SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 19 August 2024 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 27 - Miscellaneous Documents

Volume 12

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The terms of that restriction order are published on the Inquiry website.

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From: White C (Craig)
Sent: 08 October 2019 21:39
To: Cabinet Secretary for Health and Sport; Birch J (Jason)
Cc: Murray D (Diane); Dunk R (Rachael); Shepherd L (Lesley); Aitken L (Louise); Hart S (Suzanne); Communications Healthier; Klein G (Gerard); Mair S (Suzi); DG Health & Social Care; Burgess E (Elizabeth); Ives J (Josephine); Hutchison D (David); Wright M (Malcolm); McQueen F (Fiona); Minister for Public Health, Sport and Wellbeing; Henderson C (Calum)
Subject: RE: Follow up work for Monday following GIQ and letters
Attachments: Prof White - Remit - Final Version Approved.docx

Follow Up Flag: Follow up
Flag Status: Completed

Categories: Printed for DG

Jack

The attached has minor amendments (none of them substantive to the content) after my meeting with the Chairman of the Board, John Brown, today – all relating to consistent and his proposed use of the terms NHSGG&C and the Board. I will circulate to the Chair and Chief Executive in the morning.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: Downie J (Jack) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 08 October 2019 14:27
To: White C (Craig) [redacted]; Cabinet Secretary for Health and Sport [redacted]; Birch J (Jason) [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Craig,

Ms Freeman is content with the revised remit – reattached for ease.

Many thanks,
Jack

From: White C (Craig) [redacted]
Sent: 08 October 2019 09:02
To: Cabinet Secretary for Health and Sport [redacted]; Birch J (Jason) [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Andy

Thank you. I have attached a Track Changes version of the Remit (for ease of reference to track actions in response to the Cabinet Secretary's response) and a Clean copy. I have a meeting with the Board Chair today at 1300hrs so have prioritised sending this back to you now in the hope that it will be possible to have Ms. Freeman's sign off at some point before that time, meaning I can go through the Remit and also circulate to other relevant staff within GG&C.

Hope this is helpful,

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: Corr A (Andrew) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 08 October 2019 08:42
To: Birch J (Jason) [redacted]; Cabinet Secretary for Health and Sport [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]>; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; White C (Craig) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and

Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Morning Jason,

The Cabinet Secretary has considered the draft remit and Board's Action plan. In respect of the draft remit she has asked that this be amended as follows:

• to specify patients and families (not people) and specify it is those in paediatric oncology/haematology- at the minute it could be everyone at RHC/QUEH

• to be clearer that Craig's job is to ensure all issues raised by patients and families are addressed and addressed at pace - being clear which ones properly belong to the review and/or PI

• re IMT delete 'may provide' and replace with 'will provide...'

• the ongoing channels to be established are of engagement and information (NHSGGC think PR when we say communication) This needs stressed with NHSGGC because their plan continues to talk about Comms and social media.

• re staff in this area of work, he needs to work with the board to ensure they are provided with additional support they identify

In respect of the NHSGGC action plan the Cabinet Secretary has commented that the review of readiness of 6A to open to new admissions must involve the oncology/haematology clinicians as well as CNO. She has also added that it wasn't especially 6A cleanliness families raised as cleanliness across QUEH and she thinks that what the plan is missing so far is ensuring staff in any ward used for these patients are familiar with relevant protocols.

I would be grateful if you could take these points up with NHSGGC as soon as practically possible. I would also be grateful if you could amend the draft remit and have a new version to us by 1300 today.

Many thanks,
Andy

From: Birch J (Jason) [redacted]
Sent: 07 October 2019 16:20
To: Cabinet Secretary for Health and Sport [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; White C (Craig) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Jack,

Thanks for the message. Please find attached a copy of Prof Craig White's remit together with the Board's Action plan for completeness. I would be grateful if the Cabinet Secretary could confirm she is content with the remit so that it can be shared with the Board; in particular to support focused engagement with the Board's staff and ensure that access is provided to required background information.

Prof White met with Jane Grant today and they agreed that the co-ordination of the communication with the families is essential and all proposed communications and responses to families will be passed to Prof White to ensure a clear and person-centred approach. Therefore the Board will communicate to all the 200 families with links to the service in NHSGGC imminently to request that they confirm their interest in the proposed meetings with HPS and the Independent Review of the QEUH. Both the Independent Review and HPS are aware of the requests and will organise meetings accordingly – noting the Cabinet Secretary's urgency with the situation following the meetings with families.

Prof White has agreed to base himself at the Board HQ for most of the rest of this week and is in the process of settings up meetings with key colleagues on Wednesday and Thursday. We will provide an update on progress to the Cabinet Secretary later in the week – noting the urgency in progress which is needed on the issue.

Regards

Jason

Jason Birch | Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | T [redacted] | M [redacted] | [redacted]

From: Downie J (Jack) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 04 October 2019 14:44
To: McQueen F (Fiona) [redacted]; Cabinet Secretary for Health and Sport [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Birch J (Jason) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; White C (Craig) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]
Subject: Follow up work for Monday following GIQ and letters

Fiona,

Following on from today's GIQ and the letters to parents/patients, the Cabinet Secretary would be grateful for a full update on Monday. This update should cover when you plan to meet with clinicians/HPS/QEUH IC Doctors; confirmation from Glasgow on how they are progressing with their action plan (as per the ask below) and an update on when HPS, and then the Co-Chairs of the QEUH Review, plan to meet with the families.

The Cabinet Secretary has commented that there is some urgency to getting this work progressing so I would be grateful for an update on where we are by 3pm on Monday.

Many thanks,
Jack

From: Downie J (Jack) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 04 October 2019 12:15
To: JJBrown [redacted]; jane.grant [redacted]; Cabinet Secretary for Health and Sport [redacted]

Cc: leanne.law2[redacted]; Duncan, Gillian [redacted]; McQueen F (Fiona) [redacted]; Wright M (Malcolm) [redacted]; DG Health & Social Care [redacted]; Birch J (Jason) [redacted]
Subject: Follow up from Wednesday

John, Jane,

Following your meeting with the Cabinet Secretary on Wednesday, I attach a copy of the Government Inspired Question (GIQ) issue today which updates parliament; a template of the letters issue individually to each of the families the Cabinet Secretary met on Saturday 28 September/Tuesday 1 October and log of the issues raised by the families of children treated on the Haemato-oncology wards at QEUH and RHC.

As discussed at the meeting, you indicated that you would produce a plan of action to engage with parents/patients involved here and how you could take forward the queries they have raised. The Cabinet Secretary would be grateful for an update on these plans to progress matters by 1pm on Monday.

Many thanks,
Jack

Jack Downie
The Scottish Government | Health & Sport Ministerial Private Office | St Andrews House, Edinburgh | [redacted]

Scope, Role and Remit of Professor Craig White re Concerns Raised by Patients and Families within Paediatric Oncology/Haematology Service at Royal Hospital for Children/Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde

On 04 October 2019, the Cabinet Secretary for Health and Sport appointed Professor Craig White, Divisional Clinical Lead, Directorate of Healthcare Quality Improvement, Scottish Government to lead and direct the work required to ensure that the voices of the families affected by the infection outbreaks at NHS Greater Glasgow and Clyde ("NHSGGC") are heard and that the information they have asked for and entitled to receive is provided as a matter of priority. Professor White will:

- review the concerns of patients and families who have experienced care within the paediatric oncology/haematology service at RHC/QEUH ("those affected"), ensuring that these are addressed urgently and advising on those that should be considered by the ongoing independent review and/or public inquiry. An initial summary of these has been collated and shared with NHSGGC, though should not be regarded as exhaustive as further questions, clarifying questions or requests for information may be identified through further dialogue, through Professor White's consideration of the NHSGGC's proposed responses and/or others affected who may submit concerns or issues.
- consider the work of NHSGGC's Incident Management Team (IMT) to date in addressing the areas of concern raised by those affected and staff involved. He will be supported as necessary by subject matter experts within Health Protection Scotland and will provide advice and make recommendations to the Chief Nursing Officer.
- establish ongoing channels of communication, engagement and information provision with patients and families within the paediatric oncology/haematology service, their representatives and others as deemed appropriate
- ensure that the issues raised by those affected are addressed by NHSGGC with a specific focus on:

- infection control measures
- the work underway in the haematology/oncology areas of the hospital
- the intended outcome and timeline of the enhanced safety measures which NHSGGC has put in place
- other specific matters that have and may be raised by those affected

Professor White will:

Agree with the Chief Executive and Board of NHSGGC that he will be provided with all responses and supporting information requested in respect of ensuring that satisfactory responses are provided to the know existing questions, issues and requests for information from those affected. He will act as the Scottish Government's point of contact for affected individuals and work in partnership with NHSGGC's senior staff, providing direction, support and guidance on the actions required in support of his review of the issues, questions, concerns and needs of those affected.

Meet in person with any of those affected who wish to do so

Work with NHSGGC to ensure that the staff involved in considering and addressing the concerns of patients and families receive the support that they identify as necessary.

Liaise with staff within NHSGGC who may be able to assist him in considering, understanding, supporting or advising him in any aspect of the action required to review the work that has been undertaken by NHSGGC to date; that which needs to be undertaken now and may be required in the future to effectively address and respond to the issues raised by those affected.

Seek information in support of his exploration, consideration and examination of all actions, decision-making and any relevant supporting information as will be necessary to enable him to ensure that those affected receive responses that reflect best practice in the necessary communications, support and engagement in the current circumstances.

Ensure that his actions are at all times informed by best practice in the handling and management of the issues raised in respect of infection control, safety, clinical governance, effectiveness, improvement support and person-centredness of perspective, approach and response.

In discharging these responsibilities, Professor White will report directly to the Cabinet Secretary for Health and Sport and will be supported in this work by officials from the Directorate of the Chief Nursing Officer of the Scottish Government.

Professor White will make recommendations to the Chief Executive and Board of NHSGGC on any actions required to address the issues considered by the Cabinet Secretary for Health and Sport; including any actions required to improve the effectiveness of NHSGGC's responses to the incidents/outbreak (including those required in respect of the approaches required in the future by NHSGGC, HPS and Scottish Government).

08 October 2019

From: White C (Craig)
Sent: 09 October 2019 17:58
To: Cabinet Secretary for Health and Sport; Birch J (Jason)
Cc: Murray D (Diane); Dunk R (Rachael); Shepherd L (Lesley); Aitken L (Louise); Hart S (Suzanne); Communications Healthier; Klein G (Gerard); Mair S (Suzi); DG Health & Social Care; Burgess E (Elizabeth); Ives J (Josephine); Hutchison D (David); Wright M (Malcolm); McQueen F (Fiona); Minister for Public Health, Sport and Wellbeing; Henderson C (Calum)
Subject: RE: Follow up work for Monday following GIQ and letters
Attachments: Prof White Letter - RHC Families - 091019.pdf; S5W-25642 GIQ.pdf; Prof White - Remit.pdf

Follow Up Flag: Follow up
Flag Status: Completed

Categories: Printed for DG

PS/Cabinet Secretary for Health and Sport

I have issued the attached today, along with the GIQ and finalised remit and scope documentation. Following the provision of advice and proposed amendments from me to the letter to be issued by NHSGGC Chair and CEO to all patients and families tomorrow, I approved the final version earlier this afternoon. I will circulate a copy of this when it issues.

NHS GG&C staff also sought my advice and support late this afternoon with the drafting of a communication to patients and families following yesterday's Incident Management Team. Changes were made to this and I have now confirmed I am content with this.

I have had helpful and productive conversations this week during one to one meetings with the CEO, Chair, Head of Corporate Administration, Board Nurse Director, Chief Nurse (RHSC) and Director of Estates and Facilities.

I met with the CEO today to provide some feedback on the Incident Management Team meeting I attended yesterday evening, making it clear that I am beginning to review that in general in line with my remit. I have had a useful meeting today with the Board's Director of Communications and have requested several pieces of background information to inform my support, advice and assessment of the approach taken to supporting internal and external communications, engagement and information provision to date. I have also agreed with the Chief Nurse that she and her team will make it clear that I would be happy to meet or visit any families in the ward, day or out patient service if this would support her and her team.

I am continuing my series of meetings of senior staff, with meetings scheduled tomorrow with the Board Medical Director, Director of Childrens Services, Acting Infection Control Manager and General Manager, Womens and Children's Services. I intend to circulate a briefing with an update against all elements of my remit early during the course of next week.

Best wishes,

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |

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From: Corr A (Andrew) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 09 October 2019 08:32
To: White C (Craig) [redacted]; Cabinet Secretary for Health and Sport [redacted]; Birch J (Jason) [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Craig,

The Cabinet Secretary was grateful for sight of this and is content with the changes. She thinks it would be beneficial for you to send this remit with a covering letter introducing yourself to all the families she met recently, using this to agree with them how they can use you. Would you be able to do this today and share with us the letter that you send?

Thanks,
Andy

From: White C (Craig) [redacted]
Sent: 08 October 2019 21:39
To: Cabinet Secretary for Health and Sport [redacted]; Birch J (Jason) [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Jack

The attached has minor amendments (none of them substantive to the content) after my meeting with the Chairman of the Board, John Brown, today – all relating to consistent and his proposed use of the terms NHSGG&C and the Board. I will circulate to the Chair and Chief Executive in the morning.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: Downie J (Jack) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 08 October 2019 14:27
To: White C (Craig) [redacted]; Cabinet Secretary for Health and Sport [redacted]; Birch J (Jason) [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Craig,

Ms Freeman is content with the revised remit – reattached for ease.

Many thanks,
Jack

From: White C (Craig) [redacted]
Sent: 08 October 2019 09:02
To: Cabinet Secretary for Health and Sport [redacted]; Birch J (Jason) [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Andy

Thank you. I have attached a Track Changes version of the Remit (for ease of reference to track actions in response to the Cabinet Secretary's response) and a Clean copy. I have a meeting with the Board Chair today at 1300hrs so have prioritised sending this back to you now in the hope that it will be possible to have Ms. Freeman's sign off at some point before that time, meaning I can go through the Remit and also circulate to other relevant staff within GG&C.

Hope this is helpful,

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: Corr A (Andrew) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 08 October 2019 08:42
To: Birch J (Jason) [redacted]; Cabinet Secretary for Health and Sport [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; White C (Craig) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]; Henderson C (Calum) [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Morning Jason,

The Cabinet Secretary has considered the draft remit and Board's Action plan. In respect of the draft remit she has asked that this be amended as follows:

• to specify patients and families (not people) and specify it is those in paediatric oncology/haematology- at the minute it could be everyone at RHC/QUEH

• to be clearer that Craig's job is to ensure all issues raised by patients and families are addressed and addressed at pace - being clear which ones properly belong to the review and/or PI

• re IMT delete 'may provide' and replace with 'will provide...'

• the ongoing channels to be established are of engagement and information (NHSGGC think PR when we say communication) This needs stressed with NHSGGC because their plan continues to talk about Comms and social media.

• re staff in this area of work, he needs to work with the board to ensure they are provided with additional support they identify

In respect of the NHSGGC action plan the Cabinet Secretary has commented that the review of readiness of 6A to open to new admissions must involve the oncology/haematology clinicians as well as CNO. She has also added that it wasn't especially 6A cleanliness families raised as cleanliness across QUEH and she thinks that what the plan is missing so far is ensuring staff in any ward used for these patients are familiar with relevant protocols.

I would be grateful if you could take these points up with NHSGGC as soon as practically possible. I would also be grateful if you could amend the draft remit and have a new version to us by 1300 today.

Many thanks,

Andy

From: Birch J (Jason) [redacted]
Sent: 07 October 2019 16:20
To: Cabinet Secretary for Health and Sport [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi) [redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; White C (Craig) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]; McQueen F (Fiona) [redacted]; Minister for Public Health, Sport and Wellbeing [redacted]
Subject: RE: Follow up work for Monday following GIQ and letters

Jack,

Thanks for the message. Please find attached a copy of Prof Craig White's remit together with the Board's Action plan for completeness. I would be grateful if the Cabinet Secretary could confirm she is content with the remit so that it can be shared with the Board; in particular to support focused engagement with the Board's staff and ensure that access is provided to required background information.

Prof White met with Jane Grant today and they agreed that the co-ordination of the communication with the families is essential and all proposed communications and responses to families will be passed to Prof White to ensure a clear and person-centred approach. Therefore the Board will communicate to all the 200 families with links to the service in NHSGGC imminently to request that they confirm their interest in the proposed meetings with HPS and the Independent Review of the QEUH. Both the Independent Review and HPS are aware of the requests and will organise meetings accordingly – noting the Cabinet Secretary's urgency with the situation following the meetings with families.

Prof White has agreed to base himself at the Board HQ for most of the rest of this week and is in the process of settings up meetings with key colleagues on Wednesday and Thursday. We will provide an update on progress to the Cabinet Secretary later in the week – noting the urgency in progress which is needed on the issue.

Regards

Jason

Jason Birch | Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | T [redacted] | M [redacted] | [redacted]

From: Downie J (Jack) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 04 October 2019 14:44
To: McQueen F (Fiona) [redacted]; Cabinet Secretary for Health and Sport [redacted]
Cc: Murray D (Diane) [redacted]; Dunk R (Rachael) [redacted]; Birch J (Jason) [redacted]; Shepherd L (Lesley) [redacted]; Aitken L (Louise) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Klein G (Gerard) [redacted]; Mair S (Suzi)

[redacted]; DG Health & Social Care [redacted]; Burgess E (Elizabeth) [redacted]; White C (Craig) [redacted]; Ives J (Josephine) [redacted]; Hutchison D (David) [redacted]; Wright M (Malcolm) [redacted]
Subject: Follow up work for Monday following GIQ and letters

Fiona,

Following on from today's GIQ and the letters to parents/patients, the Cabinet Secretary would be grateful for a full update on Monday. This update should cover when you plan to meet with clinicians/HPS/QEUH IC Doctors; confirmation from Glasgow on how they are progressing with their action plan (as per the ask below) and an update on when HPS, and then the Co-Chairs of the QEUH Review, plan to meet with the families.

The Cabinet Secretary has commented that there is some urgency to getting this work progressing so I would be grateful for an update on where we are by 3pm on Monday.

Many thanks,
Jack

From: Downie J (Jack) [redacted] **On Behalf Of** Cabinet Secretary for Health and Sport
Sent: 04 October 2019 12:15
To: JJBrown [redacted]; jane.grant [redacted]; Cabinet Secretary for Health and Sport [redacted]
Cc: leanne.law2 [redacted]; Duncan, Gillian [redacted]; McQueen F (Fiona) [redacted]; Wright M (Malcolm) [redacted]; DG Health & Social Care [redacted]; Birch J (Jason) [redacted]
Subject: Follow up from Wednesday

John, Jane,

Following your meeting with the Cabinet Secretary on Wednesday, I attach a copy of the Government Inspired Question (GIQ) issue today which updates parliament; a template of the letters issue individually to each of the families the Cabinet Secretary met on Saturday 28 September/Tuesday 1 October and log of the issues raised by the families of children treated on the Haemato-oncology wards at QEUH and RHC.

As discussed at the meeting, you indicated that you would produce a plan of action to engage with parents/patients involved here and how you could take forward the queries they have raised. The Cabinet Secretary would be grateful for an update on these plans to progress matters by 1pm on Monday.

Many thanks,
Jack

Jack Downie
The Scottish Government | Health & Sport Ministerial Private Office | St Andrews House, Edinburgh | [redacted]

Healthcare Quality and Improvement Directorate
Planning and Quality Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: [redacted]
E: [redacted]

By email

9 October 2019

Dear

As you may be aware, following your meeting with Jeane Freeman MSP, Cabinet Secretary for Health and Sport, I was appointed by her to review the concerns that you have raised, to act as a dedicated point of contact and to work with NHS Greater Glasgow and Clyde to ensure that your wish for responses to questions is addressed promptly and the immediate practical issues you have raised are also dealt with swiftly.

I have attached a copy of the Cabinet Secretary's response to a question posed in the Scottish Parliament, along with a document outlining the scope and remit of my appointment for your information. I also wanted you to have my contact details (see above). I have been meeting this week with the Chief Executive, Chair and relevant Directors within NHS Greater Glasgow and Clyde and will also be meeting with several other senior clinicians and managers over the coming week.

I have based myself with the Board's Corporate offices at JB Russell House in Glasgow in order that I can undertake my work in partnership with staff. You will shortly be receiving a letter from the Chair and Chief Executive which will confirm that you should contact me if you wish to make arrangements for contact with relevant staff working in Health Protection Scotland and/or the Independent Review team (as agreed in the meetings with Ms. Freeman).

Please do not hesitate to contact me if I can advise, support or respond to any questions, concerns or issues that you might have.

Yours respectfully,

PROFESSOR CRAIG WHITE
Divisional Clinical Lead

c.c. Jane Grant, Chief Executive, NHS Greater Glasgow and Clyde
John Brown, Chair, NHS Greater Glasgow and Clyde
Fiona McQueen, Chief Nursing Officer, Scottish Government
Malcom Wright, Director General Health and Social Care, Scottish Government

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S5W-25642
To ask the Scottish Government what discussions it has had with families of paediatric cancer patients affected by the infection outbreaks at the Royal Hospital for Children and the Queen Elizabeth University Hospital, NHS Greater Glasgow & Clyde?

Answer:

On Saturday 28 September and Tuesday 1 October 2019 I met with a number of families of paediatric cancer patients, and some young patients themselves who have been treated at the Royal Hospital for Children and Queen Elizabeth University Hospital. I was able to listen directly to their concerns and hear of the impact of the infection outbreaks which have affected some patients at these hospitals.

I am very grateful to the families for their time and for the frank and open way they detailed their concerns and feelings to me and the impact these have on their lives. They raised a number of important issues with me. Some of these will be answered by the Independent Review I commissioned in January and which I expect to report by Spring next year and by the Public Inquiry I announced on 18 September. But many are pressing now and will be answered and resolved in the coming weeks.

The central thread running through the concerns about the current situation, is that families want detailed information on current levels of safety in the environment in which paediatric cancer patients are treated, including work undertaken to determine the cause of an outbreak and the rationale for infection prevention and control measures that are taken. Families also want information on the work under way in the haematology/oncology areas of the Children's Hospital, the intended outcome in terms of enhanced safety measures from that work and the timeline for completion.

All of this is information they are entitled to and should receive. Whilst this level of detail must come from the Board, families should not be expected to seek it piecemeal from a range of individuals. Nor would it be right that the responsibility for providing this should sit with the clinical teams. That is why I have appointed 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 has worked for the Scottish Government since 2014 and led the Scottish Government's work on organisational duty of candour. He has established his expertise in a broad range of areas spanning the governance, assurance and improvement processes implicated by the concerns raised by families.

The families raised a number of specific questions and requirements and Professor White will, work with them and the Board to seek to have these addressed, at pace. In addition, I have asked Health Protection Scotland to undertake an external review of the Board's data on healthcare associated bloodstream infections.

In the coming weeks the Chair and Chief Executive of NHS Greater Glasgow and Clyde will meet with those families who wish to do so and I expect to see a number of the immediate practical issues addressed and a clear and full information flow to

families established. I also expect to see additional steps taken to support all the staff involved who continue to deliver high quality compassionate care in difficult circumstances.

In all of these discussions the families I met were very clear that all the frontline staff they dealt with, in whatever role, were compassionate, caring and skilled. They were clear that they wanted their gratitude recorded together with their thanks. I hope to meet with staff in the near future but want to use this opportunity to record my personal thanks to them. I will continue to take a close interest in the progress made against the issues and concerns families raised.

