Scottish Hospitals Inquiry
Witness Statement of
Dr Scott Davidson

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Professional History

1. Please list your professional qualifications, including dates.

1994	MB ChB University of Aberdeen
1998	MRCP (UK)
2007	FRCP (Glasgow & Edinburgh)
2008	MD (University of Glasgow)

2. Please give your chronological professional history, roles held, where and when. Please also provide an up-to-date CV.

A. I have provided my professional history and roles held since 2006;

2006- 2015 - Consultant Respiratory Physician, Lead Clinician Medicine (2011-2015), Southern General Hospital (SGH), Glasgow

2015 – 2017 - Clinical Director Medical Services, Consultant Respiratory Physician, Queen Elizabeth University Hospital (QEUH), Glasgow

2017 – 2019- Chief of Medicine – South Sector, Consultant Respiratory Physician, Queen Elizabeth University Hospital (QEUH), Glasgow

2019- 2024- Deputy Medical Director- Acute Services, NHSGGC, JB Russell House, Gartnavel Royal Hospital, Glasgow

2024- present, Executive Medical Director, NHSGGC Board, JB Russell House, Gartnavel Royal Hospital, Glasgow

My CV

B. Clinical Director for Medical Services – Queen Elizabeth University Hospital (QEUH) - 2015

3. Please describe your role and responsibilities as Clinical Director for medical services in QEUH from 2015.

A. I was the Clinical Director for Medical Services in the South Sector NHSGGC between the summer of 2015 and July 2017 with responsibility for approximately 100 Consultant Physician colleagues. I worked closely with six Lead Clinicians as well as two General Managers and two Clinical Service Managers within the Medical Directorate. I reported managerially to the general manager for medical specialties and professionally to the chief of medicine for South sector.

Responsibility

My role specifically related to the South Sector medical specialties. There are a number of services located within the South sector campus and my role did not include/involve service or workforce related responsibilities that were provided by the Regional/ Diagnostics or Women and Children's Directorate team.

Role

In addition to my medical management role, I had a number of additional roles as Clinical Director;

During this time, I led the successful integration of the clinical teams from four legacy sites (Gartnavel General, Western Infirmary, Victoria Infirmary and the Southern General Hospital).

I was a member of Short Life Working Groups (SLWGs) looking at standardising job planning across NHSGGC as well as a group looking at the implementation of the electronic job-planning process. Through my clinical leadership the majority of our consultant colleagues now participate in electronic job-planning.

I introduced the role of Chief Resident at the QEUH, and this has proven to be hugely beneficial. I met the Chief Resident weekly as well as attending the monthly Junior Doctor Forum.
With the help of a Scottish Government Clinical Leadership Fellow, I led successfully the restructuring of our FY1, middle tier and senior rotas using feedback from the PCAT Professionalism Compliance Analysis Tool (PCAT) tool.

I was asked to take on the Senior Responsible Officer role for a Transformation programme in addition to my Clinical Director role. Within this role I worked closely with external agencies: Scottish Government, North East Commissioning Support Unit as well as colleagues from across all disciplines at the QEUH, from Primary Care and senior managers from NHS GG&C. Through this work we successfully introduced:

- Exemplar Ward Round Principles incorporating Criteria Led Discharge
- Electronic Bed requesting
- Emergency Management Assessment and Triage for patients arriving at the Immediate Assessment Unit (IAU).
- Introduction of the ED Trakcare module in the IAU

- Introduced the target of 6-8 hour Length of Stay in IAU and 36 hours in ARU 1-5
- Introduction of the short format Immediate Discharge Letter (IDL) based on previous work undertaken at the Royal Alexandra Hospital (RAH) in Paisley.
- Introduction of the Elderly Care Assessment Nurses (ECAN) in the Assessment Unit for the assessment of the frail elderly patients
- An electronic Repository for our Ambulatory Care pathways on the Clinical Knowledge Publisher

I was a member of the Beatson Future Steering Group working closely with colleagues from both the Beatson West of Scotland Cancer Centre (BWoSCC) and the QEUH to ensure smooth lines of communication and a protocol for transfer to the QEUH of patients requiring additional medical support.

Clinical Governance Medical Specialties South sector, Please see response to question 6

4. Briefly, what groups did you sit on and what was the purpose of each of those groups?

A. As described above, I sat on several different groups including clinical governance, medical specialties and medical directorate meetings, in the main, these groups were in relation to organising/restructuring various clinical teams during this period of transition for medical services and specialty teams.

C. Chief of Medicine - South Sector

5. Please describe your role and responsibilities as Chief of Medicine – South Sector.

A. I was appointed as Chief of Medicine – South Sector in July 2017. The role of Chief of Medicine included:

Operational Sector/Directorate management;

Support and accountability to the Deputy Medical Director- Acute and Board Medical Director on a range of professional issues;

In my role, I provided professional, clinical managerial leadership to medical staff within the South Sector and contributed to the overall vision, direction and performance of medical staff and their role in service delivery.

The Chief of Medicine- South Sector had medical management responsibility for some 403 Consultant and SAS grade doctors as well as the NHSGGC out of Hours GP service.

In my role, I reported directly to the South sector Director (Anne Harkness at the time).
My other key responsibilities in this role were:

- The revalidation, appraisal and job planning activities within the Sector to ensure that all doctors are fit to practice and that all doctors are aware of and discharge their professional obligations around fitness to practice.
- Leading the clinical governance agenda for the Sector/Directorate in conjunction with the Chief Nurse.
- Supporting the Deputy Medical Director Acute (Dr David Stewart) and Board Medical Director (Dr Jennifer Armstrong) in the efficient discharge of the Medical Director's responsibilities in respect of a range of issues, including

professional accountability, revalidation and appraisal, clinical quality and patient safety, and corporate assurance.

