the organisation, has led to a culture of fear and intimidation. This has had a serious detrimental effect on staff at all levels of NHS Highland, but equally importantly, has had an adverse effect on the quality of care we are able to provide for patients.

With the recent publication of a report on governance at NHS Highland, and with the departure of the chief executive announced and now imminent, we feel now is the time to speak out and ensure effective action can be taken.

Indeed these recent events have seen more and more clinicians share with us their concerns on the impact this culture has had on them, the organisation and ultimately patients. While the majority are still fearful of speaking about these publicly, there have now been discussions at various forums for clinicians and we feel that, on behalf of the whole clinical workforce, it is vital this bullying culture is exposed and finally now dealt with.

Anyone working in our NHS needs to feel supported and able to speak out on issues as serious as this. Yet at NHS Highland, our belief is that some staff have not been able to raise concerns around bullying, or indeed some issues concerning patient care, due to the culture of bullying and fear that has pervaded across the organisation.

This is the moment that this has to change. We urgently need fresh leadership at NHS Highland to take the brave and extensive actions required to ensure NHS Highland is a safe positive place to work, based on a culture of openness, transparency, learning and honesty. That is the only way that we will be able to guarantee a safe environment, delivering high quality care for patients for the future."

29.3 The letter was signed by Dr Eileen Anderson, Chair Area Medical Committee; Dr Lorien Cameron-Ross, Vice Chair, Area Medical Committee; Dr Jonathan Ball, Chair, (GP Sub Committee and Highland Local Medical Committee Chair) and Dr Iain Kennedy (Professional Secretary, GP Sub Committee & Medical Secretary Highland Local Medical Committee), c/o Riverside Medical Practice, Ness Walk, Inverness.

Context

29.4 Another doctor associated with the named whistleblowers explained:

"After much discussion, review and soul-searching, [we] felt we were left with no option but to make a public disclosure in the interests of patient and staff safety and to try and exert pressure on NHSH to take these allegations seriously."

29.5 This was the culmination of a number of attempts to persuade the Board to take seriously allegations of a bullying culture using the committee structures which had, so far as the signatories were concerned, failed. To the whistleblowers, the Board and others in senior management seemed closed to suggestions that there were deep-seated problems.

29.6 Many people who do not recognise a bullying culture are understandably unhappy with the way in which matters became public (and the damage that has caused). However, I am

satisfied that those involved genuinely felt they had no option but to do so and that this was the only way to address matters, even with the costs which arose. That a number of senior professionals, from a variety of backgrounds and at considerable risk to themselves and their careers, came to that conclusion is itself an eloquent demonstration of how serious matters seemed to them to be and how inadequately it appeared to them that the Board was coping with the many concerns being expressed over a significant period of time.

29.7 As one whistleblower remarked:

"We have been accused of being troublesome malcontents. It would have been far easier to just continue doing the day job rather than highlighting the bullying culture but that would have been the wrong path to take."

29.8 As this Report has made clear, many of the concerns expressed in the letter have a sound basis. Many others within NHSH, with no association with the whistleblowers, have now come forward with their own stories. People are coming forward now because it appears possible to do so and they feel liberated because others are doing so. At the end of the day, my findings are not hugely influenced by the whistleblowers' allegations; they were ultimately a catalyst for others to come forward.

Damaging Effect

29.9 It has to be recognised that the effect of the whistleblowers' action is significant and, for many, damaging in its own way. Many people have been hurt and feel misrepresented and offended by what has appeared to them to be a brutal step. Individual reputations in a close community have been adversely affected. The assertion that there is an organisation-wide culture of bullying has been very distressing for those who do not have that experience and is perceived to be damaging reputationally and for patient confidence.

29.10 One respondent summed up the concerns of those shocked by the letter in this way:

"… we were deeply shocked to learn of allegations. We knew nothing about these concerns. There had been absolutely no forewarning that such a serious release was to be made to the press, at national level. You will I hope have learned that this shock was widespread across essentially the entire senior clinical workforce.

29.11 It is said that the group's decision to go to the press, the circumstances in which that decision was made, the "false claims" that the whistleblowers were speaking on "behalf of consultants and GPs", and the subsequent "lurid, extreme and even sinister" allegations that were made (for example of "cruelty spun into the thread of NHS Highland" and the need for "deep cleansing"), caused offence, anger, distress and a profound sense of bewilderment.

29.12 A nursing manager told me:

"From a professional nursing and midwifery perspective, it has felt disappointing that our medical colleagues have chosen to go down this way. We work in the highlands and that is a small community and we uphold the organisation as that instils public confidence. The allegations in the press have been very challenging for staff who have to field questions from the public. We have been powerless against the allegations. The actions of our medics have been divisive."

29.13 A member of the leadership team said: *"It has been designed to create maximum impact. Left us with zero reputation, no name. I find that upsetting. This is my organisation. This is my area. My people. I find it particularly offensive."*

29.14 There seems little doubt that certain assertions were too broad and without the support claimed: in particular the expressions "on behalf of the whole clinical workforce" and "the culture of bullying and fear that has pervaded across the organisation" imply a universality that goes beyond what this report records. It also implies that all clinicians are victims whereas it is clear that some clinicians are also viewed as perpetrators. I recall Sir Robert Francis' comments on the difficulty of making an organisation-wide assertion of bullying. And it appears that other aspects, such as the use of social media to wage a campaign, could have been conducted more thoughtfully and tactfully.

29.15 Regarding social media, one respondent expressed concern about *"a personal attack as opposed to a reasoned argument in regard to the topic matter, given this is a public platform seen by many and not the few."* There has been real concern about the use of expressions already mentioned such as *"a thread of cruelty has*

purposefully been spun throughout NHS Highland"; *"This thread of cruelty is now marbled into the culture of the organisation. It is so deeply ingrained that only deep cleansing will cure it."* As one observer said: *"'Deep cleansing' is an appalling phrase and has incredibly revolting connotations in a historical context."*

29.16 I accept that the whistleblowers themselves did not anticipate the reaction which occurred and that they have themselves suffered distress also: *"...whistleblowing has been... difficult, soul searching, time consuming and unpopular,"* one commented. *"It has been brutal and certain relationships are unlikely to recover." "I have been cornered on regular basis,"* said another. They are concerned about victimisation in the future.

29.17 All of this reinforces the need to establish a culture where this sort of action is not necessary and, if it is, where it can be done constructively and safely. Of course, none of this would have been necessary or would have developed as it did had the Board and management appeared to be open to a full exploration of the issues. As one whistleblower put it: *"If they had said 'this sounds terrible, what can we do?' That's all it would have taken. Or 'Right, let's work together and sort this'."*

Board and Management Reaction

29.18 It also appears that, as noted earlier, the initial response by some at board and management level to the whistleblowers' actions was not appropriate and signalled lack of full understanding and insight at best. It was perhaps unfortunate that the response to the letter in some quarters appeared to be to try to undermine the individual whistleblowers rather than to address the issues.

29.19 Certainly, if the reaction by some in management and on the Board was to downplay the concerns because of how and by whom they were expressed, that seems to have been a misjudgement, as it distracted the Board and others from appreciating and acknowledging how serious these concerns were.

29.20 It has been put to me that the NHSH Board publicity machinery moved to try to discredit and marginalise the signatories as well as deny the allegations, without any attempt to investigate them seriously. This observation sums up what some people have told me:

"Staffside Unions issued a statement saying they did not recognise a culture of bullying or have an awareness of bullying in NHSH. The Director of Occupational Health also issued a statement saying they were unaware of a bullying problem. ...No attempt was made to take the allegations seriously but rather all efforts were directed at discrediting and marginalising the whistle blowers. ...Instead of open minded listening given the potential for patient safety issues arising from the allegations of bullying, they chose to deny without evidence and attempt to undermine, discredit and marginalise the whistle blowers. Their actions and those of the Board have shown that being a whistle blower in NHSH is unwanted and unprotected. Energies are directed at discrediting allegations and concerns rather than welcoming them and trying to genuinely understand the issues and work collaboratively with those raising them in order to correct matters and improve the service."

29.21 Hopefully, with this experience and this report, NHSH will be able to take steps to ensure that there would be a different approach in the future. I comment further on this below.

Concerns about the Whistleblowers' Behaviour

29.22 In fairness and for balance, I am bound to record that there is some concern from a number of sources about the general behaviour of some of the whistleblowers. Social media activity can be unpleasant. A number of people say they have felt intimidated and bullied into conforming with the view that bullying has occurred.

"This has been a theme throughout this affair, where those who have raised allegations resent having them called allegations, resent the notion of other people having differing opinions about the situation."

29.23 It goes further for some:

"What we have felt and seen since the allegations of a bullying culture were made... is that fear has pervaded the organisation. This is a fear of those instigating the allegations and fear of doing anything which might incite an adverse response from this group."

29.24 In addition to these concerns about whistleblowing itself, one of the more difficult aspects of my review has been acknowledging that a number of respondents have commented on the manner of one or more of the whistleblowers more generally.

29.25 While it has been represented that this matter should not be mentioned in this report at all, I do so as it reinforces the complex, ambiguous and paradoxical nature of this situation. Ironically, this may be one of the reasons for some of the resistance the whistleblowers experienced. To be a whistleblower is not an easy thing. It does not seem right, however, that whistleblowing can provide automatic protection against allegations of inappropriate behaviour. In the future, it should not be necessary for whistleblowers to make themselves publicly known and this issue would not arise in this way.

29.26 Against this background, going forward, it seems essential to rebuild trust and confidence between and with some of the key people. This is a major and important task.

29.27 As one board member observed:

> "... the one thing that worries me is the Board and the original 4. I worry about our relationship with those 4 doctors. Trying to renegotiate the primary care contract that has been agreed nationally and they all play a pivotal part. Somehow, we need to get back into the room with these people. I'm anxious about that. There's no doubt we've lost our trust with each other."

29.28 The whistleblowers may find it difficult but I believe that it will be important for them to show leadership in a new and open approach. They can demonstrate the change in behaviour which their initiative has sought. And those who have been angered by the whistleblowers' approach will need to build bridges from their side of the story. There is no other way. There is a rebuilding job to be done. It needs to start with those who have enabled this to come to the fore. I suggest that mediation could provide a way to achieve this.

An Appropriate Whistleblowing Facility

29.29 According to the All Party Parliamentary Group on Whistleblowing, a "Whistleblower" is defined as *"a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation that is either private or public. These individuals are vulnerable to retaliation for their actions and whilst there are laws in place purposed to protect them, sometimes the laws are not adequate or effective in their practical application."*[48]

29.30 One former consultant who resigned as a result of the way his concerns about patient care were dealt with told me that:

> "NHS Highland was not willing to acknowledge that there had been shortcomings in the care provided to patients. They avoided addressing this issue by making a scapegoat of the whistleblower. Patients have been failed by NHS Highland by their unwillingness to investigate cases of neglect. The opportunity to improve services and prevent further instances of neglect has been lost. I feel that there needs to be a change in the way that managers of the organisation are held accountable for their behaviour towards patients and the staff of the organisation. Whistleblowers need to be able to raise concerns in the knowledge that they will be taken seriously, the concerns appropriately investigated and that they will not become the scapegoats. This will only happen if there is an independent body to which the concerns can be reported. It is not appropriate for Health Boards to investigate themselves."

29.31 I cannot comment on the accuracy of the statement about neglect but sense that the general point about the inadequacy of whistleblowing protection is an important one. It seems that whistleblowing provision which covers only patient safety issues is also not sufficient.

29.32 I heard from a number of further sources that the existing system did not seem to be effective:

> "Talking to the Whistleblowing champion didn't help." "First, I went to the Whistleblower. I said I wanted to discuss it. I was told "that's not what we do". The Whistleblower was in London. .... I said: "if you get lots of calls from one organisation, who do you report it to?" and he said "nobody". He said they were a charity."

48 APPG Whistleblowing. (n.d.). APPG Whistleblowing | Home. [online] Available at https://www.appgwhistleblowing.co.uk/ [Accessed 22 Mar. 2019].

29.33 Others shared similar experiences:

> "I whistleblew once and wouldn't do it again. There's a woman in NHSH who will not come and speak with you because she cannot bear to dig it up again. She was made to feel that her concerns were not valid. She's an alcoholic now."

29.34 I understand that a non-executive director has a whistleblowing champion role. My impression is that, despite that director's efforts, this has not functioned as effectively as it needs to.

29.35 I address proposals for better provision for whistleblowing later in this report.

Ways Forward for NHSH: General Underpinning

30. Leadership: Creating a Collaborative, Compassionate Place of Work

Introduction

30.1 In this chapter, I explore some of the general theory underlying the leadership challenges and opportunities for NHSH as it looks ahead. In following chapters I discuss what this might mean in specific terms.

30.2 The following quotation, adapted from a recent speech[49] by the Prime Minister of New Zealand, Jacinda Ardern, sums up the way ahead.

"...one priority will be to support the mental wellbeing of all employees.... From a purely economic perspective, there are clear benefits to supporting positive mental wellbeing, including enhanced productivity. From a kindness perspective, the modern age places huge stresses on all people, which affects their ability to live full, meaningful lives. Confronting this will make us a better [organisation]".

30.3 In summary as put by another observer:

"Once staff become safe and are treated well, you will have a workforce that is happy. A happy workforce is a motivated and productive workforce."

30.4 One respondent to the review observed:

"Your report acts as an urgent prompt/warning to help us redesign and reengineer NHS Highlands into a kind, compassionate, fair and caring organisation for both us and patients."

30.5 Others had similar views:

"We need to care for the carers as we do for the patients."

"We all need healing; it's the nature of the human condition."

"I hope that the outcome will encourage a thriving, happy, well led organisation which provides excellent patient care and looks after the people working within it."

A Better Way

30.6 History is full of examples of situations where focussing on the people who form the workforce has transformed an organisation. Research shows that when people do what they love, work feels more like play and they are more likely to keep going when the going gets tough. They end up being more productive and effective.

30.7 If leadership can be inspiring, visionary, energetic and attractive, people will deliver more. Perhaps this is especially true in public service, especially in the NHS, where people often act over and above the call of duty in order to serve. The converse is likely to be true if leadership is constraining, dictatorial and fear-based.

30.8 A recent example can be found in the fortunes of Manchester United Football Club. The writer, Matthew Syed, whose book *Black Box Thinking*[50] contrasts safety in the health service with the aviation industry, has pointed to the shift from fear-based and fear-inducing leadership, characterised by criticism, confrontation, blame and buckpassing, which impacted negatively on performance, to a joyful, supportive, liberating approach which has released players (the staff) to see things more widely (literally as well as metaphorically, as the brain responds differently), and to become more creative, responsible, and engaged. There is less fear and more interaction. More confidence and fun in what they do. Interestingly, the new (and, at the time of writing, interim) manager has also visited backroom staff and shown interest in how they support the playing staff.

30.9 I note in passing that, in the aviation industry, this is not just about a "no blame" culture; more it reflects a "just" culture, where the difference between what is acceptable and unacceptable is understood. This entails another shift in

49 Ardern, J. (2019). New Zealand hopes the world will follow its wellness-based policies. Financial Times. [online] Available at https://www.ft.com/content/6b425632-18c1-11e9-b191-175523b59d1d [Accessed 11 Mar. 2019].

50 Syed, M. (2016). *Black Box Thinking*. Hodder & Stoughton. I might add that recent events in the aviation industry may be an indicator of what happens when safety is compromised in the pursuit of financial performance.

mindset, moving from culpability and shame to acceptance of fallibility and vulnerability. This presents another useful challenge to NHSH thinking.

Resetting the Organisation

30.10 In NHSH, I believe that steps can be taken, both restorative and preventative, to reset the whole organisation and to promote an institution-wide healing and reconciliation initiative, supporting and liberating the workforce. This is likely to have a positive impact on patient care and outcomes too. Better staff relationships will lead to better clinical outcomes, especially when the tasks are complex and interdependent.

30.11 No doubt, this may take many months or even years. New thinking and fresh attitudes take time to embed. Changing habits requires conscious effort. As one respondent to the review observed, *"to turn round this liner, you need lots of people going in the same direction with confidence in those on the bridge – this will take time."* Someone else suggested that the better analogy is with a flotilla of boats all heading in broadly the same direction. In any event, there is a transition stage to be undertaken. Another senior director told me:

"We need to work through, we will be working together for a long time. It's going to take time. People have tried to sort our issues through one-off interventions. This is going to take years of counselling."

30.12 Another manager told me:

"I think people, managers, NHSH need to look at a way to work together rather than be in competition. Integrate properly. Add to that, the struggles I come across with the people I have professional responsibility for, I looked at a way to increase access. Managed to increase resources, but people need to work smarter. But there's resistance there because they feel under attack. Management think they do communicate well, but I'm not sure they communicate effectively. They need to be more open with the struggles NHSH is facing. Rather than coming up with immediate solutions, they need to work towards developing a shared vision and get people on board."

Collaboration and Interdependence

30.13 To achieve this, there is an urgent need to collaborate and work together rather than to compete, based on a deeper and wider understanding of the shared interests that allow people to cooperate more effectively and efficiently to find solutions. No man, woman, doctor or manager is an island; there is a mutual interest in supporting each other. Interdependence is the watchword.

30.14 This has its own challenges, given the geography:

"[Management] didn't come together very well in multiple sites. Now you have chief of medicines for various hospitals. It's about achieving the balance of accountability and responsibility by site and also having the ability to work collaboratively and influence in the greater interest in the organisation in other sites. Joining these sites up without losing the individual strengths."

30.15 It is likely that all of this will require an overall strategy which focusses on full engagement and openness, and the enhancement of effective working relationships throughout the organisation. This will help to build a culture of cooperation and respect which is founded on a deeper understanding of the differing roles and viewpoints of various groups such as clinicians and managers, to take an example. Inviting colleagues to participate in a rebuilding exercise will reap dividends. A coherent, integrated approach is necessary. Working in any one part in isolation will be challenging if the values are not shared by other parts of the chain.

30.16 As the consultants, The Phillips Kay Partnership, put it,

"To make sense of complex social systems requires many perspectives to be brought together. No one person or group could ever understand the whole environment. To release the collective intelligence in the system we must build strong and open relationships." [51]

51 The Phillips Kay Partnership Ltd. (n.d.). [online] Available at http://phillipskay.com/ [Accessed 11 Mar. 2019].

Process and Relationships

30.17 Put more broadly, I believe that this is an opportunity to encourage a different way of dealing with the inevitable stresses and strains of providing health services in the Highlands and to apply some new thinking, to the benefit of all concerned. It is, as Phillips Kay remind us, all about the how, the process, the journey: *"The process you use to get to the future is the future you get."*

30.18 The key to survival as an organisation is cooperation. Arguably, in order to overcome the chronic nature of any dysfunctioning body, there needs to be a shift from paradigms which are power-based (resting on hierarchy and status, win/lose, operating by command, with an expectation of obedience) and/or rights-based (resting on bureaucracy, operating by control, with a high expectation of compliance) to one of mutual interests, with shared vision and openness, where power and decision-making is shared, and distributed, wisely and thoughtfully. What might that entail?

30.19 As Ken Cloke puts it in discussing the points made in the previous paragraph, we need to develop better attitudes, behaviours, processes and relationships with skills and capacities which help to reduce resistance, overcome impasse, build trust, encourage participation, value diversity and dissent, redress injustices, encourage feedback and evaluation, and which accept ambiguity and complexity. A tall order but it needs to be done for a complex organisation to thrive.

30.20 He explains:

> *"If the content of the problem is successfully addressed and the relationship is constructive, but the process is ineffective and unfair; or if the content and process are successful and effective, but the relationship is competitive, adversarial and untrusting, chronic conflicts will arise that can prevent even the best solutions from being implemented. Yet nearly all of our focus in solving ...problems and making decisions is on the content, and comparatively little is devoted to improving either the processes or the relationships. This is often because of pressure to deliver, achieve results, under great pressure. Short term gains [but] with longer term losses."* [52]

30.21 He points out that: (a) the substance or content of the problem must be successfully identified, discussed, addressed and resolved; (b) the process for solving problems and making decisions must be inclusive, transparent, effective and fair; and (c) the relationship between the people who are impacted by the problem, or trying to solve it, or make decisions about it, must be respectful, constructive, trusting and collaborative.

30.22 Thus, as one senior NHS executive put it:

> "All improvement begins with relationships. And by that I mean good, trusting and empathic relationships. Add reliable processes to this and as long as you are using the right measurement to steer your progress then improvement will happen."

30.23 Another commented:

> "I passionately believe that the people of the Highlands deserve a better health service and that this will only be achieved if we can foster better working relationships between clinical and operational staff and create a working environment where decisions can be made more promptly so that the standard of care is improved."

30.24 Another put it succinctly, *"whatever change we seek to undertake, we are only as good as the relationships we are able, or capable of creating and sustaining."*

30.25 If relationships are not strong, respectful and open, no amount of procedural changes or micro management will lead to the kind of cultural change that is required in NHSH. The Scottish Government's Collective Leadership initiative also reminds us that: *"We cannot make this kind of change by telling people to do it. We need a clear appreciation of the power and importance of relationships to enable our work."*

52 Cloke, K. (2018). *Politics, Dialogue and the Evolution of Democracy: How to Discuss Race, Abortion, Immigration, Gun Control, Climate Change, Same Sex Marriage and Other Hot Topics*. Goodmedia Press.

Command and Control to Collective Leadership

30.26 This necessarily entails a move away from trying to control everything to a more distributed, multi-disciplinary or collective leadership and decision making. NHSH is probably too big and complex an organisation to control in any event but, in trying to do so, the trouble may have been that relationships have sometimes taken a back seat as one-off transactions seem a more efficient (or easier) way of operating. This turns out to be hugely inefficient and costly, however. A more holistic approach is needed, acknowledging complexity, ambiguity and uncertainty.

30.27 This also requires an approach to negotiating distribution of resources and addressing other potentially contentious issues which is based on interests rather than positions: the *Getting to Yes*[53] model. Ironically, perhaps, this helps to create more value. We are reminded that *"[h]elping people create more value on their own represents one of the highest forms of respect."*[54]

30.28 Many factors interact and conventional management approaches will need to give way to greater collaboration. In a sense, one is looking for a move from heroic leadership to post-heroic, as the jargon describes it. This is likely to apply both to senior management and to clinical leaders. Delegation and empowerment do not, however, mean abdication and senior leaders will still need to take appropriate responsibility. I note these words from the NHS Education Scotland Leadership Behaviour and Qualities Guidance Notes:

> *"The model of 'heroic leadership' is no longer appropriate. What is required is 'engaging leadership': "a commitment to building shared visions with a range of different internal and external stakeholder…[which] exploits the diversity of perspectives and the wealth of experiences, strengths and potential that exists within the organisation, and with partners and other stakeholders"."* [55]

30.29 Peter Senge and others commented on the leadership style of Nelson Mandela:

> *"Perhaps the most transcendent example of Mandela as a system leader was the Truth and Reconciliation Commission, a radical innovation in the emotional healing of the country that brought black and white South Africans together to confront the past and join in shaping the future. The simple idea that you could bring together those who had suffered profound losses with those whose actions led to those losses, to face one another, tell their truths, forgive, and move on, was not only a profound gesture of civilization but also a cauldron for creating collective leadership. Indeed, the process would have been impossible without the leadership of people like Bishop Desmond Tutu and former President F. W. de Klerk."*[56]

There are clear signals here for a different way to approach NHSH. Where are the Tutus and de Klerks?

Compassionate People-Centred Leadership

30.30 Such a pro-active approach requires resources and skill, of course. It needs an enabling culture from the top. Culture change needs to be owned by the leaders. That means leaders who are not afraid, who have high self-esteem and a great deal of humanity and compassion. Kindness is a critical component of the leadership which will be needed going forward. This is not some kind of passive, acquiescent, permissive approach but active engagement in building, encouraging and sustaining excellent personal and professional relationships.

30.31 As I mentioned in earlier in this report, and with reference to the NHS Highland Senior Manager and Executive cohort annual appraisal, humility, honesty, openness and self-awareness are all desirable characteristics. People-centred leadership in other words.

53 Fisher, R., Ury, W. and Patton, B. (2012). *Getting to Yes*. London: Random House Business.

54 Shook, J. (n.d.). Lean Quotes from John Shook to Inspire You and Your Team. [online] Lean.org. Available at https://www.lean.org/LeanPost/Posting.cfm?LeanPostId=688 [Accessed 13 Mar. 2019].

55 NHS Scotland (2014). Guidance Notes for NHS Scotland Leadership Qualities Framework. [online] Available at: https://www.nes.scot.nhs.uk/media/3399300/scottish_leadership_qualities_framework_-_guidance_notes_july_2014_-_copy.pdf [Accessed 13 Mar. 2019].

56 Senge, P., Hamilton, H. and Kania, J. (2015). The Dawn of System Leadership. Stanford Social Innovation Review. [online] Available at https://ssir.org/articles/entry/the_dawn_of_system_leadership [Accessed 13 Mar. 2019].

30.32 This is a profoundly compassionate approach. And I believe that it was Bishop Tutu who said in his inimitable way:

"Compassion is not just feeling with someone, but seeking to change the situation. Frequently people think compassion and love are merely sentimental. No! They are very demanding. If you are going to be compassionate, be prepared for action!"

30.33 Commenting on this, a colleague observed:

"And you simply can't be compassionate at the same time as being judgemental. When you judge you look down to get a clear view but when you feel compassion you are sitting beside someone looking at what they are looking at through their eyes with your arm round them - and you can't be in those two different places/ mindsets at once."

30.34 Research backs up the compassionate approach. The University of Edinburgh Global Compassion Initiative reports that:

"Mounting evidence from the new science of compassion demonstrates that it is key to: improving personal and organisational performance (in cooperation and productivity, resilience, employee commitment and retention), enhancing effectiveness (creativity and innovation, navigating change, collaboration, addressing conflict); supporting well-being (physical and mental health, engagement at work, and welfare); and building reputation (credibility)." [57]

All of these are highly desirable outcomes for the new approach to leadership which NHSH has the opportunity to embrace.

30.35 The challenge for NHSH is to find the right kind of leaders. One senior consultant who regretted his own unwillingness to step forward told me:

"... we seem to have promoted within the organisation those who either have a thick skin or those who just don't care. I feel sorry for the former group as they don't seem to understand the qualities of leadership that are needed. We desperately need others to step forward. How we encourage people with those skills to do so is unclear to me."

This report is a call to action for people like this consultant.

Understanding and Complexity

30.36 I sense that an honest conversation is needed more generally in the NHS, and with the general public and employees, about realistic expectations and the perhaps inevitable tensions between clinical delivery and financial reality. Seeking real understanding is a key to all of this. How well do people really understand what the underlying issues are and where others are coming from? How can that be addressed?

30.37 As has been pointed out: *"If we assume too readily we can see things from others' points of view we end up seeing them from merely a variation of our own."* [58]. So we have to go further than simply stepping into another's shoes to see what things look like: we need the competence to try to understand the context in which things are being seen by them.

30.38 That context is complex and multi-layered. I note the approach commended by the International Futures Forum (IFF):

"We follow the OECD definition that 'competence in complexity' is not an abstract achievement but "the ability to meet important challenges in life in a complex world..."". [59]

30.39 This resonates with the emerging work on systemic organisational constellations, drawn to my attention by my colleague Liz Rivers who assisted in the review:

"Systemic constellation is able to reveal embedded patterns that would otherwise be very challenging to understand and change, or simply impossible to access. Even if we intellectually recognise the patterns of negative behaviours and destructive relationships, it is in practice extremely difficult to transform these patterns. Through systemic constellations, we see the complex web of interconnection reaching into our

57 The University of Edinburgh. (2018). *Global Compassion Initiative*. [online] Available at https://www.ed.ac.uk/global-health/global-compassion-initiative [Accessed 20 Mar. 2019].

58 Baggini, J. (2018). *How the World Thinks: A Global History of Philosophy*. Granta Books.

59 Iffpraxis.com. (n.d.). Competence in Complexity. [online] Available at http://www.iffpraxis.com/competence-in-complexity [Accessed 11 Mar. 2019].

society, organisations and individual life. Experiencing this interconnectedness can have a powerful effect in our organisations and gives the possibility to transform unhealthy systems."[60]

30.40 I was struck by this comment about what is called "Eco-Leadership" which is *"very much the environment where we are concerned with emergent change, where we are no longer leading change in a traditional sense, but creating the leadership capacity under which we can handle ambivalence and uncertainty. In this situation, the leadership role is increasingly about interpretation and sense-making for the organisation."*[61]

30.41 This may all make sense as an appropriate underpinning for a 21st century NHSH and resonates again with the issues of complexity, ambiguity and uncertainty identified in the National Performance Framework referred to in chapter 4. And, of course, it fits in well with the Collective Leadership approach also promoted by the Scottish Government:

"Critical to working in this way is recognition that it is about "in here" as well as "out there" – we need to develop the skills and attributes to be able to work collectively within both the individual and groups for greatest impact on the system."

60 Cohen, D. (n.d.). What are Constellations?. [online] Isca-network.org. Available at http://isca-network.org/systemic-constellations/what-is-a-constellation [Accessed 13 Mar. 2019].

61 Simonwestern.com. (n.d.). What is Eco-Leadership?. [online] Available at http://www.simonwestern.com/leadership.asp.html [Accessed 22 Mar. 2019].

31. Looking Ahead

Acknowledgement

31.1 It is against this theoretical backdrop that, as noted above, steps need to be taken urgently, both restorative and preventative, to reset the whole organisation.

31.2 As I have noted earlier, there is a desire among some for vindication and retribution. However, fault-finding and a culture of blame will not be a productive way forward. Wherever possible, NHSH will need to look forward constructively to the future and not dwell overmuch on guilt about the past.

31.3 Looking ahead, it will be necessary, however, to find ways to acknowledge the circumstances of the past, to recognise the impact on individuals, processes and services, to demonstrate acceptance of some personal responsibility, to show that lessons have been learned, to reassure staff and indeed the general public that there is a genuine willingness to grasp the need for change and that things will be different in the future, to rebuild confidence, and to move forward with greater competence in the years ahead.

31.4 Reassurance will be needed also for those who feel that their careers have been or may be affected merely by standing up for what they believe to be important. And also for those who have failed to match the expected standards of behaviour. It will be a difficult balance to strike.

31.5 As discussed earlier in this report, it seems likely that preservation of jobs and livelihoods has been very important at many levels and has driven behaviour both by those to whom bullying behaviour is attributed and by those who have felt bullied. The various factors which are unique to the area (and identified in chapter 16) suggest that real care is needed in supporting and nurturing inter-personal relationships in NHSH and identifying where these are weak.

31.6 Some grievances will still need to be addressed formally and steps should be taken expeditiously to address outstanding claims as part of a move to make a new start. This will require significant constructive engagement by the trade unions. This will only be relevant if the unions feel that the management and Board have taken steps which fully and adequately address their members' concerns. I expand on this in my proposals in the following chapters.

31.7 Whether all of those who have participated in the events of recent years will be able or will wish to participate in such a rejuvenation is hard to know. The experience of humiliation, resentment, and anger that many people have experienced will not go away on their own and because people say they should. There is the familiar journey to be travelled from denial, through blame and on to acceptance.

31.8 A thoughtful and nuanced approach will be necessary. To what extent a truth and reconciliation approach is necessary requires to be worked out. There is a danger of moving too far too fast for some of those affected. And, as one respondent told me:

"I think the worst thing would be if your report says "we have some learning. We need to do things differently" in a wishy washy way."

Healing

31.9 It will be necessary in many cases to draw a line and move on and for many past grievances to be let go of. Individuals will need to decide whether and how they might do so. Adult conversations seem critical. Moving away from the victim/perpetrator paradigm is essential. Generosity of spirit will be necessary, even towards those viewed as perpetrators, who have often also been victims themselves. Bitterness will not assist healing. Freedom only comes with making the choice to move on. *"Resentment is like drinking poison and hoping the other person w ill die,"* as Nelson Mandela is reported to have once said. And to do this will require a lot of support and help.

31.10 One member of staff with experience in the mental health field said:

"I would observe/add that the legacy effects of working in an emotionally unsafe system, and the culpability that can come from an uncomfortable awareness of having been involved and complicit in something inherently wrong, but where there

was no voice, can be traumatic in itself. There will be advantages, if not a need, for people most affected, to have time and space to make sense of, heal and recover even as the organisation moves ahead. If there were a way to achieve this, we might take the learning and wisdom into the future."

31.11 There may be some useful guidance in remembering that, as is often said, small changes may be all that is needed or possible but may themselves result in bigger changes in due course; the past cannot be changed and it may be most useful to concentrate on the present and the future; with the right support and encouragement, people often have the resources necessary to help themselves; in a sense, they are the experts in their own situations and can (re)build relationships one conversation at a time, if they have the necessary support and encouragement to do so.

31.12 There should be little doubt that many of the resources, ideas and skills needed to take the organisation forward exist already in NHSH. These can be identified, released and facilitated. Existing good practices can be recognised and built on.

31.13 A member of staff addressed this in very specific terms:

"More than anything there needs to be a culture of support and value. This cannot be just created by a new initiative, but needs individual teams to start functioning as caring units, valuing each other and supporting each other. The expectation to work well beyond contracted hours needs to be changed, so that a work life balance can not only be achieved by staff, but be valued and used to promote the attractiveness of careers in health. It is so easy for health care staff to be coerced into working above and beyond, because if they don't patients will suffer and staff are by definition caring. The organisation needs to recognise that attention and resource must be put into supporting staff whether this is through addressing staffing levels and acknowledging that with current resources some services may be limited; or providing time for support such as the mentoring scheme for doctors (ideally for all staff), appraisal etc. It would be very encouraging to see the start of an open, honest and supportive culture within this organisation."

31.14 Another senior NHS manager provided this summary:

"It is really sad that the pressure on NHS staff means that managers rarely have time, or skills or training to defuse tension and support their staff and so situations of frustration fester and result in unfortunate situations. What is so bizarre is that these personal attributes that make for good relationships exist - in spades - but are all directed towards the patient and there is nothing left for colleagues."

31.15 In other words, as NHSH looks forward, looking after the people who are looking after the people is central.

Resilience

31.16 In my research, I came across the example of the Lockerbie air crash and the effect that a profound shock to the system had on the public sector at the time: the local authorities rose to the occasion and developed ways of working together that held good in the future. It is said that shocks can test the resilience of a system and often enable it to come back stronger and more adaptive (not bounce back but bounce forward).

31.17 A crisis can create an opportunity to learn and build a better way forward. The system that will emerge on the other side of the crisis is shaped by those leaders who are able to harness the potential in the moment and galvanise others to act. This emphasises the opportunity now available to NHSH to model a different way of behaving as an NHS organisation.

31.18 I also note this helpful reference to resilience in the context of health in the Annual Report of the Director of Public Health for NHSH on Adverse Childhood Experiences, Resilience and Trauma Informed Care, in 2018, under the heading of a 'sense of coherence' as a route to resilience:

"[Aaron] Antonovsky concluded that a healthy outcome depended on an individual's 'sense of coherence' which was the ability to make sense of, and manage the external environment. Essentially, unless an individual can view the world as being manageable and meaningful, they will experience a state of chronic stress. The former Scottish Chief Medical Officer, Harry Burns, argued that public policy should seek to enhance this sense of being able to control one's life. He puts forward the view that if policy makers persist in defining a population by its deficiencies and problems,

then services will only ever be designed to fill gaps and fix issues, which leads to a further feeling of people as 'passive recipients of services, rather than active agents in their own lives.' The key, then, is to pay attention to the emotional, psychological and spiritual resources that allow people to build relationships and establish social networks, so that people have opportunities to find what is meaningful to them, in a way that fosters optimism and control."[62]

31.19 The emphasis on resilience, empowerment, building relationships and establishing thriving networks seems crucial to the future for the workforce in NHSH.

Realism

31.20 Finally, one former director emphasises the need for realism:

"Realistic Medicine was introduced by the Chief Medical Officer for Scotland a few years ago and has gained great interest as a method of overhauling the clinical aspects of the health service. I have been suggesting Realistic Communication to be developed as a means of streamlining, and so making more effective, information dissemination at all levels. I would now add to that Realistic Management, as we need to be mindful of delegating realistic tasks ie not raising expectations of implementation with inadequate resources (especially time) which is effectively setting people up to fail and so brings about further disillusionment and disengagement."

31.21 Finding ways to promote the kind of changes commended in this and the preceding chapter while realistically managing expectations will be one of the first challenges for the leadership.

31.22 On the other hand, there is no need to reinvent wheels, rather a need to make them work and move forward. I understand that the NHS Scotland Everyone Matters people strategy has some core and common values (care and compassion; dignity and respect; openness, honesty and responsibility; quality and teamwork) which could readily underpin the kind of strategy I am suggesting in NHSH. As a keen observer commented: *"Much of what is suggested is already out there, alongside the good practice that is evident in other boards, which could help to shorten some of the journey time."* What a useful point this is.

An Example to Others?

31.23 If the entire community of NHSH can find a way to move forward from the experiences of the past several years, they might provide an example to others who will face similar challenges in adapting to a very different future. There is no choice but to face up to the need for change:

"The framework we use today may have been appropriate in earlier times, but it is no longer in touch with the complex challenges and demands of our time."[63]

Trust

31.24 I realised, when reviewing this report at a late stage, that I had not written much about trust. Everything in this and the next section of the report, however, is really about restoring trust. Without trust in the senior management, the board, managers, and each other, NHSH will struggle to move forward. With trust, everything is possible. Trust takes a long time to build. It has to be earned and maintained. "Do as I do as well as do as I say" probably sums up well the need for integrity, consistency and example as foundation stones for a trusting community.

62 van Woerden, H. (2018). Adverse Childhood Experiences, Resilience and Trauma Informed Care: A Public Health Approach to Understanding and Responding to Adversity. [online] p.38. Available at https://www.nhshighland.scot.nhs.uk/Publications/Documents/DPH-Annual-Report-2018_(web-version).pdf [Accessed 20 Mar. 2019].

63 Scharmer, O. and Kaufer, K. (2013). Leading from the Emerging Future: From Ego-System to Eco-System Economies. Berrett-Koehler Publishers.

32. Dealing with Disagreement and Difficult Situations

Introduction

32.1 In NHSH, as in many organisations, more attention should be paid to early intervention, when a difficulty or conflict is first identified. This is what is often known as preventative spend in reality. This could dramatically reduce the number of situations which escalate into full-blown bullying or harassment issues. Often, the presenting of such matters in a disciplinary or grievance context is merely symptomatic of deeper underlying concerns which are better dealt with in a non-binary or non-adversarial way.

32.2 I am told that many people accused of bullying behaviour are taken completely by surprise by the allegations, because nobody has raised concerns with them before. So often, relatively small incidents at the outset can escalate out of all proportion. Nipping matters in the bud is critical – and finding ways to do so is essential.

32.3 This can be addressed by education and training, by empowering those affected and bystanders to raise concerns early, and by introducing other different approaches which move away from adversarial or binary processes.

Dealing with Disagreement Generally

32.4 A wise observer of the NHS scene told me:

> "On complaints outcomes, I am increasingly drawn to moving away from the binary upheld/not upheld outcome of a complaint. However you dress this up, the experience of one party to a complaint on hearing the outcome is that they have 'lost' and the other is that they have 'won'. My experience is that this can have a negative effect on future relationships from the point of view of both the complainant and the organisation (including the person complained about).
>
> And in relation to the impact of culture, it seems obvious to me that the way in which an organisation approaches and deals with its own internal disputes and disagreements must have a direct effect on how it deals with external concerns such as complaints. So I would argue that in order to improve complaints handling about your services, you need first to improve the way in which you deal with internal disputes – by which I mean conflicts and grievances.
>
> I believe strongly that conflict can be positive – as long as it is open, honest and respectful. So part of the work … in future is to encourage organisations to change their internal culture by promoting the resolution of internal disputes through constructive discussions (which may be facilitated). This may mean moving away, wherever circumstances allow, from HR processes such as disciplinary and grievance investigations which can be experienced as destructive. We are not going to reduce the negative impact that being complained about can have unless we change our internal dispute resolution culture."

Mediation

32.5 One way to enhance early management of difficult situations is to make more use of mediation and other facilitated conversations. As one union representative put it to me, mediation can be very useful; when a conflict is first identified, a mediated discussion can be extremely successful in preventing escalation and avoiding future conflict. It enables people to see one another's points of view; to share their own perspectives and to have a good chance to explore all the issues in a balanced way which is not blame orientated. Because mediated outcomes are designed and agreed between the parties involved, there is increased ownership of the outcomes, and therefore higher likelihood of them being adhered to.

32.6 Many of the issues currently being addressed through conventional grievance and other procedures may be amenable to, and more effectively resolved by, early intervention through mediation. The key is to encourage acknowledgement and recognition of adverse experiences, a more positive response, and ensure that staff feel their concerns are being appropriately handled, whatever the eventual outcome may be.

32.7 One respondent offered this view:

> "Mediation in a well documented option for employees of NHS Highland as an alternative to moving straight to a first level grievance. However, it is not always selected as the way forward. This is especially the case when claims of bullying are against managers. It would be helpful to better understand the benefits of mediation as opposed to placing two or more people in adversarial proceedings where they blame and accuse each other of unreasonable behaviour and defend themselves against the same. These allegations often require lengthy and extensive investigation which often entrench positions and normally exacerbate problems in working relationships. We hope that one angle of your inquiry may be to recommend each employee of NHS Highland to take time to consider better ways of exploring and resolving conflict rather than seek to blame and punish colleagues through raising formal grievances."

32.8 A staff representative said:

> "We fully appreciate how difficult bullying and harassment cases can be for HR departments to deal with, but a change is due in the way concerns are investigated and how conflict issues are addressed. [Staff] advisers, who directly support members facing such difficulties, know that bullying and harassment complaints can take a long time to investigate and resolve. Often 6 months to a year in their experience, but even longer in some more complex cases. It is fairly common for 'counter' accusations to be raised against anyone who has raised their own concerns. This can all add up to a fairly torturous experience for all involved; prolonged investigations can drain people's confidence, resolve, self-esteem and impact significantly on mental health and general wellbeing. There are often knock-on effects for other (uninvolved) colleagues in a department, who have to continue working in what can be a highly tense environment as a process is worked through.
>
> We believe that there may often be better means for resolving issues, for example by processes like mediation. We strongly believe that mediation is not used or explored as an option often, or early, enough. Mediation has traditionally been seen by the NHS as an expensive luxury, but the potential savings to the NHS by dealing with conflict at an early stage can be considerable. Conflict can cost the NHS by way of lost working hours, staff demotivation and unease, resignations, as well as financial and time resources spent on running formal processes."

Scottish Government Initiative

32.9 I understand that, in 2016, the Scottish Government formed a Mediation Working Group. The aim was to develop an effective, alternative dispute resolution service as a shared resource for NHS Scotland employees, through engaging or establishing an "NHS Scotland Mediation Network". The network aimed to coordinate NHS resources, and to support and develop NHS Scotland mediators. I understand that work on this project ended before real headway was made.

32.10 Many feel that this was a missed opportunity to place mediation at the centre of NHS dispute resolution, and that this may reflect a common reluctance to invest in a process that is known to be of considerable benefit. The opportunity should be taken to look again at an NHS Scotland-wide mediation network. Once again, the idea of preventative spend is surely a key factor in looking at a new approach.

32.11 One trained NHS mediator put it eloquently:

> "We should reflect on the failure to translate the training as workplace mediators some of us had for the NHS as a whole in Scotland into activity that justified the investment. This was the most thorough and useful training I had in my last ten years as an employee and it was not a little frustrating that, once trained, the work place mediators were rarely used. I still do not know if this was a failure to match supply and demand or advertise the availability of (simple) mediation or if it all became bound up in HR processes and anyone who was a general manager was excluded from acting as a mediator – something that could have been sorted at the outset."

Mediation in NHSH

32.12 Therefore, it appears that the time has come to place mediation firmly at the centre of a preventative strategy in the NHS in Scotland. That could start in NHSH. The process could be introduced in a layered fashion: a system of internal informal mediation would be available

to nip matters in the bud, with more formal internal and, where necessary, external provision available for matters which had escalated or were in danger of so doing.

32.13 The preservation of independence and perceived impartiality is crucial in any mediation provision. The use of HR professionals who have already been engaged in the investigation process should be avoided. To this end, a properly resourced mediation service, independent of HR, should be inaugurated using trained mediators throughout NHSH.

32.14 This could also be shared across the public sector in Highland and the idea of a Highland Collaboration Hub has been mentioned, providing a resource for public sector bodies generally in the Highlands. This may be particularly useful given the geographic extent of NHSH.

32.15 It is recognised that mediation does not always work and that maintaining appropriate training and standards is important. It was suggested that transparency would be more likely if the mediation and dispute processes were subject to random but frequent audit by an independent reviewer from outside the health board.

Facilitation

32.16 To this, I would add, skilled facilitation. The Scottish Government's Collective Leadership initiative makes the point that more generally there is *"a clear need for skilled facilitation and creation of the spaces to explore and have frank and honest conversations... long-term facilitation helps support and hold the space for change to emerge and become embedded."*[64]

32.17 I heartily endorse this approach and commend it for some of the work which is necessary in NHSH.

32.18 Indeed, the importance of this becomes more apparent when one considers the collective impact of some of what has occurred. In the next sections, I recommend meetings and other ways to address these matters. However, this is not easy: in an article describing the work of Thomas Hübl on group coherence and collective trauma it is noted that *"When strangers come together in a meeting place, some may arrive wearing social masks, protecting themselves from expectations and judgments, or presenting an image of themselves as how they want to be perceived."*[65]

32.19 Helping people to set aside the masks and face up to and move on from painful experiences will often require skilled intervention by skilled facilitators.

32.20 In a sense, the ideas in this chapter are steps to enable the organisation itself to become a community which is geared towards prevention rather than resolution, in which the staff as a whole are aware of, and wherever possible trained to look out for, each other and encouraged to evolve into a more compassionate, supportive culture.

64 Collective Leadership (2019). Collective Leadership for Scotland: Year 1 Report. p.8.

65 Hübl, T. and Avritt, J. (2017). Thomas Hübl's The Pocket Project: Facilitating the Integration of Collective Trauma – Kosmos Journal. [online] Kosmosjournal.org. Available at https://www.kosmosjournal.org/article/thomas-hubls-the-pocket-project-facilitating-the-integration-of-collective-trauma/ [Accessed 11 Mar. 2019].

Ways Forward for NHSH: Specific Proposals

33. Specific Proposals: Leadership

Introduction

33.1 In this and following chapters, I set out proposals both for the present (restorative) and for the future (preventative), with one word of caution: if these are proceeded with in the same pressurised way that has characterised some activity in recent years, the result may be frustration and sub-optimal outcomes. This cannot simply be reactive problem-solving. A merely technical and transactional approach will risk simply repeating the errors of the past. As noted in previous chapters, this is as much about tone, attitude and relationships as it is about procedures.

33.2 This is a time for a measured, thoughtful and coherent strategy. As someone recently said, at a time of uncertainty and doubt: *"the winners will not necessarily be the ones that find an answer fast. They will be the ones that find the right questions."* And those that take full responsibility for doing so.

33.3 Throughout these chapters, readers will wish to ask the crucial questions: *Where are the gaps? What is missing? What is not clear or is misunderstood? How can this be improved upon?*

33.4 What I suggest in the following chapters is only the beginning of such an approach and constitutes some of the possible component parts of such a strategy. There is a balance to be struck between moving towards the kind of radical cultural change which will help NHSH to thrive and the need for specific actions to be taken in the short and medium term.

33.5 There are a number of caveats: various other reports (including Gallanders, Polley and Brown, all mentioned in this report, together with others which have been commissioned) have already covered many of these (and other) points and most are useful and helpful. They should be a foundation to build upon; this report may merely supplement them.

33.6 I have not captured all of the points arising in previous chapters and readers will wish to refer back to earlier sections also. I have adopted some proposals put to me by others which seem sensible and adapted others. All of these suggestions are therefore perhaps best viewed as guides.

33.7 There is a Quick Summary of Main Points and Proposals at the end of this section. While it is tempting to offer an order of priority for these, that is a task for NHSH to carry out in the manner I suggest in the following section.

Collaboration and Responsibility

33.8 As steps are taken to work out the appropriate way forward in collaboration with the NHSH community at large, it is worth remembering this maxim of The Phillips Kay Partnership:

> *"Strategy and policy designed remotely from the people who must deliver is never well implemented. It is better to design well a strategy with the people who must work with it, than to implement poorly a brilliantly thought out strategy that is developed elsewhere."*[66]

33.9 Thus, the most crucial recommendation is for the new leadership to adopt the collaborative mindset set out in chapter 30 and take these ideas to the NHSH community at large and work with all the very able people there to build a new culture. Such a participative, collaborative approach to working out the way forward seems likely to be productive.

33.10 In conducting this review, I came across many able people (at all levels, many of whom are not "the usual suspects") who would contribute hugely to the future of NHSH. Together, they could work through these ideas, suggestions and proposals and map out a great future for NHSH.

33.11 To this end, I commend a facilitated early gathering of a selected group of people who have responded to this review, to participate in a three-day retreat to consider this report, assess its proposals and plan the way ahead. I suggest that the Cabinet Secretary could attend on the final day.

66 The Phillips Kay Partnership Ltd. (n.d.). [online] Available at http://phillipskay.com/ [Accessed 11 Mar. 2019].

33.12 It also occurs to me that a Priorities Task Force could identify and lead on five initiatives which are likely to make the biggest short-term difference.

33.13 I have pondered the appointment of an Associate Medical Director with specific responsibility for overseeing the short-term tasks as one way forward. That person, or the chief executive, could write to all staff and invite them to contact him or her with issues of concern and ideas of interest.

33.14 Thereafter, regular reviews with appropriate benchmarks to assess progress will be essential and a full review in one year's time would ensure accountability. This is an ongoing learning process, asking these questions throughout: What is working? Why? What hasn't worked? Why not? What could we do differently? How?

33.15 I am particularly aware of all of the material with which I have been provided. I estimate that I may have received well over one hundred individual pieces of confidential information that would be of specific use to the senior management of NHSH as they address the issues arising in this review. It would be really helpful if a way could be found for at least the most useful of that material to be utilised by the leadership going forward.

33.16 This might be done by again inviting people to contact the chief executive or an appointed senior person and provide in confidence the information which they have provided me. If helpful, I am happy to work with NHSH as they navigate their way through this difficult area.

Short-Life Working Group

33.17 In this connection, I have noted the role of a short-life working group to look at promoting a positive working culture across NHS Highland. It is proposed that this group "will seek to hear from people across the entire organisation and will aim to ensure that any concerns raised are heard and acted upon."

33.18 While extremely worthy in itself, I am aware that the original composition of the group included people in whom I have heard, from a number of sources, there is a lack of confidence. This is for a number of reasons, including being perceived as having been sceptical about and resistant to the allegations made about bullying in NHSH and not fully to have understood their importance. I refer for example to my remarks about the response to the whistleblowers.

33.19 For NHSH to go forward positively, and given that it is essential that confidence and trust lie at the heart of all initiatives, it seems that real thought needs to be given by the new chief executive (and by the board) to the composition, chairing, remit and design of a group such as this. Again, a proper strategy rather than ad hoc reactions will reap dividends.

A Reset: People-Centred Leadership

33.20 Although there will be much focus on financial matters in the months ahead, as suggested in various parts of this report I suggest that making people the priority will ultimately produce the best outcomes. A new style of people-centred leadership will be crucial, with a more effective and competent management team and board, and a more compassionate, honest, courageous, humble, empowering culture, open to respectful challenge, communicative and accepting of the realities of operating in a very pressurised and financially challenging situation. Fear cannot be the driver. Effective relationships at all levels are key to the future.

33.21 The leadership team of executive directors and senior managers will greatly influence the future direction of travel and how NHSH is perceived both within and outwith. There seems no doubt that a resetting is needed both in senior management and at board level. There are too many, widely expressed and apparently valid, criticisms of some of those in senior management roles for it not to appear to be essential for changes to occur in order that a new way forward is seen to be both credible and competent – and for real confidence and trust to be restored. There are some very aware and insightful leaders in NHSH who have much to offer.

33.22 It has been suggested that some senior medical staff should revert back to clinical duties and undergo retraining before taking on further management roles. Certainly, ongoing training and support for the new leadership team should be provided in the months ahead.

33.23 I hope that the leadership of NHSH will consider some of the ideas discussed in my chapter on

Leadership. There should be much to be gained from taking time to engage actively with other NHS leaders in Scotland and with others in public sector leadership in Scotland through channels such as the Scottish Leaders Forum. Regular support and coaching for the leadership team is likely to be necessary going forward in what will be a crucial and challenging .

33.24 Leaders and others will also wish to reflect on and seek to align how things are done in NHSH with the National Performance Framework and its outcomes, including working to achieve the ambition that people employed by and associated with NHSH:

- *grow up loved, safe and respected so that they realise their full potential*
- *live in communities that are inclusive, empowered, resilient and safe*
- *are creative and their vibrant and diverse cultures are expressed and enjoyed widely*
- *are healthy and active*
- *respect, protect and fulfil human rights and live free from discrimination*
- *are open, connected and make a positive contribution.*

These will serve as useful benchmarks going forward.

The Chief Executive

33.25 Separately, as I have mentioned elsewhere, it seems essential for the new chief executive to exhibit an ability to engage with people at a personal level, to listen well and to seek to understand, to value contributions from all parts of the organisation and to be alive to the human effect of the inevitable tensions and constraints which funding limitations and other challenges bring. Going out and about and meeting people throughout the organisation at their places of work will make a huge difference. He will wish to be seen and recognised at all levels in the organisation (as will other senior managers).

33.26 He will need above all to build, and encourage the building of, relationships. A willingness to communicate openly and with clarity and frankness will be essential too. Ensuring the effectiveness of people-related systems and excellent communication across the organisation will be the key to ongoing healing.

33.27 This will also entail a thoughtful and open approach by the Scottish Government. The constructive interaction of Government with health boards and senior management is an inherent part of the system. Person-centred leadership ultimately comes from the very top. The availability of resources to encourage leadership development seems essential at this time.

33.28 The chief executive needs to be further supported as a leader. He will benefit from the support of like-minded and like-acting colleagues who can help lead by example and demonstrate real empathy, insight, self-awareness and vision in practice. He will need the support of an appropriately qualified Board chair who has a similar mindset. It is likely that the chief executive will benefit from high-level coaching and mentoring in this very important role.

Acknowledgement of NHSH Staff

33.29 While the chair of the Board issued a form of apology in late 2018 and the interim chief executive did much good work in his short stint by issuing supportive messages to staff, there is a real need for an authentic, meaningful acknowledgement and acceptance of how serious matters have been for many people in NHSH over a number of years, together with recognition of the impact on them of these circumstances and a reassurance that matters will be addressed now with rigour going forward. (I use the words acknowledgement, acceptance, recognition and reassurance deliberately, as each is a component in communicating how seriously matters are now being taken, along with the necessary engagement with staff and explanation to them of how things will be dealt with differently going forward.)

33.30 At the same time, there should be recognition of the impact on those who have not experienced adverse behaviour but who have been affected by the fact that the allegations themselves have been made. Healing can only occur if the different experiences are recognised and acknowledged.

33.31 *"If only they would say thank you",* one staff member said to me. Although there will be much focus on financial matters in the months ahead, I have suggested that making people the priority will ultimately produce the best outcomes. As an indication of this, generally, people need to

be, and feel, thanked for doing a difficult job in difficult circumstances. And to be, and to feel, listened to when they have a concern or a problem. Ultimately, we all need to feel valued – and in a way which is genuine and authentic. Achieving this is one of the challenges facing leaders in NHSH.

33.32 This would be a good moment to reinforce these messages in NHSH and to celebrate all the good work which is being done. Simple, clear, consistent and regular messages to all staff should become the norm. I recall one very successful chief executive who would send an encouraging blog once per week to the staff. He was able to convey supportive messages to a widely dispersed workforce. They felt they knew him and that he cared. He did. He also invited suggestions for improvement from all members of staff. In NHSH little things might make a big difference: such as an online "suggestion box"? Or a monthly open forum/drop-in session with the Medical Director?

33.33 Similarly, well thought through and transparent provision of information to the wider community, recognising the difficulties faced by NHSH, should over time help to rebuild confidence. It is unlikely that this is a quick fix, more a longer-term strategy of openness and authenticity.

33.34 It is for consideration from whom these messages should come. However, it seems important that they come from the new chair and/or chief executive, unconnected with perceptions of inadequate responses in the past to allegations of bullying.

Civility

33.35 The need for civility and respect at all levels is one of the keys to moving forward. One consultant put it this way:

> "…irrespective of any inquiry we should all, immediately, be trying to reflect on how we behave with colleagues and staff generally to ensure we are all truly more sensitive and responsive to the needs of others and cognisant of the risks of not being so."

33.36 Whatever procedures and policies are available, they are unlikely to be effective unless people are civil to one another, especially when under pressure. This comes from the top and cascades through the whole organisation. Consideration might be given to adopting something akin to the Commitment to Respectful Dialogue of Collaborative Scotland (see Appendix 4). The senior management team and the Board could lead the way.

Governance

33.37 I refer back to the chapter on Governance where a number of proposals are made.

33.38 The Board must be able to hold senior executives effectively to account, in the sense of supportively enabling and ensuring effective leadership rather than blaming or coercing. A review of governance structures, the committee network and culture will enable the kind of clear communication and taking of responsibility which this report commends. Allied to this, the Board will wish to oversee a review of the management structure also.

33.39 Review of board appointments, together with training and support for, and provision of appropriate information to, all non-executive directors is necessary, probably at Scottish Government as well as NHSH levels.

33.40 Scottish Government may wish to review governance generally to ensure that candidates with the necessary skills, knowledge, expertise and experience are appointed to NHSH and other NHS boards – and that the size of boards is commensurate with working effectively. Consideration of the appropriate mix of lay, patient and medical members will probably be useful. There is a need for deep understanding of what is necessary in the appointment and support of a non-executive director at all levels of government and the NHS.

33.41 Learning should be sought from other NHS and public sector boards in the short term. Recent independent recommendations to the Board, including by Audit Scotland and John Brown, have provided a starting point and need to be taken forward.

33.42 Specific external support should be offered to current non-executive directors who should be encouraged to continue to reflect on their position and role in handling matters going forward. I refer to the non-executive directors' own recent consideration of matters including how they may appropriately engage and encourage feedback and flow of information.

33.43 In addition to matters already reflected in this report, I endorse their suggestions of (a) an independent person for the non-executive directors to go to if they have concerns that actions are not being addressed after raising these with the chair or chief executive, perhaps following the Senior Independent Director model from England and (b) regular assurance to the Board that there is a robust and working process available for anyone who wishes to raise concerns around bullying and safety.

33.44 Recognition should be given to the amount of time needed and devoted by non-executives generally. If possible, before new board appointments are made, consideration should be given to the specific areas of knowledge and skill which the present Board needs to oversee a budget of some £800 million.

33.45 A forward-looking strategic plan and a shared vision, linked to and taking account of the need for an effective people-centred approach and clinical and staff relationships in light of this review, is imperative.

33.46 Determining the strategic direction of NHSH, including clinical strategy, will be important to bring clarity to decision making, implementation, monitoring and enabling NHSH employees to understand why change needs to happen, what the purpose of the change is and how they can contribute to it. Full engagement of clinical staff seems paramount to the realisation of an effectively delivered clinical strategy.

33.47 Finally, the Board should take primary responsibility for ensuring that the issues raised in this report are implemented and progress maintained in the future and by showing the same constructive, respectful and compassionate approach which they should expect others to follow. They should keep these matters under review on a regular basis.

Clinical Engagement in the Contemporary NHS

33.48 Reassessment of the relationship between clinicians and management seems to be an essential part of building a collaborative and mutually respectful and supportive culture. Apparently, evidence from around the world shows that improved clinical outcomes follow greater clinician involvement in management. Thus, there should be reflection on the manner and benefits of clinical involvement in leadership. This may entail changes of attitude and behaviour for some as they move towards a more collaborative approach.

33.49 Clearer management structures, a better understanding of the needs and motivations of both management and medical staff and a positive approach to the greater good, will all benefit staff and patients alike. It has been suggested that adequate investment in administrative support and communication could enable clinical staff to feel a greater sense of ownership of decisions made by their organisation.

33.50 It has also been suggested that the apparently excellently conceived "Clinical Compact – The Highland Pledge", subtitled "or how we will work better together" describing the relationship and obligations of clinicians to the organisation should be reviewed with a view to actual implementation. This is likely to raise issues of training. For example, clinicians may need training in negotiation and collaboration skills. It has been suggested that there may be scope for a Scottish NHS College.

33.51 A system for addressing urgently concerns/ complaints or differences of professional view will be valuable. The use of facilitation and mediation should be considered. The role played by an Associate Medical Director in this context could be critical.

33.52 Similarly, the relationship of GP practices to NHSH needs review and a commitment to mutual understanding and respect. Honesty and clarity about priorities and resources is key, built on the foundation of much stronger relationships.

Trade Unions

33.53 The role of trade unions and staffside representation, including the partnership agreement, merits review in order to ensure really effective representation of employees' interests. The unions will wish to re-orientate their approach to NHSH to help assist in creating a supportive culture in which they can objectively identify and promote their members' interests.

33.54 While a non-adversarial approach, and constructively articulating members' interests, seems the only way to help members in the longer term, that will only work in a more rigorous and transparent overall environment. It seems essential that everyone works together to achieve that goal.

Argyll and Bute

33.55 By reason of its geographic and possibly other specific circumstances, as noted earlier, a separate review in and about the functioning of management in Argyll and Bute should be commenced, conducted by a person or persons from outside that area.

Patient Safety

33.56 In so far as staff have any specific concerns about patient safety, these should be referred to the chief executive or to a specified independent person if preferred.

34. Specific Proposals: Present Support

Individual Support

34.1 Support is needed for individual employees in NHSH (at all levels), who have experienced inappropriate behaviour and who have suffered distress, harm and other loss. This should include providing safe spaces for many current and outstanding physical, emotional and psychological issues to be addressed fairly urgently.

34.2 This will include some people with whom I have met and others with whom there was not time to meet. Some responded to the review, others may not have spoken up at all. It is likely that there are quieter voices still to be heard. It is not enough to assume that, because people have not spoken out, there might not be a need to be pro-active now.

34.3 This support should be provided by facilitators who have a variety of skills, including trauma recognition, pastoral care and other counselling and complaint handling skills. The extent of this is not easy to measure and I acknowledge could take many months and will need to be well resourced. The number of those who may need help could be in the hundreds. A specific time limit should be set for completion of this task so that a sense of closure can be achieved.

34.4 A number of NHSH employees have "bystander" guilt or shame. They now regret not acting when they could see things occurring which were inappropriate. These people may also need support and understanding as they work through the cycle of denial, blame, confusion, acceptance and moving on. Specific recognition of this experience may be an important step.

34.5 In all of these, clarity around purpose and objectives is essential in order to avoid creating unrealistic expectations.

Listening is Key

34.6 Linked to this, as noted above, there are a number of people who approached the review with whom there was not adequate time to meet. Some of these respondents may be satisfied that the contents of this report address their concerns. However, others may still wish to be heard and offer views, whatever the rights and wrongs of what they have experienced or perceived.

34.7 A simple private listening exercise may be all that is required along the lines of the meetings I have already conducted in this review. This should be offered, again within a limited time period of say three months, if resources can be made available within that timescale.

34.8 For completeness, an invitation to participate in such an exercise should be extended to those employees who may not have received information about the review and to any others who may still wish to come forward. This needs to be well communicated and widely disseminated and, to manage expectations, there should be clarity at the outset about what the expected objectives, outputs and timescale are intended to be.

34.9 I am privy to a significant amount of information about specific instances of inappropriate behaviour in specific departments in NHSH. The steps above should ensure that a mechanism is offered to those who have contacted me and still wish to take matters forward to be able to contact a confidential resource with these concerns.

Independent Process

34.10 It is likely that these initiatives will result in a need to address some specific complaints, disciplinary matters and grievances, many of which appear to remain outstanding and/or unresolved. The cooperation of the unions, especially the GMB, will be important in this. A strategy to resolve the many outstanding cases as speedily as possible should be devised, within a set timescale so that people and the organisation can move on.

34.11 It is for discussion whether this support should be provided on a basis independent of NHSH. Certainly, as a number of issues pertain to the perceived inadequacy or lack of impartiality of internal support, it is likely that there will be much more confidence in external provision at least until NHSH internal procedures are credible

and can meet this need and there is renewed confidence in governance and leadership. Indeed, I understand that NHSH HR department would welcome outside help from a dedicated team to help address current and outstanding individual cases.

Safe Spaces

34.12 Many of the issues currently being or which could potentially be addressed through conventional grievance and other procedures may be amenable to, and more effectively resolved by, facilitated conversations and mediation. In all of this, thought should therefore be given to designing a process to engage a number of independent facilitators and mediators who could assist with the backlog.

34.13 Separately, there is a clear need for safe and independent spaces for people, including those characterised as "victim(s)" and "perpetrator(s)", to be supported in trying to break the cycle of accusation and counter-accusation. I am mindful that providing support and compassion for those who have been viewed as perpetrators will be the most difficult aspect for many people; nevertheless, it will be necessary if healing is to occur. And, of course, these terms are not easy to apply and may be interchangeable in some contexts.

34.14 As part of this, steps should be taken, wherever possible, to rehabilitate, retrain and reintegrate staff who have been the subject of, or accused of, bullying. Where this is not possible, steps should be taken to make necessary staffing changes. Careful and wise oversight will be essential, especially in cases where there has been, or is, a diagnosis of trauma. Returning to a place where trauma has been experienced can, I am advised, be counter-productive. Trauma specialists should be asked to provide guidance.

34.15 To an extent, there is an element of truth and reconciliation and restorative justice in these proposals. This needs to be done for the longer-term health not just of NHSH but of individuals and communities.

Meetings and Workshops

34.16 Well facilitated meetings in local areas with specific groups may be useful as a way forward and to address current concerns. However, it is important to bear in mind that many issues arise within such groups. Thus, a mix of individual meetings and group sessions may be necessary. This would apply to specific departments and disciplines and to some geographic areas.

34.17 In particular, an initiative to identify, contact and support clinical departments and other practices and departments which have been particularly affected by inappropriate behaviours in recent times is necessary. In each case, steps should be taken to listen to all points of view, including the most junior staff, managers, clinicians and the quieter voices in a safe environment. A series of workshops and private meetings is likely to be the most effective combination for this.

Financial Matters

34.18 A number of people appear to have suffered some financial loss as a result of (alleged) inappropriate handling of their situations and are in financial difficulty as a result. Whether these claims are fully justified is beyond the scope of this report but many have a feeling of helplessness and hopelessness. Many feel let down by or inadequately supported by HR or other representatives, including on occasions trade unions and professional bodies. It is for consideration whether some form of independent review panel might be established for a limited period to bring closure for these individuals.

35. Specific Proposals: Training, Management and HR

Training in Better Conversations and Appropriate Behaviour

35.1 Longer term, a carefully designed ongoing comprehensive training programme addressing appropriate behaviour (including a well communicated, simple and clear definition of what constitutes bullying and harassment, together with diversity and discrimination awareness) could have a profound impact. This would help people throughout NHSH, from the grass roots up, to be more self-aware and to take responsibility themselves with confidence to manage differences, difficult situations and conversations with and for each other, in real time.

35.2 Such a programme, which could be multi- and inter-disciplinary, needs to be highly practical and interactive and not theoretical, properly structured and with regular review and reflection. An understanding of the aspects of human nature described in chapter 8 and of the cultural issues in NHS Highland referred to in chapter 16 above seems important in the design. Focus should be on the underlying causes of behaviour rather than merely on the symptoms and on finding proportionate responses.

35.3 In particular, all NHSH staff should be educated about the effects of bullying, on themselves and others, how to handle that and how to avoid entering the condition of "learned helplessness". I suggest that having (or making clear the ready availability of) an informative NHS website on bullying is a useful first step but not a substitute for personal, practical training.

35.4 This could be a prototype more generally for public sector organisations in Scotland at a time when such allegations seem likely to increase. It would fit within the aspirations of the National Performance Framework. Paradoxically, it would probably lead to substantial financial savings owing to improved staff recruitment, morale and retention, in addition to improved quality and safety of care.

35.5 I recognise the resource implications, both financial and personnel. However, this is a major project, akin to building or funding a new capital resource. I suggest that such a perspective is brought to the costs of this initiative, again applying the principles of preventative spend.

Managers

35.6 I am struck by this formulation: *"The person you work for (your boss) is 90% of the employee experience"*[67]. There is a need to rebuild confidence in and of managers. A programme of action learning, training, review, coaching and support is essential at all management levels, including for those preparing for recruitment, induction or promotion into management positions. This would cover people-handling, managing diversity and difference, handling and receiving complaints, effective communication and teamwork, giving feedback on performance, negotiation skills and multi-professional leadership development, especially for clinical leads and service managers.

35.7 Having the skills and resources to resolve difficult and sensitive situations without resorting to formal processes and being able to separate people from the problem, as well as the self-awareness and resources to accept concerns raised about one's own practice, will be invaluable.

35.8 Viewing and training managers as "facilitators" of other staff would enable a different culture to be developed. Moving from performance targets to continuous learning with psychological safety seems important. A review of the recruitment and promotion process, to ensure that it is robust and objective, would complement these proposals.

35.9 This would sit within a framework of greater clarity about the roles and responsibilities of managers and identification of the support they require to equip them to be effective, with

67 Linkedin.com. (2019). Your boss is 90% of the 'Employee Experience'. Nothing else comes close. [online] Available at: https://www.linkedin.com/pulse/your-boss-90-employee-experience-nothing-else-comes-jim-bohn-ph-d-/ [Accessed 8 Apr. 2019].

a view to minimising any situations where poor management is perceived as bullying, and/or concerns are not addressed promptly at a local and informal level.

35.10 Mentoring and honest sharing of best practice and operating values across the organisation at all levels (and across Scotland?), with tolerance to discuss when things don't work and a willingness to learn from that, will be very valuable, along with freedom and safety to discuss what is acceptable and what is not acceptable behaviour.

Meetings and Relationships

35.11 Teamwork is so important in the NHS. Encouraging daily contact between managers and frontline staff seems important. Consideration and understanding of the particular cultural issues relating to NHSH, referred to in this report, should form a part of this. Current best practices in NHSH should be identified and replicated wherever possible. The ability to have conversations which feel more adult to adult is crucial to the future.

35.12 For example, the introduction and/or enhancement of well-facilitated team meetings on a regular basis, possibly across boundaries, with opportunities to express concerns, to brief and debrief safely, and review events and experiences in a supportive culture, could help greatly. Managers could be trained and encouraged to undertake and facilitate these.

35.13 Making sure that staff have adequate facilities and the opportunity to rest, reflect, meet and talk to colleagues away from immediate work pressures and patient-facing environments, will also create a more positive culture. Facilitated conversations over a cup of coffee can be very valuable. I understand that there is a policy of taking time to go for walks; this needs to be encouraged as acceptable and beneficial. In this context, I note the work of the Institute for Health Care Improvement on What Matters to You Conversations and Joy in Work.[68]

35.14 It has also been suggested that there needs to be greater encouragement of social interaction with more of a feeling of a community spirit within Raigmore Hospital and elsewhere in NHSH, with regular and organised local social functions focussed on the community of NHSH.

35.15 Connected to this, it is suggested that there is value in small groups to build relationships, for support, intimacy and openness, and to build a sense of connection and belonging. It is hard to underestimate the value of well-hosted activities like these to help build supportive relationships where people feel secure and comfortable. There is a suggestion of appointing a trained "compassion champion" in each department to whom people could turn for support.

Mediation

35.16 Related to all of this, as discussed earlier in this report, more generally a new approach to handling internal issues should be adopted, to nip potential issues in the bud wherever possible. I refer to the chapter on mediation and other facilitated approaches.

Social Media Standards

35.17 It has been suggested that staff at all levels should sign up to NHS Highland or NHS Scotland standards of behaviour, including specific guidance on use of social media, which would be co-produced, with an expectation that everybody, including bystanders, could challenge whenever these standards are being breached, regardless of status or grade, and without fear of recrimination. I note the Commitment to Respectful Dialogue referred to earlier as a possible useful starting point.

Communication Generally

35.18 Excellent communication is essential at all levels in the organisation and becomes ever more important with increased organisational size and complexity. The age of electronic communication has resulted in a large increase in the volume of communications sent within and between organisations and has encouraged dissemination of information "to all", often

68 See "Useful Resources" Appendix

regardless of direct relevance. Ironically, the increased volume of information disseminated probably results in an inverse response to or digestion of the information.

35.19 A streamlined and realistic communication strategy should aim to direct material more effectively towards the necessary recipients and be graded in terms of the response required; other material can be posted on websites for interested parties to review.

35.20 More specifically targeted information will increase the actual impact of important messages and help to produce an informed workforce. Furthermore, by making this process more efficient, time will be saved which can be used for more necessary tasks. An effective communication strategy should ideally be led from the top levels of NHSH and be consistent throughout.

Other HR Related Matters

35.21 There needs to be an organisation wide clarity about and understanding of the role of HR, and its limitations, and it and Occupational Health need full-time direction at the highest level. As noted above, resources may need to be deployed from other regions to assist in the short term but proper resourcing in NHSH itself seems essential, including the appointment of a full-time HR Director.

35.22 All HR and other policies and procedures should be reviewed, updated and simplified, in the context of national reviews – and properly publicised. Systems for accurate and robust recording of complaints about alleged bullying and harassment should be maintained so that understanding of the extent, nature and distribution of bullying and harassment in the organisation is improved.

35.23 Work begun by HR in this regard needs to be supported and resourced. I refer back to the proposals from HR in an earlier chapter (and included in full in Appendix 3) and to my own observations in that chapter.

35.24 I note that policies and procedures already exist which purport to deliver many of the goals to which everyone aspires. Again, the apparent gulf between what is written down and what actually happens in practice needs to be addressed. It would be good to make this exercise a collaborative one in which employees and unions feel part of the process. Above all, processes must be experienced as being fair in practice, whatever the outcomes.

35.25 I am also told that the national PIN policy needs revision or perhaps to be better understood and implemented. Consideration needs to be given to the operation of the Datix system and the iMatters recording function so that they can be used safely and with confidence. Training in these matters should be clear and consistent.

35.26 The use of suspension should be reviewed and utilised only in exceptional and clear circumstances and for as short a period as possible.

35.27 In any event, as a last resort, grievance and other formal procedures, when used, must be redesigned to be speedy, transparent and fair to all. Inconsistencies in treatment between staff and lengthy delays must be avoided wherever possible.