Healthcare Quality and Improvement Directorate
Planning and Quality Division

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: [redacted]
E: [redacted]

By email

29 October 2019

Dear [redacted]

Further to my letter to you of 9 October 2019, I have been working with staff at NHS Greater Glasgow and Clyde to seek responses to the issues you previously raised with the Cabinet Secretary for Health and Sport. NHS Greater Glasgow and Clyde have prepared the attached document.

Since I was appointed, I have had several helpful and productive meetings with senior staff of NHS Greater Glasgow and Clyde and, as you have been informed in the letter sent by the Chair and Chief Executive, have agreed with their proposal that Jennifer Haynes (based at the Board's Corporate Headquarters) will be your point of contact for any questions, information or support that you or your family may require. Jennifer can be contacted at [redacted] or [redacted].

I have met with the Chair of the Independent Review that was previously established to look at the design, commissioning, handover and ongoing maintenance at Queen Elizabeth University Hospital and how these contribute to effective infection control. I have confirmed with them that I will ensure that questions, feedback, questions and experiences from you that are within their remit will be passed to them in order they they can consider them as part of their work.

I would be pleased to receive any follow-up questions or requests for information that you may have when you review the attached responses. If I can provide any further support or information then please do not hesitate to contact me at [redacted] or on [redacted].

I will continue to base myself at NHS Greater Glasgow and Clyde in order that I can oversee, support and direct the relevant actions required to ensure that you receive the information and responses that you need and deserve.

Yours respectfully,

[redacted]

PROFESSOR CRAIG WHITE

Divisional Clinical Lead

c.c. Jane Grant, Chief Executive, NHS Greater Glasgow and Clyde
John Brown, Chair, NHS Greater Glasgow and Clyde
Fiona McQueen, Chief Nursing Officer, Scottish Government
Malcom Wright, Director General Health and Social Care, Scottish Government

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List of issues raised by the families of children treated on the haemato-oncology wards at Queen Elizabeth University Hospital and Royal Hospital for Children with the Cabinet Secretary for Health and Sport

Response from NHS Greater Glasgow and Clyde

Following meetings parents had with the Cabinet Secretary for Health and Sport about infection issues in the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), a number of questions have been posed, and NHS Greater Glasgow and Clyde (NHSGGC) welcomes the opportunity to answer these fully and transparently.

The remainder of this document will address each individual question posed to us in detail. Before we do so, we wish to be clear that the safety and wellbeing of our patients and their families has, and remains, our key priority, and we are very sorry that some of those in our care have had worries about the hospital environment, at what is an already difficult time.

If, as a result of the points being addressed, any individuals have additional questions specific to their child's care and treatment, they are welcome to contact Jennifer Haynes in the Board's Headquarters, who will ensure their concerns are addressed. Jennifer's contact details are: [redacted] / [redacted].

The Cabinet Secretary for Health and Sport has also appointed Professor Craig White, Divisional Clinical Lead from the Scottish Government to lead and direct the work required to ensure that the voices of the families affected are heard and that the information they have asked for and entitled to receive is provided as a matter of priority. Professor White can be contacted at [redacted] / [redacted].

The families raised the following specific points:

Issues with the environment

1. Is the ventilation and water system currently safe?

Yes, and we would seek to reassure all our patients and their families of this.

a. Ventilation

With regards to the ventilation, there was a concern regarding the number of air changes and the air pressure within rooms where patients who were immunocompromised (which can happen as a result of cancer treatment and other treatment) were being cared for.

An upgrade was carried out in four paediatric Bone Marrow Transplant isolation rooms in 2015. Ward 6A currently has portable HEPA filters (High Efficiency Particulate Air – a type of high quality air filter) in all patient rooms and the corridor, providing additional and ongoing air cleaning. We have not identified any link between infections and ventilation.

Our priority is patient safety and we are investing £2 million to upgrade the ventilation system in Wards 2A and B to provide optimal, state of the art facilities for all our young haemato-oncology patients. This is to ensure we are taking every possible measure to reduce the likelihood of infection for this group of patients, who have an increased risk due to their treatments. We very much hope this will reassure the patients and the families in our care how seriously we are taking these issues.

b. Water

When the hospital first opened in 2015, there was no indication that there was a problem with the water in the RHC. We later had a spike in infections in 2018 (in ward 2A) and on testing the environment and water, we found organisms which can potentially cause infection in the water supply. To address this, we put extensive measures in place, including the installation of a water treatment system, as well as filters on water outlets. The water was then re-assessed by an independent authorising engineer, who described it as 'wholesome'. The Public Water Supplies (Scotland) Regulations 2014 outline in legislation the requirements that are to be met for public water supplies to be regarded as 'wholesome'. This means the water in both the RHC and QEUH is safe.

2. **Is the hospital a safe place for the children - as the families are too scared to take them in for fear of infection and want to keep them at home.**

Yes, we can reassure both patients and parents that the hospital is safe, and we are sorry for the concern caused. Whilst we continue to investigate the issues and take action, every precaution has been put in place to ensure we care for our patients safely and fully.

Patient safety is the main priority for our organisation, and this is regulated and monitored in a number of ways, from individual clinical specialty and ward meetings, right up to formal committees of the Board.

We closely monitor clinical outcomes (which are measurable changes in health as a result of care given), and complete tests of the environment, including sampling of air and water tests, as well as wider water quality analysis throughout the site. In addition, doctors, nurses and estates staff undertake regular inspections of the environment for monitoring purposes, and from this, any issues are identified and addressed.

We are very sorry that families have been scared about the risk of infection, and we are committed to ensure that our staff provide all necessary supporting information and opportunity for discussion to anyone experiencing concerns about safety, or fears for their children.

3. **Can reassurance be provided that all the clinical environment is safe?**

As with the above question, yes, we can reassure parents that the hospital is safe, and we have taken every measure to ensure that each patient is cared for in the best and safest way.

4. **There needs to be a check to ensure that the water from the showers drains away properly and doesn't leak back into the rooms**

We are sorry this has caused concern, as the shower floors were designed so that water drains away appropriately. There are no problems with Ward 6A showers. If there ever was an issue with an individual shower (which was not a design issue), then this would be immediately reported to estates colleagues and the drainage issue would be fixed.

As part of the work underway in Ward 2A, we will be doing a refit of the en-suite bathrooms including floor and wall coverings, to ensure that this is not a subject of concern going forward. The work to refit the en-suite facilities will include a revised detail and new materials which should reduce the need for the same level of regular repair, and minimise disruption to day-to-day ward operations.

5. **A copy of the HPS water contamination report should be shared with the families.**

   This is available online at the following web address:

   https://www.hps.scot.nhs.uk/web-resources-container/summary-of-incident-and-findings-of-the-nhs-greater-glasgow-and-clyde-queen-elizabeth-university-hospitalroyal-hospital-for-children-water-contamination-incident-and-recommendations-for-nhsscotland/

   If any patient or family member would like us to send them a paper copy of this, we would be happy to do so (please contact Jennifer Haynes on [redacted] or [redacted])

6. **There needs to be a complete holistic look into the environment in the wards to ensure they are clean and safe.**

   We agree with this comment, and we would seek to assure families that a complete review of the ward environment involving infection prevention and control staff, senior ward charge nurses and estates and facilities staff takes place every week to monitor cleanliness and the general estates environment. If any issues are identified, then these are quickly remedied.

   In addition to the above described weekly walk round, infection prevention and control colleagues, along with estates staff, are on the ward regularly to ensure vigilance and ongoing review the environment. Any issues raised are immediately resolved between the nursing and estates and facilities teams.

7. **Why are the remediation works to the wards taking so long and why are there problems in the decant wards? Are the works so far just a sticking plaster?**

   This is a major piece of work currently underway in Ward 2A/2B. There was extensive planning, design and procurement work undertaken in order to commence this work, which began in April 2019, in order to ensure we were creating the right conditions for the physical work to start. As is normal, there was a lead in time before the physical work started, which it did in October 2019.

   There are a number of significant technical challenges to remove the existing ventilation systems and install the enhanced system. Whilst we appreciate the concern about the time taken, these are major works, and it is important we ensure the work is carried out to a high standard. At the moment, we would anticipate this work to be complete by March 2020, which given the level of work, is a reasonable and realistic timeframe.

   All works being undertaken are being done as a preventative measure to minimise the risk of infection, and to ensure absolute vigilance in our approach to the prevention and control of infection.

8. **The works in ward 6A need to be investigated with details then provided on progress.**

   In Ward 6A we have completed a number of actions to improve environmental controls within the ward, including the use of mobile HEPA filters (see response to Question 1) and the imminent installation of fixed HEPA filters in the en-suite areas. We have also increased the cleaning and maintenance of the chilled beams, which regulate the daily air temperature within the rooms, and have committed to a cleaning programme every six weeks. This is significantly in excess of the annual cleaning regime recommended by the manufacturer, and we have put this in place to be extra thorough.

The Chief Nurse and General Manager for Hospital Paediatrics regularly visit parents and patients within the ward, and would be pleased to answer any questions. We have also set up a closed Facebook page to ensure that the families of other haemato-oncology patients are also updated. If there are any other ways that families would find it helpful for us to communicate with them, we would welcome any suggestions that they would find beneficial.

9. **The extent of the works and the length of time until they are completed in wards 2A and 2B needs to be checked thoroughly with all details provided.**

   Please see our response to Question 7 and 8.

10. **Why are the rooms not cleaned properly so the families have to clean the rooms themselves and have to bring in their own bedding?**

    No families should ever have to clean hospital rooms, nor bring in their own bedding, and we are therefore extremely sorry where this has happened.

    Sometimes family members may want to do activities, such as clean the hospital room, but this should only be if they wish to do, and absolutely not because they feel they have to.

    Ward 6A has its own domestic staff and a domestic supervisor to ensure it is kept clean. There is a daily meeting between clinical and domestic staff to monitor cleaning levels. The aim is to ensure that cleaning takes place frequently and to a high standard, and we would encourage any families concerned about this to speak to the nurse in charge of their child's care.

    No patient is asked or expected to bring in their own bedding, however, if a child or young person wishes to bring in their own bedding, then we will support this. This is to help make the bedroom child-friendly and personal to the patient, in keeping with person-centred care and what matters to children.

    Parents who sleep over are also provided with a bed and bedding. If this is a concern that individual parents have, we would encourage them to get in touch with us so we can make further enquiries, as this is not an issue they should have to contend with.

11. **Why are there so few facilities on ward 6A, including the facility to make tea and coffee, warm up food in a microwave, play area for the children, space for the parents to talk and discuss very difficult issues. In addition the available food is poor and expensive on site which compounds the problems.**

    When a decision was made to decant Wards 2A and 2B in September 2018, an assessment was made at that time about the best clinical option that would see young patients remain on site with access to paediatric intensive care and specialist services. This recognised that there would be compromise in terms of social spaces for children, families and staff.

    The short term solution was for parents to use either the kitchen facilities (including microwave and kettle) in the RHC or the microwaves within the QEUH.

    Both the play assistant and the Teenage Cancer Trust Activities Co-ordinator are based in Ward 6A and arrange individual and group activities for the patients. They also ensure that the children have age-appropriate toys.

    As this is an issue of ongoing concern for families, we are currently creating some parent and child facilities in the ward, including a playroom and a parents' kitchen / social space. We would welcome any ideas patients or parents may have that they would find helpful in this regard.

12. Are there enough cleaners on the wards?

Yes, there are sufficient numbers of cleaners, and if there are any gaps (for example, due to sickness absence), then this is immediately managed to ensure appropriate cover. Ward 6A has its own domestic staff and a domestic supervisor to ensure standards of cleanliness are maintained. There is a daily meeting between clinical and domestic staff to monitor cleaning levels.

As described previously in this document, a complete review of the ward environment, involving infection prevention and control staff, senior ward charge nurses, the domestic services manager and estates and facilities staff, takes place every week to monitor cleanliness and the general estates environment. If any issues are identified, then there are quickly remedied.

13. Why were parents told that ward 6A would have a play room for children when it did not?

We are sorry that parents were told that Ward 6A would have a play room, when it did not, as we appreciate that this would have had a negative impact on experience.

We set up a play space and this was approved by infection prevention and control colleagues, however, when the incident occurred, it was agreed that this should be removed.

Both the play assistant and the Teenage Cancer Trust Activities Co-ordinator are based in Ward 6A and arrange individual and group activities for the patients. They also ensure that the children have age-appropriate toys.

As this is an issue of ongoing concern for families, we are creating some parent and child facilities in Ward 6A, including a playroom and parent space with kitchen facilities. We would anticipate that to be ready in early November 2019.

14. There is a lack of room for fold down beds for parents, the blinds don't work, the TVs also don't work. The lack of natural light in particular effects the children when they do go outside.

We are sorry that these issues have impacted negatively on care experience, particularly as we recognise that patients and their families spend a great deal of time in their rooms. These issues relate to previous concerns raised about Ward 2A and 2B, which is undergoing an upgrade, and issues with the TVs and blinds will be addressed as part of this. This will be completed for the ward reopening in March 2020. We are committed to take action whenever we receive feedback about anything that impacts negatively on care experiences, and encourage anyone with any concerns or suggestions for improvement in this area to make these known to staff.

15. Why did the Board not consider all these vital issues, relating to the lack of facilities when decanting the patients – in particular did they consider the effects on the mental health of the patients and their families?

When a decision was made to decant Ward 2A and 2B in September 2018, our absolute priority was where the best and safest place was to deliver care to our patients. We are sorry that patients and families have been worried about this, as we would have been keen to allay their concerns.

At the time of the decision, an assessment was made about the best option that would see young patients remain on site with access to paediatric intensive care and specialist services.

This recognised that there would be compromise in terms of social spaces for children, families and staff, but that this was necessary in order to be able to deliver the best care. We are sorry that we did not explain this as well as we could have to families.

All of these issues were considered at the time, but we hope we have explained that patient safety was of the highest clinical priority, as it is now.

The new family room will have a 'What matters to me' board that families can use, which we hope will act as a good communication tool in ensuring our staff know what is important to families.

16. Why aren't there enough electrical plugs in the rooms for all the medical equipment?

Our staff have advised the Director of Estates and Facilities that there are enough electrical plugs with rooms for all the medical equipment that is needed to provide safe, effective and person-centred care. More electrical plugs can be fitted if these are required. We would appreciate any questions or suggestions for improvements that can be made to ensure that concerns about the number of electrical plugs are addressed.

17. Why don't the batteries work in the mobile drip stands?

In order to keep batteries fully charged we recommend that they are connected to the electrical supply when they are not mobile or being used. We expect this to be monitored by staff so that the batteries do not run out. We also expect that any concerns about the functioning of batteries to be reported so that they can be replaced, and encourage anyone with any concern at any time about battery performance to raise this with staff in order that action can be taken in response.

18. Why do the trolleys have defective wheels?

It is not acceptable for any equipment involved in the provision of care to be defective. We expect any such defects to be reported in order that these can be repaired. If any patient or family member has any concern about whether trolley wheels (or any piece of equipment) is defective, please report this to a member of staff so that action can be taken in response to this.

All equipment defects or failures, if reported, are repaired through routine maintenance. We are sorry for the concern that has been caused by any defects in equipment that have been noted as not having been repaired.

19. Have the Board considered the practical difficulties in terms of patients using safe toilet facilities, without contaminated water, given the difficulties in moving with drip stands etc?

We think this question may relate to Wards 2A and 2B prior to the move when we put in place temporary measures whilst we dealt with investigations into water safety. Wards 2A and 2B are currently undergoing a full refit prior to reopening in April 2020. The toilet, sinks and showers within Ward 6A had filters added to the water outlets as a precautionary measure to be sure we were minimising the risk of infection wherever possible.

As previously described, patient safety is our priority, and has been our primary consideration throughout all of this.

20. How can the water be usable now in ward 2A/2B given that there are still restrictions in the floors directly above and below?

No patients are currently in Wards 2A and 2B.

The water in the hospital is safe to drink. Our on-site water plant ensures all water coming into the hospital has a low dose of chlorine dioxide, which keeps it clean and safe. In addition, any patient cared for high risk areas have point of use water filters in place as an extra precaution.

The safety of the water was then confirmed to be safe by the external Authorising Engineer, a specialist engineer who acts, and is employed, independently of NHS Greater Glasgow and Clyde. The Authorising Engineer has rated the water supply as 'wholesome', meaning it is safe.

We are sorry for the concerns that have been caused. Signs at the sinks within the single bed rooms advise that the sinks are for handwashing only. This forms part of our infection prevention and control standards. Patients and their families are discouraged from drinking water in the rooms as these sinks should be dedicated to handwashing only.

If any patient or family member has any concerns about the use of water, they should speak to the nurse in charge.

21. What happens next if the QEUH campus is not safe and what is the backup plan?

The QEUH campus is safe. We would like to assure all our patients and their relatives that the hospitals on this site are safe, and that we strive to deliver safe care at all times.

We continually monitor and test to ensure the safety and integrity of the water and ventilation systems.

22. What if the water system is found to be unsafe - is a plan B being considered at the moment?

As previously described, the water in the RHC and QEUH is safe. This has been confirmed by the Authorising Engineer, a specialist engineer who acts, and is employed, independently of NHS Greater Glasgow and Clyde. We will always consider all options and resilience plans, but we hope we have reassured that the position is that there is no issue with the water. Please see our response to Question 20.

23. Is the QEUH campus itself safe?

Yes. Please see our response to Question 21.

24. Is the overall water supply across the QEUH campus safe - in particular, McDonald House and the local residents use the same water supply so do they have the same problems?

The domestic water supply to the local population and to Ronald McDonald House is the responsibility of Scottish Water.

The water supply to the hospitals is safe – please see our response to Question 20.

25. The Healthcare Improvement Scotland HEI inspection in March and 2018 didn't go to the oncology wards or ward 6 – what was the reason?

When Healthcare Improvement Scotland undertake an independent HEI inspection, this is part of their role. They will visit a number of wards and areas, but not necessarily all wards within a hospital site. During an inspection, they will then carry out a range of checks to ensure hospitals are meeting national standards, guidance and best practice. Healthcare Improvement Scotland have been asked by Professor White from the Scottish Government to provide details on their process for deciding which wards to visit.

More information about Healthcare Improvement Scotland inspections, is available at : http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services.aspx

26. The families want to liaise directly with Healthcare Improvement Scotland on these issues.

Professor White from the Scottish Government will provide details of a named contact at Healthcare Improvement Scotland for any families who have further questions on their decisions and approach.

27. Why is the day care room at the other end of the ward – which is in itself an infection risk

When considering the decant to Ward 6A, infection prevention and control experts, with clinical teams and estates staff, agreed that the best area for the day care waiting room would be the former adults' day room, which would maintain the waiting area within the day care area. Other options were examined, but this was considered the safest and best choice due to the practicalities and available options, in a way that does not elevate the risk of infection in an unacceptable way. Putting the day care elsewhere in the ward would have meant no proper reception area for the families.

28. When specifically were the water filters put into the theatres?

The filters were installed in the theatres in June 2019 as a preventative control measure to make sure that the full patient pathway had sinks with filters.

Before June 2019, point of use filters (i.e. filters on water outlets) were not installed in theatres on the advice of infection prevention and control colleagues, because patients in theatre were not in direct contact with water.

As part of the current Incident Management Team investigation in June 2019, the decision was taken to install point of use filters as an extra precaution at every stage along the patients' clinical pathway within the RHC, including the theatres.

29. Is the cladding on the buildings where wards 2A/2B and ward 6A are located safe?

Yes. All cladding meets current safety standards, and is therefore safe.

30. Why was one of the kitchens on ward 6A shut recently – it was suggested this was down to fungus being found.

This particular staff kitchen was shut because a leak (not fungus) was noticed within the staff kitchen on 27th September 2019. The leak was as result of a faulty tap connector on a recently fitted tap. The leak has been repaired, and the kitchen is now in use again.

Issues connected to medical care

31. Are there sufficient infection prevention and control prevention measures in place?

Yes. NHSGGC have an infection prevention and control team, who provide strategic coordination and direction to ensure our programme of work reflects the National Infection prevention and control standards and requirements. We also have local infection prevention and control teams assigned to each sector of the Health Board, to provide local support, guidance, advice and action. For more information, please visit:

https://www.nhsggc.org.uk/your-health/infection-prevention-and-control/

The current incident with Ward 6A is being investigated by an Incident Management Team (IMT), which, as described earlier, is a team of experts, including infection prevention and control nurses and doctors, clinical staff, estates and facilities teams and Health Protection Scotland, who are national experts in this field. One of the responsibilities of an IMT is to confirm that all infection prevention and control measures are being applied effectively and are sufficient. This has been closely scrutinised, and the IMT continues to meet regularly.

32. Are children getting drugs they don't need?

In light of the current situation with infections, it was recommended by the IMT that prophylaxis (preventative treatment) against infections was considered. There are many scenarios when children and adults are given prophylactic treatment.

If any individual patients or parents have concerns about medications, we would encourage them to speak to the Consultant in charge of their care in the first instance.

33. An explanation of the outbreak monitoring process, and the involvement of HPS should be provided to the families.

Outbreak monitoring is the ongoing assessment of results of tests or changes we make to stop new infections from happening.

As described earlier (see response to Question 31), the current incident is being investigated by an IMT. HPS representatives are members of the IMT, and attend all IMT meetings. In addition they provide expert advice and support. NHSGGC has published information on its website on this national process:

www.nhsggc.org.uk/your-health/infection-prevention-and-control/.

This sets out that the responsibilities of an IMT are to:

- Develop theories and suggestions for testing as to which cross-transmission pathways and clinical procedures may be involved in causing the infections, to try and find the cause.
- Determine whether there are any additional cases that need to be considered, and what control measures (i.e. actions to help control the likelihood of risk) may be necessary.
- Confirm that all incident control measures are being applied effectively and are sufficient.

34. Is there an infection risk because of the smell from the nearby sewers in the QEUH campus? In particular there is a smell in the isolation ward and reassurance is sought that they are safe.

We have no evidence to say that the smell being referred to is likely to be a safety risk. At the planning stages of the new QEUH and RHC hospitals, which are on the same site as a previous hospital, an environmental impact assessment was carried out. This included a review of the air quality and considered whether there would be any detriment associated with being located next to a sewage plant. No clinical or microbiological issue was identified.

The Independent Review team have also looked into this issue as part of their independent review of the hospitals. They have stated:

> *Following the inquiry's formal Call for Evidence in June, members of the public asked for the facility to be taken into consideration by the investigation team. The site is a concern for members of the public because of the quite potent smell which is noticeable at the QEUH.*
>
> *A number of hospitals have been sited close to major wastewater treatment sites across Scotland over the years. This includes the former Southern General Hospital on which the QEUH now sits. The Shieldhall wastewater treatment site dates back to 1901.*
>
> *Dr Montgomery said: "Clearly there are concerns relating to its proximity to the QEUH. If we are to fully address public confidence issues we would be remiss not to explore any health links associated with the site as part of our review. Smell alone will not cause an infection risk but we felt that we should look into this and any associated issues. To date, nothing of concern has been uncovered."*

35. Why were patients given medication, for infections, which is only supposed to be used for a week?

Some medication is used to reduce the risk of developing certain types of infection. In light of the current situation with infections, and as described in response to Question 32, it was recommended by the IMT that medication to reduce the risk of infection be considered. We are sorry that questions about the use of such medicines, including how long this was recommended for, were not adequately addressed for some families.