- In addition to our formal team structures, I set up a regular informal breakfast meeting with the Sector Clinical Directors. This was done to help develop a real team culture between us as well as an opportunity to share and learn from each other's experiences.
- I was also responsible for introducing Electronic Job Planning. Electronic job-planning was a significant undertaking and in addition to being a member of the Job Planning steering group, I delivered talks to our clinical leaders on the policy in 2018. In terms of local implementation of the electronic job planning software, we achieved an 87% sign off in 2018 which represented real progress.
- Leading the development of a regular meetings between the sector teams and our (Primary Care) Community Cluster Quality Leads to enhance links between community and acute teams across the sector.
- Worked closely with the Department of Medical Education in the development of the Chief Resident role and we appointed Chief Residents across the clinical services whilst I was CoM – South sector.

6. Briefly, what groups did you sit on and what was the purpose of each of those groups?

A As Chief of Medicine- South Sector, I was part of the following groups;

<u>South Sector management team</u>

The South Sector Management was chaired by the sector director and consisted of senior managers and clinicians and was the main oversight group for the management and delivery of services within the South sector.

<u>South Sector Clinical Governance Group</u>

The South Sector team had a single framework for clinical governance. The purpose of the group was to ensure continual quality improvement, and assurance of patient safety within the Sector.

The South Sector Clinical Governance group is chaired by the Chief of Medicine with membership comprising the Sector Director, Chief Nurse, Chief AHP, Clinical Directors and General Managers from each of the Directorates, with representation from Pharmacy, Infection Prevention and Control, Complaints, Clinical Risk, and Clinical Effectiveness.

In addition to the above, each of the South sector sub-directorates has its own specialty specific Clinical Governance arrangements and Quality Assurance processes. They report into and are accountable to the South Sector Clinical Governance group.

The sub-directorate clinical governance meetings are chaired by the Clinical Director with the general manger, lead nurses, lead clinicians and other multi-disciplinary team members in attendance.

Terms of Reference- South Sector Clinical Governance Group **(Bundle 52, Volume 2, Document 33, Page 437)**

Job Planning steering Group

This group oversees the Job Planning policy for doctors in NHSGGC. An example of its work is highlighted above in relation to the introduction of the electronic job planning process.

Various groups looking at urgent care including with external partners

I was involved in a number of groups overseeing the redesign of urgent care in NHSGGC with the opening of the QEUH. This involved working with colleagues from NHS England (the North East Commissioning Unit), these groups were established due the challenges in urgent care after bringing the legacy sites together in 2015.

D. Deputy Medical Director for Acute Services – 2019

7. Please describe your role and responsibilities as Deputy Medical Director for Acute Services.

A. I was appointed as Deputy Medical Director for Acute Services in 2019, and I reported to the Chief Operating Officer for Acute services (Jonathan Best at the time). My key responsibilities included:

- Provision of high-level expertise and advice on clinical matters and medical management to the Chief Operating Officer and Board Medical Director to inform strategic direction within Acute Services and the Board.
- Leadership on Clinical Governance for Acute Services.
- Acute Services medical workforce planning including e-Job and team job planning
- Provision of advice on professional issues and collaborative working with the Deputy Responsible Officer, Sector/Directorate Chiefs of Medicine and the Deputy Medical Director- Corporate on a range of issues.
- Leadership on transformational change across Acute Services to support the Moving Forward Together blueprint.

During this role, I faced many challenges, one of the first of which was the Covid 19 Pandemic in which I provided clinical leadership across the Acute Sector, undoubtedly one of, if not the most challenging period I will ever encounter in my professional career as both a clinical leader and clinician.

Later in 2019, the NHSGGC Board was escalated to Level 4 of the NHS Scotland Performance Framework in response to Infection Prevention and Control issues, Unscheduled Care and Finance.

8. Briefly, what groups did you sit on and what was the purpose of each of those groups?

A. There were a number of groups which I sat on during this time. The key groups have been listed below.

Name of Group	Purpose
Senior Management Group	This group was chaired by the Chief operating Officer and consisted of all Acute sector directors.
Access Senior Team Meeting	This group predominantly dealt with issues relating to Planned care (elective surgeries), for patients and adherence to national guidelines relating to Waiting Time guarantees and Treatment Time Guarantees
Acute Infection Control Committee	This was a key group in providing assuring around the monitoring of infection and surveillance activity to reduce and prevent infections across mainly NHSGGC Acute hospitals. The group also received reports from local service around outbreaks and investigations. I believe the Inquiry team has a full set of minutes of these meetings.
Acute Clinical Governance Forum	The Acute Clinical Governance Forum included Clinical Leads from a variety of disciplines including medical, nursing and infection control from across the Acute sector.
Acute Tactical Group	This was a key group established of clinical and non-clinical colleagues overseeing the Acute sector response to the covid19 pandemic
Strategy Executive Group (SEG)	Set up to provide oversight of the COVID-19 pandemic and received reports from the above group and HSCP Tactical Group

E. Governance Reporting Structures within NHS GGC

9. For the period you have been employed by NHS GGC please explain how the governance structure and reporting lines to the NHS GGC Board and its first

line of subordinate committees received information and made and authorised decisions in respect of (a) the safe and efficient operation of the water and ventilation systems of the QEUH/RHC, (b) the management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC, (c) the need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC and (d) the processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.