35.28 Where two people (or more) separately raise issues which are related, the links need to be made and appropriate steps taken. When there is a pattern of high staff turnover, sickness or frequent themes identified, this should be identified and the chief executive informed.

35.29 I commend the recommendations in the Francis Report on "Good Practice – Promoting a no bullying culture".[69]

Mental Health Issues

35.30 In suggesting that all NHS staff should be educated about the effects of bullying, reference has been made to the trauma model, the Adverse Childhood Experiences study and how people can address unprocessed trauma leading to consequences for the alleged victim and to themselves.

69 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. p 109.

35.31 Generally, awareness of the potentially adverse impact of a return to the workplace in which bullying or other inappropriate behaviour has allegedly occurred should result in outcomes in which people feel protected from anyone who has allegedly bullied or harassed them.

35.32 Consideration should be given to a requirement that the Occupational Health department should ensure that those who appear traumatised are accurately assessed by a properly trained therapist or clinical trauma specialist or consultant within a short period and offered treatment. That assessment must be part of any investigation process. There needs to be a funded fast-track service, given the long wait times for routine psychiatry and psychology services. Mental health supervision is essential.

35.33 It has been suggested that a peer supporter ("compassion champion", mentioned earlier) or "mental health first aider" could be appointed at every layer of the organisation, educated to look for signs of stress and in the trauma model, able to raise concerns and to activate a process to help someone who is experiencing difficulties. There should be a link with the health and wellbeing committee. A staff member trained to a high degree in trauma should be a member of the health and wellbeing committee.

35.34 On the matter of confidentiality, mental health records should be completely segregated from main occupational health records and removed from the E-epos programme. Staff with relatives working in the department should declare any conflict.

35.35 Generally, the adequacy of counselling and other psychological support should be reviewed.

Bullying Generally

35.36 I am told that BMA Scotland (and the wider BMA) has recently started work to address bullying and harassment issues, and the wider workplace culture in the NHS. Many organisations with an interest in the NHS have also been addressing these issues. For example, I understand that the academies, royal colleges, GMC, and other boards in NHS Scotland itself are all looking at this subject, but possibly independently and in their own ways.

35.37 Efforts to create a more joined-up, cohesive approach to address these issues would seem useful. An honest conversation among all the stake-holders, reflecting on causes as well as symptoms, is likely to reap dividends for NHSH and other NHS boards.

36. Freedom and Safety to Speak Up

Discussion

36.1 While one would hope that the steps above would minimise the need, and that "whistleblowing" would be very much a last resort, further steps should be taken to provide a properly functioning, clear, safe and respected wholly independent and confidential whistleblowing or, more helpfully, "speaking up" mechanism, which presently does not seem to exist.

36.2 All staff should be aware of how to use this and in what circumstances its use is relevant, so that individuals with concerns are able to express these confidently in the future.

36.3 The expressing of serious concerns needs to be viewed as a good thing and acted on in a culture that is both supportive and safe. This must apply to concerns about staffing issues in addition to patient safety, realising that they are of course intimately linked. It is for consideration to what extent these matters can be addressed by internal provision and in what circumstances wholly external provision is essential.

36.4 Perhaps an internal safety valve (such as a dedicated confidential email address and telephone hotline), is necessary, with external provision if the internal function is not sufficient. Endorsement, oversight and support of, and tangible commitment to, the process from the highest board and management levels will build confidence.

36.5 In this context, provision of an independent, confidential, trained "guardian" or guardians seems essential both for those who experience and wish to report inappropriate behaviour and for those against whom such behaviour is alleged, and who feel that there is no other available resource. Such a facility could also be used to enable the current whistleblowers to address their concerns about future victimisation.

36.6 Such a person would address serious concerns and complaints and independently investigate and act on them, within a time scale. Appropriate feedback is important. Any actions should be anonymised and published.

36.7 I understand that the Scottish Public Services Ombudsman has worked closely with the Scottish Government as they develop plans for introducing the Independent National Whistleblowing Officer and on proposals for a National Whistleblowing Standard. It is to be hoped that the Scottish Government will move swiftly to implement a really effective mechanism.

The Francis Report

36.8 The content and recommendations in the Francis Report on "Freedom to Speak Up" provide a rich resource. Time should be spent considering and implementing recommendations in that report which are likely to be equally applicable to Scotland. Sir Robert refers to the Parliamentary and Health Service Ombudsman's (PHSO) vision for raising concerns in the NHS and provides an adaptation of a PHSO diagram to apply to staff raising concerns[70]. I commend it.

70 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. para 4.18

36.9 I note the presence of Freedom to Speak Up Guardians in the NHS in England[71]. I understand that, in one English trust, the FTSU guardians (as they are called) promote confidential disclosure of any issues and have open access to the Board and the executive in order to resolve concerns and issues as early as possible.

36.10 I am told that most issues can be resolved locally as misunderstandings, which would accord with adopting a preventative or "safety valve" approach in NHSH, and indeed underscores the utility of an early intervention mediation resource.

36.11 I note that Sir Robert Francis says he *"gave serious consideration to recommending that the term 'whistleblower' should be dropped, and some other term used instead."*[72] Although he still had reservations about the term, he had been persuaded that it is now so widely used, and in so many different contexts, that this would probably not succeed. Instead, there should be a focus on giving it a more positive image.

36.12 I support his suggestion that the measures recommended in his report will do much to promote the acceptance of 'whistleblowing' as normal and positive behaviour in healthcare. This seems a sensible approach for NHSH to adopt.

71 Care Quality Commission. (2019). Freedom to Speak Up. [online] Available at https://www.cqc.org.uk/national-guardians-office/content/national-guardians-office [Accessed 20 Mar. 2019].

72 Francis, R. (2013). Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS. para 5.3.24

37. Quick Summary of Main Points and Proposals

(See paragraph 33.7)

- Collective, collaborative, cooperative culture and leadership
- Compassion, kindness, relationships and people at the heart of NHSH
- Acceptance of uncertainty, complexity and ambiguity
- Acknowledgement of past, willingness to look forward
- Use best practice and current excellent resources wherever possible
- Deal with disagreements and difficulties early and promote civility
- Mediation and facilitation have important roles to play
- Measured, thoughtful and coherent strategy needed to take matters forward
- Build on earlier reports
- Seek to align how things are done in NHSH with the National Performance Framework and its outcomes
- Reset senior management – openness and communication are key
- Engage with other public sector leaders
- Chief executive to lead by example, supported by able senior managers and the Board Chair
- Engagement with staff at all levels, recognising impact of the past and recent events and acknowledging the commitment shown at all levels
- Scottish Government to demonstrate and support people-centred leadership
- Board to exercise governance function well; review governance structures
- Non-executive board members to be well trained and supported
- Board strategic vision needed
- Ensure clinical engagement and effective relationships with managers
- Enhance relationships with GPs
- Role of trade unions and staff representation to be reviewed
- Review management and other arrangements in Argyll and Bute
- Ensure support available, including listening, for those who have experienced inappropriate behaviour
- Consider strategy for meetings, safe spaces and other forums to address issues and build relationships
- Instigate programme of training for staff and managers
- Adopt social media and communication standards so that simple, clear, consistent and regular messages to all staff become the norm
- Support and develop HR-related strategies to deal with issues adequately
- Recognise importance of mental health
- Introduce effective “speaking up” / “whistleblowing” facilities
- Convene a three-day retreat to consider this report, assess its proposals and plan the way ahead
- Regular reviews with appropriate benchmarks to assess progress

38. Final Thoughts

As you finish reading this report, look again at the questions on page 3.

Reflect on them.

What is your reaction to the report?

Shock? Anger? Resistance? Acceptance? Relief?

What does your reaction tell you?

What needs to happen now? For you? For others?

For those who have been affected, how will NHSH move from fear to safety, from anger to compassion, from blame to kindness, from shame to dignity?

It can be done.

Appendices

Appendix 1 Useful Resources

A1.1 I have referred to a number of resources in this report. More generally, my attention was drawn to these further potentially helpful resources which I mention for such value as they may have.

A1.2 The work of Project Lift which "encourages a new style of leadership to rise from the complexity", with leaders "who believe that success does come through putting people at the heart of everything we do. Leaders not focused on being heroes, or being saviours, but being true collaborators – who know that working collectively, collaboratively – genuinely together – is a powerful force for future success."

https://www.projectlift.scot/

A1.3 The handbook entitled "The Duty of Care of Healthcare Professionals" by Roger Kline with Shazia Khan: published following the Mid Staffs Inquiry, "This practical handbook advises staff at every level about how, collectively and individually, to handle pressures that compromise good care standards. Underpinned by an understanding of the law, and with links to additional information and resources, it is designed to help staff uphold standards of ethical behaviour and professional accountability, and their duty of care to patients, when they feel these may be in danger of being undermined by other pressures".

http://www.publicworld.org/files/Duty_of_Care_handbook_April_2013.pdf

A1.4 The Being Complained About Guidelines, which were recently published by Glasgow University School of Law, for organisations to help them avoid the potentially negative effects of complaints and support employees who have been complained about.

https://www.gla.ac.uk/schools/law/research/groups/lawreform/beingcomplainedabout/#d.en.636617

A1.5 The Healthcare Improvement Studies Institute work on "improving the employee voice about transgressive or disruptive behaviour": "Even where reporting mechanisms are in place, employees can still be reluctant to report disruptive behaviour because they fear the consequences or don't think their organisation will respond appropriately. In the case of one American academic medical centre, that reluctance meant transgressive behaviours by "untouchables" went on unchallenged and contributed to a culture of fear. The organisation had multiple mechanisms to report incidents, but not everyone in the organisation knew how to raise concerns, and some systems were slow and complicated to use. To address the problem, the organisation launched an initiative to improve how it responded to reports of disruptive behaviour."

https://www.thisinstitute.cam.ac.uk/research-articles/improving-employee-voice-transgressive-disruptive-behaviour-case-study/

A1.6 The work of Amy Edmondson on Teaming, in a health care context:

https://hbr.org/2015/12/the-kinds-of-teams-health-care-needs

A1.7 The work of the King's Fund and Professor Michael West, whose areas of research interest are team and organisational innovation and effectiveness, particularly in relation to the organisation of health services.

https://www.kingsfund.org.uk/about-us/whos-who/michael-west

A1.8 The work of the Carnegie Trust on Kindness and Compassion in public policy:

https://www.carnegieuktrust.org.uk/project/kinder-communities/

A1.9 The work on trauma undertaken in Oregon:

https://traumainformedoregon.org/standards-practice-trauma-informed-care/

and Missouri:

https://dmh.mo.gov/trauma/docs/HRPolicyGuidance32017.pdf

A1.10 The Institute for Health Care Improvement (IHI) has a number of resources including those designed to help provide psychologically safe learning environments – linking safe environments to improved patient safety:

http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Safe-Reliable-Effective-Care.aspx

A1.11 The Institute for Health Care Improvement document "What Matters to You?" Conversation Guide for Improving Joy in Work, which includes preparing for the "What matters to you?" conversations. These are rich, learning conversations — not intended to communicate information, but rather to listen and learn. Leaders and colleagues should recognise this is a different approach than the usual "I tell you what isn't working and you fix it" approach. The guide helps leaders get started quickly with conducting effective "What matters to you?" conversations, learning as they go, and resolving issues that arise from such conversations. Builds on the IHI White Paper: Framework for Improving Joy in Work.

http://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

A1.12 The Whistleblowing Guide: Speak-up Arrangements, Challenges and Best Practices apparently offers "conceptual clarification about ... key issues, including a focus on internal and external speak-up procedures, organisational response and communication, impartiality and trust."

https://www.wiley.com/en-gb/The+Whistleblowing+Guide:+Speak+up+Arrangements,+Challenges+and+Best+Practices-p-9781119360759

A1.13 The following websites were mentioned in the context of whistleblowing initiatives:

- http://www.workinconfidence.com/speakinconfidence/
- https://www.whistleblower.org/resources/
- https://healthyworkforceinstitute.com/

A1.14 Engaging Transformational Leadership & impact on organisational performance, staff wellbeing and patient outcomes:

https://www.emeraldinsight.com/doi/full/10.1108/14777260810916560

A1.15 The Impact of Engaging Leadership on Performance, Attitudes to Work and Wellbeing at Work: A Longitudinal Study. 2012 Beverly Alimo-Metcalfe (University of Bradford School of Management, Bradford, UK and Real World Group, Leeds, UK) et al;

- https://www.hsj.co.uk/leadership/transforming-leadership-culture-after-francis/5057102.article
- https://www.kingsfund.org.uk/audio-video/beverly-alimo-metcalfe-engaging-boards

A1.16 Drama Triangle: adopting and relinquishing the tendency to fall into roles of victim, persecutor and rescuer:

- http://www.widgetlibrary.knowledge.scot.nhs.uk/media/WidgetFiles/1011649/DramaTriangleArticleE-PrintFeb05Burgess_99-114.pdf
- https://www.leicspart.nhs.uk/Library/TransactionalAnalysisforLPT2018HandoutforGroup.pdf

A1.17 Relationship between leadership, staff experience and patient outcomes:

- https://www.nhsemployers.org/-/media/Employers/Publications/Research-report-Staff-experience-and-patient-outcome
- https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/leadership-for-engagement-improvement-nhs-final-review2012.pdf

Appendix 2 Excerpts from the Gallanders' Report

A2.1 I refer to this appendix in chapter 12 at paragraph 12.33. It contains much which is useful and, I think, consistent with the contents of this report.

A2.2 The report noted that "The NHS Highland Preventing and Dealing with Bullying and Harassment Policy is based on an NHS Scotland PIN policy" and went on:

"53. The policy is very comprehensive and written in the formal style which is fairly conventional in employment policy documents of this type.

54. The policy is in line with the ACAS Guide on Bullying and Harassment and contains the components of good practice which would be expected, such as;

- Definitions and examples of bullying and harassment
- An informal stage aimed at early resolution of issues
- Access to confidential advice and other support such as mediation through HR contacts Formal investigation stage
- Right for review of outcome by the complainant
- Potential for management referral of employee or alleged bully / harasser to Occupational Health for support / counselling."

56 It has been acknowledged to me anecdotally that the policy approach is something of an unattractive and blunt instrument in addressing very sensitive, nuanced issues affecting people who may be feeling demotivated, vulnerable or isolated. Larger organisations in particular face this type of difficulty.

57. It is a commonly expressed view that once an issue of alleged bullying and harassment is positioned within a formal process of investigation, the already damaged relationship is extremely difficult to recover.

58. A formal policy is desirable to manage cases of potential misconduct and formal action may be required and the policy is fit for purpose in this respect. There appears scope however making it more accessible, particularly in simplifying language, presentation and volume.

59. In addition, it would be useful to explore the use of face to face interventions and confidential access to an independent trusted professional resource such as self-referred counselling support and mediation. This may help offer an alternative to recourse to the formal policy.

CONSIDERATION OF NEXT STEPS:

61. Today's workforces will no longer tolerate, to the same extent as their predecessors, bad behaviour which may stop short of what would be traditionally categorised as bullying. Substantial research evidence is emerging on incivility, which manifests as low level negative behaviours such as rudeness, disregard for others, or treating others with disrespect. These behaviours are seen as contributing to the creation of cultures that tacitly accept bullying and, as such, need to be addressed. This may be partly behind the growing perception of the existence of bullying behaviour across organisations.

62. Traditional approaches based on policy documents, prescribed procedures and the injection of support for employees within the procedural framework are not working in the way that was envisaged when they were established. This is recognised by ACAS who were the authors of the best practice guide on Bullying and Harassment at Work upon which most workplace bullying policies are based.

63. Solutions are increasingly being seen as workplace climate or culture focused with a greater emphasis on issues such as people management skills and emotional intelligence in managers. This is referenced in the ACAS Policy Discussion Paper – "Seeking better solutions: tackling bullying and ill-treatment in Britain's workplaces".

64. Particular challenges exist in workplaces, such as the NHS specifically and public sector more widely, where there are pressures relating to customer / patient expectations, demographic pressures and finite resources. The recent BMA Survey, "Caring, Supportive, Collaborative", demonstrated significant concerns among doctors regarding, amongst other things, inadequate resources, fear of making errors, workload pressures, and problems with bullying, harassment and undermining.

65. ...

66. In terms of good practice elsewhere, there are also examples which can be learned from.

67. London Ambulance Service (LAS) was placed in special measures in 2015 and concerns were raised about bullying and harassment. A number of measures were taken to address the problem including the nomination of a non-Executive Director sponsor, the appointment of a bullying and harassment specialist who provided training and workshops and engaged teams in dialogue around tackling bullying and culture. There have been tangible improvements in the number of staff recommending LAS as a place to work as well as sickness and turnover statistics.

68. Arising from the Mid Staffs Scandal public enquiry, "Freedom To Speak Up" originated in NHS England as a means by which concerns regarding patient safety could be raised and escalated. Bullying and harassment is one dimension of this. FTSU "Guardians" have been appointed in a number of NHS providers as a safe point of contact for concerns to be raised. Appointees have generally been clinicians who carry out the role in addition to their day job. Networks of Guardians are now in place and they are well established as an important and trusted resource for staff.

69. A "Fair Treatment at Work" initiative was implemented by Fife Council which saw two Fair Treatment Advisers appointed on a full-time basis within the HR team at a time when grievance rates were high, bullying was emerging as an issue which the trade unions were increasingly highlighting and sickness absence was above the local government average. Their role was partly educational, involving visiting management teams, trade union meetings and staff groups and partly operational, entailing coordinating investigations and producing management reports. This was part of a wider employee care programme and was credited with improvements in performance in employee relations indicators.

70. The instances where organisations can claim some success in tackling bullying and harassment generally have issues of culture and employee engagement at their heart."

Appendix 3 Views from HR

A3.1 I refer to this Appendix in chapter 25 at paragraph 25.48.

Bullying and Harassment in NHS Highland

A3.2 There are pockets where bullying and harassment occurs (like in any organisation, particularly big and highly structured and complex ones)

A3.3 Although a number of bullying and harassment complaints have been raised when looking into it (for a certain period) not one had gone to a hearing, usually due to finding of no evidence but instead pointing out relationship issues; however, by the time the investigation has been completed the relationship is often definitely destroyed and redeployment is usually required (although this is then usually left to the manager to deal with)

A3.4 Where investigations are carried out these tend to take a long time and have a huge negative impact on the complainant as well as everyone involved in the process often leading to relationship breakdowns and a need for redeployment (often the complainant) à if there is a need to move somebody out of a team does that not mean there is something seriously wrong?

A3.5 Complaints are not being dealt with consistently (e.g. consultants not easy to recruit or in other areas he/she has always behaved like that are common arguments; particularly differently dealt with in remote/rural areas)

A3.6 Raising a bullying and harassment complaint is difficult because of tendency to immediately consider the complainant as the difficult party, managers not supporting the complainant through the process, closing ranks, tendency to remove complainant rather than alleged bully away from the workplace leading to "card being marked" and fear of repercussions after the process has ended

A3.7 HR team members have been exposed to inappropriate intimidating behaviours from union representatives during meetings when supporting managers, and generally partnership working has been damaged and is not working that well

A3.8 Senior managers from across the organisation showing aggressive and intimidating behaviours towards HR (blaming for shortcomings that in our view sit within their area of responsibility) potentially indicating that the organisation is unclear about the role of HR; managers also using HR to "sound off" which can be perceived as aggressive and intimidating

A3.9 There are instances when employees appear to bully upwards and this should be taken as seriously as any other incident of alleged bullying and harassment

Bullying and Harassment Policy and Procedure

A3.10 No consistent clarity on what constitutes bullying and harassment and what is and is not inappropriate behaviour in the workplace

A3.11 Employees should have a responsibility for challenging behaviours that they consider to be inappropriate/of a bullying nature; a need to make it easier for employees to do that by offering a variety of options how they can do that (e.g. speak directly to the person, ask a colleague or the manager of the person to speak to them, confidential contacts across the organisation could assist, union rep, etc.)

A3.12 The informal stage of this policy should be strengthened to allow for more immediate and targeted intervention before we venture into lengthy and often damaging investigations

A3.13 Definition available in the policy, however, particularly bullying is about how an individual perceives another's behaviour and it is therefore very difficult to establish whether bullying has in fact occurred. That may lead to focussing too much on proving bullying or not, although focus should be on repairing the relationship and ensuring behaviours are appropriate.

A3.14 Managers do not feel that the policy supports them when dealing with people management and it's too easy to call out bullying

A3.15 Policy is too long and structure not assisting with easy application and not helpful to managers despite it saying all the right things, e.g. in appendix 2 (5 pages long and at the end of the policy) mentions what is appropriate for a manager to do when managing people

A3.16 Bullying and harassment procedure not robust enough to make it safe to raise complaints and review process often a tick box exercise biased against complainants (closing ranks and being dismissive); the review offered under the policy should be a robust and transparent appeal process and not just a desk top exercise (as it's often done); we have seen an increase in grievances for b&h issues as this is seen as a more transparent and robust process.

A3.17 Too easy to call out bullying with no consideration whether this is because of reasonable management having put pressure on the employee or even malicious complaints; even if complaint not malicious or vexatious employee should be clear what is reasonable management; Induction and regular appraisals.

People Management

A3.18 Behaviours/performance are not being challenged or not immediately being challenged (leading to a future manager being challenged over them finally managing a team/ individual)

A3.19 There is a nervousness around dealing with behaviours and general reluctance to pick up issues early (considered difficult conversations that managers either don't want to have or because they don't like it/see as a risk to their relationships or they may not feel equipped/ confident to do)

A3.20 When concerns are raised there appears to be a bit of a panic reaction and too much time is taken over what to do next, incl. copying in too many people when trying to get guidance which in turn breaches confidentiality

A3.21 We consider ourselves as a people focussed organisation (see HQA) but it appears to all be about the patients and not about the people in the organisation supporting the delivery of our services and the patient focus, i.e. employees

Management Capability

A3.22 Managers not confident to have courageous/ difficult conversations and are therefore unable to deal with bullying and harassment complaints effectively

A3.23 Mediation intervention either considered too late or often used to allow a manager not to have to deal with staff relationships (offload management responsibility); needs strong criteria around referral to mediation service and managers to develop facilitation skills to ensure they feel confident in holding facilitated meetings

A3.24 People management and any complications around this are seen as HR issues, e.g. complaint from unions against HR and not against managers; comments from staff geared towards HR (Facebook); this appears to suggest the role of manager is unclear across the organisation (and therefore the role of HR needs clarification as well)

A3.25 No repercussion for being a "bad manager"; no accountability at management level and generally performance management non-existent, specifically at Band 7 and above

A3.26 Is "financial bullying" leading to ineffective prioritisation of people management?

A3.27 Exclusive focus on measures (compliance) set by Scottish Government may have led to us forgetting about other measures we should keep an eye on as a good employer

A3.28 Has job design actually considered people management or was it just added without consideration of ensuring this is deliverable as part of the overall job of a manager?

Improvement Ideas

A3.29 Leadership development with focus on defining positive behaviours, raising self awareness and leading by example with senior management requiring to demonstrate positive behaviours and employees understanding that everyone has a leadership role – must include board members

A3.30 Introduce culture which ensures it is safe to call out inappropriate behaviours (at all levels) – developing confidence and trust amongst staff to do this through training and development/use of iMatter (ensuring iMatter does not become iDon'tMatter)

A3.31 Introduction of effective management development programme, including for those preparing for promotion into manager positions

A3.32 Review recruitment approach into manager positions to ensure that those who are appointed into manager positions do have people management skills as well as the required technical skills

A3.33 Introduce a much improved and much more supportive approach to bullying and harassment with regards to both, the complainant and the alleged bully – through improved communication and support throughout by management (not left to HR or so called contact officers within HR)

A3.34 Improve policy and procedures and ensure robust management training on new policy –in line with what has been mentioned above and ensuring clarity of the manager's responsibilities within the process

A3.35 Policy: ensure employees who have raised concerns as well as those who have been accused (suspended or not) are well supported throughout; build in a robust and transparent appeal process; ensure open and honest feedback is given to all where complaint is not going forward to a hearing; build in debrief and team building where case was considered at a hearing (consider external input); build in robust return to work process for complainants and suspended employees; outcome communicated just by letter to both the complainant and the alleged bully is common but not adequate; should we not share the report to ensure openness and transparency?

A3.36 Introduce confidential "guardians" for employees to turn to when they first experience problems and that they can speak to during ongoing processes; also for supporting alleged bullies during process

A3.37 Need a strategic approach to people management with a link to overall organisation's strategy which features an element of "striving for excellence and continuous improvement" not just in relation to clinical/patient service delivery."

Appendix 4 Respectful Dialogue and Civility

A4.1 I refer to this at paragraphs 33.36 and 35.17.

Commitment to Respectful Dialogue

A4.2 This, from Collaborative Scotland (www.collaborativescotland.org), is a useful set of ideas (of which I am the author) which capture some of what may have been missing in NHSH in recent years. Perhaps everyone could commit to this:

A4.3 "We acknowledge that how we engage with each other is just as important as any outcome. We believe that it is in the interests of a flourishing health service in the Highlands of Scotland and our own communities that we treat each other with civility and dignity. Therefore, we undertake to do our best, and to encourage others to do their best, to:

- Show respect and courtesy towards all colleagues, whatever views they hold;
- Listen carefully to all points of view and seek fully to understand what concerns and motivates those with differing views from our own;
- Acknowledge that there are many differing, deeply held and valid points of view;
- Use language carefully and avoid personal or other remarks which might cause unnecessary offence;
- Ask questions for clarification when we do not understand what others are saying or proposing;
- Express our own views clearly and honestly with transparency about our motives and our interests;
- Respond to questions asked of us with clarity and openness and, whenever we can, with credible information;
- Look for common ground and shared interests at all times."

A4.4 I note also and commend the work of healthcare professionals in Civility Saves Lives: https://www.civilitysaveslives.com/

> *"Civil work environments matter because they reduce errors, reduce stress and foster excellence.*
>
> *Almost all excellence in healthcare is dependent on teams, and teams work best when all members feel safe and have a voice.*
>
> *Civility between team members creates that sense of safety and is a key ingredient of great teams. Incivility robs teams of their potential."*

Appendix 5 Acronyms

A & B	Argyll and Bute
CE	Chief Executive
FPPR	Fit and Proper Person Requirements
FTSU	Freedom to Speak Up
GP	General Practitioner
HQA	Highland Quality Approach
HR	Human Resources
IFF	International Futures Forum
IHI	Institute for Health Care Improvement
LAS	London Ambulance Service
NEDs	Non-Executive Directors
NHS	National Health Service
NHSH	NHS Highland
NPF	National Performance Framework
OECD	Organisation for Economic Co-operation and Development
PHSO	Parliamentary and Health Service Ombudsman
PIN	Partnership Information Network
PTSD	Post Traumatic Stress Disorder
SG	Scottish Government

Scottish Government
Riaghaltas na h-Alba
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From: Raines P (Philip)
Sent: 19 March 2020 18:08
To: Cabinet Secretary for Health and Sport
Cc: Minister for Public Health, Sport and Wellbeing; DG Health & Social Care; Wright M (Malcolm); McQueen F (Fiona); Chalmers G (Greig); Leitch J (Jason); Chief Medical Officer; Smith G (Gregor); Connaghan J (John) (Health); Bell D (Donna); Foggo R (Richard); Murray D (Diane); White C (Craig); Campariol-Scott C (Carole); BROWN, Marie (NHS NATIONAL SERVICES SCOTLAND); Dryden J (Jim); Henderson C (Calum); Birch J (Jason); Dunk R (Rachael); Summers Y (Yvonne); Hart S (Suzanne); Communications Healthier; Morrison A (Alan); McCallum R (Richard); House D (Dan); Hutchison D (David); Paterson M (Matt); Ives J (Josephine); Shepherd L (Lesley); Morris K (Keith); Burgess E (Elizabeth)
Subject: R: IMPLICATIONS OF COVID-19 FOR QEUH/NHS GGC OVERSIGHT BOARD
Attachments: NHS GGC and QEUH Oversight Board- submission to Cabinet Secretary - impact of Covid-19 on Oversight Board work - 19 March 2020.docx

All

Attached is a submission for the Cabinet Secretary, offering advice on the impact of Covid-19 on the work of the NHS GGC/Queen Elizabeth University Hospital Oversight Board, and how its work should be taken forward in the current circumstances.

Phil Raines
CNOD

From: Phil Raines
Queen Elizabeth University Hospital Support Unit
CNOD

19 March 2020

Cabinet Secretary for Health and Sport

IMPLICATIONS OF COVID-19 FOR QEUH/NHS GGC OVERSIGHT BOARD

Purpose

1. To set out the impact of the Covid-19 emergency for the work of the Queen Elizabeth University Hospital (QEUH)/NHS Greater Glasgow and Clyde (GGC) Oversight Board and propose options for progressing its work.

Priority

2. **Routine**.

Update/options for progress

3. In common with other policy areas, the impact of Covid-19 is requiring changes to the work of the QEUH/GGC Oversight Board. As you will know from the regular Updates from the QEUH Support Unit, and as stated in your January statement to Parliament, the Oversight Board and its Subgroups have been continuing to progress their work through an intensive schedule of meetings and dedicated programmes of work. However, in light of the pandemic, these can no longer be progressed as originally planned. Meetings cannot be held for the foreseeable future, as the members of the Oversight Board and the Subgroups are having to divert their full energies to dealing with the emergency (not least given the infection prevention and control responsibilities many of them have).

4. In light of this, Fiona McQueen, as chair of the Oversight Board, has taken the decision to suspend meetings of the Subgroups, and, where possible, hold meetings of the Board on a reduced frequency, for the time being. She will, of course, keep in close contact with the NHS GGC Board Chief Executive and Chairman. Similar issues are being experienced by the other key groups overseeing the other Board escalations.

5. While this has presented challenges in terms of progressing fully the work of the Oversight Board, it has not stopped key work going forward, as set out in more detail below. Moreover, significant material has already been collected, which would enable the bulk of the original work of the Board to be completed. As a result, we recommend the following steps are taken with respect to the different strands of the Oversight Board's work.

Oversight Board recommendations

6. The Oversight Board had been working to a provisional timescale of reporting its findings and recommendations by the end of May. Having reviewed the material to date, we believe that such a report remains viable, but should be brought forward for the end of April. This would be a better alternative than suspending the Oversight Board process as a whole, which, despite the mitigating circumstances of the pandemic, could jeopardise any faith by the families in this process and reverse much of the good work that has already been done, not least in communications and engagement. It is vital that this process demonstrates progress, even if circumstances prevent it from setting out 'closure'.

7. A report in this timescale would be informed by key pieces of work that continue to be taken forward, despite the strictures. This includes:

- the Peer Review, in which a team of non-NHS GGC infection prevention and control experts have examined the internal processes of the Board (this is distinct from the Case Note Review, which is described in more detail below): the fieldwork for the Peer Review has now taken place and it is on track to report to Fiona McQueen before Easter; and
- development of a comprehensive and annotated timeline of infections and NHS GGC's response across the whole period since the opening of the QEUH: this will also be provided before the Easter recess.

8. The Oversight Board's report will set out the actions that NHS GGC must take to address the issues leading to its escalation to Stage 4 late last year (and indeed the actions that have already been undertaken and are starting to show positive results). It will also provide a full update on the work to refurbish Wards 2A and 2B in the Royal Hospital for Children, the testing regime for water safety going forward and plans for returning patients to those wards.

9. The report will also be accompanied by advice on how the Oversight Board might be stepped down in its current form, how the essential work of monitoring and verifying NHS GGC actions in response to the recommendations should be taken forward, and advice on escalation/de-escalation. There will be a number of preconditions put in place before the Oversight Board steps back. The Oversight Board will:

- know and understand the timeline for opening of wards 2A and 2B;
- be content on water safety across the QEUH site, including the governance of monitoring water safety;
- be confident that the arrangements of Infection Prevention and Control (IPC) are satisfactory and safe; and
- be assured that the Case Note Review covers, as far as possible, children whose care has been a source of anxiety and distress for their families, to ensure that the right quality of care has been delivered.

Internal NHS GGC actions

10. In parallel with the work of the Board, there is important work being undertaken by individuals within NHS GGC.

- As specially-appointed Executive lead for Healthcare-associated Infections, Professor Marion Bain has been reviewing the strategic operations of IPC within NHS GGC, and her work will inform the recommendations of the Oversight Board report. Her placement with NHS GGC is scheduled to come to an end over the next few months, and longer-term changes to how IPC should be addressed in governance terms within NHS GGC will be set out in the Oversight Board's recommendations.
- Angela Wallace has taken up position as interim Operational Director of IPC within NHS GGC and is making significant changes in the roles and structures of IPC. This includes bringing in new personnel to undertake key IPC responsibilities within the Board. We can update you more fully on these changes and their impact.
- Professor Craig White has continued to provide the role of liaison between families and the Board and advising on improvements on NHS GGC's approach to communications and engagement. Those improvements will be fully reflected in the Oversight Board recommendations, which would allow his specific role, like Professor Bain's, to come to an end.

11. In addition, Professor Bain has led on vital Organisational Development work within IPC in NHS GGC to help address the very difficult relationship issues that have developed within the Board's IPC teams. This work will continue.

Case Note Review

12. Since our update to you on the Case Note Review (10 March), it has become clear that the pandemic will slow the work of the Case Note Review, again mainly as individuals are diverted to other critical work – however, it has not halted it. To date, the reviews of several case notes have already been completed, and it is currently anticipated that the full cohort of cases can continued to be reviewed through this period, albeit it at a slower pace. We are currently assessing the impact on project timelines.

13. To ensure that the maximum value can be secured from the Case Note Review despite the changed context, key cases are being prioritised for review, notably those where children have died, so that the offer can be made to bereaved families for a report on the individual findings as soon as practicable.

Timing

14. The QEUH Support Unit is liaising with the team supporting the Independent Review of Dr Andrew Fraser and Dr Brian Montgomery on the potential timing of any reports, to ensure that the publication of the two reports can be as coordinated as fully and appropriately as possible.

15. We would recommend some form of update to Parliament on the work of the Oversight Board in later April, depending on other, more urgent circumstances.

Recommendation

16. **You are asked to note the update set out here and agree that the Oversight Board offer you and the Director General its final report by late April.**

17. Fiona McQueen and myself would be happy to discuss the situation and the recommendation with you.

Phil Raines
Mobile: [redacted]

Cabinet Secretary for Health and Sport

NHS GREATER GLASGOW AND CLYDE/ QUEEN ELIZABETH UNIVERSITY HOSPITAL OVERSIGHT BOARD: UPDATE ON PROGRESS

Purpose

1. To provide an update on the work of the Oversight Board to improve the performance of NHS Greater Glasgow and Clyde (NHS GGC) at the Queen Elizabeth University Hospital (QEUH), in relation to infection prevention and control and connected communication with patients and their families.

Priority

2. Urgent. No specific urgent action is required from this note, but the Cabinet Secretary will wish to note this update in advance of her meeting with the chairs of the Independent Review, Drs Andrew Fraser and Brian Montgomery, scheduled for Friday, 15 May. Phil Raines will be participating in that call as official support on Oversight Board issues.

Background

3. NHS GGC was escalated to Stage 4 of the NHS Scotland Performance Framework on 22 November 2019. An Oversight Board, chaired by the Chief Nursing Officer, Professor Fiona McQueen, was established, with a programme of work being taken forward through a series of Subgroups, continuing refurbishment work on Wards 2A and 2B in the Royal Hospital for Children (RHC), expert support for the Board and the commission of a Case Note Review. Each of these areas is covered below.

4. As highlighted previously, the Covid-19 pandemic has significantly affected the working of the Oversight Board. Meetings of the Board itself and its constituent Subgroups were suspended as part of the lockdown and competing Covid-19 pressures drew CNOD staff away for a short period. However, work on key elements – such as the Timeline and Peer Review reports below and the Case Note Review – has been progressing, albeit at a necessarily reduced pace, and internal resourcing issues have now been resolved.

Progress in findings and recommendations of the Oversight Board

5. Although the Oversight Board is currently not meeting as part of the pandemic, work is continuing on developing a final report for the Cabinet Secretary on this phase of escalation. All three Subgroups – Communications and Engagement; Infection Prevention and Control (IPC), and Governance; and Technical Issues – are currently preparing their findings and recommendations to inform that final report. The aim is to finalise the Oversight Board report by the end of June. Advice will be presented in due course with a more detailed timescale for the Cabinet Secretary.

6. As part of the Oversight Board programme of work, there are two key reports which have been commissioned to inform the final report.

i. Timeline report. Sandra Aitkenhead of KPMG has provided a detailed timeline of how the infections were uncovered and dealt with in the NHS GGC governance structure. The draft report is being fact-checked by NHS GGC. Its provisional findings – which will inform the Oversight Board report – are attached under separate cover. When the full report is finalised – by the end of May – we will provide the draft with you with advice on handling/publication.

ii. Peer Review report. At the request of the Oversight Board, Lesley Shepherd – professional advisor to CNOD – led a team to undertake a peer review of the operation of IPC within the QEUH. Covid-19 pandemic work has made completion of the draft of that report difficult, but a draft will be completed in early June and will inform the final report of the Oversight Board.

7. With the drafting of its report in June, the Oversight Board is aiming to complete this phase of activity on escalation. It is likely that the report will carry a number of recommendations that will need to be overseen going forward, so some form of oversight will continue to be necessary. However, it may be that a bespoke issue-specific board may not be required. Advice/options on how this might be taken forward will also be provided in June.

Work on Wards 2A/2B in the Royal Hospital for Children

8. An update on the construction work on Wards 2A/2B was set out in Alan Morrison's note of 30 April on advice for the FM. While the Ward 2A/2B project was identified as an essential project in guidance, NHS GGC found it difficult to maintain progress because the main contractor stopped all physical work on the site. The sub-contractors had stood down their staff, as a result of concerns around the health and safety of staff, and the project was not deemed large enough to justify these companies remaining open. There have also been concerns around the supply chain's ability to obtain the necessary materials to complete this project.

9. As the 30 April note set out, DG Health and Social Care officials are liaising with the Restart Group (chaired by the Minister for Local Government, Housing and Planning), which aims to increase activity across the construction sector in a safe and controlled manner. A further update on the implications of this for Wards 2A/2B will be provided to you in June.

Expert assistance

10. Professor Marion Bain was appointed to NHS GGC to lead and have Board level responsibility for Healthcare Associated Infection, as well as lead on any transformation work required in NHS GGC to ensure improvements to the systems, processes and governance in relation to IPC. She was supported in that role by Professor Angela Wallace as Operational Director of IPC within NHS GGC on secondment from NHS Forth Valley.

11. Professor Bain has now been appointed as the Deputy Chief Medical Officer in the Scottish Government and will consequently not continue the range of her responsibilities in NHS GGC. In updating on different elements of hers and Professor Wallace's work below, arrangements for taking forward her different responsibilities are set out below.

12. Under Professor Wallace, an operational plan is now in place to ensure required IPC actions are agreed and progressed. There has been an ongoing focus and rigour around addressing the Gram-negative incident in the Paediatric Intensive Care Unit. It has also been agreed that Professor Wallace will take over the Executive Lead role for IPC within NHS GGC for the time being.

13. In terms of addressing issues within IPC, the key areas for action are:

i. pressures on overall capacity to be able to respond to current IPC requirements (even ahead of Covid-19), in particular within the QEUH and RHC;

ii. challenges around problem solving in the current complex IPC environment; and

iii. ensuring effective linkages and joint working, with clarity about respective roles and responsibilities – this applies within IPC, and between IPC and other parts of the system, both clinical and managerial.

14. There is a clear consensus between NHS GGC and the Scottish Government that ongoing senior IPC leadership is going to be crucial. NHS GGC will proceed with the permanent appointment of a Director of IPC as soon as possible, but this recruitment will take into account the findings and recommendations of the Oversight Board and the Independent Review. In addition to the Director role, additional capacity for IPC operational delivery and expert Infection Control Doctor input is also being taken forward. The Covid-19 pandemic has meant that this has not yet been progressed. However, the substantive Director of IPC, once appointed, will take forward recruitment to strengthen the IPC function as an early priority.

15. External Organisational Development work is now underway with leadership from Jenny Copeland and practical plans are in place for delivery. It is recognised that this will need continued focus over a period of time to deliver the changes that are required.

16. With respect to those staff who raised concerns about IPC within NHS GGC, Professor Bain has been liaising with the relevant individuals regularly. Concerns continue to be raised and are being systematically considered and addressed wherever possible. Specific issues with NHS GGC's responses to the families' questions and media releases are being addressed. This work will now be overseen by Professor Wallace going forward.

17. Lastly, Professor Craig White has continued to provide a key role in supporting families and liaising with NHS GGC on emerging issues, not least those arriving in the Covid-19 pandemic. He has written to you with recent update notes/SBARs on issues relating to the families – most recently on 11 May, attached with this submission. Good progress has been made in identifying the contributory processes and factors as set out before, and an improvement in communication, engagement and information provision that has been recognised by the families. The work is being reflected in the findings and recommendations of the Communications and Engagement Subgroup to the Oversight Board.

Case Note Review

18. Work on the Case Note Review is progressing at a steady pace. The first meeting of the Expert Panel is taking place on 15 May, when the first set of cases will be fully reviewed by the experts. Staff at NHS GGC have been populating the Paediatric Trigger Tool with clinical data which will be analysed by the Expert Panel as they go through the cases. Capacity issues due to COVID-19 have affected the pace of the work carried out by National Antimicrobial Resistance & Healthcare Associated Infection (ARHAI) Scotland (formally Health Protection Scotland) on epidemiological data, but colleagues are still progressing work, albeit at a reduced pace. ARHAI is committed to supporting the work and will continue to review capacity over the course of the project.

19. Discussions have started around a communications strategy for the review and how to communicate emerging findings with key audiences. Professor Craig White is leading on the development of a communication strategy that addresses the issues. We will review the case note review timeline as the review progresses in the context of COVID-19 and update accordingly.

Conclusions

20. **You are asked to note this update, especially the aim of completing the Oversight Board's report for the end of June and the provision of further advice on the future of the Oversight Board, as set out in paragraphs 5 and 7 above.**

Phil Raines: CNOD
[13] May 2020

SCOTTISH HOSPITALS INQUIRY

SCOTTISH MINISTERS' RESPONSE

to Parts 1 and 3 of Annex A of

Section 21 Notices

dated 2 May (as amended) and 17 May 2023

By section 21 notices dated 2 May 2023 (as varied) and 17 May 2023 (together "the Notices") the Scottish Ministers are required to produce narratives in relation to their awareness of, amongst other things, the possibility of water contamination (and other concerns with the water systems) and of concerns in relation to the safety of ventilation systems at the QEUH campus.

Whilst the Notices raise questions as to the Scottish Ministers' awareness of concerns with water and ventilation systems separately, this narrative provides the Scottish Ministers' response to the Notices in a single document. This is consistent with the way in which the Scottish Ministers became aware of issues arising, in view of reporting responsibilities of NHSGGC to Health Protection Scotland and the Scottish Ministers.

The occurrence of "infection" or other significant incident is reported to the Scottish Ministers at (or near to) the time it arises. At that time, the cause of the infection or incident, and whether this may or not be linked to the hospital environment (including ventilation and water systems) may be unknown. For example, the hypothesis that infections linked to contamination of water systems at the QEUH campus started to develop in 2018.

The timeline noted in the table below includes a record, at a high level, of infections (and other relevant incidents) reported to the Scottish Ministers during the time period specified in the Notices. All of the incidents recorded in the table occurred within the hospital environment and, to that extent, form part of the Scottish Ministers' awareness of possible risks within that environment. They have been included for that reason. It cannot, however, be said (and nor should it be assumed) that simply because an infection or other incident is reported to the Scottish Ministers, this demonstrates an awareness on the part of the Scottish Ministers at that point in time as to the underlying cause of the incident or any actual defect in the hospital environment.

As the Inquiry is aware, NHSGGC were escalated to Level 4 of the Scottish Government's NHS Boards Performance Level Escalation Framework in respect of infection prevention and control and engagement and information with patients and families. As a consequence, an oversight board, chaired by the then Chief Nursing Officer Fiona McQueen, was established. The Oversight Board published their final report in March 2021. Appended to the Oversight Board's final report is a *"Timeline of incidents in Queen Elizabeth University Hospital and Royal Hospital for Children for the period 2015 to 2019"* produced by the Scottish Government. The document sets out "…*a timeline of the infections and colonisations which occurred in the Royal Hospital for Children (RHC) and latterly the Queen Elizabeth University Hospital (QEUH) during the years from 2015 to 2019. The timeline only looks at paediatric patients in the Haemoncology/Oncology Bone Marrow Transplant (BMT) wards that were affected by these incidents.*" The timeline is appended **[Appendix 1]** to this narrative and the Inquiry is invited to have regard to its content in respect of the period 2015 - 2019 so as to avoid duplication herein.

A Review of Healthcare Infection Incident and Outbreak Reporting Templates (HIIORT) scored RED/AMBER in NHSGGC 2015-2019 is also appended **[Appendix 2]** to this narrative. A brief explanation of the HIORRT process is also appended **[Appendix 3]**. It is hoped that this will assist the Inquiry.

This narrative has been prepared following a review of relevant documentary evidence submitted to the Inquiry and represents the Scottish Ministers' current understanding of the matters covered in the Notices. The narrative responds to the matters raised in parts 1 and 3 of the Notices.

QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH), NHS GREATER GLASGOW AND CLYDE - OVERVIEW OF EVENTS AND TIMELINE

Key dates	Issues	Related actions taken. (NB this narrative does not provide a detailed record of all interactions between the Scottish Government, HPS and NHS GGC – the Inquiry has access to all relevant documentation available to the Scottish Ministers from this period should it wish to interrogate that detail)
2015 and 2017	**2015** NHSGGC commissioned the DMA report which was not made public. DMA suggested the site should be considered for background dosing. **2017** DMA returned to NHSGGC in 2017 to review the situation and no evidence was presented that the issues identified in the 2015 report had been addressed. It was unclear who in NHSGGC were involved or aware of the review.	**2015** The DMA report was not provided to Scottish Government. The Scottish Government were not aware that the report had been commissioned until the HFS/HPS review had started in 2018. Health Facilities Scotland (HFS), on the instruction of the Cabinet Secretary, undertook a comprehensive technical review of the water management system at QEUH in 2018. The technical review was used to inform the Health Protection Scotland (HPS) report. In February 2019, the Scottish Government published the HPS report - 'Summary of Incident and Findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children water contamination incident and recommendations for NHS Scotland'. HPS recommended NHSGGC produce 'a detailed action plan addressing all points identified within the HFS technical review'. The action plan was ready by the time the report was published in February 2019. To address the concerns about the water systems, NHSGGC installed a dosing plant to treat the water systems and reduce the level of water-borne organisms While the HFS technical review was not published, the HPS report contains recommendations that clearly references the HFS technical review.

March 2017	**March 2017** There was a higher than expected incidence of Aspergillus in ward 2A RHC.	**March 2017** HPS reported to the Scottish Government.
April 2017	**April 2017** There was an outbreak of Rotavirus and Astrovirus in ward 2A RHC.	**April 2017** HPS reported to the Scottish Government.
July 2017	**27 July 2017** NHSGGC reported a RED (Healthcare Infection, Incident and Outbreak Reporting Template) HIIORT to HPS. This outlined a small number of positive cases of Stenotrophomonas maltophilia bloodstream infections within Ward 2A RHC.	**27 July 2017** HPS reported to the Scottish Government.
August 2017	**15 August 2017** NHSGGC de-escalated a HIIORT to GREEN as typing of both organisms were distinct from each other therefore the Board deemed that they were not linked.	**15 August 2017** HPS reported to the Scottish Government.
January/February 2018	**29 January 2018** First waterborne infection case identified at NHSGGC. Investigations and control measures commenced. Testing yielded positive results for various gram negative organisms and fungal growth in tap outlet and shower heads (including wards 2A, 2B and 4B). Some positive tests in sinks in Prep and Treatment Rooms. Water supply tests negative. **30 January 2018** Investigations began in aseptic pharmacy having had a case associated with the pharmacy in February 2016. **5 February 2018** A Problem Assessment Group (PAG) was convened to review findings from patient review and actions resulting from the investigations into the aseptic pharmacy in February 2016. Water samples obtained from the aseptic pharmacy as an action from this PAG were negative and all standard operating procedures were being followed in relation	The Scottish Government was not informed. (*NB the Scottish Government would not anticipate being told about a one patient case at this stage. Further information pertaining to reporting requirements can be found in the National Infection Prevention and Control Manual.)*

	to handling of medicines and water outlets on the aseptic pharmacy. **9 February 2018** The focus of a potential source shifted to ward 2A, haemato oncology ward, RHC. Water samples were obtained initially from treatment room and preparation room as these were the rooms where IV medications are reconstituted. **15 February 2018** Results of water testing available showing Cupriavadis. Treatment/preparation room sinks were removed from use until adequate dosing could take place by estates. **19 February 2018** A second PAG was held to discuss water results and control measures required. Testing extended to patient rooms including those occupied by the positive patient isolate. Some additional random patient rooms tested also. **20 February 2018** Dosing of the affected outlets complete and re-sampling carried out. Main hospital tanks sampled. **27 February 2018** Further positive isolates were found from patient sinks and showers in ward 2A reported by water lab. Cupriavadis was isolated from a number of outlets. Pseudomonas isolated from one outlet in room 3 on 2A. IPCT noted a patient blood culture was positive for Pseudomonas from a sample obtained on 21 February. A Water safety checklist was carried out as per NHSGGC Pseudomonas aeruginosa standard operating procedures in response to a Pseudomonas blood culture. The findings were reported back to clinicians at the time of audit. The patient bedrooms from which water outlets were	

	positive were taken out of use until dosing could be carried out.	
March 2018	**1 March 2018** More widespread Cupriavadis reported in water samples from ward 2A. Incident Management Team (IMT) meeting. It was agreed that patients would not use showers and instead should be washed in bottled water. Patients also instructed to drink bottled water and not mains water. Staff and parents allowed to use hand wash basins for washing hands but must follow with alcohol based hand rub. Parents could also use the showers. Communications for parents prepared and issued. Tests of water tanks were negative suggesting that the outlets (horne taps) might be the source of the contamination. Infection Prevention and Control nurse present on ward to support hand hygiene practice following roll out of control measures. **2 March 2018** The IMT was re-convened. Tap and showerhead components were removed and sent to microbiology lab for testing. The hypothesis was that outlets were the source and that seeding of others has taken place. The dosing of the entire 2A water system was planned for same day, however only half the system could be dosed due to broken valve. Full control measures remained in place until entire system dosing could take place. **5 March 2018** Cupriavadis grown from tap components and shower heads. **6 March 2018** A further IMT was held. There was a request to change all shower heads to disposable shower heads and for the	**1 March 2018** HPS notify Scottish Government about the contamination of the water system, and that their support was not requested by the Board at this stage. This is in line with usual reporting arrangements.

	remainder of the system on 2A to be dosed. It was requested that flow straighteners were replaced in taps followed by chemical and thermal disinfection of the individual taps. Cupriavadis was added to IPC alert organism list from whole of RHC. There was a review of domestic cleaning practice to help understand how contamination may have spread from one tap/showerhead to another. No concerns identified although it was accepted that the same cloth could have been used to go between outlets when cleaning. Domestic practice reviewed by facilities management. Ongoing enhanced IPC presence on the ward. **7 March 2018** It was agreed that water outlets could be used to bathe/shower children on the basis that the hot supply was where the positive isolates had been found and the hot supply had been fully dosed. It was only the cold supply dosing which was still awaited. **9 March 2018** A further IMT was held. No new patient cases were reported. A program of tap exchange, thermal disinfection and replacement of flow straighteners was ongoing. Chemical disinfection of system planned once disinfection of taps complete. Resampling took place after chemical disinfection. Water testing extended to ward 2B – within the outpatient area. **9 March 2018** (Late evening) IPC was informed of preliminary results which showed cupriavadis remained in water following the silver peroxide dosing on 2 March. In addition, Stenotrophomonas had been isolated from 2 outlets in 2A. Relevant SMT and clinicians contacted and requested that full control measures be re-instated including removal of showers and mains outlet use for all patients in ward 2A and 2B. Patients were to be bathed in bottled water and all staff and parents to	**7 March 2018** HPS provided an update to the Scottish Government.

	use alcohol based hand rub after hand washing in mains sinks. **10 March 2018** Sampling of second half of water system now completed (cold supply), no access to tap water in showers since 8pm. **12 March 2018** The IMT was re-convened. All shower heads replaced by 10.00 pm same evening. In depth discussions around water testing, results and sanitisations to date. Contingency in case ward 2A water was still positive following further sanitisation. Bone Marrow Transplant patients could move to ward 3C. It was agreed to test water supply in ward 3C first. Also tested ward 4B in adult hospital (this ward will become the adult BMT unit). **13 March 2018** Further sanitisation of system completed with Sanisil at a dilution rate of 3000 ppm. Sampling of water outlets then repeated. Portable Wash Hand Basins installed on ward 2A and mains hand wash basins taken out of use all together. Replacement of taps ongoing. Ongoing enhanced IPC presence. **14 March 2018** Additional measure of sterilium gel to be used after hand hygiene. **15 March 2018** New patient cases. Stenotrophomonas in a blood culture; requiring antimicrobial therapy and line removal. Water outlets in 2A remained positive despite sanisil dosing on 13th March. Positive Cupriavadis water sample now	**11 March 2018** Officials brief the Cabinet Secretary for Health and Sport as potential for media interest following information being given to parents. **12 March 2018** HPS provide further update to the Scottish Government. **13 March 2018** HPS provide further update to the Scottish Government.

	also from ward 3C and adult ward 4B (QEUH). Ward 4B only had 1 positive outlet. Control measures rolled out to all wards which housed immunocompromised patients – 2A, 2B, 2C, 3A, 3B, 3C and PICU. IPC support and advise rolled out to all wards on 15 March 2018. Fileda filters to be fitted to taps of the sinks which contained immunocompromised patients. Ciprofloxacin cover for all immunocompromised patients. Support sought from HFS, HPS, Public Health and Scottish water. **16 March 2018** The Board hold a further IMT, new cases linked to ward 2A identified, and a link to PICU. As part of ongoing investigations in an attempt to find a contingency ward should this be required, NHSGGC take the decision to test water outlets in other areas of the hospital. Scottish Water was contacted. **19 March 2018** Further IMT held. New case of Stenotrophomonas positive on admission to ward – considered to be before control measures rolled out. Ongoing fitting of Fileda filters to tap outlets and showerheads. Once filters fitted to all tap outlets, water was retested. **20 March 2018** HPS confirm that filters are currently being installed and due to be in place by close of play on Tuesday 20 March. Sampling will be taken post filter fitment from four locations to ensure the water is deemed safe. Patients are being asked to use wipes and also have access to warm water via the portable sinks supplied with bottled water NHSGGC confirm they are rolling out testing to other areas, and have increased lab capacity to 100 samples a day. Along with estates colleagues, they risk assessed	**16 March 2018** HPS provide further update to the Scottish Government. **20 March 2018** Chief Nursing Officer invokes the National Support Framework (escalation process) on 26 March 2018 following the Health Secretary's request that the policy unit works with HPS to coordinate a thorough investigation as a matter of urgency, in particular to review the installation and maintenance of the taps and shower heads, within the QEUH and RHC. This was invoked under section 1: criteria for invocation Healthcare Infection incident/outbreak(s)/data exceedance: 'ongoing exposure of individuals to

	the entire site and have a plan for water testing moving forward. This will include higher risk areas such as ICU and theatres. **23 March 2018** The case numbers total 6 since January 2018 and continued to rise over the following months despite widespread investigations and control measures.	infectious agent as a result of healthcare (water) system failure'. HPS commissioned to undertake more detailed review of the incident, with support of HFS. (This report was published in February 2019 as per details above.) Policy officials request details of tap testing and maintenance plans. HPS coordinating with Health Facilities Scotland.
April 2018	**5 April 2018** A new case of Stenotrophomonas Bacteraemia was identified. The exposure was thought to potentially have occurred during a previous admission in December 2017 or March 2018 - before control measures were implemented. **10 April 2018** There was an outbreak of Astrovirus on ward 2A of the RHC. HPS supported NHSGGC on an informal basis and were of the view that the outbreak was not linked to the water contamination issue. This was due to the nature of astrovirus (virus causes D&V) being very different to the water based bacteria in the previous situation. **13 April 2018** An update from HPS advised that no new cases have been identified and no patients were giving cause for concern. Sampling across both QEUH and RHC continues with positive results being identified. Point of use filters remain in place in high risk areas and testing of these filters are underway on a weekly basis in Ward 2A (RHC) and Ward 4B (QE). Point of use filters are being changed within the 30 day period with the exception of children's BMT where as an added precaution they are being changed weekly. IMTs meet every Friday.	**5, 10, 13 April 2018** HPS provide further updates to the Scottish Government. **18 April 2018** Update from HPS to advise that the ward underwent a terminal clean following the

		Astrovirus outbreak and re-opened on 17 April.
May 2018	**18 May 2018** HIIORT from HPS relating to an increased incidence of stenotrophomonas blood stream infections in Wards 2A/2B. Whilst HPS support continues into the water contamination incident, support with this new incident has been offered and not required. **30 May 2018** Further HIIORT from HPS relating to Wards 2A/2B. New case of Enterobacter blood stream infection has been identified (now 5 cases in total). HPS support with his incident not required however HPS support for a wider review of Wards 2A and 2B has been agreed. HFS (with support from HPS) drafted Water Management Issues Technical Review – 1st draft in May 2018. It was finalised and provided to NHSGGC in March 2019, but it was not published. This covered a number of issues – one excerpt: "visible signs of contamination immediately after handover and highlighted issue with the water sampling test results".	**18 & 30 May 2018** HPS provide a further update to the Scottish Government.
June 2018	**4 June 2018** Update from HPS - over the past two weeks NHSGGC have reported 3 cases of Stenotrophomonas and 5 cases of Enterobacter blood stream infections potentially linked to Wards 2A/B RHC. **7 June 2018** The HIIORT following the IMT on 6 June was received: there were 9 cases – 5 enterobacter and 4 Stenotrophomonas. 1 case was giving cause for concern.	**4, 7, 12, 21 June 2018** HPS provide further updates to the Scottish Government. **11 June 2018** CNO wrote to HPS to confirm that The National Support Framework should be updated to ensure that a board; 'would be supported with management of any/all subsequent incident(s)/outbreak(s)/data exceedance within the same ward/area that occur while the original

		incident(s)/outbreak(s)/data exceedance is still under investigation.' **15 June 2018** DCMO Chairs a call with NHSGGC to discuss the situation.
	12 June 2018 One new probable case; positive for ESBL Enterobacter.	
July 2018	**23 July 2018** HPS advise of a case of Aspergillus Fumigates.	**23 July 2018** HPS provide a further update to the Scottish Government.
August 2018	It was agreed at the Water Technical Group that NHSGGC to ensure that any tap replacement programme has no flow regulators. NHSGGC also ensure that the management of water systems is as described in guidance, including letters of appointment; appropriate numbers of authorised persons and competent person and appropriate training.	
September 2018	**4 September 2018** HPS advise of a further 3 potential cases (first case identified 5 August) linked to this incident. An IMT is scheduled. **10 September 2018** HPS provide an update to advise that a further case has been identified. Total cases now 21. None of the patients are giving cause for concern. **11 September 2018** HPS provide an update to advise of a further case, bringing the total number of cases to 22	**September 2018** A series of weekly teleconferences with NHSGGC and HPS begin during September 2018 until approximately January 2019. These were Chaired by the Scottish Government and concerned handling of the incidents. **4, 10, 18, 23 September 2018** HPS provide further updates to the Scottish Government.

	23 September 2018 Case numbers since January - 23. Ward 2A/2B RHC decanted to ward 6A QEUH (and Bone Marrow Transplant (BMT) patients to 4B QEUH) on 26 September due to increased infection rate linked to drains and environment. This was to enable remedial work to be undertaken in 2A/B. **28 September 2018** Drain survey in wards 2A/2B underway. Ventilation review will be undertaken as part of decant review.	**25 September 2018** DCNO escalates the situation in NHSGGC to DG Health. **28 September 2018** HIIAT de-escalated to AMBER
November 2018	[redacted] **21 November 2018** NHSGGC announces that RHC would be without running water for a short period of around four hours on Thursday 22 and Thursday 29 November, scheduled to take place during the night (12 midnight until 4am) to minimise any disruption. This was to allow chlorine dioxide dosing to be carried out, allowing for the removal of water filters. Clinicians confirmed that there were no safety concerns and a mixture of cleaning wipes, hand gel, bottled water, portable sinks, commodes and portable toilets will be used during these short periods.	[redacted]
December 2018	**21 December 2018** Cryptococcus neoformans in wards 6A/4C (Haematology units) in the QEUH is found. One paediatric patient, [redacted] and one other patient affected.	**21 December 2018** HPS provide an update to the Scottish Government.
January 2019	**13 January 2019** The Board issue communications to staff to update 6A parents/ patients. This included information on the installation of HEPA	

	filters in high risk areas and that patients are being given prophylactic antifungal medication **15 January 2019** A Significant Case Investigation (SCI) was commenced by NHSGGC. **17 January 2019** The likely source was thought to be via the plant room. Two rooms in Ward 6A were taken out of use due to evidence of mould in the shower areas. **21 January 2019** 2 cases of Mucoraceous mould. One of the cases was colonised and discharged the other was infected within the intensive care unit at QEUH due to their underlying co-morbidities. An investigation into the cause of this was undertaken, however, no obvious source was found. **22 January 2019** Patients from Ward 6A moved to the Clinical Decision Unit where there are four Positive Pressure Ventilation Lobby (PPVL) rooms. The decant is for up to four weeks to allow completion of remedial estates work and further air sampling once this work is complete. **23 January 2019** Ward 6A decant: All inpatients in Ward 6A moved to CDU (Clinical Decision Unit). Bone Marrow Transplant patients remain in Ward 4C. Repairs to shower rooms being made. **25 January 2019** No further cases since 21 December. Further sampling underway. Review of the helipad. Request for expert help from Public Health England on the ventilation system. **29 January 2019** Patients transferred or receiving treatment in Edinburgh.	**21 January 2019** HPS provide an update to the Scottish Government. **29 January 2019** Issues at NHSGGC escalated to DG Health. DG Health requests the Scottish Government's Health Resilience Team to formally support the work. Daily meetings

		are held with DG Health, Directors and Policy officials until 11 February. There are also regular calls with the NHS Boards; the outputs being detailed below in terms of the updated guidance documents. Daily internal SitReps are also produced.
January 2019	**Independent Review announced** **22 January 2019** Ward 6A patients (paediatric haemato/oncology) moved on 22 January to the clinical decision unit (CDU) in RHC to allow for remedial work to be undertaken related to showers / bathrooms. BMT patients remained in ward 4B. Day care patients relocated to Day surgery area.	**25 January 2019** Letter issued from DG Health**:** Boards to confirm controls were in place and working effectively: All plant rooms must be secure and have adequate access controls in place at all times; • All plant rooms maintained clean and free of vermin; • Standard Operating Procedures for the management of plant rooms are in place and being followed; All critical ventilation systems inspected and maintained in line with 'Scottish Health Technical Memorandum 03-01: Ventilation for healthcare premises'.
February 2019	Work completed as planned and patients moved back on 11 February from CDU to ward 6A QEUH. Day care patients service all returned to ward 6A. **22 February 2019** HPS report published: Summary of Incident and Findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children water contamination incident and recommendations for NHSScotland.	**11 February 2019** Letter issued by Deputy Chief Nursing Officer Boards were reminded of the mandatory requirements of assessment and reporting of infection incidents, outbreaks and data exceedance. **22 February 2019** Letter issued by DG Health Boards were asked to ensure requirements in relation to the earlier letter were adhered to and the importance to communicate effectively and learning is shared.

		26 February 2019 Cabinet Secretary for Health and Sport delivers statement in Parliament on infections at QEUH/RHC. [https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-26-02-2019?meeting=11959&iob=108132]
March 2019		**8 March 2019** Letter issued by DG Health Board Chief Executives were asked to ensure that all relevant aspects of the Requirements and Recommendations contained in the QEUH report are implemented in their Boards as standard practice.
June 2019	**5 June 2019** GNB outbreak at Ward 6A. first notified to Scottish Government. **21 June 2019** 5 cases, 2 considered hospital acquired and 3 healthcare associated possibly due to underlying risk factors including chemotherapy, steroids and neutropaenia. Holding press statement prepared. **28 June 2018** 6 cases plus one possible additional case: 2 are considered hospital acquired and 5 (including the possible) considered healthcare associated, possibly due to underlying risk factors including chemotherapy, steroids and neutropaenia.	**5 June 2019** HPS notify the Scottish Government of the GNB. **6 June 2019** Letter issued by CNO CNO wrote to Board CEOs and Chairs to reemphasis the importance of high standards of building cleanliness including plant rooms and an instruction to advise of compliance with the guidance. **21 June 2019** HPS notify the Scottish Government – HIIART amber. **28 June 2019** HPS notify the Scottish Government - HIIART amber.

July 2019	**5 July 2019** 8 patients (7 confirmed and one possible); the hypothesis is that cases linked by the water system and not person-to-person spread. HIIART amber	**5 July 2019** HPS notify the Scottish Government - HIIART amber.
August 2019	Ward 6A closed to new admissions, with patients diverted for treatment to Edinburgh and Aberdeen. **30 August 2019** 12 cases (11 confirmed, 1 possible). 1 possible case reported previously has now been removed from the case numbers. This patient had a gram positive bacteraemia.	 **30 August 2019** HPS notify the Scottish Government – HIIART red.
September 2019	**9 September 2019** One new case. There are now 13 cases (12 confirmed, 1 possible).	**9 September 2019** HPS notify the Scottish Government – HIIART red. **17 September 2019** A public inquiry in announced by the Cabinet Secretary to examine safety and wellbeing issues at the new children's hospital in Edinburgh and the QEUH. **25 September 2019** Chief Nursing Officer (CNO) meets with NHSGGC, HFS and HPS to discuss the management of the ongoing incident in relation to increases in Gram-negative bloodstream infection on Ward 6A, QEUH (paediatric haemato/oncology). The CNO commissioned HPS to undertake a review of NHSGGC's paediatric haemato/oncology data. **28 September 2019** The Cabinet Secretary meets with some of the families and patients involved in the incident.
October 2019	**October 2019** HPS carry out a retrospective look back at the paediatric haemato/oncology unit's Gram-negative data. HPS found an upward shift with a run of ten data points above the mean from March to December 2017, with the upper warning limit (UWL) breached in August 2017, March	**1 October 2019** The Cabinet Secretary meets with families and patients involved in the incident. Deputy CMO, Senior Medical Officer (paediatrics) and SG Professional HCAI Nursing Advisor met with medical and nursing staff on to hear concerns

	2018, May 2018 and again in September 2019. **11 October** HIIAT escalated to Amber in light of the further 2 cases. Total cases now 15 +1 possible case. Ward remains closed to new admissions. NHS GGC wrote to a wider cohort of around 230 families of patients who have experienced care within the paediatric oncology/haematology service at RHC/QEUH since 1 March 2018, to alert them of investigations into a number of uncommon cases of infection and to offer points of contact within GGC and SG	**4 October 2019** On 4 October 2019 the Cabinet Secretary announces the appointment of Professor Craig White, the Divisional Clinical Lead in the Healthcare Quality and Improvement Directorate at the Scottish Government, to review their concerns and act as their dedicated liaison person and single point of contact for families in respect to these issues. Professor White commences his work on 7 October 2019. **30 October 2019** Families who met with Cabinet Secretary were provided with answers to the questions raised with Cabinet Secretary. These answers were published on NHSGGC's website.
November 2019	**14 November 2019** The Daily Record run a whistle-blower/ Anas Sarwar story about 27 cases of infection in 2017 in the paediatric haemato/oncology unit at RHC, which were claimed to have been 'covered up'.	**20 November 2019** The Cabinet Secretary delivers parliamentary statement on QEUH regarding issues relating to infection prevention, management and control at the QEUH. [https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-20-11-2019?meeting=12376&iob=111835] **22 November 2019** The Health & Social Care Management Board (SG) agree to escalate GGC to Stage 4 of the performance framework

	28 November 2019 During FMQs on 28 November, Anas Sarwar brings a number of reports commissioned locally by NHSGGC to the Chamber and subsequently sent a briefing pack to journalists with links to the full reports. This included two reports by DMA, in 2015 and 2017.	NHS healthcare standards: Board performance escalation framework - gov.scot (www.gov.scot) An Oversight Board chaired by the CNO is established by Scottish Government (letter from Malcolm Wright DG Health to John Brown, Chair of NHS GGC). The Oversight Board under the chair of the Chief Nursing Officer, Professor Fiona McQueen, has been set up to address two specific sets of issues that led to escalation: infection prevention and control and associated governance with respect to the QEUH; and communications and engagement with affected families. A third workstream related to the technical issues in the QEUH campus will also be considered as part of the OB. The chairs of each sub-group are: 1) Infection Prevention and Control – Irene Barkby MBE followed by Diane Murray, Deputy Chief Nursing Officer (IB stepping down in 2020 for health reasons); 2) Engagement and Communications with Families – Professor Craig White; 3) Technical aspects – Alan Morrison Oversight Board will meet weekly. **27 November** The first GGC Oversight Board meeting took place,
December 2019		**10 December 2019** The Cabinet Secretary delivers parliamentary statement on QEUH. **11 December 2019** First meeting of Infection Prevention & Control and Governance Sub Group (IPC), chaired by Irene Barkby MBE, NHS Lanarkshire **12 December 2019** First meeting of communications and Engagement Subgroup

	17 December 2019 NHS Greater Glasgow and Clyde announce that they have instructed legal action against Brookfield Multiplex, the contractor that was responsible for the design and construction of the £575m Queen Elizabeth University Hospital (QEUH) complex in Glasgow.	
January 2020	**January 2020** Technical Sub Group to the Oversight Board Established with Alan Morrison as Chair to provide technical review, advice and assurance on the relevant technical matters relating to the built environment of the hospitals. **28 January 2020** The Cabinet Secretary commissioned the QEUH Case Note Review.	
March 2020	**27 March 2020** Update provided in response to SG's request of 20 March 2020.	**20 March 2020** SG Health Finance Directorate request update from NHSGGC in relation to: • A current update on the refurbishment of Wards 2A and 2B – with a detailed programme for the project, along with a note on any risks (covid related or otherwise) • Water testing regime – SG sought assurance that NHSGGC had an effective water testing regime in place and sought relevant vouching. • Water dosing plant – an update in relation thereto.
June 2020	**15 June 2020** The QEUH Independent Report is published.	
September 2020	**3 September 2020** NHSGGC provide SG with a "water information pack" that clarifies the process and dialogue that was ongoing in 2018 in regards to the selection of the preferred water treatment technology.	

	Additionally NHS GGC provide SG with a number of documents about water safety and how it is governed within the Board as well as how it is managed at a site level, in this case the QEUH. (NB NHSGGC provided SG with a number of documents related to water safety during the time-period specified in the notice. The provision of this information was not an isolated incident and should not be read as such.) **16 September 2020** HFS respond to SG with comments on NHSGGC "water information pack".	**4 September 2020** SG instruct HFS to review the documentation provided by NHSGGC. In particular, SG sought assurance that processes followed by NHSGGC in relation to water treatment and safety. SG sought HFS' views on the robustness of the processes.
October 2020	**27 October 2020** NHSGGC provides SG with an update on recorded Cupriavidus Bacterium and gram-negative bacteria species recorded in water sampling following installation of chlorine dioxide dosing plant.	**27 October 2020** SG sought further advice from HFS on the information provided by NHSGGC.
November - December 2020	**November - December 2020** Further correspondence between HFS, SG and NHSGGC re water sampling at QEUH and RHC. **21 December 2020** The QEUH Oversight Board publishes its final report.	
March 2021	The QEUH Oversight Board publishes its final report. The interim and final reports of the oversight board should be considered together as a single suite of documents. **22 March 2021** The QEUH case note review is published.	

APPENDIX 1 - Timeline of incidents in Queen Elizabeth University Hospital and Royal Hospital for Children for the period 2015 to 2019

Section 1
Introduction

Introduction and Summary of Timeline

Introduction

The slides in this report set out a timeline of the infections and colonisations which occurred in the Royal Hospital for Children (RHC) and latterly the Queen Elizabeth University Hospital (QEUH) during the years from 2015 to 2019. The timeline only looks at paediatric patients in the Haemoncology/Oncology Bone Marrow Transplant (BMT) wards that were affected by these incidents. It does not contain reference to any instances where such infections occurred in adults wards.

The timelines includes any infection or colonisation either caused by a Gram Negative Bacteria (GNB) or a Fungus. Some Gram Positive Bacteria are also included in the timeline but only as a result of being included within a wider set of GNBs or is relative to the context that is being described.

An Incident Management Team (IMT) is set up when certain triggers (which are laid down in the National Infection Prevention and Control Manual which is written by Health Protection Scotland (HPS)) are reached. The trigger is normally based on a certain level of an organism in a specified period. The level and period are dependent on which organism is being considered.

An IMT will normally follow a Programme Assessment Group (PAG) which will look at any infection or colonisation that has occurred in a patient. If the trigger is breached, then an IMT will be convened to investigate the incident more fully. The timeline consider each of the incidents from when the IMT was convened, rather than the PAG. However, if the incident was only considered by a PAG this will be included in the timeline.

The timeline looks at both the activities of the Infection Prevention and Control Team (IPCT) and also the Facilities and Estates Team (F&E) who are normally both involved in the IMT and to show the interaction between these two teams. In respect of the F&E team, the timeline also incorporates activities performed by the team in responding to issues with the hospital campus following it being handed over by the main contractor who built the hospitals. The timeline also considers the development of the F&E team over the period in respect of development of its levels of compliance and also the handling of a two reports prepared by a company called DMA which highlighted concerns with the water system at the time the hospital was handed over.

Summary of Timeline

Haemoncology/Oncology and BMT patients were originally accommodated in Ward 2A and day patients were seen in Ward 2B of the RHC. Patients could also be accommodated in or transferred to and from the Paediatric Intensive Care Unit (PICU) depending on the severity of their condition. The timeline shows that an increasing number of incidents occurred in Wards 2A from 2017 onwards. In 2018 the level of incidents results in Wards 2A and 2B being closed and BMT patients were moved to Ward 4B in the QEUH and the remainder of patients were moved to Ward 6A in the QEUH. This relocation occurred at the end of September 2018 but was intended only to be for a short time.

The timeline shows that the hypothesis that infections were caused by contamination of the water system starts to develop in 2018 when the first incidents starts to occur in March of that year. A Technical Water Group (TWG) was set up in the April of that year to investigate this hypothesis further and to consider and come up with both short and long term solution to this problem.