This is something that continues to be monitored. If any patient or family member has any questions or concerns about any aspect of clinical care/use of medicines, suggestions to improve the current approaches to the provision of information, or unanswered questions about this, these should be directed to the Consultant in charge of the care being provided. The IMT continues to review the position.

36. Why were patients given prophylaxis without consent of the parents?

We expect all families to be informed and fully involved in discussions regarding all medication and any treatment changes. The named Consultant is responsible for ensuring ongoing discussion with the parents about the care of their child, and we are committed to reviewing the concerns of any family where they felt they were not involved in discussions or decisions about their child's care. As described in previous responses, the use of medication to reduce the risk of infection is not unusual, and not all infections are preventable, but as with any medication, it should be clear why it is being prescribed.

We welcome the opportunity to look into this for any parent who has concerns about how this essential element of care planning has been delivered.

37. Why if all the infection prevention and control measures are in place are the patients still being given prophylaxis?

Please see our response to Questions 32 and 35.

38. Are the clinicians all able to access the same, correct, information?

Yes. Clinicians are active participants in the IMT, along with colleagues from Health Protection Scotland, where the data is presented and assessed.

Because not all clinicians can attend all meetings, as they are in clinics or looking after patients, those who attend feed back to those not present. The Chief Nurse and General Manager provide verbal updates to the clinical teams following IMT meetings. Any actions or matters arising are passed over to each new shift via ward safety briefs (which are verbal meetings). Special meetings with all clinicians were organised to ensure all had a chance to discuss progress.

39. Why are the staff washing their hands in contaminated water?

As described above, the water quality has been assessed and is clean and safe. There has been extensive work and action undertaken to fix the issues identified with the water; the water has been through a general filtration process, water treatment and a point of use filter at the sink. As noted in response to precious questions, the water has been deemed as 'wholesome' by an independent expert. It is therefore not the case that staff are washing their hands in contaminated water.

40. Why are families being told that their child has not got an infection only for them to be subsequently treated for the infection?

There are occasions when families would be informed that their child has not got an infection and would then receive treatment. This could be if information became available to suggest the presence of an infection at a later stage, or if a decision was made to commence medication to reduce the risk of infection developing. As referenced earlier, the IMT also recommended that prophylaxis against infections was considered (see Question 32).

Any parents who have unresolved concerns about treatment, the reasons for this and how this relates to information they have been given should raise this with the Consultant responsible for the provision of care.

41. Do families have sufficient access to relevant medical records? - in particular as diagnosis has been changed or even denied on a few occasions.

We will support any family who wishes to discuss access to relevant medical records and, in cases where there are questions about diagnosis, take all necessary steps to discuss and respond to any questions about this. This should be raised with the Consultant in charge of care in the first instance.

42. There needs to be external scrutiny of the Board.

There are currently a number of internal and external reviews of the QEUH and RHC ongoing. As well as our own internal reviews, there is the Independent Review commissioned by the Cabinet Secretary of Health and Sport (more details of which can be found at https://www.queenelizabethhospitalreview.scot/), an investigation by the Health and Safety Executive and the recently announced Public Inquiry. We are fully contributing to all of these reviews.

43. What are the long term effects on health given the delay in treatment caused by the infections?

All patients are individual, and going through different illnesses and treatment. For this reason, this question needs to be answered on a case by case basis with the relevant Consultant in charge. We are happy to help facilitate this for any parent with concerns about delays in treatment (or any other issue regarding the care provided).

44. Why were toys, particularly those from a local charity not allowed on the ward and who made the decision?

Sometimes soft toys are not allowed on the ward as they can be more difficult to keep clean. The play service provides toys for children and staff are committed to ensuring that the provision of appropriate toys is supported and that conversations take place in a way that addresses any concerns regarding infection, while taking account of the importance of this as a part of an individual child's plan of care.

45. Where will the children go if the wards are not safe? For example are the only other suitable hospitals in Newcastle, Manchester and London? (for bone marrow treatment.)

There are no concerns for Bone Marrow Transplant (BMT) patients within NHSGGC. The BMT patients are currently in a dedicated BMT unit, and have not been part of this incident. They continue to receive their care at the RHC, QEUH and Beatson West of Scotland Cancer Centre.

46. Have the Board considered issues such as patients having to travel to different wards to use the toilets because of the risk posed by contaminated water.

It is not necessary for patients to visit other wards to use the toilets. We would welcome further detail on any situation if this has been advised, so that we can ensure that this is reviewed, and action taken to make sure that accurate information is being provided.

47. Has the Board considered the mental health effects on the families and in particular the children, who through a lack of facilities are in effect institutionalised.

Yes. We are committed to doing everything possible to ensuring that these issues are considered as part of care planning and co-ordination. Clinical psychologists are available to any families who has concerns about the impact of the care environment on the psychological health and wellbeing of children and their families.

48. Why is there an issue with patients getting chemotherapy overnight? Are the correct clear details being provided?

There are no restrictions on patients getting chemotherapy overnight. Concerns about this issue should be discussed with the Consultant in charge of care.

49. Where do the patients go if they have a spike in temperature?

For patients who are no longer staying in the ward, from Monday to Friday day time hours, parents should call the day care unit and patients would be brought there. Out of hours access would be via the Emergency Department, or parents can call NHS24 for advice.

Parents can also call the ward their child was in for advice at any time, who in turn can let the Emergency Department know they are going to attend, if that is what the advice is.

50. Is there an argument for moving the Schiehallion patients to Edinburgh and retrospectively fit Glasgow in the meantime?

High risk patients are assessed on a case by case basis. Those who are clinically assessed by the haemato-oncology consultants and infection prevention and control doctors, may be admitted to either Ward 4B in the RHC, or another centre. Other patients are safe to be cared for in Ward 6A, outpatients and day care at the RHC.

Issues with communication

51. The families need to know exactly what is happening – as at the moment they have no details or understanding of the remedial works.

We realise how important it is to keep families informed and are committed, based on feedback, to continuously improve how we do this. The parents of all inpatients directly affected have been provided with regular verbal updates on the work underway within Ward 6A. As described earlier, we have also set up a closed Facebook page to ensure that the families of other haemato-oncology patients are also updated.

Please also see our response to Question 8 in relation to this point.

52. Why was advice given by staff that patients were perfectly safe in terms of infection risks from the environment but then contradicted by other staff who said that the environment, and water, was not safe? This led on occasion to the position changing overnight and patients being moved at very short notice.

We are very sorry for confusion and distress caused by differences in the information that was provided or when changes in information have not been fully explained.

The hospital is safe. Since late 2018, we have put in place a number of additional preventative control measures to mitigate further the risk of infection in this vulnerable group from the environment. This has meant a number of patient moves over eighteen months. We apologise again for the inconvenience, distress and concern this will have undoubtedly caused. Patient safety is always our main priority and we remain committed to continuously improving our communication, support and provision of information to patients and families on the basis of feedback. In a situation like this, we are constantly monitoring and investigating the position. That means we regularly receive updated information and it is a changing picture.

53. Who has the information that the wards are safe? – where does it come from and why is there so much contradiction?

We have local infection prevention and control and infection data that is collected as a matter of routine, which shows trends and highlights issues across the hospital, and in individual specialties. It has been a changing picture rather than contradictory, but we are sorry that this has caused confusion.

54. Why are the families not being told everything about their children's treatment, in terms of what medication is required and what might be the side effects.

It is our expectation that patients and parents are fully informed, and we apologise for all instances when this has not been patients and families experience. We are committed to reviewing and learning from all instances where this has not been the case; and to ensuring that everyone is clear on the importance of supporting discussion with the Consultant in charge of care provision. If you would like to tell us more about this, we would welcome your feedback and any questions so we can ensure you have all the information you need and want.

55. Why are staff members told to not tell the facts and the truth of the situation?

Staff should always be truthful in their discussions with patients and families. Staff have not been told not to talk to families, and have been encouraged to share information about what they know. If they cannot answer questions, they are asked to pass these questions onto relevant colleagues, for instance senior management and infection prevention and control colleagues, in order that points of concern can be addressed.

As described earlier, the Chief Nurse and General Manager of the hospital regularly visit the ward to provide an update to families, and to give written updates, and we also have a closed Facebook page for parents to provide regular updates and answer questions.

56. Why did families first hear in the STV news about the 6 children moving?

We make every effort to keep families informed in a timely manner, and we are therefore sorry parents found out this information from STV. We ensure that parents directly affected are informed of any press statement prior to issue, however, we are unfortunately unable to control when the media will start to report on issues that they are informed about by other sources.

57. Why did the NHSGGC management not explain the situation and instead offered no communication – they appear to be concerned about legal action.

We have sought to prioritise the information and support needs of patients and families throughout this situation. We are sorry that there has been an appearance that concern about legal action has compromised our commitment to explain and ensure timely, sensitive and appropriate communication.

Throughout the past eighteen months we have made a number of public statements and regularly updated families on the actions taken. We are committed to continuously improving our approach to providing information, responding to questions or concerns and providing any support that may be required.

58. Why is the Board so defensive?

We are sincerely sorry that any actions taken have been experienced as defensive. The IMT are continuing with their investigations; there are a number of areas where questions remain and where we do not yet have the full answers. It is important that when questions are asked that we do not know the answers to, that this is explained openly, supportively and sensitively.

The Chairman and Chief Executive have committed to meeting every family that wishes to do so to discuss any concerns, and they have written to all families to offer this.

59. Why are the staff prevented from telling the truth – why do they have their hands tied?

Please see our response to Question 57.

60. Why did the Board issue a press release stating that the water was safe to drink when the families were clearly told that it wasn't safe to drink? Why did the Board lie?

Although the water is safe to drink, water from basins in patient rooms should not be used, as they are for handwashing only; this is advice from infection prevention and control colleagues. If this has caused any confusion, then we sincerely apologise.

As previously described, the water is safe to drink, and this has been confirmed by the Authorising Engineer, a specialist engineer who acts, and is employed, independently of NHS Greater Glasgow and Clyde.

We understand, however, that there may have been confusion because of the signs at the sinks within the single bed rooms, which advise patients that they are for hand washing use only. Patients and their families are discouraged from drinking water in the rooms as sinks are dedicated to hand washing.

As there was no parent kitchen currently in Ward 6A, we provided patients with bottled water. This was not connected to the quality of the water supply, but due to the fact that there was no facility for the parents access tap water.

61. All the staff, including the clinical staff need to be praised for their hard work and providing fantastic care – they should not be singled out for criticism.

We greatly value our fantastic staff and completely recognise that recent events have been difficult and stressful for them.

The health and wellbeing of our staff is hugely important, and we have therefore put in place additional support for any member of staff who wishes to access it.

The senior management team of the children's hospital regularly praise the work of the clinical and support team and ensure that they get the recognition they deserve.

62. Why is the Board not speaking to the families and complying with the Duty of Candour Legislation?

Organisational Duty of Candour legislation has very clear and defined criteria of what needs to be considered in relation to an incident that may require activation of the procedures outlined in this legislation. Regardless of whether an issue or incident meets the criteria outlined by this legislation, all regulated healthcare professionals have a professional duty of candour and NHSGGC is committed to ensuring that our actions are always informed by the principles of openness and honesty; we understand that this is key to creating trust in situations such as those that have rightly concerned families.

We are therefore very sorry for the perception that we have not been candid, as this was absolutely not our intention and we will learn from this. We have asked Professor White from the Scottish Government to review all individual care incidents to provide us with advice on the approach that has been taken to decision-making in respect of the application of the organisational Duty of Candour legislation, reflecting our commitment to ensure that we are continuously improving the way we respond to incidents where we need to consider whether the organisational Duty of Candour applies.

63. Reassurance was sought that the patients won't be stuck in a ward which doesn't provide oncology care and therefore the relevant protocols.

We can assure you that we will always care for patients in an appropriate setting. Patients will always be looked after by staff who are specifically trained for work with children who have cancer. They may have to be cared for in another ward for a number of reasons, but in that ward they will still receive specialist care by staff who are appropriately trained.

64. A public apology is also needed from NHS GGC to clinicians and staff who have being doing their jobs very well. This would start to build trust. There needs to be real engagement with the staff as they feel vulnerable.

We are very grateful to our excellent staff and we are sorry that our views of how well staff have been doing their jobs has been doubted. We completely agree that this is essential to supporting our staff and minimising any feelings of vulnerability they might experience. We recognise this is a difficult time for staff as well as parents.

Our Chairman and Chief Executive met staff on the ward on October 2019, 8 October 2019, and 23 October 2019. Our Medical Director and Deputy Medical Director also spoke with staff on Ward 6A, as well as Ward 4B. We are working with clinical and nursing staff to address the issues raised in these meetings, and in a meeting with the Deputy Chief Medical Officer for the Scottish Government.

As described in response to Question 62, the health and wellbeing of our staff is important and we have therefore put in place additional support for any member of staff who needs it. The senior management team of the children's hospital regularly praise the work of the clinical team, particularly the nursing staff, and ensure that they get the recognition they deserve.

65. Why did the children get moved into an unsuitable adult ward?

Please see our responses to questions 11, 15 and 65.

Children have not been moved to any area that we would regard as unsuitable. We have always endeavoured to take all necessary measures to ensure continuity of care, in the best and safest way possible.

Issues raised that will potentially fall within the remit of the Public Inquiry or are within the remit of the Independent Review

66. Is there a risk because the QEUH campus (including the RHC) was built next to the main sewage plant?

No. Please see our response to Question 34.

67. Why were patients admitted to wards 2A and 2B after meeting minutes established that the ventilation was not fit for purpose prior to the ward opening?

Please see our response to Question 1.

68. Why are all the problems happening in a new hospital?

The design, commissioning, build and maintenance of the RHC and QEUH are the subject of a number of internal and external reviews to examine these issues. These reviews will provide answers to questions such as this one.

69. Can the Terms of Reference of the Public Inquiry have child/patient experience at the heart of it?

Whilst the Terms of Reference of the Public Inquiry is not for NHSGGC to determine, we would agree that this issue should be a key feature. Professor White from the Scottish Government will liaise with officials supporting the establishment of the Public Inquiry to make them aware of this suggestion.

70. Confirmation that a decision will be taken by the chair of the inquiry (following appointment) as to persons who will be required to attend or otherwise provide evidence to the inquiry, for example the First Minister (who was Cabinet Secretary for Health and Sport at the time of the QEUH's construction) and former Chief Executives/ senior staff.

These are matters that will be determined by the Public Inquiry in accordance with the arrangements in place for establishing processes and procedures that will support this work.

From: White C (Craig)
Sent: 15 November 2019 18:52
To: Cabinet Secretary for Health and Sport
Cc: McQueen F (Fiona); Lloyd E (Elizabeth); Allan L (Lara)
Subject: FW: NHS Greater Glasgow and Clyde

PS/Cabinet Secretary for Health and Sport

The below has issued to affected families that met with Ms Freeman and any other affected families who were not at these meetings but attended the meetings with the Chair and Chief Executive of NHS Greater Glasgow and Clyde (which I was in attendance at) or have been in touch with me directly since the Cabinet Secretary appointed me to the role in respect of NHSGGC.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: White C (Craig)
Sent: 15 November 2019 18:49
To: White C (Craig) [redacted]
Subject: NHS Greater Glasgow and Clyde

To all families who met with the Cabinet Secretary for Health and Sport, the Chair and Chief Executive of NHS Greater Glasgow and Clyde or who have made contact with me personally

As you know, the Cabinet Secretary for Health and Sport has appointed me to lead and direct the work to ensure that the voices of families affected by the infection outbreaks at NHS Greater Glasgow and Clyde are heard and that the information asked for is provided. You may be aware of the coverage in the media of the concerns of a parent whose child died in 2017. NHS Greater Glasgow and Clyde have recognised that they need to improve their approach to communication and engagement with affected families. The Scottish Government recognise the distressing impact of the news coverage that a parent has such important and significant unanswered questions and have been assured that all necessary steps are now being taken to ensure that communication channels are in place.

I'm contacting you to remind you that I am available to support you in any way you would find helpful.

Best wishes

Craig White

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
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[redacted]

From: White C (Craig)
Sent: 19 November 2019 18:15
To: Cabinet Secretary for Health and Sport
Cc: McQueen F (Fiona); Ives J (Josephine); Birch J (Jason); Allan L (Lara); Hutchison D (David)
Subject: FW: Update on Discussions with NHS Greater Glasgow and Clyde
Attachments: QEUH WATER TESTING_Redacted 1.pdf; Dr. Crichton - Explanation re Water Sample Report - 191119.pdf

PS/Cabinet Secretary for Health and Sport

Further to my update to parents on Saturday and yesterday, I have issued this by way of my commitment yesterday to sit down with NHS Greater Glasgow and Clyde and review water sampling data with a view to providing data to parents. This is attached, along with some narrative I asked for from the Deputy Director of Public Health who chaired the Ward 6A Incident Management Team recently. I have also issued this.

As you will note, there were other data on sampling of air and the environment that were not easily interpretable and I have therefore asked NHS Greater Glasgow and Clyde to prepare a written narrative that would be suitable to share with parents to aid their interpretation of this.

You will note that some parents have been asking for sight of the HPS data report. Jane Grant has been, quite rightly in my view, pressing Colin Sinclair of NSS to review their previously stated position that the report was a confidential management report that was not to be shared, requiring that he instruct the relevant assessments, controls and assessment of the substantial public interest requirements of the DPA to be more explicitly considered. Given several requests I have received from parents, I thought it appropriate to provide them with this update on the current position as it relates to the HPS report.

Best wishes

Craig

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T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: White C (Craig)
Sent: 19 November 2019 18:01
To: White C (Craig) [redacted]
Subject: Update on Discussions with NHS Greater Glasgow and Clyde

Update on Discussions with NHS Greater Glasgow and Clyde

I met earlier this afternoon with the Director of Estates and Facilities. He has provided examples of the most recent water sampling results from Ward 6A at the QEUH. I have attached these.

As outlined in my email to you of 16 November 2019, this forms part of the sampling, monitoring and scrutiny arrangements in place for providing assurance of water safety.

There are other environmental monitoring and sampling data available, though these will clearly require staff with specialist knowledge to explain and summarise the data to support our understanding. I arranged to speak with the Board's Deputy Director of Public Health this afternoon and she has agreed to ask one of her Consultant team to provide us with a summary of what these other monitoring data mean, taking account of your particular interests. I have asked to receive this by 1pm tomorrow.

The attached most recent water sampling data confirms the absence of any water borne contaminants. I have also attached an email from the Deputy Director of Public Health explaining what these reports show.

I have sought an update today in respect of the status of the report by Health Protection Scotland. I have been advised that, in accordance with the disclosure protocol followed by Health Protection Scotland, the content of the document is being reviewed against the various legal and regulatory requirements to make sure that it does not breach of any confidentiality or privacy requirements they are required to have considered. I have sought and received assurances that the Chief Executive of NHS Greater Glasgow and Clyde has made it clear to the Chief Executive with responsibility for Health Protection Scotland that this work must be completed as a matter of urgency, reflecting her commitment to provide this information to parents. I will update you with any detail that I receive on this when this is available.

Please do not hesitate to get in touch with me if you have any further questions arising from these data or my update.

Best wishes

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

gov.scot

QEUH WATER TESTING

TEST REQUIRE :

TVC/COLI/EC/PS/~~SAB~~/
GNB

Target : _____

Postn

[redacted]

[redacted]

WOT

SGOW ROYAL INFIRMARY DEPARTMENT OF MICROBIOLOGY
REQUEST FOR ANALYSIS

QUEEN ELIZABETH UNIVERSITY HOSPITAL

		Building:	ADULTS 6A	Received by:	
Email:	[redacted]	**Sampled by:**	[redacted]	Date Received:	
Web:	[redacted]	**Date:**	22.10.19.	Date Commenced:	

alysis Label 3 - QEUH WATER TESTING TEST REQUIRED: **TVC/COLI/EC/PS/GNB**

Laboratory Number	DMA Sample Number	TVC @ 37°C	TVC @ 22°C	Coliforms	Faecal E.Coli	Pseudomonas	GNB	Other
		cfu/ml	cfu/ml	cfu/100ml	cfu/100ml	cfu/ml	cfu/ml	(As directed by ICT)
[redacted]	KID 4629							
[redacted]	KID 4630							
[redacted]	KID 4631							
[redacted]	KID 4632							
[redacted]	KID 4633							
[redacted]	KID 4634							

ned by: _____ Checked by: _____ Date: _____ Comment: _____

epartment of Microbiology, New Lister Building, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

QEUH WATER TESTING
TEST REQUIRE :

TVC/COLI/EC/PS/SAB/
GNB

Target : _____

[redacted]

[redacted]

WOT.

SGOW ROYAL INFIRMARY DEPARTMENT OF MICROBIOLOGY
REQUEST FOR ANALYSIS

QUEEN ELIZABETH UNIVERSITY HOSPITAL

		Building:	ADULTS 6A	Received by:	
Email:	[redacted]	Sampled by:	[redacted]	Date Received:	
Web:		Date:	22.10.19.	Date Commenced:	22 OCT 19 15:06

alysis Label 3 - QEUH WATER TESTING TEST REQUIRED: **TVC/COLI/EC/PS/GNB**

22 OCT 19 15:06

Laboratory Number	DMA Sample Number	TVC @ 37°C	TVC @ 22°C	Coliforms	Faecal E.Coli	Pseudomonas	GNB	Other
		cfu/ml	cfu/ml	cfu/100ml	cfu/100ml	cfu/ml	cfu/ml	(As directed by ICT)
[redacted]	KID 4635	0	0	0	0	0	0	
[redacted]	KID 4636	0	0	0	0	0	0	
[redacted]	KID 4637	0	0	0	0	0	0	
[redacted]	KID 4638	0	1	0	0	0	0	
[redacted]	KID 4639	0	0	0	0	0	0	
[redacted]	KID 4640	0	0	0	0	0		

ned by: _____ Checked by: _____ Date: _____ Comment: _____

partment of Microbiology, New Lister Building, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

QEUH WATER TESTING
TEST REQUIRE :

TVC/COLI/EC/PS/SAB/
GNB

Target : _____

[redacted]

for

W017.

SGOW ROYAL INFIRMARY DEPARTMENT OF MICROBIOLOGY
REQUEST FOR ANALYSIS

QUEEN ELIZABETH UNIVERSITY HOSPITAL

Email:	[redacted]	Building:	ADULTS 64	Received by:	
Web:	[redacted]	Sampled by:	[redacted]	Date Received:	22 OCT '15 15:03
		Date:	22.10.15	Date Commenced:	[illegible]

alysis Label 3 - QEUH WATER TESTING TEST REQUIRED: **TVC/COLI/EC/PS/GNB**

Laboratory Number	DMA Sample Number	TVC @ 37°C cfu/ml	TVC @ 22°C cfu/ml	Coliforms cfu/100ml	Faecal E.Coli cfu/100ml	Pseudomonas cfu/ml	GNB cfu/ml	Other (As directed by ICT)
[redacted]	KID 4641	0	0	0	0	0	0	
[redacted]	KID 4642	0	0	0	0	0	0	
[redacted]	KID 4643	0	0	0	0	0	0	
[redacted]	KID 4644	0	0	0	0	0	0	
[redacted]	KID 4645	0	0	0	0	0	0	
[redacted]	KID 4646	0	0	0	0	0	0	

ned by: _____ Checked by: _____ Date: _____ Comment: _____

partment of Microbiology, New Lister Building, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

QEUH WATER TESTING
TEST REQUIRE :

TVC/COLI/EC/PS/SAB/ GNB

Target : _____

GOW ROYAL INFIRMARY DEPARTMENT OF MICROBIOLOGY
REQUEST FOR ANALYSIS

QUEEN ELIZABETH UNIVERSITY HOSPITAL

[redacted]

WOT.