You should be aware that Hearing Bundle 13 contains minutes of the Board Infection Control Committee and the Acute Infection Control Committee and that Hearing Bundle 11 contains minutes of the Board Water Safety Group.

A. I think it would be helpful for me to set out some of the governance arrangements that exist with NHSGGC and how reporting of issues is escalated to various groups and committees. NHSGGC is the largest Health Board in Scotland, employing over 41,000 staff. To put this into context, the South Sector directorate alone is bigger than other Health Boards across Scotland. Given the size, it is therefore a critical requirement to ensure governance systems are embedded within the local as well as Board structures.

a) I am currently the Executive Medical Director and Responsible Officer for NHS GGC, and I report directly to the Chief Executive and provide professional advice to the Board as well as medical leadership to medical professionals across NHSGGC. I took up this post in October 2024. I do not hold responsibility for Infection Control as from January 2020, this was re-configured with the Nurse Director assuming the HAI Executive Lead role.

b) Our management structure includes an Acute Division consisting of 6 directorates (South, North, Clyde, Regional, Diagnostics, Women and Children). As mentioned earlier, I was located in the South Sector directorate

from my appointment as a Consultant Physician as well as my Clinical Director and Chief of Medicine roles. Each directorate is managed by an Acute Director, supported by a Chief of Medicine and a Chief of Nursing (the triumvirate structure) and the Acute Directors then report to the Chief Operating Officer for Acute services. The Chief Operating Officer then reports directly to the Chief Executive.

c) Within the Acute Division, front line clinical services were delivered by consultant teams, within a local management structure of clinical leads reporting to a Clinical Director for each service. The Directorate will (usually) be led by a "triumvirate" of Clinical Director, Lead Nurse and General Manager. Each Clinical Directorate varies in size and geographical area of responsibility but all report through a Sector triumvirate structure consisting of a Sector Director, Chief of Medicine and Chief Nurse. Each Sector Directorate then reports to the Chief Operating Officer, Deputy Medical Director (Acute) and Deputy Nurse Director. The reporting line is then to the Chief Executive, Executive Medical Director and Executive Nurse Director.

d) There are also 6 Health and Social Care Partnerships with each partnership being led by a HSCP Director. The HSCP Directors are accountable to both the NHSGGC Chief Executive and the respective local Authority Chief Executive.

e) Separation regarding clinical decision making and the governance structure

Clinical decision making is the responsibility of individual consultants (or primary care physicians) working within multi-disciplinary teams. Governance structures support clinicians in decision making through oversight of clinical guidelines and guidance, maintaining policies on investigation of serious adverse events (SAERs), managing the incident reporting system (Datix) and supporting the sharing of learning and best practice across the system. I have described the system of "clinical governance" in NHSGGC below back in 2019 (see Figure 1). As part of the review of the Clinical Governance Policy, the Corporate Management Team was included with the overall governance structure.

Clinical Directors have delegated responsibility for oversight of clinical governance within their service, including oversight of morbidity and mortality meetings, review of clinical incidents and ensuring that policy is followed regarding Duty of Candour, commissioning and conclusion of SAERs and provision of reports to the appropriate Clinical Governance meetings. Summary reports from local meetings are discussed at the Divisional Clinical Governance Forum which then report to the Board wide Clinical Governance Forum chaired by the Executive Medical Director.

Figure 1

f) Within my roles prior to 2019 I had no involvement nor responsibility for RHC and therefore unable to answer any questions relating to this.

g) In relation to Infection, Prevention and control, there is a "Governance and Quality Assurance Framework for the Infection Prevention and Control Service" which was developed in 2019. It is sometimes referred to as the "Assurance and Accountability Framework document". This document sets out NHSGGC's arrangements for surveillance, prevention, treatment and control of communicable diseases. It also describes the escalation processes within NHSGGC from "Ward to "Board". There are also a number of groups/ committees which provides governance and assurance on how and when infection control issues are discussed and escalated.

h) I have outlined below my specific response to the questions that have been asked during my role as Chief of Medicine and Deputy Medical Director Acute Services.

Chief of Medicine – South Sector in July 2017

The safe and efficient operation of the water and ventilation systems of the QEUH/RHC	I was not involved and I am not technically qualified to advise on these issues.
The management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC,	I was not aware of any issues relating to water and ventilation systems at this time.
The need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC and	I was not aware of this issue or need at this time other than becoming aware of the need for a ward in RHC to decant to ward 6A in QEUH to allow work to be undertaken.
The processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in	I can only comment on this from when I was working at the QEUH. I believe across the clinical teams that I was responsible for, I have always encouraged open

performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.	discussion and to report any issues or concerns. Outwith this, the Board has a number of tools in place. This would include escalation to immediate line manager, incident recording on DATIX along with policy for the management of Significant Adverse Events (SAER) as well as whistleblowing where this is required.

Deputy Medical Director- Acute Services 2019

The safe and efficient operation of the water and ventilation systems of the QEUH/RHC	This was the time, I became aware that some rooms did not have 10 Air changes as outlined in the specifications. I was involved in discussions around positive and negative pressure rooms at the QEUH site.
The management and reduction of risks to patient safety from infections that had the potential to be connected to the environment (particularly the water and ventilation systems) of the QEUH/RHC,	I was part of the Acute Infection Control committee, and we received assurance around the level of infection across all of our hospitals (including QEUH/ RHC) alongside actions and mitigations that were taking place. The governance arrangements for this reporting have been set out in the Infection, Prevention Control Framework document which I mentioned earlier. Reports would then be discussed at the Board Infection Control Committee which was chaired by the Board Medical Director.