The decant of patients from Ward 2A and 2B was in order to allow a thorough investigation of the wards to understand what was the cause of the infections/colonisations and if indeed was the water supply. It was also to allow replacement of taps, showers and drains to be fitted. As work begun further issues in relation to the ventilation of the ward became apparent and the extent of the work required became much more extensive. As work has progressed other problems have been discovered, such as mould in shower rooms due to faulty floor sealings. At the time of writing the work on the wards is still progressing and the estimated timescale for completion is [September 2020]

Following the move to Ward 6A infections continue to be seen during 2019 and leads to more detailed analysis of patient pathways and their access to other sources of water and locations outside of the wards. New admissions to the ward are restricted until no further cases are reported for a period of time. The ward continue to accommodate these patients to the present day and BMT patients still remain accommodated in Ward 4B.

It should be noted that the timeline also included infections in other areas of the RHC such as PICU and wards 1E, 3A and Theatre 6 which are all contained in the RHC. The level of occurrence of incidents in these Wards was much less, with the exception of PICU which also saw more incidents in 2019. All these Wards remained open and preventative measures were taken to control the spread of the organism involved in the incident.

The TWG has continued since it was first convened in April 2018 and initially conducted a large number of water tests across the whole campus to ascertain whether the issues with the water supply were confirmed to just Ward 2A or beyond. The results of these tests revealed that the problem was widespread and a solution to address this would have to cover the entire campus. Following discussion with third parties and water experts, the long term solution that a chlorine dioxide (CD) plant should be installed and continual dosing of the water supply in both the RHC and QEUH would take place. The CD plant was installed and the RHC has received dosing of the water supply since November 2019 and the QEUH since January 2020. Weekly water tests are conducted and the results producing a large number of negative results, indicating that the CD is having a positive effect.

Also included in the timeline are incidents which occurred in the Neonatal Intensive Care Unit (NICU) in the Maternity Building which is connected to the RHC. The unit cares for very premature babies and is included in the timeline as the building's water supply is dosed with CD. This was building was part of the original site and is not a new building. This is the reason that it is dosed with CD.

Structure of Report

There are a number of sections contained in this report as follows

- **Timeline for 2015 to 2019** – these sections set out the investigations made by the IMTs and also the control measures put in place to prevent the spread and transmission of the infection/colonisation. The type of GNB or Fungus is noted together with the which ward or location in the RHC they were when the infection/colonisation occurred and also the number of patients that were affected. Timeline of the Technical Water Group

Introduction and Summary of Timeline

- **Timeline of Technical Water Group –** this looks at the work of this group and the decisions taken in relation to the instalment of the CD plant. It is shown as a timeline for the group from April 2018 up to December 2019. The TWG continues to meet on a monthly basis to the present day. The timeline also details the development of the further issues identified with wards 2A and 2B and details the reasons for the delay in being able to return patients to these wards.

- **Heat Map of Infections –** this table brings together in one table all the incidents that occurred during the time from 2015 to 2019. The table shows where the incident occurred, which month it occurred, the organisms involved and the number of patients that were identified with that organism at the time. The table highlights the increase in incidents in years 2018 and 2019.

- **Reflections on Governance** – this table shows how each of the above incidents detailed in the heat map have been reported up to the GGC Board and the governance structure that is in place around such incidents.

- **Conclusions and Lessons Learned –** this sets out the conclusions drawn and also the lessons that that can be learned from the incidents which have occurred at the QEUH and RHC and how they can be managed. The lessons learned section incorporates now only those for GGC as a Board but also from a national perspective for other organisations and heath boards..

Information Source

The information contained in this report has been taken from a number of sources including, but not limited to, the following

- Interviews with members of the GGC Infection Prevention and Control Team and Facilities and Estates team;
- Minutes of IMTs and/or PAG set up to investigate each incident
- Minutes of meetings of the GGC Board, Acute Infection Control Committee (AICC), Board Infection Control Committee (BICC), Board Clinical Governance Forum (BCGF), Clinical and Care Governance Committee (CCGC) and the Acute Clinical and Governance Committee (ACGC)
- Minutes of the Technical Water Group (TWG), the Board Water Safety Group (BWSG) and the South and Clyde Sector Water Group (SCSWG)
- Papers provided by Facilities and Estates in relation to water risk assessments, audit and compliance documents.
- IPC Summary documents attached to papers of the AICC.

A full list and details of the information used to the preparation of this report is contained in the folder “Information Sources for Timeline” attached to this report. It should be noted that some of the documents used were contained on a secure SharePoint site and in this case, the physical document can not be included and therefore the title of the document is included within the folder. It would require the reader of this report to request a copy of the relevant document from GGC or permission to gain access to the SharePoint site.

Limitations

The timeline has been completed for the period 2015 to 2019 and has not taken into account, unless otherwise specifically stated, the events that have occurred after that period. The minutes of the GGC Board and its various committees have not been reviewed for 2020.

The timeline does not include any information in relation to infections and colonisations that occurred during the period 2015 to 2019 in the adult hospital or within the adult patient population. The exception to this is when the paediatric haemoncology/oncology patient group moved to wards 6A and 4B in the adult hospital The absence of any such similar incidents relating to the adult population from the timeline should not be taken to mean that such incidents did not occur.

The information for this report is based on that provided up to and including 27 March 2020. If any further information comes to light that changes the content of this report, then the right is retained to update the report accordingly.

Section 2
Key and Glossary

Glossary

- A - Aspergillus
- AB – Acinetobacter Baumanii
- AC - Achromobacter
- AE – Authorised Engineer
- AICC – Acute Infection Control Committee
- ACGF – Acute Clinical Governance Forum
- BCGF – Board Clinical Governance Forum
- BICC - Board Infection Control Committee
- BMT – Bone Marrow Transplant
- Board – NHS Greater Glasgow and Clyde Board
- BWSG – Board Water Safety Group
- CA – Cryptococcus Albidus
- CCGC Board Clinical and Care Governance Committee
- CD – Chlorine Dioxide
- CH - Chyrseomonas
- CEO – Chief Executive Officer
- CH - Chrseomonas
- CN – Cryptococcus Neoformans
- CU – Cupriavidus
- DA – Delftia acidovorans
- DSR – Domestic Services Room
- EA – Enterobacter Aeromonas
- EC – Enterobacter cloaecae
- EM – Elizabethkingia Miricola
- EC – Enterobacter Cloacae
- FG – Fungal Growth
- F&E – Facilities and Estates
- GGC – NHS Greater Glasgow and Clyde
- GNB – Gram Negative Bacteria
- GPB – Gram Positive Bacteria
- HAIRT – Healthcare Associated Infection Reporting Template
- HEPA - High-efficiency particulate air filter
- HH – Hand Hygiene
- HIIAT – Healthcare Infection Incident Assessment Tool
- HIORT – Health Outbreak and Incident Reporting Template (predecessor of HIIAT)
- HFS – Health Facilities Scotland
- HIS – Health Improvement Scotland
- HPS – Health Protection Scotland
- IMT – Incident Management Team
- ICD – Infection Control Doctor
- ICN – Infection Control Nurse
- IPCT – Infection Prevention and Control Team
- LICD – Lead Infection Control Nurse
- MB – Microbiologists
- MC – Mycobacteria Chelonae
- MD – Medical Director
- NICU – Neonatal Intensive Care Unit
- OPD – Out Patient Department
- Pan - Pantoea
- PAG – Problem Assessment Group
- PanS – Pantoae Septica
- POUF – Point of Use Filters
- PICU – Paediatric Intensive Care Unit
- Ps - Pseudomonas
- PsA – Pseudomonas aeruginosa
- PsP – Pseudomonas Patuida
- QEUH – Queen Elizabeth University Hospital, Glasgow
- RCA - Root Cause Analysis
- RHC – Royal Hospital for Children, Glasgow
- SCBU – Special Care Baby Unit
- SCN – Senior Charge Nurse
- SCSWG – South and Clyde Sector Water Group
- SG – Scottish Government
- SICP – Standard Infection Control Precautions
- SM - Serratia Marcescens
- SPC – Statistical Process Charts
- STM – Stenotrophomonas Maltophilia
- TBP – Transmission Based PrecautionssTVC – Total Viable Count
- ToR - Terms of Reference
- TVC – Total Variable Count
- TWG – Technical Water Group
- VGNB – Variety of Gram Negative Bacteria

Key

Gram Negative Bacteria

- AB - Acinetobacter Baumanii
- AC - Achromobacter
- CH - Chryseomonas
- CU - Cupriavidus
- DA - Delftia acidovorans
- EA - Enterobacter Aeromonas
- EC - Enterobacter cloaecae
- EM - Elizabethkingia Miricola
- Pan - Pantoea
- PanS - Pantoea Septica
- Ps - Pseudomonas
- PsA - Pseudomonas aeruginosa
- PsP - Pseudomonas Patuida
- SM - Serratia Marcescens
- STM - Stenotrophomonas Matophilia
- GNB - Gram Negative Bacteria not yet identified
- NUO - Numerous unidentified organisms

Fungal Infections

- A - Aspergillus
- CN - Cryptococcus Neoformans
- FG - Fungal Growth

Gram Positive Bacteria

- MA - Mycobacteria abscessus
- MC - Mycobacteria chelonae
- SE - Staphylococcus epidermis

Other Symbols

- → - activity continues into future
- ← - activity continues from the past
- ↔ - activity continues from past and into the future

Locations

- 1E - Ward 1E
- 2A - Ward 2A
- 2B - Ward 2B
- 3A - Ward 3A
- 4B - Ward 4B
- 6A - Ward 6A
- PICU - Paediatric Intensive Care Unit (PICU)
- NICU - Neonatel Intensive Care Unit (NICU)
- ??? - Unidentified ward
- T6 - Theatre 6, RHC

Section 3
Timeline for 2015

Timeline for 2015

- Hospital campus handed over.
- Contractor tests water in Dec 2014 Jan 2015 show high TVC and E.coli
- Outlets with high TVC counts, are disinfected, but still fail test. No further evidence that further action taken.
- No evidence these results notified to the Project Team, IPCT or HFS/HPS.

Hypothesis - work may have introduced contaminants into water system.

Main Contractor (Multiplex) is Working on mains water tanks, calorifiers and pipework. The Project Team is not aware.so no controls in place over this work.

- DMA Legionella L8 Risk Assessment 2015 (pre-occupancy) received
- Recommendations refer to adjustments to water temperature, removal of dead legs and debris in water tanks. **No evidence that report actioned until 2018**
- Notes that sampling programme (for TVC, e-coli, coliforms and legionella) was being conducted and daily flushing and local disinfections were underway where positive results were found. Method of sampling was acceptable to microbiologists. DMA were not given the sample results and disinfection process to review.

30 July 2015

26 January

March

Early May

Facilities and Estates (F&E)

1 Jan 2015

End Jan to June?

2 Feb

April

18 May

23 June

27 July

- Flushing regime Is instigated to Ensure turnover of Water prior to Occupation
- This performed By estates staff and Also agency staff.

200 contractors appear on campus to finish work on hospital systems and address issues being found. These contractors had been working with the main contractor to deal with snagging issues. . See Appendix 1

- GGC conducts testing of water outlets from April to December. Testing is for Legionella only.
- April results show positive results for legionella species in certain areas
- Sampling is performed by 2 estates managers with no training in taking samples which are taken from 500-600 sentinel points throughout the campus
- Where positive samples are found, then area/outlet Is disinfected until 3 consecutive samples are negative.

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Board Infection Control Committee (BICC) Notes there is concern with treating immune compromised patients at the new hospital due to the ongoing building work there. Notes that dust control people been contacted to ask For method statement and list of the demolition work planned and period.

- Board paper details the move to the new campus. Notes some initial operational difficulties but these were quickly and effectively resolved by staff.
- Other operational issues which have emerged include ongoing issues with the pneumatic tube system. No mention of any water issues either in this paper or the Board minutes

- Noted at BICC meeting that the patients In the Bone Marrow Transplant (BMT) Unit have been transferred to the Beatson as the unit was not built to the correct specification and main contractor has agreed to fund the rebuild for this areas. Timeframe Is 12 weeks.
- Concerns again raised around treatment of immune compromised patients due to demolition of surgical block in September. Alternative route will be identified for these patients so that they enter the hospital at the further point away from the demolition work.

1 Jan 2015

18 May

14 June

23 June

27 July

Infection Prevention and Control (IPCT)

30 July 2015

27 April

1 May

10 June

- Completion of the move by All units and hospitals to the new campus

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- Southern General Out Patient move to new campus
- Commencement of adult patients from Western Infirmary, Victoria Infirmary and Mansion House Unit, Gartnavel General Hospital

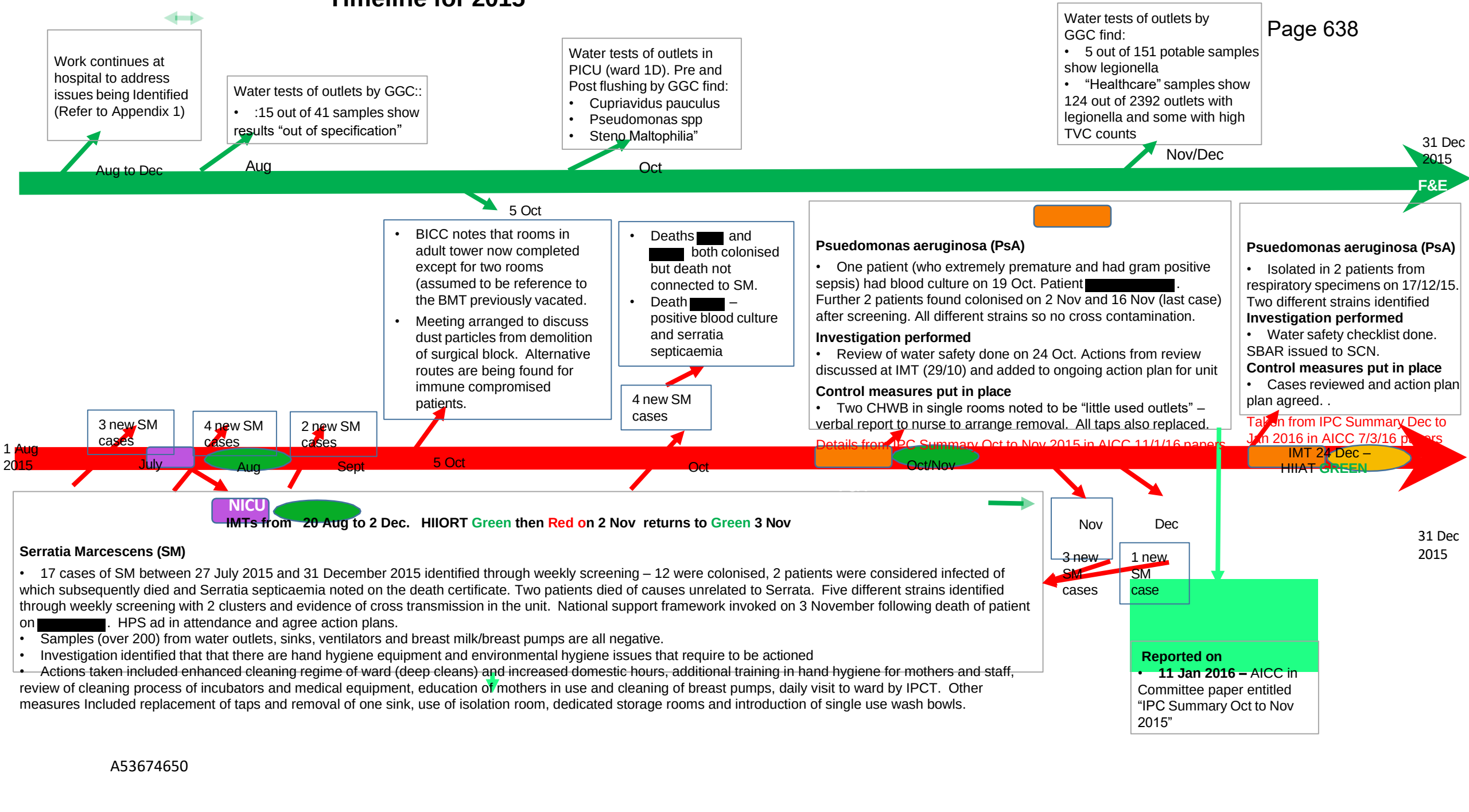
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- Southern General In Patient Department moves moves to new campus

- The Royal Hospital for Sick Children at Yorkhill Moves Into the new Royal Hospital for Children on the campus

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Timeline for 2015



Serratia Marcescens (SM)

- 17 cases of SM between 27 July 2015 and 31 December 2015 identified through weekly screening – 12 were colonised, 2 patients were considered infected of which subsequently died and Serratia septicaemia noted on the death certificate. Two patients died of causes unrelated to Serrata. Five different strains identified through weekly screening with 2 clusters and evidence of cross transmission in the unit. National support framework invoked on 3 November following death of patient on [redacted]. HPS ad in attendance and agree action plans.
- Samples (over 200) from water outlets, sinks, ventilators and breast milk/breast pumps are all negative.
- Investigation identified that that there are hand hygiene equipment and environmental hygiene issues that require to be actioned
- Actions taken included enhanced cleaning regime of ward (deep cleans) and increased domestic hours, additional training in hand hygiene for mothers and staff, review of cleaning process of incubators and medical equipment, education of mothers in use and cleaning of breast pumps, daily visit to ward by IPCT. Other measures Included replacement of taps and removal of one sink, use of isolation room, dedicated storage rooms and introduction of single use wash bowls.

Timeline for 2015

R**eporting**

- **2 Nov and 11 Jan 2016 – AICC –** meeting on 2 Nov briefed through the IPC Summary for Aug – Sept included in papers. **30 Nov and 25 Jan 2016** – Board Infection Control Committee (BICC) – notes only hospital which does weekly screening and to seek from HPS if this is appropriate and what should be screened for. Noted care required when switching from IV to oral feeding and this should be included in staff safety brief. **6 Nov and 7 Dec** – Board Clinical Governance Forum (BCGF) **15 Dec** – Board – Update given.
- HAIRT for **December**

Section 4
Timeline for 2016

Timeline for 2016

Work continues at hospital to address issues being Identified (Refer to appendix 1)

Jan to Jun

Board Water Safety Group(BWSG)

- Noted discussion between LICD and Senior Estates Manager of water and environmental issues.
- Discussion of pseudomonas risk of tap straighteners. No taps on market without flow control mechanisms and HPS advice not to sample water but remove, sanitise, return flow straightener to tap and replace plastic components every 3 months.

Check to be made with HPS

2 Feb

- Estates compliance team was formed to update policies, procedures, share best practice, training. Also an assurance role, to do audits of estates but this has not occurred

March/April

- Raw water tanks are tested and are clear of legionella spp

June

31 July 2016

SM

F&E

1 Jan 2016

Cupriavidus

- A patient tested positive for Cupriavidus pauculus
- Investigations found patient had parenteral nutrition which was reconstituted in the Aseptic pharmacy.
- Samples taken from a tap on a wash hand basis in the aseptic pharmacy which also isolated Cupriavadis and typing of both isolates were found to be the same
- The wash hand basin was subsequently removed
- Note – documentation not yet provided for this incident but referred to in 2018 incident (see slide X

IMT 8 July to 22 July

Serratia Marcescens (SM)

Note: Incident continues until 13 October 2016

- Between 13 June and 22 July 8 babies are colonised. Four types identified suggesting practice issue and not point of source

Investigations performed

- Two lots of Environmental and water sampling performed. Negative results for SM but on one sample round found TVC counts > 100 but none were pseudomonas or serratia.
- Review of antimicrobial prescribing for colonised patients passed to clinicians but no actions required.
- Daily monitoring of practice and hand hygiene audit
- Noted unit very busy with "RED" levels of staffing which may be contributing to incidents.

Control measures put in place

- Enhanced cleaning, cleaning checklists introduced and additional cleaning staff taken on.
- hand wipes for bathing Babies,
- Education literature on PPE and SM precautions provided
- Reorganisation of equipment store room to allow equipment at patient beds to be stored.
- Thermal disinfection of tanks to be accelerated.

BICC meeting notes still Ongoing discussions on the Specifications for adult BMT But all ventilation issues now Complete. Notes meeting last Week with contractor and Chief Executive to discuss this And look at guidance to ensure area is compliant.

25 Jan

I new case – Final one of this incident

1 Jan 2016

Jan

Jan HIIAT remains at **GREEN**

Serratia Marcescens (SM)

- Actions on last slide extend to January. In addition SM is added as an alert organism for IPCT to monitor trends
- Infected babies who die will trigger a clinical review, single cases will be isolated, 2 HAIs will trigger review by ICT. Definition of outbreak is 2 infected or 3 colonised cases.
- Incident highlighted different interpretation of HIIART assessment with that of HPS and HPS will implement training to address this.

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PICU

June

Acinetobachter Baumanii

- Two patients test positive for AB in ward 1D
- Prior to this both patients and had cardiac surgery
- Patient 2 acquires AB 14 days after surgery.

Patient 1 in next bed acquires AB 4 days later. .

- Hyporthesis is that patient 1 acquired AB from Patient 2.

Note – based on document setting out review of case Notes. No IMT held. (See appendix 2)

Reported to

- **25 July** – BICC

29 July

HAIORT submitted – Status **Green** as all patients have been asymptomatic however reported due to increase in numbers. This Advised by HPS who had been contacted about this Incident.

31 July 2016

Reporting

- **2 Jan and 7 March** - reported to AICC
- **21 March and 23 May** – reported to BICC. At 23 May meeting report from GGC and HPS is issued on the outbreak, which includes recommendations and action plan.
- **16 Feb -** (in HAIRT only) – GGC Board – discussion on 16/2 is on alert systems, infection cycles, and evidencing actions to address emerging themes
- Reported in HAIIRT for February

Timeline for 2016

Work continues at hospital to address issues being Identified (Refer to appendix 1)

Original structure included estates officers on day, back and night shift. Due to the activities that were on going at the hospital and requirement to "fire fight" issues, it was decided to change those officers on back and night shift to day shift to assist with the volume of work being undertaken. Year on year cost savings also required this to be done as resource was being cut. Once work completed (circa end of 2017/beginning of 2018 these individuals are moved to the compliance team

1 Aug 2016 — Aug to Dec — Between August and December (exact date not known) — Nov 30 Dec 2016

IMT 5 Aug

Aspergillus A

- 2 cases in ward 2A – 1 definite and 1 probable case subsequently confirmed as not Aspergillus. Medical Director notified.

Contributing factors considered

- Tears identified in ventilation ductwork now repaired;
- Condensation from chilled beams creating damp conditions and Dust - had been cleaned and disinfected. Noted that condensation issue had been raised with main contractor as this should not occur.
- Construction/demolition work on site causing

Investigations performed

- Air samples of chill beams were taken and were negative. Samples from air handing unit showed fungus.
- Ceiling area of previous water leak inspected and no fungus found.

Control measures put in place included

1) Increased cleaning and cleaning of chilled beams
2) Proplylaxis given to high risk patients with Ambisome
3) Portable HEPA filter units to be placed in unit – notes all rooms filtered but not HEPA filtered due to design of air handling united and chilled beams.

Incident closed by ICD [redacted] ust and HAIIORT updated.

Aug to Oct

Serratia Marcescens (SM) SM

- Continuation of outbreak that commenced in July 2016 (see previous slide)
- Further colonisation of babies in NICU with SM with a further 3 in August and 1 in September. The later is due to a gastric aspirate which was positive for SM.
- A total of 5 different strains have been identified to date. Five cases were discharged by 9 August. One baby develops a positive blood culture but remains well.

Control measures put in place

- Mixture of cohorting of patients and use of isolation rooms with transmission based precautions (TBPS) instigated.
- Deep clean of entire unit is completed with Hydrogen Peroxide Vapour – methodology is Discussed between IPCT and Estates teams. Clean is completed by 30 August.

Closure of incident

- By 13 October, 2 babies remain in NICU in a cohorts with TBPs, 2 are discharged to Special Care Baby Unit (SCBU), 5 discharged home and 3 transferred to other health boards
- No new cases have been reported since 12 September and incident is closed by chair of
- IMT with 2 babies remaining in MICU in a cohort.

- Note IMTs have been held throughout this period but documents not yet provided.

Serratia Marcescens (SM)

- 6 patients reported with SM.
- HIIAT Green at IMT on 04/10/2016.
- Typing confirmed all cases were different types.

Note – taken from Dec 2016 HAIRT

Reported
- **3 Oct** – BIICC
20 Dec – Board
9 Jan 2017 - AICC
6 Feb 2017 - BCGF
December HAIRT

Serratia Marcescens (SM)

- Four cases of colonisation in NICU Identified from weekly screening with the Last identified on 6/11/16.
- Of the 4 cases 3 were unique strains And 1 similar to isolate from previous Cluster.
- Control measures put in place and IMTs held. Incident was closed on 9/12/16

Note – documentation not yet provided for this incident but mentioned in a Summary of HIIORT reviews (appendix 3) And also in HAIRT Feb 2017 and papers For [redacted] meeting in March 2

30 Dec

1 Aug 2016

5 Aug

HAIIORT – reported as **AMBER**
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- First case on 25 July
- Second case 4 August

16 Aug

HAIIORT – updated to **Green**

4 Aug
- 1 new case
- Total now 9

16 Aug
- No new cases
- Total stays at 9

Aug to Oct - HAIIORT **Green** during this time

31 Aug
- 2 new cases
- Total now 11

5 Sept

13 Oct
- 1 new case
- Total now 12
- Incident closed

Sept/Oct

Reported to
- **3 Oct** and **28 Nov**
- **18 Oct** - Board
- **14 Nov** and 9 Jan 2017 – AICC
- **6 Feb 2017** - **BCGF**

Nov

- HIIORT Sent to HPS and SG Date not known. Status is **AMBER.**

Note – HIIORT

Nov 2016

Reported to
- **27 Mar 2017** - BICC
- **21 Feb 2017** – Board
- **6 Mar 2017** – AICC
- **24 Apr 2017** – BCGF

Feb and April 2017 HAIRT

Reported to
- 18 Oct - Board
- 14 Nov - AICC
- 28 Nov - BICC
- October HAIRT
- December HAIRT

- AICC meeting notes Adult and Paediatric BMT rooms fall below standards implemented in other units. Risks to adult patients and corrective action being considered. Work is ongoing in Paediatric BMT to achieve required specification
- IPCT involved in design/functionality of 4 new neurological theatres to meet building standards
- Guidance waited from HPS/HFS on suitability of QEUH for infectious disease patients.

Section 5
Timeline for 2017

Timeline for 2017

- Report of the audit conducted by the Authorised Engineer (AE) on 4 May is received. This audit is normally conducted annually but this is the first time since the campus was occupied. It is assumed an audit did not take place in 2016 as the Campus was in the process of being occupied. The reasons why an audit did not take place in 2016 however is not known.
- The audit focuses on the compliance processes and documentation that is in place around the management of water quality and not of the physical system itself. So, for example it will consider if a risk assessment process is in place, what this covers, if is documented, that actions identified from the risk assessment are recorded and there is evidence to show these have been addressed. Other areas considered will be servicing records, whether staff have requisite training and experience, documentation of roles and responsibility and sampling protocols for example.
- A copy of the audit report for 2017 is contained at Appendix 4. It is noted that apart from one entry, all actions have been completed. The one entry shown to be in progress is completed by the 2018 audit. he report gives a score of 99% Compliance but it is not clear whether this is before or after the actions noted were taken [to be checked with Estates]

Work continues at hospital to address Issues Identified (Refer to appendix 1)

Reported to 6 Mar – AICC meeting - Included in paper "IPC Summary Dec – Jan 2017

Reported to 8 May – AICC meeting - Included in paper "IPC Summary Feb – Mar 2017

Jan - June

4 May

30 June 2017

1 Jan 2017

Serratia marcescens (SM)

- Cases of SM in PICU and ward 1D
- Review of domestic cleaning especially pendants.
- Estates review of trough Sink relocation from trolley bay.
- Typing of isolates.
- Chlorine clean of bed spaces.
- Timeline created.
- Patients reported as not giving cause for concern at time of reporting.

Note – taken from IPC Summary Dec to Jan paper [illegible] meeting in March

Elizabethkingia Miricola (EM)

- Three cases are isolated from patient line cultures between Sept 2016 and February 2017. All unique strains.
- Review of vent cleaning and maintenance by estates.
- Sampling of vents, chill beams and water outlets were negative
- IPCN carried out visual inspection of environment.
- Incident closed 27/3/17

Note – taken from Summary of Incidents and Outbreaks on Ward 2A - see Appendix 3 and IPC Summary Feb to Mar attached to [illegible] May meeting

Serratia marcescens (SM)

- One patient in NICU with systemic infection caused by Serratia marcescens. Blood culture positive 26/02/17.
- In addition, 2 other patients on the unit remain colonised with SM.
- All 3 patients remain isolated in cohort and patient with systemic infection stable and making good progress at time of report.

Note – taken from IPC Summary Feb To March paper for AICC meeting in May

Aspergillus

- Three cases in ward 2A reported to HPS.

Investigations performed

- IPCT review level of dust from ongoing works at site
- IPCT review full ward and ceiling void after mouldy ceiling tiles noted.
- Cleaning of ward was inadequate.
- Inspection of cooling beams which leaked periodically
- Air and water sampling done – air isolates Aspergillus.
- Hand hygiene performed – score 85%

Control measures put in place

- Removal of mouldy tiles and ceiling void repairs
- Full terminal clean of ward
- Anti fungal given to all patients
- Ongoing surveillance by clinical teams to alert IPCT As lab testing unreliable
- ICD and Estates produce water damage policy.

Details from Appendix 5 as IMTs docs not yet provided.

Serratia marcescens (SM)

SM

- Incidence of SM in PICU

Notes – taken from Appendix 5 as documents Awaited

BICC meeting - concern about disruption in ward 2A due to a Rotovirus/ Astrovirus outbreak. Concerns were

- Level of cleaning/use of professional cleaners,
- Shortage nursing resource to Implement IPC measures.
- Low level of HH

Actions taken are HH Education, seeking extra Nursing/domestic staff

- BICC ask IPCT to Check resource issue is being addressed

1 Jan 2017

30 June 2017

30 Jan

6 Feb

6 Feb

HIIAT reported as **Green**

28 Feb

28 Feb

HIIAT reported as **Green**

26 Feb to 3 Mar?

3 Mar??

6 Mar

IMTs between7 March to 28 April

HIIAT initially reported as **RED** then down graded to **AMBER** and then **Green** once ceiling repairs Completed. Incident closed on 28 April

10 March?

10 March ?

HIIAT initially reported as **AMBER** and subsequently upgraded to **RED**. No details of when downgraded and incident closed

15 May

8 May

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BICC meeting

- ICD submits a paper entitled “Role of Infection Control Team in New Builds”
- Notes approved by Director of F&E and states that IPCT should be involved
- In all stages of project from initial planning through to completion and handover.

Paper submitted due to issued due to issues with new build and was an abbreviation of SHFN 30 – which covers the role of IPCT in new builds. MD questions if need for specialist expertise in ventilation beyond ICT.

- A larger document used at time of build and agreed to cross refer both documents

HIIAT reported as **Green**

Noted at AICC that QEUH Isolation rooms are not Suitable for air borne infection Infectious disease physicians Are reviewing the facilities Based on HFS report In interim patients will be transferred to GRI or Monklands

AICC informed 2 Isolation rooms in Ward 2A being Changed over from Positive to negative Pressure. Patients Will remain in situ While work done.

Reported to
8 May and **3 July** – AICC. Meeting on 8 May updated Through IPC Summary Feb – Mar document in papers. **27 June** - Board **31 July** – BICC **7 Aug** – BCGF June 2017 HAIRT

Timeline for 2017

Work continues at hospital to address issues Identified (Refer to appendix 1)

- The AE report for 2018 of the audit Conducted on 23 July 2018 is is received and actioned.
- The report gives a score of 99% Compliance but it is not clear whether this is before or after the actions noted were taken [to be checked with Estates]
- A copy of the report is contained at Appendix X and shows all actions are completed.

- Ward 4a shows positive results for
- legionella spp in outlets
- Some results remain after disinfection.
- Taps are replaced and a thermal disinfection

Is performed. Final test results are negative.

- Work on September 2017 DMA report begins

1 July 2017 — July - Sept — 23 July — July - Aug — Sept — 31 Sept 2017 — F&E

AICC Meeting

- Records that some Extra alert organisms Have been added onto The minimum alert Organisms listed in Appendix 13 of the National Infection Prevention and Control Manual (NIPCM). Noted No changes required as IPCT already includes These extra organisms In their systems.
- This includes GNB And GPB – see SBAR Issued by GGC on 4 Aug

Stenotrophomonas Maltophilia (STM) STM

- Two cases of STM line associated bacteria in 8 days. Typing revealed both isolates unique.
- One patient discharged home well but other became septic when line removed and was too ill to have line reinserted. Admitted to PICU but died on [redacted]. STM recorded on part 1c of death certificate. HPS informed.

Control measures put in place

- Many control measures already ongoing from previous incidents on Ward 2A. Additional staff and parent education provided. Teaching provided for medical staff by IPCD on 2nd August.

Note this taken from Appendix 5, IPC Summary June to July and IPC Summary Aug to Sept for AICC meetings in September and November respectively as no IMT yet provided.

2 Aug

Pseudomonas (Ps)

- One patient with pseudomonas positive blood culture and one patient with a colonisation.
- Epidemiological link between the two.
- Neither patients giving cause for concern as a result of the pseudomonas.

Control measures put in place

- Full terminal clean of unit carried out.
- IPCAT of unit by IPCT – 78% which is an amber marking and action list generated to address failings.
- Water checklist completed and practice Issues identified reported to SCN.
- Monitoring continues

Note above details from IPC Summary Aug to Sept for AICC meeting in November. Documents Awaited

4 Aug

Stenotrophomonas Maltophilia (STM)

- Four patients with STM Isolated from blood cultures.
- None of the patients giving cause for concern as a direct result of positive blood cultures.

Control measures put in place

- SPCs now developed to allow ongoing monitoring of cases.

Note above details from IPC Summary Aug to Sept for AICC meeting in November. Documents awaited

Sept — Still ongoing in 2020

- During September three consultant microbiologists in the South Sector raised concerns about the facilities in QEUH and RHC and the structure of the IPCT Service in GGC.
- Themes raised by the microbiologists
  - Ventilation issues
  - Protective Isolation
  - Cleaning
  - Water quality and testing
  - Plumbing in neurosurgical block
  - Decontamination of respiratory equipment
  - Structure of IPCT
- A meeting was held on 4 Oct with the microbiologists to discuss these concerns and agree an action plan to address them. This action plan was ratified by the CCGC on 5 Dec and noted by the Board on 20 Feb 2018. Work to address the action plan is still ongoing (see Appendix 6 for further Details – see IPCG presentation on 30 Jan 2020)

3 July — 26 July — 2 Aug — 4 Aug — Sept to 2020

1 July 2017

- HAIORT status **RED** due to severity of illness.
- PAG held on 26 July but no IMT's – reason recorded in HAIORT
- Downgraded to **Green** on 15 August

Further documentation awaited

26 July

Reported on

- **17 Oct** – Board **4 Sept** and **6 Nov** – AICC – Meeting of 4 Sept Incident noted through IPC Summary Jun – July" document in papers
- **4 Dec** – BCFG **2 Oct** – BCGF **9 Oct and 27 Nov** – BICC (see next slide). October HAIRT

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31 July

BICC Meeting

- Report on meeting on 16/6 on genome sequencing of Mycobacterium Abscessus.
- Samples sent to Reference Lab who said some are linked.
- IPC unclear how transmitted and national guidance awaited
- Lothian and Aberdeen also

- HIIAT status is **Green**
- PAG held 2/8/17.

As noted above, further documentation awaited

2 Aug

Reported on

- **6 Nov** – AICC through briefing and In "IPC Summary Aug – Sept" document In papers

- HIIAT status is **Green**
- PAG held 4/8/17.

As noted above, further documentation awaited

4 Aug

Aug

SBAR issued by GGC Advising IPCTs of a list of alert organisms in appendix 13 of the NIPCM which may require further investigation. This list includes GNB

4 Sept

AICC Meeting

- Noted SBAR circulated at 3 July meeting is withdrawn as there is some outstanding work to be performed

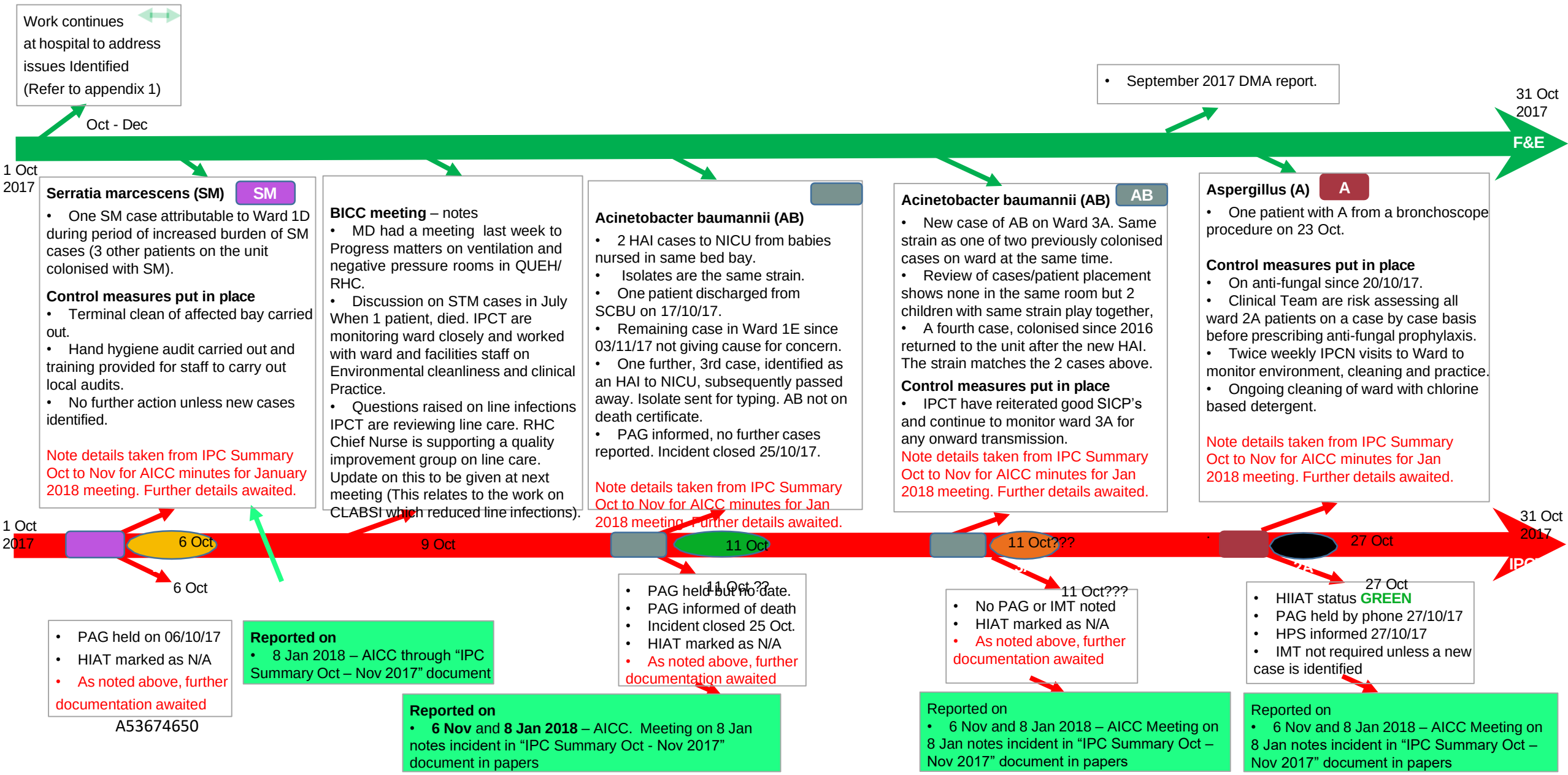
Sept

Date not known but patient presented with Cupriavidus bacteraemia. This patient received product from the aseptic pharmacy.

Note of this case in paper for CCGC meeting in June 2018. Unclear from this whether the

31 Sept 2017

Timeline for 2017



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Timeline for 2017

Work continues at hospital to address issues Identified (Refer to appendix 1)

Nov - Dec

1 Nov 2017

31 Dec 2017

F&E

AICC Meeting

- Committee advised that in relation to Ward 2A work is ongoing as they have had a high number of outbreaks with lines associated with blood cultures. There have been a few issues in the ward and enhanced visits and education have been carried out.
- Compliance with the Care Plan resulted in a score of 50%.
- A single case of Aspergillus was identified in a patient (see previous slide for case in October). The patient is clinically well and there is ongoing cleaning of the ward with chlorine based detergent. Committee advised that the patient did not have anti fungal prophylaxis.
- Committee advised that Ward 2A has 8 beds that are PPL rooms and 4 of these have been converted to positive pressure rooms but there would be a significant expenditure required to change all these to positive pressure rooms.
- Committee asked whose Risk Register this would sit with and were informed that it would be Woman & Children's directorate and they have been invited to the next BICC meeting to provide an update on Ward 2A.

Acinetobacter baumannii (AB) AB

- Two new cases of HAI colonisation although only 1 is an HAI to PICU (2nd is an HAI to 1E).
- Also a third case previously diagnosed in Oct 2017 who is currently now in PICU (believe this relate to incident in ward 3A (see previous slide) but it is unclear from the document if this the case).

Investigations performed

- Time and place link to one bed bay for all 3 cases above.
- Look back at 3 cases from September and October found 2 further cases associated with this bed bay.
- Currently 2 patients remain in 1D. Neither giving cause for concern.

Control measures put in place

- TBP's around bed spaces.
- Hand hygiene audit and environmental sampling completed.
- Ongoing IPCT investigations and monitoring.

Taken from IPC Summary Oct – Nov 2017 in papers for AICC meeting On 8 Jan 2018,

CCGC Meeting

- CCGC were informed of the concerns raised by the microbiologists In September and were provided with papers contained in Appendix 7.
- CCGC were advised that the concerns raised were in relation to The facilities in QUEH and RHC and structure of the IPCT service.
- Noted that the Chief of Medicine for Diagnostics and members of The IPCT Senior Management team met with the consultants to discuss all the concerns raised.
- The consultant microbiologists tabled a list of concerns and it was confirmed that all of the issues have been reviewed and where required acted upon to address all concerns
- CCGC were also advised that the infection rates on the QUEH Site are some of the lowest on the health board and in line with Scottish infection rate standards.
- It was recognised that the QUEH was planned and designed in 2007/08 but a number changes in the structure and patient case mix meant the original planning assumptions needed to be updated.
- The CCGC noted that the paper was clear and gave assurances

1 Nov 2017

6 Nov

13 Nov

5 Dec

31 Dec 2017

AB PICU 1E

IPCT

Reporting to

8 Jan 2018 – AICC through document "IPC Summary Oct – Nov 2017" Included in committee papers

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Section 6
Timeline for 2018

Timeline for 2018 (January to April)

1 Jan 2018

- DMA report for 2017 has been completed and finalised
- A work plan is being Formulated by Facilities and Estates to action recommendations

31 January

- HFS and HPS requested in March 2018 to assist into the Investigation of the water incident detailed below.
- Papers sent to HFS by a senior estates manager Include a copy of the DMA report for 2015. This senior estates manager Had received this in 2015 (as per 2015 time line).
- GGC conduct internal investigation as to why the 2015 DMA report had not been actioned (see appendix 1 for further details)
- The DMA 2015 report recommendations are similar to those in the 2017 DMA report and were included in the action plan for the 2017 report.

March onwards

BICC Meeting

- In providing an update on the "water incident" the ICD advises GGC water testing is fully compliant with national guidance and MBs receive both routine results and those requested during outbreaks of Water borne bacteria. Yearly risk assessments are done for areas not included in the guidance but who may benefit from additional water testing.
- A routine investigation into an unusual type bacteria found in a clinical case, led to additional testing and positive results being found in ward 2A in RHC and 4B in QEUH.
- MD asks if there is a clear way forward for handling this incident and to involve Public Health and IPCT. ICD and Interim Director of F&E advise that they want to get a Water expert on board along with HPS/HFS to look at short and long term solutions.

28 March

Water samples taken from water tanks showing number Of Cupriavidus, delftia, Acidovorans Pseudomonas, Mexicana, M Oxydans, Sphingomon and other Environmental gram Negatives, fungal organisms apergillus and Saprophytic also noted.

16 April

.First meeting of Technical Water Group (TWG). [See details in Slide X]

28 April

30 April

2018

17 April

Pseudomonas aeruginosa

- Two cases In PICU. Two cases linked in time and place with another 2 cases on the unit (long-term). Cases at opposite ends of ward).
- All isolates sent for tying – confirmed to be different strains so no evidence of cross-transmission.
- Water environmental testing both negative
- IPC audit completed and scored 91%
- Review of cleaning practice of sinks And drains performed.

Note – taken from HAIRT for April 2018

IMTs held 2 March to 27 March – HIIAT RED until 27 March then changes to AMBER

Various Gram Negative Bacteraemia

Patient on ward 2A has Cupriavidus at end of January 2018.

Investigation and testing performed

- Comparison with a Cupriavidus case in 2016 attributed to the aseptic pharmacy. Water tests from that location prove to be negative.
- Other comparison made to other historical cases and other hospitals to identify links.
- Various gram negative organisms (different strains) and fungal growth in tap outlets (flow straighteners particularly) and shower heads in RHC and QEUH (including 2A, 2B and 4B - see slide x). It is noted the taps were evaluated by HPS/HFS prior to fitting in the new QEUH
- Main water supply tests negative.
- Consult with HPS, HFS, Public Health England and water experts
- Concerns raised 2 years ago about campus - responses not alleviate concerns.

hypothesis – outlets are the source, Flow straighteners linked to other outbreaks as prone

Actions taken in high risk areas

- Water dosing only reduces organism counts, so taps are replaced, sanitised and point of use filters fitted.
- Filter changed every 25 days and taps tested weekly.
- Disposable shower heads fitted and changed quarterly
- Mobile wash hand basins and bottled/sterile water used for washing and drinking while above actions taken
- Cupriavidus and Stenotrophomonas added to IPCT alert organism software system.
- Patients receive Ciprofloxacin prophylaxis and additional line protection measures introduced
- Increased hand hygiene and cleaning regime.
- Water Group created to find long term solutions

Board Meeting

- Board updated on recent identification of Infections which may be linked to water and overview given of the circumstances, ongoing Work to identify the cause and measures put I n place to prevent further contamination.
- Advising risk rating was reduced to amber and investigations confirmed no cross-transmission had occurred.
- Board asked if source of the infections had Been identified. Advised Scottish Water were regularly testing the water supply to both hospital site and neighbouring residential properties but state Infection is not present in water supply.
- Board told extensive work ongoing to Identify infection's origin in the water system.

17 April

1 Jan 2018

Jan

HIIART status:
19 Jan – AMBER
24 Jan - GREEN

1 March

HIIART – from 26 Jan and 1 Mar - 4 cases in ward 2A

- Cupriavidus (CU) (1 case), Pseudomonas (Ps) (1 case) and Stenotrophomonas (STM) (2 cases). Water tests positive in sinks in Prep and Treatment rooms which removed. Water dosed.

2 Mar to 27 Mar

15 March

3 new cases of Stenotrophomonas

- I patient in 2A and 1 in PICU
- I discharged from 2A but came into 2B for line care
- 1 in 3C (renal) – unsure if HAI as day care

19 March

- Two cases in 2A of patients with pyrexia
- Some patient cases In 3C with Possible fungal growth. IPCT to Investigate.

13 April

- Full incident management report – details incident and actions taken. Final case count is 1 Cupriavidus ,
- 5 Stenotrophomonas and I Pseudomonas auerginosa – later excluded following different identity of water isolate.

30 April 2018

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Reported to - 31 Jan – **BICC** (PsA incident only) **28 Mar - BICC** –notes discussions on the potential long term solutions and that the Executive team and Board updated on progress.**17 April –** Board and April HAIRT. **27 Apr** – **AICC** and April HAIRT – update provided to Committee on incident and upgrading of BMT rooms. Questions on impact of chlorine dioxide on renal system. Assured this a different water supply and water expert involved Further 3 RHC rooms and 4 QEUH rooms to be converted from positive to negative pressure. **6 June** – **BCGF** notes April HAIRT. **12 Mar** – **ACGC** – reports issues with Mixer taps in ward 2A but IMT set up And equipment sanitised. **9 April –** **ACGC** – incident reported and situation resolved with appropriate Filters fitted over all taps. **17 April** – **Board** April and August HAIRT

Timeline for 2018 (May to August)

During the period May to June, members of the F&E team receive formal training as an Authorised Person for Water as well as other services such as Mechanical and Electrical. Certificates are obtained and signed off by the Authorised Engineer to state that the person has passed the training and is now responsible the safe operation and maintenance of the water (or whatever system is relevant) system.

Biofilm in drains – June 2018 Main water tanks cleaned.

1 May 2018 — May to June — June — 30 June 2018

F&E

PAG/IMTs held 11 May to 6 June. HIIAT **GREEN**

IMTs held 29 May to 21 June – HIIART AMBER changed to Red 4 June until 18 June when Amber and Green on 21 June (Water Incident)

12 June

Acinetobacter baumannii (AB)
Three colonisations of AB in April, then 2 in May. IMT count a further case colonised in Feb who remains in the unit..

Investigations performed
- Two patients in adjacent bed spaces.
- Domestic audit identifies cleaning concerns.
- IPCT raise concerns over TBP adherence.
- All isolates sent for typing.

Control measures put in place
- a list of actions relating to above are put in place including a review of TBPS in the unit
- IPCT monitor for new cases.

- IMT set up following PAG on 18 May which looked at the incidence of 4 EC from 28 April to14 May and 3 STM since 4 May.

Investigation and Testing
- Drain swabs reveal a variety of GNB (different strains) including those listed below plus Sphingomnas and Klebsiella oxytoca and Elizabethakinga. Black grime was seen in the RHC and QEUH drains
- Dissection of a sink waste pipe shows exposed metal parts with bio-film. All waste pipes are replaced In wards 2A/4B with new plastic ones as were sink drains, following complaints of water not draining away.
- Review of cleaning regime and additional resource allocated following issues identified. Noted rooms are cluttered and large number of visitors/medical staff to ward. Numbers are restricted. Parent education provided to prevent clutter
- Analysis being done by HPS through comparison with Yorkhill taking into accounts changes in the environment, patient population, and historic lookback and comparison with rest of Scotland. HPS and water experts being consulted
- Ongoing meetings with clinical staff around their concerns that environment not safe and staff not confident there is control of the environment. Concerned there has been issues since ward opened.

Hypothesis – drains are source due to links in time, place and person. Believe water is clean but bio-film can build up due to hand washing and inappropriate liquids poured down drains eg coffee/tea. Research shows aerolisation of bio-film can occur when tap turned on and this spreads around sink area.

Actions Taken
- Drains are cleaned and then decontaminated with Hydrogen Peroxide Vapour in wards 2A, 2B, 7A, 7D, PICU, NICU, ITU and HDU in RHS, QEUH.
- Replacement of waste pipes and sink drains
- Enhanced hand hygiene introduced – alcohol gel to be used after washing.
- Chemo therapy and BMTs are delayed/stopped, admissions restricted and patients given Ciprofloxacin while drains decontaminated.
- IPCT to conduct peer reviews focusing on SICPs and TBPS and environment.
- Site visited twice by water experts to advise on Long term solutions including use of chlorine dioxide To dose and decontaminate the water system.
- Water Group confirms chlorine dioxide dosing begins In November, followed by tap replacement in January 2019.

CCGC Meeting
- CCGC updated and provided with a paper on the "water incident" (see Appendix 8)
- CCGC told further water tests revealed evidence of a systemic problem In RHC and QEUH.
- Note that working closely with HPS/HFS on this incident.
- Notes a special water group was set up and UK water experts Consulted to develop a long term solution, which includes chemical dosing of the water supply
- Member noted the above and were assured by long term preventative methods and use of water experts

12 June

1 May 2018 — 6 May — 4 June — 4 June

Case of Pantoea In ward 2A on 6 May.

BCGF meeting + April HAIRT
- Update provided on this Incident and actions taken.
- Notes that outlets remain Positive even after chemical dosing so POUFs were fitted to outlets.
- Further testing found evidence of a Systemic problem and work is ongoing to solve these problems.
- Further updates to be provided

HIIAT reported a total of 9 cases in ward 2A/2B with
- Stenotrophomonas
- Pseudomonas Aeruginosa
- Enterobacter cloacae

Patient who out on

During this period that are 17 gram negative cases some with some patients displaying multiple organisms. Total of 23 organisms identified.

- **Enterobacter** (6)
- **Acinetobackter** (2)
- **Pantoea** (1) –occurred in ward 2A on 6/5/18 and reported to HPS.
- **Pseudomonas** (4)
- **Stenotrophomonas** (9)
- **Cupriviavidus** (1)

Reporting updates - 28 May and 25 Jul – BICC – 28 May notes chlorine dioxide system to go out to tender. **26 Jun, 21 Aug** – Board **6 Aug**– BCGF **11 Jun** – ACGC – Notes infection controls working, Technical Water Group set up to address wider implications. Still significant clinical concern. **19 Jun**

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Reported to 19 June – AICC through

Board Meeting + June Hairt 26 June
- Upd ate provided to Board on actions taken to address the bacteria in the water system.
- Board disappointed to note that QEUH had consistently been worst performer in GGC for cleanliness over the past 12 months. Comparison made with GRI was superior performer and had more challenges.
- Another member noted QUEH complied with national requirement of >90% compliance and methodology used at sites was different.
- Board asked for further update at October meeting

30 June 2018

AICC – Update provided on incident and TWG actions **13 Aug** – ACGC – notes control measures appear to be effective. **June and August HAIRT**

Timeline for 2018 (July to August)

- The action plan to address the recommendations of the 2 DMA Reports from 2015 and 2017 is completed. Actions are allocated to members of the F&E team and work starts from July onwards. All actions are completed by the end of 2018.
- A record is kept setting out the recommendations from the 2 DMA reports and the details of the work performed to address each recommendation plus any supporting evidence. The date the work is performed (a job ticket) and also the supporting evidence is contained on the F&E own computer systems.
- It was noted that this record was updated during, July, Sept, Nov and Dec to reflect Work completed by these points and status of work not started or not yet completed.

5 July onwards

- HFS/HPS produce a draft report on its findings from its investigation into the suspected contamination of the water system. The report entitled "Technical Review Water Management Issues NHS GGC QEUH and RHS" is passed to GGC in a final draft status for comments. The conclusion of the Report is that the system was potentially contaminated during the construction phase and lack of proper maintenance has led to the build up of bio-film and Consequently GNB. HFS recommend that GGC implement the recommendations set out in the DMA reports.
- GGC respond with comments and discussions take place between the Board and HFS/HPS. There is a general,
- broad concern about the size and technical content of this report given it is intended as briefing information.
- The recommendations in the report for GGC are in summary to address the recommendations made in the 2 DMA reports of 2015 and 2017 which are already being actioned .(See appendix x for further details)

Aug

31 Aug 2018

21 Aug

1 July 2018

Board Meeting + August HAIRT

- Update on water incident is provided to the board. .
- Notes that continue to work closely with HPS/HFS
- A report from HPS is expected and will be presented to Board in due course.
- Board notes concern regarding the water issues given this was a new hospital and query if there were issues with the building specifications..
- Chief Executive advises that work to identify problems with the initial specifications is underway so that learning can be obtained and shared.

Serratia Marcescens (SM) SM

- Four HAI Serratia marcescens colonisations attributable to NICU between 8 Jul and 13 Aug 2018 in NICU breaching trigger for 3 colonisations within 2 weeks.
- PAG held 15/08/18 HIIAT GREEN (4 minors).
- Case 4 developed sepsis and confirmed with Serratia marcescens in blood culture from 15/08/18.
- HIIAT re-assessed by ICD on 17/08/18 and remained as GREEN.
- Typing reported on 14/09/18 revealed 2 cases to be a match (both patients in same room) and 2 cases to be unique.
- Environmental and water testing was carried out which all came back negative.
- No further cases reported since and no concerns identified with environment or practice.
- incident was closed on 13 Aug.

Note details taken from the minutes of the AICC meeting on 26 October 2018.

21 Aug

8 July to 13 Aug – PAG held = HIIAT GREEN

1 July 2018

30 Aug 2018

Reporting

26 October – AICC contains the above details in Document entitled "IPC Summary Aug – Sept 2018" Which included in AICC papers

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Timeline for 2018 (September)

- A review of GGC's Water Safety Policy is conducted by an external consultant is commenced a first draft produced in Sept with the final version being created in Jan 2019.
- The policy sets out the roles and responsibilities, governance structure, risk reduction strategy, operational arrangements, water testing and reporting and monitoring requirements in respect of the management of water safety.
- A copy of the policy is contained at Appendix X .
- [check with Estates which committee approved The policy]

1 Sept 2018

Sept

30 Sept 2018

F&E

IMTs held 5 September to 28 September – HIIAT initially Green, RED from 13 September then changes to AMBER on 28 September

Investigation and Testing

- Drains swabbed in 2a on 29 Aug as thick black and yellow grime visible after cleaning only 4-6 weeks ago - findings are that 2 of 3 cases match the patients. Tests show coliforms, delftia acidovarons and chryseomonas indologenes, cupriavadis, pseiudomonas aeruginosa and klebsiella oxytoca.
- Further investigation of drains and trough sinks show that only some have a problem. This issue is only in RHC and not QEUH. HPS advised drains should not be cleaned so regular cleaning had stopped. Further guidance awaited from HPS.
- IPCT had been visiting ward daily with more formalised reporting twice weekly. High Standard of environmental and equipment cleanliness being achieved and visits now decreased to twice weekly. IPC have no concerns and environment and domestic audits score well. IPC note less people and clutter on ward.
- IPCT conduct physical inspection of drains and sinks and note some appear to have sealant in the drain and black gunge is noted. Reported to Estates who confirm sealant is a gasket in the drain that has become porous due to use of hydrochloride cleaning products. Speaking to manufacturer as known issue.
- Greater level of domestic hours for cleaning but general build up of dust especially vents and chill beans. Noted that air changes are 3 in RHC and 6 in Adult Hospital which may explain levels of dust. Air sampling on chill beams is negative.
- Note staff are being pulled from the ward to work elsewhere in the hospital and makes maintaining standards difficult. Additional funding is being requested.
- Discussion with water expert results in a survey of the drains being agreed as well as scopes down drains to see if any blockage.
- On 17 Sept IMT notes an Executive Management meeting reject a decant until the result of the drain survey are known. Clinicians concerned about decision and a paper is sent to the Director of Women and Children asking for decant to go ahead.

Hypothesis - Concerns expressed that IMT is no nearer the source of these infections. Feeling is that seeing more gram negatives than usual. Note that Water Technical Group doing a lot of work to investigate source. Dust levels consistently high and ventilation changes lower than recommended which may explain dust. HPS reviewing ventilation for 2A/2B. Feeling is that the ward should close

.

Actions Taken

- Reinstatement of weekly Cleaning of sinks and shower drains and with mechanical brush monthly to agitate any build up.
- Charting of patient pathways to and from theatre with review of drains and sinks in those areas.
- Drain survey and ventilation survey are commissioned. The Drain survey did not find any issues.
- Admissions to ward 2A continue to restricted and judged on a case by case basis.
- On 18 Sept Water Technical Group take decision to decant BMT patients in Ward 2A to ward 4B in adult hospital.
- On 26 Sept ward 2A was decanted with BMT patients moving to Ward 4B and all other patients to ward 6A, both in the Adult hospital.
- Both wards were inspected and made ready for patients including repairs being made and full deep cleans.
- Following decant, IPCT make daily visits to wards 4B and 6A to offer advice and support.

30 Sept 2018

1 Sept 2018

CCGC Meeting

- Update on the above "water incident" is given along with progress on actions.
- CCGC advised that a report from HPS is awaited and there is close supervision of the ward

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4 Sept

5 Sept

Since 5/8/18 have Been 3 cases in 2A of bacteraemia caused by gram negative organisms Isolated from drains

10 Sept

I new gram negative bacteraemia in Ward 2A

Total now 21 Cases this year.

13 Sept

I new case of Serratia in Ward 2A

Total now 22 cases this year.

17 Sept

I new case of Stenotrophomonas in ward 2A

Total now 23 cases this year.

20 Sept

1 new patient with gram negative in Ward 2A not yet identified.

This is the last Case and total now 24

Reporting

10 Sept – ACGC – update regarding 3 bacteraemia cases since 5 Sept and link found to drains. Notes enhanced inspection and cleaning process remain in place.

26 Sept – BICC. Update on latest outbreak and relocation of patients. Member notes concerns of the clinical risks of a move. MD advised risk assessment was performed and several options given to the Executive Group which included the Chief Executive and Board Directors to discuss. Risk Assessment of all issues/options to be shared with AICC and ACGC. MD to set up meeting with SG Policy Unit, HPA and GGC are set up to discuss the incident fully.

1 Oct – BCGF **16 Oct** – Board **26 Oct** – AICC – update given on latest incident and decant

Timeline for 2018 (October to December)

- New Director of Facilities and Estates takes up post. .

- As a result of the "water incident" the Compliance team start to review and develop standard operating practices for sector estates offices to follow to ensure consistency and appropriate quality of work is performed. The Water policy is also being reviewed at this time. This work continues into 2019

- Following the appointment of the new Director of F&E and from lessons learned from the water incident, new SOPs are created for Water and other services eg ventilation, electrical etc to provide direction and enhance compliance. This includes protocols for dealing with DMA reports and AE audits to ensure findings are discussed and actioned, and also for flushing and sampling regimes.. Registers are also created to record the location of little used outlets, dead legs, flexible hoses to ensure they are monitored and maintained.
- Compliance managers are also appointed for each service including water. These managers are responsible for ensuring the completion of the SCART process and all compliance with SOPs. Internal audits are also conducted to identify sector issues and ensure these are addressed as well as to share best practices.
- The above work is progressed over the next 18 months to 2 years

1 Oct 2018

From October onwards

October onwards

31 Oct 2018

16 October

IMTs continue in October and HIIAT is AMBER

- IMTs continue to assess environment. Contents of blocked drains discussed, which contain a variety of foreign objects eg small toys, syringes, metal and plastic material and lumps of adhesive. ICD to address this issue
- Consideration of whether waterless ITU can be put in place in BMT setting but this not fully possible.
- Water Group outline scope of work and completion expected on 14 Dec. dosing of water with CD to be implemented, taps and wash hand basins changed and elements of plumbing to be replaced.
- Consideration also given to changing roles of the prep and treatment rooms.
- Call with Scottish Government on 18 Oct to update on current position with proposed work on ward 2A and on patients in wards 6A and 4B .

IMTs from 15 October to 6 Nov HIIAT GREEN

Variety of Gram Negative Bacteria (see below)

Breach of IPC surveillance triggers associated with NICU. First over-arching IMT held 15/10/18 due to a number of incidents investigated over recent months within NICU. Multiple different strains circulating suggesting an environmental source. Organisms are STM PsA, SM and also Staphylococcus epidermis (SE).

Investigations performed

- All environmental sampling from NICU are negative including water sampling results.
- A separate Facilities meeting held on 26/10/18 to discuss cause of repeated interruptions to NICU water supply and leaks within the unit.

Control measures put in place

- All actions from IMT meetings completed.
- No new case clusters of concern since the last reported case of Staphylococcus epidermis on 12 October. Incident closed by IPCT on 06/11/18.
- Pseudomonas and Stenotrophomonas cohorts disbanded with care of all NICU babies reverting to SICPs for management of patients positive for environmental organisms (with the exception of Serratia marcescens requiring isolation in NICU).

Note – taken from IPC Summary Oct to Nov 2018 included in papers for AICC meeting on 7 January 2019.

Reported to

7 Jan 2019 - AICC – Briefing given and also Contained in document "IPC Summary Oct to Nov 2018" included in papers

Board Meeting

- Update provided on current water incident. Noted there had been no cases since June but there had been further cases in September which were thought to be associated with drainage Issues in ward 2A.
- Following a risk assessment a recommendation was made to the Board Directors to close the ward This was approved with patients relocated to QEUH on 26 Sept.
- A detailed investigation of the water system in 2A and 2B was underway by external experts.
- Director of F&E advised that plans to dose the water system with chlorine dioxide continued and a mobile dosing plant would be installed by the end of week. Future plans to remove wash hand basins and taps and replace draining system were being taken forward.
- Board questioned about frequency of these incidents in similar facilities. MD advised these did not appear to be common.

October

16 October

1 Oct 2018

October

31 Oct 2018

Reporting

16 Oct – Board - updated on current plans and work being performed
28 Nov – BICC - Update provided of ongoing work in wards 2A and 2B with expectation that work will be completed in December. Notes that the ventilation system is being looked at and implications for this and discussions are ongoing with clinicians. Advised that chlorine dioxide will also be done in the adult hospital in January. SG being kept informed.
3 Dec – BCGF - Noted as part of the December HAIRT which covers incident from Feb to Nov 2018.
28 Jan 2019 – BICC – update given on chlorine dioxide system and "discussion" over removal of sinks in ward 2A.
October and December HAIRT – continues to be reported in HAIRTs and the various committees during 2019.
February 2019 HAIRT covers incident from Feb 2018 to Jan 2019 noted HIIAT returned to Red on 13 Sept, then Amber on 28 Sept.

Timeline for 2018 (October to December)

1 Nov 2018

31 Dec 2018

F&E

- Register of assets is received from main contractor in late 2018 after 3 years of asking for the maintenance schedules for the systems in the hospital which should have been provided This allowed the F&E team to construct more appropriate maintenance schedules for all systems In the hospital and was completed in 2 to 3 months.

Late Nov

- Children's hospital Is dosed with CD. This continues to the present day.

22 Nov

- The actions to address the Recommendations set out in the 2015 and 2017 report are completed by 16 December

Dec

- Remainder of campus is dosed with CD. This continues to the present day.

Dec

IMTs on 2 November and 14 November – HAIIRT GREEN

Pseudomonas Aeruginosa (PsA)

Following a PAG held on 25 October an IMT set up On 2 Nov to investigate 5 cases of PsA isolated from patients who had all had appendectomies in same theatre in Oct 2018.

Investigations performed

- A number of investigations have taken place including sampling of equipment which all negative.
- Typing results have shown 2 matches, 2 unique Strains and 1 results is still outstanding.
- Sample of drains found PsA growth from the Anaesthetic trough and this has been sent for typing.
- Excessive amount of debris including nail picks found in u-bend traps of drains also.

Control measures put in place

- All drains throughout theatre have been cleaned.
- No further meetings were planned unless new cases identified. .

Details taken from IPC Summary Oct to Nov 2018 which included in papers for AICC meeting on 7 January 2019

Reported to

7 Jan 2019 –
AICC – Briefing given and included in document "IPC Summary Oct to Nov 2018" which Included in papers

BICC Meeting

Notes that the SOP Entitled "Environmental Organisms in High Risk Areas" is being issued

New SOP is issued by GGC entitled "Environmental Organisms in High Risk Areas" (see appendix x). This refers to Appendix 13 of the NIPCM and appears to be the replacement to the SOP that was circulated and then withdrawn in Aug/Sept 2017 – see slide 15

Nov

28 Nov

IMTs ongoing during November and HIIAT is AMBER

WARD 2A

- Updates provided on the progress of work in wards 2A/2B. Ventilation discussed and this should be positive in rooms other than BMT rooms. Design had stipulated rooms to be neutral/slightly negative pressure. Not clear what impact have on return of patients if rooms cannot be transferred to positive pressure
- Following review of ventilation system and other issues noted, an option appraisal is requested from a specialist ventilation engineer on what to required to rectify and bring system up to standard.
- Significant discussions between ICD and Clinicians over removal Of trough sinks and being replaced with 2 stage hand hygiene process. Trough sinks seen as potential source of bacteria. ICD decides to remove against wishes of Clinicians.
- Further debris found from scrubbing brushes in theatre Drains. Communication strategy had been previous action of IMT to prevent items in drains. ICD to email lead surgeon and lead Nurse to ensure All staff made aware of findings. Alternative brushes to be sourced.
- Call with Scottish Government on 18 Oct to update on current position with proposed work on ward 2A and on patients in wards 6A and 4B.
- ICD notes that now decanted there is marked reduction in bacteraemia. Final HIIORT Completed and incident closed on 30 November

Nov

11 Dec

CCGC Meeting

- CCGC advised that installation of Chlorine dioxide plant is complete with a further 12 localised dosing sites being installed.
- Ongoing reviews of the efficacy of the dosing will be undertaken.
- HIS/HFS and external advisors continue to investigate cause.
- Update on the work being performed in Ward 2A/2B was given. This included replacement of taps, drainage, outlets and air handling Unit. CCGC were advised this work take some months.
- Questions raised by CCGC regarding original design of facility. CCGC were advised that work was underway to consider all the identified issues across the site in relation to the original specification requirements of the building.

20 Dec

- Following concerns on the length of the HFS/HPS report issued in Aug, HPS create a summary report entitled "Summary of Incident and Findings of NHS GGC QEUH/ RHC."
- The report's Recommendations refer to those already Contained in the Aug HFS report i.e. to Implement the DMA 2015 and 2017 Recommendations. (See appendix x for further details)

IPC

1 Nov 2018

31 Dec 2018

Reporting

16 Oct – Board - updated on current plans and work being performed
28 Nov – BICC - Update provided of ongoing work in wards 2A and 2B with expectation that work will be completed in December. Notes that the ventilation system is being looked at and implications for this and discussions are ongoing with clinicians. Advised that chlorine dioxide will also be done in the adult hospital in January. SG being kept informed.
3 Dec – BCGF. Noted as part of the December HAIRT which covers incident from Feb to Nov 2018.
28 Jan 2019 – BICC – update given on chlorine dioxide system and "discussion" over removal of sinks in ward 2A.
October and December HAIRT – continues to be reported in HAIRTs and the various committees during 2019.
February 2019 HAIRT covers incident from Feb 2018 to Jan 2019 noted HIIAT returned to Red on 13 Sept, then Amber on 28 Sept.
April 2019 HAIRT covers period from February 2018 to February 2019 noting CD system now installed in both QEUH and RHC

12 Nov

ACGF Meeting

- Notes cases of bacteraemia Continue and wards 2A and 2B have been decanted to 4B (for BMT patients) and 6A (for all other patients) in the adult hospital.
- Notes investigation work continues and decant still in place
- Notes discussion about removal of Sinks from 2A is a "hot topic".

10 Dec

ACGF Meeting

- Notes the investigations into the Water issues in ward 2A has uncovered a ventilation issue which may require significant infrastructure work and prolong the current decant arrangements.

- On 20 Dec an IMT is set up following 2 cases of Cryptococcus identified on 17 Dec.
- A PAG was held on 18 Dec and control measures were put in place.
- See first slide of 2019 For further details.

Section 7
Timeline for 2019

Timeline for 2019

The 2018 DMA Risk Assessment Report is finalised And action plan Created to address recommendations

Each year the AP for Water completes a Standard Compliance and Risk Tool (SCART). This is a national tool for monitoring water Quality developed by HFS. A series of 60 questions are answered with supporting documents provided. Once completed the tool calculates the level of compliance against national water standards. This results are reviewed by HFS and also by the AE during the course of their audit. The score for Jan 2019 was 98.21%. In Jan 2020 the score rose to 98.96% following introduction of the CD plant and servicing of all thematic mixer taps and values on site.

The HPS report Summary of Incident and Findings of NHS GGC QEUH/RHC" is published on the HPS website.

Jan

Feb

Feb

28 Feb 2019

1 Jan 2019

F&E

Jan

19 Feb

Cryptococcus Neoformans (CN)

- Two isolated cases (1 adult 1 paediatric case) of a fungal infection CN. which is a fungi found in soil and pigeon droppings.
- On 16th Jan 2019 air sampling found Cryptococcus albidus (CA).in ward 6A which is a different strain. No CN was found.
- The potential source was thought to be the plant room on the roof of the adult hospital as pigeon droppings were found but air samples did not support this. Pest Control removed droppings and area cleaned.
- During investigation a separate issue was identified with the sealant in some of the shower rooms. In order to perform remedial work patients were moved to Ward 4B and others moved to the Clinical Decision Unit in the RHC.
- Repairs now complete and air sampling results confirm air quality in the ward is optimal and patients have returned to ward 6A. HEPA filters have been placed in all rooms, corridors and treatment areas in ward 6A as a precaution.
- No further cases have been identified and of 1,800 samples taken, only 10 detected CA but none have identified CN. Air sampling is ongoing
- High risk patients are on antifungal prophylaxis.
- Work to create more protection isolation rooms which sealed, under positive pressure and HEPA filtered air.
- Short life Expert Advisory Group is convened which will report to the IMT. This includes representatives from GGC HPS, HFS and UK expert on ventilation. The group will review the hypotheses to establish whether a definitive source of Cryptococcus can be established.

AICC Meeting – Case of PA

- South Glasgow Paediatrics advise of 5 cases of Pseudomonas aeruginosa (PsA).
- Patients had all been in theatre 6 during October 2018.
- Some typing returned – 2 Matches.
- Drain samples from the Anaesthetic trough found PA
- Inspection of drain found Excessive amounts of debris Including nail picks in u-bend.
- All drains now cleaned.

NICU

- Also notes increase in numerous organisms In NICU.
- Multiple different strains
- Environmental and water sampling all negative.

Serratia marcescens (SM)

- First case identified on 14/01/19. This Incident continues into March.(see next slide)

Investigation performed

- Following review by ICD isolation precautions were discontinued on 29 May
- 12 isolates have been confirmed as the same type, and 2 are unique. One typing typing result awaited.
- Drain samples found numerous outlets positive for serratia.

Control measures put in place

- Outbreak control measures continue until drain and tap components are replaced
- Ongoing surveillance monitoring is in place Including weekly screening.
- HPV clean has been done and regular drain cleaning. HPV cleans done in NICU/SCBU RHC.

Note - take from minutes of the AICC on 7 Jan and IPC April to May 201[illegible] Summary

Board Meeting

- The CEO updates the Board on the recent Issues at the QEUH and RHC and advises that 3 work streams are to be commissioned, as follows:
  - review of the Estates, Facilities and environmental issues at the QEUH and RHC
  - review of capacity and flow to assess the current position against original model and planning assumptions for the hospitals;
  - review of clinical outcomes over the period to provide assurance.
- The CEO advises a Programme Board will be established, chaired by the CEO and comprising the leads of the 3 work streams and other key member of the senior staff.
- The Board is also advised that the Cabinet Secretary has announced an independent external review of the QEUH and RHC.
- Following questions around timescales, the Board is advised that These will be made explicit through the relevant Governance Committee for each work stream and a final report will be presented to the Board in due course.
- It was noted that members were pleased with the organisations good work over the last few months to address the issues and Expressed gratitude for the continued work and actions to provide safe reliable and professional healthcare.