Email:	[redacted]	Building:	ADULTS 6A	Received by:	
Web:		Sampled by:	[redacted]	Date Received:	
		Date:	22.10.19.	Date Commenced:	

alysis Label 3 - QEUH WATER TESTING — TEST REQUIRED: **TVC/COLI/EC/PS/GNB**

Laboratory Number	DMA Sample Number	TVC @ 37°C	TVC @ 22°C	Coliforms	Faecal E.Coli	Pseudomonas	GNB	Other
		cfu/ml	cfu/ml	cfu/100ml	cfu/100ml	cfu/ml	cfu/ml	(As directed by ICT)
[redacted]	KID 4647	0	0	0	0	0	0	
[redacted]	KID 4648	0	0	0	0	0	0	
	KID							
	KID							
	KID							
	KID							

ned by: _____ Checked by: _____ Date: _____ Comment: _____

epartment of Microbiology, New Lister Building, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

QEUH WATER TESTING
TEST REQUIRE :

TVC/COLI/EC/PS/~~SAB~~/
GNB

Target : _____

[redacted]

POTW - 2017

[redacted]

GOW ROYAL INFIRMARY DEPARTMENT OF MICROBIO
REQUEST FOR ANALYSIS

QUEEN ELIZABETH UNIVERSITY HOSPITAL

		Building:	ADULTS 6A	Received by:	
Email:	[redacted]	Sampled by:	[redacted]	Date Received:	
Web:		Date:	21.10.19.	Date Commenced:	21/10/19

alysis Label 3 - QEUH WATER TESTING — TEST REQUIRED: **TVC/COLI/EC/PS/GNB**

Laboratory Number	DMA Sample Number	TVC @ 37°C	TVC @ 22°C	Coliforms	Faecal E.Coli	Pseudomonas	GNB	Other
		cfu/ml	cfu/ml	cfu/100ml	cfu/100ml	cfu/ml	cfu/ml	(As directed by ICT)
[redacted]	KID 4609	0	0	0	0	0	0	
[redacted]	KID 4610	1	0	0	0	0	0	
[redacted]	KID 4611	0	0	0	0	0	0	
[redacted]	KID 4612	0	0	0	0	0	0	
[redacted]	KID 4613	1	0	0	0	0	0	
[redacted]	KID 4614	1	0	0	0	0	0	

ned by: [redacted] Checked by: _____ Date: 24/10/19. Comment: _____

partment of Microbiology, New Lister Building, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

QEUH WATER TESTING
TEST REQUIRE :

TVC/COLI/EC/PS/SAB/
GNB

[redacted]

POTW Lab WOI7

[redacted]

GOW ROYAL INFIRMARY DEPARTMENT OF MICROBIOL
REQUEST FOR ANALYSIS

Target : _____

QUEEN ELIZABETH UNIVERSITY HOSPITAL

[redacted]	Building:	ADULTS 6A	Received by:	
Email: [redacted]	Sampled by:	[redacted]	Date Received:	
Web:	Date:	21.10.19	Date Commenced:	21/10/19

Analysis Label 3 - QEUH WATER TESTING — TEST REQUIRED: TVC/COLI/EC/PS/GNB

Laboratory Number	DMA Sample Number	TVC @ 37°C	TVC @ 22°C	Coliforms	Faecal E.Coli	Pseudomonas	GNB	Other
		cfu/ml	cfu/ml	cfu/100ml	cfu/100ml	cfu/ml	cfu/ml	(As directed by ICT)
[redacted]	KID 4615	0	0	0	0	0	0	
[redacted]	KID 4616	0	1	0	0	0	0	
[redacted]	KID 4617	0	1	0	0	0	0	
[redacted]	KID 4618	0	0	0	0	0	0	
[redacted]	KID 4619	0	1	0	0	0	0	
[redacted]	KID 4620	0	0	0	0	0	0	

ed by: [redacted] Checked by: _____ Date: 24/10/19 Comment: _____

partment of Microbiology, New Lister Building, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

QEUH WATER TESTING
TEST REQUIRE :

TVC/COLI/EC/PS/~~SAB~~/
GNB

Target : _____

[redacted] POTW

[redacted] WOT

GOW ROYAL INFIRMARY DEPARTMENT OF MICROBIO
REQUEST FOR ANALYSIS

QUEEN ELIZABETH UNIVERSITY HOSPITAL

rer: [redacted]		Building:	ADULTS 6A	Received by:	
Email:		Sampled by:	[redacted]	Date Received:	21 OCT 19 12:40
Web:		Date:	21-10-19.	Date Commenced:	21/10/19.

alysis Label 3 - QEUH WATER TESTING — TEST REQUIRED: **TVC/COLI/EC/PS/GNB**

Laboratory Number	DMA Sample Number	TVC @ 37°C	TVC @ 22°C	Coliforms	Faecal E.Coli	Pseudomonas	GNB	Other
		cfu/ml	cfu/ml	cfu/100ml	cfu/100ml	cfu/ml	cfu/ml	(As directed by ICT)
[redacted]	KID 4621	0	0	0	0	0	0	
[redacted]	KID 4622	0	0	0	0	0	0	
[redacted]	KID 4623	0	0	0	0	0	0	
[redacted]	KID 4624	0	1	0	0	0	0	
[redacted]	KID 4625	0	1	0	0	0	0	
[redacted]	KID 4626	0	0	0	0	0	0	

ned by: [redacted] Checked by: _____ Date: 24/10/19 Comment:
epartment of [redacted] ilding, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

A50491351

QEUH WATER TESTING
TEST REQUIRE :

TVC/COLI/EC/PS/[redacted]
GNB

Target : _____

[redacted]

Post [redacted]

WOI4

[redacted]

GOW ROYAL INFIRMARY DEPARTMENT OF MICROBIOL
REQUEST FOR ANALYSIS

QUEEN ELIZABETH UNIVERSITY HOSPITAL

Tel:	[redacted]	Building:	[redacted] AQ25	Received by:	
Email:		Sampled by:		Date Received:	21 OCT 19 13:40
Web:		Date:		Date Commenced:	21/10/19

Analysis Label 3 - QEUH WATER TESTING — TEST REQUIRED: TVC/COLI/EC/PS/GNB

Laboratory Number	DMA Sample Number	TVC @ 37°C cfu/ml	TVC @ 22°C cfu/ml	Coliforms cfu/100ml	Faecal E.Coli cfu/100ml	Pseudomonas cfu/ml	GNB cfu/ml	Other (As directed by ICT)
[redacted]	KID 4627	1	0	0	0	0	0	
[redacted]	KID 4628	0	0	0	0	0	0	
	KID							
	KID							
	KID							
	KID							

ned by: [redacted] Checked by: _____ Date: 24/10/19 Comment:
epartment of Microbiology, New Lister Building, Glasgow Royal Infirmary, 10-16 Alexandria Parade, Glasgow, G31 2ER. Tel: [redacted] Fax: [redacted]

A50491351

White C (Craig)

From: Crighton, Emilia [redacted]
Sent: 19 November 2019 17:24
To: White C (Craig)
Cc: Steele, Tom
Subject: Water testing results explanation

Dear Craig,

Water samples are processed in the laboratory to identify the overall number of bacteria present in the water that is able to grow (known as TVC – total viable count). Testing at two different temperatures shows the level of environmental bacteria (at 22^0 C) and bacteria that can grow at body temperature (at 37^0 C).

Coliforms and *E. coli* are faecal indicator bacteria and the presence of these means that faecal contamination has occurred and the water is unfit to drink. Pseudomonas and GNB (gram negative bacteria) are types of bacteria NHS Greater Glasgow and Clyde are looking for when testing the water.

Water tests are required to be free from coliforms and E. coli bacteria and TVC levels <1000 cfu per ml are satisfactory (standard SHTM 04-01).

The results of the water testing are shown to be within acceptable limits.

With kind regards,

Emilia

Dr Emilia M Crighton
Deputy Director of Public Health
NHS Greater Glasgow and Clyde
1055 Great Western Road
Glasgow G12 0XH

Tel [redacted]
Email: [redacted]

From: White C (Craig)
Sent: 19 November 2019 18:04
To: 'Bustillo, Sandra'; 'jane.grant[redacted]'; 'Brown, John'; 'Vanhegan, Elaine'; 'Steele, Tom'; Crighton, Emilia
Cc: 'Law, Leanne'
Subject: FW: Update on Discussions with NHS Greater Glasgow and Clyde
Attachments: QEUH WATER TESTING_Redacted 1.pdf; Dr. Crichton - Explanation re Water Sample Report - 191119.pdf

For information, the attached has issued to the group of families who attended the meeting with the Cabinet Secretary for Health and Sport, families who attended the 02 November 2019 meeting and another parent who asked to be added today to the distribution list for this.

Best wishes

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: White C (Craig)
Sent: 19 November 2019 18:01
To: White C (Craig) [redacted]
Subject: Update on Discussions with NHS Greater Glasgow and Clyde

Update on Discussions with NHS Greater Glasgow and Clyde

I met earlier this afternoon with the Director of Estates and Facilities. He has provided examples of the most recent water sampling results from Ward 6A at the QEUH. I have attached these.

As outlined in my email to you of 16 November 2019, this forms part of the sampling, monitoring and scrutiny arrangements in place for providing assurance of water safety.

There are other environmental monitoring and sampling data available, though these will clearly require staff with specialist knowledge to explain and summarise the data to support our understanding. I arranged to speak with the Board's Deputy Director of Public Health this afternoon and she has agreed to ask one of her Consultant team to provide us with a summary of what these other monitoring data mean, taking account of your particular interests. I have asked to receive this by 1pm tomorrow.

The attached most recent water sampling data confirms the absence of any water borne contaminants. I have also attached an email from the Deputy Director of Public Health explaining what these reports show.

I have sought an update today in respect of the status of the report by Health Protection Scotland. I have been advised that, in accordance with the disclosure protocol followed by Health Protection Scotland, the content of the document is being reviewed against the various legal and regulatory requirements to make sure that it does not breach of any confidentiality or privacy requirements they are required to have considered. I have sought and received assurances that the Chief Executive of NHS Greater Glasgow and Clyde has made it clear to the Chief Executive with responsibility for Health Protection Scotland that this work must be completed as a matter of urgency, reflecting her commitment to provide this information to parents. I will update you with any detail that I receive on this when this is available.

Please do not hesitate to get in touch with me if you have any further questions arising from these data or my update.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]



From: White C (Craig)
Sent: 25 November 2019 12:34
To: Allan L (Lara)
Subject: Multiple Documents - "draft letter options" (A26403223), "FW: Letter from Prof Craig White" (A26403214), "FW: S20190027715.pdf - QEUH - fast track as requested by Cab Sec." (A26403219), "FW: Update on Discussions with NHS Greater Glasgow and Clyde" (A2...
Attachments: draft letter options; FW: Letter from Prof Craig White ; FW: S20190027715.pdf - QEUH - fast track as requested by Cab Sec.; FW: Update on Discussions with NHS Greater Glasgow and Clyde; FW: Update on Discussions with NHS Greater Glasgow and Clyde; FW: Update on Discussions with NHS Greater Glasgow and Clyde; FW: Update on Discussions with NHS Greater Glasgow and Clyde; FW: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport ; FW: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport ; Key Docs for Parents' Meeting; Letter from Prof Craig White ; NHSGGC - Letter Issued by Chair and CEO - 111019; RE: Update on Discussions with NHS Greater Glasgow and Clyde; RE: Update on Discussions with NHS Greater Glasgow and Clyde; RE: Update on Discussions with NHS Greater Glasgow and Clyde; RE: Update on Discussions with NHS Greater Glasgow and Clyde; RE: draft letter options; Response to questions raised with the Cabinet Secretary for Health and Sport ; Response to questions raised with the Cabinet Secretary for Health and Sport ; Response to questions raised with the Cabinet Secretary for Health and Sport ; Response to questions raised with the Cabinet Secretary for Health and Sport ; SBAR NHSGG&C meeting with families 2 November ; Update on Discussions with NHS Greater Glasgow and Clyde; Update on Discussions with NHS Greater Glasgow and Clyde; Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport ; Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport

White, Craig C (Z601250) has sent you copies of the following 26 documents from Objective:
"draft letter options" (A26403223) v1.0
"FW: Letter from Prof Craig White" (A26403214) v1.0
"FW: S20190027715.pdf - QEUH - fast track as requested by Cab Sec." (A26403219) v1.0
"FW: Update on Discussions with NHS Greater Glasgow and Clyde" (A26403136) v1.0
"FW: Update on Discussions with NHS Greater Glasgow and Clyde" (A26403137) v1.0
"FW: Update on Discussions with NHS Greater Glasgow and Clyde" (A26403138) v1.0
"FW: Update on Discussions with NHS Greater Glasgow and Clyde" (A26403140) v1.0
"FW: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport" (A26190856) v1.0
"FW: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport" (A26190863) v1.0 "Key Docs for Parents' Meeting" (A26202853) v1.0 "Letter from Prof Craig White" (A26403212) v1.0 "NHSGGC - Letter Issued by Chair and CEO - 111019" (A26190853) v1.0 "RE Update on Discussions with NHS Greater Glasgow and Clyde" (A26403206) v1.0 "RE Update on Discussions with NHS Greater Glasgow and Clyde" (A26403208) v1.0 "RE Update on Discussions with NHS Greater Glasgow and Clyde" (A26403209) v1.0 "RE Update on Discussions with NHS Greater Glasgow and Clyde" (A26403211) v1.0
"RE: draft letter options" (A26403222) v1.0 "Response to questions raised with the Cabinet Secretary for Health and Sport" (A26190857) v1.0 "Response to questions raised with the Cabinet Secretary for Health and Sport" (A26190864) v1.0 "Response to questions raised with the Cabinet Secretary for Health and Sport" (A26355503) v1.0 "Response to questions raised with the Cabinet Secretary for Health and Sport" (A26403524) v1.0 "SBAR NHSGG&C meeting with families 2 November" (A26275013) v1.0 "Update on Discussions with NHS Greater Glasgow and Clyde"

(A26403139) v1.0 "Update on Discussions with NHS Greater Glasgow and Clyde" (A26403521) v1.0 "Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport" (A26355502) v1.0 "Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport" (A26403523) v1.0

From: Bustillo, Sandra [redacted]
Sent: 21 November 2019 10:08
To: White C (Craig); Best, Jonathan; Vanhegan, Elaine; Davidson, Scott; Devine, Sandra; Hill, Kevin; Redfern, Jamie
Subject: draft letter options
Attachments: Draft Letter Version 2.doc; Draft Letter Version 1.doc

Importance: High

Dear All

There are two options for a draft letter for the various parent cohorts (as set out in the draft letter). The key difference in the two is the level of detail we provide on the HPs report about which, as you are aware, there are ongoing discussions concerning publication.

The key issue to consider is whether we believe the higher level detail in parent letter 2 offers sufficient assurance about the findings from HPS for these groups of parents or whether the additional information might be necessary to respond to current levels of anxiety/questioning.

Can I have views please?

Sandra

From: White C (Craig)
Sent: 30 October 2019 09:53
To: Allan L (Lara)
Cc: Burgess E (Elizabeth); Ives J (Josephine)
Subject: FW: S20190027715.pdf - QEUH - fast track as requested by Cab Sec.
Attachments: HCAI - Ministerial Correspondence - Cabinet Secretary draft response to [redacted] September 2019 CW.docx

Lara

Can you please find out if this letter has issues as I agreed with NHSGG&C that when it did I would let them know so that they could make contact. If it has issued then perhaps you could let Jennifer.Haynes[redacted] know ? As you will have noticed she is the Board's point of contact for the QEUH/RHC families.

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: White C (Craig)
Sent: 15 October 2019 11:46
To: Burgess E (Elizabeth) [redacted]; McQueen F (Fiona) [redacted]
Cc: Birch J (Jason) [redacted]; Shepherd L (Lesley) [redacted]; Dunk R (Rachael) [redacted]; Murray D (Diane) [redacted]
Subject: RE: S20190027715.pdf - QEUH - fast track as requested by Cab Sec.

Elizabeth

See attached, which I have amended to refer to my remit (with the suggestion that you include that as an attachment) and that I have agreed with NHS GGC a point of contact, who will get in touch with [redacted] when you confirm with me that the letter has issued.

Hope this is helpful,

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

-----Original Message-----
From: Burgess E (Elizabeth) [redacted]
Sent: 09 October 2019 13:56
To: McQueen F (Fiona) [redacted]; White C (Craig) [redacted]
Cc: Birch J (Jason) [redacted]; Shepherd L (Lesley) [redacted];
Dunk R (Rachael) [redacted]; Murray D (Diane) [redacted]
Subject: FW: S20190027715.pdf - QEUH - fast track as requested by Cab Sec.

Hi Fiona and Craig

Please see attached draft response from the Cabinet Secretary to [redacted], whose [redacted] died after receiving treatment for [redacted] at the QEUH in 2017. [redacted] email is also attached.

We received this case on 23 September as a fast-tracked MR and provided the attached reply on 24 September. Private Office have today sent the response back for redrafting with this comment: "Ms Freeman would like Craig White/CNO's input. The Cabinet Secretary feels that the correspondent deserves more answers. Grateful if a holding response could be drafted in the meantime. Thanks"

On 23 September, we discussed with Andy Corr the draft reply and the sensitivities of what it can cover, since in cases such as this we cannot comment on cause of death.

Grateful for your comments on what should be added to this draft response. We will draft the holding reply.

Many thanks

Elizabeth

Elizabeth Burgess | Chief Nursing Officer's Directorate | Scottish Government | 2 ER St Andrew's House | Regent Road | Edinburgh | EH1 3DG | [redacted] Email [redacted]

-----Original Message-----
From: Burgess E (Elizabeth)
Sent: 24 September 2019 15:00
To: Hope S (Steven) [redacted]; Ives J (Josephine) [redacted]
Subject: RE: S20190027715.pdf - QEUH - fast track as requested by Cab Sec.

HI Steven

Here is the draft response to this MACCS case, to go back onto the MACCS system please as soon as possible. It has been cleared by Jason, Jo, Rachael and Diane.

Many thanks

Elizabeth

Elizabeth Burgess | Chief Nursing Officer's Directorate | Scottish Government | 2 ER St Andrew's House | Regent Road | Edinburgh | EH1 3DG | [redacted] Email [redacted]

-----Original Message-----
From: Hope S (Steven) [redacted]
Sent: 23 September 2019 10:00
To: Ives J (Josephine) [redacted]
Subject: S20190027715.pdf - QEUH - fast track as requested by Cab Sec.

Hi Jo

Looks like this MR is for us - are you happy for me to accept it? - the deadline is 30 September.

S.

From: White C (Craig)
Sent: 29 October 2019 16:03
To: Haynes, Jennifer
Subject: FW: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport
Attachments: Response to questions raised with the Cabinet Secretary for Health and Sport

You may already have been forwarded this, but if not here is copy

C

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: Allan L (Lara) [redacted]
Sent: 29 October 2019 15:57
To: Jane.Grant [redacted]; Leanne.Law [redacted]; JJBrown [redacted]
Subject: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport

Colleagues

Professor White has asked me to send you copies of his communications with the patients and families who met with the Cabinet Secretary for Health and Sport, which sent today. As discussed with Jane Grant, there was one proposed response he was not content to sign off today and I understand that he has explained the background to this decision. Copies of these communications have also been provided to the Cabinet Secretary for Health and Sport, who has also been advised of the intention to use the work that has been undertaken to develop separate generic FAQ documents to support further engagement, communication and support with patients, families and staff.

Best wishes on behalf of Professor White

Lara Allan

Lara Allan
Executive Support to Professor White
The Scottish Government I 2ER I St Andrew's House I Regent Road I Edinburgh EH1 3DG
Tel: [redacted]

From: White C (Craig)
Sent: 29 October 2019 15:58
To: Nicol L (Lynne); Pollock LA (Linda)
Subject: FW: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport
Attachments: Response to questions raised with the Cabinet Secretary for Health and Sport

For interest – will be around SAH briefly tomorrow from mid-morning, will see if can catch you to say hello. Hope all is well – it's taken 25 calendar days, though now have responses to 70 of the 71 issues raised with CabSec !

Craig

From: Allan L (Lara) [redacted]
Sent: 29 October 2019 15:50
To: Cabinet Secretary for Health and Sport [redacted]
Cc: Minister for Public Health, Sport and Wellbeing [redacted]; Minister for Mental Health [redacted]; DG Health & Social Care [redacted]; FM Policy Team Mailbox [redacted]; McQueen F (Fiona) [redacted]; Murray D (Diane) [redacted]; Birch J (Jason) [redacted]; Klein G (Gerard) [redacted]; Hart S (Suzanne) [redacted]; Communications Healthier [redacted]; Dunk R (Rachael) [redacted]; Ives J (Josephine) [redacted]; Aitken L (Louise) [redacted]; Hutchison D (David) [redacted]
Subject: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport

PS/Cabinet Secretary for Health and Sport

Professor White has been working closely with senior staff in NHSGGC to seek answers to questions and issues raised by the families that met with Ms. Freeman. The attached email issued to the families today contains NHSGGC's response to the questions which has been approved by Professor White. There is one question asked about infection rates that Professor White is not content with the response to, therefore this has been removed. Professor White did not approve the response as it is at odds with the draft report submitted by Health Protection Scotland on 25 October 2019. He has informed the families that a further response to the question will be issued when he has had further discussions with NHSGGC.

In view of the commitment to provide answers within weeks of his appointment, he agreed with NHSGGC about structuring the responses around the note prepared in summary by officials present at the meetings, recognising that there is some overlap in the themes but respecting the fact that this document had already been circulated to patients and families by way of summary.

He has agreed with NHSGGC that they will use this to generate a themed FAQs document that can be made available more widely to other patients and families and also to staff within the service.

Lara Allan on behalf of Professor White
Lara Allan
Executive Support to Professor White

The Scottish Government I 2ER I St Andrew's House I Regent Road I Edinburgh EH1 3DG
Tel: [redacted]

From: Haynes, Jennifer [redacted]
Sent: 01 November 2019 16:28
To: White C (Craig)
Subject: Key Docs for Parents' Meeting
Attachments: Presentation for Parents Meeting (v5).pptx; RHC Parents Meeting - Agenda.docx; Parent and families - attendees.docx; Issue Log - Meetings with QEUH (FINAL).pdf; FAQ QEUH Ward 6A.DOC; SBAR prophylaxis.docx

Importance: High

Hi Craig

Please see attached the documents for tomorrow, which are:

- Final version of presentation (pending Jane's approval)
- Final version of agenda (pending Jane's approval)
- List of families attending
- Copy of Q+A document that was sent to parents
- An FAQ doc that was previously completed for Ward 6A
- A briefing on prophylaxis

Jane has asked if you can join the pre meeting (in room L0-005) at 10:30?