The need for and authorisation of works to improve or remedy deficiencies in the water and ventilation systems of the QEUH/RHC and	I was aware of the work to assess and rebalance pressure cascade on wards, authorisation of any type of work to improve/ remedy any deficiencies would be through the Estates and Facilities Team. I was not involved in any authorisation works.
The processes put in place to ensure that disclosure by staff of evidence of wrongdoing, failures in performance or inadequacies of systems was encouraged and reacted to by the Board to ensure that the safety of patients and the best value use of public funds were protected.	In relation to Infection, Prevention and Control, there was a professional reporting line which had been established for Medical Microbiology to escalate any concerns or inadequacies of systems. Concerns would be reported through the general management structure within the Diagnostics Directorate team (as this is where Medical Microbiology sat at the time) I have always encouraged colleagues to report any issues or concerns as described earlier.

10. Please explain what informal and formal meetings or groups met outside the structures you have described in the previous question that made decisions about the issues listed in Question 2.

A. I am responding to this question based on Question 9 and not Question 2. I am not aware of any other informal groups that I was directly involved in at the time.

2017-2019 Chief of Medicine - South Sector	I was aware of the need to decant a Ward (2A) from RHC to 6A QEUH.
2019 onwards- Deputy Medical Director- Acute Services	As part of my Deputy Medical Director- Acute role, I was asked to attend various Incident Management Teams during 2019. The IMTs for infection control were set up in line with the guidance that was included in the Infection, Prevention and Control Accountability Framework and there would be a minute of each IMT available. I was involved in the discussions around risk assessment for Ward 4c in relation to suitability of the ward for the patient population, I have attached the risk assessment below. <u>Risk Assessment</u>

11. How was it decided which issues, decisions and reports would be escalated to the full Board or one of the first line of subordinate committees?

A. I have assumed that by Subordinate committee, you are referring to standing committee and therefore answered the question on this basis. There is a structure chart available which shows all of the Standing committees that report into the Board.

It is the responsibility of the chair of the particular subcommittee to prepare a report/approved minutes for the first line subordinate committee and then in turn that first line subordinate committee reports to the full Board. All committees have an agreed annual cycle of business.

12. What procedures were put in to ensure all significant questions about the issue listed in Question 9 were being taken to the Board or one of first line of subordinate committees, discussed and actioned?

A. In relation to Question 12, most if not all the issues relating to the “first line of subordinate committee would fall under the remit of mainly one committee. This would have been the Clinical and Care Governance Committee. This can be seen in Section E, Question 9, figure 1.

I was not a member of that committee at the time; therefore, I am unable to comment around exact process around what actions were taken/discussed through it.

13. What procedures were put in place by the Board to ensure monitoring, progress and resolution of issues related to the list in Question 2 that had been reported to the Board or one of first line of subordinate committees?

A. During my time as Chief of Medicine, (2017- 2019), I did not have membership of any of the subordinate committees of the Board as my role was sector based. I am therefore unable to answer this question for this time period. I would also like to state that shortly after my appointment to Deputy Medical Director- Acute, the Board was escalated to Level 4 of the Performance Assessment Framework. I think this happened in November 2019. With this now in place, the reporting of issues and oversight changed, and I was asked to support new arrangements through the oversight board and its subcommittees.

I have attached the Board paper from February 2020 which provides further detail on these arrangements **(Bundle 42, Volume 4, Page 1488)**.

<u>Oversight Board</u>

14. Please refer to **Dr Redding's witness statement at paragraph 186 – Witness Bundle – Week commencing 26 August 2024 – Volume 3 (External Version), Document 2, page 122)**. Dr Redding states, "The SMT and Clinical Governance Committees take decisions on what information is discussed at meeting of the full board." Is this statement correct? Please explain your answer.

A. I refer back to the question response which I gave earlier. It is the responsibility of the chair of the particular subcommittee to prepare a report/approved minutes for the first line subordinate committee and then in turn that first line subordinate committee reports to the full Board. All committees have an agreed annual cycle of business.

15. Please refer to the NHSGGC Audit Scotland audit reports 2016/17 and 2017/18 **(Bundle 29, Document 13, Page 485 and Bundle 29, Document 14 Page 532).** What led to the changes in the Board's governance structure in 2016/17, specifically the establishment of new committees and the subsequent requirement for the chairs of the standing committees to update on discussions and decisions made at their respective committees (see audit report 2017/18 – **Bundle 29, Document 14, Page 523 at page 541)?** Was the Board satisfied that the implementation of these changes enhanced and strengthened governance at GGC?

A. Please note my response to Question 2.

I was not a member of the Board in 2016/2017**,** as I was working in the South Sector as Clinical Director and based at the QEUH. I cannot respond on behalf of the Board in response to this question.

I was not a member of the Board in 2017/2018 as I was working in the South Sector as Clinical Director/ Chief of Medicine- South Sector and based at the QEUH. I cannot respond on behalf of the Board in response to this question.

a) In your statement at question 9(ix) you state that you were not involved in the water and ventilation systems of the QEUH/RHC and the management and reduction of risks to patient safety from infections in your role as Chief of Medicine in 2017. When you became aware of issues with air change rates, in your role as Deputy Medical Director in 2019, what was your initial reaction? Were you concerned that guidance had not been followed?