Jan – HIIAT RED on 20 Dec and GREEN from 15 Feb

No new cases since 12 Oct

PsA 7 Jan

6A

Jan to Feb –

HIIAT GREEN

SM

19 Feb

1 Jan 2019

28 Feb 2019

Reported on and to

7 Jan – AICC – update on PA and NICU. **14 Jan, 8 Feb** – ACGC – update provided on CN. **28 Jan, 25 Mar, 3 June – BICC** - update given on CN and information to be shared with SCI team. **4 Feb, 8 Apr, 27 May – BCGF –** update on CN on 4 Feb. Minutes of 8 April refer to April HAIRT which covers CN. 27 May minutes refer to June HAIRT which covers CN **19 Feb, 16 Apr, 25 Jun and 20 Aug –** GGC Board told and note CN incident on 19 Feb. Questions on 16 Apr on the publication of Cryptococcus data from sampling. MD advised this being reviewed and will be presented in near future. **5 Mar** – CCGC provided with update on the CN incident. Questions asked around the national recommendations and guidance in respect of the use of

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GNB - From 5 Jan to 3 Feb there are 2 PS, 2 AB and 1 SM. A PAG is held on 7 Feb

Jan/Feb

- Environmental issues identified.
- Repeat of SPE audit section due to low score
- Ongoing monitoring surveillance by IPCT

Reported to 12 Mar, 13 May, 16 July, and 2 Sept – AICC

Reported on – 12 Mar and 13 May – AICC

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Timeline for 2019

AICC Meeting
Notes CD system In both QUEH and RHC to be completed by end of March.

The HFS/HPS reported entitled "Technical Review Water Management Issues NHS GGC QEUH and RHS" is finalised but is not published.

The action plan to address the recommendations in the 2018 is completed and tasks are allocated to the the F&E to begin to complete the work required

12 Mar

Mar

April

1 Jan 2019 — **F&E** — **30 April 2019**

Mar (incident ongoing since Jan)

Serratia marcescens (SM)
- This is a continuation of the incident that started on 14 Jan (see previous slide). The last new case identified is on 18 Mar. No new cases reported since.

Investigation continued on from Jan and Feb
- Following review by ICD isolation precautions were discontinued on 29 May
- 12 isolates have been confirmed as the same type, and 2 are unique. One typing result awaited.
- Drain samples found numerous outlets positive for serratia.

Control measures continue from Jan and Feb
- Outbreak control measures continue until drain and tap components are replaced
- Ongoing surveillance monitoring is in place Including weekly screening.
- HPV clean has been done and regular drain cleaning. HPV cleans done in NICU/SCBU RHC.

Note - take from minutes of the AICC on 7 Jan and IPC April to May 2019 Summary

CCGC on 5 Mar BICC on 25 Mar, BCGC on 8 April, ACGC Meeting on 15 April

- Paper presented providing update on concerns raised by MB In 2017. Update as at Dec 2017 and Jan 2019 provided. Confirmed paper will be presented to all appropriate governance groups

- **CCGC –** Question on issues associated with the move of the Adult and Paediatric BMT units into facility in 2015. MD advised adult BMT Unit had high particle counts so unit was moved back to the Beatson and an extensive refurbishment took place.
- CCGC asked about number of vacancies in the Estates Team and level of training and experience requirements. Estates Director noted It was working with universities to develop expertise in required areas, create modern apprenticeship and management opportunities.
- CCGC asked ICD if they and their colleagues were content with progress of actions to address their concerns and ICD confirmed they were content with the good progress made on all areas
- CCGC were assured of actions being taken, progress made, that patient safety was the top priority and noted lack of water Incidents in last 6 months.

- **BCGC -** noted the plan could be clearer on where concerns were not factually accurate, were already addressed and new concerns with proposed actions.

- **ACGC** noted issues had been addressed, it was a comprehensive update, with no further actions required.

Mar – HIIAT **GREEN**

25 Mar to 15 April

13 April

PAG 16 April – no HIIAT

1 Jan 2019

30 April 2019

Reported to
12 Mar, **13 May, 16 July, and 2 Sept – AICC**

- Patient admitted on 13 Apr to 6A
- Day patient 15 days earlier.
- Positive for STM on 13 April, 14 April (twice) and 17 Apr

Reported on and to
16 July, 2 Sept, 12 Nov – AICC given update.
29 July and 26 Sept – BICC **19 Aug and 28 Oct** – BCGF **20 Aug** and **22 Oct** – GGC Board **Aug** and **Oct** HAIRT

Acinetobacter baumannii
- Two identified on 21 Feb and 9 Mar

One died but not on death certificate.
- No link between cases
- SPE Audit section repeated as scored red
- Ongoing surveillance monitoring by IPCT in place

Reported on - 16 July,– AICC

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Timeline for 2019

1 May 2019

31 June 2019

F&E

IMT on 19 and 25 June - HIIAT - AMBER

IMT – Further case Enterobacter Cloacae on 12 June and one case of Mycobacteria chelonae (MC) isolated from a patient's chest wall around line site and also water sampling on ward 6A. Of total cases 2 are HAI (possibly source is patients own gut) and 4 are HCAI. Total of 6 cases from April

Investigations performed

- Had been case of MC in May 2018 during previous water incidents. Rare pathogen and only 4 adult cases and no paediatric cases reported by GGC in last decade. Confirmed new MC patient had no contact with unfiltered water.
- Drains in theatre and trough sinks clean but clinical wash had basins in anaesthetic room, clean and dirty prep room have heavy build up of grime.
- Water samples from theatre negative. Drains grew unique strains of Steno, Enterobacter and other organisms. Water sampling in 6A with POUF off found MC in several areas. Significant reduction in gram negative bacteria noted.
- Drains dosed with Hysan disinfectant regularly and have no grime.
- Discussed recent leaks from chilled beams due to boiler failure and leaking pipe with water ingress into ceiling space. Mould evident on ceiling tile.
- Noted that some areas within A&E, outpatients and theatres have no POUF on their CHWB
- Three shower heads and Domestic Service Room (DSR) from 6A positive for MC. Samples from taps with filters removed show fungal growth.

Hypothesis – MC patient had contact with unfiltered water. Three ways this could have happened:

1) Aerolisation from drains when water from take hits drains
2) Bio-film creep from staff washing hands in CWHB were aerolisation occurs
3) Patient washing their hands and touching their lines afterwards.

Control measures taken

- Timeline for patients with MC to be developed to see if any contact with unfiltered water.
- HPS to research what instances other health boards have of MC so GGC can compare own figures.
- Dosage of chlorine dioxide to be increased.MC Isolate from patient and water samples to be sent for genome sequencing.
- MC now included on IPCT alert organism list.
- POUFs to be fitted in theatres, Interventional Radiography and Out Patient Departments.
- Chill beams to be sampled as leaks reported within last month. Estates to review all leaks from 6a in last month to see if any commonality with patients
- Air sample to be done in water 6A with water running into sink to check for aerolisation of drains.
- Hand washing to be followed by gel.
- Cleaning of drains in theatre.
- Water sampling in ward 6A to be done with and without POUFs.,
- Talk to POUF manufacturer to see if there is evidence that filter prevent MC entering water from the tap,
- Check previous water sample results for MC.

- Patients admitted on 20 May to ward 6A
- Multiple day care visits
- Positive for Stenotrophomonas on 20 May, 21 May and 22 May
- Patient had caught their line 2 weeks earlier causing trauma to the site.

- Patient admitted on 28 May to Ward 6A
- Day visits to 6A and OPD.
- Also attended Ninewells where had positive culture for Pantaea Septica.
- Repeated on arrival but negative so far

1 May 2019

20 May

27 May

June

13 May

29 May

12 June

30 June

AICC Meeting - Notes HPS Issue guidance for consultation which states IPCT will carry out a review for every water infection. Notes document not specify what water organisms or High risk areas are to be included

- Patient admitted on 8 April to ward 6A. New Patient. Tested positive for Enterobacter Cloacae on 12 June
- Further patient also tested with Mycobacteria chelonae (MC) which isolated from lessons around The patients line site on 19 June.

Reported on
29 July and 26 Sept - **BICC** – update given on this incident. **10 Jun and 5 Aug** – **ACGC** – minutes of 10 Jun state that incidents at QEUH are noted but not which ones. Minutes of 5 Aug make reference to 2 rare water borne bacteria. **16 July, 2 Sept and 12 Nov – AICC** give update. Minutes of 16 July note major problems in validating theatre in new ICE building but not why this is the case. **20 Aug and 22 Oct – GGC Board 19 Aug and28 Oct** – **BCGF August** and **October HAIRT**

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admitted on 14 May to ward 6A • Positive ECon 29 May

- Transferred to PICU

2019

Reported on and to
16 July, 2 Sept, 12 Nov – **AICC** **29 July and 26 Sept** – **BICC** **19 Aug and 28 Oct – BCGF**
10 June and 5 Aug – **ACGC** **20 Aug and 22 Oct – GGC Board** **Aug and Oct HAIRT**

Timeline for 2019

1 July 2019

31 Aug 2019

- The F&E compliance team commence a substantial exercise on Smartsheet (a computer database programme) to create electronic compliance dashboards for Senior Managers and Estates Managers to allow instant visibility of the Compliance level on a site/sector and Board level for all SCART topics, AE Audits, Water Risk Assessments, Sustainability issues along with all action plans supporting these reports. Evidence to support completed action is also held
- The exercise was completed in 2020 and means that all compliance related documents and action plans are in one Place rather than in several. Where action plans are not being followed or instigated, these can be follow up more quickly.

F&E

IMT on 3 July – HIATT AMBER

Pseudomonas Putida (PP) – Two further patients have tested positive for PP and these have been classed as HAI. No new cases of MC. Total cases now 8

Investigations performed

- Water results taken from sink, with a filter, in the Arjo bathroom is positive for MC. This sample was subsequently found to have been mislabelled at the lab.
- The sink within the DSR cannot have a POUF fitted to it. Discussions with manufacturer to see if filter can be fitted retrofitted to the sink.
- Genome sequencing results are awaited.
- IPCT carried out SICP audit of ward 6A – score 93%. Very few issues Identified and practice was very good.
- Notes POUFs being fitted to everywhere along a patients pathway and Drain cleaning been completed in Theatres and CDU. Nuclear Medicine/MRI also to be done.
- TWG are looking into using a higher dose of chlorine dioxide to shock dose the water supply.

Hypothesis – unclear if gram negative bacteria numbers are normal background rate or is related to ward or outlying area environment. For MC case group working on basis patient/staff had access to unfiltered water in another area.

Control measures put in place

- Sink in Arjo bathroom to be retested to ensure filter working.
- Future water tests to be carried out for half the ward every 2 weeks then other half for following 2 weeks to give an overview of all water outlets in the whole ward.
- Arjo both to be removed and reinstated once patients move back to 2A/2B.
- Taps in an unused prep room to be replaced as a preventative measure as POUF cannot be Fitted to them.

IMT on 1, 8, 14 and 23 August – HIATT RED

IMT – PAG held on 3 June but with a further 1 case and 1 possible case as noted

Below, an IMT is set up. Total of 11 cases plus 1 possible case since April.

Investigations performed

- Water tests from taps with POUFs are negative in ward 6A and elsewhere. A sample of POUFs have been tested by manufacturer for integrity and all passed.
- Noted that chilled beams suffer from leaks and condensation. Samples show Pseudomonas oleovorans (PO) and Pseudomonas aeruginosa (PA) in the cold water. Swabs of grills on the beams show small growth of Acinetobacter, Klebsiella and Patoae species. Discussion held with HPS on where samples should be taken from.
- Water sample from plant room tests positive for Klebsiella and Psuedomonas Putida It is not known if this a pre or post filter sample.
- Air samples from patient room en-suites show small counts of Aspergillus.
- Enhanced daily supervision by IPCT, HH and SICP audits continue and any issues identified are raised and actioned. Central line audit produces very good results.
- Clinicians express concerns that patients are in rooms with chilled beams but noted all rooms in hospital are same apart from ward 4B. Options discussed are use of beds in 4B, a further decant and use of a temporary mobile unit.
- There is disagreement amongst microbiologists with regard to the reliability of Swabbing and also whether the level and nature of GNB being seen is unusual.
- Change of chair on 23 August. Chair notes asked to demit but IPCT advised That following a conversation between them about the complexities of being the Chair and an active participant, the Chair was in favour of another chair.

Hypothesis – patients have either had contact with unfiltered water or the chilled beams are either leaking or dripping condensation onto patient.

Control measures put in place

- Admissions restricted from 2 Aug and new patients diverted to other NHS boards.
- Patient timeline to be completed
- Biocide is introduced to chilled beam System and subsequent testing is Negative. Cleaning of grills increased to Every 6 weeks rather than every 3 months.
- Estates to draw up dedicated action Plan for chilled beams in 6A and how Issues/services are managed
- Cleaning of chilled beam grills Increased To every month/6 weekly.
- Clinicians to speak to MD regarding Alternative accommodation
- Review to be done as to what patients Could be moved to Ward 4B
- HEPA filtration units to be installed in Patient's en-suite bathrooms in ceiling void.
- All patients receiving ciprofloxacin.
- Chlorine Dioxide dose to be increased
- Change of sink in the domestic services Room (DSR) to be completed as has no POUF and one cannot be fitted.

August

1 July 2019

Reported to

29 July (PsP only) and 26 Sept – BICC – given update
5 Aug – ACGC – given update on incidents to date.
19 Aug and 28 Oct – BCGF - August HAIRT
20 Aug and 22 Oct – GGC Board
2 Sept and 12 Nov – AICC Noted at 2 Sept meeting that the re-opening of ward 2A/2B is due March/April 2020
August and October 2019 **HAIRT**

- **Between 3 July and 1 Aug** –
  - 1 patient with Chryseomonas who also developed Pseudomonas a week later
  - 1 patient with Enterobacter cloacae and Elizabethkinga Miricola
- **Between 2 Aug and 8 Aug** –
  - 1 patient with Stenotrophomonas on 6 Aug admitted 4 Aug and
  - 1 patient in at Raigmore in Inverness with Enterobacter Aeromonas who previously had Psuedomonas. This second patient is possibly linked to ward 6A as I

- s post trans plant at RHC
- Total case

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snow11plus1possiblecasewhichispatientadmittedtoRaigmor

e.

31 Aug 2019

Timeline for 2019

AICC Meeting - A specialist sub group formed to look at ventilation in PICU. This group includes clinicians, IPCT and F&E and ventilation AE. PICU is non-compliant as has a lower number of isolation rooms than required. An options appraisal was done and an option will be recommended to allow a derogation to be signed off and agreed so that the unit can operate in its current set up. This will be shared with Health Facilities Scotland.

The work to address the recommendations of the 2018 DMA report is completed.

A review of GGC's Water Safety Policy is conducted by an external consultant is commenced a first Draft produced.

1 Sept 2019 — 2 Sept — Sept — Sept — 31 Oct 2019

F&E

IMTs held on 6, 13, 18 and 20 Sept. HIIAT starts as **AMBER** and reduced to **Green** on 18 Sept

IMTs held on 8, 11 and 25 Oct.- HIIAT **AMBER** then **GREEN** on 25 Oct

IMTs continue - to date 12 + 1 new case of GNB. 3 patients remains as inpatient with one in 6a, one in 4b and other in PICU. It is noted from this point on the previous Chair of the IMT is not in attendance.

Investigations performed

- An SBAR is received from MBs outlining a number of concerns which include issues about air changes and pressure, use of HEPA filtration, infection risks from chilled beam technology, existence of pathogenic fungi, exposure to unfiltered water, risk from toilet plume, ceilings not solid, lack of play area, door entry, sinks and prep room. The issues and responses sent to the MBs is discussed at the first IMT meeting in September. (See appendix 9 for further details). At the next IMT meeting on 13 Sept it is noted the Chair has received a response from the is unwilling to share the content of that email.
- Enhanced supervision by IPCT and HH and SICPs audit continue and are achieving good scores.
- Environmental sampling in ward 6A and Beatson is negative.
- Noted that the typing of the GNB organisms from sampling and from patients are different and unique.
- Discussion that patients are feeling unwell due to the prescribing of ciprofloxacin
- F&E visited Great Ormand Street to look at the water and air ventilation systems and will provide a report on their findings. F&E state all work is completed on the ward apart from installation of HEPA filtration units in patients' en-suite bathrooms which will be done in 6 weeks time when units arrive.
- A number of epidemiology reports produced by MB and HPS are discussed on the number and types of infections compared to other hospitals. The MB conclude that the environment is safe but there is debate over methodology and whether measures are appropriate. Clinicians state there an impasse between MB and what is to be done to resolve this. These reports are to be submitted to the Executive Committee following further analysis being performed.
- An options paper is prepared by the clinicians for moving patients to alternative accommodation and submitted to the Executive Committee, MD and CEO. Agreed be used if further problems occur.
- On 18 Sept the Chair reduces the HIIART to Green based on above data but clinicians and SG express concerns. Chair asks HPS to explain to SG the level of detail considered by the IMT and that Green rating is based on the decision to lift restrictions.

Control Measure in place.

- Confirmation that patients transferred From other hospital did not have positive Blood cultures.
- Timeline to be created for new patient.
- Restrictions on admissions continue
- Weekly enhanced supervision by IPCT to continue.
- Detailed review of all confirmed (12) and possible (1) cases to be done
- Full micro biological analysis and root Cause analysis (RCA) to be performed On all cases going forward.
- SOP developed for obtaining regular Water, environmental and chilled beams Sample. HPS to help with this.
- Central line infection triggers to be put in place so if reached action can be taken.
- Consideration of how IMT's triggered i.e. GGC suggest 2 cases of same Infection in 2 week period (proposed by GGC) or 2 infections regardless of type (proposed by HPS). Paper to be Circulated for comment and approved On basis of discussion.

IMTs continue and SG representatives join the first IMT following its and clinicians concerns on the lifting of ward restrictions. Agreed at meeting these should continue

Investigations performed

- Discussion and development of the RCA started in Sept to include detail on patient pathways when outside ward and what they do. Noted lines are accessed in multiple areas e.g. ward, OPD, Beatson, oncology, patient's home etc.
- Debate on case definition and if informed by the past or is more forward looking. Agree aim is to identify common source, link and route of transmission but accept definition evolves over time
- Noted water sampling results are reported through TWG. August results show some very low and higher levels of coliforms but sequent testing are negative. Sept results show DA and STM but retest results are awaited. Notes HPS/HFS sit on TWG but currently no MB sits on both TWG and IMT. Noted previous chair had been this liaison
- A leak in the ward kitchen has been repaired and is now open.

Hypothesis – new one from RCA that infections may be from Smart Site Hubs which allow needleless injections of medication into patient line.

Control measures put in place

- Ciprofloxacin only to be given to in patients and not day case patients
- Seek external advice on recommendations made when patients go home
- Smart site hubs to be tested. Normally replaced weekly but will now be replaced when contamination spotted.
- Agree use of a Multi disciplinary team for cases going forward.

September — October

1 Sept 2019 — 3 Sept — 22 Sept — 29 Sept — 1 Oct — 31 Oct

1 patient admitted on 22 Sept tested positive For Achromobacter spp on admission. .

Reported to

26 Sept – BICC – given update
28 Oct – BCGF - August HAIRT
22 Oct – GGC Board
12 Nov – AICC

Reporting on

7 Oct and **11 Nov**– ACGC – update
22 Oct – GGC Board – notes the 3 work Streams commissioned in Feb are nearly Complete. **28 Oct –** BCGF through HAIRT. **12 Nov –** AICC ongoing reporting of these Incidents.
Oct HAIRT

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1 patient admitted on 2 Sept has a positive culture next day. Details not provided but there were multiple organisms. Patient was in 3B, then 6a mid Aug and then day care. Line accessed at day care on 27 in Beatson and 28 Aug in 6A. Was home between mid and late Aug.	I patient admitted on 27 Sept tested positive for Stenotrophomonas maltophila on 29 Sept.	• I patient who had a line inserted on 24 Sept. Came In for treatment on 1 Oct and tested positive for Delftia acidovorans (DA). • The total is now 15 cases and 1 possible case.	2019

Timeline for 2019

1 Nov 2019

31 Nov 2019

F&E

IMTS on 5, 11 and 14 Nov when Incident closed. HIIAT **GREEN**

- IMTs continue into November with incident finally closed on 14 Nov. A report by HPS notes there is no clinical reason to keep restrictions in place and no single source of infection has been identified. HPS give formal agreement to lift restrictions.
- Genetic sequencing of Enterobacter cases shows there are no links and source likely to be patient's own gut. Cases are removed from RCA.
- RCA is finalised with SG and HPS
- New procedure for cases is agreed as follows
  - RCA to be done for all cases
  - PAG set up if there are 2 GNB cases in 30 days or upper warning limits of SPC charts are met.
  - Escalation to IMT will be based on Boards standard Outbreak procedures
  - If immediate source not identified external advice will be sought early
  - Findings of PAG will be reported to Clinical Review Group
  - Data collection form, developed with help of HPS, to be Used by multi disciplinary team to collect the relevant data,
- Water results are noted as being pristine with very low TVCs
- Patients to be given Taurolock rather than Ciprofloxcin
- Enhanced surveillance by IPCT is still ongoing with education Being given to parent on HH which scored very poorly
- Agreed Increased portering, nursing and potential housekeeper resource, water testing will provide reassurance to patients/parents

19 Nov - HIIAT **GREEN**

- IMT convened to review 2 PsA cases below to asses if HAI or not. Medical history of patients discussed and agreed HAI
- Noted that typing results do not match.
- Both had treatment on an ECMO machine on 21 Sept and 7 Nov respectively. ECMO has disposable circuits and sterilised weekly and after patient use. Water in machine is tested after each patient and has been negative.
- Also both used hemofiltration unit which has disposable circuits but not sure if tested.
- Noted that patient one came from NHS Ayrshire and Arran. No samples taken so unclear where infection is from. Suspect infection already present given rate of deterioration.
- Patient 2 was negative before going on ECMO

Actions taken

- ECMO out of use pending results of water samples. taken last week. Water samples to be taken from NICU and Theatre 8 as patient 2 was in both. If all negative ECMO can be used
- HH education to be put in place and IPCT to do audit.
- Trial of BD Pure Hub sites as these now used in ward 6A after a successful trial
- Lead Nurse and SCN agreed to carry out peer hand Hygiene reviews.
- No water checklist or domestic issues were highlighted.

- IMT convened to review an **SM** (noted below) case and discuss cases since 5 Oct for **AB** and **PsA**. Noted case of **P** reported 27 Nov which still to be investigated and may be a transfer in.

Investigations performed

- Water samples taken with filters removed were negative. Noted only connection is with the first 2 P cases is theatre 8 which has tested clear.
- Noted no recent cases of SM to compare typing. Last reported in Aug 2019 A retrospective case mentioned at a IMT for ward 6a is mentioned but no details provided in minutes. HH education is ongoing and ward is getting excellent HH results despite lots of visiting doctors. ,
- Observation of BBAL procedure noted no issues.
- Weekly assurance checklists for equipment are being completed and new keyboards ordered that can be immersed in water
- Discussion around sinks and little-used outlets and uncertainty about changing style of sink. Agreed this would be looked at separately.

Hypothesis – is that the SM is likely a sporadic case in a susceptible patient. No hypothesis Noted in relation to other cases.

Control measures being performed

- Patient equipment control measures to be tightened up. A plan on splash risk at sinks to Be developed
- Discussion with domestic staff around who responsible for cleaning the Relatives' room to be taken forward. Parent education to be provided.
- Environmental sampling of frequently touched surfaces is being done.
- SM case to be sent for typing.
- To look to address visiting doctors from a HH perspective. .

November

19 Nov - **GREEN**

27 Nov HIIAT **GREEN**

1 Nov 2019

5 Nov

- PAG held after 3 cases (5, 9 and 17 Oct) of AB over a 12 day period. HAI Trigger is 3 cases in 2 weeks.
- Two patient in same bed bay so cross transmission Suspected. Match patient in Aug but patient PICU on 16 Sept.
- .**Actions –** use of checklist to ensure weekly cleaning of shared patient equipment after issues found, enhanced IPC surveillance, HH and IPCAT audits to be repeated.

A53674650

12 Nov – HIIAT **GREEN**

- PAG held on 12 Nov following 2 cases of PsA.
- First identified on 21 Sept and was community acquired. Patient died on [redacted] and P noted on part 1b of death certificate
- Second on 7 November was a HAI and patient died on [redacted] but P not stated on death certificate.

21 Nov – HIIAT **GREEN**

- PAG held following another case of PA Identified from a bronchoscope investigation to gain sample from lower airways (BBAL) on 18 Nov. Patient [redacted] Hospital on 29 Sept.
- HH education being coordinated and further audits and IPCT to observe procedure for BBAL
- No domestic or water checklist issues identified.
- Water samples taken on 14 Nov are negative.

24 Nov

- Case of Serratia marcescens on 24 Nov. Patient died on [redacted]
- SM not cited on provisional death certificate but now retracted and post mortem to be performed.
- Transferred from [redacted]

30 Nov 2019

Timeline for 2019

- Since the appointment of the Director of F&E the structure of the F&E has been changing and this is still the case in 2020. The date this reorganisation started is not clear but Facilities and Estate activities have been separated were previously they were both the responsibility Of a sector general manager. There is now a separate Associate Directors in charge of Estates and one in charge of Facilities.
- A chart of the structure pre and post this reorganisation is contained at Appendix X. It can be seen there is a greater definition around and allocation of roles and responsibilities to allow individuals to develop expertise in specific areas.

1 Dec 2019

Dec????

31 Dec 2019

F&E

- SG advise that the last 3 incidents in PICU are investigated together retrospectively and prospectively using the HPS case definition used in relation to the recent GNB incident in ward 6A. (See appendix 9)
- The IMT consider each infection category and come up with 3 separate hypothesis as follows:
- Pseudomonas – 3 cases reviewed by IMT on 19 Nov. Noted that case 1 was a sepsis as per death certificate and not a bacteria as per the minutes. Patient had 5 negative blood cultures. Hypothesis was as cases 1 and 2 had both attended theatre 8 there had been transmission. There was no link for case 3.
- Serratia – 1 case which referred to procurator fiscal so unable to establish cause of death. Noted IMT hypothesis was a possible water transmission.
- Acinetobacter – 3 cases and hypothesis was cross transmission between case 1 and 3 as typing Identical. Noted typing also matched a case in Aug 2019. Noted appropriate controls were in place.
- Water samples from PICU, Theatre 8 and NICU are negative. HH and IPCAT audits also reviewed with deficiencies noted in SPE section which red.

Additional control measures put in place

- Weekly Safe Patient Environment audits to be put in place
- Weekly swabbing of POUFs, drains and CHWBs and water sampling for GNB over 4 week period. Monthly water sampling for Mycobacterium.
- Drains will have weekly Hysan dosing
- A SPC chart for all Gram negatives in PICU with bed days to be supplied
- Trigger is 2 GNB in 30 days or 2 HAI in 2 week period and RCA to be Completed.
- Retrospective look back of a 6 month period and RCA completed for 2 cases In that period

- IMT noted that GNB cases were to be investigated collectively but this complicated by different case definitions applied when GNB being reviewed separately.
- Agreed that SPC chart for blood cultures to be used going forward as well as normal triggers.
- Noted that robust definitions for the above were required to ensure consistent reporting.
- Clinical review of all cases is suggested to allow for a more descriptive picture of the situation. Agreed that SPC will be completed first, then RCA on patterns identified and then patterns will be discussed.
- Notes new case of serratia on 10 Dec. Not HAI based on review by clinical team..
- Tests in theatre 8 were all negative. All water sources tested against P, SM and AB on 10 Dec including inside filters, trough sinks and HH sinks in peripheral rooms..
- Environmental screens picked up a number of organisms in drains including SM in trough sink adjacent to bed space. Sent for typing and re-swabbed this morning.
- Hypothesis update as follows:
  - AB – patient to patient transmission, all in same bed space with index case being Aug 2019/ One sporadic case. IPC continue surveillance monitoring, ensuring shared equipment Clean and all TBPs in place.
  - P – potentially theatre 8 for cases 1 and 2 but water/environment samples show no links so water hypothesis now closed
  - SM – 2 cases with different typing. First patient died, Second patient came in colonised. Water hypothesis now closed. New hypothesis about drains as a positive sample was found in the room the patient was nursed in. IMT agreed that Patient colonisation status should be reviewed.

Additional control measures put in place

- Clinical Review Group set up for ward 6A and suggest same done for PICU. Should be weekly and Include directorate management, F&E, IPC, Clinical Staff and Deputy Director of Nursing.
- Results as to why staff fail HH audits should be recorded.
- SPC to be developed for first isolates of any other clinical sample, eg wounds, BAL etc. Noted that this should be sample type specific for every GNB and to use 3 organisms P, AB, SM. Noted that patient pathway also needs to be considered as BAL could be done in theatres as well as PICU.

- Fourth case of AB since 5 Oct.
- Environmental samples including drains taken on 11 and 19 Dec are negative.
- IPCT contacting Wishaw to see if patient Had any historic organisms
- Work in Oct/Nov to upgrade ventilation With all 4 bedded rooms complete and few Cubicles still to be completed.

Hypothesis – sporadic case as no overlap in time and place or equipment. No AB isolated in environment, water, theatre 8 or in specific rooms tested. Possible transmitted by hand but awaiting typing results. No further IMT arranged but will be held if another new case or trigger activated.

Control measures put in place

- Patient being isolated in single room
- Enhanced IPCT supervision weekly
- HH scored 90% same day
- SPC regarding BC and BAL specimens from PICU being drawn up for submission to to Clinical Review Group once IMT closed.
- Facilities will survey PICU to check for leaks and dampness
- Water samples of all water outlets in 4 bedded areas and also room 17 to be done.

10 Dec

17 Dec

30 Dec

SM **PICU** **IPCT**

1 Dec 2019

10 Dec

- Second case of Serratia (SM) reported from A blind BAL sample. Patient discharged to ward 2C on 16 Dec.
- Typing was different from any seen in the Hospital so far.
- Patient transferred from [redacted] Hospital
- Clinical team consider not HAI on review of Case

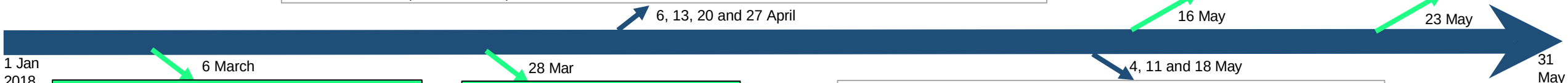
23 Dec

- Case of AB on 23 Dec taken from a Blind BAL
- Patient admitted on 28 Nov from [redacted] hospital.

31 Dec 2019

Section 8
Timeline for Water Groups

Technical Water Group Timeline for 2018 (Jan to May)



Board Water Safety Group (BWSG) Meeting

- Given an update on the "water incident" in Ward 2A
- Notes that need to identify if problem was elsewhere to determine if there was an issue with the cleaning regime or simply the implementation of the cleaning regime in that ward.
- Note the need to be proactive with this situation given nature of patients. Agreed a different practice (not stated what this is) for this ward would be needed and this should be reflected in the written scheme.
- Use of disposable shower heads was discussed.
- ICD recommends water sampling on the ward is increased to monthly and on Instruction from ICT

BICC Meeting

- A copy of the Terms of Reference (ToR) for the TWG were issued with the agenda and noted.
- Agreed that these would be reviewed as part of the IPCT annual work plan and ToR should set out how TWG reports to BICC and Health and Safety Group. It will also take account of any local or national advice on water safety.
- Chair of the TWG to keep the executive team and Board updated on Progress

- To understand where bacteria is located water samples are taken from all parts of the water system. Results show each floor has some contamination indicating that problem is widespread.
- Positive results are returned from water coolers (which are maintained by a third party) and are disinfected.
- Group agrees that POUF will only be fitted to high risk areas rather than the whole campus.
- Discussions held with tap manufacturer who advises issues with pseudomonas in the flow straightener are known but not other organisms. Manufacturer notes these should be decontaminated and replaced as required. Taps are sent for further analysis to determine if source, but replacement of taps is also discussed.
- Discussion on how long bio-film takes to develop – opinions vary from a very short period up to a year.
- Report from water expert (Sarah Lees) notes it likely system contaminated before handover and the fluctuations In the water temperature experienced since opening was also a likely contributing factor. Fungus in the system is thought to be due to dust levels around the site during construction and demolitions. Noted air tests carried out during the works were all recorded within parameters. Visits by further Expert – Tom Makin is planned.
- Discussion about plans to review information on water temperature to identify trends but advised majority of data has been lost due a system failure. Some manual records can be reviewed but these not extensive.
- Group discuss long terms solutions. Options include shock dosing, thermal cleaning, chemical cleaning including chlorine dioxide. Each option will require investigation into, the impact on the water system, effectiveness against organisms and bio-film and impact on hospital. Paper on all options to be prepared and presented to group. Noted that whatever option is selected a full risk assessment would be required and options selected would cause the minimum disruption to wards/patient care

- The Group decide that chemical cleaning is more appropriate than thermal disinfection (which boils the water in the system) due to risk and safety concerns. Would start with continual dosing followed by a shock dose and then back to continual dosing. Water will not be available during the shock dose. Process for shock dosing to be written up and risk assessment performed.
- Meeting with another water expert Tom Makin concludes chlorine dioxide (CD) is best choice for striping bio film. Expert notes there are issues with new builds and method of construction – sealed buildings and many now showing water issues never previously seen in hospital buildings. Agreed input of experts should be continued going forward.
- Manufacturers being contacted to determine the appropriate doses of CD and what impact this will have on pipes.
- Agree that flow straighteners are replaced on a 3 monthly basis and taps are steam cleaned and put back with POUFs in place. Noted that until replaced caution must be taken that taps do not re-cede the system. Suggested flow straighteners are analysed. Taps will be replaced in 2A and 4B and rest of campus will be monitored.
- Group agreed that acceptable sample levels need to be agreed going forward.
- Efforts are being made to locate water certification sign off at time of handover.

South and Clyde Sector Water Group (SCSWG)

- Update given to group on the "water incident" at QEUH.
- Notes over 2000 water samples Taken and mapped to floor plans and within schematic diagrams concluding there was a bio-film build up in the system which requires to be eradicated and preventative Measures put in place.
- Water dispensers were removed From Children's hospital.

BICC Meeting

- ToRs for the TWG are now Included in the IPCT work plan.
- MD asks that lessons learned from recent water issues were reviewed and a plan prepared to address these for review at the TWG then BICC.

Technical Water Group Timeline for 2018 (June to July)

- Group confirm chlorine dioxide dosing is their recommended option. GGC Board to be informed of the process and financial implication. The impact on pipework is unclear but doses anticipated will not effect pipework warranty. Water sample testing regime following implementation is also discussed.
- Purchase of dosing plant will be by an accelerated tender process and plant will be place by Oct/Nov with continual dosing starting on 1 November.
- A work programme setting out the logistics for the implementation of the shock dosing is discussed as water will be turned off. Discussion includes use of portable wash hand basins, bottled water, flushing of system after shock dose, and impact on patients and wards. Notes a better system is required to record and and audit flushing regimes by domestics. Noted Board Water Safety Group and South Sector Water Group should assess risk assessment outcomes and be involved in work plan. Noted that POUFs will need to be changed after shock dosing.
- Following discussions with experts a replacement tap, the Marwick with Bio Guard is selected for high risk areas. The tap chosen requires the flow straightener replaced every 3 months.

Raw and bulk water tanks and one section of the filtration plant are sanitised during this month (with rest to be completed in July), Debris is found in a tank (which one not stipulated) which looks like sponges And this has been sent for analysis.

- Cleaning of drains and replacement of flow straighteners in high risk areas is on going. Water coolers also removed from wards 2A and 2B. HFS informed of debris found in drains as this is a potential national issue.
- Noted that commissioning validations record data cannot be found and contacting project advisers, Director and IPC to see if they can provide any clarification on what was done and signed off. Some flushing Carried out at time but not all for the period after handover or records from main contractor on its flush regime.

8, 15, 22 and 27 June

1 June 2018

31 July 2018

5 June

BWSG Meeting

- Notes no legal requirement for Scottish Water to supply water at a particular temperature which is an issue as water supplied is at a higher temperature than that required for a hospital setting
- Discussion on possible causes of the issues in new buildings being created by the temperature of water increasing from the inlet to the actual user. When new buildings are being constructed, consideration should be given to ensuring there is sufficient space to include chillers to ensure temperature of water remains stable until the last user outlet.

AICC Meeting

- Advised that a TWG has been set up which will report to the BICC and is Looking to resolve long term issues On tap replacements, implementation Of water dosing of the full campus and Ongoing HPV cleaning of patients Rooms in Wards 2A/2B
- The ToRs for this group will be Confirmed at the next BICC meeting.

6,11, 13, 20 and 27 July

- Group discuss how long continuing dosing should be performed before a shock dose is administered and if latter Is required. Agreed position will be monitored through test results and if counts do not fall to below acceptable levels shock dosing will be undertaken.
- Development of the work plan continues and looks at impacts on clinical services and the detailed logistics that need to be in place for the shock dosing.
- Group discuss options for taps in other parts of the hospital. Options are whether existing taps are retained with tap being modified and regulator removed, or regularly replacing the flow regulator or complete replacement of the taps. Modification of the current tap is not viable. Other taps on the market would need to be modified to contain a bio guard making the tap either not compliant or mean separation of components which is not recommended. A Delaby tap is to be Investigated as has smooth surface and has disposable parts that can be changed. It has a disposable spout and built in POUF. Discussion with manufacturers and guidance being sought from HFS/HPS.
- Regulators sampled have counts but no bio-film. Replacement regulators are not individually sealed and also show counts when they arrive. This means they have to be sanitised before being put in place. Re-cycling also considered through use of a ultrasonic bath and then soaking in a sanitising agent.
- Advice being sought from HFS/HPS on whether drains are cleaned and if so what agent Is used. Cleaning is against national policy but agree this should continue in high risk areas. Drain parts affected by cleaning are being replaced. Debris noted down drains and this to addressed with nursing staff.

Technical Water Group Timeline for 2018 (Aug to Sept)

SCSWG Meeting

- Notes that water temperature coming into QEUH is above acceptable levels.
- Noted that there were similar Issues at the GRI site.
- Noted a large increase in daily Water usage at QEUH and 23 Dump values to dump water were Constantly open to try and resolve Issue. Consumption being monitored
- Noted that flushing was being Undertaken and POUFs would Remain in place.
- Hoped that drop in external Temperature will significantly Reduce water consumption

- Air sampling in tank room found fungi. Leak found in one tank and manhole cover are both repaired. Room being monitored and HEPA filters installed.
- Timeline agreed for CD system. Monitoring system to be put in place to give indication of strength of the CD in different parts of the system and give early warning of any issues. Drawings will map the Efficacy of CD around the site and allow dosage to be adjusted. Noted it can take 3 years for CD to be effective but as pipework new it will not provide any resistance to CD, so effect may be quicker. Noted taps may need to be removed and cleaned separately.
- Updated on incident with drains in 2A and need to understand where this is coming from. CCTV survey suggested to rule out blockages. Agree drains to be cleaned weekly with CD and mechanical agitation monthly. Shower drains pooling and this to be investigated. A German product which does a thermal clean of drains and is fitted to the pipework to be researched. Concerns around scalding and damage to pipework but would elevate the effect of chemicals on seals.
- Group also reviewed progress to date and decisions taken. No guarantee CD will work but water experts, MB, Department of Health and other agencies indicate best option. Other options were Clorus2 but this not proven as CD was, in a healthcare environment. Copper silver and hydrogen peroxide were proven not to work. Shock dosing ruled out after discussion with clinicians due to smell, effects on pipework and need to decant hospital.
- Discussion on work needed in ward 2A/2B with regard to pipework, drains and ventilation. Agreed taps will not be changed as no suitable alternative. Cause of issues discussed and if this water, drains, ventilation or combination or simple hand washing into drains. Decant will allow full investigation. Note only Haemao-oncology but not BMT patients affected even though bio film in both areas.

1 Aug 2018

15 Aug

7 and 20 Sept

30 Sept 2018

3, 10, 17 and 31 Aug

- Following further discussion it was agreed that shock dosing would be difficult to deliver given the extent of disruption. Agreed continual dosing would be done with increasing amounts of CD being injected Into the system and results will be monitored. The initial dose would be 1ppm increasing in 0.5ppm stages up to 2ppm for a 3 month period. If the results were still not within limits, a risk assessment would be required. This option is more flexible and allows fine tuning of dosage as and when required.
- Notes that in hot water system CD will become a gas and could lead to corrosion of pipes which will invalidate warranty. Noted that dosing will be within manufacturer recommendations but Board has little choice and will Incur the cost of any adverse impact.
- Tender process for CD system has resulted in only 1 bidder with 2 possible bidders withdrawing due to lack of resources. Remaining bidder has proven track record and process is accelerated so contract can be placed. First meeting is to take place 3rd September and timelines for work to be agreed. CEO to be notified of timeline. Anticipate dosing of RHC will occur mid October.
- Testing of flow straighteners shows that bio-film is built up after a month and whether filters can be fitted Further up the taps but this is against regulations. Not clear whether flow straightener the issue or water supply. Agreed that once CD in place, could review and then plan a maintenance programme is the former is the issue.
- POUFs will remain in place for at least 6 months after dosing starts to catch any bio-film dislodged. POUF will only be in high risk areas as organisms only harmful to these patients. Sampling will occur every 4 weeks to obtain a baseline before CD implemented. Work ongoing to determine monitoring points in system once CD in place to monitor counts. Automatic and manual testing will be done – former will give early warning if results are not within limits.
- Water testing of tank room shows water mostly negative post filtration but raw water tanks have positive results from drain connections which not capped or sanitised. This action to be progressed. Bulk storage Tanks also positive believed to be due to environmental conditions – noted to be cockroaches, fungal odour, Room not ventilated, water ingress and dried algae on floor. Area to be disinfected, repainted with anti-fungal paint, repairs made and pest control called in. Testing to be done once work completed. .
- HPS noted build up of grime in drains in ward 2A/2B despite only recently being cleaned. Investigated and believe silicone washer is source. Speaking to manufacturer to see if can be re-designed and also whether cope with CD

4 Sept

BWSG Meeting

- Notes that TVC guidance is likely to be changed nationally to include GNB testing but this cannot be introduced until this is confirmed.
- Noted that this specifically an issue for Immune compromised patients and this Is why POUFs are currently in place in these high risk areas and RHC in particular.
- BWSG notes it is taking the correct approach as this based on information received from clinical, water experts and HPS.
- Noted there needs to be careful management of placement of patients in a hospital setting but this is ultimately a clinical decision and determination

Technical Water Group Timeline for 2018 (Oct to Nov)

- Timescales for CD system are agreed with contractor. Work will start on 22 October and anticipated that dosing of RHC will begin on 19 November. Anticipated work will be concluded by 21 December at latest, so patients would back until January 2019.
- The impact of the work is considered by the group and discussions are held with clinicians to decide when the work involved with the installation of the CD system can be done so that it limits the disruption to clinical services.
- A work plan is developed detailing all work to be performed in wards 2A/2B and to progress procurement of the necessary materials and contractors. Costs of the work are also obtained so that budget can be approved. This also includes alterations to the treatment and prep rooms as discussed by the IMT and also the removal of certain sinks including trough sinks
- Agreed by group that clinical sinks are to be replaced with ones that have a trap type to prevent material going down drain. Chosen sink is Contour 21 which is easy to maintain.
- Various different taps for wards 2A/2B are assessed and discussed by the group and a final decision is taken to Fit a tap called Marwick 21.
- Testing of a sample of POUFs is done following two POUF testing positive for rust. Test for integrity Is passed and it is unclear where rust originates. Agree to check with domestic supervisors this not due to cleaning issues.
- Reports are received on the survey of the drainage and ventilation system. The report on drains finds nothing of concern that would impact on ward 2A/2B. The ventilation report shows the system does not have as much capacity as initially thought. Currently there is negative pressure in the ward which is not suitable for immune compromised patients and pressure needs to be positive. A meeting will be held to review the findings and discuss what options are available to address this issue and what work will be required – this is likely to be extensive.
- Drains were checked and rated for level of contamination by domestic staff . Clinical drains score the worst. .

1 Oct 2018

5, 12, 19 and 26 October

BICC Meeting

- Provided with an update of the ongoing work in Ward 2A/2B. A list of Remedial actions had bee drawn up and this includes changing the clinical Taps, lights and flooring and work will be completed in December.
- Advised that ventilation system also being looked at and the implication for this and discussions are ongoing with clinicians.
- Noted that with regard to CD there is a wider plan to carry this out in the Adult hospital on 24th and 27th January, where the water system will need To be shut down.
- Advised that the SG are being kept informed of the work and Communications are ongoing.

28 November

16 October

Board Meeting

- Board is advised that a detailed investigation of the water systems in wards 2A/2B is currently being performed by an expert external company.
- Director of F&E advised that plans to dose the water supply with CD continue and a mobile dosing plant would be installed by the end of the week. There are also plans to remove wash hand basins and taps and to replace the drainage systems and these plans are being taken forward. This work would result in the requirement for extensive flooring repairs and redecorating.
- Boards members ask about the frequency of these incidents in similar facilities but are advised that they do not appear to be common.

26 October

AICC Meeting

- AICC were updated on the programme for the water dosing being introduced to the QEUH and RHC hospitals.
- Advised that there will be a period where there will be no running water For 4 hours and no hot water for 24 hours.
- Guidance has been written for staff/patients which is currently being reviewed and will be issued once it has been agreed.
- The water dosing of the two hospitals is planned to be completed by the 12 Jan 2019.
- AICC advised that F&E will arrange for portable toilets, mobile hand washing sinks and bottled water to be provided to each of the wards in advance of the water being turned off.

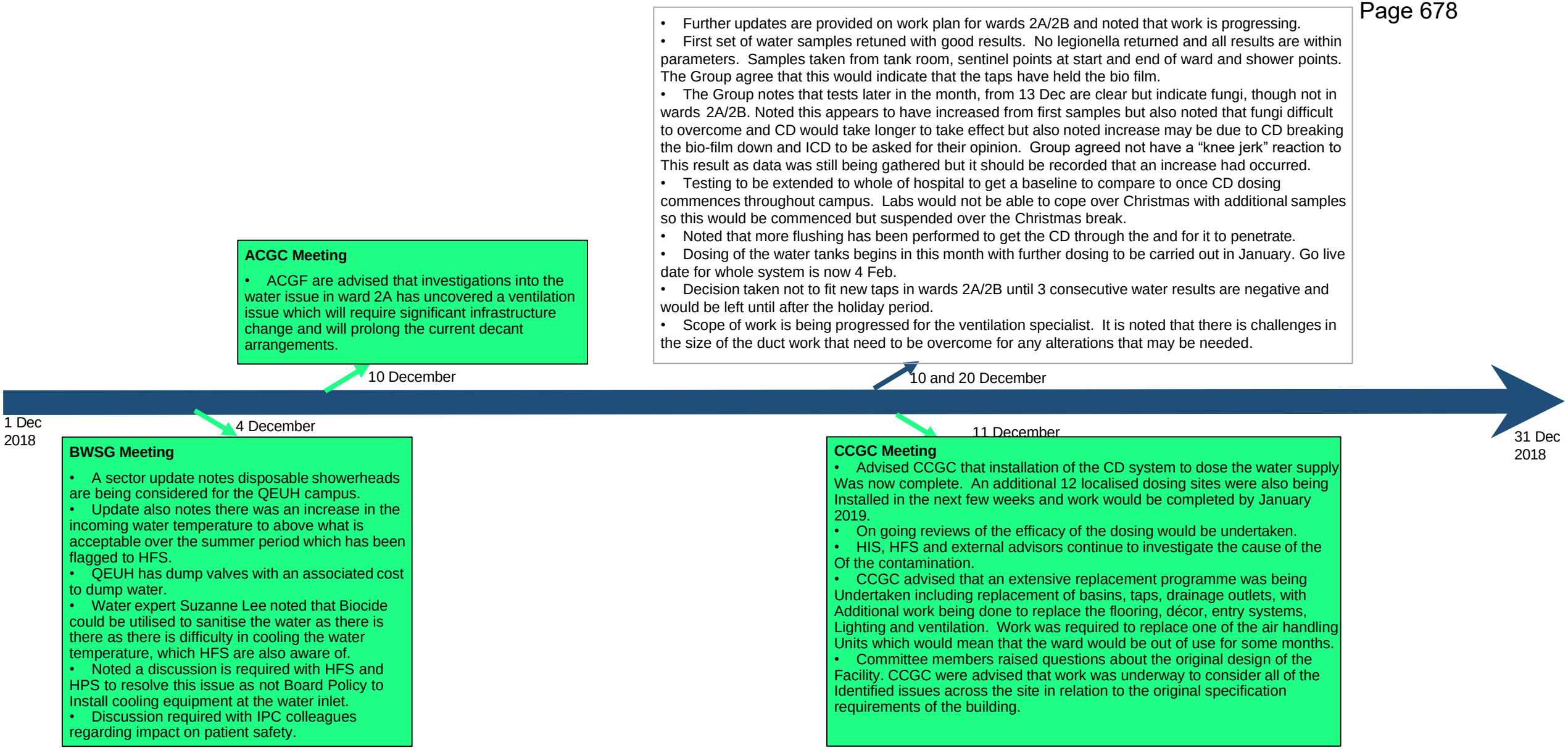
9, 16 and 23 November (note meeting also on 30 Nov but minutes not provided)

- Updates on the installation of the CD system and CD starts to be fed into the system on 12 Nov. It is noted there are issues with connecting the tanks to the CD system and existing pipework requires modifications. Incorrect parts were ordered meaning the deadline may extend beyond 29 Nov. A temporary dosing plant is put in place for wards 2A/2B but notes there is less control over dosing. Once CD is embedded, water testing can begin. If deadline of 29 Nov is met then whole site will be dosed by 25 Jan 2020. Impact on clinical services continues to be managed and discussed with clinicians
- Main contractor who built the hospital has been asked to provide certificates for pipework to show this is WRAS approved to give assurance it can cope with CD. Current contractors on site (who previously worked with main contractor) advise that water was in the system for 9 months during construction but no flushing was done. Group advised that while installing CD system in ward 2A some corrosion of values was noted and could be the reason for metal findings in recent water tests, although noted this within parameters. Group considered whether these issues could be the cause of increased bacteria.
- New showers heads and hoses sent through by PAL filter manufacture are being trialled in staff changing area. Only require one part to be replaced. MBs note that while effective, once contaminated, they become less so. Literature and research is gathered and members asked to comment. Group agree high risk areas should continue with disposable shower heads and hoses but PAL ones could be used for other parts of the hospital depending on trial.
- Discussion and review of ventilation report highlights problems with pressure and air changes. Air changes were recorded during commissioning but not air pressure. Derogation was made from 6 to 3 air changes and this applied everywhere apart from BMT areas. Noted that the Project Board did not have the capability to challenge the impact of this change. This not a deliberate error but was just not picked up. Report also highlights that the dirty and clean extractor fans are connected and means dirty air could be re-circulated potentially causing the problems with bacteria.
- A variety of solutions to address the recommendation made in the ventilation report are discussed but none are thought to be a Viable solution. A ventilation specialist is to be engaged to complete a design feasibility study but this will delay the move back to Wards 2A/2B. Clinicians are advised that it may be end of Jan/beginning of Feb before patients can move back

30 Nov 2018

A53674650

Technical Water Group Timeline for 2018 (Dec)



Technical Water Group Timeline for 2019 (Jan to Feb)

AICC Meeting

- AICC advised that upgrading of the ventilation system in ward 2A is required to bring the system up to the standard required for these patients
- Advised that the work will take 12 months to complete.
- Patients are to remain in the adult hospital In ward 6A will the work is being performed.
- AICC advised that there had been no cases associated with water since the ward moved to the adult hospital.
- Clinicians noted that the communication from F&E had been really good and no issues were reported when wards were without water during transition to the water dosing system.

7 January

- Update on work plan for ward 2A/2B was given. CD run through RHC system since 22 Nov and by end of Jan work is complete with 4 CD units in place for hot and cold water systems.
- Water results for ward 2A/2B show some out of spec, some very low level counts which acceptable, some fungal counts and 4 CU counts. Pre CD results much higher. One consultant room in ward 2B and treatment rooms show higher counts. he latter is being modified and sanitised. Playroom wash hand basin and sink show positive on cold water. Agreed to address issues, retest and if still an issue CD level will be increased. If fungi levels are acceptable new taps can be fitted. When taps are fitted they all leak which is resolved by adjusting the connection. Tap must also be aligned manually to prevent a splash risk but noted it could still be easily knocked and create this risk. These issues are taken up with manufacturer. Ventilation review is postponed as ward is used for low risk patients due to winter pressures.
- Discovery that Slop sinks used to dispose of clinical waste have flexible hoses which is against guidance. These are all over hospital and ICT had advised not to use them. Group will talk to nursing staff to ask if used. If so will be included in flushing regime and if not, they will be removed.
- CD is now embedded in RHC and cold water system for rest of campus and will now be Introduced into the hot water system.
- Noted that across campus, 240 water samples were taken with only 30 showing issues. Both hot and cold systems tested to indicate where issues are and allow these to be targeted. Monthly samples being taken but will increase to weekly when system fully up and running.
- Water meter are corroding (this prior to introduction of CD). Manufacturer to be asked about this before deciding if they replaced. Higher spec meters will be obtained for drinking water so impact of CD can be assessed on this water.

11 and 25 January

BICC Meeting

- Advised there is bacteria in the water system in RHC but there have been no water related cases since September 2018.
- Following advice from HPS, HFS and National water experts a CD system has been installed in RHC and will be completed in QEUH by end of March 2019.
- Chair of the TWG advised that the group will not be stood down until TVCs are at an acceptable level but the results appear to be better than anticipated and the TWG continue to meet fortnightly.
- One clinician notes there is debate about the number of sinks that need to be changed and is concerned regarding the implications for patients. The ICD advises that there is agreement to reduce the number of sinks and remove the trough sinks but there will still be sinks available.
- Noted that a meeting will be arranged with senior clinicians and TWG to discuss the plans regarding the ventilation and sinks.

28 January

1 Jan 2019

14 January

ACGC Meeting

- Sector update advises that water and Ventilation issues found in ward 2A will now take up to 12 months to address.
- Sector also advises that to address the ongoing water quality issues at QEUH and RHC, chlorine dioxide dosing will commence in December/January to bring the system under control and allow removal of filters which were a short term control measure only.

8 and 22 February

- CD is introduced into the hot water system and monitoring system goes live. All work will be completed by 15 Mar.
- At start of month, out of a total of 142 water tests, only 12 are positive for fungal yeast. These have gone for typing. Later in the month good results are being seen but there are 3 legionella results which may be due to bio-film being removed but decided resampling of the area is conducted, test area is extended to ensure this not further afield, taps and shower heads are removed and tested as are rooms on either side. Both hot and cold outlets are tested.
- Tender process for ventilation has recommenced and review identified one preferred bidder. Purchase order being raised and tender and design phase will take 3 to 4 months to complete.
- Issue identified with taps last month were discussed with manufacturer. The leak is due to a production fault and being addressed. The movement of the tap is thought to be due to a stress or corrosion crack through incorrect fitting. Manufacture is attaching a locking mechanism to the tap and providing training on installation and working with tap.
- A TVC protocol document is agreed setting out when POUFs could be removed. This would be after 4 week of consecutive clear tests and then moving to monthly then quarterly for 3 consecutive acceptable results to confirm control values are maintained long term. Noted that getting below thresholds may not happen and may need to accept results are as good as can get and monthly checks will remain in the high risks areas for legionella and pseudomonas.
- Communication and protocol for reporting little used outlets is developed and shared with nursing staff to ensure such outlets are reported are actioned and not left. This includes escalation if report made to senior nurses and F&E but no response is received. To be ratified by Board Water Safety Group.
- Manufacturer confirms water meters will be affected by CD and should be removed when system is sanitised. Not practicable with continual dosing. Guidance from HPS being sought. .
- Following a review of the options for shower heads and hoses, conclusion is hose is the issue and none on market are better than replacing hose on a regular basis. With CD in place Group agreed that replacement can be reduced to

25 February

28 Feb 2019

South and Clyde Sector Water Group (SCSWG)

- Noted that written scheme is being updated to reflect the installation of the CD plant.
- Confirmed to group that both the QUEH and RHC are both receiving CD dosing with good positive results.
- Group noted that installation of the CD will make a good impact on quality if correct dosage is utilised.

3 times a year instead of every 43 days but in high risk areas this remains at 62 days.

Technical Water Group Timeline for 2019 (Mar to Apr)

- Remedial work has been completed to address the legionella results from Feb and test results are clear. The Feb 2019 results showed Ward 2A had CU in certain rooms. This ward has received the most exposure to CD but Is the only one showing CU. CD dosage to be increased for this area. Noted that if this does not solve issue then further works will be required to look at potential engineering issues.
- Report on water meters shows that paintwork on cases unevenly applied and affected by water with damage caused prior to CD implemented and does not meet healthcare quality requirements. Report to be sent to HFS who. Advise consulting WRAS to see if approval process covers paintwork. WRAS confirms testing does not cover coatings and paint coverings. GGC to request HPS to update national guidance on this basis.
- The CD installation will be completed this month with only 6 hot water systems still to go live.
- Ventilation tender has been awarded and a pre-start meeting is held this month to discuss feasibility works. The full design and feasibility work will take 4 months and construction work will be phased over 6 months.
- Slop hoppers found to be in dirty utilities and not used for disposable waste. Hopper to be disconnected, capped And sanitised, then covered to make a work surface – where these are not used.
- Water results for March show only one sample has legionella count of over 200 counts. This area was serviced and sanitised and results are awaited. Group agreed to sample a few rooms either side and check pipework to determine if testing was required as far as the pipework runs.
- Complaints received about odour and taste of water. Noted this may be due to bio film break down which can cause odour and taste issues for short 24-48 hour period. Investigate to see if test can be carried out to determine.
- Second report in connection with tap connection failure notes that a chemical reaction with ammonium compound may have caused the failure. This chemical been used many times before to disinfect but manufacturer will propose an alternative.

8 and 29 March

1 Mar 2019

12 March

AICC Meeting

- Update that CD installation is scheduled for completion by end of Mar 2019 and will service both QEUH and RHC.
- F&E staff continue to undertaken drain cleaning arrangements with areas specified by IPCT colleagues.
- Domestic service staff will perform flushing as part of their duties and a SOP has been developed and will be implemented to inform domestic staff of how flushing is performed.
- Water coolers/dispensers are being removed from high risk areas across GGC.

18 March

ACGC Meeting

- Now confirmed that the the water and ventilation issues found in ward 2A will take up to 12 months to address.

25 March

BICC Meeting

- ICD reported that the taps and sinks in Ward 2A/B were changed and the filters will be kept on long term in the Haematology unit as fungi was identified there.
- ICD also advised that low levels of Legionella were picked up but levels are not clinically significant.
- ICD also advised that discussions Are underway to determine if the taps should be removed from other critical care areas.

8 April

BCGF Meeting

- The Forum noted that installation of a continuous (low level) chlorine dioxide water treatment system has been completed in the QEUH and RHC.
- Forum notes that results have been extremely encouraging with no cases of bacteraemia associated with water in RHC since September 2018.

16 April

Board Meeting

- The report provided an update on the water and ventilation system at QEUH and RHC, and MD noted that installation of a continuous (low level) chlorine dioxide water treatment system was now complete and there had been no cases of bacteraemia associated with water since September 2018.

MD also advised that over 800 air samples had been taken in relation to Cryptococcus neoformans, however Cryptococcus had not been identified in air sampling since the end of January 2019. Air sampling continued and no incidence of infections had been identified since December 2018.

11 and 26 April

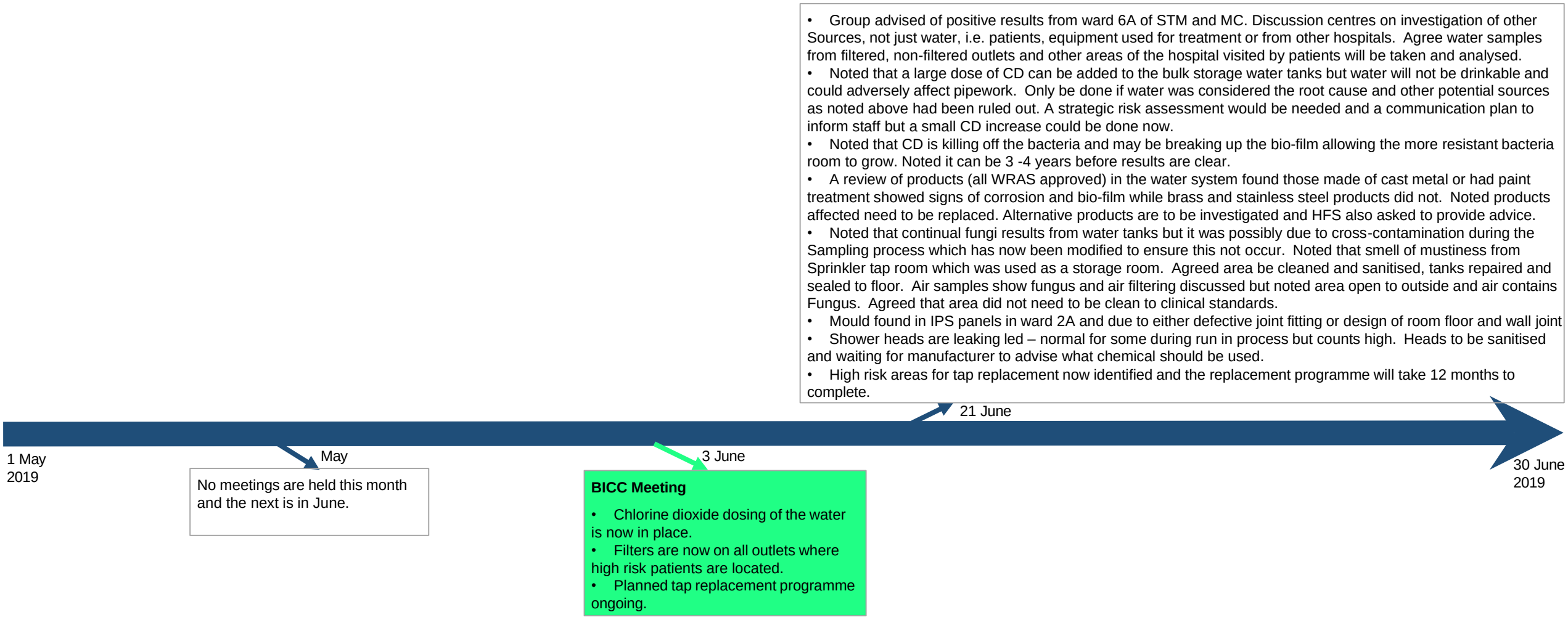
- Work is completed on the CD installation and snagging list is also addressed by the end of this month.
- Water tests for March show 16 fungal results but agree CD will eradicate these over time. High TVC counts recorded in the Acute Receiving Unit (ARU) which will be investigated. Feb e-coli results were in the Porters rest room and pipework was reconfigured to remove dead legs and 5 little used outlets.
- General results for RHC are good apart from certain areas in ward 2A - Hospital at Night (HaN) tested positive for EC and cold water system and TCT rooms 3 and 6 routinely record fungi counts and Cuprividus Pauculis respectively. Noted 2 water coolers, dead legs and a little used wash hand basin in HaN room were removed and automatic flushing of outlets was installed. Pipework configuration will be examined f followed by a high level CD treatment programme and resampling of whole area. If this does not work then further investigations will be required to see if this an engineering problem.
- Complaints from staff about removal of all water dispensers – a preventative measure taken by the BWSG. Staff do not believe assurances that water is safe to drink. Matter to be raised at next BSWG.
- Noted that other products are in the water system that have the same coating as water meters. Given the concerns raised a sample of these will be tested to assess condition and Impact on water quality.
- Water meters designed to monitor and automatically dose the water based on volume are found to be under dosing the water system. Other sensors are still to be installed which may resolve this issue. Replacement of water meters would involve additional cost and shut down of the system and require senior management approval. Group agree to defer decision until other sensors are in place.
- Group decide that they will meet monthly from now on and technical advisers will attend quarterly.
- Discussion on replacement taps for all high risk areas given issues found in ward 2A.

Selection of taps for high risk areas is reviewed given issues found in ward 2A. Agree that Marwick 21 is Still the tap of choice as it is fitted with a copper lined open orifice bio-guard anti microbial flow straightener.

30 Apr 2019

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Technical Water Group Timeline for 2019 (May to June)



Technical Water Group Timeline for 2019 (July to Sept)

- At the previous months meeting it was decided that the sprinkler water system on the helipad should be treated with CD but manufacturer information reveals this cannot be used with aluminium which houses the system. A SOP Is to be developed to ensure there is sufficient turn over of the water in this system. The firefighting water tank can have CD treatment but clarification on the dose is being sought.
- DMA are commissioned to carry out a survey of the products in the water system that are cast iron or Have paint treatment but no replacement is to be carried out. Noted only be able to survey accessible products but will help to develop a plan for replacement and what would be involved.
- The work to address the mould in the water tank has been carried out but a visit yesterday found that there was standing water and hoses left on the floor. The room will be checked and a message relayed to those using the room that it should be left in a clean and tidy state.
- Following the reports of STM in ward 6A in April/May, a sweep of tests were performed on outlets but the results from these are all negative.
- Weekly testing will commence from first week in August as the CD has now embedded into the domestic hot water supply. Commencement of weekly testing is dependent on the "residual" values reaching a certain level across all water systems. These "residuals" are the elements such as bacteria, particles, being extracted from water.
- The automatic flushing has been stopped in ward 2A as this is thought to have exacerbated the mould found in the IPS panel. Investigation being carried out in other areas of the hospital to check if this is just located in 2A or further afield.
- Following installation of sensors, the issue with water meters under-dosing the system is resolved
- Noted tap replacement in 12 high risk areas will take 2 months to complete.

19 July

BICC Meeting

- BICC advised that after positive pre filter water results being returned for Ward 6A, the CD dose to the water supply was increased but remains within WHO standards.
- A shock dose treatment to Ward 6A water is being considered but post water results are negative.
- Current samples taken on 8 July are looking specifically for Mycobacterium but results will not be available until mid August.
- BICC advised that one theory as to why mycobacterium is showing up is that its is resistant to chlorine and with the introduction of the CD it has eliminated other types of organisms which is allowing more unusual types of bacteria to grow.
- TWG to work with IPCT and Public Health Consultant to research public literature to see what advice and guidance is available.

29 July

ACGC Meeting

- Advised that the estimated completion date for the work to address the water and ventilation issues on Wards 2A/2B is now March 2020.

5 Aug

Board Meeting

- Following a briefing on the incidence of u Unusual GNB being found on ward 6A Board Members asked how long children would be Accommodated in ward 6A, the Director of F&E advised that while Wards 2A/2B were Being renovated patients would remain in Ward 6A. The work on Wards 2A/2B is Expected to be completed by March 2020.

20Aug

1 Jul 2019

16July

AICC Meeting

- AICC informed that the QEUH chlorination system is fully fitted and there have been good results and gram negative count has reduced significantly, however the mycobacteria issue has recently appeared and is resistant to chlorine at the original used levels. It is noted that the increase in mycobacteria may be due to existing biofilm or it is being selected out and proliferating because it is resistant to chlorine.
- AICC are advised that the initial step is a slight increase in the chlorine levels, and that the level is still within the W.H.O guidelines. AICC are advised that if this measure is not successful then shock dosing may be considered but this would have a significant impact on all clinical areas (water would have to be closed down for a period of time).
- The Water Technical Group continues to meet and support the QEUH.
- The Board also continue to have International Water experts on retainer for advice as required.
- The issue of bottled water coolers has been discussed at the BSWG and there is a current National Directive that all bottled water coolers, irrespective of location, should be removed. This will be discussed at the next BWSG.

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16 August

- SOP for sprinkler and helipad fire fighting water tanks have been drafted and further information is awaited on The dose of CD to be applied to the latter. A CD dosing apparatus will not be installed for these tanks due to cost And ongoing maintenance requirements and manual dosing will be performed.
- External contractor appointed to perform tap replacement and a survey was performed for establish the scope of work and approximate costing and will be provided next week.
- Water tank room now in good order. The new CD apparatus has an ongoing leaking making the floor wet. Leak being managed on an ongoing basis until principle contractor has remedied the defect.
- Group advised that there was MC in the water and whether the CD should be increased further was discussed. dose currently 0.5 ppm and increase to 0.7ppm suggested. Noted by one member this was unlikely to have a major effect based on literature read and dose of 1.2ppm should be considered. Group considered this not feasible given engineering challenges and potential impact on services.
- Testing shown positive results for Ps and coliforms from the main water tank room. Two filtered water tanks and an outlet downstream of the tanks in the children's OPD ground floor were sampled and have been submitted to lab. Noted that water sampling is identifying consistent activity for Mould and Yeast which have been sent for typing. Noted that where counts are low this often due to dirty taps or sampling errors. Need to know coliform counters and Results of nearby outlets upstream and downstream and results following disinfection and resampling. The ongoing Issues in the basement plant room in terms of yeast and mould need to be further investigated including broadening The scope to include air sampling.
- Noted that issue with mould identified in ward 2A are only in this area and not further afield. Work to be added ventilation upgrade project.

30 Aug 2019

Technical Water Group Timeline for 2019 (Sept to Oct)

- SOP for sprinkler system and fire tanks now completed as CD for fire tanks been provided by manufacturer. DMA are currently draining and flushing these tanks so they do not become a little used outlet.
- Basement tank is found to be leaking and repairs are instigated.
- Discussion on whether air quality testing should be performed in tank rooms and areas outside as this would Indicate is any mould spores in the humid air. After further discussion it was decided this instruction would have to Come from an IC representation and this decision would be taken outside of the meeting.
- A review of sample results of failures show there was an increase initially but then a steady decrease over the following weeks. These results are only showing yeast and moulds – initially results had shown coliforms and E.coli etc but never any legionella and psuedomonas have been found. The group discussed the possible environmental impact as noted the results had been higher were during a period wet weather. Thought that a look back might reveal increases during wet periods of weather and lesser numbers or none during warm weather.
- Cost of tap replacement is £3M which includes replacement of sinks, reduction of pipework and replacement of taps and IPS panels including any additional work required. The decision to progress has not yet been given and is likely to be a phased implementation. Taps will be replaced with Marwick and although issues noted with these taps in other areas it removes the Optitherm taps which giving cause for concern in other areas.
- Showers in ward 2A are now being manually flushed and funding is available to remove and resolve the mould issue within this ward. Will investigate market to obtain options to resolve this issue.
- Noted that some rooms in ward 2A had high humidity at 15% and 12% was the accepted limit.
- Agreed that water sampling would stop in ward 2A as no patients and flushing of system is continuing. Testing Will be recommenced once work completed and patients are due to return to the ward.

13 September

1 Sept 2019

2 September

AICC Meeting

- Advised that further sampling for mycobacteria has been carried out across QEUH to find out how widespread the issue is and the results expected within 4-6 weeks.
- The dosage applied to the water supply for Wards 2A/2B is to be Increased from 0.5ppm to 0.7ppm and for this to be monitored for a period of time to review its impact on water results.
- The increase is within the WHO guidelines and has been approved by the TWG and IMT

The TWG continues to meet and support the QEUH and continue to have International Water Experts on retainer for advice as required.

BCGF Meeting

- Advised that the work for address the background water/ventilation issues in Ward 2A/2B is estimated to be completed by March 2020.

28 October

25 October

31 Oct 2019

- Tests of flow straighteners for last 3 months show no Ps or bio film. Conclusion is CD keeping these clean but this needs to be confirmed by experts. Agreed periodic testing should continue as agreed to allow any changes to be noted quickly and actioned. Agreed to re-run test and previous results to be reviewed by expert group.
- Testing of basement tanks post filter show Delftia in one tank and room. One Ps found in the drain points and TVCs showing in raw water tank but only in certain lines. Noted room has high level of humidity and musty smell. Air sampling to be done in the room and corridor to see if any spore counts and justify a dehumidifier being installed.
- Out of 142 samples from campus only one shows bacteria. Noted that samples over last couple of months are clearer and clearer. However minutes also note a minor TVC and one coliform was found, the DSR and dirty utilities had positive results (agreed was this not surprising) and adult first floor critical treatment room recorded a repeat coliform failure and high TVCs which needs to be investigated.
- View of Scottish Water around coliform failures in August and September is that based on pattern of results this due to either tap hygiene or lab issue but probably a sampling issue. Advised length of flushing time should be increased given the size of campus. Offered to review GGC SOP and carry out observation of practice for water sampling and this agreed as a good way forward
- Meeting discusses what information IMTs want from this group and it was agreed that the following was needed
  - Visibility of any current positive water samples
  - Local water groups are to discuss any issues with IC and Estates to be present at these meetings
  - Any positive results are to be reported to IC and patient pathways followed to identify any issues
  - Written statement of process to be followed when positive results found (currently only for Legionella and Ps)
  - Agree that carry out more than usual sampling on QEUH and this would include yeast and mould samples.
  - Statement on the water quality and potability and also on status of flow straighteners.

Technical Water Group Timeline for 2019 (Nov to Dec)



No meetings are held this month and the next is in December.

- Meeting unclear whether air sampling of the basement tank room was performed. Will check and results will be reviewed in January. Sampling of the air vents at top of tanks to be performed to see if anything there which might Infect tanks. Discussion will also be held with F&E to see what options there are to increase ventilation which is an Issue. Re-sampling also to be done to determine if air in room is infecting the tank.
- Discussion of the results returned from ward 6A that had led to the conclusion of contamination and also around method of sampling which had led to this result. This had been shared with people within the Board. This conclusion was contrary to what previously reported and that the water was safe. It is not clear whether the results were expected or this was just a spurious result but has now led to ongoing discussion with SG. A number of observations were made that sampling methods may vary and that there had been reactive reaction to all issues with no closing off of actions, no reporting of conclusions or understanding or knowing why actions were taken and there was a need to shut down and conclude on the outcome of the samples. The use of technology to review, action and understand the sample results should also be used. It is noted that national guidance is needed in this area, but Group agrees the following action going forward:-
  - Use of flop swabs for sampling and systematic procedures to be put in place for sampling. SOP to be developed to ensure all areas tested in the same way using the same technique
  - Cognisant of any changes to baselines and impact to ICT results
  - Other opportunities to prevent infections – patient information, nursing methods
  - Better analysis of data - are the bugs in the drains the same as in patients, are they harmful to patients, test to look for failures in the system Ie tanks, testing to reassure of system safety. Statistician to look at data going forward to determine if results show trends, focus on recurring incidents and allow appropriate reactions.
  - Consider what can do with information that is produced to allow clinical teams to remove POUF and also

Water Testing Process

F&E have provided further detail on the water testing that is performed and copies of spreadsheets showing the results of tests that have been performed in late 2019 and each 2020.