Thanks

Jen

Jennifer Haynes
Board Complaints Manager
Phone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: White C (Craig)
Sent: 14 October 2019 12:30
To: Cabinet Secretary for Health and Sport
Cc: Birch J (Jason); Ives J (Josephine); Burgess E (Elizabeth); Shepherd L (Lesley); McQueen F (Fiona); Murray D (Diane); Allan L (Lara); Dunk R (Rachael); Hutchison D (David); DG Health & Social Care; Leitch J (Jason); Connaghan J (John) (Health); Sheriff C (Carmel); House D (Dan); Chief Medical Officer; Smith G (Gregor); Hart S (Suzanne); Rogers S (Shirley); McLaughlin C (Christine); Mitchell E (Elinor); Foggo R (Richard)
Subject: NHSGGC - Letter Issued by Chair and CEO - 111019
Attachments: NHSGGC - Letter to Families as Issued - 111019.pdf; Prof White - Remit.pdf; Prof White Letter - RHC Families - 091019.pdf

PS/Cabinet Secretary for Health and Sport

To see attached, the letter issued on Friday by Chair and CEO of NHS Greater Glasgow and Clyde. I approved the content of this before issue, following feedback I provided on the proposed content of earlier drafts.

Following agreement with Board Chief Executive this morning, I am now liaising with a dedicated member of staff in NHS Greater Glasgow and Clyde who has an established process for noting and tracking contact, information provision and engagement with patients and families previously and currently in contact with the paediatric haematology/oncology service. This will support the elements my agreed remit as it relates to ensuring that the patient and family voices are heard, information provided and concerns reviewed and acted upon.

This communication is in addition to the letter I issued last week to families who met previously with the Cabinet Secretary, attached again with my remit for ease of reference for any colleagues on copy list who may have not seen.

Best wishes

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: White C (Craig)
Sent: 20 November 2019 08:40
To: John Cuddihy
Subject: RE: Update on Discussions with NHS Greater Glasgow and Clyde

John

Thanks for your email. NHS Greater Glasgow and Clyde received the final report on 13th November 2019. Initially Health Protection Scotland said that they did not believe it was appropriate to publish the report and the Chief Executive of NHS Greater Glasgow and Clyde challenged this (quite rightly in my view).

I will ask for the various other dates and get you a copy of the protocols that I understand HPS are using to conduct the relevant disclosure risk assessments. If I have not heard by lunchtime today of a decision, I intend to contact HPS too to support Jane Grant's position.

I will be in touch.

Best wishes

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: John Cuddihy [redacted]
Sent: 19 November 2019 22:35
To: White C (Craig) [redacted]
Subject: Re: Update on Discussions with NHS Greater Glasgow and Clyde

Thank you for the information which I will review and revert to you with any questions that may arise.

In respect of the HPS report can you please confirm

1. Has the report been completed? If so, can I have the date of completion.
2. Is the delay in sharing the report a result of the review of the document to satisfy disclosure protocol? if so, when did this review commence?
3. May I have a copy of the disclosure protocol being applied.
4. Is NHSGGC in receipt of the report either in draft or completed form? if so, when did they take receipt of the unredacted version, if indeed it is to be redacted in accordance with the protocol.

I look forward to receiving a response to those questions above. If you are unable to answer those questions directly, please let me know the details of the CEO at HPS in order that I may ask those questions directly.

Thank you

John

On 19 Nov 2019, at 18:01, <Craig.White[redacted]> <[redacted]> wrote:

Update on Discussions with NHS Greater Glasgow and Clyde

I met earlier this afternoon with the Director of Estates and Facilities. He has provided examples of the most recent water sampling results from Ward 6A at the QEUH. I have attached these.

As outlined in my email to you of 16 November 2019, this forms part of the sampling, monitoring and scrutiny arrangements in place for providing assurance of water safety.

There are other environmental monitoring and sampling data available, though these will clearly require staff with specialist knowledge to explain and summarise the data to support our understanding. I arranged to speak with the Board's Deputy Director of Public Health this afternoon and she has agreed to ask one of her Consultant team to provide us with a summary of what these other monitoring data mean, taking account of your particular interests. I have asked to receive this by 1pm tomorrow.

The attached most recent water sampling data confirms the absence of any water borne contaminants. I have also attached an email from the Deputy Director of Public Health explaining what these reports show.

I have sought an update today in respect of the status of the report by Health Protection Scotland. I have been advised that, in accordance with the disclosure protocol followed by Health Protection Scotland, the content of the document is being reviewed against the various legal and regulatory requirements to make sure that it does not breach of any confidentiality or privacy requirements they are required to have considered. I have sought and received assurances that the Chief Executive of NHS Greater Glasgow and Clyde has made it clear to the Chief Executive with responsibility for Health Protection Scotland that this work must be completed as a matter of urgency, reflecting her commitment to provide this information to parents. I will update you with any detail that I receive on this when this is available.

Please do not hesitate to get in touch with me if you have any further questions arising from these data or my update.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG | T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

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<QEUH WATER TESTING_Redacted 1.pdf><Dr. Crichton - Explanation re Water Sample Report - 191119.pdf>

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From: White C (Craig)
Sent: 20 November 2019 08:17
To: [redacted]
Subject: RE: Update on Discussions with NHS Greater Glasgow and Clyde

[redacted]

I will ask and will also make enquiries as to whether this is something that the independent review by Drs Montgomery/Fraser is considering.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: [redacted]
Sent: 19 November 2019 21:17
To: White C (Craig) [redacted]
Subject: Re: Update on Discussions with NHS Greater Glasgow and Clyde

Dear Professor White.

Another question. Have the building been tested for Radon before opening?

Kind regards
[redacted]

On 19 Nov 2019, at 18:01, Craig.White[redacted] wrote:

> Update on Discussions with NHS Greater Glasgow and Clyde
>
> I met earlier this afternoon with the Director of Estates and Facilities. He has provided examples of the most recent water sampling results from Ward 6A at the QEUH. I have attached these.
>
> As outlined in my email to you of 16 November 2019, this forms part of the sampling, monitoring and scrutiny arrangements in place for providing assurance of water safety.
>
> There are other environmental monitoring and sampling data available, though these will clearly require staff with specialist knowledge to explain and summarise the data to support

our understanding. I arranged to speak with the Board's Deputy Director of Public Health this afternoon and she has agreed to ask one of her Consultant team to provide us with a summary of what these other monitoring data mean, taking account of your particular interests. I have asked to receive this by 1pm tomorrow.

The attached most recent water sampling data confirms the absence of any water borne contaminants. I have also attached an email from the Deputy Director of Public Health explaining what these reports show.

I have sought an update today in respect of the status of the report by Health Protection Scotland. I have been advised that, in accordance with the disclosure protocol followed by Health Protection Scotland, the content of the document is being reviewed against the various legal and regulatory requirements to make sure that it does not breach of any confidentiality or privacy requirements they are required to have considered. I have sought and received assurances that the Chief Executive of NHS Greater Glasgow and Clyde has made it clear to the Chief Executive with responsibility for Health Protection Scotland that this work must be completed as a matter of urgency, reflecting her commitment to provide this information to parents. I will update you with any detail that I receive on this when this is available.

Please do not hesitate to get in touch with me if you have any further questions arising from these data or my update.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

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<QEUH WATER TESTING_Redacted 1.pdf>

<Dr. Crichton - Explanation re Water Sample Report - 191119.pdf>

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From: White C (Craig)
Sent: 20 November 2019 08:15
To: [redacted]
Subject: RE: Update on Discussions with NHS Greater Glasgow and Clyde

Dear [redacted]

Thank you for your email. I will review today if these data are part of the additional information I requested yesterday. I will ensure that the specific question relating to your [redacted] is picked up and responded to directly by someone within NHS Greater Glasgow and Clyde.

Best wishes

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: [redacted]
Sent: 19 November 2019 18:17
To: White C (Craig) [redacted]
Subject: Re: Update on Discussions with NHS Greater Glasgow and Clyde

Hi. When are they going to disclose the tests that we requested from 2A and 6A when the water was found to be contaminated? I would also like to see the results from when the micro bacterium was found within the water that my [redacted] caught and had to stop treatment because of?
Kind regards
[redacted]

On 19 Nov 2019, at 18:02, Craig.White[redacted] wrote:

Update on Discussions with NHS Greater Glasgow and Clyde

I met earlier this afternoon with the Director of Estates and Facilities. He has provided examples of the most recent water sampling results from Ward 6A at the QEUH. I have attached these.

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Best wishes

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG | T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

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<Dr. Crichton - Explanation re Water Sample Report - 191119.pdf>

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From: White C (Craig)
Sent: 21 November 2019 10:36
To: Bustillo, Sandra; Best, Jonathan; Vanhegan, Elaine; Davidson, Scott; Devine, Sandra; Hill, Kevin; Redfern, Jamie
Cc: Allan L (Lara); Shepherd L (Lesley); Law, Leanne; 'jane.grant[redacted]'
Subject: RE: draft letter options
Attachments: draft letter options

Sandra

Thanks. Some feedback to inform a further drafting:

- Content needs to be clear on who commissioned the HPS report (I have also asked SG colleagues for clarity on this and copying in colleagues for their awareness that I have posed this question)
- Needs to be clear that the recommendation to open to re-admissions comes from the IMT and was informed by HPS being assured that all actions effectively implemented and arrangements in place for ongoing review etc (suggest using wording from the CabSec's statement to Parliament yesterday)
- More information on how monitoring of the safety of the water is implemented – and needs to restate clear message focused on specific issues and questions raised before re handwashing sinks, drinking, washing etc
- Include reference to the Cabinet Secretary's request the the clinical management group being supplemented by external experts from the National Managed Network as per the statement to Parliament
- Consider referring to the re-opening bundle and provide a copy of the action plan relating to this
- Include contact details for any child-specific concerns emphasising that this to ensure that families have rapid access to care, support of information needs that related to their child's current care plan, medicines and/or parental fears/decision making about access to the hospital building. You may also wish to provide the Board HQ (ie J Haynes) and my contact details for any general questions in relation to the wider issues.

Happy to review further drafts if helpful.

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

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From: Bustillo, Sandra [redacted]
Sent: 21 November 2019 10:08
To: White C (Craig) [redacted]; Best, Jonathan [redacted]; Vanhegan, Elaine [redacted]; Davidson, Scott [redacted]; Devine, Sandra

[redacted]; Hill, Kevin [redacted]; Redfern, Jamie [redacted]

Subject: draft letter options
Importance: High

Dear All

There are two options for a draft letter for the various parent cohorts (as set out in the draft letter). The key difference in the two is the level of detail we provide on the HPs report about which, as you are aware, there are ongoing discussions concerning publication.

The key issue to consider is whether we believe the higher level detail in parent letter 2 offers sufficient assurance about the findings from HPS for these groups of parents or whether the additional information might be necessary to respond to current levels of anxiety/questioning.

Can I have views please?

Sandra

From: White C (Craig)
To: [redacted]
Subject: Response to questions raised with the Cabinet Secretary for Health and Sport
Attachments: Professor White - Letter with GGC Responses - 291019 14.pdf; NHSGGC Responses to Family Questions - For Issue - 291019.pdf

Dear [redacted]

I have attached a letter from me along with the response prepared by NHS Greater Glasgow and Clyde to the questions and issues raised in meetings with the Cabinet Secretary for Health and Sport. There is one question raised where I need further details before I am in a position to approve the response. I did not want to delay the issue of this letter to you and, for that reason, am sending this to you now with a view to being in touch again with the further response when this is available.

Best wishes

[redacted]

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | E: [redacted] | Twitter: [redacted]

gov.scot

Lara Allan
Policy Manager, Nursing and Midwifery
The Scottish Government I 2ER I St Andrew's House I Regent Road I Edinburgh EH1 3DG
Tel: [redacted]

From: Allan L (Lara) on behalf of White C (Craig)
Sent: 04 November 2019 09:54
To: Cabinet Secretary for Health and Sport; McQueen F (Fiona)
Cc: Minister for Public Health, Sport and Wellbeing; Minister for Mental Health; DG Health & Social Care; Hutchison D (David); Holmes A (Ann); Murray D (Diane); Dunk R (Rachael); Birch J (Jason); Communications Healthier; Hart S (Suzanne); Klein G (Gerard); Aitken L (Louise); Wood A (Allison); Ives J (Josephine); White C (Craig); Burgess E (Elizabeth); Morris K (Keith); Henderson C (Calum); Shepherd L (Lesley); Smith G (Gregor)
Subject: SBAR NHSGG&C meeting with families 2 November
Attachments: SBAR NHS Greater Glasgow and Clyde (003).docx; Annex A NHSGGC - Letter to Families as Issued.pdf; Annex B - NHSGGC Slide Content - 011119.pdf

PS/Cabinet Secretary for Health and Sport/ Fiona McQueen

Please find attached SBAR from Professor Craig White in relation to meeting with Chair and Chief Executive of NHS Greater Glasgow and Clyde and families of QEUH on Saturday 2 November.

Kind regards

Lara

Lara Allan
Policy Manager, Nursing and Midwifery
The Scottish Government I 2ER I St Andrew's House I Regent Road I Edinburgh EH1 3DG
Tel: [redacted]

From: Allan L (Lara)
Sent: 29 October 2019 15:50
To: Cabinet Secretary for Health and Sport
Cc: Minister for Public Health, Sport and Wellbeing; Minister for Mental Health; DG Health & Social Care; FM Policy Team Mailbox; McQueen F (Fiona); Murray D (Diane); Birch J (Jason); Klein G (Gerard); Hart S (Suzanne); Communications Healthier; Dunk R (Rachael); Ives J (Josephine); Aitken L (Louise); Hutchison D (David)
Subject: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport
Attachments: Response to questions raised with the Cabinet Secretary for Health and Sport

PS/Cabinet Secretary for Health and Sport

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He has agreed with NHSGGC that they will use this to generate a themed FAQs document that can be made available more widely to other patients and families and also to staff within the service.

Lara Allan on behalf of Professor White

Lara Allan
Executive Support to Professor White
The Scottish Government I 2ER I St Andrew's House I Regent Road I Edinburgh EH1 3DG
Tel: [redacted]

From: Allan L (Lara)
Sent: 29 October 2019 15:57
To: Jane.Grant[redacted]; Leanne.Law[redacted]; JJBrown[redacted]
Subject: Update on letter to RHC/QEUH families addressing questions raised with Cabinet Secretary for Health and Sport
Attachments: Response to questions raised with the Cabinet Secretary for Health and Sport

Colleagues

Professor White has asked me to send you copies of his communications with the patients and families who met with the Cabinet Secretary for Health and Sport, which sent today. As discussed with Jane Grant, there was one proposed response he was not content to sign off today and I understand that he has explained the background to this decision. Copies of these communications have also been provided to the Cabinet Secretary for Health and Sport, who has also been advised of the intention to use the work that has been undertaken to develop separate generic FAQ documents to support further engagement, communication and support with patients, families and staff.

Best wishes on behalf of Professor White

Lara Allan

Lara Allan
Executive Support to Professor White
The Scottish Government I 2ER I St Andrew's House I Regent Road I Edinburgh EH1 3DG
Tel: [redacted]

From: White C (Craig)
Sent: 19 November 2019 17:02
To: John Cuddihy
Subject: RE: Update on Discussions with NHS Greater Glasgow and Clyde

Dear John

I asked for an update on this today. I understand that the response to your questions is being updated to ensure it takes account of the discussions and follow-on actions from the recent meeting with Jane Grant, John Brown and Jennifer Armstrong. I have asked if I can see the proposed draft tomorrow when I am back at the Board's Corporate HQ in the afternoon.

I am about to an issue an update to the wider group of parents that I have been updating, which will outline the latest position in respect of the Health Protection Scotland report.

I have been thinking about how [redacted] is doing and send my ongoing best wishes to you all,

Best wishes

Craig

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

[redacted]

From: John Cuddihy [redacted]
Sent: 19 November 2019 10:03
To: White C (Craig) [redacted]
Subject: Re: Update on Discussions with NHS Greater Glasgow and Clyde

Good Morning Craig

Thank you for the email. I look forward to receiving the data around the water sampling. Additionally, I wonder if you can advise as to timeframes for the outstanding matters from our earlier correspondence following your meetings with NHSGGC Board and your assessment as to whether the information you have received, answers those questions I have asked.

In relation to the sharing of information from the HPS report on the review of paediatric hemato-oncology data, is there any perceived issue with regard to the sharing of this data? Obviously with the passage of time and my understanding that the report, at least in part, has already been received by NHS, communication of the delay and as to the reasons why, is critical especially as this has significant impact and implications for patients/families requiring of chemotherapy within ward 6A.

I look forward to hearing from you.

John

On 18 Nov 2019, at 17:44, Craig.White[redacted] wrote:

Update on Discussions with NHS Greater Glasgow and Clyde

Further to my email below, I met with the Director of Estates and Facilities, NHS Greater Glasgow and Clyde first thing this morning to ask for summaries to be prepared of the water sampling arrangements that are in place – accompanied by illustrative examples of the data and a summary of what these data have shown over time.

I have been advised that this has been worked on this afternoon, so have arranged a meeting with the Director again in the morning to review what has been collated and will arrange for this to be sent on thereafter.

I also intend to attempt to clarify the current position in respect of sharing the findings and recommendations from the Health Protection Scotland report on the review of paediatric hemato-oncology data.

Best wishes,

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T:[redacted] | M:[redacted] | E:[redacted] | Twitter:[redacted]

<image004.jpg>

From: White C (Craig)
Sent: 16 November 2019 10:57
To: White C (Craig)[redacted]
Subject: Further Information - NHS Greater Glasgow and Clyde - Water Safety

Summary of Arrangements for Determining Safety of Water

Dear All,

Further to some further communications about the water supply at the QEUH, I have prepared the following summary of my understanding of the position. As you will note, I intend to supplement this with the provision of some illustrative data from water sampling referred to below ,which I will be asking NHS Greater Glasgow and Clyde for on Monday morning.

The decision to switch back to filtered water was taken in light of the new kitchen facility being open and the standard precautions in place across all hospitals/the NHS that discourage drinking water from ward sinks dedicated for handwashing.

As you may recall from responses to prior questions and concerns, NHS Greater Glasgow and Clyde have confirmed that an independent engineer has confirmed that the water is 'wholesome', which is the industry term to say that it is safe. This is defined in legislation in thePublic Water Supplies (Scotland) Regulations 2014. I thought it may be helpful to provide the link to this legislation by way of providing the background of the criteria set out in legislation that have been used to inform the independent expert's assessment of the water: http://www.legislation.gov.uk/ssi/2014/364/regulation/4/made

I have been informed of several other ongoing actions and monitoring processes in place in respect of water safety:

- Sampling of the water system is undertaken by an external specialist water hygiene company and analysed in their laboratory.
- NHS Greater Glasgow and Clyde undertake additional sampling by their own laboratory staff and analyse this locally.
- Results of water sampling are reported and considered by the laboratory team and a group within NHS Greater Glasgow and Clyde called the 'Water Technical Group' – this has representatives from infection control, external advisors and local technical staff.
- The on-site water plant ensures all water coming into the hospital has a low dose of chlorine dioxide added to keep it clean and safe.
- Any patient cared for high risk areas has point of use water filters in place as an extra precaution.

Recognising the understandable concern and anxiety that the media coverage this week has resulted in, I am going to ask NHS Greater Glasgow and Clyde to provide further information relating to water safety for parents such as data on the frequency of water sampling and the results from the tests on samples. I am confident from some of the data I have seen referred to in meetings that this will provide a further level of assurance as to the evidence being used to make decisions and inform communications on the safety of the water.

I remain yours sincerely,

Best wishes

Craig White

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

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From: White C (Craig)
Sent: 20 November 2019 08:38
To: [redacted]
Subject: RE: Update on Discussions with NHS Greater Glasgow and Clyde

Dear [redacted]

Thank you for your follow-up questions. I will ask the Deputy Director of Public Health about the water temperature question, in respect of immunocompromised patients and your questions about chlorine dioxide.

My email on Saturday morning referred the external scrutiny of the samples and results – I will make sure that this is expanded upon in the description of process and data that I have asked for from NHS Greater Glasgow and Clyde (as well as reviewing the sampling dates covered by the detail provided).

The sample data shared yesterday were the most recent results.

I will also request the documentation that explains the decisions made about closure to new admissions.

The Chief Executive of NHS Greater Glasgow and Clyde has been emphasising the urgency of making the Health Protection Scotland report available, reflecting the fact that she shares your view about this report. I will update you as soon as I hear anything about this from HPS or NHS Greater Glasgow and Clyde.

I have found that the Chair and Chief Executive have recognised that there could have improved communication and provision of information and are committed to ensuring greater levels of openness and transparency in response to the ongoing concerns and questions. They understand that much remains to be done to rebuild trust and provide responses that you will find more reassuring.

My complete independence from the Board and the autonomy I have been given to undertake my remit in whatever way I feel is necessary to ensure the voices of parents are heard and responded to should also assist us in continuing to improve this situation – something that is helped significantly by your helpful follow-up questions.

I will be in touch with a further personal update as soon as I can.

Thanks again [redacted],

Best wishes

Craig W

Professor Craig White | Divisional Clinical Lead
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
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From: [redacted]
Sent: 19 November 2019 20:50
To: White C (Craig) [redacted]
Subject: Re: Update on Discussions with NHS Greater Glasgow and Clyde

Dear Professor White.

Thank you for you email. I have a few questions.

1. Are these levels also the same for cold water that the hospital want us to give to our children to drink? 22 and 37 degree water is warm and hot water.

2. Are the levels acceptable for a child who is immune compromised? And is same as adequate levels for other words? If that is the case why are children still on prophylactic medication?

3. Do you have any water sampling's dates back to march 2018 this year ? Our [redacted] contracted Pseudomonas and spiked a very high temperature hours after [redacted] port have been accessed by a nurse. Upon speaking to many medical professionals I was sure that this is something that waterborne and there is only one way for it to get into [redacted] port and that is through breaking access. Now this is not something that we would've done at home so that only leaves the hospital responsible.

4. These forms have not been checked or received by anyone. What are the process? From what we can see it seems like it was one persons word against the world. This isn't good enough. You would've expected at least a stamp on these forms.

5. Without an independent microbiologist doing waters and air sampling this means nothing. In a world where parents don't trust the hospital how do you expect us to trust their sampling?

6. We are all waiting for the report from Health Protection Scotland as a matter of urgency.

7. What we would like is to see samplings from water and air dated back to 2015 when the hospital opened.

8. The information on this form is already a month old. A month in which the hospital ward remain shut for new admissions. Why was that? If the water is "wholesome" should the ward not have administered chemotherapy.

9. If the hospital is adding chlorine dioxide to water supply is that not the same as when you go abroad and add chlorine dioxide to contaminated water to ensure that it safe to drink? The side-effects of chlorine dioxide is that it can irritate the lungs. Repeated exposure may cause bronchitis to develop with cough, phlegm, and/or shortness of breath. Is this an added risk our kids are under ?

This is just another attempt to silence parents. We are not reassured. A child had [redacted] chemo stopped 6 months early due to a infection [redacted] got from hospital water with microbes in it. The hospital admitted to this. They even offered this parent compensation.

We need proper answers.

Kind regards
[redacted]

On 19 Nov 2019, at 18:01, Craig.White[redacted] wrote:

> Update on Discussions with NHS Greater Glasgow and Clyde

I met earlier this afternoon with the Director of Estates and Facilities. He has provided examples of the most recent water sampling results from Ward 6A at the QEUH. I have attached these.

As outlined in my email to you of 16 November 2019, this forms part of the sampling, monitoring and scrutiny arrangements in place for providing assurance of water safety.