A. When I became aware of the issue with air change rates I was concerned and wanted to understand the potential significance of this.

b) Did you have concerns in respect of patient safety arising from your knowledge that the single rooms of the hospital had been deliberately built with a ventilation system that supplied air at half the rate than that called for by Scottish Government Guidance? What steps did you take to ensure the infection risk to patients was reduced?

A. I was not aware of any deliberate attempts to deliver a ventilation system that did not meet the guidance and specification.

I chaired AICC and through this we had regular IPC updates, see S1d. as an example of work, I was involved in and as part of a wider team to develop a patient placement policy, agreed May 2020.

As a clinician, I always take my personal role in minimising risk to the patients that I care for incredibly seriously by following infection control practices such as good hand hygiene and wearing appropriate Personal Protective Equipment (PPE). I had also previously practiced in hospitals with nightingale wards and I saw the move to a hospital with single rooms a real positive in relation to Infection control practices and patient care.

c) With reference to your discussions surrounding positive and negative pressure rooms mentioned in the box in response to Question 9(h) (a), what was the nature of the discussions, when did they take place and who did they take place with?

A. I am sorry, but I can't recall the dates of the conversations that took place in relation to rebalancing positive and negative pressure rooms, but would have involved colleagues, including those from estates explaining the position and the need for this to be addressed.

d) With reference to the assurances you report receiving around the level of infection across all hospitals including QEUH/RHC (Question 9(h) (b)), can you identify from the meetings of the AICC that that you chaired from 20 September 2019 onwards **(Bundle 13, Document 23, Page 177)** or

attended (see **Bundle 13, Document 22, Page 169)** what these assurances were and from whom they were received?

A.. In the minute of 20th September 2019, as well as other AICC minutes, there is a set structure and standard items of business which provide a GGC wide picture in relation to IPC including sector updates detailing any issues and actions taken. Updates are given by the members of the AICC representing their sector.

e) Why does the minute of the AICC on 20 September 2019 **(Bundle 13, Document 23, Page 177)** not contain any report of the change in the chair of the Gram Negative Bacteraemia IMT in Ward 6A on 23 August 2019 or the reasons for it? Were you aware of this change and why it took place?

A. I do not recall when I became aware of the change of IMT chair and I do not know why this change was not discussed at this meeting.

f). Were you aware of concerns raised by Infection Prevention Control and microbiology colleagues (including Dr Inkster and Dr Peters) before you took up your role in 2019? What do you recall about these concerns? To what extent were these valid concerns?

A. I do not recall specific concerns being raised with myself pre-2019

g). In your answer to question 10 you refer to the risk assessment for airborne pathogens which you undertook in respect of Ward 4C in 2020. This risk assessment considers the risk associated with not having the appropriate air change rate in the ward as set out in the guidance and list the subsequent improvements/modifications. Were you satisfied that these modifications mitigated the risk to patients from being in an environment which was substandard to that recommended in the guidance?

A. The risk assessment was undertaken by a number of colleagues, and I was content with this.

h). Has any risk assessment for air borne pathogens been carried out for the

single rooms of the hospital outside Ward 4C had been deliberately built with a ventilation system that supplied air at half the rate than that called for by Scottish Government Guidance?

A. I am not aware of any additional risk assessment for single rooms outwith 4c, as previously mentioned there was work done around patient placement in the hospital.

F. Issues at Queen Elizabeth University Hospital (QEUH)

16. The Inquiry has information that you chaired a meeting concerning the Health and Safety Executive Improvement Notice - Ward 4C - dated 17 December 2019. What was the purpose of the meeting? Who attended the meeting? What was discussed? Can you provide a copy of the minutes to the Inquiry?

A. I am sorry but I do not recall chairing a meeting. I did meet with clinical and Health and Safety colleagues to discuss the notice and of course there was a subsequent multidisciplinary risk assessment undertaken.

17. Did you gain insight into ventilation requirements in the healthcare environment from the meeting? What were you made aware of? Were technical aspects of the ventilation system explained to you at this time, or at any other time? What was explained?

A. I am aware of the broad principles in Scottish Health Technical Memorandum 03-01 which sets out guidance on maintenance and operation of specialised ventilation in healthcare premises providing acute care, namely 10 ACH.

The above memorandum is a technical document, and I do not have specialist knowledge on this. What I do know is that some of the rooms in the QEUH/ RHC had not been developed to SHTM standards

A risk assessment was carried out and is attached.

18. Were clinicians made aware of the work being done by the Estates and Facilities Team, and what it was hoped to achieve? Were you made aware of the work being done by the Estates and Facilities Team, and what it was hoped to achieve? If not, can you say why? What work was being done to the ventilation system in ward 4C?

A. The clinical lead and Clinical Director were both aware and involved in the risk assessment for Ward 4c. Documentation included.

Ward 4C Assessment and Action Plan (**Bundle 20, Document 73, Page 1534**)

Ward 4C Summary for SHI (**Bundle 52, Volume 2, Document 27, Page 386**)

Ward 4C Risk Assessment (**Bundle 20, Document 62, Page 1428**)

Ward 4C and other levels summary for SHI (**Bundle 20, Document 1, Page 8**)

Please see (Bundle 13, Document 101, Page 772).

19. QEUH was placed in special measures, Level 4 for Infection Prevention and Control in November 2019. Professor Marion Bain was appointed Healthcare Associated Infection (HAI) Executive Lead, and any issues were to be reported to you in the first instance. What issues were reported to you and by whom? What actions did you take as a result?

A. The majority of the conversations I recall with Professor Bain were around patient placement with the onset of what was to become the covid19 pandemic when we were admitting and isolating potential patients within the QEUH; we corresponded around a specific patient placement issue and concern in January 2020. I do not believe I was the 1st recipient of other situations.