Testing Process

- F&E advised they maintain a register of the total ongoing sampling that is being conducted at the QUEH on a weekly basis. A 142 tests are taken from 71 designated points throughout the QEUH and RHC. Two samples are taken from each designated point such as a tap or shower and an outlet to a drain.
- The results are recorded on a 'sample matrix ' for the QUEH which F&E receive on a regular basis. Anytime samples are taken the matrix is updated by a specialist water consultant. This means the frequency of getting this matrix varies depending on the sample being taken and analysed. This matrix covers the 'full sampling regime' across the Adult and Childrens Hospitals.
- From this sampling grid the operational estates team reviews two specific areas (as required by SHTM04-01), legionella and TVC's at a water temperature of 37 and 22 degrees centigrade . If these results are found to be 'out of spec' then the results are uploaded onto a further spreadsheet and actioned accordingly. The spreadsheet lists the sample reference and actions taken to address the out of specification issue.
- All other bacteria found in the samples are reviewed by the ICD and if action is required to be taken then the ICD discusses this with F&E. These other bacteria are
    - Coliforms,
    - LP Sero Group,
    - Psuedomonas
    - SAB at a water temperature of 30 and 22 degrees centigrade
    - Cupriavidus
    - AMS
    - Other (which includes GNB)
- Samples of these spreadsheets were provided by F&E and a copy of the spreadsheet showing the lastest results is attached at appendix x. The spreadsheet covers the period from 7 Jan 2020 to 6 April 2020. The spreadsheet also pulls out into a separate tab those results that are out of specification. A summary of the results is given in the table below

Month and Year	Total number of samples	Samples not received	Samples awaiting results	Results returned	Out of spec samples
January 2020	347	-	-	347	14
February 2020	352	2	4	346	21
March 2020	357	-	27	330	3
April 2020	55	-	52	3	0
Total for period 7 Jan to 6 April 2020	**1,111**	**2**	**83**	**1,026**	**39**

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- Although the 39 samples that were out of specification, some samples had counts of more than one type of organism. In total there were 62 organisms classified as follows:

Organism	January	February	March	Total
TVC at 22 degrees centigrade	2	4		6
TVC at 37 degrees centigrade	2	6	-	8
SAB at 22 degrees centigrade	3	4	-	7
SAB at 30 degrees centigrade	6	6	1	13
Psuedomonas	2	9	-	11
Cuprividus	1	3	1	5
Coliforms	2	-	2	4
Enterobacter cloacae	2	-	-	2
Other	-	6	-	6
Total	**20**	**38**	**4**	**62**

- The Other category is made up of a number of GNB organisms which are
    - Aeromonas Media (1)
    - Sphingobium Xenophagum (1)
    - GNB Enviro (1)
    - Delata Acidovorans (2)
    - Chryseobacterium Indologenes (1)
- Also included in appendix x is a sample of a spreadsheet which shows actions that have been taken in relation to out of spec samples.
- A SOP was developed in December 2019 in respect of the sampling that was required to be undertaken and what action should be performed once the sample matrix is received and around those samples that our out of specification. A copy of this SOP is included at Appendix X.
- While the overall number of samples that are out of spec seem relatively low, there is a lack of context around these results to allow any meaningful conclusions to be drawn. This highlights the need for a more statistical approach for the analysis of these results to identify trends over a period of time and whether there are "hot spots" within the campus where bacteria is located.
- It is noted that in the December 2019 minutes for the TWG that statistical analysis was being proposed but it is unclear whether or not this was taken forward [check with GGC as to whether this is done and whether a sample can be provided] If this has not taken forward, then this would be recommended to ensure that there is a continuing trend downwards in respect of all bacteria across the whole campus and to ensure that the CD is adjusted according for "hot spots" identified by such analysis.

Section 9
Heat Map of Infections

Ward/Year	2015	2016	2017	2018	2019
Ward 1E - RHC			AB (Nov) (1)		
Ward 2A – RHC		A (Aug) (1) CU (Feb) (1) EM (Sept 2016 to Feb 2017) (3)	A (Mar/Apr) (3) STM (July) (2) CU (Sept) (1) A (Oct) (1)	STM (Mar) (5) CU (Mar) (1) PsA (Mar) (1) Pan (May) (1) AB (June) (2) CU (June) (1) GNB (Sept) (5) SM (Sept) (1) Ps (Mar) (2) FG (Mar) (1) EC (June) (6) STM (June) (9) Ps (June) (4) STM (Sept) (1) Ward Closes 26 Sept	
Ward 3A – RHC			AB (Oct) (4)		
Ward 6A - RHC				CN (Dec 2018 – Jan 2019 (2) PsA (Jan) (5) STM (Apr) (1) PanS (May) (1) STM (May) (1) MC (June) (1) EC (May /June/Aug) (3) PsP (July) (8) CH (Aug) (1) EM (Aug) (1) EC (Aug) (1) EA (Aug) (1) Ps (Aug) (1) STM (Aug/Sept) (2) GNB (Sept) (Multiple) AC (Sept) (1) DA (Oct) (1)	
PICU - RHC	PsA (Dec) (2)	AB (June) (2) SM (Sept/Oct) (6)	SM (Feb) (?) SM (Mar) (3) Ps (Aug) (2) SM (Oct) (4) AB (Nov) (1)	PsA (Jan) (4) AB (Feb /Apr/May) (6)	AB (Jan/Feb) (2) AB (Apr) (2) PsA (Nov) (3) Ps (Jan/Feb) (2) AB (Nov) (3) AB (Dec) (1) SM (Jan/Feb) (1) SM (Nov/Dec) (2)
NICU - MATERNITY	SM (July to Dec) (17) PsA (Oct/Nov) (3)	SM (Jan) (1) SM (July to Oct) (12) SM (Nov) (4)	SM (Feb/Mar) (3) AB (Oct) (3) STM (Aug) (2)	SM (July- Aug) (4) PsA (Oct) (?) STM (Oct) (?) SM (Oct) (?) SE (Oct) (?)	NUO (Jan) (?) SM (Jan-Mar) (14) GNB (Jan) (?)
Ward not identified			MA (July?) (?)		
Theatre 6 - RHC				PsA (Nov) (5)	

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Key

- Continuation of same incident

(17) – the numbers in brackets are the number of patients that were identified with this organism.

Key for Heat Map

Gram Negative Bacteria

- AB - Acinetobacter Baumanii
- AC - Achromobacter
- CH - Chryseomonas
- CU - Cupriavidus
- DA - Delftia acidovorans
- EA - Enterobacter Aeromonas
- EC - Enterobacter cloaecae
- EM - Elizabethkingia Miricola
- Pan - Pantoea
- PanS - Pantoea Septica
- Ps - Pseudomonas
- PsA - Pseudomonas aeruginosa
- PsP - Pseudomonas Patuida
- SM - Serratia Marcescens
- STM - Stenotrophomonas Matophilia
- GNB - Gram Negative Bacteria not yet identified
- NUO - Numerous unidentified organisms

Fungal Infections

- A - Aspergillus
- CN - Cryptococcus Neoformans
- FG - Fungal Growth

Gram Positive Bacteria

- MA - Mycobacteria abscessus
- MC - Mycobacteria chelonae
- SE - Staphylococcus epidermis

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Heat Map of Infections

The first slide in this section provides a pictorial representation of all the incidents contained in the timeline by location, month they occurred, the type of organism involved and the number of patients that were identified with this organism. It should be noted that this does not represent the total number of patients affected as some patients had more than one organism at any given time.

There are a number of observations that can be drawn from this table and from the narrative within the timeline, as follows:

Development of water contamination hypothesis and timing of incidents

The table shows that the incidents started to appear in 2017 but were more numerous in the subsequent years. It will be noted from the timeline that the hypothesis that the incidence of these organisms was due to contamination of the water system started to develop in 2018. Actions, such as replacement of taps or removals of basins, were precautionary measures or ones whether a definite link had been identified to the tap or wash hand basin rather than indicating a real concern about the quality of the water.

GNB can originate in water so the development of the hypothesis that water was the source was not an unreasonable one to conclude. However GNB are contained throughout the environment and also in the human body where they generally remain harmless and do not affect a normal healthy individual. Those such as haemoncology/oncology patients are however at risk from GNB as their immune system is compromised and as a result they are more susceptible to infections from these organisms.

The development of the hypothesis around water was led by the ICD in charge at the time. However it is noted that other avenues of investigation were pursued such as hand hygiene, ward cleanliness, operating practices and the work undertaken in respect of line infections. Given that GNB are contained throughout the environment and risks in terms of transmission and wider spread of such organisms, it would appear reasonable that these other lines of investigation were pursued as well as that relating to the water supply.

In July 2017 two patients contracted STM. One was subsequently discharged home well but the second passed away with STM being noted on the death certificate. It was noted that the strains of the STM in the two patients was different indicating that there was no transmission between patients and no common source. The case of the patient who passed away became high profile news in the press and when Ward 2A was closed in 2018 the family subsequently blamed the death on the contamination of the water supply.

Prior to the above case there had been thee cases of another GNB considered by a PAG in February 2017 of Elizabethkingia. The cases were spread between September 2016 and February 2017 and were all unique strains. Questions have been raised as to whether the death of the patient in 2017 could have been prevented and the link to the water system and potential contamination could have been made at an earlier point than 2018. This is a difficult question to answer on the basis that a lot of emphasis is put on connection between the strains of the organism – each one was unique and given the time period over which the incidents took place it is a matter of debate as to whether this conclusion could have been reached at that time and the death of the patient prevented. A review of the patient case would need to be performed to consider all the aspects of the patients condition as well as a more detailed analysis of the organisms that were found at that time.

It is noted in the timeline and was ascertained through the HFS investigation in 2018 that prior to the hospital being handed over there was water testing performed by the main contractor which returned high TVC counts in some locations. These areas were sanitised and retested but it was noted that not all locations passed the second test and the information is confusing as to whether these areas subsequently passed. The HFS report “Technical Review Water Management Issues NHS GGC QEUH and RHS” notes that these results were not brought to the attention of the project board or any outside agency.

It is also noted by the timeline that a senior estates manager instructed two members of his team to conduct water sampling following the building being handed over. An interview with one of these staff members revealed that only tests for legionella were conducted and they are their colleague had no training in taking water samples. Where positive results were identified these areas were sanitised and retested. Only once three consecutive negative results had been obtained was no further action taken – if positive results were obtained, then further sanitisation was performed.

Anecdotal evidence from contractors who installed the CD plant and worked with the main contractor who built the hospitals was that the system contained water for 9 months during the construction period without any flushing of the system to turn the water over, being performed.

The HFS report above and the findings of water experts engaged in 2018 concluded that contamination was likely to have occurred during the building of the hospitals and led to the build up of bio film and consequently the organisms that were seen. The water experts also concluded that the advent of fungal bacteria was the result of temperature fluctuations in the water temperature. The temperature is controlled by the Energy Centre and there have been issues with this building since it first opened.

The report generated by DMA in 2015 should have been a key indicator that there were issues with the water system but this report seems to have been “lost” amongst the host of other issues that were being experienced in the hospital following handover. The extent of the issues being identified with the hospital and the level of work still to be completed, resulted in this report not being actioned and “lost” in the fire fighting that was being performed at that time by the F&E team.

It can be seen that the “loss” of the DMA report and the main contractor not informing the project board that there had been high TVC counts noted, resulted in the opportunity to address any issues in the water system being lost. This adds to the debate as to whether the hypothesis around contamination of the water could have been developed prior to 2018. On reflection it is doubtful that this hypothesis could have been developed earlier and would have required much greater expertise and knowledge around GNB to identify the possibility that the water supply may be contaminated.

Location of Incidents

The table shows these are predominantly in Ward 2A until 2019 when ward 6A starts to display the most organisms. It is noted that Ward 6A prior to accommodating the patients from Ward 2A was a general adult ward and therefore the level of incidents has not been reviewed.

It is noted from a review of the TWG minutes that initial water testing found that there were

organisms located throughout both hospitals and this was consequently a widespread problem. It is also noted that issues with the ventilation system were also noted in this ward. The results from the water testing would therefore support the hypothesis around contamination of the water supply.

It is also noted that PICU also had a number of GNB incidents during the period from 2015 to 2019 with 2019 having the most incidents. The type of GNB is much more restricted and is confined to either Ps/PsA, AB and SM bacterias.

In NICU the predominate bacteria is SM although there are instance of GNB spread throughout the period 2015 to 2019. The NICU building as an old building has been receiving CD dosing and therefore two different conclusions can be drawn. The first is that the CD will not kill all bacteria or the dose of the CD needs to be increased to eliminate this bacteria. The second is that the CD is effective but other sources are responsible for the incidents of GNB for example cross transmission between patients or from a mother's flora to the baby or poor operating practice. Both of these conclusions would need further investigation to determine the cause and whether the CD is operating at an effective level.

Typing of organisms

It is noted throughout the timeline that the organisms were sent for typing to see if the strain of each positive sample was the same, thereby indicating either a common source, or cross transmission. In some cases this would be the same but in many instances these were unique both in terms of the cultures taken from patients but also from those taken from water outlets and drains.

From an observational and layman point of view, the focus on whether strains were unique or not seems to have detracted from the investigation of the cause of these bacteria. It may have been more helpful to look at the incidents as a whole rather than by individual strain. While it is important to know whether cross transmission has occurred, it should not detract from the overall question of why and what the cause is of multiple different strains of bacteria. The focus on the different strains of EM and STM in 2017 may have detracted attention from that very question and it could be debated that had this focus not been so intense, the hypothesis around water as a potential cause may have been raised and further investigation been performed. However as noted in the hypothesis section further investigation of these cases would be required.

Level of expertise and role of IPCT

During the time period covered by the timeline there was no apparent guidance available around the management, control and investigation of GBB and water borne organisms. HPS is currently working on such guidance and produced an aide memoire on the "Prevention and management of healthcare water associated infection incidents/outbreaks". Another aide memoire for infections/outbreaks associated with ventilation was also produced. It is noted that both areas are to be covered in a new chapter of the Infection Control Manual but currently the aide memoires are the only guidance available on water and ventilation associated infections/outbreaks.

This highlights the lack of expertise which was available to GGC during the course of 2015 to 2019. Throughout this period GGC drew on the expertise of HFS, HPS, water experts, Public Health England, and the experience of other health boards in Scotland and England and even from hospitals abroad and in London for example Great Ormand Street hospital. Reviews of available literature was also performed to inform thinking and investigation. It is clear that from 2018 that GGC were seeking outside assistance in trying to resolve the issues it was facing.

One water expert noted that there are issues with new build hospitals and the method of their construction. These buildings are hermetically sealed and many are now showing water issues never previously seen in hospital buildings. On this basis it would seem clear that a further level of expertise is required to deal with such incidences and certainly further guidance is needed.

The question arises as to whether further research is required into these bacteria and how they develop and are transmitted in such environments. It is also unclear to what extent that IPCT, ICD and ICN are educated in this field and what true knowledge and expertise they poses in relation to these bacteria and how they should be managed. Many of the solutions and preventative measures involved action being taken by the F&E teams on the instruction of the ICD/IPCT. Anecdotal evidence shows that the knowledge and experience of F&E staff regarding these bacteria was low. Further national training and education in this area for these two group may therefore be necessary across all health boards to ensure that the experience and lessons learned by GGC are shared and can inform ad potential prevent any future incidents in new and existing hospitals in the future.

In addition the knowledge and experience related to these incidents gained by IPCT, ICD and F&E staff should not be lost. It is important to ensure that this knowledge and experience is retained and capitalised on. To that end consideration should be given to setting up an expert group to include these staff so that if further incidents occur, then these are referred to this group for investigation and knowledge and expertise they have already gained can be utilised in the investigation of the current incident. This should quicken the process of investigation as the group will have a better idea of what to look for and what to consider in these circumstances.

Section 10
Reflections on Governance

Reflections on Governance 2015

In this and the following slides, a summary of how each of the incidents that occurred during the period 2015 and 2019 was reported through the governance structure is provided. A copy of the governance structure is provided at Appendix X. In summary incidents will be reported at Sector level, then up to the AICC, then up to the BICC. The AICC also reports to the ACGF which is the senior management group. The BICC reports both the GGC Board but also the BCGF which in turn reports to the CCGC and then the GGC Board. It will be noted from the following slides that incidents can be reported via both routes. The information presented in these tables has come from the minutes of each of the committees, forums and GGC board together with the HAIRTs. It should be noted that the minutes of the committees are also noted at the next meeting of the committee it reports to, so for examples, the minutes of the AICC will be considered and noted at the BICC.

Ward/ Building	Year	Gram Negative/ Fungus (number of incidents)	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
NICU – Maternity Building	July to Dec 2015	**SM (17)**	December 2015	2/11/15 – included in IPC Summary Aug – Sept included in committee papers 11/1/16 – briefing given	30/11/15 – Discussion on screening and notes only hospital that screens for this organism notes only hospital which does weekly screening and to seek from HPS if this is appropriate and what should be screened for. Noted care required when switching from IV to oral feeding and this should be included in staff safety brief. 25/1/16 – Briefing given	6/11/15 – Briefing given 7/12/15 – Briefing given			15/12/15 – Briefing given
NICU – Maternity Building	Oct to Nov 2015	**PsA (3)**		11/1/16 – included as part of committee papers in document "IPC Summary Oct – Nov 2015					
PICU – RHC	Dec 2015	**PsA (2)**							

Reflections on Governance 2016

Ward/ Building	Year	Gram Negative/ Fungus (number of incidents)	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
NICU – Maternity Building	Jan 2016	**SM (1) Continuation of 2015 incident**	December 2015 February 2016	11/1/16 – briefing given 7/3/16 – no briefing but February HAIRT noted	25/1/16 – Briefing given 21/3/16 – briefing given 23/5/16 – Report by GGC and HPS issued on outbreak together with recommendations and action plan.	1/2/16 – no briefing but February HAIRT noted.			16/2/16 – Briefing given and discussion is on alert systems, infection cycles, and evidencing actions to address emerging themes
Unidentified Ward	Feb 2016	**CU (1) Ward not stated**	No reporting noted at any committee, forum or Board						
PICU - RHC	June 2016	**AB (2)**	No reporting noted at any committee, forum or Board						
NICU – Maternity Building	July 2016	**SM (8)**			25 July – Briefing given				
Ward 2A	Aug 2016	**A (1)**	October 2016	14/11/16 – no briefing but noted through October HAIRT	28/11/16 – no briefing but not through October HAIRT				18/10/16 – no briefing but noted through October HAIRT
NICU – Maternity Building	Aug to Oct 2016	**SM (12)**	October 2016 December 2016	14/11/16 – no briefing but noted through October HAIRT 9/1/17 – no minutes but papers include December HAIRT	3/10/16 – Briefing given 28/11/16 - no briefing but noted through October HAIRT	6/2/17 – no discussion but not through December 2016 HAIRT			18/10/16 – no briefing but noted through October HAIRT 20/12/16 – not briefing but noted through December HAIRT
PICU - RHC	Oct 2016	**SM (6)**	December 2016	9/1/17 – no briefing but noted through December HAIRT	3/10/16 – Briefing given that one patient who transferred from NICU to PICU has SM.	6/2/17 – no discussion but not through December 2016 HAIRT			20/12/16 – not briefing but noted through December HAIRT
NICU – Maternity	Nov 2016	**SM (4)**	February 2017 April 2017	6/3/17 – no briefing but noted through	27/3/17 – no briefing but noted through	24/4/17 – no briefing but noted			21/2/17 – not briefing but noted through February HAIRT

Reflections on Governance 2017

Ward/ Building	Year	Gram Negative /Fungus (number of incidents)	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
PICU - RHC	Feb 2017	SM (??)		6/3/17 – noted through "IPC Summary Dec – Jan 2017" document in Committee papers					
Ward 2A - RHC	Feb 2017	EM (3)		8/5/17 – noted through "IPC Summary Feb – Mar 2017" document in Committee papers					
NICU – Maternity Building	Feb/Mar 2017	SM (3)		8/5/17 – noted through "IPC Summary Feb – Mar 2017" document in Committee papers					
Ward 2A - RHC	Mar/Apr 2017	A (3)	June HAIRT	8/5/17 – noted through "IPC Summary Feb – Mar 2017" document in Committee papers 3/7/17 – notes nothing to report as waiting next HAIRT but June HAIRT is included in papers which refers to this incident 4/9/17 – noted through "IPC Summary Jun – July 2017" document in Committee papers	31/7/17 – no discussion but noted through June HAIRT.	7/8/17 – no briefing but noted through June HAIRT			27/6/17 – no briefing but noted through June HAIRT
PICU - RHC	Mar 2017	SM (??)							
Unidentified ward	July 2017??	MA (??)			31/7/17 – Genome sequencing of this organism discussed. HPS do not consider this an ongoing incident. No detail provided of number of cases or how organism identified.				

Ward/ Building	Year	Gram Negative /Fungus (number of incidents)	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	[illegible] Ward
Ward 2A - RHC	July 2017	STM (2)	October HAIRT	6/11/17 – Briefing given and also noted in "IPC Summary Aug – Sept" document in papers	9/10/17 – Briefing given and discussion. Notes IPC monitoring ward closely. Questions on reducing the number of line infections notes work is being performed on this led by the Chief Nurse (CLABSI work). 27/11/17 – no briefing but noted through October HAIRT. Update on CLABSI work provided.	2/10/17 – no briefing but noted through October HAIRT 4/12 /17 – no briefing but noted through HAIRT which is for October, despite being discussed above.			17/10/17 – no briefing but noted through the October HAIRT
PICU - RHC	Aug 2017	Ps (2)							
NICU – Maternity Building	Aug 2017	STM (2)		6/11/17 – Briefing given and also noted in "IPC Summary Aug – Sept" document in papers					
Ward 2A - RHC	Sept 2017	CU (1)							
PICU - RHC	Oct 2017	SM (4)		8/1/18 – noted in "IPC Summary Oct – Nov 2017" document in papers					
NICU – Maternity Building	Oct 2017	AB (3)		6/11/17 – Briefing given 8/1/18 – noted in "IPC Summary Oct – Nov 2017" document in papers					

Reflections on Governance 2017

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
Ward 3A - RHC	Oct 2017	AB (4)		6/11/17 – Briefing given 8/1/18 – noted in "IPC Summary Oct – Nov 2017" document in papers					
Ward 2A - RHC	Oct 2017	A (1)		6/11/17 – Briefing given 8/1/18 – noted in "IPC Summary Oct – Nov 2017" document in papers					
PICU - RHC	Nov 2017	AB (1)		8/1/18 – noted in "IPC Summary Oct – Nov 2017" document in papers					
Ward 1E - RHC	Nov 2017	AB (1)		8/1/18 – noted in "IPC Summary Oct – Nov 2017" document in papers					

Reflections on Governance 2018

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
PICU – RHC	Jan 2018	PsA (4)	April HAIRT	27/4/18 – no discussion but noted through April HAIRT	31/1/18 – briefing given. .	6/6/18 – no discussion but noted through April HAIRT			17/4/18 – no discussion but noted through April HAIRT
Ward 2A – RHC	March 2018	CU (1) PsA (1) STM (5) Fungal Growth (1)	April HAIRT which covers "water incident" from February to March June HAIRT which covers "water incident" from February to June"	27/4/18 – Briefing given and covered in April HAIRT Ongoing updates through June and Sept – see next two slides	28/3/18 – briefing given and ICD notes that engaging with HFS/HPS and water expert is to be sought to develop short and long term solutions Ongoing updates through June and Sept – see next two slides	6/6/18 – Briefing given and also covered in April HAIRT Ongoing updates through June and Sept – see next two slides	12/3/18 – noted in update from Women and Children's Directorate that there is an issue with mixer taps in ward 2A. Notes full IMT involvement and sanitising of equipment. 9/4/18 – briefing given on current status in ward 2A Ongoing updates through June and Sept – see next two slides		17/4/18 – briefing given on incident to date and precautions and measures taken. Board ask whether the possible waterborne source of infection has been identified. Advised Scottish Water advised after testing that infection not present in water supply. Board advised that work continues to pinpoint the source. Ongoing updates through June and Sept – see next two slides
PICU - RHC	Feb/April/ May 2018	AB (6)		19/6/18 – included in *IPC Summary April – May 2018 in AICC papers					

Reflections on Governance 2018

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
Ward 2A – RHC	May 2018	Pan (1)	June HAIRT which covers "water incident" from February to June August HAIRT which Covers "water incident" from February to June	19/6/18 – briefing given and updated in respect of incident and action taken to June. Noted that a TWG has been formed who report to BICC who are looking at taking long term measures to address these issues. Notes that there is also an executive group that overarches these two groups to make sure that the actions agreed in these groups are completed. .	28/5/18 – update given. Advised site visited by UK water experts and agreed both sites should be dosed – this is going out to tender. Replacement of taps also advised. MD asks that Corporate Management Team and Directors be informed of actions and costings. 25/7/18 – update given and "water incident" is declared over. Advised no incidents in past 2 months. Report on incident to be presented to AICC. Advised meeting with water experts regarding dosing of water with CD. Once certain level of CD reached in water, tap replacement will commence. Update on this to be given at next BICC	6/8/18 – no discussion but draft copy of June HAIRT was presented to the meeting, which covers "water incident" from February to June.	11/6/18 – briefing given and note that infection control measures appear to be effective with regard to the incident. Notes also that still significant clinical concerns 13/8/18 – update given and advised that a water report would be going to cabinet secretary next week and that current control measures appear to be effective.	12/6/18 – paper is presented to the CCGC on the "water incident" (see appendix 8) Provided with a briefing setting out the events that have occurred and the actions that have been taken. It is noted that working closely with HFS and HPS and that a water group has been set up and UK water experts consulted to develop a long terms solution. Member note the above and were assumed by long term preventative methods and use of water experts.	26/6/18 – briefing given on "water incident" and actions taken. Board member is disappointed to note that QEUH had consistently been worst performer in last 12 months for cleanliness. Advised that site complied with national requirement of .90% and external verification had not raised any concerns. Compared to GRI which has more challenges but advised that methodology different at each site. Confirmed that this being reviewed by HIS and Board requests further update at October meeting. 21/8/18 – update given. Board notes concern regarding the water issue given this a new hospital and question if there were issues with the specifications of the building. Board advised that work to identify problems with initial
Ward 2A – RHC	June 2018	EC (6)							
Ward 2A – RHC	June 2018	STM (9)							
Ward 2A – RHC	June 2018	Ps (4)							
Ward 2A – RHC	June 2018	A (2)							
Ward 2A – RHC	June 2018	CU (1)							

Reflections on Governance 2018

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
NICU – Maternity Building	July/Aug 2018	SM (4)		26/10/18 – Briefing given and included in "IPC Summary Aug – Sept 2018" document which in AICC papers.					
Ward 2A	September 2018	GNB (5)	October HAIRT – covers incident from February to closure of Ward 2A on 26/9/18 December HAIRT – covers incident from February to closure of Wards 2A.	26/10/18- briefing given and informed of move of patients in Ward 2A to Ward 6A and for BMT patients to ward 4B in the QEUH.	26/9/18 – briefing and update given. Advised of move to Wards 6A and 4B in the QEUH. BICC express concerns at move. MD advises a risk assessment was performed and Executive Team were given a number of options. MD to set up meeting with SG, HPS and GGC to discuss incident and if any other action needed	1/10/18 – no discussion but noted through October HAIRT.	10/9/18 – briefing given and update given.		16/10/18 – briefing and update given. IMT reconvened in Sept as additional bacteraemia reported and ward was closed with patients transferred to wards 6A and 4B in QEUH. Board members ask about frequency of these incidents in similar facilities and MD explains these incidents are not common.
Ward 2A	September 2018	STM (1)							
Ward 2A	September 2018	SM (1)							
NICU – Maternity Building	October 2018	PsA (?)		7/1/19 – Briefing given and also included in "IPC Summary Oct to Nov 2018" document included with papers					
NICU – Maternity Building	October 2018	SE (?)							
NICU – Maternity Building	October 2018	STM (?)							
NICU – Maternity Building	October 2018	SM (?)							
Theatre 6 - RHC	November 2018	PsA (5)							

Reflections on Governance 2016

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
Ward 6A - QEUH	Jan 2019	**CN (2)**	February HAIRT April HAIRT June HAIRT August HAIRT	7/1/19 – briefing given	28/1/19 – briefing given 25/3/19 – update given 3/6/19 – update given	4/2/19 – briefing given 8/4/19 – update given 27/5/19 – no discussion but noted through June HAIRT	14/1/19 – briefing given 8/2/19 – update given	5/3/19 – report on incident presented to CCGC. Questions asked around the national recommendations and guidance in respect of the use of HEPA filters and nature of the fungus	19/2/19 briefing given. CEO advises that 3 works streams are to be commissioned, namely • review of the Estates, Facilities and environmental issues at the QEUH and RHC • review of capacity and flow to assess the current position against original model and planning assumptions for the hospitals; • review of clinical outcomes over the period to provide assurance. The CEO advises they will chair a Programme Board will be established and comprising the leads of the 3 work streams and other key member of the senior staff. A report will be presented to the Board in due course. Questions around timescales raised by members and advised these will be notified through the relevant governance committee for each work stream Members note they are pleased with and express gratitude for continued actions to address these issues. 16/4/19 – update given 25/6/19 – update given 20/8/19 – no discussion but noted through August HAIRT

Reflections on Governance 2016

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
NICU – Maternity Building	Jan 2019	NUO (?)	Not reported in HART	7/1/19 – briefing given					
Ward 6A - QEUH	Jan 2019	PsA (5)							
PICU	Jan to Feb 2019	Ps (2)	Not reported in HAIRT	12/3/19 – not discussed but included in IPC Summary Dec 2018 to Jan 2019 document included in papers 13/5/19 – not discussed but included in IPC Summary Feb to Mar 2019 document including in papers					
PICU	Jan to Feb 2019	AB (2)							
PICU	Jan to Feb 2019	SM (1)							

Reflections on Governance 2016

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
NICU – Maternity Building	Jan-Mar 2019	**SM (14)**		12/3/19 – briefing given 13/5/19 – update given 16/7/19 – update given 2/9/19 – update given and noted incident closed.					
PICU - RHC	April 2019	**AB (2)**		16/7/19 – no discussion but in IPC Summary Apr to May included in papers					
Ward 6A - QEUH	April 2019	**STM (1)**	August HAIRT October HAIRT	16/7/19 – briefing given 2/9/19 – update given 12/11/19 – update given	29/7/19 – briefing given and through draft August HAIRT 26/9/19 – no discussion but noted through draft October HAIRT	19/8/19 – no discussion but noted through August HAIRT 28/10/19 – no discussion but noted through October HAIRT.	10/6/19 – comment that recent incidents are noted at QEUH but it is not clear if this relates to ward 6A 5/8/19 – briefing given 7/10/11 – update given 11/11/19 – update given		20/8/18 - briefing given. Noted Authorised Engineer (AE) had reviewed all water reports for the campus and described water supply as "wholesome" Board members ask how long it will be before patients can return to ward 2A/2B. Advised that wards were still being renovated. 22/10/18 – update given.
Ward 6A – QEUH	May 2019	**STM (1)**							
Ward 6A - QEUH	**May 2019**	**PanS (1)**							
Ward 6A – QEUH	**May 2019**	**EC (1)**							

Reflections on Governance 2016

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
Ward 6A - QEUH	**June 2019**	**MC (1)**	August HAIRT October HAIRT	16/7/19 – briefing given 2/9/19 – update given 12/11/19 – update given	29/7/19 – briefing given and through draft August HAIRT 26/9/19 – no discussion but noted through draft October HAIRT	19/8/19 – no discussion but noted through August HAIRT 28/10/19 – no discussion but noted through October HAIRT.	10/6/19 – comment that recent incidents are noted at QEUH but it is not clear if this relates to ward 6A 5/8/19 – briefing given 7/10/19 – update given 11/11/19 – update given		20/8/18 - briefing given. Noted Authorised Engineer (AE) had reviewed all water reports for the campus and described water supply as "wholesome" Board members ask how long it will be before patients can return to ward 2A/2B. Advised that wards were still being renovated. 22/10/18 – update given.
Ward 6A - QEUH	**June 2019**	**EC (1)**							
Ward 6A - QEUH	July 2019	**PsP (8)**	August HAIRT October HAIRT	2/9/19 – update given 12/11/19 – update given	29/7/19 (PsP only– briefing given and through draft August HAIRT 26/9/19 – no discussion but noted through draft October HAIRT	19/8/19 – no discussion but noted through August HAIRT 28/10/19 – no discussion but noted through October HAIRT.	5/8/19 – briefing given 7/10/19 – update given 11/11/19 – update given		20/8/18 - briefing given. Noted Authorised Engineer (AE) had reviewed all water reports for the campus and described water supply as "wholesome" Board members ask how long it will be before patients can return to ward 2A/2B. Advised that wards were still being renovated. 22/10/18 – update given.
Ward 6A - QEUH	**August 2019**	**Ps (1)**							
Ward 6A - QEUH	**August 2019**	**CH (1)**							
Ward 6A – QEUH	**August 2019**	**EM (1)**							
Ward 6A - QEUH	**August 2019**	**STM (1)**							

Reflections on Governance 2016

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
Ward 6A – QEUH	**August 2019**	**EA (1)**	August HAIRT October HAIRT	2/9/19 – update given 12/11/19 – update given	29/7/19 (PsP only– briefing given and through draft August HAIRT 26/9/19 – no discussion but noted through draft October HAIRT	19/8/19 – no discussion but noted through August HAIRT 28/10/19 – no discussion but noted through October HAIRT.	5/8/19 – briefing given 7/10/19 – update given 11/11/19 – update given		20/8/18 - briefing given. Noted Authorised Engineer (AE) had reviewed all water reports for the campus and described water supply as "wholesome" Board members ask how long it will be before patients can return to ward 2A/2B. Advised that wards were still being renovated. 22/10/18 – update given.
		EC (1)							
Ward 6A – QEUH	**September 2019**	**GNB (Multiple)**	October HAIRT	12/11/19 – update given	26/9/19 – no discussion but noted through draft October HAIRT	28/10/19 – no discussion but noted through October HAIRT.	7/10/19 – update given 11/11/19 – update given		22/10/19 – update given
Ward 6A – QEUH	**September 2019**	**AC (1)**							
Ward 6A – QEUH	**September 2019**	**STM (1)**							
Ward 6A – QEUH	**October 2019**	**DA (1)**							

Reflections on Governance 2016

Ward/ Building	Year	Gram Negative /Fungus	HAIRT	AICC	BICC	BCGF	ACGF	CCGC	GGC Board
PICU – Maternity Building	**November 2019**	**AB (3)**	It is assumed that this incident have been reported in the 2020 minutes and HAIRTS but these have not been reviewed.						
PICU – Maternity Building	**November 2019**	**PsA (2)**	It is assumed that this incident have been reported in the 2020 minutes and HAIRTS but these have not been reviewed						
PICU – Maternity Building	**November 2019**	**PsA (1)**	It is assumed that this incident have been reported in the 2020 minutes and HAIRTS but these have not been reviewed						
PICU – Maternity Building	**November 2019**	**SM (1)**	It is assumed that this incident have been reported in the 2020 minutes and HAIRTS but these have not been reviewed						
PICU – Maternity Building	**December 2019**	**SM (1)**	It is assumed that this incident have been reported in the 2020 minutes and HAIRTS but these have not been reviewed						

Reflections on Governance

Review of minutes

The table shows that reporting of incidents in Wards 2A and 6A were reported at most if not all of the committees and also to the Board. The review of IMT minutes reflected a lot of challenge and debate around the issues being investigated and in some cases there was opposing points of view being expressed. The IMT minutes reflect a differing of opinions of MBs and Clinicians around whether levels of GNB infections had risen and what was the source of these organisms. This level of debate and challenge however is not reflected in the review of the committees, forums and boards that the incidents were reported to.

The tables above show that where incidents are reported these tend to be noted by the relevant committee or board. The minutes reflect that in the majority of, but not all, cases, there has not been a detailed discussion of the matter or that questions have been asked. The minutes do not reflect any challenge to the action or decisions that have been made by the IMT in managing a particular situation. This may be due to the way the minutes have been written but the essence of such challenges and questions should be documented so that a rigour around the process is evident.

In some instances, the incident is simply contained in the HAIRT which is contained in the papers to the committee/board and noted through that document. However this does not provide clear evidence that the Committee/Board has taken note or considered such incidents in depth as the discussion is predominantly or all on the levels of SAB and Cdiff that is extensively reported in the HAIRT and which is a national requirement.

It should also be noted however that the level and extent of reporting to the committees, forums and boards improved from 2018 onwards but there remains, in some instances, a time delay between the occurrence of the incidents and the actual reporting and this is very much dependent on the cycle of the various committee, forum or Board. There does not appear to be a clear path to escalate incidents quickly up to the Board, should this be required.

The GGC Board is first notified of the 2018 “water incident” at is meeting on 17 April 2018 and are updated at subsequent Board meetings in June and September. The meeting in April generates questions around whether the source of the possible waterborne source of infection has been identified. The Board are told that Scottish Water had advised that after testing of the water supply it had not found any infection in the water. The Board are advised that work continues to identity the source. The Board in being briefed on the water incident are also advised of the preventative and control measures that have been put in place by the IMT.

The Board is again updated in June 2018 regarding the ongoing water incident and that the long term solution is to install a CD dosing plant. This generates comments around the cleanliness of the hospital and that it has been the worst performer in the Board over the last 12 months. The Board are advised that the campus has still complied with national requirements and external verification had not raised any concerns about the cleanliness of the campus. While the issue of cleanliness is an important one it does not indicate a sense of urgency by the Board over the ongoing water incident or that a source of these infections as raised in the April meeting has not yet been identified. No questions are recorded in connection with the installation of a CD plant and implications this will have for the hospital, either from a disruption to services or a cost perspective.

It is noted in the August 2018 that the Board is provided with a further update on the water incident. Questions are raised around whether there was an issued with the specification of the building given it is a new building. The Board are advised that work to identify problems with the initial specification is underway.

In June admissions to Ward 2A had been restricted and patients were having treatment delayed. This would not only put pressure on other health boards but have an impact on patients that had treatment delayed or transplants postponed. A review of the minutes show that the Board do not appear to have been informed of this fact either at its meeting in June or August. These measures would not only put pressure on other health boards but have an impact on patients that had treatment delayed or transplants postponed. It is surprising that therefore that the minutes do not record the Board being informed of these measures.

By September 2018 ward 2A has been closed and the patients moved to the adult hospital. The Board are informed of this at their October 2018 meeting. The Board is also informed that following a risk assessment being performed by the senior management team, a recommendation was put forward by that team to the GGC Board Directors that the ward should be closed. The GGC Board Directors approved that recommendation. The Board was also informed that plans to install a CD dosing plant were in progress and a mobile dosing plant would in the interim be installed at the RHC so that dosing could begin more quickly. Questions are asked about the frequency of these incidents in similar facilities and the Board is advised that these incidents are not common. Again there seems to be a lack of detailed discussion about the decision taken.

Throughout all of the minute the Board appears to place reliance on and gain assurance from the actions taken without any challenge or debate. This is not to question the decisions taken per se, the point being observed is that there is a lack of debate and challenge within that process and would normally be expected in circumstances which could and would have a significant impact on the hospital.

As the incident in Ward 6A occur in 2019, the Board is briefed at its February meeting by the CEO who advises that 3 work streams have been commissioned to

- review of the Estates, Facilities and environmental issues at the QEUH and RHC
- review of capacity and flow to assess the current position against original model and planning assumptions for the hospitals;
- review of clinical outcomes over the period to provide assurance.

The CEO advises they will chair a Programme Board comprising the leads of the 3 work streams and other key member of the senior staff. A report will be presented to the Board in due course. It is noted that these work streams eventually lead to the Board taking legal action against the main contractor and other parties involved in the building of the campus.

Questions around timescales raised by members and advised these will be notified through the relevant governance committee for each work stream. The members note they are pleased with and express gratitude for the continued actions to address these issues.

The minutes of the various committees, forums and Board reflect the actions taken by the executive and senior management teams and the IMT to address the incidents that occurred and to implement a long term solution to address these issues. However from review of the minutes there seems to be an apparent

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reliance by the GGC Board itself and the various committees/forums on the actions of others, rather than being the instigator of such actions or to apply some rigour to the decisions and actions being taken.

It was noted from the TWG minutes there is potential for the CD to affect existing parts of the water system and reduce their working life expectancy. The minutes do not show that the TWG has developed a plan to address this issue and interviews with F&E staff have confirmed that there is a need to address this issue. F&E advised that some parts can be accessed and physically checked to identify issues at an early stage. Others however are hidden eg in walls, ceilings, wards and are therefore difficult to access without major disruption to the hospital. F&E advise that the potential damage caused by failing parts would be a leak but accept it is not an acceptable to wait until a leak occurs before action is taken and there is a need to address this issue in advance before this occurs. The input of a water expert may be helpful to both F&E and the Board to help devise a solution to the problems faced around degradation of parts of the water system.

It was noted in the previous section that there is a lack of expertise around the issues that GGC were facing in relation to GNB and water associated infections and this may explain the lack of debate and challenge in these meetings. It may be beneficial for the GGC Board to have access to a water (and indeed a ventilation) expert to advise and participate in discussion over such matters and to provide a level of expertise to the Board. This may also explain why the risks posed by potential contamination of the water supply were not fully appreciated either from an operational, cost, and public anxiety point of view.

Risk Appetite and Recording

GGC provided information on its risk reporting structure and some of its risk register. The information is provided in Appendix X.

It is noted that the Risk Steering Management Group (RSMG) is responsible for maintaining the corporate risk register (CRR) and reports to the Audit and Risk Committee and the CEO who in turn report to the Board. The CRR is discussed and updated at each RMSG meeting (three times a year), The minutes of the RMSG are noted at each Audit and Risk Committee (ARC). The ARC meet on a quarterly basis and reviews the CRR on an annual basis as a minimum. It should be noted that there has not been an opportunity to review the minutes of the RSMG on the basis that they have not been requested from or provided by GGC [can these be provided for 2018 and 2019]

It is noted in the Risk Strategy (contained at appendix X) that the MD is the lead executive responsible for all Clinical risk and clinical risk management. The Senior Management Teams in conjunction with the RMSG perform an annual strategic risk assessment and the output is captured on the CRR for ongoing monitoring. In terms of clinical risk, the CCGC is responsible for the appropriate governance of clinical and safety risks. The CCGC is responsible for risk identification, assessment and mitigation and also review of risks identified.

The IPC risk register is submitted to the BICC for approval and the highest rated risks are submitted to the corporate risk register (as detailed on the IPC work plan which is a standing item at each BICC meeting. Risks are regularly discussed at BICC meetings. The IPC risk register is reviewed annually with risks considered for inclusion on the CRR and is monitored/reviewed quarterly.

A review of the minutes, work plans and risk registers was performed and the observations from that review are noted below.

Review of IPC risk registers and work plans

A review of the work plans for 2018 and 2019 revealed that there is no specific risk or actions recorded in relation to GNB or water associated infections and outbreaks. However, the BICC minutes of 8 March 2018 record that the MD suggests that the formation of the new TWG should be added to the action plan. The minutes of 23 May 2018 confirm that this has been added to the work plan and copy of the work plan (appendix x) shows an entry relating to the ToR for the TWG being agreed and that an update on water safety will be a standing agenda items on all IPC committees.

The work plan also includes another new entry which is the development of IPC SOPs in relation IPC Alert Organism Surveillance and Management in High Risk Areas, and also the management of resistant organisms. The minutes of 23 May also note the work plan has been updated for the development of SOPs in relation to appendix 13 of the national manual.

GGC provided copies of the IPC Risk Registers for 2018 and 2019 (appendix X). The 2018 shows that while the above addition of the TWG is included in the work plan it is not included in the risk register for 2018. It is however included in the 2019 risk register. Both registers have a section relating to emerging pathogens but there is no specific reference to GNB or water associated infections and outbreaks.

The BICC minutes of 3 June noted that a new work plan for 2019 to 2020 has been created and is reviewed by the BICC. The work plan (appendix x) shows entries in relation to a new group that has been set up [check when this was set up – think 2019?] – the Infection Control Built Environment Group (ICBEG) which is chaired by the Director of F&E and includes members from F&E, IPCT and ICD and the Decontamination team. ICBEG agrees policies in relation to water quality. The BWSG reports to ICBEG and the ICBEG in turn reports to BICC and through them to the Board [check that the purpose and reporting route is correct]. The work plan for 2019 – 2020 does not contain any specific reference to risks associated with GNB or water associated infections and outbreaks.

In the BICC minutes of 29 July the MD suggests the work plan could be more focussed and should include more detail on what the IPC are doing regarding problems rather than say IPC are attending meetings. The MD suggests it should focus on how IPC are going to lower infection rates and what is planned to achieve this. MD further suggests that it should also mention the new built environment group and how IPC are going to work with estates/facilities to provide improvements.

It is not clear from the BICC minutes or the minutes of the BCGF, CCGC and Board how the risks contained on these register percolate up to the CRR. It is noted in the minutes of the BCGF on 5 February 2018 that on the recommendation of the ARC that the CCGC would take direct oversight of the relevant corporate risks. The BCGF was asked to note this new governance step, review the extract of the clinical risks from the CRR and consider and comment on the scope of the risks identified and the controls described.

The minutes note that the CRR was discussed at length and noted that some of the mental health risks looked “peculiar” and further discussion was required around the nature of expectations. The minute notes that there was some concerns raised that the nature and profile of clinical risks within the service setting may not be adequately reflected within the current corporate risk register. The minutes notes that it was agreed that local conversations with Directors were required about the way various clinical governance forums can contribute to clinical risks. The outcome of this discussion is noted recorded in any subsequent minutes

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It is also noted in the minutes of 19 August that the BCGF are asked to endorse 2 new risks to be included in the CRR relation to patient centred care and clinical quality.

- ***Review of CCGC minutes***

The minutes of the CCGC for 2018 and 2019 show that at the meeting of 11 December 2018 the clinical risks to be included in the CRR are discussed and an extract from the CRR setting out these clinical risks is provided to the CCGC. It is noted that there are no risks that are specific to the incidents that have occurred at the hospital nor to GNB bacteria or water associated infections and outbreaks. It is also noted that the review of the CRR extract is after the CCGC has been given an update on the installation of the CD plant to sanitise the water supply.

On 11 June 2019 the CCGC are presented with an extract of the CRR dated 13 June which contains the clinical risks identified. The CRR does not contain any specific risks relating to incidents at the hospital or those in connection with the water supply. On 3 September the CCGC is advised that 2 new risks are to be added to the CCR this being around patient centred care and clinical quality but this is not in relation to risks associated with water associated infections or outbreaks.

It can be noted from the governance tables at the start of this section, that the CCGC only received two updates on the incidents at the hospital with regard to GNB and the installation of a CD plant, this being on 12 June 2018 and 5 March 2019. It is not clear as to how the CCGC would identify risks associated with these incidents and in the installation of the CD plant. It is also not clear, how the risks from the BICC and the nature and profile of clinical risks within the service setting are communicated and adequately reflected in the CCR as noted by the BCGF.

- ***Corporate Risk Registers***

The CRRs dated May 2018, December 2018, June 2019 and December 2019 were provided by GGC and are contained at appendix X. A similar picture can be seen in all of these CRRs – namely that the risks included appear to be fairly generic from a clinical perspective and not tailored to specific risks and issues being faced at the hospital at that time. The exception to this is that the CRR from June and December 2019

Where there is an entry in the CRR relating to the issues that are being faced in the hospital and the reputational damage this could cause. The entry states

"***There is a reputational risk in respect of the recent issues and concerns expressed relating to the QEUH and RHC, including:• facilities and environmental issues• capacity flow across the south sector• intense media scrutiny regarding patient care"***

It is noted that the actions to address and reduce this risk is the completion of the three work streams commissioned eluded to by the CEO at the April 2019 Board meeting and also it is noted that the internal review and subsequent public enquiry commissioned by the Cabinet Secretary will assist in reducing this risk.

In the December 2018 CRR there is an entry that states the cladding of the hospital is similar but not the same as that used in the Grenfell Tower as follows:

"The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. As part of the inspection work on cladding, a further issue was uncovered regarding a section of cladding on the RHC. HFS conducted an inspection and deemed the building safe."

It is noted that this is noted included within the June 2019 CRR and it is assumed that the risk had been addressed by that point. However it appears contradictory that the above risk is included within the CRR (and rightly so) but the issues relating to a potential contamination of the water supply is not. It would have been expected that such a risk, even if only a hypothesis would have been included and at a much earlier stage than June 2019 given that it had resulted in the closure of a ward, introduction of a CD plant and a vast amount of public anxiety.

- ***Audit and Risk Committee***

GGC provided copies of the minutes for ARC for the period June 2018, December 2018, June 2019 and December 2019. The minutes predominantly talk about audit and financial planning matters rather than about risk but it and the CRR are covered in the meetings. Much of the role of ARC is to approve and endorse the CRR which has been extensively reviewed by the RSMG. It is noted from the minutes that while the CEO is in attendance, there is no attendance from the MD. On the basis that the MD is the lead executive responsible for clinical risk, it would be expected that the MD would be part of this forum if clinical risks are being approved.

It is noted in the December 2019 minutes that members sought clarification on the process, whereby risks were identified for inclusion on the CRR. The Director of Finance agrees to provide details of the process, which would be issued to the standing committees for their information [can this be shared]. It is noted that following discussion the CRR was approved. This lack of understanding raises questions as how the ARC gained comfort that the CRR was complete and all appropriate risks were included.

The minutes of June 2019 confirm that the CRR has already been considered by the RMSG, the CMT and relevant sub-committees and is before the ARC for consideration and approval. The ARC discuss how often the CRR should be review by them, currently this is twice a year with the minutes of the RMSG being brought to the ARC for information and attention if necessary. ARC is advised that going forward that individual governance committees will produce an annual report taking account of relevant risks throughout the year with a summary report being presented to the ARC. It should be noted that copies of these reports have not been reviewed.

The December 2019 minutes record that the ARC undertook its half yearly review of the CRR, which had been the subject of detailed review by the RMSG. Amendments to a number of strategic risks were noted reflecting the increased focus on infection control and financial performance. The minutes note that following established practice, the amended CRR would be distributed to standing committees as appropriate for oversight and management of risks within each service area. It is assumed but is not clear that the reference of inclusion of infection control risks relates to the inclusion of the risk opposite in relation to the reputational risk noted opposite.

As noted earlier the minutes of the RMSG have not been reviewed and have not been requested from or provided by GGC. It would therefore be helpful in understanding the risk process if a better understanding

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could be obtained around the structure and make up of the RMSG and how it ensures that all risks from the service lines are incorporated into the CRR.

- ***Board***

A review of the Board minutes for 2018 and 2019 show that the ARC reports to the Board and a copy of its minutes are included within the Board papers. It is not clear or apparent whether this includes a copy of the CRR but the impression is that this is just the minutes. A review of the Board minutes notes that updates provided by the ARC are more related to audit issues and plans and findings from various internal and external audit reports and discussions with auditors rather than elements included in CRR or discussions around those risks. Again there is no evidence that the Board is aware of the contents of the CRR or applies any rigour as to what is included within that document. Reliance appears to be placed on the ARC to ensure that this process is managed and that all appropriate risks are captured.

In the minutes of the 16 April 2019 the Board members raise questions as to whether they can feed into the Audit Plan. Members are advised that they will have the opportunity to contribute but the plan will be subject to approval by the CMT and ARC before presentation to the Board. The Chairman assure Board members at this point that the risk management process and system would be considered as work developed to review corporate governance.

ARC provide an update at the Board meeting of 25 June and noted that the CRR had been considered at the ARC meeting and it had been agreed to accept the proposal to consider new risks at the year progressed. Noted that the CRR would be circulated to Board members for information.

It would be expected that a Board would be fully involved in the process of reviewing the CRR given that the Board has ultimate responsibility for the services that GGC is providing. A risk process will incorporate not only the risks that have been raised and considered from the ground up but also the risks which only the Board can articulate as they have a much wider and broader perspective of the organisation as a whole. There is a lack of transparency from the minutes as to how the Board incorporates the risks that they have identified as a Board. If the Board are not involved in the process of inputting to and reviewing the CRR then it is difficult to see how the Board gains comfort that all risks have been identified and those included in the CRR are appropriate.

Summary of observations

It can be appreciated that as risks are identified at ground level and work their way up a risk structure they may become very summarised but that summarisation should not result in the meaning of the risk not being articulated fully. The review of the IMT minutes expresses considerable concerns at the potential of a contaminated water supply and the impact on and risk to patients. This concern does not seem to be reflected in the risk register (at least not until June 2019 and even then does not address steps to address any further incidents which might occur) so there may potentially be a disconnect between the risks being raised at a ground level with its progress up the risk structure. That is not to say that the risks are not being managed on a day to day basis but the recording of those risks in full seems to be lacking.

It is not clear from the documentation reviewed, how risks of potential further water associated infections and outbreaks would be identified and managed should they occur and until it is known that the CD is constantly addressing the issue of potential contamination of the water system. Further review, such as through a peer review of the process of the how risks are identified at the ground level and feed up the risk register should be conducted, to ensure that that the risks are not being dissipated as they progress up the risk structure and if they do progress how the amalgamation and summarisation is performed to ensure that the essence of the original risk is not lost.

The combination of audit and risk matters should be reviewed as the focus of the ARC (based on a review of a limited number of minutes) appears to be more on audit rather than risk related issues. Consideration could be given to the separation of these two functions and the appointment of a Chief Risk Officer to ensure that each is given the appropriate focus within the organisation. The transparency of the risk process needs to be clearer and the role of the Chief Risk Officer would be to ensure that this transparency of achieved, but ensure that there is no disconnect in the process from ground to Board and that in exceptional circumstances risks can be escalated quickly to the Board to ensure the situation is addressed appropriately and without delay.

Overall conclusions

There is no doubt that GGC faced a complex set of incidents and issues. It appears that the water system was handed over in a failing condition. However there were opportunities to identify issues with the water system but these were either lost of not taken. It took time for the hypothesis around the water supply to develop here was very much a process of learning as these incidents occurred and a lack of expertise in knowing how to deal with them. GGC was proactive in asking and seeking help in order to address these issues. A lot of reliance was placed on the shoulders of the relevant IMT and the passive response from committees and Board are probably reflective of this lack of expertise and experience of these incidents. Although the risks arising from these incidents were being managed at ground level the more strategic risks which could impact the Board and GGC do not appear to have been fully recognised and appreciated until much later and certainly now reflected in the CRR.

GGC has gained a lot of experience and knowledge through these incidents and it is important that this should be retained and capitalised on going forward. If further incidents occur then GGC should have a head start in being able to manage such incidents. However it is also incumbent on GGC to take proactive steps to minimise the risks of such incidents occurring and that when they do they are managed and resolved quickly and efficiently. Such measures could include the establishment of a specialist group to manage any future incidents, contained and more detailed analysis of patient pathways and water samples for example. In the next section the lessons learned from this experience are detailed and also measures that could be taken to gain a greater understanding around GNB and their management.

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Conclusions

The situation faced by GGC was a complex one and one that would not have been expected in a recently new build hospital. Water experts and the reports produced by HPS/HFS concluded that the water supply was likely contaminated at the point of handover. The HPS/HFS report also noted that some of the water tests for TVCs conducted by the main contractor initially failed and that in subsequent tests, only some areas which had failed previously now passed. It was not clear from the documentation provided by the main contractor whether those areas that failed a second time, ultimately passed. The HPS/HFS report notes that these results were not raised by the main contractor with the project board or any other agency. There appears to be agreement that the water supply was potentially contaminated before handover however it is clear that there were opportunities where this issue could have been discovered but these were lost.

There are a number of conclusions that can be drawn from the timeline which can be split between different periods of time. These being, the period before and after handover, management of the incidents themselves, and future plans and actions.

Pre and post handover period

A number of lost opportunities occurred when potential issues with the water system could have been noted but were not. These were as follows:

- ***Commissioning***

Based on discussions held (see appendix 1) it is noted that the commissioning of the hospital was carried out by an assessor appointed by the main building contractor rather than being a joint appointment made with GGC. Normally the role of the assessor is to confirm that the building has been built in line with the specifications agreed between the client and the main contractor. Any anomalies are reported so that these can be corrected. Normally the appointment is made jointly by the client and main contractor to ensure independence. On this occasion the assessor was appointed purely by the main contactor and therefore independence was lost and the opportunity for issues to be missed may have been created.

- ***GGC Water Testing post handover***

Based on discussions with the F&E team, it is noted that at the instigation of a senior estates manager, water testing was conducted by 2 members of the estates team throughout the campus after handover. The tests were for legionella only as there is no longer a standard requirement to test for TVCs. The members of the estates team conducting the sampling were not trained in how to take samples and potential contamination when taking the samples could have occurred as a result. Where positive results were found, sanitisation of the area was conducted, until 3 consecutive negative tests were obtained. Despite the lack of training, this would have been a good opportunity to test also for TVC counts, while although no longer a standard requirement it does provide an indication of the quality of the water supply i.e. high counts would indicate that the water was contaminated with faecal material and dirt.

It should also be noted that during this time and before occupancy, the water system was being flushed on a regular basis to ensure that the water in the system was turned over and to prevent stagnation. The F&E team advised that agency staff as well as domestic staff were used to ensure that each outlet on the campus was turned on for a period of time to keep the water moving in the system.

- ***DMA 2015 report and lack of clarity over roles and responsibilities in the F&E team***

The receipt of the DMA 2015 report should have alerted GGC to the fact that there were issues with the water system but this was “lost”. The report was received by a senior estates manager who passed it off to a more junior member of staff to action. There is no clear evidence to confirm whether or not action was taken in respect of the report, however the DMA report of 2017, contained most of the same recommendations which would indicate that little or no action was taken with the 2015 report.

The context around this is laid out in Appendix 1 but it is important to note the impact of the situation at the time and why the report got “lost”. At the time of handover the hospital was incomplete and over 300 sub-contractors arrived the next day to complete work started. F&E staff had to sign these sub-contractors into the site and gain an understanding of what work they were there to do. Issues with the hospital quickly started to arise as clinical services started to move into the campus and these also had to be handled by the F&E team.

The “fire fighting” being conducted by the F&E team to rectify issues that were arising meant that the team was working long hours. The DMA 2015 reports appears to have got “lost” in the flurry of activity that was taking place. GGC acknowledge that the “ball was dropped” and that had the report been actioned at the time, this would have alerted GGC to potential issues with the water system.

One of the reasons that appears to have contributed to the “loss” of the DMA report was that there was a lack of clarity over the roles and responsibilities within the F&E team at that time. Based on discussions with the F&E team and the consultant who investigated the “loss” of the DMA report, there was no formal Authorised Person responsible for the water system. It was recognised that people had particular expertise or knowledge of an area, such as water but they were not formally assigned responsibility for looking after than area. In addition, based on information provided in appendix 1, there was also a high turnover of staff at this time and lack of proper handovers. This also contributed to the “loss” of the report.

It should be noted that the structure of the F&E team has now significantly changed and there is assignment of specific roles and responsibilities in the team. Since the “water incident” in 2018 and the appointment of the new Directors of F&E, there has been a greater level of formal compliance systems introduced within the organisation and formal training and appointment of Approved Persons, not only for water, but for other systems as well. SOP have also been introduced to ensure consistency among the work performed by the various sector estates teams.

- ***Lack of controls***

According to the HFS/HPS report the main contractor was also on site after handover of the campus, performing work on the water system. This was without the knowledge of the project board and consequently there was a lack of control over the work being progressed by the main contractor and the impact of this on the water system itself and potential contamination.

- ***Lack of maintenance records***

The F&E team also acknowledge that while some maintenance was performed on the water system, the full

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scale of the maintenance which is now performed was not done initially. The F&E team advised that maintenance schedules should have been provided by the main contractor but was never supplied. It was not until late 2018 and what was received was a list of assets detailing the parts of each system. The F&E team were required to draw up maintenance schedules from this list. Based on discussion with the F&E team, it is clear that the information received from the main contractor in relation to systems in place, was confusing and incomplete and the labelling and referencing of systems and its parts was incorrect. This made identification of the various parts of the system difficult and consequently to maintain in line with the manufacturers guidelines. If these records had been in place, this may have provided opportunity to identify the issues with the water system.

Management of GNB and Fungal Incidents

There are a number of key conclusions when considering how the incidents were managed. Much revolves around the lack of guidance and research around managing such incidents as well as a large degree of reliance on the decisions made at a ground level.

- ***Research and development of national policy***

It is clear that there is a lack of research and guidance available when it comes to managing an infection or outbreak that is suspected to be associated with the water supply. It is noted that HPS now have 2 aide memoires on its website on how to manage water associated and ventilation associated outbreaks and infections. It is also noted on the website that additional guidance will be included in a new chapter of the National Infection Manual.

While GNB are known to exist within the environment and also in and on a person's body, knowledge about their development and growth within a water system seems to be much less common. In addition knowledge on how the organisms are transmitted from a water system to a patient does also not appear to be understood other than by water experts. These comments equally about the development and growth of bio-film which protects organisms and allows them to multiple.

The matter is also complicated by the build of the new hospitals as was noted by the water experts. One water expert noted that because new builds were hermetically sealed, then hospitals were seeing issues such as this, were previously there had been none. However it is also noted that through the course of the timeline, MB reports comparing infection rates at the hospitals previous location of Yorkhill did not show that the level of infection rates had increased.

Of course, infection rates are only one part of the equation, the others being the severity of illness of the patients, their length of stay, the mix of patients, number of patients, line practice etc as well as many more factors. Such large hospitals have not been built before and therefore the growth, development and transmission of such bacteria and fungus in these complexes is as yet unknown.

The lack of clear research and guidance on how to handle such incidents was very clear to the IMT team and they sought advice and guidance outside of the organisation. This included HPS, HFS, water and ventilation experts, contacting other health boards and Public Health in England to see if they had any similar experiences of such incidents. Facilities, such as Great Ormand Street hospital was also visited to understand and see their practices and facilities in relation to water and ventilation system. GGC asked for help and it was acknowledged that external advice, guidance and expertise was required in order to resolve the issues that were being faced. GGC also asked for help from other health boards when the decision was. taken to restrict admissions to Ward 2A and also Ward 6A.

The lack of research and guidance that was available in this area hindered GGC's response and the organisation was on a "learn as you go" footing. Much of its actions seem reactive but given the lack of policy and guidance this is to be expected. However now that this experience has been gained, there needs to be a period of reflection as to how this knowledge can be retained and utilised going forward to ensure that investigation of any further incidents benefit from this prior experience and can be resolved much more quickly and effectively.

- ***Typing of organisms***

An observation from the timeline is that attention and focus placed on determining the type or strain of the bacteria in order to determine whether cross transmission has occurred and also whether a source can be identified. While the benefit of this can be understood and seen, there is also the consideration that when dealing with such incidents the fact that a bacteria or several different bacteria have occurred should also be considered. The incidents should be seen as a whole incident rather than a collection of incidents.

The timeline highlights that clinicians were of the opinion that they were seeing more instances of GNB than usual and this raised their concerns. This observation is from the benefit of hindsight but had this position been taken in 2017, there is a possibility that questions may have been raised when the two STM infections appeared. This is a matter of conjecture however, but certainly was a taken by SG in 2019 when they asked GGC to look at the incidents as a whole and not separately. This flexibility of thought and interpretation while still being guided by policies and procedures may be necessary when managing and dealing with unusual circumstances such as those faced by GGC.

- ***Development of the hypothesis***

It is noted from the timeline that the hypothesis around the water system did not start to develop until 2018. Any actions taken before then in connection with water outlets, wash hand basins or any other connection to the water system either appears to be a cautionary measure or the link has been made specifically to that outlet was the case in the aseptic pharmacy in 2016 when a patient had CU following food being prepared in that area. Even though there was a number of GNB incidents in 2017, a connection was not made on the basis that each had a unique strain and the period over which they occurred was to long to create a trigger for further investigation i.e. in that the STM infections were several months after the EM infections.

The hypothesis around contamination of the water system was, from the timeline, that of one particular ICD although concerns around the environment had also been expressed by other MB and clinicians. It is noted however, that had the drive of, and actions instigated by, this individual not been there, it is possible that the number of incidents could have been potential higher and a longer time taken to implement a permanent solution not been instigated. One of the first actions taken by the TWG was water samples for all parts of the campus and the results showed that positive samples were returned from across the campus indicating that there was a widespread problem with the water, thereby supporting the hypothesis. However as noted by

Conclusions

the TWG itself, that it was not clear whether it was water outlets that was the problem and were creating the bio-film holding these organisms or the water itself which contained them and was infecting outlets.

It is also fair to say that other hypothesis were investigated, but the focus on water, may have distracted from the full investigation and further research of these hypothesis. It is noted that towards the end of 2019, actions were taken to look at full patient pathways. This considered patient's access to areas where water was unfiltered. It also highlighted took a much wider view of what happens to a patient when they are outside the ward and at home. Development of this analysis is in value both in determining whether there are any other cause of the infections but is also likely to provide assurance to the public that all avenues are being investigated.

- ***Governance and Risk***

In the previous section on governance it was noted that there seemed to be a lack of discussion and debate on incidents that have been reported. The committees and boards appear content to place assurance on the work of the individuals managing the incident and there appears to be lack of rigour and challenge as to the actions being tested. This is not to say the actions are wrong, but if there is a lack of testing or discussion around the actions being taken, there is a lack of rigour to the whole process. It is appreciated that minutes are by their nature a summarised version of events and this could just be the result of the summary process.

It is clear that GGC has a governance structure and process in place which appears to be reasonable but having a structure in place is not enough in itself. The structure needs to apply the necessary rigour to ensure that the appropriate actions and decisions are being taken. It is possible that given the nature of the issues that were being faced that the committees and board did not have the requisite expertise to pose such challenge and were also "learning as they went along". It may be that consideration should be given to an alternative reporting structure where water incidents occur. As noted in the Heat Map of Infections section of this report, if a expert/specialised group is formed to look at any future incidents then they should report directly to the Board who along with the assistance of an expert can understand the full implications of what they are told. The group should also report to the CCGC so that risks can be reported directly into the RMSG and included within the CRR.

In terms of risk, there is a lack of transparency as to how risks are escalated up the organisational structure and there appears to be a disconnect between the concerns expressed at the ground level with those articulated in the CRR. Again a peer review should be considered to really understand this process in practice. It is noted that the structure and the minutes of the RMSG have not been reviewed and this should be performed as part of the peer review.

In addition it is noted that the ARC covers both audit and risk but the focus of this committee is more on more on the former rather than the latter. It is also concerning that ARC does not have representation from the MD when it is being asked to consider and approve medical risks. It was also noted that the members of the ARC were unclear of the process of how risks found their way into the risk register. This has probably now been addressed but it does raise the question as to whether the CRR is complete. Furthermore given the dual focus of the ARC, consideration could be given to appointing an experienced chief risk officer to achieve a more dedicated focus on the risk process and to address the apparent disconnect which has already been noted by the BICC.

Future Plans and Actions

The long term solution implemented by GGC to address the potential water system contamination was the Implementation of CD dosing plant. This decision was taken after discussions with water experts, MB and various outside agencies as noted in the TWG timeline. CD was considered the best option for stripping bio-film and had the longest contact time of all the chemicals considered. An extract of the water results provided by the F&E would seem to support their view that water samples are relatively clear. However there are a number of issues that still require attention and corroboration as noted below

- ***Analysis of water samples***

It was noted in the TWG timeline section of this report, that while the water results on first glance appear to indicate low levels of bacteria, there is no point of reference or comparison as to the baseline that was created prior to the CD being installed into the system and therefore whether the counts are reducing or increasing. In addition the results are at one point in time, rather than showing the results per outlet over time.

It is noted in the December 2019 minutes for the TWG that statistical analysis was being proposed but it is unclear whether or not this was taken forward. If this has not taken forward, then this would be recommended to ensure that there is a continuing trend downwards in respect of all bacteria across the whole campus and to ensure that the CD is adjusted according for "hot spots" identified by such analysis which show variable or persistently high results. .

- ***Water outlet replacements***

The TWG has also researched, analysed and investigated various water outlets as suitable replacements. It is however noted from the TWG minutes that issues were experienced with the tap that was selected and these taken up with the manufacturer. Other replacements were considered but not found to be as viable of as the one already selected. It is not clear from the minutes whether these issues have now been resolved and this should be checked with GGC.

- ***Contingency plans if CD is no longer viable***

It was noted in discussions with the F&E team that the level of CD can be increased and decreased as required in the water supply, not only for the whole campus but for individual areas to treat "hot spots". This means that should the current dosage not be sufficient to kill off the bacteria then the dosage can be increased to a point where this occurs. It is noted in the TWG timelines that the current doses are within WHO guidelines. It is noted that it can take 3 to 4 years for the negative results to be obtained therefore the use of POUFs in high risk areas and water testing is likely to continue for a considerable time yet.

Apart from increasing the dosage of the CD, there is no contingency plan if the CD stops working or there is a requirement to exceed the WHO maximum levels. There is of course, that the organisms could mutate and become more resistant to the CD. While it may be sometime before either of these two scenarios are reached, consideration should be given to discussing contingency plans with water experts to ensure that if this does occur then action can be taken. Further research into the nature of these organisms would also

Conclusions

help inform this discussion. It is appreciated that this may not be an alternative at the current time, but keeping up with advancements in the industry may provide alternative solutions in the future, so there will be benefit in monitoring these to see if a contingency plan can be developed sooner rather than later.

- ***Replacement plans for corroded parts of the water system***

Following on from the above observation is that the CD does have an impact on the water system and can potentially corrode values and reduce the life expectancy of these parts. Discussion with the F&E team, it is acknowledged that a plan needs to be developed to address the shortened life expectancy of these parts and to determine when and what action needs to be taken.

The F&E team advised that some parts can easily be checked through observation or access, and this is performed. However many of the parts that could be affected are not accessible and cannot be seen as they are contained in walls, ceiling etc. The impact of the CD will eventually cause these parts to fail and cause a leak. The F&E team acknowledge that it is not practical or reasonable to wait until this happen and that the TWG need to determine a solution to this problem. This solution also needs to ensure that there is no or minimum disruption to clinical services as wards and rooms cannot be put out of action for long period of time.

Further discussion with the water experts may help to resolve this matter and provide further clarification as to when these problems may start to occur and how they can be resolved and allow a plan to be developed.

The timeline also notes that prior to introduction of the CD, certain water meters and other products within the system are already corroded due to the use of cleaning agents and due to type of paint coating that was on these products. DMA had been asked to conduct a survey of the system to identify where such parts were located so that the extent of the work required could be assessed. It is not clear from the minutes whether this survey took place and what was the outcome. This should be clarified with GGC.

- ***Sharing of experiences***

The construction issues that have been found with the hospital campus and the solutions that have bee implemented to address those issues should be recorded and shared. This would be with the aim of preventing a repetition of the issues faced by GGC when further new hospitals are built.

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Section 12
Lessons Learned

Lessons Learned

Area of Learning	Lessons Learned
Lessons learned from pre and post handover	
Active participation of Operational F&E staff members in the Project Board	Appendix 1 highlights the need for the inclusion of Healthcare F&E management on the project board. The SHTM guidance which applies during the course of the construction of a hospital needs to be interpreted and applied in a way that provides the safest, optimum environment for the clinical staff, allowing delivery of healthcare to the many and varied patient groups that would be users and occupants of the building. A working and operational knowledge of health care settings is therefore required to ensure that the design and options that are agreed upon will fit this purpose and provide the best setting possible for the services to be provided. It was noted by the F&E staff that the members of the project board mainly had contractual backgrounds rather than a healthcare background. This meant that they lacked an operational understanding of how different interpretations of the SHTM guidance could impact on clinical services and patients. It is noted in appendix 1 that the interpretation and application of the guidance was left to third parties and there is evidence that the design decisions that were taken resulted in less than optimum clinical environment for some patient groups. These may have been suggested and agreed with the best of intention but subsequent experience has cast some doubt on the decisions taken. It is noted in the timeline that while the project board for the construction of the campus had access to operational F&E staff they acted in an advisory capacity rather than active member of the project board itself. Based on discussions with F&E staff, it was highlighted that most of the project board members had a contract background rather than experience of working in a hospital background. It was highlighted by the team that input from a operational senior estates manager was asked for once designs had been approved. This left no opportunity for design changes to be made if a problem was highlighted on a design from an operational perspective. The lack of operational F&E staff members on the project board has meant that a number of alternations have had to be made to the hospital such as the changes being made to ventilation, air changes and pressure. Consideration should therefore be given to including operational F&E management in any future project board set up to manage the construction of a hospital. Their input to the interpretation and application of the SHTM in a practical setting will be invaluable in ensuring that the design is fit for purpose and that subsequent rectification work is not required. In addition with the advent of issues being seen in new build projects in relation to water and ventilation, experts in relation to these systems should also be included in project boards going forward.
Commissioning / Independent Assessor	It is important to ensure that during the construction of any new hospital that the role of the independent assessor is a joint appointment and not appointed by just one party as was the case of the QEUH/RHC campus. The role of the independent assessor is to ensure that the building has been built in lines with the agreed specification. If independence is jeopardised as it was in this construction, then there is a increased likelihood of issues being missed or not reported. It should be noted that it is not the role of the independent assessor to test the suitability of the design of a system and if this is required additional cost would be involved.
Operational readiness	One of the lessons learned was that there was a lack of operational readiness at the point the hospital was handed over. Discussions with F&E staff highlighted that the records and documentation handed over by the main contractor was incomplete, there was a lack of training and familiarisation with the systems that had been constructed, there as a lack of maintenance records and the facilities management system which would have contained such records and documentation was poorly laid out and it proved difficult to extract information. There was also a clack of assigned roles and responsibilities and insufficient resource to deal with the multiple of issues that were identified in the hospital and had to e managed and rectified. It should be noted that the F&E has addressed these issues and is a much more structured department with assigned roles and responsibilities, increased compliance and standard operating practices and is in a much better position to deal with the issues still facing the hospital campus. One potential legacy which still has an impact is that the original contract for the hospital the maintenance of the hospital was to be performed by the main contractor. The nature of the contract changed so that the maintenance would be the responsibility of GGC i.e. the F&E team. F&E staff advise that little if any consideration was given to the impact this would have on the resourcing levels of the F&E team and this has never been reviewed. Consideration should therefore be given to conducting a review to confirm whether the resources are in place to ensure the maintenance of a large scale hospital such as QEUH/RHC.