There are other environmental monitoring and sampling data available, though these will clearly require staff with specialist knowledge to explain and summarise the data to support our understanding. I arranged to speak with the Board's Deputy Director of Public Health this afternoon and she has agreed to ask one of her Consultant team to provide us with a summary of what these other monitoring data mean, taking account of your particular interests. I have asked to receive this by 1pm tomorrow.

The attached most recent water sampling data confirms the absence of any water borne contaminants. I have also attached an email from the Deputy Director of Public Health explaining what these reports show.

I have sought an update today in respect of the status of the report by Health Protection Scotland. I have been advised that, in accordance with the disclosure protocol followed by Health Protection Scotland, the content of the document is being reviewed against the various legal and regulatory requirements to make sure that it does not breach of any confidentiality or privacy requirements they are required to have considered. I have sought and received assurances that the Chief Executive of NHS Greater Glasgow and Clyde has made it clear to the Chief Executive with responsibility for Health Protection Scotland that this work must be completed as a matter of urgency, reflecting her commitment to provide this information to parents. I will update you with any detail that I receive on this when this is available.

Please do not hesitate to get in touch with me if you have any further questions arising from these data or my update.

Best wishes

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG | T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

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<QEUH WATER TESTING_Redacted 1.pdf>

<Dr. Crichton - Explanation re Water Sample Report - 191119.pdf>

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From: Allan L (Lara) on behalf of White C (Craig)
Sent: 11 December 2019 14:12
To: [redacted]
Subject: FW: Response to Oversight Board Survey
Attachments: u418806_27-11-2019_18-37-46_2.pdf

Further to your response to the recent survey asking for your views on communications with NHSGGC and how you think these can be improved, I am writing to confirm you received the letter regarding the Public Enquiry sent on 28 November (copy attached) If you have any follow-on questions then please do get in touch and I will pass these on to colleagues who can advise/provide information by way of a response.

Regards

Craig

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
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Cabinet Secretary for Health and Sport
Jeane Freeman MSP

Scottish Government
Riaghaltas na h-Alba
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T: [redacted]
E: [redacted]

28 November 2019

Dear Parent and Relative

Earlier this year I announced that a Public Inquiry would be held into the matters of concern that have arisen at the Queen Elizabeth University Hospital (QEUH) campus, Glasgow and the Royal Hospital for Children and Young People (RHCYP), Edinburgh. The Inquiry will be held under the Inquiries Act 2005.

This is an extremely important and complex task of national significance and I am glad to confirm that the Right Honourable Lord Brodie QC PC, a senator of the College of Justice, has agreed to take up the position of inquiry chair. Lord Brodie is a serving Judge of the Inner House of the Court of Session and I am pleased that someone of his stature and legal standing will chair this important inquiry. I intend to notify Parliament today.

I have a statutory obligation to consult the prospective chair on the proposed terms of reference for the inquiry and I intend to meet Lord Brodie before Christmas to discuss this and other practical matters relating to the inquiry's establishment, including timescales.

I also intend to share terms of reference with affected patients and families for comment before the inquiry's formal setting-up date. I will be in touch again early in the New Year with an update on this.

If you have any thoughts or concerns you would like to share at this stage, please continue to communicate these through Professor Craig White ([redacted] / [redacted]).

Kind regards

[redacted]

JEANE FREEMAN

[redacted]

INVESTOR IN PEOPLE
POSITIVE ABOUT DISABLED PEOPLE

White C (Craig)

From: White C (Craig)
Sent: 29 November 2019 18:31
To: White C (Craig)
Subject: Update on NHS Greater Glasgow and Clyde - Establishment of Oversight Board - Communication and Engagement Sub-Group

Update on NHS Greater Glasgow and Clyde – Establishment of Oversight Board – Communication and Engagement Sub-Group

As you know, ongoing issues relating to infection prevention, management and control at the Queen Elizabeth University Hospital and the Royal Hospital for Children have resulted in NHS Greater Glasgow and Clyde being escalated to stage 4 of the NHS Board Performance Escalation Framework for these specific matters. This action was deemed necessary to support the health board to ensure appropriate governance is in place with a Scottish Government led Oversight Board being introduced to strengthen current measures already in place to mitigate avoidable harms.

The Oversight Board, Chaired by Professor Fiona McQueen, Chief Nursing Officer for Scotland met for the first time earlier this week. It was agreed that there would be a 'Communication and Engagement' Sub-Group that will specifically consider the issues identified in respect of communication, provision of information and engagement with patients and families involved.

I have accepted an invitation to Chair this Sub-Group and will also be a member of the Oversight Board.

I want to ensure that in taking this work forward that the Sub-Group's work takes account of feedback on where communication, provision of information and engagement has worked well and where this could have been improved. I will be writing to everyone who has had contact with the paediatric haemato-oncology service to inform them of this and seek ideas and preferences on how best to capture a range of experiences and how best to ensure these are captured and influence the work of the Sub-Group. This might involve setting up specific meetings, seeking views on specific questions about experiences and/or providing the Oversight Board with your perspectives, proposals and questions.

You will be included in that communication when it is issued – though in the meantime and given our prior contact, I wanted to make you aware of this development and let you know that I would be interested in any suggestions or ideas that you might have to ensure that the voices of patients and families continue to be heard and responded to, acknowledging the importance of this particularly for those of you have kindly shared with me that this has sadly not always been your experiences. I am aware that some parents have expressed an interests in attending meetings such as those proposed – I will be in touch individually with those who have done so to discuss how this can be progressed and ways we might work together to ensure that this work results in positive impact and outcomes.

I continue to be available of course if you have any questions, requests for information or further support in the meantime.

Yours respectfully

Craig W

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |
T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]

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T: [redacted]
E: [redacted]

03 December 2019

To all patients and families
NHS Greater Glasgow and Clyde
Paediatric Haemato-Oncology Service

Dear Parent

As you may be aware following a letter sent to you by the Chairman and Chief Executive of NHS Greater Glasgow and Clyde, I was appointed by the Cabinet Secretary for Health and Sport to ensure that the voices of patients and families within the paediatric haemato-oncology service are heard and that information and responses to questions and concerns are provided.

Ongoing issues relating to infection prevention, management and control at the Queen Elizabeth University Hospital and the Royal Hospital for Children have resulted in NHS Greater Glasgow and Clyde Board being escalated to Stage 4 of the NHS Board Performance Escalation Framework for matters relating to infection control matters related to governance, communication, engagement and public confidence. Professor Fiona McQueen, Chief Nursing Officer for Scotland will be Chairing the Oversight Board. I will be a member of the Oversight Board and will also be Chairing an Engagement and Communication Sub-Group.

I want to ensure that our work is informed by feedback on your experiences, that you have the opportunity to tell me about your preferences for further communication or action required and raise any specific concerns or matters where you would like to receive a response or see further action taken.

A survey has been developed for you to provide your response. This can be accessed online at: https://tinyurl.com/NHSGGC

If you would prefer to receive a copy of this survey in printed format or would like to provide your responses by telephone then please contact my colleague Lara Allan at [redacted] and she will be pleased to help you. Lara can also be contacted on [redacted].

Yours respectfully,

[redacted]

PROFESSOR CRAIG WHITE
Divisional Clinical Lead

From: Emma MacKay [redacted]
Sent: 05 March 2021 10:55
To: Craig WHITE; White C (Craig); Marie Brown; STEVENS, Mike (UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST); Raghavan S (Shalinay); Fluka M (Martina); Campariol-Scott C (Carole); Paterson M (Matt); John Cuddihy
Subject: Case Note Review- Communications & Engagement meeting
Attachments: Agenda 2021-03-09 (2).doc; Action log 21-01-21 v1.0.doc

Dear all

Please find attached the agenda and action log for our next Communications & Engagement meeting taking place on Tuesday 9 March.

Kind regards

Emma

Emma Mackay ¦ Project Support Officer ¦ Programme Management Services (PgMS) ¦ Strategy, Performance and Service Transformation ¦ NHS National Services Scotland ¦ Area 003, Ground Floor ¦ Gyle Square ¦ 1 South Gyle Crescent ¦ Edinburgh ¦ EH12 9EB

M: [redacted]
e: [redacted]

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Agenda

Meeting: **Case Note Review Communications Meeting**
Date: Tuesday 9 March 2021 @ 13:30-15:00
Location: Microsoft Teams / Teleconference

Proposed Attendees:
Professor Craig White, Communications Lead, Case Note Review (Chair)
Marie Brown, Programme Manager, Case Note Review
Carole Campariol-Scott, QEUH Support Unit, Scottish Government
Shalinay Raghavan, Interim Head of QEUH Response Team, Scottish Government
Professor John Cuddihy, Patient and Family Representative
Professor Mike Stevens, Expert Panel Lead, Case Note Review
Emma Mackay, Project Support Officer, Case Note Review
Martina Fluka, Senior Policy Manager, Scottish Government
Matt Paterson, Senior Media Manager, Scottish Government

Apologies
Phil Raines, QEUH Support Unit Head, Scottish Government

1.	**Welcome and Apologies**	**Verbal**	**C White**
2.	**Matters Arising**		
	2.1. Action Log	**Paper 01**	**All**
3.	**Overview Report – Update**	**Verbal**	**M Stevens**
	3.1. Sharing with Families/Notification Email	**Verbal**	**M Stevens**
4.	**Media Handling**	**Verbal**	**M Paterson/All**
5.	**Individual Patient Reports**		
	5.1. Consent to Share	**Paper 02 ***	**M Stevens**
	5.2. Letter to Families	**Paper 03 ***	**M Stevens**
6.	**Contact Information - Meeting with GGC Update**	**Verbal**	**M Brown**
	6.1. Available Support Services	**Verbal**	**M Brown/All**
7.	**Any Other Business**	**Verbal**	**All**

***paper to follow**

Action Log

Meeting: **QEUH/RHC Case Note Review – Comms and Engagement**
Date: Thursday 21 January @14:00-15:00
Location: Microsoft Teams

Attendees
Professor Mike Stevens, Expert Panel Lead
Professor Craig White, Deputy Director, Health & Social Care, Scottish Government
John Cuddihy
Shalinay Raghavan, Interim Head of QEUH Response Team, Scottish Government
Martina Fluka, Senior Policy Manager, Scottish Government
Marie Brown, Programme Manager, NSS
Emma Mackay, Project Support Officer, NSS

Apologies
Phil Raines, Interim SRO Case Note Review/Head of QEUH Support Unit, Scottish Government
Carole Campariol-Scott, QEUH Support Unit, Scottish Government

Action Ref	Action	Due Date	Owner	Update
Actions 21-01-21				
01-2021-01-21	M Stevens to discuss with P Raines the date for publication for the Oversight Board report.	24-02-21	M Stevens	24-02-21- Complete.

02-2021-01-21	J Cuddihy to send a message to the families via the closed Facebook page to get feedback regarding views on sharing individual patient reports with Clinicians at GGC. All agreed that this should be discussed at the meeting with GGC	22-01-21 12-02-21	J Cuddihy E Mackay	22-01-21- Complete. 12-02-21-Complete.
03-2021-01-21	J Cuddihy to mention the creation of the mailbox in message to families on the closed Facebook page. J Cuddihy to highlight in the message that the mailbox will have the pre-fix of NSS. Will also include question about their preferred method of receiving their individual reports.	22-01-21	J Cuddihy	22-01-21- Complete.
04-2021-01-21	E Mackay to create mailbox once Facebook post has been shared by J Cuddihy. Ensure an automatic message is sent on receipt of a new message to explain to the recipient when to expect a response.	26-01-21 26-02-21	E Mackay E Mackay	26-01-21- Complete. 26-02-21- Complete.
05-2021-01-21	Support Services available to families- E Mackay to include this on the agenda for meeting with GGC J Cuddihy to ask families in the Facebook post what support services they have used and would recommend. Discuss with GGC the matter of GGC liaising with local health boards of patients and families in relation to providing support.	12-02-21 03-03-21 05-03-21	E Mackay J Cuddihy M Brown	12-02-21- Complete. 03-03-21- It was agreed that we consider all resources/support available via GGC and partner agencies. Available support sevices discussed with GGC at meeting on 05 March and update provided as part of agenda item 6. 04-03-21 This has been discussed with GGC on 12-02-21 and will be followed up by M Brown on 05-03-21.

06-2021-01-21	Date of next meeting- Agreed that this should take place following meeting with GGC Date of March meeting- agreed this should take place after the Overview report has been published.	February 2021 March 2021	 E Mackay	15-02-21- Complete.

Actions 20-11-20				
01-2020-11-20	Individual Reports for Families: • Liaise with GGC to obtain the preferred method of contact and most up to date contact details for the families of all 85 children (should we ask the families to provide their preferred contact details or do GGC already have this?) • Confirm if there is more than one contact per child e.g. mother and father separated, social care/foster care involvement • Ensure the Panel are aware of any change in circumstance of any child included in the review before writing to the families • Consider support services available for families and how we can incorporate this information into future communications	January 2021	All	04-03-21 – Update will be provided at the meeting on 9 March by M Brown. 10-12-2020 – A meeting with this Comms Group and GGC should be scheduled in the new year to agree a process for communicating with families on individual reports. 21-01-21- All agreed that a meeting with Mags Macguire, Executive Director at GGC should be arranged to agree the process for communicating with families on individual reports.

02-2020-11-20	Phil Raines to engage with the Crown Office and give them sight of the timeline of reporting with purpose of giving them an opportunity to guide us what they would need or want to see in terms of the findings	27/11/20	P Raines	29-01-21 Complete. 21-01-21- S Raghavan & C White to discuss background. 06-01-2-21 P Raines emailed the Crown Office with the Oversight Board Report and received an acknowledgement email. 09-12-2020- P Raines emailed David Harvie at the Crown Office and to date has not received a response.
03-2020-11-20	Carole Campariol-Scott to liaise with David Anderson at the Public Inquiry office to understand their position in obtaining data and reports from the Case Note Review.	27/11/20	C Campariol-Scott	21-01-21- Closed. This action is now with SG and they will provide an update to the Review Team. Update as per note of 13-01-21. C White also informed meeting of his discussions with Kenny Warren, Solicitor for the Public Inquiry and supporting the process of the Public Inquiry as well as sharing helpful organisation details, such as the Harmed Patients Alliance. 13-01-2021 The Public Inquiry Team are keen to receive all information from the Case Not Review. M Brown shared the Information Sharing Agreement (between SG and GGC) with the Public Inquiry Team and it was agreed to meet again once data sharing has been agreed. 10-12-2020 Meeting with D Anderson, M Brown and C Campariol-Scott scheduled for 16-12-20.
04-2020-11-20	Meetings with families- M Stevens to add to the Planning for the reports document that families can record the meeting 'if they wish'.	8/12/20	M Stevens	09-12-2020- Complete.
05-2020-11-20	Meetings with families- M Stevens to add narrative outlining guidance for other represntatives attending vitual meetings with the Panel e.g.'normally' (default position would be…)	8/12/20	M Stevens	09-12-202- Complete.
06-2020-11-20	Time limit for meetings with families- J Cuddihy suggested that for bereaved families a time limit is not set for virtual meetings with the Panel.	8/12/20	M Stevens	09-12-2020- Noted.

07-2020-11-20	Project team to revise timeline following planning meeting (14-12-2020) and draft comms to families to review at next comms meeting.	11/12/20	M Brown/M Stevens	09-12-2020- Complete and added to agenda for meeting on 17-12-2020.

Decision Ref	**DECISIONS – 20-11-20**
01-2021-01-21	Consent to share the individual patient reports- all agreed that a consent form was not required.
02-2021-01-21	All agreed that when sharing the individual patient reports with GGC, the letters should go to the lead Consultant, who could then circulate it to Clinicians who treat the patient.
03-2021-01-21	All agreed that a Mailbox should be set up to communicate with patient families.
01-2020-11-20	Overview report- Overview report will be available to families and stakeholders 1 day prior to publication.
02-2020-11-20	Overview report- Scottish Government will handle the publishing of the Overview report.
03-2020-11-20	Overview report- Scottish Government will be responsible for circulating copies of the Overview report to families and other stakeholder 1 day before publication.
04-2020-11-20	Individual Patient reports- JC confirmed he is happy that the format of individual reports will be in the form of a letter, using headings which are contained in reports used by the Panel. Medical acronyms will be taken out.

Family questions/ issues to fed back to Independent Review

Building

- Questions were raised around the risk of the QEUH being built next to a sewage plant and why all these problems were occurring in a new- build hospital.

- Structural issues were also raised with families questioning the safety of the cladding used on the buildings where wards 2A/2B and 6A are located and the safety of windows, one family member saw a window pane fall from the 10th floor.

Water System

- The water system is of major concern to the families as this is where they believe the majority of infections stemmed from. Families queried if the overall water supply across the QEUH campus was safe. McDonald House and local residents use the same water supply and families asked if there were any issues there.

- Parents have been keen to find out when the hospital first became aware of contaminated water and why they continued to admit children to the wards when they were aware of this.

- There was concern around the safety of the internal plumbing. One family raised that the infection their child developed, Stenotrophomonas Maltophilia, could only be eradicated by the replacement of plumbing once it colonised, due to its protective biofilm. So although water was safe entering the hospital and exiting taps that have filters, they asked about areas that didn't have these facilities and what the processes were regarding internal services. Mains fed water coolers were also raised as being a risk.

- Families wanted to know more about the water sampling. Families asked if neutropenic patients were considered when sampling was undertaken and wanted to know why an independent microbiologist wasn't engaged by NHSGGC to take samples of water and environment. Families had sight of the current water sampling report and wanted to know why the report wasn't signed off by an external verifier.

- It was asked if adding chlorine dioxide to the hospital water supply was comparable with chlorinated water supplies abroad which had to be treated to make them safe to drink. They were also concerned about the side-effects of exposure to chlorine dioxide on their child's health.

Ventilation

- Ventilation was a concern with families asking if the current system was safe. Questions were raised around the correct number of air changes and air pressure within immunocompromised patient rooms.

- Families asked why patients were admitted to wards 2A and 2B when it was raised that the ventilation was not fit for purpose prior to the ward opening.

Maintenance

- Why were drains within shower rooms not replaced when other drains/traps were replaced during remedial works, with work seen as "sticking plaster" and taking too long.

- Workmen who were working on rooms that had been closed down due to infection, wore normal work clothes and shoes, not white Tyvek suits and foot coverings.

SCOTTISH GOVERNMENT
HEALTH AND SOCIAL CARE DIRECTORATES
COMMUNICATION AND ENGAGEMENT SUB GROUP
– QUEEN ELIZABETH UNIVERSITY HOSPITAL AND ROYAL HOSPITAL FOR CHILDREN, NHS GREATER GLASGOW AND CLYDE (NHSGGC)

Draft Terms of Reference

Purpose and role of group:

The Communications and Engagement Sub Group for Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), NHSGGC, is a time limited group to offer advice and assurance working with Scottish Government and NHSGGC to:

- Ensure appropriate governance is in place to increase public confidence
- Strengthen current approaches that are in place to mitigate avoidable harms

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 Communications and Engagement Sub Group will take a values based approach in line with the National Performance Framework (NPF) and the values of NHSScotland (NHSS).

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 AAOB individually and collectively:

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

The values of NHSS are:

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality and teamwork

These values will be embedded in the work of the Communications and Engagement Sub Group, and this work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members / patient representatives.

The Communications and Engagement Sub Group is focused on improvement. Sub group 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 Communications and Engagement Sub Group will meet fortnightly for the first two months and timings will be discussed thereafter. Tele-conferencing will be provided.

Full administrative support will be provided by officials from Scottish Government. The circulation list for meeting details/agendas/papers/action notes will comprise Oversight Board members, their PAs and relevant CNOD staff.

Objectives, deliverables and milestones:

The objective for the Communications and Engagement Sub Group is to:

- through proactive engagement and enhanced communications, have a positive impact on patients and their families in relation to how problems are identified, responded to, communicated and managed,
- ensuring respect at all times towards families relative to their rights to information and participation
- identify what has worked well and where the provision of information, communication and engagement could be enhanced and improved

In order to meet these objectives, the Communications and Engagement Sub Group will retrospectively assess issues at the QEUH and RHC with communication and public engagement; having identified these issues, work with NHSGGC 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.

Specific deliverables which will contribute to these objectives being met are as follows:

Analysis of the Patient Survey issued by Professor White on week commencing 25 November and the effectiveness of subsequent follow up actions informed by responses

A review of the following documents within NHS Greater Glasgow and Clyde:
Strategic Communications plans for both internal and external communications

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Milestones:

Prioritise communications and information provided to families with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised
Development of a strategic Communications and Engagement Plan
Review of policies and procedures in respect of communications, engagement and decision-making regarding consideration of the organisational duty of candour, significant clinical incident reviews (including engagement, involvement and provision of information to families in relation to these processes).

Governance:

The Communications and Engagement Sub Group will be chaired by Professor Craig White, and will report to the Oversight Board.

The Oversight Board will be chaired by the Chief Nursing Officer, Scottish Government, and will report to the Cabinet Secretary for Health and Sport.

Membership:

Communications and Engagement sub-group	
Member	**Job Title**
Craig White (Chair)	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate
[redacted]	Families representative
John Cuddihy	Families representative
Lynsey Cleland	Director of Community Engagement at Healthcare Improvement Scotland
Andrew Moore	Head of Excellence in Care for Healthcare Improvement Scotland
Secretariat	CNOD

In addition to these members, other attendees may be present at meetings based on agenda items: Chair of Infection Prevention & Control and Governance sub-group; relevant Directors and senior staff from NHSGGC; communications staff from Scottish Government.

Stakeholders

The Communications and Engagement Sub Group recognise 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 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 staff of NHSGGC and Trade Unions
- The senior leadership team of NHSGGC and the Board

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Communication and Engagement Sub Group
NHS Greater Glasgow and Clyde Oversight Group
Meeting: 5 December 2019

Note of Meeting

Attendees:

Professor C White, Scottish Government (Chair)
L Cleland, Health Improvement Scotland
A Moore, Health Improvement Scotland
Professor J Cuddihy, Family Representative
[redacted], Family Representative
Dr M Maguire, NHS Greater Glasgow and Clyde
E Van Hagen, NHS Greater Glasgow and Clyde
P Raines, Scottish Government
S Hart, Scottish Government
C Henderson, Scottish Government (Secretariat)

Apologies:

S Bustillo, NHS Greater Glasgow and Clyde

Welcome and Background:

The Chair welcomed everyone to the first meeting.

NHS Greater Glasgow and Clyde 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 intention of the escalation is to 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 has been put in place, chaired by Professor Fiona McQueen, Chief Nursing Officer. This was being augmented with specific support for Infection Prevention & Control, and communications and engagement.

Professor C White has continued 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 explicitly support improvements in the delivery of effective clinical governance and assurance arising from this work.

This Sub Group will specifically look at Communications and Engagement.

The first meeting was an open discussion to discuss the purpose of the group, its priorities and how we best communication and engagement between NHS Greater Glasgow and Clyde and the patients and families affected could be improved.

Key Points of the Discussion:

The group discussed the survey that was issued to families in week commencing 25 November. This piece of work will obtain further evidence around communications and engagement, and the Sub Group will examine the feedback to provide the basis of the work required to improve communication.

There was acknowledgment that parents had been asking questions with a significant delay to receiving adequate responses. The group discussed the need to increase public transparency i.e. website publication. One action was for consideration if further information could be made available on the website, such as governance and management structures with NHSGGC.