Patient Placement Document (May 2020) **(Bundle 52, Volume 2, Document 28, Page 390)**.

G. The Acute Infection Control Committee (AICC)

20. You joined the Acute Infection Control Committee (AICC) around June 2018, and thereafter from time to time chaired the AICC. Please describe the function of the AICC. What did your role as Chair involve?

A. The AICC Terms of Reference is described in the "Governance and Quality Assurance Framework for the Infection Prevention and Control Service 2019". I believe the inquiry already has a copy of this document. The main objective of the AICC is to:

- To reduce the risks of healthcare associated infection to patients, relatives and healthcare workers by:
- Reporting to the BICC on any matter which has wider infection control implications for the services.
- Support the local infection control team in discharging their responsibilities by identifying resources and facilitating changes in work practice.

ii)The Terms of Reference for the AICC are

- Monitor and review the epidemiology of alert organisms and patients with alert conditions and ensure action taken.
- Devise and approve the individual site-specific aspects of the Annual Infection Control Programme and implementation plan.
- Assist in the implementation of policies.
- Monitor compliance with infection control HEI standards.
- Report to the BICC any identified infection control incidents or outbreaks.
- Report to the BICC any unresolved infection control risks or challenges.
- Assess local risks in relation to building and engineering services including water and ventilation.

21. What are your views on the effectiveness of the AICC? What evidence can you point to which supports your views?

A. I believe the AICC is a good committee and I believe the minutes of these meetings reflect a wide range of issues and there is clear evidence of transparency of discussion. I believe that the minutes of these meetings have already been shared with the inquiry.

The AICC has good representation from a number of staff from across NHSGGC, including Infection Control Doctors, Chief Nurses from each of the sector teams, Surveillance Nurse Lead, lead infection prevention and control nurses from various sectors and public health consultants.

The meetings are well structured with updates from each of the sector teams and there is a lot of detail that is shared at this meeting. There are also Estates and Facilities updates included in the discussion. I have attached sample minutes of meetings where I attended.

Therefore, I believe the AICC was an effective committee in relation to its ToR.

AICC Minute 2nd September 2019 **(Bundle 13, Document 23, Page 177).**

AICC Minute 12th November 2019 **(Bundle 52, Volume 2, Document 29, Page 401).**

AICC Minute 14th January 2020 **(Bundle 13, Document 24, Page 185).**

H. The Board Infection Control Committee (BICC)

22. Have you been a member or Chair of the BICC? If so, when and what was your role on the committee? Please describe the function of the Board Infection Control Committee (BICC).

A. The BICC is a core committee within NHSGGC consisting of a range of multi-disciplinary members. This committee may set-up standing or ad hoc sub-groups to address particular issues, e.g. decontamination, vCJD, policy development. The committee was chaired by the Board Medical Director and membership includes; the Head of the Antimicrobial Team, the IPC Manager, the Associate Nurse Director (IPC), the Nurse Consultant in IPC, the Lead IPC Doctor, Acute and Partnership Services, Occupational Health, Pharmacy, Public Health Consultant, Infectious Disease Consultant, Health & Safety, Facilities Services and lay representatives.

The objectives of the BICC were: To reduce the risks of infection to members of the public and patients by:

- Advising the Chief Executive, NHSGGC on all matters relating to communicable diseases throughout the NHS Board area.

- Functioning as the single corporate function for policy approval and strategic monitoring in relation to Infection Prevention and Control.

- Facilitating collaboration and co-ordination between NHS organisations, local authorities and other relevant agencies.

- Liaising with other appropriate committees within the NHS Board area and monitoring performance.

- Ensuring consistency in Infection Prevention and Control Policy application and cross system working.

The Terms of Reference were;

- Provide leadership and support to the Infection Prevention and Control service in the implementation of IPC policy and practice from board to ward (point of care).
- Review and implement the National Infection Prevention and Control Policy Manual within NHSGGC.
- Develop and approve local addendums to the National Infection Prevention and Control Policy Manual where required/appropriate.
- Advise the Board Clinical Governance Forum where NHSGGC requires any deviation from the National Infection Control Policies and present evidence to support this.
- Receive Annual Infection Control Programme and Annual Report from Board Infection Control Manager and draw the attention of the Chief Executive and NHS Board to any serious potential or actual risks relating to Infection Prevention and Control.
- Receive the bimonthly report on KPIs (HAIRT) from the Infection Control Manager.
- Provide regular reports on progress with implementation of programme and exception reports on KPIs to the Clinical Governance Forum and NHS Board.
- Receive and review regular reports and updates on key HAI related Performance Indicators from AICC and PICSG.
- Provide core personnel for any outbreak control team, set up within the NHS Board area.
- Consider national guidance, letters from the Scottish Government and other national agencies and advise on implications and required actions.
- Promote and facilitate the education of all Healthcare Workers on Infection
- Prevention and Control policies and procedures. Draw up and agree plan to deal with communicable diseases outbreaks.
- Responsibility for assessment of Glasgow and Clyde-wide compliance levels with the HAI Code of Practice and HEI Standards.

The BICC was chaired by the then Medical Director, Dr Jennifer Armstrong. However, following escalation to Level 4 of the Performance Framework, the chair changed to Professor Marion Bain. The current chair of BICC is Professor Angela Wallace, Executive Nurse Director who is the Board HAI lead and reports directly to the Chief Executive. As Chair of AICC, I attended BICC

23. What are your views on the effectiveness of the BICC? What evidence can you point to which supports your views?

A. I didn't attend the BICC as a standing committee member, however during my brief time in attendance below, I believe the committee was effective.

