Scottish Hospitals Inquiry
Witness Statement
Professor Jann Gardner

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.

Whether disclosures of evidence relating to patient care and safety are encouraged in NHS GGC

1. You were appointed as Chief Executive of NHS GGC on 1st February 2025. On 27 March 2025 Health Improvement Scotland (HIS) published a review of the emergency departments at the Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital (**Bundle 51, Document 7, Page 904**) ("the HIS Review") which included consideration of issues raised between 2021 and 2023 in a series of written and in-person exchanges between the emergency medicine consultants and NHS GGC senior management which ultimately led to the escalation to HIS of concerns over "Leadership and Culture".

   Do you consider that there any similarities between the events that led to the HIS Review and the raising of concerns by Dr Redding, Dr Peters, Dr Inkster and others about the impact of the water and ventilation systems at the QEUH from 2015 to date?

A. As noted, I joined NHS GGC as Chief executive on 1st February 2025 therefore I can provide a detailed account of actions and assurances undertaken from that date, however, can make only limited comment on events taken prior to my time in post.

To assist the Inquiry, I can explain the following:

1. The HIS Review and the issues which led to concerns being raised with HIS.
2. Whether there are any parallels to be drawn with the issues raised previously.
3. In relation to the water and ventilation systems at the QEUH, the response of the Chief Executive, Chair and Board to the 'HIS ED Review' and ongoing concerns including the development of the GGC Way Forward Improvement Programme.

THE 'HIS REVIEW' AND RELATED ISSUES

The issues raised in the HIS report result from a number of very complex issues as set out below:

Significant system challenges with resultant impact on staff and patients. Whole System flow issues (as seen across NHS Emergency Systems in Scotland and the UK) led to tensions in relationship within teams, between teams but predominately between clinical teams and site and system management reflected in the review as leadership and cultural issues. The complex issues were set out in the following themes:

a) Medical and Nurse Staffing
b) Facilities
c) Flow and Escalation
d) Incidents/Reporting and Organisational Learning
e) Culture
f) Communication

External escalation of these issues by staff who were frustrated by the ongoing issues which they felt were not being adequately addressed.

PARALLELS

There are significant differences both in relation to firstly, the actual issues raised by the ED Consultants and those raised by Drs Redding, Peters and Inkster and secondly, the Executive leadership in post at the point of the publication of the HIS Review (including a new Chief Executive, Medical Director, HR Director).

While I am unable to comment on the decisions and actions at that time, on the basis of the information I have seen on these matters, there would appear to be some parallels in relation to leadership and culture.

RESPONSE/ACTIONS-

The GGC Way Forward Improvement Plan 2025. In response to both the HIS review the following actions were taken:

Significant staff engagement including circa 40 hours of meetings with myself plus my senior Executive colleagues. A clear narrative expressing importance of values and culture with a personal commitment from me to staff about what they should expect from me, my executive team and from one another. In addition, an outline of how to raise issues to managers, via process, through the GGC Way Forward and a direct offer to email exec colleagues or myself directly.

Apology to Staff – in meetings, through media and at Board by both the Chair and myself.

Development of a comprehensive improvement Programme based on the themes from the meetings and HIS Review – The GGC Way Forward which was approved by the Board in April 2025)

This is a co-produced programme with co-Chairs from the ED departments – medical – nursing and site management.

The Programme is split into 3 layers – sector, whole system and executive oversight. To ensure transparency and challenge non-executive Board members, CfSD (Centre for Sustainable Delivery) and HIS (Healthcare Improvement Scotland) are members of the latter two layers.

Human Factors/People/HR – a range of actions to support people and resolve issues. An essential component of the programme is the commissioning of external expertise to help us improve culture, trust, professional relationships and leadership culture. This includes psychological support and/or occupational health referral where appropriate as well as facilitation, mediation and career conversations.

The GGC Way Forward reflects a collective commitment to learning, improvement, and building a stronger, more compassionate NHS Greater Glasgow and Clyde.