Lessons Learned

Area of Learning	Lessons Learned
Consideration of what should be tested for in water and ventilation.	It is noted that upon completion of a construction contract, it is only a requirement to test the water for legionella and not TVC, although the main contractor did so on this occasion. However based on the comments of the water expert that new issues are being seen in hospitals, consideration should be given to extending the range of organisms tested for when water testing is performed at the end of construction. If more issues are being seen, then it would seem reasonable to test for such organisms in the event that new hospitals are built and allow any irregularities to be identified and addressed before the hospital if handed over and opened.
Management of Incidents	
National research programme and development of guidance	There is currently a lack of guidance on how to manage water associated infections and outbreaks although it is noted that HPS are currently in the process of producing some guidance and have already issued aide memoires on how to management water and air borne associated infections and outbreaks. Further research needs to be conducted to gain a detailed understand of how GNBs develop and grow within a water system and how they are subsequently transmitted from the water system to a patient. The same applies to how bio-film develops and grows, the time it takes to grow and how it protects and proliferates the growth of GNB and also the ability of such organisms to mutate. It is especially important that this research takes account of the conditions in a sealed water system so that the context of the research can be applied to both the new and existing hospitals that are built. The same points as above are also applicable to ventilation system. The research should also take into account (if it does not already do so) look at the occurrence of GNB and fungal infections and outbreaks so that a baseline can be established as what “normal levels of such infections” are expected to be, especially in respect of patients with suppressed immune systems. A national group should be convened to look at this area and to draw upon the experiences of other boards both in Scotland and England, those of water and ventilation experts, MB and other agencies such as HFS, HPS and Public Health England. As noted by one water expert issues are being seen in newly built hospitals that have not been seen before and the method of their construction is causing problems. It is important this research is conducted before further hospitals are built to ensure incidents seen in GGC are not repeated.
Education and Training of IPCT and F&E staff	Following on from the above, IPCT, ICD, ICN and also F&E staff would benefit from further education and training in this area. It is unclear to what extent IPCT/ICD/ICN are educated in this field and what true knowledge and expertise they posses in relation to these bacteria and how they should be managed. Many of the solutions and preventative measures involved action being taken by the F&E teams on the instruction of the ICD/IPCT. Anecdotal evidence shows that the knowledge and experience of F&E staff regarding these bacteria was low. The question arises as to what are the exact expectations of the IPCT team. It is noted the actions taken by the IMT are also included in the HPS aide memoire. Further national training and education in this area for these two group across all health boards should be considered and developed to ensure that the experience and lessons learned by GGC are shared. This would inform the management of any future incidents in new and existing hospitals in the future and could potentially prevent such incidents. This education and training should draw on the results noted above and include input from outside agencies and water and ventilation experts as noted above. To inform this learning the IPCT team at GGC should be given an opportunity to truly reflect and discuss their experience of the incidents and how they managed them. There has not been an opportunity for the team to do this, nor indeed the wider GGC organisation and a formal process should be set up to allow GGC to do this, so that lessons can be captured, shared and inform further education and training.

Lessons Learned

Area of Learning	Lessons Learned
Expert Group for investigation of water incidents	The knowledge and experience gained by IPCT, ICD and F&E staff who were involved in the IMTs that investigated these incidents should not be lost. It is important to ensure that this knowledge and experience is retained, capitalised on and utilised in future. To that end consideration should be given to setting up a specialist group, with these particular staff invited to join. If further incidents occur, these would then be referred to this group for investigation and the knowledge and expertise they have already gained can be utilised in the investigation of the current incident. This should quicken the process of investigation as the group will have the benefit of "hindsight" based on their previous experience and thereby have a better idea of what to look for and what to consider in these circumstances. In addition this group should have a direct reporting line to the Board – see Governance below. It is noted that the ICD who first put forward the hypothesis that the water system was potentially contaminated ultimately withdrew from the IMT process. This may be a way to re-integrate this ICD into the organisation and capitalise on the experience and knowledge that they gained. The importance of their knowledge and experience of these matters should not be ignored. A group focused dedicated to investigating such incidents and reporting directly to the Board will also provide a direct means of communication to quickly identify and raise any concerns and risks that are noted, as they arise.
Governance - access to water and ventilation experts	It was noted in section 10 that there was a lack of challenge and debate in the committees and particularly in the Board, when water incidents were reported and assurance seemed o be taken from the IMT that the incidents were being managed and the appropriate actions were being taken. This is not to say that this was not the case, but the minutes of the committees/board do not reflect a sense of urgency and this may be due to a lack of expertise in these meetings around this particular area. As already noted, GGC were "learning as they went" with these incidents. This may also explain why the risks posed by potential contamination of the water supply were not fully appreciated either from an operational, cost, and public anxiety point of view. As noted above, a specialist group should be set up to deal with any incidents related to GNB going forward on that basis that the knowledge they have gained will assist in the investigation of these incidents and could potentially quicken the process. To ensure that the Board understand the full risks from any incident going forward, this group should report directly to the Board. In addition it would be beneficial for the GGC Board to have access to a water (and indeed a ventilation) expert to advise and participate in discussions over such matters and to provide a level of expertise to the Board that they currently do not posses. It will also allow the Board to fully understand the risks associated with such incidents and how they can be managed. It is not anticipated that this would be required at every meeting but as and when the need arose and incidents occurred. This would also help with public reassurance that if any further incidents occurred, these were investigated and reported quickly and relevant experts were consulted. Consideration should also be given to this specialist group reporting into the risk structure directly for example through the RSMG to ensure that risks identified are discussed and included in the CRR. Further incidents will have a significant impact on the Board from an escalation and public anxiety point of view, and therefore it is important these risks are acknowledged, recorded and managed until it is known for certain that the CD system has achieved the results in terms of water quality required.
Peer review of risk structure	GGC have a formal risk structure in place but from the review of minutes (albeit limited in nature) here is a lack of transparency in how risks identified at ground level percolate up the risk structure and are considered for inclusion in the CRR. While the risk strategy lays out the structure in detail, the risks identified by the IPCT in their work plans, do not appear to be reflected in the CRR. It is noted that there will be a summarisation of risks as they progress up the structure, but this seems to have resulted in risks becoming less specific. It is not clear therefore how the risks associated with any further water associated infections would be identified and reflected in the CRR. Until it is known for certain that the CD is constantly and successfully addressing the issue of potential contamination of the water system, it would be expected that these risks are reflected in the CRR. Given the limited nature of the review of the risk process that has been conducted (extensively through a review of minutes and policies) consideration should be given to conducting further review, such as through a peer group, to gain a greater practical understanding of the risk process. This should include how in practice risks are identified at the ground level and feed up the risk process through the various committees to the RMSG and into the CRR. The aim of the peer group would be to ensure that that the risks are not being dissipated as they progress up the risk structure and if they do progress how the amalgamation and summarisation is performed to ensure that the essence of the original risk is not lost. A greater understanding of the role and responsibility of the RMSG should also be obtained. Finally the Board's input to the process should also be more clearly understood. The Board minutes suggest the Board takes assurance from the ARC that all appropriate risks have been identified rather than having an active role in reviewing and contributing to the CRR..

Lessons Learned

Area of Learning	Lessons Learned
Potential separation of Audit and Risk process	The combination of audit and risk matters should be reviewed as the focus of the ARC (based on a review of a limited number of minutes) appears to be more on audit than risk related issues. It is also noted that when reporting to the Board that the focus is on audit rather than discussions of risk. Consideration should be given to the separation of these two functions and a Chief Risk Officer (CRO) appointed, who reports directly to the Board. The aim of such an appointment would be to ensure that each area receives the appropriate individual focus that is required within the organisation. The transparency of the risk process needs to be clearer and the role of the CRO would be to ensure that this transparency is achieved, but also ensure that there is no disconnect in the process from ground to Board and that in exceptional circumstances risks can be escalated quickly to the Board to ensure the situation is addressed appropriately and without delay. The CRO should also be actively engaging with the Board to identify the wider risks to the organisation. It is also noted that the ARC does not appear to have any clinical representation for example the MD and this should be addressed given that clinical risks are contained in the CRR and the ARC approves the CRR.
Bacteria strain – the wider perspective	When positive blood cultures are returned, attention and focus is placed on determining the type or strain of the bacteria. This is in order to determine whether cross transmission has taken place and also whether a source can be identified. This is an important part of the process but it should not be the only view taken. When dealing with such incidents the fact that a bacteria or several different bacteria have occurred should also be considered. The incidents should be seen as a whole incident rather than a collection of separate or individual incidents or bacteria. The questions is that not only whether the bacteria are connected but the fact that a variety of bacteria have occurred. In this way incidents may be caught and resolved more quickly. This and the typing of bacteria should compliment each other and inform investigation. As noted in the recommendation above for further research, there is a potential for organisms to mutate and the extent and speed of that mutation needs to be ascertained and taken into account. It is not known from a layman perspective whether the typing process can take account of such mutations.
Trend analysis and patient pathways	It was noted in section 7 that RCA was performed in respect of the incidents that occurred in 2019 in ward 6A. There was an acknowledgement that while investigating the source of the infections, that other sources of infection also needed to be considered and what happens to patients outside of the ward and whether they had access to unfiltered water. . It was noted that patients had access to many parts of the hospital where this was the case and that patient's lines could be accessed in various parts of the hospital. It was also acknowledged that a greater understanding of what the patient was doing when they were at home also needed to be understood. It is noted that the RCA was performed in conjunction with HPS. This RCA and its conclusions have not been reviewed and this should be done to clearly understand the findings and this should also feed into the research mentioned earlier. Based on a review of this material, consideration should be given as to whether this analysis should continue and incorporate any future incidents. It is important that all sources of potential infection are identified so that these risks can be mitigated and managed appropriately. If the RCA has identified other potential sources, then action to mitigate and manage those sources should be taken.
Future Plans and Actions	
Alternative to CD	It is noted the level of CD can be increased and decreased as required in the water supply, not only for the whole campus but for individual areas to treat "hot spots". This means that should the current dosage not be sufficient to kill off the bacteria then the dosage can be increased to a point where this occurs. The current doses are within WHO guidelines. Apart from increasing the dosage of the CD, there is no contingency plan if the CD stops working or there is a requirement to exceed the WHO maximum levels. There is also the possibility that the organisms could mutate and become more resistant to the CD. While it may be sometime before either of these two scenarios are reached, consideration should be given to discussing contingency plans with water experts to ensure that if this does occur what alternative action can be taken. Further research into the nature of these organisms would also help inform this discussion. Monitoring advancements in the industry may provide alternative solutions in the future and inform discussions held with the water experts.

Lessons Learned

Area of Learning	Lessons Learned
Action plan for replacement of parts in water system – role of expert	It is noted that the CD can have an impact on the water system and can potentially corrode values and reduce the life expectancy of these parts. The F&E team advised that some parts can easily be checked through observation or access, and this is performed. However many are not accessible and cannot be seen as they are contained in walls, ceiling etc. The impact of the CD will eventually cause these parts to fail and cause a leak. The F&E team acknowledge that it is not practical or reasonable to wait until this happen and that the TWG need to determine a solution to this problem. This solution also needs to ensure that there is no or minimum disruption to clinical services as wards and rooms cannot be put out of action for long period of time. A plan therefore should be developed to address the shortened life expectancy of these parts and to determine when and what action needs to be taken. Further discussion with the water experts may help to resolve this matter and provide further clarification as to when these problems may start to occur, how they can be resolved and allow a plan to be developed.
Analysis of water samples	Statistical analysis of the water samples was being proposed but it is unclear whether or not this was taken forward. If this has not taken forward, then this would be recommended to ensure that there is a continuing trend downwards in respect of all bacteria across the whole campus and to ensure that the CD is adjusted according for “hot spots” identified by such analysis which show variable or persistently high results.
Continuation of the use of POUFs and water sampling in high risk areas	That while water results appear to be improving it has been noted by the F&E team that it can take up to 3 to 4 years for the CD to fully achieve the desired effect in water quality. As a precautionary measure and until it can be shown categorically through consistent negative water results the use of POUFs should continue as should the level of water sampling. The above analysis of water sample results over time should also help to inform the decision as to when these POUFs can be remove.
Sharing of experience	The construction issues that have been found with the hospital campus and the solutions that have bee implemented to address those issues should be recorded and shared. This would be with the aim of preventing a repetition of the issues faced by GGC when further new hospitals are built.

APPENDIX 2 - Review of Healthcare Infection Incident and Outbreak Reporting Templates (HIIORT) scored RED/AMBER in NHSGGC 2015-2019

In total there were 40 HIIORTS completed from 2015 to 2019.

Year	No. of HIIORTs
2015	1
2016	8
2017	15
2018	9
2019	7

The incidents/outbreaks were assessed and recorded as:

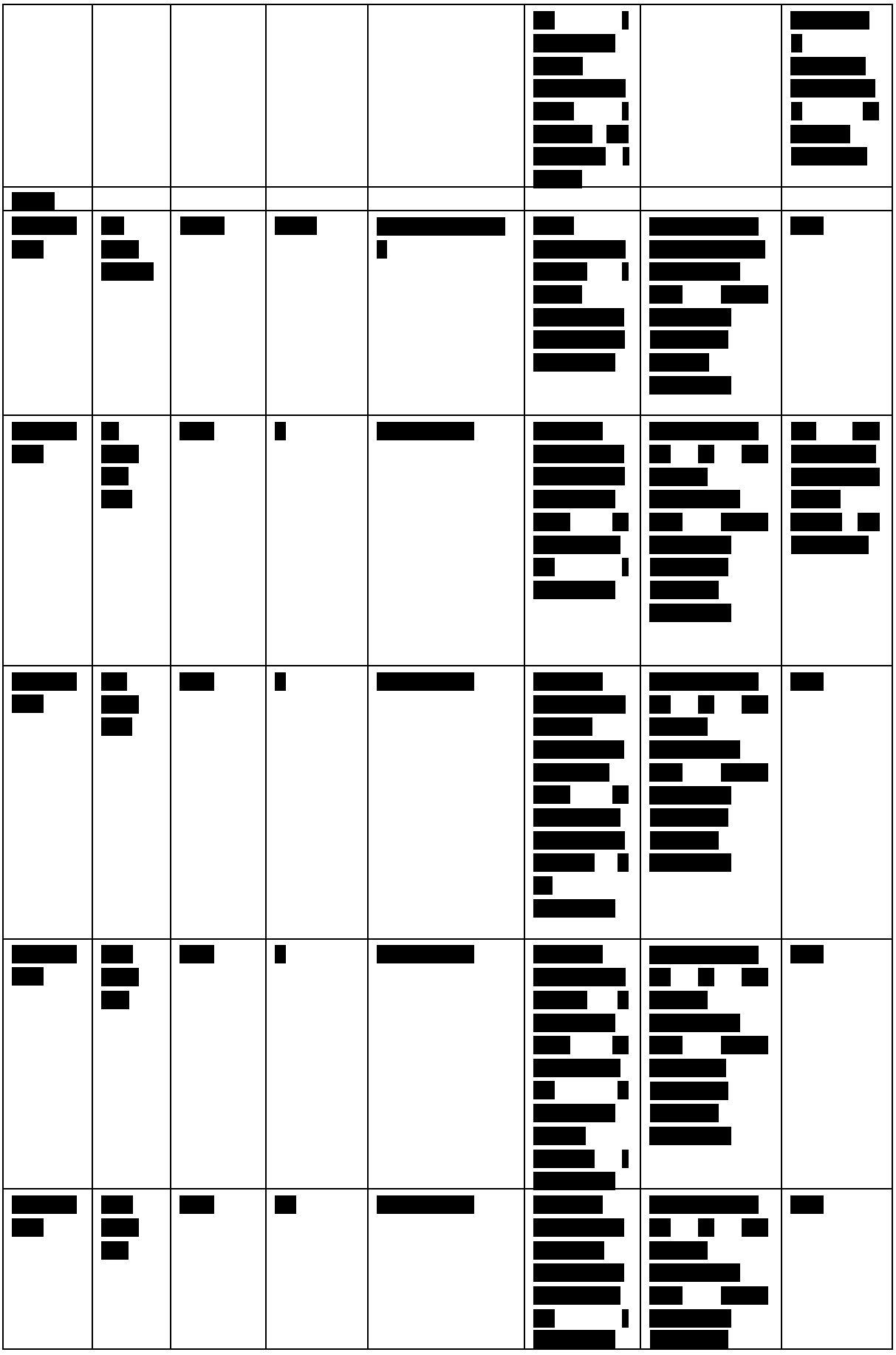
RED	16
AMBER	23
GREEN	1

4 HIIORTs were initially assessed as AMBER but were escalated to RED during the incident. This is clearly documented in the HIIORT
Overall the HIIORTs give a good summary of the reason why it is being completed and the progression of the outbreak/incident
Several of the HIIORTs covered outbreaks/incidents over several months and there is comprehensive notes recorded following each IMT/review of the HIIAT.
Not all HIIORTs have the fact that the outbreak is over or that a final HIIAT has been assessed as GREEN recorded.
One HIIORT appears to have been started but not updated during the outbreak. There are IMT minutes and actions and a final outbreak report for this outbreak.

HIIORT DATE	AUTHOR	HOSPITAL	WARD	REASON/ORGANISM	INITIAL HAIIT	DOCUMENTATION	DE-ESCALTION TO GREEN HIIAT RECORDED in HIIORT
2015							
02/11/2015	CW PJ	RHC	NICU	Serratia marcescens 13 cases, 12 asymptomatic colonisation, 1 symptomatic	RED – death of one patient septicaemia recorded on death certificate.	Narrative updates recorded. IMT dates recorded. Quickly de-escalated to Green but managed as an Amber by IPCT.	Yes
2016							
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
06/01/2016	CP	QEUH Maternity	44 & 47	Exposure to TB 11adult contacts 9 infant contacts	AMBER Impact on patient – minor/moderate Impact on public health – moderate Impact on public anxiety - moderate	One narrative update recorded. Dates of meeting recorded.	Yes
05/08/2016	SDe	RHC	2A	Aspergillus 1 confirmed case 1 probable case	AMBER Impact on patients – moderate/ major IMT agreed to HIIAT as above	IMT date recorded. Documentation of control measures. Once probable case identified as not being aspergillus. Incident closed down	
10/08/2016	PJ TI	RHC	NICU	Serratia marcescens 8 cases all colonisations	GREEN From HIIORT "This has been classified as GREEN as all the patient have been asymptomatic however weekly screening since mid	Documentation of control measures. Dates of IMT's recorded. Narrative updates recorded.	N/A

					June has identified 8 cases two of which were identified this week. Due to the increase in numbers we have completed the HAI-ORT and would appreciate if the SGHD were made aware of this situation"		
02/11/2016	PJ TI	RHC	NICU	Serratia marcescens 3 cases all colonisations	AMBER Impact on public health - moderate Piloting new HIIAT if using old HIIAT this would have been GREEN	Documentation of control measures. IMT dates recorded Narrative updates recorded	No but closure of incident recorded
[redacted]							
[redacted]							



[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
03/11/2017	SDe	QEUH/ GGH	10D/3C	CRO pseudomonas	RED Impact on services – major Severity of illness, risk of transmission and public anxiety all moderate	Documentation of control measures. IMT held. 1 definite and 2 probable cases, on typing all 3 specimens were different. Recorded in narrative and incident closed.	Yes

22/12/2017	PJ	QEUH	53,54,55	Influenza A and Norovirus	AMBER Severity of illness, Impact on services and risk of transmission - moderate	IMT date recorded. No narrative updates.	No
10/03/2017	TI SDo	RHC	PICU	Serratia marcescens	AMBER Impact on patients and public health both moderate. HIIAT escalated to RED Impact on patient - major	One narrative update recorded.	No
14/04/2017	AD	RHC	2A	Rotavirus and Astrovirus	RED Impact on patients and services - major Risk of transmission - moderate	Documentation of control measures. IMT's held. Narrative updates recorded.	No
28/04/2017	TI SDo	RHC	2A	Aspergillus fumigatus	RED Severity of illness – major Risk of transmission - moderate	Documentation of control measures. IMT's held. Narrative updates recorded. This may same one as on other sheet - SA	Yes
29/05/2017	SDo CP	RHC	3A	Varicella zoster	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. PAG x2 held Narrative update recorded.	Yes
26/07/2017	AD SDo	RHC	2A	Stenotrophomonas maltophilia	RED Severity of illness - major	Documentation of control measures PAG held. No IMT's Reason recorded in HAIORT	Yes

						Narrative updates recorded.	
2018							
[redacted]							
[redacted]							
[redacted]							
26/06/2018	TI SDe AB LP	QEUH	Spinal Unit	CPE Klebsiella	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. Narrative update recorded.	Yes
20/12/2018	TI SDe LP SDo	QEUH/ RHC	Haematology	Cryptococcus neoformans	RED Severity of illness and public anxiety (in this group of patients) – major Risk of transmission – moderate	Documentation of control measures. Narrative updates recorded.	Yes
01/03/2018	TI SDo	RHC	2A	Cupriavidus pauculus Pseudomonas aeruginosa	RED Severity of illness – moderate	Documentation of control measures. IMT's held, Narrative	No

					Risk of transmission – major	updates recorded.	
09/04/2018	SDoAM	RHC	2A	Astrovirus	AMBER Impact on services and risk of transmission – moderate	Documentation of control measures. PAG held.	No
18/05/2018	TI SDo	RHC	2A	Stenotrophomonas maltophilia	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. PAG held No narrative recorded	No
04/06/2018	TI SDo	RHC	2A	Various Gram negative organisms	RED Severity of illness, risk of transmission and public anxiety – major Impact on services moderate	Documentation of control measures. IMT's held. This was a prolonged incident over several months	No
2019							
15/02/2019	LP	QEUH	ITU1 & ITU 2	Mucoraceous Mould	RED Severity of illness and public anxiety - major Impact on services and risk of transmission – moderate	Documentation of control measures. IMT's held. Narrative updates recorded.	Yes
15/03/2019	TI LP	QEUH	Renal	Acinetobacter baumannii CRO	AMBER Risk of transmission and public anxiety – moderate	Documentation of control measures. IMT's held. Narrative updates recorded.	Yes
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
20/06/2019	TI SDo	RHC	6A	Various Gram negative organisms Mycobacterium chelonae	AMBER Severity of illness, impact on services and public anxiety all moderate. HIIAT escalated to RED Severity of illness – major.	Documentation of control measures. IMT's held Narrative update recorded.	Yes
23/09/2019	KH	RHC	PICU	Pertussis	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. IMT held. Narrative update recorded.	Yes

Appendix 3 – Infection control processes

Antimicrobial Resistance & Healthcare Associated Infection ("ARHAI") Scotland is a clinical service providing national expertise for infection, prevention and control ("IPC"), antimicrobial resistance ("AMR") and healthcare associated infection ("HAI") for Scotland. ARHAI Scotland, along with Health Facilities Scotland ("HFS"), is part of NHS Scotland Assure. NHS Scotland Assure sits within the Procurement, Commissioning and Facilities Strategic Business Unit of NHS National Services Scotland ("NSS").

In Scotland we have a National Infection Prevention and Control Manual ("NIPCM"). As the document is based on the current literature and evidence, it is updated regularly by ARHAI Scotland. The NIPCM was first published on 13 January 2012, by the then Chief Nursing Officer (CNO (2012)1) and updated on 17 May 2012 (CNO(2012)01-update). It is intended to be used by all those involved in care provision.

The current version of the manual contains:

- Chapter 1 – Standard Infection Control Precautions ("SICPs")
- Chapter 2 – Transmission Based Precautions ("TBPs")
- Chapter 3 – Healthcare Infection incidents, outbreaks and data exceedance
- Chapter 4 - Infection control in the built environment and decontamination

The purpose of Chapter 3 is to support the early recognition of potential infection incidents and to guide IPCT/HPTs in the incident management process within care settings; (that is, NHSScotland, independent contractors providing NHS services and private providers of care). This Chapter also sets out the reporting responsibilities of organisations and when support from ARHAI Scotland can be requested. Chapter 3 also sets out the rationale for when the National Framework may be utilised.

This is the link to the National Framework as at June 2018: REF 14A (scot.nhs.uk)

Please note that the current version will differ slightly from the version in use during these outbreaks. As noted above, it is updated regularly by ARHAI Scotland as evidence changes: for example in 2017, 2018 and 2019 there would not have been information on COVID.

Meeting Note

Attending: Jim Leiper (JL) (GGC)

Sandra Aitkenhead (SA) (SG)

Tom Steele (TS) GGC – Director of Estates & Facilities

Date of Meeting: 16 December 2019 and 19 December 2019 and 10 January 2019 (including Tom Steele on this last meeting)

Place of Meeting: JB Russell House, Gartnavel Hospital

Background of Jim Leiper ("JL")

JL explained that he has been engaged by GGC Health Board since 28th May 2018 (on a part time basis) to assist them with several special projects.

JL retired from his career in the NHS in April 2017 but previously worked at NSS as a Strategic Director of Facilities. JL runs his own consultancy which provides advisory services in respect of Healthcare Engineering and Estate Management. JL is a Chartered Engineer.

Prior to his retirement from NSS JL had worked in the NHS for 38 years, starting in NHS Argyll and Clyde Health Board, then moving to NHS Tayside where he was Head of Estates and then NHS Fife where he was the Director of Estates, Facilities and Capital Services.

DMA Reports

In 2015 and 2017 reports were commissioned from a company called DMA Canyon to conduct a L8[1] Risk Assessment. The reports were an assessment of the water system in place at the QEUH and RHC in respect to risks associated with the development and spread of legionella.

The 2015 report provided a large number of red risk ratings and recommendations. A similar report was commissioned in 2017 by the same company. The number of red risk ratings and recommendations in the 2017 assessment remained largely unchanged from those that were contained in the 2015 report.

JL was asked by the CEO to complete a review to ascertain the facts around what actions were taken in relation to the two DMA reports that had been commissioned and what action had been taken by following receipt of these reports. JL performed this work over a 2 month period (August – September 2018).. The investigation was a very short exercise and therefore the depth of the investigation was very limited and it was focussed on trying to get an understanding on what had happened with the DMA reports and what, if any contribution the operational situation had made to the apparent inaction against the reports' recommendations. JL organised and conducted structured interviews with 8 members of staff of the estates and facilities management team who were around and involved with the Project in the lead up to and during the construction and handover of the new construction. The staff members had agreed to provide information on a 'non-attributable' manner about their knowledge, observations and experience and they were given assurance of confidentiality. Many members of staff and Project Team members had retired or moved jobs and were not available for interview. JL also reviewed facilities and estates

documentation, action plans and minutes of meetings held. JL created a timeline of events, informed by several other timelines, documents and personal reflections of staff, to help with the understanding about where people (being interviewed during the investigation) were and what they were doing prior to the project and around the time of the project. The Timeline created by JL went from before the inception of the project, through the various phases of the project and through to May 2018.

The findings of the investigation, although limited by the its scope, provided enough information to form a reasonable understanding of events allowing some logical conclusions to be drawn.

The content of this meeting note is based on discussions with JL and the findings from his review.

Construction of the QUEH and RHC

JL advised that it was important to try to understand the context about what the operational reality was like leading up to the two DMA report being received.

The site works for the construction of the hospital began in 2011. During construction there was a change of project director. The first retired in July 2013 and a second project director took over in 2014 until the completion of the project. The first project director had an engineering background and was very experienced having worked in the healthcare sector in Scotland for a long number of years (since 1980). The second project director had a contracting background and when he was appointed as Project Director and Designate Director of Estates & Facilities, his experience of Scottish healthcare engineering standards and guidance may not have been very detailed or comprehensive.

There were also changes in the Estates & Facilities team during the course of the project. The second project director became the new Director of Estates and Facilities, (as planned when he was taken on) in 2014 when the then Director of Estates & Facilities retired. Following taking up the role of Director of Estates & Facilities, this individual subsequently left GGC three years after the completion of the project.

JL advised that there was a Project Board and a Project Team during the course of the construction project.

Project Board

JL advised that the members of the Project Board mainly had a contract background gained within the building industry rather than in a healthcare setting.

The Project Board did however have access to individuals in the Facilities and Estates Management teams, two of whom had a mechanical and electrical engineering background gained in a healthcare setting. There was some anecdotal evidence that communications between the Project Team and these individuals took place, but it was fairly infrequent and on a very light touch basis.

Representatives of the Scottish Futures Trust also sat on the Project Board. .

Project Team

There was also a project team which was made up of external advisers and consultancy agencies. The project team would have reported via the project director to the project board.

JL advised that there were a number of issues common to this type of contract. . JL explained that the SHTM guidance was written in a manner that in many cases would require consideration interpretation in order to achieve the optimum outcome.. JL explained it was beneficial to have a background in Healthcare Estates management, as a 'caring professional' to allow the SHTM guidance to be interpreted and applied in a way that would provide the safest, optimum environment for the clinical staff, allowing the delivery of healthcare to the many and varied patient groups that would be users and occupants of the buildings. . .

JL commented that in this type of construction procurement, this interpretation and application of the guidance was 'gifted' to third parties whose objectives and ambitions may have competing priorities.. There was evidence that design decisions that were taken resulted in a less than optimum clinical environment for some patient groups. These may have been suggested and agreed with the best of intention, but subsequent experience has cast some of these decisions on another light.

Contract for construction of the Hospital Campus

The contract was originally to be let under a PPP arrangement with the design and initial cost of construction being borne by the contractor's funders. The cost of construction along with the maintenance costs would be amortised over the life of the contract, normally paid on a monthly basis by the Board. The form of procurement was changed from a PPP model to a Treasury Funded procurement. This meant the design and building of the hospital would still be the responsibility of the contractor but NHS GGC would then be responsible for the future maintenance of the facility.

It is understood from conversations with staff during the investigation, that the budget for the funding the maintenance of the new hospital was based on the last year of budgeted expenditure at the demitting hospitals and according to evidence presented to JL the budget was 'capped' at [redacted], (around half the amount anticipated by staff). JL and TS advised that, if this was the case, this would not have reflected the true cost of maintaining the new campus for two reasons:

- The budget of the old hospitals would not have represented the full and accurate cost of maintaining them t to normal levels, as there would have been a running down of the maintenance services as the hospitals were closing; and
- The new campus has much more highly serviced engineering systems in comparison to the older demitting hospitals and it also contained lots of new technology. The maintenance of these complex systems, machinery and devices is expensive. It is thought that the costs of the necessary maintenance contracts for specialist equipment, together with the life cycle costs of maintaining the installed engineering systems did not form the basis of setting the maintenance budgets. It is recognised that economies of scale and efficiencies will be realised as long as plant and equipment are appropriately maintained. It is not possible to maintain systems to appropriate standards if the funding required to do so is not provided. It is thought that the cost of doing so was about double than that allocated.

The contract for the construction of the new campus was awarded to Brookfield Multiplex. Multiplex produced the designs for the hospital and the Project Board would review these, together with any suggested variations to the original design during the course of the project.

The whole project was subject to the Scottish Governments Gateway process which monitors progress on the project. These involve short focused reviews that occur at key decision points. The review is conducted by a team of experienced practitioners and are independent of the Project Board/Team. The assessments involve interviewing of staff, visiting the construction site, understanding key decisions and making recommendations.

JL explained there was anecdotal evidence/hearsay, that a Senior Estates Manager (SEM), criticised an aspect of the design at one of the Project meetings in 2012. This criticism was firmly rejected by the first project director in a subsequent meeting with the SEM . JL explained that at this point the designs had probably been finalised and significant alterations could not be easily achieved and changes to finalised designs would be expensive and possibly affect project timescales. Project Directors generally, are disinclined to entertain these kind of, 'late in the day' suggested changes.

JL advised that this 'firm rejection' resulted in the senior estate manager being subsequently side-lined in the Project Team. In August 2012 the SEM was given responsibility for the Maintenance of the new laboratory block and he also highlighted concerns at this time about basic engineering systems and other areas such as windows and ventilation. The Laboratory Building was opened in November 2012. This SEM also fed some comments on proposed electrical systems of the new hospital into the Project Team and was eventually seconded to the Project Team in January 2013.

Timescale for movement of department and patients into the new campus

Based on JL timeline (not provided) the timescales for the hand handover and transfer of departments and patients was as follows:

Timescale		
Handover of Labs Building	-	January 2013
Handover of campus by contractor	-	26 January 2015
Southern General Hospital Out Patient Department	-	27 April 2015
Southern General Hospital In Patient Department	-	1 May 2015
Royal Hospital for Sick Children	-	10 June 2015
Handover of Adult Hospital	-	26 January 2015
Start of transfer of patients to new Adult Hospital	-	27 April 2015
Completion of move of patients to new hospital	-	14 June 2015

Problems following handover of the hospital

JL explained that the hospital was handed over to GGC on 26 January 2015. It is normal that the services of an Independent Assessor are utilised for the final assessment / commissioning of engineering systems. During JL's investigation, he was informed that the Assessor in this instance was appointed by the Contractor, which perhaps reflected the confidence held at that time between the parties in the contractual relationship, but gave him some concern about a potential conflict of interest and possible conflict of impartiality if this was indeed the arrangement.

Following the handover on 26 January 2015, the movement, installation and commissioning of equipment continued into the new hospital. During JL's interview with the SEM, he advised that the building was not complete at handover and that the Monday following the 26/1/15, 200 plus construction workers were required to be signed in to complete the work.

Following the handover, in addition to the work that was not completed there were numerous problems identified with the building – these included the following:

- Blocked sewers
- Flooding
- Water filters
- Issues with temperature regulation
- The building management system, which monitors the operational parameters of engineering systems in all areas (including critical and emergency areas) –was producing hundreds of alarms which were not an all considered to be emergency in nature. This 'over sensitivity' set up by the Contractor had the effect of masking true emergency alarms due to the quantity coming through. All of this had to be corrected to allow a practical level of necessary and true emergency alarms.
- Breakdown of systems.

One of the senior estates officers provided details of the type and volume of major issues that required to be rectified. The resolution of these issues spanned from January 2015 to August 2017 and beyond. These were all major issues and by way of example covered issues such as:

- Pipework was not CE marked, which is a requirement of the Pressure Systems Equipment Directive 2014 which set out the required specification of pipework which is being used under pressure. It was identified that the pipework installed did not have this marking and approval that it confirmed the pipework system to CE standard had to be obtained retrospectively over a 2 year period;
- Resolution of constant drainage issues which required the use of CCTV cameras in the sewers to identify blockages thought to have been left during construction. This survey was applied to the whole system.
- Resolving operational issues with the pneumatic tube transfer system – which meant items which would be delivered using this system, would need to be transported by Porters which would have inevitably impacted on the staff available for other patient services. This system covered the whole hospital and so identifying where issues was time consuming as miles of pipework needed to be inspected.

- Issues with the hot water system which was not fully online until a year later which had implications for the regulation of the temperature of the hot water system;
- Manage and develop solutions to drainage failures in theatres resulting in surgeons refusing to use theatres and these being closed for six weeks.
- Found and replaced 6 metres of mild steel pipework connected to a portable water system rusted through. (Mild Steel should not be used in a potable water system as the Iron Oxide (rust) is considered to be an encouraging contributory factor of microbiological growth in water systems)
- Multiple issues with ventilations issues with regard to positive and negative pressures in isolations, Adult BMTU and PPVL areas which included rework of some facilities.
- Raising concerns regarding non compliances in RHC isolation rooms and PPVL isolation room facilities for the adult hospital. Also contract omissions in theatres.
- Installing of fixed equipment across new build and supporting and facilitation the installation and commissioning of 3rd party equipment. This included the installation of the patient entertainment system in the Adult hospital which had not been installed during construction.
- Issues with pipework connections in the water system which caused wide spread flooding damage.
- Commissioning and implementing Written Schemes of Examination for example the hot water system (requirement to have written description of pressure systems)

These were just a few of the issues that the SEM and his colleagues had to address and note as defects and which required the management of the design and procurement process of various solutions to problems detected.

Maintenance of New Hospital

JL explained that there needs to be a Facilities Management System in place to create a list of planned maintenance tasks that need to be performed for each part of the building and the systems contained within the building. It is the responsibility of the contractor to ensure that such a system is in place before handover. Ideally, the Computer Aided Facilities Management (CAFM) Systems' efficacy would be tested 'end to end', before handover, to ensure that it was operationally appropriate, practical and efficient. It didn't appear that this level of assurance was achieved in this case or whether this was even a contractual obligation of the Contractor.

JL explained that the CAFM system normally used to contain the statutory inspections and routine maintenance checks that are required, such as lubrication of systems, validation air flows and operation of ventilation systems, changing of filters, flushing of water systems etc.

The CAFM should contain and identify the individual assets of a particular Engineering system, for example water, air, electrical etc. The Asset numbers for each part of the Engineering systems should be contained on the CAFM system. The identification of the asset through this numbering protocol is essential and the fundamental means of identification required to identify all of the Assets that need to be maintained. If this is programmed accurately and efficiently it should be a

very simple procedure to print off a list of the maintenance required at any one time, normally on a weekly basis. The CAFM system would normally also contain other basic but necessary maintenance records, operational manuals etc., for each system.

Multiplex had provided a system called Zutec which they considered to be a CAFM System. But this system was much restrictive and found to be difficult to use for the intended purpose as it required multiple actions to ascertain the maintenance required at any one time. Zutec also did not contain all the relevant parts of a service system, for example, parts of the water system were not recorded. It also contained incorrect identification Asset Numbers for parts of the Engineering systems or there were duplicate Asset Numbers, which made identifying the relevant part of a service system difficult, if not impossible.

JL explained that ideally, the contractor should walk the Facilities and Estate team through each system to provide a detailed understanding in addition to the provision of the operational manuals for each of the systems. This was not done effectively by the contractor in the opinion of all of the Estates staff spoken to.

JL explained that the absence of an effective CAFM System resulted in the Facilities and Estate team having to identify and renumber all of the Assets before being in a position to create a new CAFM system.This allowed a satisfactory maintenance programme to be developed. JL advised that the size of the hospital and scale of the systems in place did not make this an easy task and was a very time consuming process.

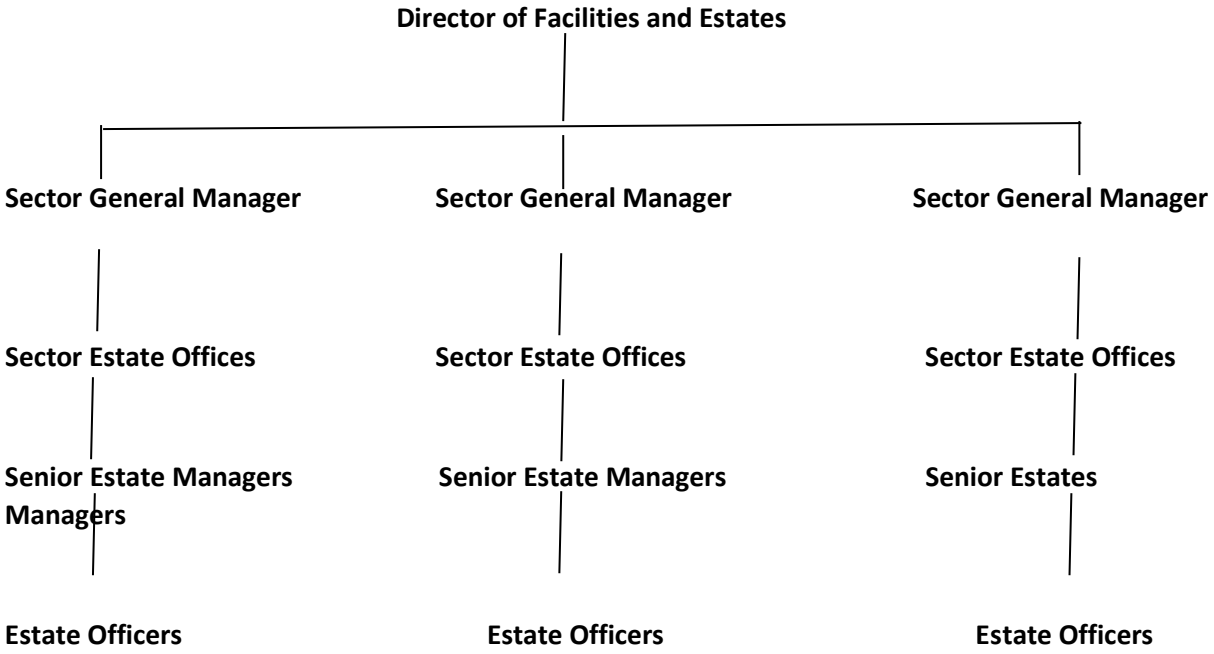
Lack of Operational Readiness

JL advised that the operational readiness for the hospital in terms of the Estate systems was far from optimum. The new hospital had been built on the site of the Southern General Hospital. Some parts of this hospital still remained on the site and the Estates team was based at this location. JL advised that there appeared to be confusion within the Estate team about their specific responsibilities for the maintenance of the new hospital. JL had been advised that there was no effective communication to individual Estates staff. It was therefore not clear how the existing team was to be integrated into the new site. It was also not clear how the other Estate teams from the other hospitals transferring to the new site, would be integrated into the existing team.

JL explained that from the interviews he conducted that it was apparent that the management structure of the Facilities and Estate team was quite weak with the numbers of Whole Time Equivalents (WTEs) being far less than thought by the Estates staff to be appropriate to effectively maintain the hospital systems. There was a lack of formally assigned roles and responsibilities within the team which would normally be expected to be put in place via the management structure.

JL advised that at this time, many of the Facilities and Team were newly promoted but despite this lack of experience in dealing with some of the major issues that were emerging, the small team reacted with tenacity, working long hours for extended periods of time. In JL's view the formal (Responsible Person / Duty Holder / Authorised Person etc) structure was dysfunctional. Added to that there was a high level of staff turnover in the team and as noted earlier this led to less than effective handover of work and activities.

The structure of the Facilities and Estate team was as follows:



JL advised that the General Managers (GMs) could not be expected to be 'expert' in every discipline they were responsible for. All of the GMs had individual expertise in specific areas of Estates and Facilities professions, but none of the GMs had specific expertise in an Estates function, (e.g. Engineering, Building Services etc). While there was estates and senior estate managers with specific engineering experience, the roles and responsibilities of these individuals appeared disjointed and confused. No individual had the formally appointed role of an Authorised Person (AP) for some specific Engineering systems.

Authorised Persons

JL advised that for certain services, such as for Water, Electrical Systems, Piped Medical Gas and Vacuum Systems there should to be an AP formally appointed to carry specific responsibilities for these specific Systems. This is laid down in the SHTM guidance and is part of the recognised structure recommended to manage the various Systems. a Statutory Instrument and is therefore required by law. It is the responsibility of the Board to ensure that such persons are in place. These individuals need to be trained and appropriately qualified to be able to advise on and manage the maintenance of such services. JL could find no evidence that such individuals had been appointed in the Estate team for the new hospital at the time of handover. It also appeared that no formal structure, commensurate with the SHTM guidance, had been put in place prior to handover of the hospital by the Contractor, despite the water systems being filled with water and effectively operating during this time.

Action on 2015 DMA Report

During this period the first DMA report was commissioned by the Senior Estates Manager. The assessment was completed by 29 April 2015 which implies that the investigation for the risk assessment was mainly conducted pre-occupancy of the building. The report was addressed to the Senior Estates Manager. It is not entirely clear when the final report was passed to the Estates team but it reviewed and signed off by the Director/L8 risk assessor on 1 May 2015. The report notes that

verbal (both informal and formal meetings) and email updates had been given to the Senior Estates Manager and an estates manager in their team.

JL advised that the report was given to the senior estates manager who reviewed it briefly but not in depth and then handed it off to the estate manager to action. JL explained that the 2015 DMA appeared to "get lost" and it was unclear who actually got the report with any specific instruction to action. JL advised that he was unable to identify any record or audit trail of what happened to the report. JL advised that a number of factors appeared to have caused this as follows:-

- The estates manager to whom the report was eventually handed off to, may not have had the relevant level of experience to recognise its urgency and effectively deal with the report's recommendations in respect of the water system;
- The report seemed to be handed off to a succession of individuals to find the person who would have been responsible for the maintenance of water systems and for that person to take action on the report; it was unclear who the relevant person was to action this report;
- There was a high level of turnover in the Estates team. It seemed that when the report eventually reached the most relevant person to action the report, this individual left and there was limited time for the handover, due to holidays and other work commitments. The quick succession rate meant that each handover became less and less detailed and complete.
- In addition given the emerging serious issues being identified with the new campus, the focus of the small, largely inexperienced team, was on keeping the hospital operating and trying to resolve the issues that could immediately affect patient care.
- JL advised that the lack of operational preparedness meant that a proper understanding and a record of the water system and its constituent parts was difficult to achieve. This would have made actioning the DMA report much more difficult in implementing the recommendations.

JL advised that the 2015 DMA report was a standard assessment and report that would have been normally requested by the Facilities and Estate team. Similar reports would be requested for other systems such as electrical, mechanical etc.

On receipt of the reports, the Authorised Person would discuss the recommendations with the assessor. Following discussions some recommendations (which are graded green, amber, light and dark red) might be changed depending on the responses and comments received from the AP or additional evidence provided by the AP.

Following this discussion the remaining recommendations would be adopted and action taken to ensure these recommendations were implemented by the AP/s team of estate managers or below. The report and it's recommendations are normally fairly routine, treated as day to day actions which would not normally be submitted for consideration by the GGC Board. This would normally only happen if any high risk was identified that could not be either removed or managed and mitigated. Where a severe risk is identified that cannot be appropriately managed it would be reasonable to assume that it would be escalated through the risk structure and added to the corporate risk register with its routine governance oversight.

Action on 2017 DMA Report

It had been suggested to JL that the second DMA report dated 2017 was commissioned shortly after receipt of the 2015 report was commissioned and was conducted during the period following the occupation of the hospital. Due to the hospital being occupied it took longer to conduct the assessment. The assessment was completed in stages as follows:

- Plant survey - completed 8 September 2017
- Outlets surveyed - 10 to 24 October 2017
- Management Review Meeting for Gap Analysis - 30 January 2018
- Final Submission of report - 25 April 2018

The recommendations contained in this report were very similar to those that had been included in the 2015 report. The report was handed over to a different member of the estates team] this time. Again, verbal and email communication had been exchanged as the assessment was progressing.

JL advised that this time recommendations in the report appeared to have been actioned and the work plans reviewed by JL appeared to confirm that this was the case. JL advised that at the time of his review, most of the recommendations had been put in place and a few [were in progress but were still to be completed. JL advised that the work plans appeared to be a combination of work identified by the team and also the DMA report recommendations.

Health Facilities Scotland Technical Report

JL advised that in March 2017 testing of the water was conducted. JL was advised that the National Protocol for testing water samples had been followed and the water samples examined for Legionella, Pseudomonas, Total Viable Count (TVC) and Coliforms.

JL understood that further Infection Control investigations, carried out as part of the Board's on going investigations had identified a number of microorganisms that are not routinely screened for. Jl had seen communications that identified these as:

- Cupriavidus Pauculus
- Pseudomonas Fuorescens
- Pseudomonas Aeruginosa
- Stenotrophomonas Maltophilia
- Acinetobacter Ursingii
- Enterobacter Cloacae
- Klebsiella Oxytoca
- Serratia Marcescens
- Pseudomonas Putida
- Pantoea sp
- Klebsiella Pneumonia
- Chryseomonas Indologenes

In addition to the organisms detailed above there was evidence of fungal growth in the water system however there have been no associated clinical cases reported. The results of this testing was reported to Health Facilities Scotland (HFS) by the Incident Management Team.

The HPS/HFS Team conducted a review and produced a Technical Report in July 2018 – this was later published in 2019. During the course of thetheir investigations, they reviewed documentation held

by the Facilities and Estate team. This resulted in the DMA 2015 and 2017 reports coming to light. It also highlighted that despite the presence and operation of a technical maintenance team in the new hospital, no formal appointments had been made to the structure for the management of the new hospital's water system as recommended in the Scottish Healthcare Technical Memorandum (SHTM) 04-01.

In May/June 2018, training was provided by external trainers to get members of the Facilities and Estate team accredited. JL and TS provided access to the certificates that had been awarded to members of the team. Accreditation was not just for water but for other technical services as well. The certificates are signed by an Authorised Engineer (AE). There are AEs for each major technical engineering services in healthcare premises e.g. water, electrical, medical gasses etc. The AE is an qualified, independent engineer who will assist the Board to undertake audit and provide general expert advice and guidance. The AE will also assist in ensuring the Authorised Persons are appropriately trained and otherwise qualified to be able to discharge their professional responsibilities and are considered capable to manage the safe operation of the appropriate Engineering system e.g. water system. There is a legal requirement for Authorising Persons to ensure that they are complying with their specific responsibilities. It was noted in an AE's audit which was conducted in May 2017 that the management structure was loose and lacked assigned roles and responsibilities. It also noted that there was no APs within the team and relevant training to become and AP was not in place or had been conducted, but the follow-up AE report indicated satisfaction at the very good progress that had been achieved with the structure and other elements.

A further DMA assessment was conducted in 2018. The recommendations from this report and also in the HFS technical report were fed into the action plan for the Facilities and Estate team. This resulted in the introduction of the chloride dioxide flushing regime being implemented in December 2018 which continues to the present day. Currently 142 water samples are take each week

The DMA 2018 report also led to a Water Technical Group being formed which is looking and considering the best technology to clean the water system and is referring to external experts and the AE. The group is also addressing and implementing the recommendations made in the DMA 2018 report. The chair of this group is also the chair of the National Advisory Water Group.

Restructuring of the Facilities and Estate team

The current Head of Estates (HOE) joined in Sept/Oct 2018. Following the appointment of the HOE, the structure of the Facilities and Estate team was re-organised (this was around 18 months ago). There was a separation of the Facilities activities from the Estate activities. In addition to this "Statement of Practice" and policies have been implemented to ensure consistency throughout the sector teams and allow movement of team members between different sectors. This is an attempt to increase the flexibility of each of the teams and eliminate the view that teams can only operate in one sector.

Greater interaction and co-operation between the sector teams is being encouraged and implemented such as through a combined "on-call system". This ensures that assistance can be provided at any time by any one rather than just being reliant on one person being present or available in the particular sector where the issue arose.

TS acknowledged that when any work was performed (e.g. maintenance, remedial work etc.) by the Estates & Facilities team which may have an infection risk, a risk assessment known as a HAI-SCRIBE is completed. This is required by HFS's standard SHTM 30 Part B. This requires an assessment to identify, eliminate or manage building environmental infection control risks where work is being carried out. It will also consider the impact on patient care. The key personnel involved will be the clinical team, infection control nurse (ICN) and infection control doctor (ICD). This risk assessment will be signed off either by the ICN and ICD.

Lessons Learned

JL and TS advised that a number of lessons could be learned from the building and operation of the hospital as follows:

- The method of procurement of large hospital facilities should be reviewed.
- The actual operational requirements of the hospital should be considered and planned well in advance of the completion of the facility rather than being considered once handover had been completed;
- Operational readiness in respect of the Facilities and Estate team should have be in place prior to handover, with all systems being tested end to end to assure the Board that everything is fit for purpose and operate with practical proficiency – the team should know the building inside out, how systems operated and maintenance regimes required;
- As well as the commissioning of the building, the people who will be working in the hospital should also be commissioned i.e. they should know how the hospital works, and how it can be used. The timescale to orientate staff to the building appeared to be insufficient.
- The above was made clearly evident when after opening the Accident and Emergency waiting times grew increasing long. This was caused by staff not having a clear understanding of how the building worked and was laid out.
- Some aspects were constructed after the completion of the hospital – such as car parking. This initially caused chaos with much inconvenience to the public and staff and criticism was received, accompanied by widespread negative media coverage.
- Although the new hospital was designed to be operationally efficient, there was a lot of new technology (at the time) installed. This required much more maintenance than the systems available in the demitting hospitals. Maintenance is essential to ensure that it was maintained to appropriate safety standards and kept in optimal condition. The size of the building also increased the amount of time required to perform maintenance.
- The maintenance budget provided was a fraction of that considered appropriate by Estates & Facilities. This meant that some repairs/replacements needed to be funded from other budgets, (e.g. minor capital funding), and therefore it took longer to effect the repair/replacement etc. TS indicated that in these situations, it is often considered by Estates & Facilities teams that the matter of resources should not be raised because of a general belief that there was no money to rectify such issues. The method of establishing operational budgets and staff resources need to be scrutinized meticulously and established for the life cycle of the facility. This is the process adopted for PPP procurements, so it is

difficult to understand the rationale for an alternative without compromising safety and legal compliance.

- The hospital is comprised of single rooms with no general wards. One simple defect can affect capacity as a complete room would need to be closed if a tap washer was required on the room's wash hand basin, whereas this may not happen in a general ward where there would be other wash hand basins in the same space.
- Once the hospital was handed over, there were mixed opinions from the interviews JL conducted, with regard to response from the contractor when faults and defects, thought to be the responsibility of the contractor, were identified. The process of reporting defects to the contractor was considered over-bureaucratic and resulted in a reluctance to use the process. Some reported the contractor's response was good whilst the majority opinion was that the contractor was unresponsive and aggressively defensive when issues were reported.
- Political pressure was also being felt and no consideration was given to delaying the opening of the hospital despite the issues being faced with completion and operation.
- The process of contractual derogations and variations needs to be improved and the people considering them need to be suitably qualified and experienced to understand the implications of their decisions.
- Designs need to be led by the principle objective of achieving the safest, optimum clinical provision with systems designed with robust contingency and resilience with it green credentials being a high priority, but firmly behind these other priorities. Achieving these priorities needs to be achieved by the most economically efficient means, but this, together with the ease of construction should be secondary.
- The drive to minimise the cost/m2 should be secondary to achieving the safest, most resilient clinically appropriate facility.
- The duties of the technical consultancy support to Health Boards need to be more closely defined and they should also have some contractual accountability for their actions.

Glossary

1 L8 – Approved Code of Practice, published by the HSE as guidance aimed at dutyholders, including employers, those in control of premises and those with health and safety responsibilities for others, to help them comply with their legal duties in relation to legionella. These include identifying and assessing sources of risk, preparing a scheme to prevent or control risk, implementing, managing and monitoring precautions, keeping records of precautions and appointing a manager to be responsible for others.

Review;

Patients with Acinetobacter baumanii in Ward 1d, June 2016-06-28

Patient 1: [redacted]

Hypoplastic aortic arch, VSD, small apex forming L ventricle. Born [redacted] and admitted to [redacted], transferred to Ward 1d.

DoB: [redacted]

DoA: 10/06/16

DoSp: 16/06/16 BBal *Acinetobacter baumanii*

Surgical procedure:
13/06/16 Mr Peng / Gabir : Application of R and L pulmonary arterial bands

Movement

10/06/16 – 12/06/16 Bed 15 (multi 13-15))

12/06/16 – 15/06/16 Bed 20 (multi 19-22)

15/06/16 - bed 13 (13-15)

Patient 2: [redacted]

DoB [redacted] - NICU

DoA: 20/05/16

DoSp: 07/06/16 BBal *Acinetobacter baumanii*
13/06/16 BAL *Acinetobacter baumanii*
18/06/16 BBal *Acinetobacter baumanii*
25/06/16 BBal coliform bacilli

Surgical procedures:
10/03/16 Mr Pend / Gabir / Goldie / Jutta: Arterial switch procedure

23/05/16: Mr Peng / Danton: Ghent : Sternotomy, coronary artery procedure, mitral valve partial Anuloplasty

24/05/16: Mr Peng / Gabir / Ghent : mediastinal exploration

25/05/16 Mr Gabir / Peng : Take down ECMO

Movement

20/05/16 Ward 1e; Bed 6 (SR)

22/05/16 Ward 1d; Bed 17 (SR)

22/05/16 Ward 1d; Bed 19 (19-22)

Overlap:

Both cardiac patients

Both cardiac surgery prior to acquisition

Patient 2 in room 108 since 22/05/16. Acquired AB 14 days after cardiac surgery

Patient 1 in room 108 since 12/06/16. 4 days later acquires AB while next to [redacted].

Patient 1 possible transient colonisation from patient 2?

Review of Healthcare Infection Incident and Outbreak Reporting Templates (HIIORT) scored RED/AMBER in NHSGGC 2015-2019

In total there were 40 HIIORTS completed from 2015 to 2019.

Year	No. of HIIORTs
2015	1
2016	8
2017	15
2018	9
2019	7

The incidents/outbreaks were assessed and recorded as:

RED	16
AMBER	23
GREEN	1

4 HIIORTs were initially assessed as AMBER but were escalated to RED during the incident. This is clearly documented in the HIIORT

Overall the HIIORTs give a good summary of the reason why it is being completed and the progression of the outbreak/incident

Several of the HIIORTs covered outbreaks/incidents over several months and there is comprehensive notes recorded following each IMT/review of the HIIAT.

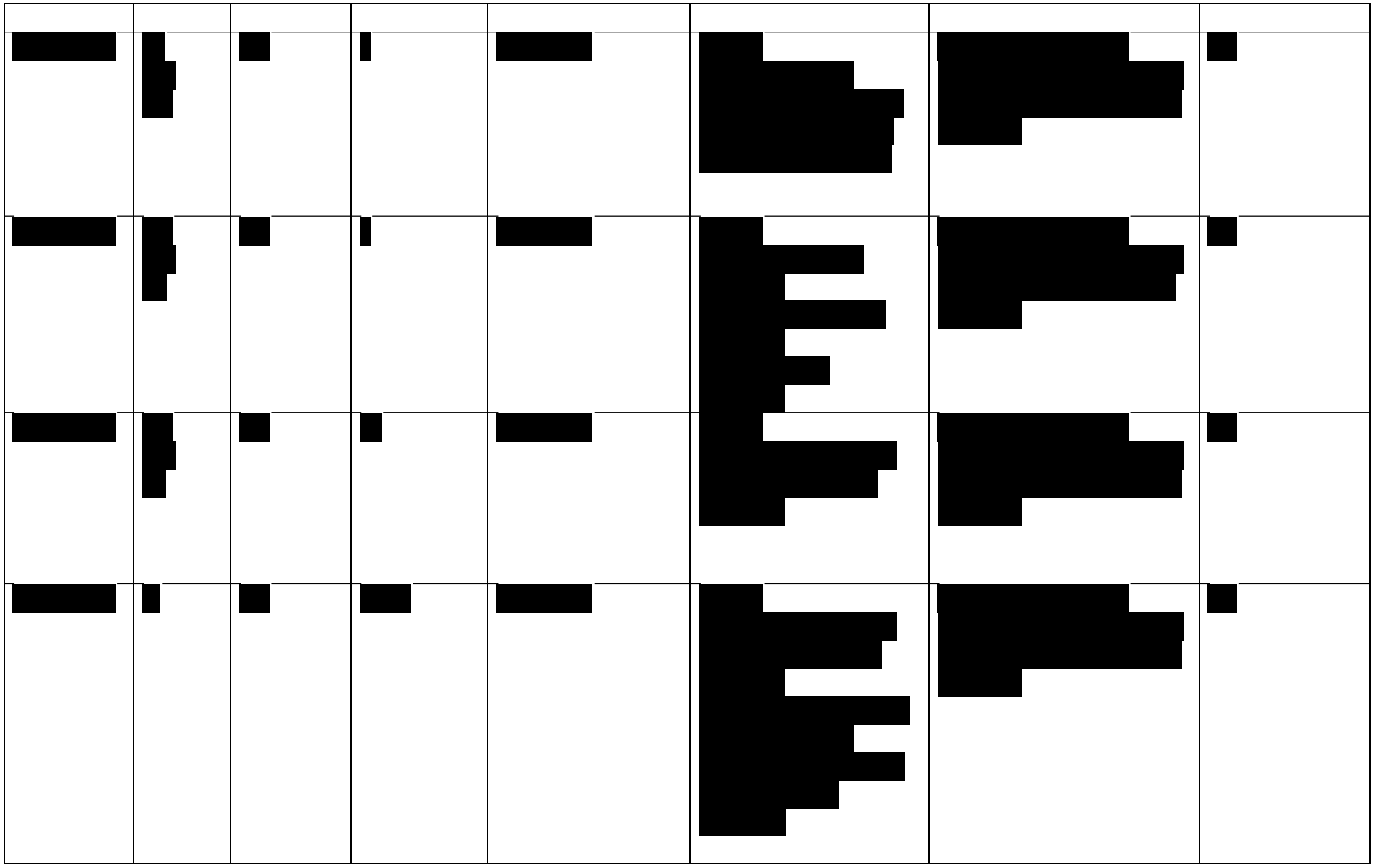
Not all HIIORTs have the fact that the outbreak is over or that a final HIIAT has been assessed as GREEN recorded.

One HIIORT appears to have been started but not updated during the outbreak. There are IMT minutes and actions and a final outbreak report for this outbreak.

HIIORT DATE	AUTHOR	HOSPITAL	WARD	REASON/ORGANISM	INITIAL HAIIT	DOCUMENTATION	DE-ESCALTION TO GREEN HIIAT RECORDED in HIIORT
2015							
[redacted]	CW PJ	RHC	NICU	Serratia marcescens 13 cases, 12 asymptomatic colonisation, 1 symptomatic	[redacted]	[redacted]	[redacted]
[redacted]							
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	AMBER Impact on patient – minor/moderate	One narrative update recorded. Dates of meeting	Yes

				9 infant contacts	Impact on public health – moderate Impact on public anxiety - moderate	recorded.	
05/08/2016	SDe	RHC	2A	Aspergillus 1 confirmed case 1 probable case	AMBER Impact on patients – moderate/major IMT agreed to HIIAT as above	IMT date recorded. Documentation of control measures. Once probable case identified as not being aspergillus. Incident closed down	
10/08/2016	PJ TI	RHC	NICU	Serratia marcescens 8 cases all colonisations	GREEN From HIIORT "This has been classified as GREEN as all the patient have been asymptomatic however weekly screening since mid June has identified 8 cases two of which were identified this week. Due to the increase in numbers we have completed the HAI-ORT and would appreciate if the SGHD were made aware of this situation"	Documentation of control measures. Dates of IMT's recorded. Narrative updates recorded.	N/A
02/11/2016	PJ TI	RHC	NICU	Serratia marcescens 3 cases all colonisations	AMBER Impact on public health - moderate Piloting new HIIAT if using old HIIAT this	Documentation of control measures. IMT dates recorded Narrative updates recorded	No but closure of incident recorded

					would have been GREEN		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
2017							
14/02/2017	SJ SDe KMcD	[redacted]	OPD	Endophthalmitis	RED Severity of illness - major Impact on services - moderate	Documentation of control measures. IMT dates recorded. Narrative update recorded.	Yes
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]



[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
03/11/2017	SDe	QEUH/[redacted]	10D/3C	CRO pseudomonas	RED Impact on services – major Severity of illness, risk of transmission and public anxiety all moderate	Documentation of control measures. IMT held. 1 definite and 2 probable cases, on typing all 3 specimens were different. Recorded in narrative and incident closed.	Yes
22/12/2017	PJ	QEUH	53,54,55	Influenza A and Norovirus	AMBER Severity of illness, Impact on services and risk of transmission - moderate	IMT date recorded. No narrative updates.	No
10/03/2017	TI SDo	RHC	PICU	Serratia marcescens	AMBER Impact on patients and	One narrative update	No

					public health both moderate. HIIAT escalated to RED Impact on patient - major	recorded.	
14/04/2017	AD	RHC	2A	Rotavirus and Astrovirus	RED Impact on patients and services - major Risk of transmission - moderate	Documentation of control measures. IMT's held. Narrative updates recorded.	No
28/04/2017	TI SDo	RHC	2A	Aspergillus fumigatus	RED Severity of illness – major Risk of transmission - moderate	Documentation of control measures. IMT's held. Narrative updates recorded. This may same one as on other sheet - SA	Yes
29/05/2017	SDo CP	RHC	3A	Varicella zoster	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. PAG x2 held Narrative update recorded.	Yes
26/07/2017	AD SDo	RHC	2A	Stenotrophomonas maltophilia	RED Severity of illness - major	Documentation of control measures PAG held. No IMT's Reason recorded in HAIORT Narrative updates recorded.	Yes

2018							
[redacted]	[redacted]	[redacted]	[redacted]		[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
26/06/2018	TI SDe AB LP	QEUH	Spinal Unit	CPE Klebsiella	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. Narrative update recorded.	Yes
20/12/2018	TI SDe LP SDo	QEUH/RHC	Haematology	Cryptococcus neoformans	RED Severity of illness and public anxiety (in this group of patients) – major Risk of transmission –	Documentation of control measures. Narrative updates recorded.	Yes

					moderate		
01/03/2018	TI SDo	RHC	2A	Cupriavidus pauculus Pseudomonas aeruginosa	RED Severity of illness – moderate Risk of transmission – major	Documentation of control measures. IMT's held, Narrative updates recorded.	No
09/04/2018	SDo AM	RHC	2A	Astrovirus	AMBER Impact on services and risk of transmission – moderate	Documentation of control measures. PAG held.	No
18/05/2018	TI SDo	RHC	2A	Stenotrophomonas maltophilia	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. PAG held No narrative recorded	No
04/06/2018	TI SDo	RHC	2A	Various Gram negative organisms	RED Severity of illness, risk of transmission and public anxiety – major Impact on services moderate	Documentation of control measures. IMT's held. This was a prolonged incident over several months	No
2019							
15/02/2019	LP	QEUH	ITU1 & ITU 2	Mucoraceous Mould	RED	Documentation of control	Yes

					Severity of illness and public anxiety - major Impact on services and risk of transmission – moderate	measures. IMT's held. Narrative updates recorded.	
15/03/2019	TI LP	QEUH	Renal	Acinetobacter baumannii CRO	AMBER Risk of transmission and public anxiety – moderate	Documentation of control measures. IMT's held. Narrative updates recorded.	Yes
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
20/06/2019	TI SDo	RHC	6A	Various Gram negative organisms	AMBER Severity of illness,	Documentation of control measures. IMT's held	Yes

				Mycobacterium chelonae	impact on services and public anxiety all moderate. HIIAT escalated to RED Severity of illness – major.	Narrative update recorded.	
23/09/2019	KH	RHC	PICU	Pertussis	AMBER Severity of illness and risk of transmission - moderate	Documentation of control measures. IMT held. Narrative update recorded.	Yes

Summary of Incidents and Outbreaks on Ward 2A since 1st March 2017

Ward 2A, RHC, is a 25 bedded Haemato oncology ward which cares for some of the sickest children in the hospital. Many of these patients have complex medical diagnosis and are very immunocompromised. Since the beginning of March, a number of incidents and outbreaks have been recognised in this ward requiring a high volume of Infection and Prevention Control Team resource and input, creating an increased workload for staff with associated anxiety and stress and detrimental outcomes for patients. Below is a list of the outbreaks and incidents since 1st March 2017.

Date	Incident	IPC Actions	Outcomes
28/02/17	X3 cases of Elizabethkingia miricola isolated from patient line cultures. This is a very rare organism and associated with water and environment.	Problem Assessment Group (PAG) convened 3/3/17. • HIIAT Green. • Review of vent cleaning and maintenance by estates. • Lab sampling of vents and water outlets for analysis. • Infection Prevention and Control Nurse (IPCN) carried out visual inspection of environment.	• All 3 strains unique • Water and vent testing negative • Incident closed 27/3/17 • Water testing of chilled beams was negative
03/03/17	Increased bacteraemia rates. General upward trend identified since July 2016. 11-13 positive blood cultures per month.	PAG convened 3/3/17. • HIIAT Green • Observational review of line care carried out by IPCNs – poor practices identified. Report collated and fed back to clinical team. • Review of environment for reconstitution of medications – inadequate space available and IV drugs therefore being prepared on a corridor worktop. Suggestions for improvements submitted. • Quality Improvement group focusing on Catheter Associated Blood Stream Infections (CLABSI) developed by Dr Timothy Bradnock. • Review of line care in Royal Marsden and Great Ormond Street Hospital by Lead IPCN – Findings relayed to CLABSI QI group and local teams.	• Continued high rates of bacteraemias within the unit. • QI group continue to meet and work on various aspects of action place specific to line care however as yet, no changes have been implemented.

Date	Incident	IPC Actions	Outcomes
03/03/17	Perceived increase of invasive fungal infections first highlighted by medical staff.	PAG convened 6/3/17. • ICD carried out review of invasive fungal isolates and in general did not find rates of invasive Candida infection to be any higher however it was recognised that there had been 3 cases of invasive Aspergillus fumigates infection within an 8 month timeframe which was higher than expected. Incident Management Team arranged for 7/7/17 specific to Aspergillus (see next entry).	• Incident specific to invasive Candida infections closed 06/03/17.
07/03/17	3 cases of invasive Aspergillus. All 3 cases were significantly affected and had increased morbidity as a result. 1 patient spent a lengthy period in PICU and 1 patient required lobectomy. All 3 had chemotherapy postponed and required long term anti fungals.	IMT convened 7/3/17. • HIIAT red and subsequently reported to HPS. • Non BMT patients therefore not in specialist ventilated area of ward • Review of construction and demolition works on and around the site by IPCT and exposure to patients. • Review of CLIC sargent house (Resident facility for patient and families of RHC) as possible risk by IPCT. • Review of general ward environment by IPCT for water leaks/estates works which may have exposed patients – a subsequent inspection by IPCT found mouldy ceiling tiles. Inspection of full ceiling void then followed and necessary repairs carried out. • General cleaning of ward found to be inadequate - Full terminal clean of ward took place. • Inspection of cooling beams which were reported to leak periodically. • Air sampling ongoing and water sampling carried out. • Hand hygiene audit carried out – Scored 85% • Anti fungals administered to all ALL patients on commencement of treatment.	• All 3 patient cases recovered from the episode of Aspergillus infection and HIIAT was downgraded to Amber then eventually green once ceiling void repairs had been carried out. • Incident closed 28/4/17. • Ongoing surveillance reliant on clinical teams reporting a clinical diagnosis of Aspergillosis as lab testing is not reliable. To date, IPCT have been alerted to possible cases only after querying any new cases with clinical teams. • ICD working with estates colleagues to produce a water damage policy

Date	Incident	IPC Actions	Outcomes
11/4/17	Increased incidence of Vancomycin Resistant Enterococci (VRE) isolates in stool. Total of 9 cases over 1 month period (previously 2 cases over 6 months). 8 of the 9 are HAI, 1 of which is to [redacted]. VRE not the cause of GI upset however will be dispersed into the environment if patient having loose stools for any reason .	• PAG convened 12/4/17. The incident then became an outbreak of Rotavirus and Astrovirus (tabled below). • Review of antimicrobial prescribing carried out which revealed a marked increase in the use of Vancomycin and teicoplanin most likely as a result of the increased bacteraemia rates. • All isolates sent for typing – 4 patients had matching strains. The rest were unique. • Full terminal clean of ward carried out. • Actichlor cleaning daily previously discontinued across GGC after winter then resumed on a permanent basis for this ward. • Enforce use of Bristol stool chart to accurately record which patients were having loose stools. Further PAG held 28/4/17 after Astrovirus/Rotavirus outbreak was closed. • Action plan developed mainly focused on reduction of bacteraemia rates. • Increased visits to ward by IPCNs to reinforce Standard Infection Control Precautions (SICPs), Transmission Based Precautions (TBPs) and hand hygiene.	• Total cases now 10 with only 1 new HAI since the initial reporting. • Ongoing monitoring by IPCT. • Action plan still ongoing.
12/4/17	Rotavirus and Astrovirus outbreak. Lasted 14 days affecting 9 patients with 1 patient admitted to PICU as a direct result of vomiting associated with Astrovirus. Significant impact on service with transplant cases being diverted to Edinburgh.	PAG convened 12/4/17 initially to review VRE increase. PAGs held over subsequent days then identified the transmission of Rotavirus and Astrovirus. • HIIAT initially Amber then upgraded to Red following transfer of patient to PICU. • Infection Prevention and Control Audit (IPCAT) carried out 20/4/17. Scored within green range (87% overall) however significant concerns with cleaning standards (scored 33%) despite twice daily	• Ward reopened 25/4/17 with an increase in staff numbers to allow for burden of patients in isolation. • SICPs audit repeated with SCN and IPCN. Scored 96% although some environmental issues identified again. • Hand hygiene sessions ongoing. • Agreed to increase domestic hours in Ward 2A.

		cleaning prior to audit and terminal clean in previous days. • Extensive cleaning carried out and external contractor brought in to terminally clean ward before reopening. • Hand hygiene audit – scored 70%. Poor practice amongst medical staff. • Hand hygiene education sessions provided – currently 8 sessions carried out. Poor attendance by medical staff. • Daily IPCN visit to ward, sometimes twice daily. • Daily IMTs. • Staffing levels were increased on the ward. • Meeting held with Infection control doctor, GM facilities and GM of Ward 2A to discuss cleaning concerns on the ward.	• SOP to be developed in relation to access to clean arrangements • SLWG to be established by GM facilities to look at novel technologies i.e. hydrogen peroxide
30/5/17	3 cases of Norovirus on ward, 2 HAI, 1 non HAI. All 3 symptomatic and nursed in rooms in close proximity to each other.	PAG convened 31/5/17. • HIIAT green. • IPCAT audit repeated 1/6/17 – poor score of 74% (SICPs 69%, SPE 69%, TBPs 94%, QA 50%) • Hand hygiene audit carried out – results awaited. • Daily visits to ward • Meeting requested with facilities management again to discuss cleaning standards on the ward.	• Ongoing daily assessments • Education to be arranged for staff re. SICPs.