BICC Meeting 7th October 2019 **(Bundle 13, Document 59 Page 433).**

BICC Meeting 25th November 2019 **(Bundle 42, Volume 1, Page 360).**

BICC Meeting 20th January 2020 **(Bundle 13, Document 60, Page 441).**

BICC Meeting 15th June 2020 **(Bundle 13, Document 61, Page 450).**

I. QEUH/RHC Advice, Assurance and Review Group (AARG)

Please see Minutes of 2nd AARG Meeting – 19 August 2021 (Bundle 27,Volume 12, Page 390)

24. You attended the second meeting of the AARG with Jonathan Best, what was the purpose of your attendance at the meeting?

A. I attended this meeting on the 10th August 2021 and co- delivered a presentation with the Chief Operating Officer- Jonathan Best. The minute of the meeting is below as I am sorry, but I have been unable to locate a copy of the presentation itself.

Minute of Meeting- AARG **(Bundle 27, Volume 12, Document 38, Page 390)**

a) do you recall why you had been asked to present to the AARG? Did you attend any further meetings of the AARG? Did you find the AARG to be effective?

A. I am sorry that after this time I do not recall the specifics of my presentation at the AARG but a review of the minute has shown my part of the presentation was focused on initiatives and activities to improve staff engagement. I do not recall attending other meetings and therefore unable to comment on its effectiveness.

25. Have you read the reports and recommendations of the Oversight Board, Independent Review, and Case Note Review?

A. Yes

26. Are you satisfied that NHSGGC implemented all of the recommendations of the Oversight Board, Independent Review, and Case Note Review and continues to have processes in place now which meet those recommendations? Please point to evidence which supports your view.

A. Yes, we recently updated the Board in April 2025 on all of above and I have provided the paper that was presented **(Bundle 52, Volume 2, Document 30, Page 408).**

27. Please explain how the public can be satisfied that NHSGGC has implemented all of the recommendations of the three reviews and continues to have processes in place now which meet those recommendations.

A. The Board was recently updated in April 2025 on the three reviews, and we also provided a high-level summary of work to ensure environmental risk to patients are minimised. This includes:

- A summary of internal and external audits including government commissioned reports and HIS inspections
- A summary of local measures and actions to improve ventilation and water quality and planned maintenance

- Implementation of actions from the various reports including HIS recommendations.

a) Please refer to NHS GGC IPCT Incident Management Process Framework SOP **(Bundle 27, Volume 17, Document No. 28, Page 315)**. It is the position of Laura Imrie, Lead Consultant, ARHAI Scotland and Clinical Lead NHS Scotland Assure that this local SOP appears to advise that a separate assessment is carried out locally prior to deciding if an assessment using the NIPCM HIIAT is required. This may account for the variation in reporting against the NIPCM. Might this NHS GGC SOP result in incidents not being reported to ARHAI Scotland following initial review by the IPCT in NHS GGC?

A. I don't believe this to be the case. I see no reason why any NHSGGC colleague would produce a SOP that led to under-reporting.

b) Is this NHS GGC SOP consistent with the letter and spirit of the National Infection Control Manual?

A. I refer to the response above.

c) Should the Inquiry be concerned by the terms of this NHS GGC SOP when considering its Term of Reference 9 in respect of learning Lessons from the process and practices of reporting healthcare associated infections?

A. I don't believe so and NHSGGC remains committed to understanding any lessons that can learned around reporting of incidents. We are, however, working with colleagues from another Board to ensure demonstrable alignment and consistency of approach and assurance that we are in keeping with National guidance.

J. Conclusions

28. Is there anything further that you wish to add that you think may assist the Inquiry?

A. No

Declaration

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

Name Dr Scott Davidson **Date: 26/08/2025**

Appendix A

The witness was provided with the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

A47390519 - Bundle 11 - Water Safety Group

A48890718 - Bundle 13 - Additional Minutes Bundle

A32221533 – Bundle 13 - Additional Minutes Bundle

A32221641 - Bundle 13 - Additional Minutes Bundle

A47648810 – Bundle 13 – Additional Minutes Bundle

A49650695 – Bundle 27, Volume 12 – Miscellaneous Documents

A50811313 - Bundle 27, Volume 17 – Miscellaneous Documents

A50976001 – Bundle 29 – NHS Greater Glasgow and Clyde Audit Reports

A50976005 - Bundle 29 – NHS Greater Glasgow and Clyde Audit Reports

A49725923 – Witness Bundle – Week commencing 26 August 2024 – Volume 3

Appendix B

The witness provided or referred to the following documents when they completed their questionnaire statement.