2. The Inquiry Team notes that you have made a number of responses to the HIS Review including in a press release on the day of its publication (**Bundle 52, Volume 2, Document 40, Page 572**), in a paper to the NHS GGC Board on 23 April 2025 (**Bundle 52, Volume 2, Document 36, Page 549**) and a "new strategic improvement programme – The GGC Way Forward Programme". A press release was also issued (**Bundle 52, Volume 2, Document 38, Page 566**). The Inquiry Team also notes that the draft minutes of the Additional Board Meeting of 23 April 2025 (**Bundle 32, Volume 2, Document 37, Page 559**) record an apology from the Chair, Dr Lesley Thomson KC that it was "wholly unacceptable" that emergency medicine consultants were required to raise issues externally in May 2023 and an apology from you that "the organisation did not respond more effectively when concerns were raised and staff had to escalate concerns". With these matters in mind:

a) Did NHS GGC respond effectively to the patient safety concerns raised by Dr Peters and Dr Inkster in July 2015 (**Bundle 14, Volume 1, Pages 414-415 and 416-42**)?

A. I have set out the approach I think is necessary to listen to staff, provide pathways for escalation, establish an improvement programme, where required, with full staff involvement to ensure a shared commitment and satisfaction.

I cannot comment on how effectively actions were undertaken previously as I was not in post at that time.

b) Did NHS GGC respond effectively to the patient safety concerns raised in the SBAR of 3 October 2017 (**Bundle 4, Document 20, Page 104**).

A. As I was not in post at the time, I do not have any detail about these matters. However, I understand that significant evidence has already been heard in respect of the Board's response to the concerns raised by the microbiologists in the SBAR dated 3 October 2017, which should be considered here.

c) Is it acceptable that Dr Redding had to escalate the concerns she had to a Stage 2 and the Stage 3 whistleblowing?

A. I have set out the approach I think is necessary to listen to staff, provide pathways for escalation, establish an improvement programme where required with full staff involvement to ensure a shared commitment and satisfaction.

I cannot comment on the detail in relation to the whistleblowing process relating to Dr Redding or on how effectively actions were undertaken previously as I was not in post at that time.

d) Is there any inconsistency between the approach NHS GGC has taken since the publication of the HIS Review in respect of the emergency medicine consultants to raise concerns about patient safety and the approach taken by NHS GGC to the actions taken by Dr Redding, Dr Peters and Dr Inkster to raise concerns about patient safety? If, not, why not?

A. I refer back to the approach I have taken in the GGC Way Forward.

Learning Lessons from the process and practices of reporting healthcare associated infections

3. 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.

a) Might this NHS GGC SOP result in incidents not being reported to ARHAI Scotland following initial review by the IPCT in NHS GGC?

A. As Chief Executive and Accountable Officer I seek advice from my Professional Advisors.

In respect of the SOP, we are now working with colleagues from NHS Lothian to ensure complete alignment and consistency with their approach moving forward.

As I am not an expert in this field I would not be in a position to comment further.

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

A. As advised, in respect of the SOP, we are now working with colleagues from NHS Lothian to ensure complete alignment and consistency with their approach moving forward.

As I am not an expert in this field I would not be in a position to comment further.

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. Term of Reference 9 – 'To examine the processes and practices of reporting healthcare associated infections within QEUH and determine what lessons have been or should be learned.

As advised, In respect of the SOP, we are now working with colleagues from NHS Lothian to ensure complete alignment and consistency with their approach moving forward.

As I noted previously, The GGC Way Forward reflects a collective commitment to learning and improvement.

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.

Appendix A

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

A52454817 – Bundle 51 – Sir Robert Francis Whistle-blowing Expert Report

A53376430 – Bundle 52 Volume 2 – Miscellaneous Documents

A53376428 - Bundle 52 Volume 2 – Miscellaneous Documents

A53376429 - Bundle 52 Volume 2 – Miscellaneous Documents

A53376427 - Bundle 52 Volume 2 – Miscellaneous Documents

A38176264 – Bundle 14 Volume 1 – Further Communications

A32310963 – Bundle 14 Volume 1 – Further Communications

A38694873 - Bundle 4 – SBAR Documentation

A50811313 – Bundle 27, Volume 17 – Miscellaneous Documents