It was also suggested that the Facebook group for families that had been created was not working as well as it should. There was recognition this mechanism needed to be revised, and the group would examine ways in which the Board could engage with the families involved more effectively.

There was a discussion around the fundamental difference around confidentiality and duty of candour. It was stated that the issue was not the quality of the clinical care that was being provided – and the appropriate information provided as part of that care – but issues relating to the environment for care, and the candour with which relevant information was being shared with affected families. Professor White is currently overseeing a review in NHSGGC's policies with respect to the Duty of Candour. This piece of work will return to the Sub Group to triangulate with the experiences of the families.

The group discussed the need to improve the consistency of the messaging that was being provided by the Health Board. It would consider what good communication looks like and how this should address the needs of different stakeholder groups. It was noted that trust came from a proactive approach to communication rather than a reactive one.

The group also discussed the corporate responses that were coming from the Board with regards to complaints and queries. Tone was an issue. Any correspondence should provide empathetic responses which focused on providing reassurance around protection and prevention as well as building and maintaining trust.

It was also noted that the Board should consider the need to be transparent around the time likely to be taken to respond to a request. Representatives of the Board committed to consider how best to do this going forward.

In developing a workplan, the group will consider what the short, medium and long term objectives should be but ultimately the initial focus will be to improve the communication between the Health Board and the families.

The Chair will take discuss the terms of reference of the Sub Group with the Chair of the Oversight Board. The Scottish Government will take forward the comments from the meeting to form draft terms of reference, which will be circulated to the members by the 13 of December for initial comments.

It was also noted in terms of membership that there were several other family representatives who wanted to be members of the Sub Group, or at least take part in its work.

Date of Next Meeting:

This is to be confirmed by the Secretariat.

Actions:

1. Secretariat to consider the timings and frequency of the meetings
2. Secretariat to produce a draft Terms of Reference to share with group by 13 December
3. Scottish Government to consider how we can engage with the families for the next meeting and for those that want to be part of the reference group who will support the work of the Sub Group
4. The Sub Group Chair to discuss with the Chair of the Oversight Group around the expectations of the outputs of the Oversight Group

The group will consider which documents it would be helpful to review for example the business continuity plan and any strategic communications plans with regards to internal and external communication

Communication and Engagement Sub Group
NHS Greater Glasgow and Clyde Oversight Group
Meeting: 18 December 2019

Note of Meeting

Attendees:

Professor C White, Scottish Government (Chair)
L Cleland, Health Improvement Scotland
A Moore, Health Improvement Scotland
[redacted], Family Representative
Dr M Maguire, NHS Greater Glasgow and Clyde
S Bustillo, NHS Greater Glasgow and Clyde
C Henderson, Scottish Government (Secretariat)

Apologies:

Professor J Cuddihy, Family Representative
E VanHegan, NHS Greater Glasgow and Clyde
P Raines, Scottish Government
S Hart, Scottish Government

Welcome and Background:

The Chair welcomed everyone to the meeting and apologies were noted.

Minute of Meeting of 5 December:

The minute of the last meeting was accepted. There will be one minor amendment to list of actions to include inviting a representative from the Schiehallion Unit to our meetings

Action:

- Scottish Government to amend the minute to reflect additional action.

Terms of reference:

The Scottish Government will amend the Terms of Reference to reflect the comments from the Sub Group. This will be presented at the next Sub Group meeting.

The Sub Group discussed membership, Greater Glasgow and Clyde will ask Jen Rogers to join the group as an attendee to represent Schiehallion Unit.

The Scottish Government will invite a Director for Communications and Head of Public Engagement from other territorial boards to provide additional insight into the work of the Sub Group.

Action:

- Scottish Government to amend ToR for clearance at the next meeting.
- NHS Greater Glasgow and Clyde to invite Jen Rogers to Sub group
- Scottish Government will invite additional members with regards to expertise in Communications and Public Engagement

Families engagement with the Sub Group:

The Scottish Government are currently undertaking the logistics of establishing a parent reference group in January to feed into the work of the Sub Group.

Action:

- Scottish Government to confirm the plans for the parent reference group at the next meeting

Initial Survey Feedback:

The group discussed the need for the Health Board to review where public engagement did not work correctly and the Sub Group can undertake a review of lessons learned from these events.

The Sub Group discussed the need that answers to questions should be clear and the Board should examine what is currently made available on the public website. The Board have published the answers to the 71 questions asked by families but these are not clearly accessible on the website. The Board will provide an updated webpage on the Ward 6A.

Professor Cuddihy had provided a paper in advance of the meeting which included questions regarding proposed legal action and the statement made by the Chief Executive. The Board will provide answers to the questions raised in this paper. The Chair highlighted there are still a number of the families questions to be answered he has asked that all known questions should be shared with CH to allow responses to be taken forward.

Action:

- NHS Greater Glasgow and Clyde to review website content and circulate suggested pages on Ward 6A for Sub Group members comment
- NHS Greater Glasgow and Clyde to provide responses to Professor Cuddihy's questions
- Sub Group members to provide the questions from families that remain unanswered to CH to allow us to coordinate responses and provide the necessary answers.

AOB:

The Chair highlighted that there was an unknown number of families who did not receive the letter from the Cabinet Secretary regarding the Public Inquiry and the Sub Group Chair's letter regarding the experience survey. The Board will undertake to

review the distribution methods to establish the number of patients who may have not received these letters.

The Sub Group agreed further action to provide assurance around prescribing.

Action:

- NHS Greater Glasgow and Clyde to undertake a review to understand the number of patients who may not have received the letters.
- NHS Greater Glasgow and Clyde to consider the option of a senior clinician drafting a letter regarding prescribing.

Date of Next Meeting:

The next meeting will be the 9 January 2020.

Communication and Engagement Sub Group
NHS Greater Glasgow and Clyde Oversight Board
Meeting: 9 January 2020

Minute of Meeting

Attendees:

C White, The Scottish Government (Chair)
L Cleland, Health Improvement Scotland
J Duncan, NHS Tayside
A Wallace, NHS Forth Valley
M Maguire, NHS Greater Glasgow and Clyde
S Bustillo, NHS Greater Glasgow and Clyde
E VanHegan, NHS Greater Glasgow and Clyde
J Rodgers. NHS Greater Glasgow and Clyde
P Raines, The Scottish Government
C Henderson, The Scottish Government (Secretariat)

Apologies:

J Cuddihy, Family Representative
A Moore, Health Improvement Scotland
[redacted], Family Representative
S Hart, The Scottish Government

Welcome and Background:

The Chair welcomed everyone to the meeting and apologies were noted.

Update from the Chair:

The Chair reflected on the Cabinet Secretary commitment to deliver a more specific communication strand. The Board continues to review the communications database alongside the clinical database to ensure that the families that should receive Communications continue to do so in a manner that is consistent with their preferences and consideration of individual circumstances.

NHS Greater Glasgow and Clyde will undertake a person centred review of those families who have experienced a bereavement as to whether it would be appropriate for them to receive the letter from the Cabinet Secretary regarding the Public Inquiry chaired by the Right Honourable Lord Brodie. Clinicians within the Board to review and consider whether this is the appropriate form of communication. CW confirmed that he would be pleased to provide advice and/or make contact with individual parents if there is a need for support with this action.

NHS Greater Glasgow and Clyde to provide a paper at the next meeting of the Sub Group highlighting the various strategies, policies and procedures with regards to Communications and Engagement and how this has informed the actions taken previously in respect of information provision, communication and engagement..

At future meetings, NHS Greater Glasgow and Clyde will bring forward specific examples of communications over the past few years to allow the Sub Group to drill down and examine how strategic commitments and supporting procedures influenced and informed actions.

The Sub Group recognised the opportunity to discuss reflections arising from the handling of other NHS Boards who have dealt with communication and engagement during investigations and reviews involving large groups and/or wider public interest (e.g. breast cancer treatment review in NHS Tayside).

The Sub Group agreed that it will be important to capture what has worked well and where further improvement support could be focused within NHS Greater Glasgow and Clyde.

ACTIONS:

- NHS Greater Glasgow and Clyde to undertake a person centred review which families should receive the PI letter. CW to take forward any communication if the Board recommends it would be more appropriate for him to do so.
- NHS Greater Glasgow and Clyde to bring a 'Service Family Masterlist' to the next meeting, with linked descriptions of the communication and engagement mechanisms in place for individual families

Minute:

The minute will be updated to reflect the following changes:

- Correction to recording attendee list.
- Addition of 'group' to the section under Families engagement with the Sub Group.
- The minute was updated under AOB to reflect the Sub Group agreed that options around prescribing will be explored. The action was also be reflected to parallel this change to the minute.

The Scottish Government to share ane Action Tracker with all members of the Communications and Engagement Sub Group.

The Scottish Government to consider publication of minutes to ensure a consistent approach to the minutes of Oversight Board.

ACTIONS:

- Minute of 18 December 2019 to be updated.
- Secretariat to consider the minute to ensure constituency with Oversight Board.
- Action tracker to be shared with members of Sub Group

Terms of Reference:

Colleagues to provide comments to the Secretariat by close of play 13 January. The Terms of reference will be amended with a view for it to be signed off at the next Communications and Engagement Sub Group

ACTIONS:

Sub Group to provide further comments on Terms of Reference by close 13 January

SBAR:

When children are started on any medication this is discussed with the family by the doctor. Children in this group may receive prophylaxis for a number of reasons relating to their individual condition, treatment and circumstances. So a standard letter to all would not be appropriate.

All parents on the 'master list' were written to and offered an opportunity to meet to discuss any concerns they may have. Of those that responded either to meet or continue a discussion by phone, email or letter and where prophylasis was discussed those families received within their letter further detail on the prophylaxis both specific to them and in general terms.

The consultant team is currently working with Scott Davidson regarding ongoing improvement and tests of alternative prophylaxis that has been utilised in other centres.

Updated Website Content

The Sub Group agreed the updated website content should go live on Monday 13 January. The Scottish Government will circulate the staging site with new members of the Sub Group to allow them to feedback on the contents in advance of 13 January.

NHS Greater Glasgow and Clyde to include as many of the recommendations from Professor Cuddihy in advance of the site going live but will continue to adapt and improve over time.

The Scottish Government to review the site on the areas on the Oversight Board by close on Friday 10 January to ensure this accurately reflects the work.

ACTIONS:

- Proposed website content to be shared with JD and AW.
- The Scottish Government to provide comments on Oversight Board content in advance of the site going live on Monday 13 January.

Families Reference Group:

The Sub Group agreed it was not satisfactory to give families little notice for engagement events. The Scottish Government and NHS Greater Glasgow and Clyde to consider the needs and preferences of families, recognising the communication and engagement channels now in place, ensuring that any wider information session is considered as part of the commitment to describe actions in support of person-centred responses based on preferences and need.

ACTIONS:

- The Scottish Government and NHS Greater Glasgow and Clyde to consider further when the Master list is linked with current mechanisms outlined, enabling potential further actions (including meetings and information sessions) can be agreed.

Date of next meeting:

The next meeting is 21 January 2020.

Communication and Engagement Sub Group
NHS Greater Glasgow and Clyde Oversight Group
Meeting: 29 January 2020

Attendees:

Professor C White, Scottish Government (Chair)
L Cleland, Healthcare Improvement Scotland
A Wallace, NHS Forth Valley
J Duncan, NHS Tayside
Dr M Maguire, NHS Greater Glasgow and Clyde
E VanHegan, NHS Greater Glasgow and Clyde
S Bustillo, NHS Greater Glasgow and Clyde
P Raines, Scottish Government
S Hart, Scottish Government
S Aitkenhead, Scottish Government (Secondment)
C Henderson, Scottish Government (Secretariat)

Apologies:

A Moore, Healthcare Improvement Scotland
J Rodgers, NHS Greater Glasgow and Clyde
Professor J Cuddihy, Family Representative

Welcome, Introductions and Apologies

The Chair welcomed everyone to the meeting and apologies were noted.

Minute of Previous Meeting

Amendment to be made to attendee list.

The minute for both the 18 December and 9 January have been cleared without further comment.

The Scottish Government to put forward to Oversight Board that all minutes should be published on the improved content on the NHS Greater Glasgow and Clyde website.

JR has reviewed master list from the time the hospital opened and this currently sits at 421 families involved. NHS GGC have identified there around 200 families actively still using the services at the Queen Elizabeth University Hospital.

NHS Greater Glasgow and Clyde have identified that 60 families have experienced bereavement which is on top of the 421 families identified in the master list. The Clinical view is that parents who have experienced bereavement should not be contacted with regards to the Public Inquiry, this judgement is based on the individual consultants relationship with the families affected.

There will be a follow up letter on the Public Inquiry moving from start up to the consultation on the draft Terms of Reference.

CW to review the process used by the clinicians around the decisions taken with regards to appropriateness of communication.

The NHS Greater Glasgow and Clyde to bring paper to meeting on 4 February, to break down the subsets of the master list to allow to take forward conversations around the most appropriate methodology of communication with regards to Public Inquiry and Case Review

The Sub Group acknowledged the opportunity for learning from across Scotland around complexities of communications and that the master list methodology could be replicated in other Health Boards in challenging events.

The action tracker to become standing item on the agenda.

Scottish Government to consider wider action list bringing together all actions from Sub Groups and Oversight Board.

NHS Greater Glasgow and Clyde asked what does Level 4 on the escalation framework mean with regards to information governance and what can be shared within GDPR regulations. The Scottish Government and GGC to consider this further.

ACTIONS:

- Scottish Government to take proposal to next Oversight Board around publication of minutes.
- CW to review the process used by the clinicians around the decisions taken with regards to appropriateness of communication.
- The NHS Greater Glasgow and Clyde to bring paper to meeting on 4 February, to breakdown the subsets of the master list.
- The action tracker to become standing item on the agenda.
- Scottish Government to consider wider action list bringing together all actions from Sub Groups and Oversight Board.
- Scottish Government and NHS Greater Glasgow and Clyde to take forward discussions around information Governance.

Terms Of Reference

An amendment to be made to outcomes and deliverables sections.

The Sub Group have cleared the Terms of Reference and Scottish Government to take this to next Oversight Board for sign off.

ACTIONS:

- Final amendments to be made to Terms of Reference by 30 January.
- Scottish Government to table at Oversight Board on 6 February for clearance.

Discussion on Relevant Policies and Procedures

There were a number of documents for consideration. There were issues around information sharing with regards to access to the Dropbox. The Scottish Government to take forward action to consider options for ensuring the most effective approach to information sharing.

ACTIONS:

- The Scottish Government to take forward action to find best approach for information sharing.

Presentation on Draft Workplan

The Sub Group discussed the need for the workplan to feature very clearly leads for each of the key questions we want to cover. It was agreed that there was a need for a sequenced approach and then working through it to focus on a specific principle of communications and engagement.

The Scottish Government to consider comments shared by Angela O'Neill and Mag Maguire as part of the draft workplan.

The secretariat to share HPS Manual, which forms the basis of communications with regards to infection prevention and control. This will be discussed at the 4 February meeting of the Sub Group.

SB to bring a case-study of the Cryptococcus incident form 2018 for the 4 February meeting and how families were engaged with the incident. This will be supported by a number of documents shared in advance, to allow for questions and discussion.

NHS Greater Glasgow and Clyde to share presentation with CW in advance of the 4 February.

The 18 February meeting will focus on Duty of Candour. The presentation will be led by EVH, relevant colleagues in NHS Greater Glasgow and Clyde and supported by Sub Group members AM and AW.

ACTIONS:

- The Scottish Government to consider comments shared by Angela O'Neill and Mags Maguire as part of the draft workplan.
- The secretariat to share HPS Manual in advance of 4 February meeting.
- SB to bring a case-study of the Cryptococcus incident from 2018 for the 4 February meeting.
- NHS Greater Glasgow and Clyde to share presentation with Professor White in advance of 4 February meeting.

AOB:

CW highlighted there are various Communications amongst members of the Sub Group on matters that are of interest to the Sub Group as a whole. It was asked going forward that such communication is shared widely to help support discussion.

[redacted] has had to stand down from the Sub Group. The Chair and Sub Group noted their thanks to [redacted] for [redacted] contributions to the work of the Sub Group.

Another family representative to be considered with ongoing dialogue with those wishing to contribute. CW to utilise the master list to identify another family representative, and consider how best they can participate in the work of the Sub Group.

CW to reflect on how to ensure appropriate confidentiality in Sub Group discussions and will consider steps to address this in advance of the next meeting.

ACTIONS:

- CW to reflect on how to ensure appropriate confidentiality in Sub Group discussions and will consider steps to address this in advance of the next meeting.
- CW to identify another family representative and reflect on how best they can participate in the work.
- It was asked going forward that relevant communication between members of the Sub Group should be shared widely to help support discussion.

Date of Next Meeting:

The next meeting will be 4 February 2020.

QEUH/NHS GGC OVERSIGHT BOARD

Communications and Engagement Subgroup Update

Report Date: 14 February 2020

Details of Subgroup Meeting

Date of Meeting	Subject of Meeting	Objective of the Meeting
4 February 2020	A detailed examination of how the NHS GGC communications strategic approach operated in the context of the 2017-19 infection incidents in the Royal Hospital for Children and the Queen Elizabeth University Hospital	• This was part of the evidence gathering to support the key success indicator, *Families of children within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHSS in full*, through understanding how the NHS GGC communications approach when experiencing infection incidents.

Content of Meeting and information presented at meeting
• A presentation on the NHS GGC strategic approach to communications in the context of infection incidents, with a focus on the overall strategic approach (including the communications strategy for healthcare associated infection), the different media/messaging employed, and a case-study of the 2018-19 cryptococcus incident, with the learning that was gained. • A discussion of the key issues/challenges that arose in the case-study, including the challenges of balancing patient/family confidentiality with the surrounding media pressures, the context of situations where 'conjecture drives narrative', and the difficulties of addressing a fast-moving social media communications environment.

Findings and Observations from meeting
<u>Observations</u> • Direct communications with clinical staff and families was widely viewed as particularly effective. It was noted that it might be further supported through the targeted presence of facilities/estates colleagues on some communications issues. • A key challenge facing the Board was communicating with families that were no longer actively engaged with the service.

- There was a tension between the care (and resulting authorising environment) for communications that required clarity and accuracy and the requirements of a fast-moving social media landscape where messages could be disseminated and arguably distorted.
- There was a tension between communication for public information and assurance and the need to respect privacy/confidentiality of individual families and avoiding 'deductive disclosure'.
- The involvement/attention of senior management in communications/messaging was not always apparent in the final communications that were conveyed to families.

Findings

- The Subgroup agreed that one of its key deliverables should be development of an updated Healthcare Associated Infection Communications Strategy for NHS GGC, taking fully into account the emerging findings and recommendations of the Subgroup and with a view to developing an exemplar national document.

Date of next meeting	**Subject of Meeting**	**Objective of the Meeting**
18 February 2020	Conclusion of the discussion on the NHS GGC strategic approach to communications and engagement and IPC issues Initial discussion on the operation of the NHS GGC organisational duty of candour in the context of the 2017-19 infection incidents in the QEUH and the RHC	With respect to the duty of candour discussion, this would support evidence gathering for the key success indicator, *Families of children within the haemato-oncology service receive relevant information and are engaged with in a manner that reflects the values of the NHSS in full.*

Communication and Engagement Sub Group
NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital
Oversight Group
Meeting: 18 February 2020

Attendees

Professor C White, Scottish Government (Chair)
J Davies (attending on behalf of L Cleland)
A Moore, Healthcare Improvement Scotland
A Wallace, NHS Forth Valley/NHS Greater Glasgow and Clyde
S Bustillo, NHS Greater Glasgow and Clyde
A Crawford, NHS Greater Glasgow and Clyde
Dr M Maguire, NHS Greater Glasgow and Clyde
J Rodgers, NHS Greater Glasgow and Clyde
P Raines, Scottish Government
C Henderson, Scottish Government (Secretariat)

Apologies

S Aitkenhead, Scottish Government (Secondment)
L Cleland, Healthcare Improvement Scotland (J Davies attended on behalf)
Professor J Cuddihy
S Hart, Scottish Government
E Vanhagen, NHS Greater Glasgow and Clyde

Welcome, Introductions and Apologies

1. The Chair welcomed everyone to the meeting and apologies were noted.

Minutes of Previous Meeting

2. Comments/corrections were made on 4 February 2020 meetings..

Action: The Secretariat will recirculate amended 4 February 2020 minutes.

Actions/Matters Arising

3. Picking up on a discussion point in the 4 February meeting, there was a discussion around the specific processes around death certification and communication. It was noted that it was not clear within the group what the key communication 'points' were/should be in that process with patients/families, and there would be value in reviewing these to ensure they served the needs of families as well as they could.

Action: Craig and Jen will review the various processes relating to communication with parents following a child's death, including those relating to death certification. Craig will circulate questions previously raised to inform this work which relates to a broader range of processes and scenarios.

4. A general discussion was held on whether the Sub Group was at a point in its deliberations where it could communicate those areas within the wider set of escalation issues in communications and engagement where NHS GGC was doing well and where specific improvements could be identified. It was recognised that the Board had already identified learning from the handling of incidents, as set out in their presentation on the communication strategy and the 2018 incidents at the 4 February meeting. It was also noted that the Sub Group should aim to identify relevant learning nationally as well as for the Board.

5. It was agreed that there would be value in a 'distillation' of what went well and emerging findings from the Sub Group's work to date (as well as the Chair's experience in supporting the communications of NHS GGC with families), which could be presented at the next meeting. This discussion effectively continued (and concluded) the curtailed discussion on communications strategy from 4 February meeting.

Action: Craig will draft a note on emerging findings of the Sub Group for discussion, with an initial discussion at the next meeting of the Sub Group.

6. It was noted that there would be value in a comprehensive, single timeline of the relevant incidents for the Sub Group. It was also noted that work was being commissioned to undertake this in the Infection Prevention & Control and Governance (IPCG) Sub Group, and that this would be shared with the Communications and Engagement Sub Group at the earliest opportunity.

Action: Timeline work for the IPCG Sub Group would be shared with the Sub Group as soon as it was available.

Duty of Candour

7. Andy spoke to his paper on the application of the organisational duty of candour by the Board in the circumstances of these infection incidents, which had been distributed in advance. The following was noted.

- It was confirmed that in relation to infection incidents (ie. any gram-negative bloodstream infections from 1 April to 31 December 2018) the organisational duty of candour procedure was not considered appropriate and had not been activated.
- There is a known, and significant, risk of infection arising from both condition and treatment, which is subject to consent-to-treatment procedures, and, therefore, it was felt that this would not meet the description of 'unexpected' incidents in the Act.
- The continued uncertainty over the relationship between the occurrence of infection and environmental factors – which might form the basis of recognising an incident as defined in the regulations – did not make it obvious as to how the duty of candour would apply.
- It was also felt that the benefit of applying the duty of candour procedures in terms of any added benefit to communication was recognised as uncertain.
- In reviewing how the organisational duty of candour provisions were applied by NHS GGC in these incidents, the Board had consulted a number of other

Boards to confirm that they would have acted similarly in considering how Duty of Candour applies to a range of different scenarios in which infection occurred.

- NHS GGC suggested that there was a need for national consideration and learning around how the organisational duty of candour could be developed form reflections on the these circumstances.