A32180724 – Bundle 13 – Additional Minutes Bundle

A32190571 – Bundle 13 – Additional Minutes Bundle

A36709936 – Bundle 13 – Additional Minutes Bundle

A32812676 – Bundle 13 – Additional Minutes Bundle

A32221641 – Bundle 13 – Additional Minutes Bundle

A41791079 – Bundle 20 – Documents Referred to in the Expert Reports by Andrew Poplett and Allan Bennet

A41791405 – Bundle 20 - Documents Referred to in the Expert Reports by Andrew Poplett and Allan Bennet

A44943543 – Bundle 20 - Documents Referred to in the Expert Reports by Andrew Poplett and Allan Bennet

A49650695 – Bundle 27, Volume 12, Miscellaneous Documents

A51852509 – Bundle 42, Volume 4 – Previously Omitted Board Minutes and Relevant Papers

A53228319 – Bundle 52, Volume 2 – Miscellaneous Documents

A41790501 – Bundle 52, Volume 2 – Miscellaneous Documents

A45320377 – Bundle 52, Volume 2, Miscellaneous Documents

A32180399 – Bundle 52, Volume 2 – Miscellaneous Documents

A53228226 – Bundle 52, Volume 2 – Miscellaneous Documents

Appendix C

Curriculum Vitae

Dr. Scott M Davidson

MBChB MD FRCP (Glasgow, Edinburgh)

May 2024

PERSONAL DETAILS

NAME: *SCOTT M DAVIDSON*

GMC NUMBER [redacted] Full registration

UNIVERSITY EDUCATION

1994 MB ChB University of Aberdeen

QUALIFICATIONS

1998 MRCP (UK)
2007 FRCP (Glasgow & Edinburgh)
2008 MD (University of Glasgow)

AWARD

2016 Winner FTFT – Acute Services – South Sector – Staff Awards for Excellence; Clinical and Managerial Leadership in QEUH

LEADERSHIP COURSES

2023/4 - **Developing Senior Systems Leadership (DSSL)**
Cohort 2

2019/20 - **Quality Governance Collaborative Fellowship**
Royal College Physicians of Edinburgh

CONSULTANT APPOINTMENTS

2024 – **Executive Medical Director**
NHS GGC

2019 – 2024 **Deputy Medical Director, Acute services**
NHS GGC
Consultant Respiratory Physician
Queen Elizabeth University Hospital (QEUH)

2017 – 2019 **Chief of Medicine – South Sector**
Consultant Respiratory Physician

Queen Elizabeth University Hospital (QEUH)

2015 – 2017 **Clinical Director Medical Services**
Consultant Respiratory Physician
Queen Elizabeth University Hospital (QEUH)

2006 – 2015 **Consultant Respiratory Physician**
Lead Clinician Medicine (2011-2015)
Southern General Hospital (SGH)

ADMINISTRATIVE EXPERIENCE

2015 Elected member '**Scottish Partnership for Palliative Care'**

2015-17 Organising committee and speaker at Medicine 24 RCPSG

2013 Clinical Director planning the RCPSG 'State of the art Medical Symposium' symposium committee for subsequent conference in 2014

2008 SCOTS Clinical supervisor course facilitator and member of faculty
Greater Glasgow and Clyde Respiratory planning group
Respiratory ACH transition group
Greater Glasgow and Clyde Endoscopy users' group

2007 RCPSG College tutor at SGH
New Drugs Committee (ADTC Subgroup NHS GG&C)

2000 RCPE Chairman of the Collegiate Members' Committee
RCPE Council Member (Collegiate Members' Representative)
IMSPEC Committee Observer (RCPE Collegiate Members' representative)
'Flexible Working in Medicine' – A Working Group
The Scottish Royal Colleges of Physicians'
Member of Council, the Royal Medico-Chirurgical Society of Glasgow

1999 Assistant Secretary Collegiate Members' Committee, (RCPE)
RCPE Council Committee on Examination
RCPE Education and Training Committee
RCPE College Ball Organising Committee

1998 Vice-Chairman Collegiate Members' Committee, RCPE
RCPE Council Committee on Examination

RESEARCH and AUDIT

MD Thesis

Analysis of Prognostic and Drug Resistance Markers in Lung Cancer

The Ian Sunter Charitable Fellowship – RCPSG

West of Scotland Lung Cancer Research Group

PUBLICATIONS

Understanding living with tracheostomy ventilation for motor neurone disease and the implications for quality of life: a qualitative study protocol
Wilson E, Turner N, Faull C, Palmer J, Turner MR, Davidson S
BMJ Open. 2023 March 13; 13(3):e071624

Morbidity and mortality associated with gastrointestinal dysfunction in neuromuscular disease: a single-centre case series
Watson-Fargie T, Raeside D, Davidson S, McCartney R, Clarke A, Farrugia ME
Neuromusc Disord. 2022 Jul;32(7):578-581

Improving care for patients with chronic obstructive pulmonary disease – a small pilot project in Scotland
Irene Stevens, Jacquelyn Chaplin, Alison Freeman, Scott Davidson
European Journal Palliative Care. 2014 May/June: Volume 21 number 3

End of life care in a general respiratory ward in the UK
Tsim S, Davidson, S
Am J Hosp Palliat Care 2014 March (31)2: 172-4

Staging of non-small cell lung cancer (NSCLC): a review. Tsim S, O'Dowd, CA, Milroy R, Davidson S.
Respir Med. 2010 Dec;104(12):1767-74. Epub 2010 Sep 15.

Rapid Response: Practical use of D-dimers in assessment of suspected PTE;
Bayes H.K., O'Dowd C., Glassford N. and Davidson S.;
British Medical Journal; on-line publication 5 May 2010; http://www.bmj.com/cgi/eletters/340/apr13_2/c1421

Non-invasive ventilation in acute respiratory failure: DOTS learning module
Co-editorr of on-line learning module that will be made available, via NHS Education for Scotland, to all medical trainees in Scotland via trainees' e-portfolios (2010).

Davidson S. Lung Cancer Symposium. **J R Coll Physicians Edinb** 2006; 36: 253-255

Davidson S, Milroy R. Lung Cancer. **Update** 2000. Update 2000; **1**: 25-31

REFEREES

William Edwards
Chief Operating

NHS GGC

William.Edwards[redacted]