QEUH AE Water Audit

	Sector	Site	Serial	Risk	Action By	Reference	Action Required	Responsible Person	Comments	Status	Target Date	Date Action Completed	Funding Required	Amount Required	EAMS Number
1		12 February 2018 to agreed date													
2	Date of Audit:	04/05/2017	New	Total Actions		Not Started	In Progress	Completed	Withdrawn				Actions where funding is required	Amount required	
3	Date of Next Audit:			95			1	94	0					£0.00	
4															
5		Total Monies required for Action Plan				£0.00		Overall % Compliance	99%						
6															
7	QEUH		1			Is there a written risk assessment in place for the building water systems?	DMA Water completed the current and only risk assessment for the QEUH on 29th April 2015. This risk assessment was completed approximately two months before the hospital was formerly opened for public use. No risk assessment, reflecting the actual operational characteristics of the water system now that the building is in full use, has been completed. It is recommended that a new risk assessment is completed as a matter of urgency on the QEUH.		02/05/18 New Risk Assessment completed by DMA water on Site survey completed 8th September 2017 (Plant) Outlets surveyed 10th, 12th, 13th, 16th, 20th & 24th October 2017 Management Review Meeting for Gap Analysis, 30th January 2018	Completed		08/09/17			
8	QEUH		2			When was the risk assessment completed and delivered to site?	Unsure of the risk assessment document handover date. The handover date is not noted on the current risk assessment document.		02/05/18 Allan McRobbie DMA Canyon Forwarded the up to date Risk assessment. Site survey completed 8th September 2017 (Plant) Outlets surveyed 10th, 12th, 13th, 16th, 20th & 24th October 2017.	Completed					
9	QEUH		3			What are the site/organisation plans with regard to reviewing or redoing the risk assessment?	There are no specific plans detailed for re-assessing the property. As stated earlier in this report it is recommended that a new assessment is completed as soon as possible.		24/05/18 Regular review of RAs carried out operationally.	Completed		24/05/18			
10	QEUH		4	0		Does the risk assessment address all the water systems in the building? Are there any systems that are defined as being excluded from the assessment in the RA scope?	There are two renal dialysis water systems on site. These systems are operated by Medical Physics. There are a number of systems mentioned on site which were also included in the risk assessment. These systems include dental equipment, emergency showers, a hydrotherapy pool, irrigation systems, Whirlpool/Arjo baths, irrigation systems, Sprinkler/wet firefighting system, endoscopy wash system, water softeners, and adiabatic cooling systems. A short description of each system, and its likely risk implications are covered in section 8 of the risk assessment document. These systems should be revisited and reassessed when completing a new risk assessment.During the audit it was noted that there is a water storage tank in a Floor 12 plant room which serves the fire suppression system for the helipad. Water from this tank mixes with foam suppressant. It may be that the pumps from this tank are tested weekly and this may result in the creation of aerosol from an otherwise stagnant tank. This tank should be included in any new risk assessment.		24/05/18 02/05/18 New Risk Assessment completed by DMA water.	Completed		24/05/18			
11	QEUH		5			Does the risk assessment review any previous risk assessment document, with particular attention being paid to the completion of identified remedial tasks identified in the previous risk assessment?	There was no previous risk assessment to be reviewed as this was a new build project.		02/05/18 There was no previous risk assessment to be reviewed as this was a new build project.	Completed		02/05/18			
12	QEUH		6			Does the risk assessment review the current risk reduction processes and procedures that are currently in use at the site?	n/a. There were no previous risk reduction processes and procedures in use on the site as this hospital was a new build project.		02/05/18 There was no previous risk assessment to be reviewed as this was a new build project.	Completed		02/05/18			
13	QEUH		7			Does the risk assessment contain details of the people/organisations who are involved in the risk reduction processes and procedures? This should include comments on the Dutyholder, the responsible person, any deputy responsible persons and also service providers and contractors.	Section 9 of the risk assessment covers the details of management and responsible personnel on site. However the details in this section state that names of responsible people and duty holder are to be confirmed by NHS GGC. There is no indication that this task has been completed. There have also recently been a number of changes to the management structure within the hospital. The names and roles of the involved people should be identified and included in a new risk assessment. No contractors had been appointed at the time of the current risk assessment. Therefore all management and control information requires to be updated.			Completed		04/07/18			
14	QEUH		8			Is there an assessment of the competency of all involved parties?	No. No specific people identified and therefore it is not possible to make comments on individual's levels of competency.		24/05/18 Training commenced. 05/07/18 COLIN PURDON- All involved personnel have now been identified and defined in the Master Written Scheme for QEUH Campus. AP training and appointment complete. CP training complete. RP and DRP appointments have been made.	Completed		05/07/18			
15	QEUH		9			Is there an assessment of the existing written scheme, including current risk reduction process and procedures in the risk assessment?	No – no existing written scheme was available as the site was a new build.		24/05/18 DMA completed RA & incorporated WS.	Completed					
16	QEUH		10			Does the risk assessment specifically address and comment on evidence of the current defect/remedial action processes and procedures?	No – there is no evidence that the current remedial requirements are being addressed.		02/05/18 New Risk Assessment document now addresses remedials.	Completed					
17	QEUH		11			Is there an assessment of the susceptibility of persons who may be affected by the building water systems?	It is stated in the assessment that there will be areas with particularly susceptible people in the hospital.		02/05/18 New Risk Assessment document now addresses outstanding point.	Completed					
18	QEUH		12			Is there a schematic diagram provided with the risk assessment?	There was a set of as fitted drawings for all the water systems in the hospital available at the time of the risk assessment.		02/05/18 Schematics stored on Zutec.	Completed					
19	QEUH		13			Was the provision of a schematic diagram by the risk assessment company part of the scope of supply?	Unknown if this was part of the scope of supply.		08/05/18 The provision contained no schematic diagram request, however, Schematics stored on Zutec.	Completed		08/05/18			
20	QEUH		14			Is there an assessment of the availability and validity of an up to date schematic diagram?	Yes.			Completed					
21	QEUH		15			Is there a new written scheme provided as part of the risk assessment?	General guidance is given on what should constitute a written scheme in section 10 of the risk assessment document.		05/07/2018 Andy Wilson: There is a new master written scheme in process to cover improvements to processes and procedures to manage water safety across the campus.	Completed		05/07/18			
22	QEUH		16			Does the assessment contain details of all the component parts of the water systems? This could include tanks, calorifiers, pipework and pipework layout, outlets, TMV's, expansion vessels etc etc etc.	Yes.		08/05/18 Risk Assessment makes reference to tanks, etc.	Completed		08/05/18			
23	QEUH		17			Is consideration given to system design, flow, temperature and the opportunity for bacteria to grow and develop in the water systems?	Yes. This covered in detail in the risk assessment.		08/05/18	Completed		08/05/18			
24	QEUH		18			Does the risk assessment identify any particular areas of spray and aerosol creation?	Yes – these areas are noted in section 7 of the risk assessment document.		08/05/18	Completed		08/05/18			

	Sector	Site	Serial	Risk	Action By	Reference	Action Required	Responsible Person	Comments	Status	Target Date	Date Action Completed	Funding Required	Amount Required	EAMS Number
25	QEUH		19			Are areas of low use and low flow identified in the risk assessment?	Yes – these areas are noted in section 7 of the risk assessment document. It should be noted that as the building was not in full use at the time of the assessment, this information is likely to change when a new assessment is completed.		08/05/18	Completed		08/05/18			
26	QEUH		20			Are dead legs specifically detailed in the risk assessment?	Deadlegs are noted in section 7 of the risk assessment.		08/05/18	Completed		08/05/18			
27	QEUH		21			Is there a set of remedial actions clearly identified in the risk assessment?	Section 2 contains details of the recommended remedial actions. These are also assigned a remedial action urgency category to assist in prioritizing the required/recommended works.		08/05/18	Completed		08/05/18			
28	QEUH		22			Is there a clearly explained risk scoring system in the risk assessment?	The risk scoring system is explained at the beginning of section 2 of the risk assessment document.		08/05/18	Completed		08/05/18			
29	QEUH		23			At what level of risk is the building/property assessed to be at?	Various areas of the hospital are assessed as being areas of high risk.		08/05/18	Completed		08/05/18			
30	QEUH		24			Are schematic drawings available in the written scheme, or in some other place in the property?	A copy of some drawings was available in the folder entitled "Monthly Sentinal (this should be sentinel) Water Temps". They are in A3 format and are difficult to read. They are floor plan drawings and do not cover the water systems. Full sets of as fitted drawings are stored electronically. Although it was stated that there were very few changes or amendments made to the water systems, it is unlikely that any amendments have been made to the as fitted drawings. A set of up to date drawings, reflecting any changes in the water systems since they were brought on line, should be created. Given the size of the building and number of drawings involved, it would make sense to continue to store these electronically. If that is the case then access should be available to the responsible person and anyone else who may need it in order to complete work on the water systems.			Completed					
31	QEUH		25			Do the schematic drawings show all the components of the water systems?	The drawings show all the required components of the water systems.		08/05/18	Completed		08/05/18			
32	QEUH		26			Are there system deadlegs included in the schematic drawings?	No obvious dead legs will be shown in the in the schematic drawings.		08/05/18 Check risers in Childrens. 03/07/18 COLIN PURDON- Deadlegs would not ordinarily be shown on the water systems schematics. Where deadlegs are identified they should be recorded in the Water Logbook for the Block/Building and scheduled for removal as soon as possible. Removals should be recorded by date, person carrying out the work and schematics should be updated to reflect any changes.	Completed		03/07/18			
33	QEUH		27			Are the water system return legs shown on the schematic drawings?	The hot water return legs are shown on the as fitted drawings.		08/05/18	Completed		08/05/18			
34	QEUH		28			Are secondary and tertiary loops shown on the drawings?	The drawings are laid out by floor. There will be a number of secondary loops and these should be identified from the drawings to ensure that the correct outlets are being temperature monitored as directed in the HSG 274 guidance.		08/05/18	Completed		08/05/18			
35	QEUH		29			Have any amendments been made to the schematic drawings?	No.		08/05/18 Annual review added to the Master Control Logbook.	Completed		08/05/18			
36	QEUH		30			If amendments have been made are they signed and dated?	Not applicable		08/05/18	Completed		08/05/18			
37	QEUH		31			Is there any indication that drawings are regularly inspected and updated if required?	No. It is recommended that drawings are amended as any changes are made to the pipework systems. An annual review of the drawings is also recommended.		24/05/18 An annual review of drawings and schematics has been scheduled within the Master Logbook.	Completed		24/05/18			
38	QEUH		32			Is there a duty holder and responsible person nominated in writing?	There is a folder entitled "Water Safety Log Book" in the Estates office. This folder has, as section 3, information titled "Management of Water Systems". There is a description of roles and responsibilities in this section. This section gives a generic description of the roles. It looks like the description of the roles is identical to what would be found in the NHS GGC policy document. It states in this information that details of all named persons for these roles are kept in the site written scheme. However none of this information could be found on site. A copy of the required detailed information should be added to the written scheme on site.		24/05/18 This information is outstanding and Colin Purdon to email. 03/07/18 COLIN PURDON- I have attached the table of Roles and Responsibilities to this Smartsheet line. Interpreting that the Duty Holder is automatically appointed based on position; therefore Jane Grant as Chief Exec.	Completed		03/07/18			
39	QEUH		33			Is there a clearly defined management structure which includes the relevant on site personnel and also all service providers and contractors?	No named management structure available on site. One should be created and added to the written scheme on site.		24/05/18 List advised by Ian Powrie.	Completed		24/05/18			
40	QEUH		34			Is there a clearly defined line of communication in the written scheme?	No. As in points 32 and 33 above, contact details and lines of communication should be clearly defined and added into the written scheme.		24/05/18	Completed		24/05/18			
41	QEUH		35			Are the responsibilities of all involved parties clearly defined in the written scheme?	A complete written scheme is not available on site. A full written scheme, in accordance with the requirements as outlined in Appendix 2 of the HSG 274 document should be created for the site.		24/05/18	Completed		24/05/18			
42	QEUH		36			Are copies of the involved on site personnel training records available in the written scheme?	All site Estates' personnel have a specific training file which lists details of all courses that have been attended. As a consequence of this, the details of training course attendance was available on site. There was no form collating the training records. A collated form such as this can be useful in identifying and planning future training needs. Consideration should be given to creating a form which carries the training details of the involved on site staff.The on site Estates' Manager who has day to day responsibility for the operation of the risk reduction processes and procedures has recently been appointed. The manager has not had any water or legionella based training. The manager is not an authorised person. Training, and the appropriate competency check, should be arranged as soon as possible fro the Estates' Manager.		08/05/18 Central Training Record held by Joe MacIlwee on behalf of NHGGG&C.	Completed		08/05/18			
43	QEUH		37			Do all staff have relevant up to date training in place?	It was not possible to state as to whether all the relevant staff have received training as a full list of all the relevant staff was not available in the written scheme or any of the on site log books.		08/05/18 Mark McInally, Willie Fenn and Shaun O'Neill + Paul Shorts outstanding. Training to be identified in PDP.	Completed		08/05/18			
44	QEUH		38			Is there evidence available in the written scheme of the competency of service provider and contractor staff?	Evidence of the contractor competence was not available in the written scheme. There is not a formal written scheme available on site. However, DMA Water, the contractor who completed the risk assessment in April 2015, did include a copy of their Legionella Control Association accreditation in the risk assessment document. Copies of the training records of the DMA staff involved in the creation of the risk assessment were also included in the risk assessment document. It is recommended that any contractors who are working on the water systems on site are able to show proof of competency for the work being completed. This should, fro example, include plumbing contractors who may be used on the site. The on site involved Estates' staff should ask for copies of proof of competency for any contractor's staff who will be working with the water systems on site.		08/05/18 Awaiting response from Procurement in respect of contractor competency, however the Written Scheme does detail contractors. 03/07/18 C.Purdon: This point has been addressed by ensuring that contractor and service provider competency is checked as part of a 6 monthly review of the Master Written Scheme, Section 3.10. 05.07.2018 A.Wilson: All future plumbing frameworks will contain a clause regarding training of plumbers as competent persons in a healthcare environment.	Completed		05/07/18			
45	QEUH		39			Are service providers and contractors LCA accredited or do they have other means of proving competence?	The risk assessment contractor is LCA accredited. No other contractors are currently used on site for the provision of risk reduction processes and procedures on the hot and cold water services.		08/05/18 DMA accredited.	Completed		08/05/18			

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46	QEUH		40			Is there a formal contractor management process in place? If so what format does this take?	There does not appear to be a formal contractor management process in place. There was no evidence of contractor management in the on site records. The only contractor that appears to be used for risk assessment and cleaning and disinfection works appears to be DMA. There are no minutes or records of any review meetings having been held with DMA. NHS GGC should consider what contractor management processes should be introduced to ensure the quality and standards of the contractors are acceptable.		08/05/18 Awaiting Ewen Forsyth confirmation of contractor management. 03/07/18 COLIN PURDON- Section 3.10 addresses this requirement and identifies the need for 6 monthly audit of contractor competence. It also includes guidance for managing contractors. 05.07.2018 A.Wilson: All future plumbing frameworks will contain a clause regarding training of plumbers as competent persons in a healthcare environment.	Completed		05/07/18			
47	QEUH		41			Is there evidence available in the written scheme of review meetings with service providers and contractors?	No.		08/05/18 Awaiting Ewen Forsyth confirmation of contractor management. 03/07/18 COLIN PURDON- Section 3.10 addresses this requirement and identifies the need for 6 monthly audit of contractor competence. It also includes guidance for managing contractors. 05.07.2018 A.Wilson: Procurement to continue to hold supplier meetings but include the AP or someone else from the estates management team present to manage any issues.	Completed		05/07/18			
48	QEUH		42			Is there any evidence in the written scheme of management reviews of the data and results as produced by the monitoring and control processes and procedures?In the healthcare sector is there evidence that authorised person competency checks have been completed?	No. It is recommended that the outcomes from the risk reduction processes and procedures are reviewed regularly, and at least annually. Part of the review should focus on the out of specification results, and the associated follow on remedial actions, to ensure that they have been appropriate and successful.No. No. It is recommended that the outcomes from the risk reduction processes and procedures are reviewed regularly, and at least annually. Part of the review should focus on the out of specification results, and the associated follow on remedial actions, to ensure that they have been appropriate and successful. There was no evidence available that authorised person checks have been completed on the relevant on site personnel. The relevant personnel for the role of authorised person should be defined, and they should receive adequate training prior to being competency checked by the AE. It was discussed during the audit that the Estates' Manager for QEUH, who has been recently appointed to the position, has not had any legionella training. Training, at the appropriate level, should be arranged for the newly appointed Estates' Manager as soon as possible.		08/05/18 Training commenced. 05/07/18 COLIN PURDON- The written scheme has been updated and includes a review procedure in section 3.11. This will be carried out on a 6 monthly basis.	Completed		05/07/18			
49	QEUH		43			Is there a written scheme in place?	There is no adequate written scheme, in terms of the requirements as detailed in the HSG 274 document, for the QEUH currently available on site. There are however a number of the required elements of the written scheme available. As examples of this we would state the following:- There is no adequate written scheme, in terms of the requirements as detailed in the HSG 274 document, for the QEUH currently available on site. There are however a number of the required elements of the written scheme available. As examples of this we would state the following:- •There is a risk assessment available but it was completed prior to the facility being fully operational and as such may be considered to be pout of date. •There is a folder in the Estates' office titled water safety logbook. It contains some of the requirements of the written scheme including copies of some of the elements of the SHTM 04-01 document, some method statements, blank sheets that require to be completed covering the lines of communication and responsible persons. There is also an outline of the required tasks but this is in a generic form and not specific to the QEUH and a brief description of the water systems on site. The written scheme does not have the required level of detail for the site. It does not have incident plans. •There are a number of logbooks with recorded data from the risk reduction processes and procedures. However, there are elements of the required procedures missing. The missing elements include no records of TMV servicing, no flushing of expansion vessels. There are some gaps in the records. More details on the records are shown below. Overall, while it is pleasing to note that there is some of the required elements of a risk reduction programme available on site, this is not yet a comprehensive approach to water associated reducing risk at the QEUH.		A guidance document for the Written Scheme was obtained from DMA in Section 10 of the original 2015 Pre-Occupancy Risk Assessment. The recommendations from the Written Scheme Guidance are being incorporated into the site-wide Water Control Manual & Logbook document. This document is under review as of 03/07/18 by Colin Purdon.	Completed		03/07/18			
50	QEUH		44			Does the written scheme reflect the findings of the risk assessment?	It is unlikely that the written scheme fully reflects the findings of the risk assessment as the assessment was completed before the building went into full operation.		08/05/18 Andy Wilson Template now addresses.	Completed		08/05/18			
51	QEUH		45			Is there a logbook, either paper or electronic, defining all the required tasks for the risk reduction processes and procedures?	There is a paper based log book system on site. It does not appear to define all the required tasks for the risk reduction processes and procedures for the site.		08/05/18 Awaiting receipt of Electronic Log Book via email from Jim Guthrie and Tommy Romeo. 03/07/18 COLIN PURDON The Master Written Scheme is under review at the moment by Colin Purdon. This will incorporate all of the recommendations of the written scheme guidance submitted by DMA as Section 10 of the Pre-Occupancy Risk Assessment 2015. 05.07.2018 A.Wilson: There is a logbook for each block within the site. The master written scheme will be completed by 12.07.2018.	Completed		05/07/18			
52	QEUH		46			Are all tasks in the records signed and dated?	Although many of the records appear to be signed and dated, there are some record sheets with neither dates nor signatures. All records should be signed and dated.		08/05/18 All records from present will be signed & dated.	Completed		08/05/18			

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53	QEUH		47			What is the level of completion of the programmed tasks in the written scheme over the past twelve months?	There are a number of folders in the Estates' office containing records of the various risk reduction procedures that are completed on site. At the time of the audit the following folders were available:-It is unlikely that the written scheme fully reflects the findings of the risk assessment as the assessment was completed before the building went into full operation. There is a paper based log book system on site. It does not appear to define all the required tasks for the risk reduction processes and procedures for the site. Although many of the records appear to be signed and dated, there are some record sheets with neither dates nor signatures. All records should be signed and dated. There are a number of folders in the Estates' office containing records of the various risk reduction procedures that are completed on site. At the time of the audit the following folders were available:- •Monthly Sentinal Water Temps Folder – this folder contains records of temperature checks running from Jun 2015 to Oct 2016. Room reference numbers define where the temperatures should be taken. Records are not available for Jan, Feb, Mar 2016. Many of the record sheets are not signed and dated. Almost without exception the temperature records have a cold temperature recorded, and a mixed temperature recorded. There are very few measures made of stand alone hot water temperatures. Accordingly, in these records, it is difficult to know how the hot water system is performing in the hospital. It is recommended that temperatures are taken from the hot water pipework that supplies hot water to the Thermostatic Mixing Taps. •Legionella Folder – this folder contains the following:- oHot Water Calorifiers - Details on calorifier temperature testing. The temperatures are measured at the bottom and the top of the calorifiers. The records run from Mar 2015 until Mar 2017. The temperatures appear to be taken weekly. Results for Nov 2015, and Sep 2016 are missing. The test sheets are not signed. Flow and return temperatures to the calorifiers can be found in the BMS system. There may be a possibility therefore to discontinue taking manual temperatures from the top and the bottom of the calorifiers and instead look at the BMS trends on a monthly basis and note this in the log book. oCold Water Tanks - Details on cold water storage tank water temperatures are recoded on a minimum monthly basis. Records exist from Mar 2015 to Mar 2017. The records are not signed. HSG 274 calls for temperatures to be measured annually in the summer. SHTM 04-01 calls for temperatures of the tank water remote from the ball-cock, and for the mains water temperatures to be recorded on a six monthly basis. The temperature of the mains make up should also be measured and recorded. The condition of the tank both internally and externally should also be recorded. It can be useful to take internal photographs and add them to the records. There is again an opportunity to reduce the amount of measurements taken with this process to what is required in the SHTM 04-01 part B document. oCWS Tank Room checks – forms exist in the folder for this. This is not a requirement of the HSG 274 or SHTM 04-01 documents. oHydrotherapy Shower Forms – There is a deluge shower at the hydrotherapy pool which is flushed weekly. Records exist for Jun 2015 to Mar 2016. It may be that this flushing procedure has now stopped. If this flushing procedure has been stoped it should be reinstated. oOutside Tap Forms – The unused forms in this section call for twice weekly flushing of outside taps/tradewater. There is no indication that this has been happening. This procedure should be reinstated on site. oIt was noted that there is a water storage tank in a 12th floor plant room. There are no monitoring or risk reduction processes and procedures in place for this tank. The tank should be risk assessed and appropriate procedures put in place if required. oAHU Trap Monthly Check – this is a recording		08/05/18 Awaiting Electronic Log Book and detailed PPMs from Tommy Romeo and James Guthrie. 12.09.18 Assessment of PPM records prior to new PA being appointed described in "Action Required" column to the left and challenges were around this not being managed through the FM First CAFM system. Process ongoing to implement all water safety PPM being done by internal maintenance staff in FM First. Some has been implemented and remaining are being worked on in accordance with the new Master Written Scheme. This will not however impact on previous records so action being closed.	Completed	13/07/18				
54	QEUH		48			Are there any TMV's on the site and are they serviced in accordance with manufacturers recommendations?	There are 1000's of TMT's on site. There are records indicating that they are being operationally checked. There are no records to suggest that they are being serviced. It is recommended that the service requirements are defined, and that the service programme is put in place and recorded.		08/05/18 Collating lists presently. 03/07/18 COLIN PURDON- The PPM system is currently being set up on FM First to automatically schedule the tasks required within the written scheme. Est completion of this process is late July 2018.	In Progress	31/07/18				
55	QEUH		49			Are the remedials actions from the previous risk assessment completed and are they signed and dated?	No evidence that the remedial actions have been completed. A new risk assessment should be completed, and the appropriate remedial actions from this assessment should be completed.		08/05/18 Checking lists at present. Assume this is referring to the pre-occupancy risk assessment. 18.07.18 AW: Most actions now closed, remaining will be closed before this action is also closed. 12.09.18 AW: New Risk Assessment has been arranged and pre-start meeting held with DMA.	Completed	20/07/18				
56	QEUH		50			Does the written scheme contain any incident plans?	No. These require to be completed and added to the written scheme.		08/05/18 Scottish Water Incident Plan on QEUH compliance page. Fill points outstanding from Incident Plan.	Completed		08/05/18			
57	QEUH		51			Is there a copy of the risk assessment in the written scheme?	A copy of the risk assessment was available with the records in the Estates' office.		08/05/18 Current Risk Assessment stored on Estates Office shelf.	Completed		08/05/18			
58	QEUH		52			Is there a copy of the training records in the written scheme?	Training records are held in individual personnel files. It is recommended that an overall register of the completed training course, and the required training course, is created for the on site staff		08/05/18 Training statement to be added to Written Scheme. 03/07/18 COLIN PURDON- Training records and training needs analysis will be held within the Master Written Scheme. This will be reviewed on a 6 monthly basis. 05.07.2018 A.Wilson: There is also an SOP within the Operational Procedures covering this (Appendix 3 of this document).	Completed		05/07/18			
59	QEUH		53			Is there a description of the correct and safe operation of the water systems in the written scheme?	No. A definition of the correct and safe operation for the water systems at the QEUH should be created and added to the written scheme.		08/05/18	Completed		08/05/18			
60	QEUH		54			Are non conformances addressed in a timely manner?	Unknown. There is one record of a non conformance having been addressed. However, as an example, there are temperature records from the shower cleaning and disinfection procedures which show out of specification cold water results. There are no records of this being raised as an out of specification situation. There is no record of any corrective actions having been taken. A response to out of specification situations should be recorded in the folder created for the purpose. The remedial actions should also be recorded.		11/05/18 Procedure now in place.	Completed		11/05/18			
61	QEUH		55			Is there an escalation procedure for non conformances?	Yes.		11/05/18	Completed		11/05/18			
62	QEUH		56			Are legionella samples taken as part of the written scheme tasks?	Yes. There is a rolling programme of sampling monthly in the acute areas of the hospital.		11/05/18	Completed		11/05/18			

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63	QEUH		57			Is there a specific escalation procedure for positive Legionella results?	Unknown. An escalation procedure for NHS GGC requires to be created and sent to all sites.		11/05/18 Infection Control developing escalation procedure. 03/17/18 COLIN PURDON- The current escalation procedure will be included in the Master Water Control Manual & Logbook pending review by the Infection Control Team	Completed		03/07/18			
64	QEUH		58			Who takes legionella samples and are they being taken in accordance with BS7952:2008?	Legionella samples are taken by Estates' staff. The question was asked as to their level of training and understanding regarding legionella sampling but there is no record that they have been trained. The competency status of the involved staff should be checked and training, if required, should be put in place.		11/05/18 Proposed training. 03/07/18 COLIN PURDON- Samples are no longer taken by Estates staff. This task is only undertaken by trained personnel from DMA Water. Samples are transported in coolboxes to the GRI Water Lab for analysis. Results are then returned to the Lead Microbiologists for action.	Completed		03/07/18			
65	QEUH		59			Does the written scheme contain an "audit trail" for out of specification situations which allows for remedial actions to be tracked through to completion?	No. This has been commented on earlier.		11/05/18 Written Scheme audit trail description to be amended. 05/07/18 COLIN PURDON- The updated WS Section 5 gives guidance on remedial actions and the tracking of any non-conformance issues.	Completed		05/07/18			
66	QEUH		60			Are there copies of method statements for any procedures that are completed in house or by external providers?	There are copies of method statements for shower cleaning. It should be checked that method statements for all in house tasks are in place in the written scheme.		11/05/18 Written Scheme to be amended to include method statements and procedures reference to these documents within the Log book. 05/07/18 COLIN PURDON- WS Section 4 contains method statements. This section will be reviewed regularly against legislation and best practice and updated accordingly.	Completed		05/07/18			
67	QEUH		60 (95)			Is there a statement of "correct and safe operation" detailing targets for temperatures and other control measures?	No. This issue has been commented on earlier in this report. The HSG 274 guidance document recommends that this statement is part of the written scheme.		11/05/18	Completed		11/05/18			
68	QEUH		61			Is there evidence in the written scheme that any deadlegs are removed?	There is no evidence that any dead legs have been removed from the site. The risk assessment that was completed in April 2015 identified some deadlegs. These are detailed in the recommendations sections of the risk assessment report. If they have not already been removed the known dead legs in the risk assessment should be removed as soon as possible		11/05/18 Check file name. 05/07/18 COLIN PURDON- Any identified deadlegs found on the system will be recorded in the building logbook. An action list will be drawn up and each entry will be signed off when removed. Where removal is not possible, a flushing regime will be implemented.	Completed		05/07/18			
69	QEUH		62			What is the primary means of control within the water systems?	Temperature.		11/05/18	Completed		11/05/18			
70	QEUH		63			Is there any form of water treatment being applied to the water systems?	No chemical water treatment is being used on site. The water coming into the site goes through an ultra filtration membrane process. Elga services the membrane filtration system. On site Estates' staff check the pressure drop across the cartridge filter which is in front of each filtration unit. The membrane filtration system service records were not available at the time of the audit. Records are being kept of the pressure changes across the cartridge filtration unit. It is recommended that these records become part of the overall legionella risk reduction records.		11/05/18 No	Completed		11/05/18			
71	QEUH		64			Are little used outlets listed and are they then flushed?	Other than the flushing of outside areas, for which there are some records, there is no indication that any other outlets are being flushed. It may be that the cleaning staff are cleaning every wash hand basin and sink every day, and, as a result, technically these outlets will not be classed as little used. A check should be made to ensure that domestic staff are cleaning all wash hand basins and sinks in the appropriate manner.		11/05/18	Completed		11/05/18			
72	QEUH		65			Is the flushing of little used outlets recorded in the records system?	Where external taps and outlets are flushed by Estates' staff, then some of this has been recorded in the log books. The records however do not seem to be complete and it may be the case that there are little used outlets that are being flushed, but are not being recorded, or there could be little used outlets that are not being flushed at all. An audit of the flushing procesdures should be undertaken to ensure that all the required outlets are being flushed as required.		11/05/18 Procedure in place. 05/07/18 COLIN PURDON- Flushing of little used outlets including unoccupied wards is recorded in the building logbooks held in the Estates Office. 05.07.2018 A.Wilson: Request for information on little used outlets is sent out on a quarterly basis by AP.	Completed		05/07/18			
73	QEUH		66			Is there any seasonal difference in the use profile of the water systems?	No.		11/05/18	Completed		11/05/18			
74	QEUH		67			Are any pieces of duty standby equipment that require to be switched on a weekly basis, and do the records show that they are being switched?	No.		05.07.2018 A.Wilson: Confirmed with AP that we do not have any duplex plant on Domestic Hot Water system so this is N/A for adult's and children's hospitals. For the cold water system, require confirmation from manufacturer on program of switching. These pumps are staged and also switching but require confirmation on frequency. 10.07.18 A.Wilson: Contractor from SAC in to review this today but could not access the pump control system without WILO. He did confirm that he believes the pumps operate a 6 hour running time before changing to one of the other 4 pumps but is arranging for someone from WILO to come back to site with him to interrogate the control system and confirm operation. 12.09.18 A.Wilson: Based on the above, we now have a PPM task being recorded on template 028a to monitor running time on each booster set.	Completed	13/07/18				
75	QEUH		68			Is there any form of water treatment in use on site?	No.		11/05/18 No.	Completed		11/05/18			
76	QEUH		69			Is there any form of secondary disinfection in place on site?	n/a		11/05/18 No.	Completed		11/05/18			
77	QEUH		70			What is the secondary disinfectant that is in use in the water systems?	n/a		11/05/18 No.	Completed		11/05/18			
78	QEUH		71			Are the required checks for secondary disinfection levels being completed and recorded on site?	n/a		11/05/18 No.	Completed		11/05/18			
79	QEUH		72			Are the required levels of disinfection being achieved in the water systems?	n/a		11/05/18 No.	Completed		11/05/18			
80	QEUH		73			Is there a record of stock levels of biocide in the written scheme?	n/a		11/05/18 No.	Completed		11/05/18			
81	QEUH		74			Is any of the water base exchange softened?	n/a		11/05/18 No.	Completed		11/05/18			

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82	QEUH		75			Are service records for the base exchange softeners available in the written scheme?	n/a		11/05/18 No.	Completed		11/05/18			
83	QEUH		76			Is filtration in use in any of the water systems?	Yes.		11/05/18	Completed		11/05/18			
84	QEUH		77			Are service records for the filtration equipment available in the written scheme?	No. It is suggested that the service records for the water filtration system are made available as part of the written scheme.		11/05/18	Completed		11/05/18			
85	QEUH		78			Are system cleaning and disinfection procedures in use on site?	Comments and Recommendations on Ongoing Water Treatment		11/05/18	Completed		11/05/18			
86	QEUH		79			Are these procedures completed in response to sampling results or as a matter of procedure?	Not applicable		11/05/18	Completed		11/05/18			
87	QEUH		80			Is there a suitable method statement available in the written scheme covering the cleaning and disinfection procedures?	Cleaning and Disinfection Procedures		11/05/18	Completed		11/05/18			
88	QEUH		81			If chlorine is used, is the impact of pH considered on the disinfection process.	There are no cold water storage tank cleaning and disinfection procedures currently being undertaken on site. Cleaning and disinfection would be undertaken on an "as required basis".		11/05/18 In progress. 05/07/18 COLIN PURDON- DMA are currently on site conducting cleaning of the water tanks. pH is measured during the disinfection process to account for the efficacy of the sodium hypochlorite. 05.07.2018 A Wilson: This will be confirmed in the report that DMA will supply on completion of the process.	Completed		05/07/18			
89	QEUH		82			Are there completion certificates in the written scheme covering any disinfection procedures that have been undertaken?	As required.		11/05/18	Completed		11/05/18			
90	QEUH		83			Are localised outlet disinfections in use on site?	A contractor would undertake any cleaning and disinfection procedures on site. While no method statements were available on site at the time of the audit, it is recommended that should any clean and disinfection procedures be required, then the contractor method statements are inspected and deemed to be suitable. If cleans and disinfections are to be completed by in house staff, then suitable method statements require to be completed. Training should also be given to the involved in house staff.		11/05/18	Completed		11/05/18			
91	QEUH		84			Is there a suitable method statement available in the written scheme covering the localised cleaning and disinfection procedures?	Yes.		11/05/18	Completed		11/05/18			
92	QEUH		85			Have any new build or refurbishment projects, which impacted on the water systems, been completed in the past 12 months	None as the hospital is essentially a new build property.		11/05/18	Completed		11/05/18			
93	QEUH		86			Were the implications of this work risk assessed.	n/a		11/05/18	Completed		11/05/18			
94	QEUH		87			Was the assessment added to the log book and water system records	n/a		11/05/18	Completed		11/05/18			
95	QEUH		88			Was the written scheme amended to account for the implications of the new build/amended water systems	n/a		11/05/18	Completed		11/05/18			
96	QEUH		89			Were the details of the new systems discussed with the Estates Department and any other involved personnel	n/a		11/05/18	Completed		11/05/18			
97	QEUH		90			Are minutes of discussions regarding the new water systems recorded and entered into the log book	n/a		11/05/18	Completed		11/05/18			
98	QEUH		91			Was all new equipment commissioned in accordance with manufacturers recommendations	n/a		11/05/18	Completed		11/05/18			
99	QEUH		92			Are manuals with details of all new equipment available in the record systems	n/a		11/05/18	Completed		11/05/18			
100	QEUH		93			Were systems. if required, cleaned and disinfected.	n/a		11/05/18	Completed		11/05/18			
101	QEUH		94			Are records of all cleans and disinfections available in the record systems.	n/a		11/05/18	Completed		11/05/18			
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From: Downie J (Jack) on behalf of Cabinet Secretary for Health and Sport
Sent: 05 February 2020 13:06
To: Henderson C (Calum); Cabinet Secretary for Health and Sport
Cc: Chalmers G (Greig); White C (Craig); Hutchison D (David); Raines P (Philip); Murray D (Diane); McQueen F (Fiona)
Subject: RE: Critical care patient placement - Dr Peters
Attachments: u418806_05-02-2020_11-34-45.pdf

Calum,

The Cabinet Secretary has signed and the letter is attached for your records.

Many thanks,
Jack

From: Henderson C (Calum) [redacted]
Sent: 03 February 2020 16:18
To: Cabinet Secretary for Health and Sport [redacted]
Cc: Chalmers G (Greig) [redacted] White C (Craig) [redacted]; Hutchison D (David) [redacted] scot>; Raines P (Philip) [redacted] Murray D (Diane) [redacted] McQueen F (Fiona) [redacted]
Subject: RE: Critical care patient placement

Jack

Please find proposed response to Dr Peters

This has been cleared by CNO.

Thanks

Calum

From: McQueen F (Fiona)
Sent: 26 January 2020 14:12
To: Cabinet Secretary for Health and Sport <[redacted]
Cc: Chalmers G (Greig) [redacted]; White C (Craig) [redacted]; Hutchison D (David) [redacted] Chalmers G (Greig) <[redacted]; Raines P (Philip) [redacted] Murray D (Diane) [redacted]
Subject: RE: Critical care patient placement

Jack/Cabinet Secretary,

By way of background to ongoing work in GGC by a number of colleagues I thought it would be helpful to highlight a summary of wc 20 January interaction around Drs Peters (CP) and Inkster(TI). I appreciate that Dr Peters has real concerns and is anxious about patient safety and as a team we are doing whatever we can to help support her.

Within the draft response to Dr Peters I am suggesting the Cabinet Secretary will visit QEUH over the next few weeks – and have also asked if Cab Sec may find a meeting with Professor Marion Bain (put into GGC as Director of Infection Control) to discuss ongoing progress prior to Tuesday's statement?

Monday
CNO e-mails CP and TI to suggest it might be helpful to catch up and discuss progress.

Tuesday
CNO, Professor Marion Bain (MB), Lesley Shepherd, Policy Advisor, Infection Control Nurse (LS), Diane Murray DCNO (DM) meet with CP and TI at 16.30 in QEUH for two hours. The meeting was relaxed and congenial and covered a wide range of issues, some having been previously rehearsed and some new. The discussion covered:

- CP and TI repeated their advice that some of the media statements and the Q&As on the GGC website were inaccurate, despite them having been cleared by GGC clinicians including the clinical lead for microbiology and the current Infection Control Doctor. (**action - agreed that MB would review information issued with CP and TI)**
- CP advised there had been infections in PICU in 2017 similar to the current issues (that both TI and CP had forgotten about until CP was reviewing her files).(**action - this information would be taken into account with regards to ongoing PICU infections and possibly included in the case review).**
- CNO raised concerns around HIIAT rating of infections. There was general agreement that this would benefit from review, along with finding ways to better involve TI and CP in ongoing HAI work **(action - MB to take forwards with TI and CP including finding ways to free up TI and CP time – if necessary pay additional sessions).**
- Discussion took place around the case note review and options for CP and TI to advise/be involved **(action – in particular around 2017 incidents as TI had not been involved, DM to work with TI on how her involvement would be helpful).**
- TI and CP brought up the fact that TI had now received a copy of an investigation into a whistleblowing concern that had been made to HPS about the functioning of the Incident Management Team for 6A. In line with agreed protocol HPS passed this to GGC for investigation. The issue was investigated by Dr Linda de Caestecker (Director of Public Health and designated director for whistleblowing in GGC) and Barbara Ann Nelson(External HRD from NHS Fife). At face value TI reported that her understanding was that the result suggested she needed training in chairing of meetings and that not all those present at the IMT had been interviewed, notably those TI believed would have had an alternative view. Both TI and CP were very distressed by this outcome. **(action CNO to request further information on the investigation from GGC).**
- CNO highlighted that there would be a peer review of the IPC team workings and arrangements were being made for that to happen as soon as possible. TI and CP welcomed this.

At the end of the meeting TI and CP indicated that they had covered everything they wanted to discuss and the fact that there were serious concerns around patient placement or that there had been insufficient movement in cultural matters within IPC team was not raised.

Wednesday
There had been a prearranged planning meeting with Diane Murray and others to plan the case note review. **CP contributed to that meeting by phone and made some valuable contributions about what infections, other than gram negative should be included in the case note review.**

Thursday

CNO met with Jane Grant and discussed a number of issues around IPC. In particular discussion took place around the fact that there was now a significant split amongst the clinicians, with the Rcn and BMA advising a number of members of the microbiology team and IPC team around the behaviour of TI and CP. Building on previous discussions around actions needed to integrate the IPC team, Jane Grant and CNO agreed that highly skilled mediator and OD practitioners were needed as a matter of urgency. **(action - Jane Grant agreed to discuss further with MB as she had been having discussions with practitioners across the whole team). Following the discussion CNO has asked GGC for information on previous OD work and what actions had been taken.**

[For information CMO visited QEUH to meet with paediatricians who very much welcomed her visit. CNO to discuss with CMO possibility of CMO meeting with microbiologists and ICDs.]

Friday
CP e-mails to CNO and MB around concerns about patient placement at 15.41, **with MB responding at 16.14** to CP advising her that MB had been liaising with the clinical lead of microbiology around the matter of patient placement and that she would link with CP.

Over the weekend CNO has been in contact with JG and MB about CP correspondence **requesting advice on what steps the Board is taking with regards to placement of high risk patients. This will be available on Monday. JG also agreed that as a matter of urgency she would prepare a submission for CNO's review on mediation and OD intervention for microbiology and IPC, in partnership with MB**.

Happy to discuss with Cabinet Secretary, however have drafted the following that may be helpful.

Dear Christine,

Thank you very much for your e-mail outlining your concerns.

Firstly I would like to thank you for your continued drive to ensure patient safety is at the heart of everything that is being done and that families and the general public receive the best possible information around infection prevention and control and in particular the matters that are affecting the QEUH at the moment.

I know that speaking to CNO and her team, your input is very much valued and helping to shape thinking – such as your helpful contribution about the case review that will shortly be undertaken. I have instructed my officials to seek clarification on the placement of patients with regards to ensuring they are placed in appropriate and safe environments, and in particular I understand that Professor Bain is actively looking into the concerns you had raised.

With regards to the other two matters you raise Fiona has advised me that Marion has agreed to meet with you and Dr Inkster to review the information that is being presented to the families and the public and also that in discussion with Jane Grant, and Marion work is going on to secure external support to help the microbiology department and IPC team to function in a supportive environment that has patient safety at its heart.

I intend to visit the QEUH in the near future and would very much welcome meeting with you and Dr Inkster if you would find that helpful.

Best wishes

JF

Jack – you'll see I've put in the response to Christine that Cab Sec will visit QEUH again. I have not raised this with Cab Sec but think it would be helpful if we could arrange another visit – probably post February recess and before the next statement- and we could agree arrangements for the visit with Cab Sec.

Also – I'm not sure if the Cabinet Secretary would find a meeting with Professor Marion Bain before this Tuesday's statement helpful?

I hope the above is helpful and as always, happy to discuss or provide further information should this be required.

FIona

#hellomynameis...
Fiona McQueen | Chief Nursing Officer |
Chief Nursing Officer's Directorate | Scottish Government | 1E.14 St Andrew's House |
Regent Road | Edinburgh | EH1 3DG |☎ [redacted]

follow me on twitter @FionaCMcQueen

From: Downie J (Jack) <[redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 24 January 2020 17:56
To: McQueen F (Fiona) [redacted]; Cabinet Secretary for Health and Sport [redacted]
Cc: Chalmers G (Greig) [redacted]; White C (Craig) [redacted]; Hutchison D (David) [redacted]
Subject: FW: Critical care patient placement

Fiona,

Per the below, I would be grateful for your initial views/comments on this before sharing with the Cabinet Secretary. Given the statement on Tuesday it would helpful to have these by Monday lunchtime.

Many thanks,
Jack

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN) [redacted]
Sent: 24 January 2020 16:13
To: Cabinet Secretary for Health and Sport [redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Subject: Fw: Critical care patient placement

Dear Cabinet Secretary,

Thank you for meeting with Penelope, Teresa and me a few weeks today and for your supportive words in parliament regarding whistleblowing.

I am writing to make you aware that I continue to have concerns regarding the IPCT situation in GGC.

1.in the light of the current global alert to a novel coronovirus I have written an SBAR as per below regarding isolation facilities. The reponse to sorting this has been too slow considering that it has been central to IC concerns since the moment the building opened.
2. every time there is a public statement about infection related issues I find myself astonished regarding the obvious deviations from fact and have felt the need to raise objections in writing repeatedly.
3. there is no sign of the GGC management culture changing with communications, decision making and treatment of QEUH MIcrobiology entirely unaltered.

I note that the the entire Board is now on level 4 , however the embedded infection control aspects of the organisation remain fairly intact .

I very much appreciate the time that Prof McQeen and Prof Bain have taken to engage with Teresa and I, and we have been doing our very best to help in this difficult situation. My concern is that infection control issues can escalate rapidly and from my position I remain sceptical regarding the functioning of the team.

kind regards,

Christine Peters

From: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Sent: 24 January 2020 15:41
To: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND); Fiona.McQueen [redacted]
Cc: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Jason.Birch [redacted]
Lesley.Shepherd [redacted]
Subject: Re: Critical care patient placement

Hi Marion and Fiona,

Situation
I am writing to you to emphasise the urgency and grave seriousness of the current situation in GGC with regards to placement of patients.

Background

Microbiology Consultants including ICDs have repeatedly raised concerns regarding the management and provision of appropriate standard isolation facilities for the complex patient cohort treated at the QEUH and RHC site since 2015 and especially as part of the 2017 whistleblow, evidence to Review, to SG, to HSE, HFS, HPS and finally in many recent discussions with MIcrobiology, Infection Control and operations management.

There are Infectious Diseases unitis in both paeditric and adults hospitals as well as the largest acute admissions units in Scotland . Infectious patients can be expected to be admitted on a regular basis. The chances of imported Coronovirus patients arriving here , being next to an international aerport is as reasonably high as other cities in UK.

There are both adult and paediatric BMT and haem onc units on site. We can therefore predict a large number of patients who will require appropriate HEPA filtration including at ITU level (this is why the Beatson moved over in the first place)

Assessment

Currently there is a global alert regarding a novel coronovirus with very detailed and helful advice from both WHO and PHE available. The critical point of control is the first few cases in any country. There needs to be a fail safe strategy for isolation of patients who may meet the criteria as POSSIBLE cases - not for implementation after the positive result is found.

Today I have the following worrying information:

1. one of the negative pressure rooms in ITU that has been mentioned as a validated room has had repeated alarms going off and recent filter changes (key question _ was there an HAISCRIBE in place for the work - were patiens moved, why were Micro on call not informed of deftects despite numerous communications asking for clarity?)? why would filters need changed so soon after validation?

2. A severely immune compromised patient has been isolated in a NEGATIVE pressure room on ITU. This is the exact oppositie of what is required and poses a significant risk to the patient. This was only discovered by Teresa who did a walk around at the request of the ITU consultants.

3. There is a significant level of concern amongst ITU medical staff regarding communication from IPCT regarding patient placement in the light of the coronovirus threat. They do not understand the different types of room and have not had guidance regarding them.

4. We have been told that our responsibility as Microbiologists is simply to advise the type of room that is required, irrespective of whether this is available of not. I do not agree. This may/may not exempt us from responsibility but does not actually help patients. Sometimes situations arise where JUDGEMENT is required eg when capacity is reached. This involves understanding the situation.

5. Furthermore it is repeatedly indicated to us that it is not really our job to advise re patient placement. And yet every day, often out of hours one of us is called regarding this - even by ID consultants

6. One ICD was contacted today by the ID consultant regarding an HIV positive AAFB positive patient. Given the issues on ITU it was decided to place this patient on 5C. This is a ward without negative pressure, houses other HIV patients, and has 3ACHs , no ante room. Ie it is worse than many DGH facilites for open TB in a " flag ship " hosptial. Please be aware of the risk this poses. It is no fault of those making the decision - as the conditions here are designed to force us into such compromised decisions on a regular basis which I find unacceptable after this length of time.

Therefore I conclude :

- the patient placement policy is not fit for purpose
- members of the IPCT do not understand the requirements nor the risks of the different types of room eg ICN advising negative pressure ok for immune compromised, missing out on estates communication regarding current status of all rooms which should have occurred as an urgent action as soon as WHO gave a warning re novel coronovirus. (and routinely due to MERS risks)
- there is a real risk of misplacement and therefore crosstransmission events if the following heirarchey of control is not rapidly established as per best practice:
    - administrative - plans are tested and rooms funnctioning and actions on failures documented
    - engineering- all rooms fully evidenced as correctly functioning
    - PPE - including fit testing recors and training documentation
-
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Recommendations

1.Roles need to be clarified with regard to WHO is best qualified to firstly sign off on a policy and secondly advise on patient placement in the event of complex situations. This would normally be the ICD who undersatands all matters ventilation.
2. those MIcrobiologists giving advice need to be able to ask questions to enable sound judgement and get answers in real time from estates and IPCT
3.In terms of preparedness for pandemics there needs to be unequivicol readily available plans which are communicated with training to front line teams.

Please be assured this is not being alarmist , simply a matter of following very basic and well established methods of infectoin prevention.

kr
Christine

From: Peters, Christine [redacted]
Sent: 24 January 2020 14:40
To: PETERS, Christine (NHS AYRSHIRE AND ARRAN)
Subject: FW: Critical care patient placement

From: INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]
Sent: 24 January 2020 14:33
To: Leanord, Alistair [redacted]
Cc: BAIN, Marion (NHS NATIONAL SERVICES SCOTLAND) [redacted]; Cadamy, Andrew (NHSmail) [redacted]; Ramsay, Sarah [redacted] uk>; Binning, Sandy [redacted]; WRIGHT, Christopher (NHS GREATER GLASGOW & CLYDE) [redacted] Peters, Christine [redacted]; Balfour, Alison [redacted]
Subject: [ExternaltoGGC]Critical care patient placement
Importance: High

Dear Al,

I am the microbiologist covering ICU this week and attended the ward round today. There are a couple of concerning issues regarding patient placement;

1) A [redacted] patient who is immunosuppressed with lymphoma is in a negative pressure room and has been for several days. Unfortunately this patient has been placed at risk of infection when they should have been in protective isolation in a PPVL room. The patients consultant Dr Wright was going to inform the family as per duty of candour and was planning to call you regarding this . I have requested this patient be moved into a HEPA PPVL room

2)It is not clear which negative pressure rooms are suitable for ? coronavirus patients. There are 4 negative pressure rooms on the critical care floor; 4, 24, 43,44. These were signed of by myself last year however it is not clear what the current validation status is off these rooms. Room 24 has been alarming and apparently there was work done on changing filters recently - did this room require revalidation and has it been signed of by IPCT? One of the rooms has an XDRTB patient who will need to remain there.

I did a walk round with the ICU consultants and the rooms are as follows;

3 - non hepa PPVL
4 - negative pressure
11- non hepa PPVL
23- non hepa PPVL
24 - negative pressure
31 - Hepa PPVL
40- non hepa PPVL
43- negative pressure
44- negative pressure
50 - hepa PPVL

The three room types are confusing and are made complicated by the pressure gauges reading different things ie. PPVL measures lobby, negative pressure measures patients room. It would be useful to have signage which makes it clear which patient group can go into each room to avoid a similar patient placement error in the future

In light of the current Coronavirus issue has the possiblity of ring fencing these negative pressure rooms been discussed? You will be aware of the emails from Pauline Wright recently regarding the difficulty in placing a ? MERs patient

It would be useful if some urgent guidance on placement could be issued to critical care ahead of the weekend as I am aware that ID colleagues are receiving lots of calls re possible Corona.

Lastly and not as urgent, in light of CAR-T cell therapy two hepa PPVL are unlikely to suffice and I wonder if consideration has been given to upgrading some of the non - hepa PPVL to hepa PPVL to accomodate this patient group

Kr
Teresa

Dr Teresa Inkster
Consultant Microbiologist, QEUH
National Training Programme Director Medical Microbiology
Dept of Microbiology
Queen Elizabeth University Hospital
Glasgow
Direct dial : [redacted]

****
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Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0300 244 4000
E: scottish.ministers@gov.scot

Dr Christine Peters

By Email.

5 February 2020

Dear Christine

Thank you very much for getting in touch with me. I would like to reiterate my thanks for your contributions to the ongoing work.

Professor Bain in her role as Director of Infection Prevention and Control at NHS Greater Glasgow and Clyde continues to report and be supported by the Chair of the Oversight Board, Professor Fiona McQueen.

Professor McQueen has discussed patient placement with Professor Bain last week. Professor Bain has highlighted she now has regular weekly meetings with you and Dr Inkster, I hope that you find these opportunities beneficial. Professor Bain has also confirmed that the draft patient placement policy plan has now been circulated with colleagues for consideration and comment. I hope you will feed in your contributions to this draft policy plan.

I intend to visit the Queen Elizabeth University Hospital in the near future and would very much welcome meeting with you and Dr Inkster if you would find that helpful.

I am grateful for your communication with regards to this matter.

Kind regards

[redacted]

JEANE FREEMAN

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

From: McQueen F (Fiona)
Sent: 21 December 2019 18:40
To: Cabinet Secretary for Health and Sport
Cc: Minister for Mental Health; DG Health & Social Care; Leitch J (Jason); Birch J (Jason); Smith G (Gregor); Foggo R (Richard); McLaughlin C (Christine); Bell D (Donna); Rogers S (Shirley); Mitchell E (Elinor); Dunk R (Rachael); Allan L (Lara); Shepherd L (Lesley); White C (Craig); Hutchison D (David); Hart S (Suzanne); Mair S (Suzi); Communications Healthier; Morris K (Keith); Wright WA (Billy); Connaghan J (John) (Health); Sheriff C (Carmel); Wood A (Allison); Ives J (Josephine); Judge F (Fraser); Minister for Public Health, Sport and Wellbeing; Walker K (Kirsty) (CNOD); Edmond Y (Yvonne); Healy M (Michael); Wright M (Malcolm); Hill A (Adam); Martin SM (Stephen); Chalmers G (Greig); Raines P (Philip)
Subject: RE: Official - Sensitive: Daily update on QEUH escalation management
Attachments: Daily update - QEUH - 21 December 2019.fm.docx

Follow Up Flag: Follow up
Flag Status: Completed

PO/Cabinet Secretary

Please find attached the daily update on QEUH escalation management. New information is highlighted in yellow.

Kind regards,

Fiona

#hellomynameis...
Fiona McQueen | Chief Nursing Officer |
Chief Nursing Officer's Directorate | Scottish Government | 1E.14 St Andrew's House |
Regent Road | Edinburgh | EH1 3DG | [redacted]

Daily update – QEUH escalation management

Date	Key developments
Week 6 – w/c 16 December	
21 December 2019	**Key Developments** • Late yesterday evening CEO of GGC telephoned CNO to advise her that a day patient had been looked after in a room in 6A that had a point of use filter that had been out of date. The room had been sealed off for maintenance since 29th November and the work had been completed with the room ready for occupancy on 20 December 2019. A nurse placed a day patient in the room for treatment before the point of use filter had been changed. The patient was in the room for two hours and whilst it is recognised that this should not have happened, it is believed to be low risk. A written briefing will be sent on Monday which will include steps that will be put in place to ensure rooms that have been closed for maintenance are appropriately commissioned to be put back into use. The Cabinet Secretary will recall being on Ward 6A and discussing the 'routine' maintenance that takes place in 6A – such as replacing of chilled beams or replacing the HEPA filters. The handling of media lines in detailed under media lines. **Media** • Late yesterday afternoon the Sun approached GGC about whether or not point of use filters had been changed at the appropriate times. Initial lines put up by GGC correctly identified the point of use filters reported by a father to Craig White had not been in a high risk area. The filters in this case had been in a surgical ward where the son had been treated as opposed to 6A. However the media lines had been submitted by the time CEO phoned CNO, hence the lines were changed to exclude the reference to high risk area and the number of filters altered to three (two identified by the father and one in the recently opened room. **Parliament/MSPS** Nile of note **Communication with Families** Nil of note
20 December 2019	**Key Developments**

	• CNO and CMO spoke with Marion Bain as well as Mike Stevens, the external Paediatric Heamato-oncologist to discuss, the requirement for case reviews and external validation of methodology, and Dr Stevens' role in advising the Oversight Board. There were also discussions of potential approaches, including in relation to prioritisation of cases. **Media** • NHSGGC been in touch regarding a follow up story the Daily Mail is doing on [redacted] death. The Cabinet Secretary was asked and cleared the lines. **Parliament/MSPs** • An oral PQ has been received from Anas Sarwar: To ask the Scottish Government whether it will provide an update on the independent review of water contamination issues at the Queen Elizabeth University Hospital. Officials are seeking clarity as to whether this relates to the HPS water contamination report or the Independent Review directly. **Communication with families** • There have been no further developments today.
19 December 2019	**Key Developments** • The Oversight Board met on 19 December and discussed developing the programme plan for the Board and the subgroups, including concrete deliverables. The Oversight Board will next meet in early January. **Media** • Georgia Edkins of the Mail on Sunday asked 20 questions following the request for an interview with the Cabinet Secretary being declined. • Hannah Rogers of the Sunday Herald also asked follow up questions following the interview with the Cabinet Secretary and is scheduled to speak with Jane Grant on Friday 20 December. **Parliament/MSPs** • There was no reference to the QEUH at FMQs **Communication with families** • NHSGGC have confirmed that 400 families were sent letters. The Oversight Board noted today that Professor White has posted a request on the Closed Facebook Group for anyone who did not receive

	letters to make contact. NHSGGC and Professor White will be discussing further work required to validate and update the addresses of all families to ensure that risks of not receiving letters is mitigated (e.g. cross referencing addresses with GP systems). • Professor White met with NHSGGC Nurse Director, Deputy Nurse Director, Chief Nurse (Children's and Paediatrics) this morning to discuss how to ensure that clinical leads have more influence over external communications, the provision of tailored information that is not explicitly driven my media releases and how existing processes focused on point of care conversations can continue to provide opportunities for person-centred communication.
18 December 2019	**Communication with families** • NHSGGC has agreed to review why SG has received feedback that some families have reported not having received letters after SG has been told letters had been sent to all families. NHSGGC will ensure that any actions required to address this situation are taken immediately. SG will support getting this information to families if required. • The Communications and Engagement sub group agreed with Dr Andrew Murray's recommendations on the position regarding the prescribing of prophylaxis. This will be communicated to parents by a senior clinician and will include the various ways in which individual questions about children can be addressed. NHS GGC will prioritise this information being sent to families as soon as possible and the information will also be made available on their website. • Parent representatives on the group have confirmed that that improvements in information provision and communication have been positively experienced in recent weeks. They welcomed the commitments made for further contribution and collaboration on the plans for work to review the approaches taken to date and where changes and improvement work needs to be focused. • The communication sub group has also agreed to undertake a review of previous communications plans and routes of engagement that NHS GGC has used. Examples of previous events will feed into the wider improvement work being completed at Glasgow around transparency and quality of information to parents.
17 December 2019	**Key Developments** • The NHS GGC Board met today. One of the papers prepared for the Board reported NHS GGC's decision to take legal action against the construction company responsible for the QEUH campus project, Brookfield Multiplex (see yesterday's update). The Board has taken this action as a result of the evidence included in an external advisors' report, which describes issues with the facilities. As the report may assist in the

	preparation of legal proceedings by GGC, the Board will not publish it for the moment, lest publication prejudices their case. • Comms have provided lines and this issue is covered in this week's FMQ brief. **Media** • Various media outlets including BBC online reported that the Board was going to take legal action against the construction company responsible for the QEUH campus project. • The Cabinet Secretary was interviewed by Hannah Rodger for the Sunday Herald today at 4 pm. **Parliament/MSPs** • Nothing to note today. **Communication with families** • Professor White has spoken with a parent who, having responded to the recent letter and survey, is interested in being involved in discussions with NHSGGC's Nurse Director about how learning from recent experiences of communications with parents can support future work to build on what has worked well and where improvement could be focused. He has agreed to arrange a meeting with him. NHSGGC Nurse Director and parent in January 2020. • Professors White and McQueen met with Professor Cuddihy to discuss his concerns about a recent meeting with NHSGGC. They have agreed to provide advice to NHSGGC on how to support an improved experience of communication and the provision of information with senior staff in the Board.
16 December 2019	**Key Developments** • The NHS GGC Board papers will be published tomorrow (17 December) and include a summary paper, prepared for the CEO. This paper summarises 3 reports commissioned by the CEO: Capacity and Flow; Clinical Outcomes; and the [redacted] into the design, build, and commissioning of the QEUH. The [redacted] is not summarised in significant detail as legal action is being taken by the Board with respect to the construction of the building. Currently, the [redacted] has not been published. • Officials have liaised with the Board, PO and Comms with regard to the paper and Comms are providing lines separately. • Greig Chalmers has moved roles from Head of Medicines to take up Interim Deputy Director providing additional senior policy support to the QEUH escalation work in particular. **Media**

	• The Scotsman, the Scottish Daily Mail, The Herald and The Times ran a story on the Healthcare Improvement Scotland (HIS) inspection of the QEUH on 19-22 November 2019, which was a follow-up to the HIS/HEI unannounced Safety and Cleanliness inspection of the QEUH on 29-31 January 2019 that resulted in 14 requirements and one recommendation in March 2019. • The Cabinet Secretary will be briefed separately on this issue tomorrow and it will also be covered in this week's FMQ brief. **Parliament/MSPs** • Nothing to note. **Communication with families** • Professors McQueen and White have arranged a meeting tomorrow with the parent who contacted Professor White to express dissatisfaction with a recent meeting with senior staff in NHS GGC, with a view to providing advice. • Professor White considered and rejected a proposal from NHS GGC to issue a copy of a media release to parents and families that had been proposed to provide reassurance in relation to new media coverage about findings from a HIS/HEI inspection report in March 2019 (see above). He has advised NHS GGC that they should aim to provide a more meaningful description of the actions taken in response to the inspection, explaining how the effectiveness of actions taken in response to the inspection have been effectively implemented. • Professor White has continued to correspond with individual parents who have contacted him, including a parent who has raised concerns about not having received any response to two prior requests for [redacted] deceased child's medical records. He has asked for details of the dates and recipients of the requests in order that he can investigate this on [redacted] behalf. He has requested and received assurance that the third request has been received and is being responded to as a priority. • Meetings for the Communication and Engagement Sub-Group of the Oversight Board have now been arranged for the first quarter of 2020 and work is ongoing to establish a wider Parent Reference Group that will meet at dates and times to ensure linkage with these meetings.
Week 5 – w/c 9 December	
15 December 2019	**Key Developments** • No key developments **Media**

	• The Sunday Post ran a story about the January 2019 inspection • Daily Mail followed up the Sunday Post story **Parliament/MSPs** • Nil of note **Communication with Families** • Nothing to note today
14 December 2019	**No new developments today**
13 December 2019	**Key Developments** • The third meeting of the Oversight Board took place. Members reviewed and agreed further refinements to the Terms of Reference, noting that Professor Marion Bain's role needs to be added; received an SBAR from Dr. Andrew Murray on prophylaxis, accepted his recommendations and remitted them to sub-groups for action with the IPCG subgroup to seek evidence that the practice suggested is in place, and C&E subgroup to consider how the outcome of Dr Murray's work be shared with families; heard updates from the Communications & Engagement and Infection Prevention & Control Governance sub-groups and noted the establishment of a third sub-group to lead on technical issues, to be chaired by Alan Morrison; and commissioned a draft work plan and timelines which will be brought to meeting 4 (19 December) for review. **Media** • Briefing was put up by the HCAI / AMR policy unit for the Cabinet Secretary's interview with Hannah Rodger, Chief Reporter at the Herald, on Tuesday 17 December. • There was a bid for an interview with the Cabinet Secretary from Georgia Edkins of the Scottish Mail on Sunday. **Parliament/MSPs** • Nothing to note today. **Communications with families** • Professor White has provided an update to the parents who alerted him to their concerns about a point of use water filter that was overdue for change, explaining the actions taken by NHSGGC when they were alerted to this and informing them that further assurances have been requested by the Scottish Government, an update on which will be provided to the parents next week.

	• Professor White met with NHSGGC senior staff to discuss the questions previously raised about their consideration of the organisational duty of candour legislation and agreed the scope and supporting process to identify historical decision that were made and encourage this to include reflections on possible areas for improvement. • Professor White met jointly with the Chief Executive and Board's Nurse Director to discuss ways in which the work of the Oversight Board Communication and Engagement Sub-Group can inform changes identified as necessary in the approach and supporting infrastructure in respect of person-centred care, communication, engagement and the provision of support and information. • Professor White met with Jane Grant to discuss concerns that had been communicated him by a parent who was dissatisfied with a meeting with NHSGGC yesterday. He agreed to provide advice on how to respond to the dissatisfaction and spoke with the parent personally early this evening and has agreed to arrange a meeting with him and/or Fiona next week to provide support and ensure that the distress about the meeting specifically informs various commissions in process through the Oversight Board. • Professor White agreed to remit Dr. Andrew Murray's recommendations regarding the provision of information, communication and engagement with families about prophylaxis to the Communication and Engagement Sub-Group meeting next week, ensuring that the actions required in general and for individual families are actioned. • CNO met with Jane Grant and John Brown to discuss working with SG team on moving forwards, and in particular how information should be presented to the NHS Board in a balanced (rather than overly positive) way. CNO was asked to review the summary paper of the three reports (capacity, infection control and [redacted]) prior to submitting to the Cabinet Secretary. CNO liaising with the DG and colleagues on this matter over the weekend and the report will come to the Cabinet Secretary prior to being presented to the NHS Board.
12 December 2019	**Key Developments** • The HCAI/AMR Policy Unit are drafting a letter on behalf of the Cabinet Secretary to the microbiologists reiterating that the Cabinet Secretary would like them to be involved in the work of the Oversight Board going forwards and the Chief Nursing Officer has asked Prof Bain to arrange a meeting with Dr Peters and Dr Inkster to discuss and agree specific arrangements. In addition to this, NHS GGC will be inviting Dr

	Peters and Dr Inkster to meet with the Non-Executive Director who has already met with Dr Redding in recent days. **Media** • Nothing to note today. **Parliament/MSPs** • Nothing to note today. **Communications with families** • Subsequent to NHS GGC's offer to meet [redacted] when [redacted] contacted the Board in November 2019 and their letter to [redacted] of 3 December 2019, the Board has subsequently offered to meet [redacted] to discuss the specific issue of referral of [redacted] case to the Procurator Fiscal. [redacted] has responded today saying that [redacted] will consider the offer and get back in touch with the board. NHSGGC will ensure SG are advised of any progress in this regard. • Professor White has prepared a summary report of the responses from families to the survey which he sent out on 3 December.
11 December 2019	**Key Developments** • The Oversight Board's Infection Prevention and Control Governance (IPCG) sub-group met for the first time today. • The IPCG sub-group discussed the draft Terms of Reference, proposed review framework and proposed meeting schedule. Members agreed first priority for the sub-group would be to agree the methodology for the review, identifying appropriate measures and a recording mechanism. • CNO also met with NHSGGC Chief Executive, Chair and Medical Director to discuss progress on actions. **Media** • Coverage of the Ministerial Statement to Parliament yesterday was in the Courier, Daily Telegraph, Daily Record, Scottish Daily Mail, Daily Express, Scotsman, Scottish Sun. Issues emphasised were i) the fact that DMA reports commissioned in 2015 and 2017 by NHS GGC were not passed on to the Scottish Government, ii) the possibility of [redacted] death being reported to the Procurator Fiscal, iii) calls for resignations and accountability. **Parliament/MSPs** • Nothing to note today. This issue was not raised at FMQs.

	Communications with families • Professor Craig White passed a summary of themes from family communications and unanswered questions raised with him to Drs Fraser and Montgomery (the Co-Chairs of the Queen Elizabeth University Hospital Independent Review) in order that they can consider this as part of their ongoing work. • Now that Professor White has direct Admin rights to the NHSGGC Paediatric Haemato-oncology Facebook Group, he has uploaded a link to the Official Report from Parliament yesterday and the Scottish Government's News Release. He has also uploaded and distributed the themed summary of communications of issues relating to the scope of the Montgomery/Fraser review, informing families that this has been passed on to them. • Professor White has asked Dr. Andrew Murray to provide advice based on the clinically led review re prophylaxis of the proposed approach to the provision of information provision, support and communication for families with specific questions on this issue and the wider group of families more generally.
10 December 2019	**Key Developments** • The Cabinet Secretary met NHS GGC Board members this morning. • The Cabinet Secretary made a Ministerial Statement to Parliament updating on the QEUH at 2.20 pm. **Media** • There was no coverage of the QEUH in this morning's media. **Parliament/MSPs** • Nothing to note today apart from the Statement above. **Communications with families** • The text of the Cabinet Secretary's Statement was shared on the NHS GGC closed Facebook site for parents, and also emailed to parents, just before delivery.
9 December 2019	**Key Developments** • The Oversight Board's Infection Control and Governance subgroup will meet for the first time on Wednesday 11 December. • Briefing and draft Ministerial Statement for tomorrow are being revised by the HCAI team by close. • Draft note to the First Minister on tomorrow's Statement is being provided by the HCAI team by close. **Media**

	• The Times on 7 December and Scotland on Sunday on 8 December quoted Andrew Robertson, former chairman of NHS GGC, saying that infection fears are being blown "out of proportion". • On 8 December, the Scottish Mail quoted a whistle-blower claiming that the QEUH's operating theatres are dilapidated and a breeding ground for infection, and the Scottish Sun ran the story of maintenance on ward 7A (directly above ward 6A), quoting the concerns of several parents of patients on ward 6A. • The Herald on 8 December and the Daily Record and Daily Express on 9 December queried why [redacted] death in 2017 was not reported to the Procurator Fiscal. **Parliament/MSPs** • Nothing to note today. **Communications with families** • NHSGGC have confirmed that follow-up actions for family survey respondents requesting specific details on a range of issues (e.g. how to submit feedback or a complaint, how to arrange a meeting with Chair and CEO) have all been actioned. • Professor White has been granted direct access to the NHSGGC Closed Family Facebook Group in order that he can review historical posts and ensure the communication requested by the Cabinet Secretary tomorrow, 10 December, can be posted as desired.
Week 4 – w/c 2 December	
7 December 2019	**Key Developments** • On Friday NHSGGC Estates advised that there may be a delay in opening 2A/B due to mould being found behind panels. As a matter of urgency GGC are being asked for an estimate of time of occupancy. • Legal advice has been received by GGC that the [redacted] should neither be published nor referred to in a public forum until consideration on legal action has been finalised. Further more detailed briefing will be sent to the Cabinet Secretary on Monday. **Media** • Only one follow up query to GGC around a death in PICU and whether or not the [redacted] died as a result of an HAI. The [redacted] have been explicit that they do not want [redacted] death discussed in the media however Hannah Rodger has continued to press for further information. **Parliament/MSPs** • Nothing to note.

6 December 2019	**Key Developments**
	• The CNO met with another clinician to discuss concerns and consider how they could be involved in the work going forwards.
	• Initial draft briefing for Tuesday's Statement shared with PO at 17:30.
	• Andrew Murray, Co-Chair of the Managed Clinical Network for Children's Cancer Services Scotland, had an initial meeting with GGC clinicians to discuss prescribing of prophylactic antimicrobials. We await a full readout from this meeting, which will be shared with the Oversight Board. Initial high-level feedback: clinicians explained that they assess whether to prescribe antibiotics for patients based on all the information and advice they have available to them and balance the risks and benefits; the current use of antibiotics conforms with that clinical decision making.
	
	Media
	• There have been 2 bids for interviews with the Cabinet Secretary:
	  ○ Hannah Rodger (Herald on Sunday) wants to talk about the QEUH/RHC, NHSGGC governance and accountability, plus infection control policies.
	  ○ Helen McArdle (Herald) says she wants to talk about a range of issues – the infection issues that have affected the QRUH/EHC, but also the issues with the Edinburgh Sick Kids delay and other issues like tackling NHS bullying/victimisation of whistleblowers, how we sustain general practice and the challenges of shifting care away from hospitals etc.
	• GGC have received a further inquiry about the death of [redacted] from the Herald on Sunday – HCAI Professional Advisor and CNO are liaising with the board on this.
	
	Parliament / MSPs
	• Monica Lennon has written to the Cabinet Secretary regarding the child protection investigation into [redacted]. In this letter she mentions that parents and families continue to raise concerns about the senior management teams within NHSGGC and at the QEUH.
	• The Shadow Health Secretary has emailed those parents that she has already engaged advising them of the Cabinet Secretary's update to Parliament next week, inviting them to attend the public gallery in Parliament.
	• A room has been set aside afterwards for collective discussion with the Shadow Health Secretary and opportunities for media interviews - this invitation has been uploaded onto a parents' forum.

	• The Cabinet Secretary's feedback on the proposed draft letter to Monica Lennon received in November has been sent to NHSGGC and is being revised with a view to being resubmitted for Ms Freeman to consider further. **Communications with families** • Prof White has received 17 responses to the survey circulated to families. • Replies drafted to a number of correspondence cases.
5 December 2019	**Key Developments** • The Cabinet Secretary and CNO met with clinicians to discuss concerns. • Data on positive Gram-negative blood cultures among haemato-oncology patients at QEUH was sent by NHS GGC to the Scottish Government and is being further clarified in advance of the Statement on 10 December. • Draft Statement prepared and was shared with PO at 4pm today. • A meeting is being arranged between Andrew Murray, Co-Chair of the Managed Clinical Network for Children's Cancer Services Scotland, and NHS GGC staff paediatricians and pharmacists next week. **Media** • There was media interest today in QEUH staff carrying bottled water to work. NHS GGC have recently issued lines on water quality on the QEUH/RHC campus, and this issue was covered in the FMQ brief. • There has been an enquiry from The Times about why the reports relating to estates and infection risks at QEUH didn't reach senior management, specifically the Medical Director, earlier. NHS GGC are preparing lines. **Parliament / MSPs** • There were no developments today with regards to Parliament/MSPs and this issue was not discussed at FMQs. **Communications with families** • Professor Cuddihy and [redacted], parent representatives, attended an initial meeting to discuss scope, focus and ways of working of the Oversight Board Communication and Engagement Sub-Group. Representatives from NHS GGC were also in attendance. The discussion was open and started to identify short term specific improvements that could help parents quickly and longer term issues that would feed into wider institutional and cultural changes around communications and engagement.

4 December 2019	**Key Developments** • There were no developments regarding patient care today. • Scottish Government is still awaiting responses from NHS GGC, including the number of positive blood cultures among haemato-oncology patients year by year and additional information. **Media** • No media coverage of this issue today and no bids. **Parliament / MSPs** • There were no developments today with regards to Parliament/MSPs. **Communications with families** • Professor White has confirmed arrangements for a home visit next week with a family in [redacted] who have asked previously to meet him at their home to discuss their experiences in respect of the paediatric haemato-oncology service. • Fourteen responses have been received to the survey that issued yesterday, several where indications have been provided that respondents would like information on who they can speak to in respect of questions and concerns specific to their child's care and treatment and how to make arrangements to meet with the Chief Executive and Chairman of NHS Greater Glasgow and Clyde. These requests have been passed in writing today to the Board's senior staff. • Professor McQueen has been provided with a list of the information and responses to questions that have been sent to NHSGGC on behalf of families by Professor White but where he has not received the information he needs to be able to respond to family members who have been in touch • Andrew Moore and Professor White met today in order that he could be briefed in respect of the work undertaken to date. They also met with NHSGGC Complaints Manager to outline the documentation that will need now to be passed to Andrew to take forward the outstanding concerns raised by [redacted] • A response was sent to Mr Gallacher as follow up to the meeting that the Cabinet Secretary had last Friday • Confirmation has been sent to all those who will attend the Oversight Board Communication and Engagement Sub-Group meeting on Thursday – including two parents who have previously been in contact with Professor White. Professor White has also asked senior staff within NHSGGC with Board level responsibilities for engagement and communication (Board Nurse Director and Board Head of Administration) to be in attendance at this meeting.
3 December 2019	**Key Developments**

	• The Oversight Board met for the second time. The Chair confirmed that membership and Terms of Reference (ToR) were still in draft. Members discussed revising and adding to the ToR and developing them for sub-groups; this will be actioned before the next meeting on 13 December. The Communications and Engagement sub-group will meet for the first time on 5 December. The Infection Prevention & Control and Governance sub-group will meet for the first time before 13 December. Members agreed that outcomes will be discussed by sub-groups and fed into the Oversight Board. • Letters were issued from CNO to three microbiologists, two who currently work at QEUH and one with past experience of working there, inviting them to meet her. The Cabinet Secretary will meet two of these staff members on Thursday 5 December. **Media** • There has been media interest (Scotsman, Times, Sun, Telegraph, Express, Press & Journal, Metro, Herald) in Jane Grant's assurance that the QEUH is safe, in interviews during the weekend. **Parliament / MSPs** • There were no developments today with regards to Parliament/MSPs. **Communications with families** • Professor White issued a survey in support of the work of the Oversight Board's Communication and Engagement sub-group. This was mailed to all 400 families in contact with the haemato-oncology service, inviting families to give feedback on their experience. It was also issued by email and Professor White has asked for it to be referenced on the NHSGGC Closed Facebook Group.
2 December 2019	**Key Developments** • One of the patients being treated on Ward 6A QEUH sadly died [redacted]. We have not yet been notified if infection played any part in this death. • Daily Directors' calls on NHSGGC escalation were stood down today, and daily updates will be picked up as part of the daily meeting in CNOD, including comms and relevant policy support from other HSCD teams. **Media** • There has been media interest in the issue raised by [redacted], a parent of a Ward 6A patient, when [redacted] met the Cabinet Secretary and in the weekend's media: are patients receiving additional prophylactic antibiotics to protect against the threat of infection from the QEUH environment, and what are the effects of long-term use of these prophylactic drugs? • There was a further interview (Clyde One) with Jane Grant on the same theme as yesterday's.

	Parliament / MSPs • There have been calls for the Cabinet Secretary to update Parliament earlier than the Statement scheduled for 10 December. Briefing has been provided separately. **Communications with families** • Professor Cuddihy and [redacted] were sent invitations to join the Communication and Engagement Sub-Group of the Oversight Board. Prof Cuddihy accepted and [redacted] asked if [redacted] could attend instead. They will be invited to the first meeting of the Sub-Group, which it has been provisionally agreed with Profesor White (Chair of Sub-Group) could be Thursday this week • Professor White has discussed with Professor McQueen and Davie Hutchison the possibility of issuing a survey in support of the work of the Communication and Engagement Sub-Group during the course of tomorrow (to be mailed to all 400 families in contact with the service and also issued by email and on the NHSGGC Closed Facebook Group) • NHSGGC have been asked to prioritise publication of the responses to the 70 questions previously raised by families on their website and to become more proactive in their use of social media to provide factual based responses to the various questions and comments being made.
Week 3 – w/c 25 November	
1 December 2019	**Key Developments** • There were no developments today with regards to patient care. **Media** • The Evening Times on 30/11/19 reported 4 HCAI incidents involving paediatric patients and the Cabinet Secretary asked that this be covered in the daily report: o "One HCAI incident at QEUH this week, resulting in a death": this was covered in the weekly report from the HCAI/AMR policy unit on 29/11/19. Officials were notified by HPS on 28/11/19 of a single reported case of *Serratia marcescens* in the Paediatric Intensive Care Unit (PICU), RHC. This patient was admitted to PICU after a transfer from [redacted] Hospital following a cardiac arrest. The preliminary clinical assessment is that death was caused by overwhelming disease and blood loss. This case has been referred to the procurator fiscal. The Telegraph and Global Radio contacted Scottish Government for comment. o "Three more HCAI incidents in RHC in the past three weeks": Scottish Government were notified on 19/11/19 by HPS of two cases of *pseudomonas* bloodstream infections within the PICU, RHC. Sadly

both of these patients died. The IMT concluded that Case 1 was a community-associated infection and in case 2, the infection itself was deemed healthcare associated but not listed as the cause of death on the patient's death certificate.
    - There have been no other notifications by HPS to Scottish Government of HCAI in the RHC in the past three weeks. Given that the case of *Serratia marcescens* reported above as being in the QEUH was actually in the RHC, it is possible that this is the third case referred to by the Evening Times.
- The BBC and STV interviewed Jane Grant. The interviews focussed on safety of the hospital and information for parents, with the CEO reassuring the public and emphasising that she is committed to making sure families have the answers they are entitled to. The BBC ran with the additional patient who had died of an infection – which we do not believe to be true.
- The meeting on 30/11/19 between Anas Sarwar MSP and 15 parents of children being treated on ward 6A, QEUH was covered by several outlets (Sunday Mail, Scotland on Sunday, The Sun).
- The Herald called for NHS GGC to be escalated to Stage 5 of the Scottish Government's performance framework.
- The Mail on Sunday covered the death of [redacted], whose [redacted] met the Cabinet Secretary on 28 November.
- Scottish Government received requests from The Herald, the Daily Telegraph and The Scotsman for a comment on the Conservative news release issued (below).

Parliament/MSPs

- Conservative news release issued calling for the Cabinet Secretary to make a statement to Parliament about the QEUH on Tuesday 3 December.

Communications with families

- Families in contact with Professor White were informed of the decision to have a Communication and Engagement Sub-Group of the Oversight Board
- [redacted] has emailed asking if Professor White can provide copies of the management structure for health and safety and facilities management within NHSGGC.
- Professor White has advised NHSGGC that they need to provide the data and narrative on historical water, air and environmental sampling as a matter of urgency (previously requested but not yet received) as this has the potential to contribute positively to building trust and confidence.
- Professor White has advised NHSGGC that they should create a space on their website where they will publish more information of the work they have undertaken to investigate and respond to prior incidents and concerns

30 November 2019	**Key Developments** • There were no developments today with regards to patient care. **Media** **Several outlets requested lines on:** • [redacted] stating that she continued to seek answers to her questions and that despite a number of meetings and reports did not have the answers she needed. • Move of paediatrics from [redacted] to RHC in 2018 was queried with regards to risks to [redacted] children. • An alleged new death from infection in ward 6A was queried. This is not true and the allegation was rebutted. • Why children are still receiving prophylactic antibiotics. • Whether or not the routine maintenance in ward 7A was due to mould and whether or not ward 6A which is directly below 7A would be at risk • CNO attendance at the IHI International Conference. **Parliament/MSPs** • Monica Lennon called for NHS GGC to be escalated to level 5 • Anas Sarwar met with 15 parents this morning. This led to parents and Anas Sarwar calling for senior management to be moved aside from managing the hospital.
29 November	**Key developments** • **New infection incident**: SG were notified by HPS on Thursday 28 November of a single reported case of *Serratia marcescens* in the Paediatric Intensive Care Unit (PICU), RHC. This child was admitted to PICU after a transfer from [redacted] hospital following a cardiac arrest, and sadly died. The preliminary clinical assessment is that death was caused by overwhelming disease and blood loss rather than infection/sepsis. • This case has been referred to the procurator fiscal. • **Oversight Board**: Further members for the Oversight Board have been confirmed: Irene Barkby, Executive Director of Nursing, Midwifery and Allied Health Professionals & Healthcare Associated Infection Executive Lead, NHS Lanarkshire, and Andrew Murray, Medical Director NHS Forth Valley and vice-chair, Managed Service Network for Children & Young People. Irene Barkby will also chair the sub-group on Infection Prevention & Control and Governance. In addition, two members for the Communications & Engagement sub-group chaired by Professor Craig White have been confirmed: Andrew Moore, Head of Excellence in Care and Lynsey Cleland, Director of Community Engagement, both Healthcare Improvement Scotland. The Oversight Board will meet on Tuesday 3 December. Agenda items include reviewing and agreeing the Terms of Reference, Outcomes and Action List.

	Media • Several outlets covered the appointment of Lord Brodie to chair the Public Inquiry: Evening News, healthandcare.scot, The Herald, Holyrood Magazine. • Several outlets covered the 2015 report highlighted by Anas Sarwar at FMQs yesterday: BBC News, Evening Times, Herald p.1/4, Scotsman p.1/5, STV News. • [redacted], was re-interviewed by the BBC and stated: "I believe [redacted] would still be here if action had been taken" when issues were first raised in 2015. SG lines issued. • Several bids for interviews with the Cabinet Secretary on the above. **Parliament/MSPs** • Briefing has been sent separately to the Cabinet Secretary on the points raised by Anas Sarwar MSP at FMQs yesterday. • NHS GGC informed CNO that they had been advised of a meeting with Anas Sarwar MSP and parents of children in 6A tomorrow at 11am. The purpose of the meeting is to go through the reports that he has referred to in Parliament.
28 November	**Key developments** • Oversight Board membership and Initial work focus confirmed to Cabinet Secretary before General Questions. The purpose of the Oversight Board is to: i) Ensure improvements to the systems, processes and governance in relation to infection prevention, management and control at the QEUH and the RHC: ii) Ensure improvements to the associated communication and public engagement issues; iii) Ensure improvement to appropriate governance processes at the board; iv) Ensure the building of public confidence and strengthen current approaches that are in place to mitigate avoidable harms. • Two subgroups will be established to support the work of the Oversight Board. The two subgroups will be (a) infection prevention and control & governance, and (b) communications & engagement. A draft timeline, key milestones and draft outcomes for the Oversight Board and subgroups are being drafted by officials in the Chief Nursing Officer's Directorate to be shared with Oversight Board members at the next meeting on 3 December 2019 **Media** • Several media bids followed questions on this issue at FMQs. **Parliament/MSPs** • FMQ / General Questions brief was updated with material added on Oversight Board and infection data.

	• At FMQs, Anas Sarwar MSP stated that further evidence had been shared with him revealing that NHS GGC knew that the QEUH water supply was unsafe when the hospital was transferred from the contractor to the Board, and that separate assessments in 2017 both before and after the death of [redacted] in [redacted] 2017 found the water to be unsafe. Mr Sarwar asked who would be held accountable. A separate briefing will be sent to the Cabinet Secretary. • Following FMQs, briefing was shared with CNO ahead of meeting between Cabinet Secretary and Anas Sarwar MSP at 3.30 pm today. **Communications with families** • Briefing was sent up for meeting between Cabinet Secretary and [redacted], mother of [redacted], at 6.30 pm today.
27 November	**Key developments** • Oversight Board: The first meeting of the Advice and Assurance Oversight Board to NHS Greater Glasgow and Clyde took place on the 27th November, chaired by Chief Nursing Officer, Fiona McQueen. Discussion focused on the expertise required for the Oversight Board and its subgroups, the governance structure and administrative support required to ensure delivery of outcomes once agreed, and the key areas of focus for the board. Actions were identified and will be taken forward by officials in CNO Directorate; the Board will next meet on Tuesday 3rd December to review and discuss next steps. **Media** • The National and The Times ran stories on the HPS data review report published yesterday **Parliament/MSPs** • FMQ, with sections on HPS report, HSE report and annexed timeline, drafted and sent up • Draft reply from FM to Annie Wells MSP, responding to her letters on 25 October and 22 November, drafted and sent up to PO / FM to issue before FMQs tomorrow **Communications with families** • Yesterday, NHSGGC issued a letter to families distributing the HPS data report, and also visited families on the ward yesterday evening to discuss the report and answer questions. The Cuddihy family gave positive feedback that this was much appreciated and reassuring.
26 November	**Key developments** • HPS data review published today

	• CNO and Prof White attended the NHSGGC Board Meeting where there was wide ranging discussion on the need for escalation and practical steps to move forward • The first GGC Oversight Board, chaired by CNO, will meet tomorrow (27 November) • HPS are using the datasets from the data review to calculate the total of number of positive blood cultures reported in Ward 2A/2B and Ward 6A (RHC/QEUH) from 2015 (opening of RHC) until September 2019 **Media** • SG issued pro-active lines on HPS data review report • Jason Leitch accepted bids from BBC and The Times today in relation to the publication of the report • Nursing Times query asking for more information on the Oversight Board • SG Health Comms and others are considering how NHSGGC Comms can be better supported **Parliament/MSPs** • FM known question (M.Lennon - included in update on 25 Nov) and general FMQ drafted and sent up • Oral PQ (A.Sarwar):To ask the Scottish Government when the health secretary last met the chief executive of NHS Greater Glasgow and Clyde and what was discussed. Draft response and supplementary questions drafted and sent up **Communications with families** • Following publication of HPS data review, NHSGGC are issuing a letter to families, which Prof White has approved, distributing the report. This will begin with parents on the ward and then to the wider group of families involved.
25 November	**Key developments** • HPS data review report due to publish 26 November (tomorrow) – Briefing to Cab Sec and NSS have shared lines. • Awaiting responses to SG questions sent to GGC and HPS on 23 November following receipt of clinician-led review from GGC Chief Exec • Work is in train to begin reviewing and considering options around processes in respect of HSE reviews and decisions, including enforcement notifications and prosecutions of NHS Boards – particularly any information sharing with SG and HIS. • CNO and Craig White met with GGC Chair and CEO to discuss Oversight Board and sub groups (Governance of Infection Prevention & Control and communication and engagement). The meeting covered areas where GGC would find it helpful to have additional support (comms) and where it was necessary to

	have assurance provided (IPC governance). Craig White and CNO will attend the GGC briefing session on Tuesday 26 November. The first meeting of the Oversight Board is being planned for Wednesday 27 November 2019. **Media** • GMS interview (AM) and STV interview (PM) with Jason Leitch • No new lines/stories – media continue with reports from weekend of 10 new cases from 2016 and HSE report on Personal Protective Equipment for NHSScotland staff **Parliament/MSPs** • Known PQ to FM from Monica Lennon: To ask the First Minister what action the Scottish Government is taking to reassure patients and families of the safety of the QEUH and RHC • Annie Wells letter – complaint re lack of response to previous letter asking for information about ward closures **Communications with families** • eRDM shared folder created for storage of correspondence from families • GGC arranging for Professor White and support to have access to their database to ensure accurate oversight and capture of contacts and outstanding actions • Director led email being issued to all Directorates to ensure all correspondence around issues at QEUH are being sighted and flagged. • Increase of correspondence regarding issues not related to health infections at QEUH are being directed to appropriate teams within SG
Week 2 – w/c 18 November	
23 November	Officials have responded to the Board CEO with further questions following data shared by CEO with Cab Sec and CNO.
22 November	HSCMB agree to escalate GGC to Stage 4 of SG's performance framework on basis of infection management issues. Letter issued to GGC Chief Exec.
21 November	Cab Sec followed above point up in writing to Anas Sarwar, also offered to meet the whistle-blower and Anas Sarwar.

	Monica Lennon states in the Chamber that there is a child receiving treatment in England due to ward closures at QEUH. GGC confirms that a child is receiving treatment in Newcastle. The Board CEO wrote to Cab Sec and CNO, sharing data from a retrospective lookback at cases in 2017 and an SBAR report from October 2019 reviewing lab data in relation to the number of positive blood cultures at the RHC from 2014-2019 and the type of organisms involved. CNOD assume this is the clinician-led review referred to in media on 14 November.
20 November	Cab Sec, in statement, re-iterated to Anas Sarwar that she would investigate any information he has, if he would share this.
19 November	Over email, GGC confirm to SG 26 positive isolates identified in 2017 (RHC haem/onc) from a number of different organisms, 14 children affected, but no clinician-led report shared. Cab Sec meets Parliamentary Committee on Health and Sport for pre-arranged meeting on QEUH, RHCYP and Clinical Waste.
18 November	Anas Sarwar does GMS interview at 7am – states GGC should be put into special measures.
	Cab Sec does GMS interview.
	Anas Sarwar responds to Cab Sec's letter by email – says GGC attack on whistle-blower was disgraceful. States he is happy to assist in sharing relevant info but won't compromise the whistle-blower. Makes reference to upcoming statement.
	Response to Monica Lennon sent to PO (issued by PO on 22 October)
	Information (SBAR) provided by NHSGGC to SG Monday evening regarding lookback at 3 deaths linked to *Stenotrophomonas* in 2017. Deaths weren't reported to SG at the time. CNOD doesn't think this is clinican-led review referred to in media as doesn't refer to 26 cases.
Week 1 – w/c 11 November	
15 November	HPS confirm that SG were not notified of [redacted] death in 2017.

	HPS notify SG that, based on information received from GGC, there appears to have been at least 3 cases of Stenotrophomonas during 2017 all of which were very complex cases and all sadly passed away. HPS requested details of all 3 cases including the cause of death and the information shared with families. [SBAR with this information subsequently sent directly to SG on evening of Monday 18 November – see below] Cab Sec sends letter to Anas Sarwar acknowledging that a whistle-blower has contacted him; setting out what she knows so far; and requesting that he shares any additional information with her. Monica Lennon sends second letter to Cab Sec asking for more information about when SG was made aware of the deaths.
14 November	Daily Record ran whistle-blower/ Anas Sarwar story about 27 cases of infection in 2017. Raised during FMQs.
	Officials request information from NHSGGC, via HPS, about this. HPS requested a copy (from GGC) of the review of cases prior to 2018 that is reported in the media to have been clinician led. SG requested that HPS also liaise with SG to understand whether the correct reporting processes were followed.
	SG make contact with GGC directly to ensure the board had made contact with [redacted] following Cab Sec's reply to [redacted] letter in September. GGC confirm contact had been made with [redacted] on 31 October.
	Monica Lennon writes to Cab Sec highlighting concerns about whistle-blower claims.

From: Raines P (Philip)
Sent: 20 October 2020 16:08
To: McQueen F (Fiona); Bain MB (Marion); Murray D (Diane); Shepherd L (Lesley); White C (Craig); Morrison A (Alan); Dryden J (Jim); hazelborland@[redacted] 'WALLACE, Angela (NHS FORTH VALLEY)'; 'John Cuddihy'; andrew.murray[redacted]; Angela Wallace (NHS Forth Valley)
Cc: Claire Peacock (NHS Forth Valley); Imrie D (Douglas); Stewart K (Kathryn); Campariol-Scott C (Carole); Dryden J (Jim)
Subject: Papers for the QEUH Oversight Board meeting: Friday, 30 October
Attachments: NHS GGC and QEUH Oversight Board - 4 September 2020 meeting - minutes - draft.docx; NHS GGC and QEUH Oversight Board - Interim Report - October 2020 - draft.docx; Paper for OB-version 4.docx

All

Many thanks for making time for the next Oversight Board meeting, which will take place at 2pm on Friday, 30 October.

The agenda for that meeting is significantly more compact than previously, and can be summarised as:

1. Update on Oversight Board work programme and plans for reporting
2. Discussion of draft Interim Report of the Oversight Board
3. Discussion of Mycobacterium Chelonae cases

The key papers for the meeting are the following, both of which are attached here.

- The draft Interim Report, which will be discussed at agenda item 2. As you will see, this covers some, but not all of the issues on which the Oversight Board will be reporting – the remaining will be covered in the Final Report, which will be produced for a future meeting. Nevertheless, the Interim Report sets out key findings and recommendations, as well as an update on the work underway.
- A briefing paper prepared by John Cuddihy on the Mycobateria Chelonae cases at the QEUH, as requested by the Oversight Board at its last meeting (to be discussed under agenda item 3 above).

The discussion at the meeting will focus on this draft paper. In addition, draft minutes of the last meeting of the Oversight Board (in early September) are provided as well.

A MS Teams link for the meeting will be circulated soon.

Best regards

Phil

-----Original Appointment-----
From: Campariol-Scott C (Carole)
Sent: 18 September 2020 12:56
To: Campariol-Scott C (Carole); McQueen F (Fiona); Stewart K (Kathryn); Bain MB (Marion); Murray D (Diane); Shepherd L (Lesley); [redacted] White C (Craig); [redacted]; Morrison A (Alan); Raines P (Philip); Dryden J (Jim); hazelborland[redacted] 'WALLACE, Angela (NHS FORTH VALLEY)'; 'John Cuddihy'; Morris K (Keith); [redacted] andrew.murray[redacted] laura.imrie[redacted] Imrie D

(Douglas)
Subject: QEUH Oversight Board meeting
When: 30 October 2020 14:00-16:00 (UTC+00:00) Dublin, Edinburgh, Lisbon, London.
Where: Skype Meeting

Good afternoon,

As agreed at the last meeting of the QEUH Oversight Board, please see meeting request for **Friday 30th of October, 2 to 4 –pm**, to discuss reporting.

We appreciate this date and time may not suit all of you, and we would be grateful if you could let us know by close of play next Friday (25th) of your availability.

Agenda, papers and a link to Ms Teams will follow in due course.

Regards
Carole

Briefing Paper for Oversight Board: -

Access to Information enabling informed decisions as to how NHSGGC identified, responded to, communicated and managed water contamination/associated environmental contamination and outbreak of Mycobacterium Chelonea (MC) between 2015 and 2019.

In furtherance of our discussions during the Oversight Board meeting on 04 September 2020, and my question relative to the 'super timeline'; does the time line represent all documentation and information in possession of NHS GGC and elsewhere and, subsequently disclosed to enable completion, informed recommendations and conclusion based on the sum of all its parts?

It is the case that the timeline represents an excellent piece of work by Sandra Aitkenhead, KPMG and whilst accepting it is not a forensic examination of documents, is intended to provide a summary of key events and issues in terms of identification, response, management and communication. It further provides the opportunity to understand that which is collectively known and that which is collectively unknown leading to the identification of critical information requirements to enable more informed narratives, recommendations and conclusions.

In this regard I would suggest that there are a number of documents that are not yet referenced within the timeline and if made available would enable more informed understanding and highlight strategic issues relative to

- ◊ effective governance;
- ◊ culture;
- ◊ organisational behaviour;
- ◊ leadership;
- ◊ decision making;
- ◊ compliance;
- ◊ communication; internal and external;
- ◊ resilience;

- ◊ business continuity;
- ◊ risk management; and
- ◊ responsibility and accountability.

In an effort to support this thinking, I have identified a key event, from which I seek to outline the various documents referenced, together with those I believe are critical information requirements but not yet considered within the time-line, thus depriving the author and indeed members of the Oversight Board, the opportunity of considering a more detailed timeline, leading to more informed recommendations and conclusions.

Introduction- Baseline Event

Doc No. Timeline for 2019 (June) - Slide 30

Identification

From the timeline of events, information is provided with regards to an outbreak of Mycobacteria Chelonae (MC) in June 2019.

IMT on 19 and 25 June- HIIAT Amber

" Following on from the PAG on 3 June a further case Enterobacter Cloacae on 12 June and one case of Mycobacteria chelonae (MC) isolated from a patient's chest wall around line site and also water sampling on ward 6A. "

Investigations Performed

- ***"Had been case of MC in May 2018 during previous water incidents. Rare pathogen and only 4 adult cases and no paediatric cases reported by GGC in last decade. Confirmed new MC patient had no contact with unfiltered water."***

Comment:- Of the four adult cases reported by GGC in last decade, how many were identified within QEUH and if so, when did such infection occur, what was the response, level of communication (internally and externally) and management through application of control measures, escalation and risk management?

- ***"Water sampling in 6A with POUF off found MC in several areas"***

Comment:- If any of the four cases identified previously, were within QEUH, was this information made known during the water contamination crisis. Was such information considered during the completion of the SBAR and any risk management plan resulting in patients being decanted from wards 2A to ward 6A? 2) How many positive results for MC were discovered, where were they discovered and when? 3) where any of the areas identified, similar to those areas associated with the MC in the 4 adult patients previously- if within QEUH?

- ***"Three shower heads and Domestic Service Room (DSR) from 6A positive for MC."***

Comment:- Were shower heads a source of MC within those identified previously, if within QEUH? 2) Where were positive MC taken from in the DSR; what was the plan with regard to potential cross contamination, bearing in mind domestics, move throughout the ward. Is there a relationship between the DSR, domestic and other areas of positive results?

It is correct to allude to the fact that a case of MC was identified in May 2018, however, when one refers to

Doc No. Timeline for 2018 (May to June) Slide 22

There is no mention within the 2018 timeline of this rare bacteria having been identified as a Hospital Acquired Infection, despite a personal letter from the Chair of NHSGGC Board stating

"I want to express my regret that [redacted] contracted the mycobacterium infection while [redacted] was an inpatient in the Royal Hospital for Children, and I apologise on behalf of the Board for this having happened."

This followed detailed correspondence with Dr Catherine Calderwood, (Former Chief Medical Officer) Dr Jennifer Armstrong, Medical Director GGC, various GGC Board members and Scottish Government expressing concern that papers presented to the Board under title, ***Healthcare Associated Infection Reporting Template (HIART)*** made reference only to Gram Negative Bacteria (GNB) and as such did not provide information reflective of the extent of bacterial outbreak in ward 2A. However, there were references to investigations, control measures and management of these identified and disclosed infections, within

Doc No. **NHS GGC Board Minutes dated 17 April 2018**

Doc No. **NHS GGC Board Paper 18/17 dated 17 April 2018**

Doc No. **NHS GGC Board Minutes dated 26 June 2018**

Doc No. **NHS GGC Board Paper 18/28 dated 26 June 2018**

Doc No. **NHS GGC Board Minutes dated 21 August 2018**

Doc No. **NHS GGC Board Paper 18/38 dated 21 August 2018**

Doc No. **NHS GGC Board Minutes 16 October 2018**

Doc No. **NHS GGC Board Paper 18/52 dated 16 October 2018**

although, it is of note, none of the reports to NHSGGC Board detailed the identification of the rare pathogen, **Mycobacterium Chelonae**, with specific attention focused only on Gram Negative Bacteria. If the board are not provided with information how can they scrutinise and effectively govern?

It is important to note from paper 18/52, that

'...despite implementation of extensive infection control measures, recommendation from IMT was to decant the ward (2A). This was to enable a detailed assessment of the source and remedial measures to be undertaken"

It is understood that a

Doc No **Situational Assessment Wards 2A/B Royal Hospital for Children NHS Greater Glasgow and Clyde**

was completed by Health Protection Scotland (HPS) and should be an available source of information that can be considered within the timeline of events.

Indeed, in relation to the contamination the report states

" it could be hypothesised that ventilation may have been a contributory factor in several incidents however this cannot be confirmed until a full ventilation review has been completed."

For this reason, it is considered prudent to cross reference this statement about ventilation to findings in relation to the water contamination in order to derive a more holistic view of collective environmental factors that further increased the risks to immunocompromised patients. Further the report goes on to state

"Based on the ward reviews and the epidemiological data presented in this report it is hypothesised that the increased number of HIIAT reports could all be linked to environmental factors and are not considered to be indicative of poor or compromised practice."

It is interesting to note within the section on recommendations, the authors state that consideration should be given to the ventilation review within ward 2A/2B and this should be considered with involvement of IPCT. In this regard it is important that this report

DOC No. **Innovated Design Solutions:- Feasibility Study Regarding Increasing Ventilation Air Change Rates within Ward 2A (October 2018)**

is accessed and commented upon within the timeline and governance reports for Oversight Board.

In addition, the situational assessment also makes reference to the fact that

"A ventilation review is undertaken in other areas across RHC/QEUH in particular areas where high risk patients are to ensure compliance with national guidance."

This is especially important with regards to ward 6A and patient pathways to and from this ward and other clinical services. As such it is requested that this

Doc No. **additional ventilation report**, (regret no further details of this report)

be accessed and considered within the timeline and governance reports for submission to Oversight Board.

NOTE

At the oversight Board meeting of 04 September 2020, Mr Alan Morrison made reference to having received a technical report 2 days prior to the OB and in this regard was awaiting further

interpretation from HPS. It may be that this is reference to the same document referred to above, however, if not this additional document should also be considered within the overall time line and governance report to OB.

It is also worthy of consideration that within

Doc No. Appendix 1: HIIAT Assessments NHSScotland Incident and Outbreak Summary Ward 2A RHC (January 2016- Dec 2018).

NHS Greater Glasgow and Clyde have reported a total of 10 outbreaks and 15 incidents for the clinical setting paediatric haemato-oncology. Again, it is vital to have assurance that the total number of incidents is reflective of all incidents, including MC and any other identified bacteria. Thereafter all incidents should be considered by the Oversight Board, including associated reports such as epidemiology. Indeed, this should enable further context to be derived from

Doc No. Appendix 4: Health Protection Scotland - Epidemiology Report, December 2018 Case and episode definitions

The report itself is worthy of consideration in its current format as it discloses that following data extraction from the Electronic Communication of Surveillance in Scotland (ECOSS) system. Specifically, an extract of all positive blood cultures for any patient **under 16 years of ag**e in NHSGGC was taken from ECOSS on the 13th June 2018 with an update taken on 20th August 2018. The case definition was a positive blood culture reported in patients aged less than 16 years in RHC/YC between July 2013 and June 2018. An episode was defined as one positive sample per species in a rolling 14-day period.

It is important to note that patients **16 years and over** are treated within the Paediatric Haemato Oncology Department at RHC, some of whom have contracted HAI, including MC. As such there has to be a confidence within the case note review and indeed within the review of bacterial

outbreak, that such patients are being considered as they will fall out with the parameters of this case definition and in so doing, result in under-reporting of the number of incidents.

Indeed, when one considers the Microbiology section of the referred to document, it highlights Positive blood cultures of the following micro-organisms were included:

- ◊ Gram-negative bacteria
- ◊ Gram-positive bacteria
- ◊ *Staphylococcus* species
- ◊ Environmental bacteria (all species of the following: *Achromobacter; Acinetobacter; Aeromonas; Brevundimonas; Brevibacillus species; Brevundimonas; Burkholderia; Chryseobacterium; Citrobacter; Cupriavidus; Delftia acidovorans; Elizabethkingia; Enterobacter; Klebsiella; Pantoea; Pseudomonas; Rhizobium; Rhodococcus; Serratia; Sphingomonas; Stenotrophomonas).*
- ◊ Non environmental bacteria (all species of the following: *Abiotrophia; Actinomyces; Aerococcus; Bacillus; Bacteroides; Bifidobacterium; Brevibacterium; Capnocytophaga; Clavibacter; Clostridium; Corynebacterium; Dermacoccus; Dietzia; Enhydrobacter; Enterococcus; Escherichia; Fusobacterium; Gemella; Granulicatella; Haemophilus; Kingella; Kocuria; Lactobacillus; Lactococcus; Leclercia; Leuconostoc; Microbacterium; Micrococcus; Moraxella; Mycobacterium; Neisseria; Paenibacillus; Propionibacterium; Proteus; Raoultella; Roseomonas; Rothia; Salmonella; Staphylococcus; Streptococcus; Veillonella).*
- ◊ Fungi (all species of the following: Candida; Rhodotorula).

And cross refers with the following species that were previously isolated in water samples from 2A/2B: *Achromobacter*; *Acinetobacter; Brevundimonas; Burkholderia; Chryseobacterium; Comamonas; Cupriavidus; Delftia acidovorans; Elizabethkingia; Pantoea; Pseudomonas; Rhizobium; Sphingomonas;Stenotrophomonas*, together with the following species previously isolated in drain samples from 2A/2B: *Citrobacter; Cupriavidus; Delftia acidovorans; Enterobacter; Klebsiella; Pantoea; Pseudomonas; Serratia; Stenotrophomonas.*

In summary, the overall incidence of Gram-negative, Gram-positive and environmental bacteria blood cultures increased in the 2A/2B Group after the move to the RHC. SPC Charts indicated that the Gram-negative, Gram-positive and environmental bacteria blood culture incidence rates in the 2A/2B Group **were higher than expected following the move to RHC.**
Whilst it is stated that this conclusion must be interpreted with some degree of caution, as changes in the patient population have not been accounted for in this analysis, the shift in the incidence identified by the SPC charts indicates that **the trends in blood culture incidence changed after this time.**

It is considered important to include all bacteria and fungi identified within a patient population treated within RHC over the identified period and compared against similar data. If the baseline data does not include patients 16 years and over then this must be recorded and reported to provide further context to the level of bacterial outbreak during the specified period.

With regard to the decant from ward 2A to ward 6A RHC Senior Management Team (SMT) completed a

Doc No. **Risk Assessment**

With recommendations to the Board to approve decant to suitable accommodation in the adult hospital. It is important to be able to access this risk assessment to establish if reference is made

to MC and if not, why not, with any identified control measures being considered. The importance of such access will ensure that there was due consideration of MC in September 2018, with particular regard to the identification of MC in 2019 together with associated control measures. In essence, was enough investigation, implementation of control measures and risk management considered in order to prevent further outbreak?

In addition, following the ward assessment by HPS, were the findings considered in furtherance of the risk assessment and with due regard to MC?

Further, following the decant from ward 2A an independent expert company was retained to conduct analysis of the drainage system. Where this company aware of the existence of MC and to conduct swabbing's in respect of this bacteria?

Indeed, investigations conducted by Health Protection Scotland related to GNB as did the Independent Review conducted by Fraser/Montgomery again re-enforcing the view that such investigations and reviews were not considerate of the full bacterial or fungal outbreaks on ward 2A or 6A. This is despite assurance from Professor John Brown, Chair of NHC GGC Board

"you can be reassured that single occurrences of rare infections are not overlooked"

However, when one considers that which has been provided, or NOT provided by GGC to Sandra Aitkenhead, relative to her completion of the 'super timeline", it is apparent that detail cannot be included if it has not been provided!

Indeed, when one considers

Doc No. Internal Report to Oversight Board- Reflections on Governance 2018 (slide 10)

There are no mentions of MC either as an identified bacterium nor any reference within those identified governance groups as to how GGC responded, managed or communicated in this regard. Further, when one considers the table that is used in identifying such bacteria it is titled

Gram Negative/Fungus (number of incidents)

Again, re-enforcing the belief that there is a focus on only part of the problem.

It is also worthy of note that from the identification of MC in 2019, this relates to **ward 6A** whilst the identified MC case in 2018 related to **ward 2A**, which raises further concern as to the level and spread of Mycobacterium within QEUH and RHC, more specifically within a vulnerable patient group of immunocompromised patients, over a relatively short space of time, compared to only four cases in the last decade, none of which related to paediatric patients; although as previously alluded to, one must ensure that such infection did not occur within QEUH or RHC as it would indicate that such information had never been communicated to those engaged in this crisis. In addition, one has to question, how did GGC respond, manage and communicate the outbreak of MC in 2018.

It is the case that guidance is provided, at least in part within

Doc No. **Summary of Incident and Findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children water contamination incident and recommendations for NHSScotland.**

Reference is made in this document to

"Specific microorganisms which can be tested for include: Coliforms, Escherichia coli (including O157), Pseudomonas aeruginosa, Salmonella spp, Campylobacter spp and Environmental Mycobacteria. Testing for these is not conducted as standard within current guidance and

typically occurs in response to a suspected or confirmed outbreak, or due to identification of a series of sequential cases."

As such, when one considers 'response' to this confirmed case of MC in 2018, there is information that GGC has, that can provide detail around how they responded to this *"rare pathogen'* however, at this stage such information has not been presented. In addition, it is important to note whether water samples were taken from within ward 2A at that time, given the identification of MC; and if not, why not? This is particularly important to note as reference is made to Genome testing and if no such samples were taken, how can one conclude that there is no evidence?

Indeed, questions must be asked as to whether water samples were ever taken from ward 2A, even after the decant to ward 6A. If such samples were taken, did they return any positive results for MC and if so, where exactly where such positive results found and what has been done in this regard?

In addition, when one considers

DOC No. **NHS GGC Water Systems Safety Policy:- Written Scheme and Operational Procedures**

The report details when water samples should ordinarily be taken

"Samples should be taken from key areas where it is known that patient groups are most vulnerable as defined by the Board Water Safety Group and a collection regime will include samples from these areas along with any additional areas on the site considered by the group to have increased levels of risk. A list of the areas for each site will be produced and made available on the intranet for reference" The Board will adopt as a rule of thumb an approach that where water sampling occurs as a result of increased TVC's where there have been three

clear samples the sampling regime will cease. This will be reviewed and agreed by the Board Water Safety Group."

However, following the above guidelines and NHSGGC policy, was the disclosure of MC in 2018 presented to the Board Water safety Group as per those guidelines? If not, why not?

Following review of

Doc No **Control Measures taken (slide 30 timeline for June)**

- ***Timeline for patients with MC to be developed to see if any contact with unfiltered water***

Comment- did this occur in 2018 when patient was identified with MC? Such timeline should be made available for scrutiny.

- ***HPS to research what instances other health boards have of MC so GGC can compare own figures***

Comment- what is the update for this action?

- ***Dosage of chlorine dioxide to be increased. MC isolated from patient and water samples to be sent for genome sequencing***

Comment: - internal reviews and advice suggest that increased dosage would comprise the integrity of the pipes themselves. As such, what is the control measures to be adopted in this instance?

- ***MC now included on IPCT alert organisms list***

Comment: - whilst this is a welcome addition. When was this updated to include MC.? Why was it not updated in 2018 or indeed, in 2017 when MC was first identified in QEUH? Does this indicate a less than timely or proportionate response? If this had been acted upon sooner, could there have been better protection of vulnerable patients and potentially reduced such risks, perhaps even to the patient in 2018 and most certainly in 2019?

- ***POUF's to be filtered in theatres, interventional radiography and Outpatient Departments***

Comment- is there a confidence that POUF's are present across the entire patient pathway in RHC/QEUH relative to such vulnerable patient population? If so, can a date be provided as to when this confidence level was achieved and who has signed off on this?

- ***Chill beams to be sampled as leaks reported within last month. Estates to review all leaks from 6a in last month to see if any commonality with patients***

Comment*:* - it is interesting to note that contained within

DOC No. Property, Procurement & Facilities Management Directorate:- SBAR (Nov 2018

Reference is made to ***" ventilation design was derogated from national guidance requirements…, in order to adopt chilled beam technology to meet BREAM energy performance targets" … 'this derogation seems to have been applied universally across all single room accommodation regardless of the patient risk group with no allowance for neutropenic patient groups" In addition, the report goes on to state " potential for toilet extract bypass air to enter the supply air stream introduces a risk of cross contamination into the patient environment."***

It is extremely concerning to note that patients were exposed to increased risk in order to meet energy performance targets! Who signed off on this decision and what process was in place to manage the increased risk whilst meeting energy performance standards?

- ***Air sample to be done in water (is it believed that this should read ward 6A) 6A with water running into sink to check for aerolisation of drains.***

Comment:- whilst reflecting on the comments previously, it is important to consider

DOC No. Innovated Design Solutions:- Feasibility Study Regarding Increasing Ventilation Air Change Rates within Ward 2A (October 2018)

Commissioned following decant of the patients from ward 2A to ward 6A. In this report it states

"Following analysis of the current ventilation strategy within upper areas of Ward 2A (Mid-Ward & TCT areas), we anticipate the original accommodation design philosophy was not intended for use by patients with immune response impairment/deficiency. On the contrary, the existing ventilation strategy would appear only likely to promote the risks associated with uncontrolled ingress of infectious aerosols into patient areas."

Comment: In light of the foregoing, what assurances are there that Air samples have been taken in ward 2A with water running into sinks to check for aerolisation of drains? Indeed, the results of such testing should be made available to the Oversight Board and included within the time-line of events.

The report goes on to state

"In addition to the foregoing, during our analysis works we discovered numerous significant deficiencies/inadequacies appertaining to the existing system installations, which are outlined

within the report accordingly. Of particular note, it was identified that extract ductwork distribution derived from the Ward 2A air handling unit is utilised to serve numerous 'dirty' type spaces (i.e. Toilets, Shower Rooms, Dirty Utility Rooms, Disposal Rooms, Cleaners Stores, etc.), on various floor levels. This is deemed to be a very abnormal strategy, differs from design methodology adopted within other areas, and should be investigated further.

Comment:- in furtherance of the above, was this abnormal strategy investigated further and if so, when and by whom. The report of this further investigation should be disclosed to the oversight Board and considered within the detailed timeline.

The report continues

"Moreover, whilst thermal wheel devices are regarded as an acceptable technique for energy recovery within SHTM 03-01, we would be hesitant with regards to the appropriateness of application in this instance, especially when air cleanliness would appear to be of vital importance in terms of patient safety.

Other significant discrepancies identified include, limitations in terms of air handling unit fan selections, the installation of single supply and extract fans within a unit serving numerous floor levels and acute facilities, substantial irregularities in terms of extract system air volumes, and undefined ductwork distribution pressure classification."

- ***Water sampling in ward 6A to be done with and without POUFs- talk to manufacture to see if there is evidence that filter prevent MC entering water from the tap***

Comment: - It is important to understand, within follow up reporting if such discussions returned evidence in support or otherwise of MC entering water from the tap.

- ***Check previous water samples for MC***

Comment: - what have those checks concluded in terms of identification of MC within water samples and what corporate information do GGC possess in this regard that can be scrutinised?

One would consider such control measures to be reflective of the seriousness of the identification of MC in ward 6A, however, what information has been supplied with regard to such control measures following identification in 2018? Moreover, what was the outcome following such control measures in May 2018? If no such control measures were initiated, why not?

In relation to the technical water group timeline, a number of observations are worthy of consideration as they shed light on the extent of the mutual exchange of information enabling informed decision making and thus reflect on leadership, management and risk management.

Doc No. Technical Water Group Timeline for 2019 (May to June) Side 44

It is interesting to note that the TWG were advised of positive results from ward 6A of STM and MC however when one reflects on

Doc No. Technical Water Group Timeline for 2018 (Jan to May) Slide 37

There is no such notification about MC to TWG in 2018 however there is reference within Board Water Safety Group Meeting (BWSG) that they received ***' an update on the "water incident" in Ward 2A'*** although does not expand on this. As such it would be important to access the corporate briefing documents utilised to brief between IMT and those internal governance groups to ensure that the identification, response, management and communication was appropriate with due regard to mitigation of risk and patient safety. This should be considered in terms of the TWG and BWSG.

It is noted from the

Doc No Technical Water Group Timeline for 2019 (July to August) slide 45

"AICC informed that the QEUH chlorination system is fully fitted and there have been good results and gram-negative count has reduced significantly, however the mycobacteria issue has recently appeared and is resistant to chlorine at the original used levels. It is noted that the increase in mycobacteria may be due to existing biofilm or it is being selected out and proliferating because it is resistant to chlorine"

There are two significant issues that require to be understood from this update

1. The term 'recently appeared'- does this imply recently as in 2019? Is there a timeline that highlights 'recently appeared' extending to the incident of 2018 and if so, what information was provided in this regard, to whom and when?
2. 'resistant to chlorine'- how has this hypothesis occurred. What reports are available to support this statement, and have they been made available for scrutiny?

Reference is also made within the AICC update to the fact that the Board have International Water experts on 'retainer'. It is considered appropriate to access any reports submitted to those 'water experts' that enabled them to be appropriately briefed as to the 'problem profile' together with their findings, interim or otherwise.

Indeed, within such reports, it is considered necessary to access

Doc. No Susanne Lee Report

As she alludes at the outset that

'about 95% of the patients (within RHC) fall into the category of very high risk of infection."

Comment:- is this Susanne Lee's assessment or is this information supplied by the hospital. If the latter, was this a basis for decision making from 2015 onwards and if so, is there evidence of such consideration?

A number of recommendations are made within this report and it is important to note if any of these recommendations were considered by the various governance structures, including the GGC Board. If none of those recommendations were considered appropriate, it would be helpful to understand if any contra-view to those recommendations exist, from whom did those views come and how did the relevant governance group risk manage such decisions?
Indeed, recommendation 2 of the aforementioned report states

'It is important that all internal maintenance staff; estates officers and contractors undergo training not just in Legionella awareness but also other potential waterborne pathogens of interest, the site policies; procedures; patient confidentiality; documentation requirements; requirements for bringing equipment safely on site; relevant legislation and guidelines.'

The importance of this recommendation cannot be overstated as when one reflects on both

Doc No. DMA Report 2015

Doc No. DMA Report 2017

Each are actually identified as ' Legionella Risk Assessment' reports and when one reflects on the 2015 opening summary it clearly states

" as the building is used by persons with acute underlying medical conditions which increases susceptibility to contracting legionellosis then the requirements for L8, HSG 274 and

HTM/SHTM 04-01 complience is of paramount importance. The Legionella Management was identified at the time of reporting as High Risk."

The above is separate to the numerous issues of significant concern, detailed throughout the 2015 report, referred to within the timeline for Oversight Board as the ***'lost report'***

Additionally,

Doc No Technical Water Group Timeline for 2019 (July to August) slide 45

Makes reference to the governance group BICC and the statement

'*BICC advised that one theory as to why mycobacterium is showing up is that it is resistant to chlorine and with the introduction of the CD it has eliminated other types of organisms which is allowing more unusual types of bacteria to grow"*

What report supports this hypothesis, and can it be confirmed that there was awareness within BICC of the existence of mycobacterium in 2018? It would appear important to understand this as, in the absence of any information as to the control measures in 2018, **mycobacterium** was identified at a time pre chlorine dosage and as such this hypothesis would relate only to events in 2019!

In an effort to further understand the extent of effective governance and scrutiny, reference is made within

Doc No. Technical Water Group Timeline for 2019 (November to December) slide 47

"Discussion of the results returned from ward 6A that had led to the conclusion of contamination and also around method of sampling which had led to this result. This had been

shared with people within the Board. This conclusion was contrary to what previously reported and that the water was safe. It is not clear whether the results were expected, or this was just a spurious result but has now led to ongoing discussion with SG.

Separate to the obvious and concerning confusion around high risk issues, it was important to reflect on what had '***been shared with people on the board'***? As such, examination of 2019 NHS GGC Board papers revealed

Doc No NHS GGC Board Paper 19/43 dated 20 August 2019

"Since April there have been eleven cases of gram-negative bacteraemia's and one case associated with a type of mycobacteria over a four-month period. This is in keeping with recognised background rates which are approximately two-three per month. Three of the twelve cases were of an unusual type of bacteria and as a consequence an Incident Management Team was convened to review all of the cases"

Comment: - It is assumed that the type of mycobacteria referred to is MC. This being the case it is important to access the reports, which conclude ***'this is in keeping with recognised background rates'.*** As previously alluded to, this is a rare pathogen that, separate to the case identified in 2018, had not been observed in the paediatric population in the last 10 years across NHSGGC. As such this contradicts that information and, if untrue, is grossly misleading for those on the Board.

"In addition, environmental sampling has been undertaken and at this time, there have been no links to any of the cases and the environment in the haematology/oncology ward. It should be noted that this process is ongoing.

The three unusual cases referred to were identified by the LICD. None of the cases are linked to each other however one has been linked to the general environment (water). There is evidence that the filtered water in the haematology/oncology ward is free of bacteria but as a precaution, point of use filters were placed on outlets in other areas of the hospital this

vulnerable group of patients might visit. The bacteria linked to water is harmless to the vast majority of patients and the public and published studies show this type of bacteria can be found in raw water, such as reservoirs, lochs and rivers, in public mains, household water systems and in public buildings such as hospitals. Infections with these bacteria are very rare. The authorised engineer (AE) has reviewed all the water reports from the QEUH and describes the water supply as 'wholesome'. The part of the incident related to water was closed by GGC and HPS on the 8 August 2019."

Comment:- it is perhaps requiring of such an important update to the Board, to confirm exactly what this statement is based on. If genome sequencing is what is referred to, it is my understanding that this has limitations especially when dealing with environmental incidents where many strains of bacteria are involved. It is alleged to work best for bacteria transmitted from person to person, rather than those from an environmental source. Crucially you must take environmental samples at the same time as the patient sample due to evolution of bacteria over time. **As such it is crucial to understand when such water samples were taken. Such information is crucial in managing such a high risk.**

In addition, using the phrase '*the bacteria linked to water is harmless to the vast majority of patients',* is not in the least helpful as this crisis is not related to the general patient population, a recurring theme within reviews into this crisis. Accepting that general patient care is of course important, this patient group within the haemato-oncology ward do not represent the general patient population and as such must be subject to higher control measures to mitigate and manage the increased risk. This is a continual theme throughout the management of this crisis and demonstrates a total lack of understanding as to the risks involved or at worse a demonstration of apathy and a culture amongst leaders of very poor governance and risk management.

Doc No. NHS GGC Board Paper 19/54 dated 22 October 2019

'Since April 2019 there had been13 cases of gram-negative bacteraemia (GMB) and one case of mycobacteria in the paediatric haematology/oncology unit in the QEUH. '

From this update, it appears that the board have been provided with GNB updates together with one case of MC, separated because this is a gram-positive bacteria (GPB). The significance of this update cannot be overstated as during 2018, Board members were never provided with any information regarding the GPB MC by GGC . Indeed, it appears that to date, the Board have never been provided with any information that places into context the significance of the identification of this rare pathogen within the QEUH and RHC.

Although, whilst no such information was formally provided through recognised governance groups to the Board, this information was supplied verbally and in writing to the Chair of the Board. Professor John Brown, CEO, Jane Grant, Dr Jennifer Armstrong, Cabinet Secretary for Health, Jeane Freeman and a variety of other senior managers and post holders within Scottish Government and GGC. However, none of these individuals or groups have highlighted this fact within any updates or briefings which have been made available to the author of the timeline. As such it is considered vital that any and all communication regarding the existence of MC during 2018 and prior to the outbreak in June 2019, be disclosed to enable scrutiny and understanding of how this was responded to, managed and communicated.

It is also important to reflect on language within the Timeline and for the sake of completeness and accuracy, MC has been listed as a GNB which of course it is not.

Doc No. NHS GGC Board Paper 19/65 dated 17 December 2019

This paper is considered important as it invites the board to reflect on

Doc No. HPS Report of Paediatric/Oncology BSI

And compare quantitative data covering a time period from 2013 to October 2019 in relation to the 2019 investigations into gram negative infections linked to ward 6A, and the decision to reopen the ward. In addition, board members are invited to reflect those comparisons on the combined rate of two other Scottish children's hospitals Royal Aberdeen Children's Hospital (NHS Grampian) and Royal Hospital for Sick Children (NHS Lothian). Whilst recognising the need to compare with other hospitals, one would consider that such hospitals should be similar in size,

year of build, conduct and use. One would have expected that standards for a newly built hospital with modern control measures as alluded to in the Fraser/Montgomery report, to be greater than those identified. Perhaps a more appropriate comparison would have been Great Ormand Street Hospital in London. However, perhaps more significant would be a comparison on qualitative data rather than quantitative data. As previously mentioned, MC is a very rare pathogen not evidenced within a paediatric population in the last decade. Why was this not reflected upon?

Indeed, following the various control measures initiated in June 2019, Mycobacterium was also identified on a previously, wrongly labelled sample from July 2017 as detailed in

Doc No. Internal Report to Oversight Board- Reflections on Governance 2017 (slide 8)

And

Doc No. Timeline for 2017 (June to August) slide 17

'Report on meeting on 16 June on genome sequencing of Mycobacterium Abscessus. Samples sent to Reference Lab who said some are linked.'

It is assessed that the date given on this update refers to 16 June 2019, following the identification of MC in ward 6A. This being the case, it is requested that the information from governance groups during this time be accessed to provide context around this incident with associated control measures. Clarity is also requested around the phrase ***'.reference lab who said some are linked'***- as it is vital to understand, what are linked? This statement would tend to contradict that provided in other reports which indicate no linkage between any of the three identified MC/MA cases across RNC and QEUH.

It may be that such information can be accessed from the weekly report sent to senior officers/directors which details any incident or outbreak that are HIIAT assessed as either Amber or Red as detailed in

Doc No. Internal Report to Oversight Board- Reflection on Governance- Slide 18

'GGC has advised that there is a weekly report that goes to all the senior officers/directors within the Board which details any incidents or outbreaks that are HIIAT assessed as either Amber or Red. GGC make the point that this provides for rapid escalation and briefings to be made to ensure the Corporate Management Team, Chief Executive, Chair and Non-Executives are aware of situations as they develop.'

It is therefore reasonable that such information will exist relative to the MC incidents from 2018 and 2019 and as such should be considered a valuable and critical source of information as to how issues were identified, responded to, communicated and managed. **Such weekly reports should be disclosed to enable scrutiny and inclusion within the timeline.**

Of concern is the recurring theme of internal communication, or perceived lack of communication. Since 2015, there has been an absolute desire for access to 2015 DMA report in order for those responsible for IPC the best opportunity to make informed decisions in the best interests of their patients. It is therefore concerning that within the

Doc No Technical Water Group Timeline for 2019 (September to October) Slide 46

IMT have listed ***'Visibility of any current positive water samples'*** from the Technical Water Group, suggesting that such information, even in the face of this crisis, is not routinely communicated.

<u>Governance</u>

It is noted from the information provided within slide 30, that IMT and BICC were aware of the MC incident in 2019 and presumably from 2018, as this is referenced, however, it is unclear from the information provided as to what other governance groups were aware of this prior incident of a rare pathogen within a small patient group. It is also unclear within risk management information if the presence on 3 shower heads, within the Domestic Room in ward 6A and various POUF's of this rare pathogen, was known and if so, how was this managed and communicated?

It is known that the IMT in June 2019 linked MC incident from ward 6A to the incident in 2018 in ward 2A. It is also known that a specific action was taken and agreed by the IMT to exercise Duty of Candour and advise the parents involved with due regard to confidentiality. It is understood that at a subsequent IMT meeting, members were advised that the action was discharged and as such recorded as completed.

Doc No. **IMT minutes June 2019**

Doc No. **IMT minutes June 2019**

Duty of Candour

Duty of candour refers to the ethical responsibility for healthcare professionals to inform patients or their families when mistakes have been made and they may have suffered harm or death as a result. It involves apologising, acknowledging and explaining what has happened to patients. Duty of candour is applied where moderate or severe harm has been determined to take place.

It should be noted that by understanding that causation is not a required factor, acceptance that both incidents resulted in harm, with the 2018 case resulting in significant medical intervention on numerous occasions, with continued requirement for additional medication over prolonged periods, resulting in detrimental impact on future options for medical intervention, the decision to link the incidents and advise the parents/patients accordingly was considered by the expert group of the IMT to be appropriate in communicating and demonstrating management of the incidents.

Despite the decision making of the IMT and the existence of the Duty of Candour, this statutory duty was not fulfilled.

Leadership/Management/Suspected Breach of Duty of Candour

However, it is the case that those tasked with discharging this action, Dr Teresa Inkster, Chair of IMT and Jamie Redfern, General Manager, Women and Children's Services, were countermanded from doing so by Kevin Hill, Director Women and Children Services and subsequent IMT minutes were updated to the effect that the parents from the 2018 incident had been advised accordingly. This was NOT the case and information, was not disclosed to parents of the child involved in the 2018 case. ***It is the case that in circumstances were a medical director knowingly obstructs another from performance of the statutory candour duties, such a breach can be considered a criminal offence.***

This only became apparent following requests to speak with representatives from the hospital as the facts of the second outbreak had seeped out and learned by the family of those involved in the initial outbreak.

Organisational Behaviour/Culture/Breach of Duty of Candour

During a meeting in August 2019, a parent of the family concerned was presented with a version of events, following which it was disclosed by a senior doctor,

"tell him the truth"

It is the case that in such circumstances were a medical director or senior doctor provides information to a patient or family of a patient with intention to mislead them, such conduct is deemed to co*nstitute a criminal offence., especially where such circumstances were wilfully deceptive.*

As you would imagine, separate to the breach of the duty of candour, this tends to suggest an untruth and when dealing with the health of your child, this is extremely distressing to hear. Indeed, this resulted in significant detailed correspondence between the Board, CEO and family

with various versions of events provided by GGC. However, the family were to understand that those versions of events, provided by successive governance groups did not represent the truth! Whilst it is acknowledged that this may seem to be a personal and private matter and not representative of detail for the time-line, it is considered important to provide context as the incident was a catalyst for events that would influence and illuminate aspects of governance, culture, leadership, decision making and ultimately, use of statutory instruments such as whistleblowing.

Whistleblowing

It is the case that following this incident a staff member sought guidance and council from the General Medical Council who determined the best way forward was to initiate Public Interest Disclosure Act 1998 and 'whistle blow'. As such, it is considered that the GMC provide an opportunity to harvest information relative to those events and moreover, the detail surrounding the need to 'whistle blow'. Further it is considered that both the GMC and BMA may provide additional information which surrounds the events detailed within the timeline more broadly relative to concerns of staff from 2015 through to 2019.

It is also suggested that following formal notification of suspected breach of Duty of Candour, an independent investigation is carried out which will either implicate or exculpate those involved relative to formal criminal proceedings.

Organisational Behaviour/Culture

Information has been provided that a total of 6 clinicians within GGC have resigned from the post of ICD; 3 in 2015 and 3 in 2017. It is considered that such information is worthy of comparison with other hospitals to determine if this failure to retain staff within such a vital role is commonplace. Indeed, it offers opportunity to consider Human Resource Management within

GGC as a potential repository of information regarding such Human Resource matters and may highlight the reasons as to why, disclosing information that could assist within the Peer review. Such information may also assist in the desire to 'peer review' to role of ICD within NHS Scotland, whilst negating any view that the 'lost report' impacted on the ability to manage this crisis. This course of action will highlight a body of information which references the "lost' report sufficiently to continually prompt managers of its existence and hence their actions to recover and act upon it!

Further, it is considered that such information may offer opportunities to explore, in the absence of the 'lost report' (reference to DMA report of 2015), the extent of knowledge as to the findings contained within the 'lost report', the level of response to the findings of this 'lost report' and how those identified issues were managed by those with operational service delivery responsibility in the area of IPC and more importantly those in senior management positions and roles within the executive governance groups. Such information is vital in highlighting the impact of 'losing' a report by providing significant information reflective of the serious professional concerns, expressed by clinicians in 2015 through to present day. It is understood that there exists, amongst various documents

- Numerous emails from IPC clinicians to senior managers
- HR resignation letters citing significant concerns with patient safety within RHC and elsewhere in QEUH
- 2017 DMA report (which reflects on the 2015 report)
- Letters representing concerns of a collective group of Microbiologists
- Direct information from those involved in the Duty of candour incident associated with non-disclosure of the MC bacteria incident and attempts to mislead
- Communications between the family of the patient involved in 2018 and NHSGGC

Senior Management/Decision making/Culture

Doc No. Open Letter to Patients/Parents by CEO Jane Grant dated 21 November 2019

It is the case that on 21 November 2019 Jane Grant, sent an open letter to all patients and parents associated with ward 6A in which she stated

"You will all be aware that over the past few months we have been investigating a number of cases of infection in Ward 6A to identify if there are any links between those infections and the ward environment.

As part of this, an independent review of the unit's infection rates was carried out. The purpose was to examine whether infection rates within Ward 6A are what we might expect to see or are higher than expected.

The review, commissioned by the Chief Nursing Officer, Scottish Government, and undertaken by Health Protection Scotland, has now been completed.

https://www.isdscotland.org/About-ISD/Confidentiality/disclosure_protocol_v3.pdf

Health Protection Scotland has concluded there is no evidence to support the continued restriction of new admissions to Ward 6A at the Queen Elizabeth University Hospital.

The letter continues

"Health Protection Scotland have also confirmed that they are content with the actions that have been taken by the Incident Management Team (IMT) to investigate individual cases, that they have reviewed evidence of effective implementation of the actions they recommended and are assured that appropriate arrangements are in place for ongoing monitoring of infections, including triggers for detailed scrutiny going forward.

It is important to understand the extent of HPS reviews of IMT, IMT actions, IMT minutes and associated documentation in order to elicit a confidence that they had access to ALL material especially that alluded to in the proceeding paragraphs. More-over, the CEO, Jane Grant was aware of the significant concerns raicandoursed by the families concerned, as they had been articulated to her in person and in writing, whilst also being provided to the NHSGGC Chair John Brown, Senior Medical Staff and various Statutory authorities. In all the circumstances it is vital that such information is made available to the Oversight Board and author of the 'time-line' in order that informed decisions can be made relative to effective governance, culture, organisational behaviour and corporate responsibility to address wilful falsehoods and wilful acts so reckless as to show an utter disregard for the consequences.

Conclusions

In all the circumstances it is considered that when considering Mycobacterium Chelonae within the paediatric haemato-oncology patient group, significant information is missing from the "super time-line' and Internal Report to Oversight Board which prevent considered recommendations and conclusions from being drawn.

Indeed, the events leading up to the identification of MC in a patient within ward 2A in 2018 seem to have been wiped from corporate memory, save for the retrospective mention in 2019, when MC was again identified this time in a patient within Ward 6A. There is also an absolute lack of information as to how this incident in 2018 was responded to, communicated and managed. There are no records of any update to the Board of this rare pathogen nor within any of the internal governance groups, save for the IMT. However, there is also clear evidence in relation to the case of MC in 2018, the IMT were countermanded by GGC Directors for reasons known only to them and in clear breach of Duty of Candour with evidence of wilful falsehoods.

In furtherance of increasing concerns at the time, numerous pieces of correspondence were communicated expressing significant anxiety around the response with assurances provided that seem, on the evidence of corporate documentation supplied to date, to be at best 'opaque'. Indeed, such has been the concern as to how aspects of this episode were managed, recourse was made, and advice sought from the General Medical Council (GMC) resulting in the commencement of Whistleblowing procedures.

However, even more significant was that assurances and risk assessments were completed in respect of decant to ward 6A without any obvious reference to the existence of MC. Indeed assurances, specifically in relation to the existence of MC and concern that some other child may contract such infection were provided. It is concerning as to how such assurance could be adequately provided if the information was not considered within a risk assessment. The fact that a second child contracted MC is evidence enough that those assurances were unfounded. In addition, when one considers the control measures implemented in 2019 resulting in retrospective identification of MA together with numerous positive results for MC across the whole estate, one has to conclude that senior management failed to adequately and timeously identify, respond to, communicate and manage this aspect of the crisis.

Indeed, it is considered that the suppression of information, some intentional and some a result of organisational mismanagement and lack of effective governance and compliance regimes has led to a corporate failing that has placed lives at risk and impacted directly on their failure to recognise, regardless of environmental causation, their Duty of Candour.

I would submit that there is a significant body of information that exists but not yet presented to the Oversight Board which would further inform as to the existent culture, organisational behaviour, leadership, approach to risk management; communication and management that together negatively impacted upon the physical, emotional and phycological safety, wellbeing and care of a vulnerable patient group with clear evidence that in terms of managing the risk,

more concern was expressed and documented with regards to reputational risk rather than increased patient risks.

In all the circumstances it is considered that when considering comments from NGSGGC relative to this crisis; the water contamination, ventilation issues, drainage issues, wider environmental issues, linkage between environment and bacteria in patients, numbers of complainants during the crisis, the 'lost report' duty of candour and numerous other points, absence of evidence is not evidence of absence; positive evidence of this kind is distinct from a lack of evidence or ignorance of that which should have been found already, had it existed.

In furtherance of the request by the Oversight Board to provide a report as to my concerns, I would offer the foregoing for consideration along with the documents listed below, which, I would suggest can be accessed from GGC.

Documents identified in support of the above report and considered vital in establish exactly when issues where identified, responded to, managed and communicated by NHSGGC.

It is recognised that some of those documents listed may already be in the possession of Sandra Aikenhead, however for the sake of completeness and to avoid any confusion, it is respectfully requested that NHSGGC be asked for all of the below documents. Should there be circumstances that indicate that NHSGGC cannot provide access, it would be appreciated if they could be asked for an explanation as to why this would be the case.

- HPS epidemiology report on M chelonae
- Whole genome sequencing report
- Any NHSGGC MC action plan?
- Documentation of discussions regarding Chlorine dioxide and possible resistance

- Briefings/Documents sent to the Medical director and/or senior management re mycobacteria
- Status/Situational reports sent to Medical Director and/or senior management from RHC senior management
- Extent of water contamination with MC
- MC from a shower head in 2017 - how was this escalated and actioned?
- Any communications/teleconferences between SG and GGC during 2018 water incident relative to MC.
- Weekly senior management reports of outbreaks that have been HIIAT assessed between 2015 until now and specifically related to MC.
- Board papers
- DMA 2015 report
- Ward 2A situational report
- DMA report 2017
- HFS Technical Report 2018
- [redacted]
- Additional ventilation report- (following recommendation for further investigation)
- GMC Reports in connection with MC and associated issues, including, but not restricted to water contamination from 2015 to 2020 inclusive
- BMA Reports in connection with MC, water contamination and associated issues, including 'resignations' and basis thereof, from 2015 to 2020 inclusive
- All communication between CEO, Chair of NHSGGC, Medical Director, Senior Management and any other identified staff and Professor John Cuddihy relative to alleged incident(s) surrounding the IMT of June 2019.
- Communications, including emails, reports and other forms of communication between IPC Clinicians and senior management on matters connected with the alleged water contamination and the "lost" DMA report of 2015 and follow up report on 2017;
- GGC Human Resource Management:- resignation letters citing significant concerns with patient safety within RHC and elsewhere in QEUH from 2015 onwards.

- Letters representing concerns of a collective group of Microbiologists sent to Medical Director.
- Minutes of IMT, June 2019 & July 2019- (specifically those relative to identification, response, communication and management of MC)
- Logs/reports identifying when water samples, following identification of MC, were taken, by whom and from which location within QEUH and RHC.
- Logs/reports identifying when swabs were taken, following identification of MC, by whom and where from.
- Background reports used by those presenting NHS GGC Board Paper 19/43 dated 20 August 2019.
- Reports supporting the hypothesis '***however the mycobacteria issue has recently appeared and is resistant to chlorine at the original used levels***' offered at Technical Water Group (July to August) 2019.
- Risk Assessments completed by RHC Senior management Team relative to MC and associated water contaminations.
- Any and all 'water reports between identified 'International Water Experts' and NHSGGC;
- NHS GGC Board Minutes dated 17 April 2018
- NHS GGC Board Paper 18/17 dated 17 April 2018
- NHS GGC Board Minutes dated 26 June 2018
- NHS GGC Board Paper 18/28 dated 26 June 2018
- NHS GGC Board Minutes dated 21 August 2018
- NHS GGC Board Paper 18/38 dated 21 August 2018
- NHS GGC Board Minutes 16 October 2018
- NHS GGC Board Paper 18/52 dated 16 October 2018
- Ventilation reports relative to patient pathway between wards 2A and clinical services
- Ventilation reports relative to patient pathway between wards 6A and clinical services
- Procurement reports relative to the tasking of works to DMA and there reports of 2015 and 2017; including dates reports concluded, received and payment made with name of senior responsible owner.

- Report referred to on 04 September 2020 by Mr Alan Morrison when he mentioned receiving a technical report two days prior to the Oversight Board.

From: Marshall, Julie
Sent: 29 May 2018 12:12
To: CLARKE, Colin (NHS NATIONAL SERVICES SCOTLAND); CROAN, Peter (NHS NATIONAL SERVICES SCOTLAND); Devine, Sandra; Gallacher, Alan; Hart, Alistair; Inkster, Teresa; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Jones, Brian; Kane, Mary Anne; McArdle, Alyson; McColgan, Melanie; Campbell, Myra; MCDONNELL, Laura (NHS NATIONAL SERVICES SCOTLAND); McQuaker, Grant; RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND); ROEXE, Anke (NHS NATIONAL SERVICES SCOTLAND); STORRAR, Ian (NHS NATIONAL SERVICES SCOTLAND); GRANT, Susan (NHS NATIONAL SERVICES SCOTLAND); WINTER, Mike (NHS NATIONAL SERVICES SCOTLAND); Powrie Ian (NHS GREATER GLASGOW & CLYDE); Pritchard, Lynn
Subject: BMT Unit Relocation
Attachments: Adult haemopoietic Stem Cell Transplant Service Relocation.docx

Dear all

We received no further comments on the attached paper and will therefore, now send this to our Senior Management team as the recommendation of this group.
Many thanks for all your help and support in this issue.

Kind regards
Melanie

From: Marshall, Julie
Sent: 21 May 2018 09:30
To: Colin Clarke; Croan, Peter; Devine, Sandra; Gallacher, Alan; Hart, Alistair; Inkster, Teresa; Inkster, Teresa (NHSmail); Jones, Brian; Kane, Mary Anne; McArdle, Alyson; McColgan, Melanie; Campbell, Myra; Mcdonnell, Laura; McQuaker, Grant; 'RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND)'; 'ROEXE, Anke (NHS NATIONAL SERVICES SCOTLAND)'; Storrar, Ian; 'GRANT, Susan (NHS NATIONAL SERVICES SCOTLAND)'; Winter, Mike; Powrie, Ian; Pritchard, Lynn
Subject: BMT Unit Relocation

Dear all

I am pleased to advise that air monitoring results in Ward 4B QEUH are within normal limits. The results were reviewed at a meeting on May 18th with representatives from Infection Control , HFS and HPS.

Based on agreement at meeting on March 9th we are recommending relocation of the BMT Unit to QEUH.

The attached paper will be sent to our senior management team on our behalf.

Can you please review the paper and advise of any recommended changes by Friday 25th May.

Kind regards

Melanie

Proposal to Relocate Adult haemopoietic Stem Cell Transplant Service From Beatson West of Scotland Cancer Centre to Queen Elizabeth University Hospital

1. Introduction

This paper outlines the background to the current situation within BMT services. The paper details the enabling works and monitoring processes that have been undertaken since the last paper to the Acute Services Committee in March 2017.

The paper recommends that the service relocates from the Beatson West of Scotland Cancer Centre to Ward 4B at the Queen Elizabeth Hospital as originally intended.

The Acute Services Committee is asked to endorse this recommendation.

2. Background

NHS Greater Glasgow and Clyde is commissioned by National Services Division to provide all adult allogeneic donor stem cell transplantation for the population of Scotland. The national service covers both stem cell donation from family members and unrelated donors. The SLA value in 2016/17 was [redacted] for 70 transplants. This is proposed to increase to [redacted] for 73 in 2017/18, with on-going increases in activity predicted.

In 2013, a decision was taken to move the BMT service from wards B8/B9 at the BWoSCC to the new QEUH. This was to address concerns that the planned level of support for acutely unwell patients on the Gartnavel General Hospital (GGH) site would be insufficient for such a high intensity speciality as BMT and would not meet the JACIE accreditation standards. The move also allowed for an increase of beds from 19 to 24 to support the agreed increase in the national transplant programme.

Capital funding of £1million was invested to support enabling works to 4B, such as upgrade air filtration plant, and the BMT service moved to the QEUH in May 2015.

Following the identification of air quality issues in the new transplant unit, the service was, however, returned to B8/9, BWoSCC in July 2015. This return was predicated on it being short-term, with further remedial works to be undertaken to improve the air quality in ward 4B QEUH to acceptable levels. Remedial works were completed by October 2015 and at this time the service began to make plans to move back to QEUH.

The Infection Control Team raised concerns regarding the specification of works that had been completed and requested input from Health Protection Scotland (HPS) at this time. Following the receipt of recommendations from HPS with regard to the required specification, the Infection Control Team advised that the specification did not meet the required environmental standards for a BMT Unit and therefore, they were unable to support return to the QEUH. The BMT service has remained at BWoSCC since this time. The

clinical team have on-going concern about delivering a safe and sustainable service from the BWoSCC site, given high demand for critical care support and support from other medical and surgical specialties for transplant patients.

In the autumn of 2016, a further feasibility study commenced into potential options utilising retained estate on the QEUH site. A report was produced in January 2017 and a multi professional option appraisal was undertaken. From this, the conclusion drawn was that further options on the QEUH site at this stage were neither technically, clinically nor financially viable.

The two options that remained for consideration were remaining in the existing location on B8/9 in BWoSCC or relocation to 4B at QEUH as per the current specification. Following a detailed option appraisal process, involving clinical teams, infection control and Health Protection Scotland the Acute Services Committee at their meeting in March, 2017 approved a monitoring period of the ward 4B environment be undertaken to reassess the environmental suitability of transferring the BMT service to QUEH.

3. Process

Enabling works were performed from October to December 2017 to include new solid ceilings in the en-suite areas, replacement of filters, HEPA filtration unit installed in drug preparation area, heating controls rewired to eliminate control issues and door control devices fitted to improve the pressure differentials. Validations and permeability testing were performed and confirmed as satisfactory.

In October 2017, a robust process for assessing the effectiveness of this work to provide an appropriate protective environment for patients undergoing transplantation was developed in consultation with Health Protection Scotland, Health Facilities Scotland and expert external advice. An SBAR was produced and the subsequent monitoring and validation has been completed according to these recommendations.

4. Air Monitoring

Weekly monitoring started in January 2018 for an agreed period of 6 weeks, with non-transplant haemato-oncology patients in the ward to ensure testing in real-world conditions. The air sampling results were as expected with counts generally <1000 given the unit specification and are deemed satisfactory for the intended purpose of the unit.

Active air sampling has revealed low fungal counts including Aspergillus and Mucor – this is to be expected given the lack of a HEPA filtered corridor. These counts were mainly in the corridor area rather than the HEPA filtered rooms. In view of this, keeping doors closed to rooms is essential.

Moving forward we would plan to institute monthly air sampling with the same parameters as those used in the Beatson BMT unit i.e. particle counts I<1000. Fungal colonies would trigger a review by the infection control doctor.

5. Water Monitoring

Water testing for Legionella and Pseudomonas is negative. Regular testing will be undertaken. There is a water contamination incident in QEUH and RHC with several different

Gram negative environmental bacteria and fungi. There have been no patient cases in ward 4B linked to water contamination. The source has been traced to the taps and showerheads and possibly contaminated pipework. The same taps and showerheads are in 4B therefore, the same control measures will be employed. Shower heads will be changed to disposable. All outlets in 4B have filters which is a short term control measure. Expert opinion is being sought with regards to long term control measures which will likely include different taps and chemical dosing. Fungi can be difficult to eradicate from water therefore the likely recommendation will be point of use filters in the long term.

6. Meeting to Review Monitoring Results

All relevant parties including representation from HPS, HFS, NSS met in March 2018 and agreed that testing to date was satisfactory and if confirmed in a final round of testing, the group would recommend the transplant unit to return to the QEUH. This has now been completed with recent results consistent with previous monitoring results.

7. Contingency Planning

There is an agreed contingency plan utilising mobile HEPA filter units in the event of a ventilation failure.

The costs associated with this are [redacted] to include 25 mobile units, 2 industrial supply units and critical spares.

8. Summary and Recommendation

The enabling works and subsequent validation and monitoring have been completed according to the SBAR recommendations and confirms the environment in ward 4B is appropriate for transplant patients. It is therefore recommended that the BMT unit return to the QEUH as soon as practicable with proposed date of 16th June 2018.

The Acute Services Committee is asked to endorse the recommendation that the BMT service moves back to QEUH in June 2018.

SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 52 - Volume 1
Miscellaneous Documents

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