8. In the discussion that followed, a number of points were made.

- Craig highlighted the need to consider incidents beyond the occurrence of infections specifically given the context and impact on children and their families.
- There were questions over whether application of the organisational duty of candour procedure in these circumstances might have prevented the breakdown of some relationships between families and NHS GGC given the continuing feelings among some individuals that there were questions had not been fully resolved.
- Andy queried to whether a retrospective application of the duty of candour procedure would be of assistance for the 14 families who remain aggrieved.
- It was observed that there might be circumstances in which an organisation would helpfully decide to apply the organisational duty of candour procedure at various points, particularly when new information became available.
- It was recognised that each Board's primary objective was to create and maintain a person-centred relationship, which was critically important when people had been harmed as a result healthcare.

Action: Angela, Andrew and Andy will meet to discuss the questions raised through their review of policy and procedure, with a view to providing an update for the next meeting.

Actions

i. The Secretariat will recirculate amended 4 February 2020 minutes.
ii. Craig and Jen will review the steps taken in the process of securing a death certificate and report back to the Sub Group.
iii. Craig will draft a note on emerging findings of the Sub Group for discussion, with an initial discussion at the next meeting of the Sub Group.
iv. Timeline work for the IPCG Sub Group would be shared with the Sub Group as soon as it was available.
v. Angela, Andrew and Andy will meet to discuss the questions raised through their review of policy and procedure, with a view to providing an update for the next meeting.

Date of Next Meeting

9. The next meeting will be 3 March 2020.

DRAFT

Communication and Engagement Sub Group
NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital
Oversight Group
Meeting: 3 March 2020

Attendees

Professor C White, Scottish Government (Chair)
L Cleland, NHS Healthcare Improvement Scotland
Professor J Cuddihy, Families representative
A Moore, NHS Healthcare Improvement Scotland
A Wallace, NHS Forth Valley/NHS Greater Glasgow and Clyde
S Bustillo, NHS Greater Glasgow and Clyde
J Rodgers, NHS Greater Glasgow and Clyde
E Vanhagen, NHS Greater Glasgow and Clyde
P Raines, Scottish Government
J Dryden, Scottish Government (Secretariat)

Apologies

S Aitkenhead, Scottish Government (Secondment)
J Duncan, NHS Tayside
S Hart, Scottish Government
Dr M Maguire, NHS Greater Glasgow and Clyde

Welcome, Introductions and Apologies

1. The Chair welcomed everyone to the meeting and apologies were noted.

Minutes of Previous Meeting

2. Comments/corrections were made on 18 February 2020 meetings

Action: The Secretariat will recirculate amended 18 February 2020 minutes.

Subgroup Stocktake: Discussion of Emerging Findings

3. Craig led an open discussion on the emerging findings and tentative conclusions of the Subgroup in its work to date. It was noted that the discussion would inform development of a 'stocktake' paper that would be brought for discussion at the next meeting of the Subgroup, and support the Oversight Board's own stocktake work, which is operating in parallel. The following note captures the key discussion points.

4. The key themes/headings were:
- communications and engagement with individuals;
- communication and engagement with the public; and
- the organisational duty of candour.

The group was asked to reflect on what worked well, and where there could be learning and improvement (both for NHS GGC as well as nationally).

Communications and engagement with individuals

5. What worked well:

- *Integration at point of care*: there was recognition of the effectiveness and sensitivity of communications at ward level, particularly in how highly person-centred it was to reflect individual patients' and families' circumstances. Communications with the clinical and medical staff has been highly regarded throughout this process.
- *Establishing new mechanisms for communication*: there was evidence of good learning to address the challenges of maintaining complex and often prolonged communications with families. Establishing the closed Facebook page for families was viewed positively in this context, although it was emphasised that key to its value is the responsiveness of NHS GGC to issues raised by families.
- *Evidence of compassion, care and support of the management team*: the focus and urgency with which the senior management team gave to communications on this issue has been evident across this process, although their involvement was not always as strongly communicated as might have been done or indeed that this leadership on the issue was experienced by families as it should have been.

6. What could benefit from learning and improvement:

- *Improved content of mechanisms of support/information for families*: families had noted that their questions were not all timeously or fully addressed, not least in the closed Facebook page.
- *Consistency of positively received action with all, particularly with respect to wider service and with respect to historical service issues*: not all the communications were as effective as more direct ward communications, particularly for patients and families not currently engaged with the service and where engagement was historical and where reflections have acknowledged several missed opportunities. They were sometimes characterised as being overly defensive. It was acknowledged that a key challenge facing the Board was how to communicate on a complex issue where uncertainty was prolonged – notably the source of infections – with individuals who were no longer in regular contact with the service.
- *Timeliness of some communication, which could often be more 'reactive' than 'proactive'*: communications were sometimes seen as lagging, responding 'late' to stories and issues that were circulating without official NHS GGC comment for an extended period.
- *How connected corporate messaging was*: communications did not always reflect actions or work across the organisation.
- *How well integrated were estates/facilities functions into communications and engagement*: it was noted that key messages, especially when delivered directly on wards, could have sometimes benefited from a more joined-up approach of IPC and facilities/environment personnel.

- *The strength and consistency of compassion and transparency in the tone of written communications*: there was seen to have been variation in the 'person-centredness' of the communications by the organisation..
- *Value of new mechanisms to capture information on communications preferences*: the development of the specially-commissioned database facilitating improved engagement with concerned families and how they preferred to be contacted was cited as a good example of learning in the face of the challenges faced by the Board. It was suggested that this tool could be supplemented by enhancing the existing family 'induction' packs with clear information on where families could go for information about continuing issues such as the infection incident(s). Further work was identified to find effective ways of supporting coordination and communication of the various ways in which families can raise and have their questions (about point of care or wider organisational issues) responded to.

Communications and engagement with the public

7. What worked well:

- *Senior engagement*: the focus of senior management on the issue was acknowledged, but the importance placed on the issue was not always communicated more widely and effectively.
- *Focus on reputation, though framed in a particular way*: communications reflected the importance of consideration impact of this.
- *Management focus on service provision/business continuity maintained*: despite the 'crisis management' that continued for some time, the focus on providing a high-quality service was never lost.
- *Staff impact and wellbeing considered*: the impact of the media 'storms' on staff was understood and acted upon within the Board.

8. What could benefit from learning and improvement:

- *Need for a range of methods for communicating*: it was acknowledged that a range of channels and voices for communicating by the Board was important. In particular, it was suggested that clinical voices should be deployed in messaging more often, and if there were skills/training issues about expertise and confidence in media engagement, the Board should address these. Having a visible face and clear leadership in communications was vital.
- *Clarity of narrative in corporate responses*: the consistency of the information and messages across different levels of the organisation was not always evident across the period.
- *Consistency of compassionate, person-centred tone in communications*: again, communications did not always demonstrate a clear, person-centred tone in addressing such sensitive issues among families. The willingness to recognise the nature of concerns, apologise for their impact and take decisive action in the face of unknown issues – such as the decision to de-cant Wards 2A and 2B – would have strengthened some of the communications effort and reduce the mistrust that appeared to build.
- *Impact of social media*: the role of social media as an accelerator and echo chamber for messages was not initially well understood, and difficult to adjust to. Developing better and more rapid responses to fast-moving

communications messages was recognised as an emerging need for Board communications activity.

- *Challenge of maintaining communications in 'slowburn crisis' scenario*: the gradual unfolding of the issue, with the emergence of hypotheses relating to the environment of the QEUH that could not be quickly verified or discounted, presented a particular set of difficulties in communications. It was agreed that the IMT process, while useful in more boundaried, incident-based situations, was less effective for a continuing 'crisis' where a number of incidents were linked together in media terms. A new process may need to be identified to address this (and applied nationally, as well as locally to the Board).
- *Challenge of maintaining communications where ambiguity is high*: related to the point above, the demand for clear answers and causation in the media – and indeed, at times politically – jarred with the necessary uncertainty as the Board was trying to understand the source of a complex, and at times, resolutely unsolvable set of issues. This was more difficult to deal with given concerns about competing considerations of confidentiality and transparency.
- *External support and positioning around Board communications*: the role and coordination of messaging by external bodies, particularly NHS Health Protection Scotland (HPS) and the Scottish Government, was not always clear during the period.

<u>Organisational duty of candour</u>

9. The duty of candour discussion had not been concluded at the previous meeting, and it was recognised that there was additional work by Andrew, Angela and Andy Crawford to better understand the application of the duty in NHS GGC. Nevertheless, discussion identified a few key points, which was supplemented by the minute of 18 February Subgroup meeting and the original discussion on the duty of candour.

10. What worked well:

- The duty was actively considered during the period, although it was not formerly activated for any of the instances of infection within the paediatric haemato-oncology service.

11. What could benefit from learning and improvement:

- While implementation of the duty in these circumstances has particular challenges, it is clear that the legislation does not require a view on causation to be determined in deciding whether to activate the duty (though this appears to have been a situation).
- Ensuring that the possibility that an event or incident could result in harm is given full consideration.
- Actual or potential harm outcomes are not restricted solely to patient safety events and physical harm.

Ongoing activity

12. As part of the discussion, continuing and commissioned actions for the Subgroup were noted. They include the following.

- Jen and Craig are to explore the process of communication and supportive care around a child's death (taking account of decision-making and links with external agencies such as COPFS).
- Andrew, Angela and Andy Crawford are to further review the NHS GGC application of the duty of candour.
- Further work was identified around developing a process within Boards to address 'slow major incidents'.
- The role of key external bodies – such as NHS HPS and the Scottish Government – should be reviewed to make their responsibilities in these incidents more clear.

Action: Craig/Secretariat will produce a note of the meeting and a draft of a paper that captures the emerging findings and tentative recommendations for discussion at the next meeting of the Subgroup.

Updating the NHS GGC Healthcare Associated Infection Communications Strategy

13. It was noted that the proposed updating of the Board's communications strategy in Healthcare Associated Infections would offer an opportunity to mainstream key recommendations coming from the Oversight Board. It was agreed that Sandra and Phil would liaise to explore the value and options of updating.

Action: Sandra and Phil to agree options for updating the HAI communications strategy for the Board.

Actions

i. The Secretariat will recirculate amended 18 February 2020 minutes.
ii. Craig/Secretariat will produce a note of the meeting and a draft of a paper that captures the emerging findings and tentative recommendations.
iii. Sandra and Phil to explore the value and options of updating the HAI communications strategy for the Board.

Date of Next Meeting

14. The next meeting will be in the week beginning 3 March 2020.

DRAFT

QEUH Oversight Board – Communications & Engagement Subgroup meeting Wednesday 1st of July 2020

Attendees
Craig White (CW) – Chair, Scottish Government
John Cuddihy (JC) – Families representative
Lynsey Cleland (LC) – HIS
Angela Wallace (AW) – NHS Forth Valley/GGC
Suzi Mair (SM) – Scottish Government Communications
Margaret Mcguire (MMG) – NHS GGC
Elaine Vanhegan (EV) – NHS GGC
Jennifer Rodgers (JR) – NHS GGC
Sandra Bustillo (SB) – NHS GGC
Phil Raines (PR) – QEUH team, Scottish Government
Carole Campariol-Scott (CC-S) – QEUH team, Scottish Government

Apologies
Jane Duncan
Andrew Moore

Welcome and Purpose of the meeting
CW explained the meeting was requested to discuss NHS GGC's response to the BBC Disclosure programme last week as well as the publication of the QEUH Independent Review report, in particular issues raised by some of the families on the closed Facebook page. In advance of the meeting, JC had compiled a series of questions by families arising from these events on which answers were sought.

CW noted that the responses to the questions would be covered by a number of individuals – for example, those about the Independent Review were better addressed through the process he agreed with the Co-Chairs – and that some of those issues were already covered within the remit of the Communications & Engagement Subgroup. CW and PR committed to ensuring that JC received a response on how the questions would be answered, and to forward questions relevant to the Review and the Public Inquiry.

The meeting was also an opportunity for the group to provide further feedback and suggest anything to go into the Subgroup's draft summary final report that had not already been covered, in the light of the programme and subsequent queries from families on the closed Facebook page.

CW asked MMG to speak as per her request.

MMG apologised on behalf of NHS GGC and said that on reflection as a Board, they should have handled the enquiries differently. She made the following points:

- NHS GGC were not aware of the context of the programme and were only informed 2 hours prior to the programme starting about who had been invited to speak. NHS GGC were not aware that the whistle blowers would be involved.

- MMG explained the legal context in which NHS GGC find themselves. They are constrained to a legal statement. This was done in communications with the SG.
- NHS GGC could have replied differently on hindsight and not leave it to the nurse on the ward at the time to handle the queries. A statement should have been issued early on Thursday morning, but there were a number of unfortunate complications to issuing the statement. It was recognised that the lack of communication at this sensitive point was not in keeping with the commitment to timeliness. MMG also stressed that there was no intention to 'hide' anything but admitted that the outcome had caused distress to the families.

MMG confirmed that going forward, she intends to be named as the Board level contact for families.

JC was invited to speak and made the following points:

- 88 questions were received on the Facebook page which JC sent to CW and PR. The questions cover a number of issues relating to the work of the Oversight Board, the Case Note Review, the Independent Review and NHS GGC directly.
- JC criticised NHS GGC's handling of both the responses to the programme and to the families; it had repercussions on the way the C&E Subgroup would be perceived and had led to its credibility and trust questioned by the parents. There were particular issues relating to: not offering a member of Board's senior management team to address the points raised; the Board's apparent refusal to address the issues and allegations raised by the programme (because of the pending legal case), feeding suspicions that there was information being withheld from the families; and the slowness with which responses were being provided at such a heightened time.
- JC reiterated that he would look to NHS GGC to uphold what had been agreed across the Subgroup meetings and focus on collective discussions which had to be open and transparent, with the Subgroup acting as a proactive element for improvement of communications with the families.
- He acknowledged the contrition showed in the Subgroup, but did not feel that apologies and admissions that mistakes had been made would compensate for the recurrence of such mistakes over time. The 'pattern' of behaviour was devaluing these apologies and promises of responding better in future.
- The final paper of the Subgroup should focus on accountability, transparency and timeliness, all issues that were raised by the Board's response.

<u>Actions</u>

- **The Group agreed the C&E Subgroup summary final report should make it clear who is best placed to communicate messages and have the right individual to answer the right question, while bearing in mind timing of communications. CW and PR will review the paper in light of the discussion at this meeting.**
- **CW and PR will provide JC with a clear response on how the questions raised by the families will be answered, and share this with the group.**

A few other points were made in discussion:

- While there were limits to how much the health Board could respond to due to the legal case, a difficult situation could start to emerge. If taken too far, this could be perceived as a silence that could compromise the Subgroup's commitment to person-centred and open engagement. JC warned that families may become disenchanted with the processes of engagement and explore individual routes of redress, including legal.
- LC added that there is a need to reflect on what needs to be done as a group for next steps focussing on families' trust and their feeling they are not being listened to.
- SB added while there was a process to respond to the questions from the BBC programme, she recognised that both the statement and the questions should have been shared with JC prior to the programme being aired.
- JR added that she recognised communications needed to be better with parents on the Facebook group.

Actions

- **C&E subgroup summary final report should set out concrete recommendations on what needs/ has to change, acting as directives to NHS GGC and meet the level 4 requirements. These recommendations will make clear how, when the learning is embedded, it will make a difference. They will likely be supported by a scrutiny and review process which will require some reporting on how NHS GGC ensures the application of the recommendations materialises in actions which have led to a concrete, long-term change.**

INTERIM REPORT

The Queen Elizabeth University Hospital/ NHS Greater Glasgow and Clyde Oversight Board

Progress

Findings

December 2020

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Summary: Interim Report Recommendations

This Interim Report sets out the initial findings and recommendations developed to date through the NHS Greater Glasgow and Clyde (GGC) Oversight Board's programme of work in response to the infection issues affecting the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children between 2015 and 2019. It summarises the work on investigation, dialogue and improvement from the Oversight Board's establishment in December 2019 to October 2020, and looks ahead to its remaining work and the Final Report, expected in early 2021. It captures progress and early conclusions.

The Oversight Board was put in place by the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland in November 2019. This was done to address critical issues relating to the operation of infection prevention and control, governance, and communication and engagement with respect to the Queen Elizabeth University Hospital and the handling of infection incidents affecting children, young people and their families within the paediatric haemato-oncology service. The Oversight Board was a direct consequence of the escalation of the Health Board to Stage 4 of NHS Scotland's national performance framework.

The Oversight Board consists of a group of experts and key representatives drawn from other Health Boards, the Scottish Government and the affected families themselves. Chaired by Scotland's Chief Nursing Officer, Professor Fiona McQueen, the work of the Board was carried out principally through three Subgroups: Infection Prevention and Control and Governance; Technical Issues; and Communication and Engagement. Overall, the Oversight Board has been focused on assurance of current systems and reviewing the historical issues that gave rise to escalation.

In addition, an independent Case Note Review has been established to examine the individual incidents of infection among the children and young people. This report is being overseen by an Expert Panel that will be reporting in early 2021. Its findings and recommendations will inform the Oversight Board's Final Report.

This is an Interim Report; it does not provide the final summation of the Oversight Board's work, as some key activity – such as the Case Note Review – is continuing. Consequently, this report sets out the Oversight Board's views on several (but not all) of the issues that led to escalation, and the work that remains to be done to provide assurance to Ministers and to the affected families, children and young people. It has also drawn out the wider lessons for national improvement.

Overall, the Oversight Board endorses the changes that have been introduced by NHS GGC in these areas, and welcomes its commitment to improvement. The Interim Report recommendations aim to support that continuing work, and their implementation should be integrated as far as possible into this programme of work. The recommendations are summarised below under the relevant key sets of escalation issues.

Infection Prevention and Control: Processes, Systems and Approach to Improvement

The Interim Report covers the following selected areas of Infection Prevention and Control (IPC):

- the degree to which specific IPC processes in the QEUH have been aligned with national standards and good practice; and
- the extent to which the IPC Team has demonstrated a sustained commitment to improvement in infection management across the Health Board.

It notes the improvement work already undertaken by the Health Board and sets out areas where further action is required to restore assurance.

The Final Report will set out findings and recommendations for the remaining IPC issues, particularly: IPC governance; the responsiveness of the Health Board's IPC to the infection incidents; how staff have worked together in support of IPC; and the way in which leadership has been organised for IPC.

Local recommendations

- With the support of ARHAI Scotland and Healthcare Improvement Scotland, NHS GGC should undertake a wide-ranging programme to benchmark key IPC processes. Particular attention should be given to the approach to IPC audits, surveillance and the use of Healthcare Infection Incident Assessment Tools (HIIATs).
- With the support of ARHAI Scotland, NHS GGC should review its local translation of national guidance (especially the National Infection Prevention and Control Manual) and its set of Standard Operating Procedures to avoid any confusion about the clarity and primacy of national standards.
- With the support of Health Facilities Scotland, NHS GGC should undertake a review of current Healthcare Associated Infection Systems for Controlling Risk in the Build Environment (HAI-SCRIBE) practice to ensure conformity with relevant national guidance.
- A NHS GGC-wide improvement collaborative for IPC should be taken forward that prioritises addressing environmental infection risks and ensuring that IPC is less siloed across the Health Board.

National recommendations

- ARHAI Scotland should review the National Infection Prevention and Control Manual in light of the QEUH infection incidents.
- Health Facilities Scotland should lead a programme of work to provide greater consistency and good practice across all Health Boards with respect to the use of HAI-SCRIBE.
- ARHAI Scotland should review the existing national surveillance programme with a view to ensuring there is a sustained programme of quality improvement training for IPC Teams in each Health Board, not least with respect to surveillance and environmental infection issues.

- ARHAI Scotland should lead on work to develop clearer guidance and practice on how HIIAT assessments should be undertaken for the whole of NHS Scotland.

Communication and Engagement

Recommendations are set out below with respect to the overarching question considered by the Oversight Board: *is communication and engagement by NHS GGC adequate to address the needs of the children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?* The Oversight Board acknowledged the improvements that have been made to date, but notes that more needs to be done to address the issues that gave rise to escalation.

Further work is being undertaken on other key aspects of engagement with patients and families, particularly processes of review by the Health Board and how they were applied in the instances of these infections. Consequently, issues relating to the organisational duty of candour and review processes such as Significant Adverse Event Reviews will be addressed in the Final Report.

Local recommendations

- NHS GGC should pursue more active and open transparency by reviewing how it has engaged with the children, young people and families affected by the incidents, in line with the person-centred principles of its communication strategies. That review should include close involvement of the patients and families themselves.
- NHS GGC should ensure that the recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy and an accompanying work programme for the Health Board.
- NHS GGC should make sure that there is a systematic, collaborative and consultative approach in place for taking forward communication and engagement with patients and families. Co-production should be pursued in learning from the experience of these infection incidents.
- NHS GGC should embed the value of early, visible and decisive senior leadership in its communication and engagement efforts and, in so doing, more clearly demonstrate a leadership narrative that reflects this strategic intent.
- NHS GGC should review and take action to ensure that staff can be open about what is happening and discuss patient safety events promptly, fully and compassionately.

National recommendations

- The experience of NHS GGC should inform how all of NHS Scotland can improve communication with patients and families 'outside' hospitals in relation to infection incidents.
- The experience of NHS GGC in systematically eliciting and acting on people's personal preferences, needs and wishes as part of the management of communication in these infection incidents should be shared more widely across NHS Scotland.
- NHS GGC should learn from other Health Boards' good practice in addressing the demand for speedier communication in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.
- The Scottish Government, with Healthcare Improvement Scotland and ARHAI Scotland, should review the external support for communication to Health Boards facing similar intensive media events.

Introduction

1. In November 2019, NHS Greater Glasgow and Clyde (NHS GGC) was escalated to Stage 4 of NHS Scotland's National Performance Framework as a result of a continuing series of infection incidents at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). The Cabinet Secretary for Health and Sport's letter[1] to the Scottish Parliament's Health and Sport Committee stated:

> *"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."*

An Oversight Board was established by the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland to address critical issues arising from the operation of infection prevention and control (IPC), governance, and communication and engagement at the QEUH and the RHC.

2. The following Interim Report sets out the findings and recommendations that have been developed to date by this Oversight Board. The report summarises the work on investigation, dialogue and improvement from the Oversight Board's establishment in December 2019 through to October 2020. A Final Report – capturing the results of its remaining programme of work – is due in early 2021.

3. The Oversight Board consists of a group of experts and key representatives drawn from other Health Boards, the Scottish Government and the affected families themselves (full membership is set out in **Annex A**). Chaired by Scotland's Chief Nursing Officer, Professor Fiona McQueen, the work of the Board has been principally carried out through three Subgroups, each focusing on a specific set of issues.

- **Infection Prevention and Control and Governance**: this Subgroup has examined whether or not appropriate IPC processes, systems and governance were (and are currently) in place across NHS GGC and what recommendations are needed to strengthen these. It was chaired initially by Irene Barkby MBE (Executive Director of Nursing, Midwifery and Allied Health Professionals in NHS Lanarkshire), and latterly by Scotland's Deputy Chief Nursing Officer, Diane Murray.
- **Technical Issues**: this Subgroup has focused on relevant specific elements of the technical workings of the hospitals in question, with a particular focus on infrastructure issues. It has been chaired by Alan Morrison, Deputy Director for Health Infrastructure in the Scottish Government.

[1] Update on NHS Greater Glasgow and Clyde - gov.scot (www.gov.scot).

- **Communication and Engagement**: this Subgroup has considered the operation of effective communication with the children, young people and families affected by the infection incidents, as well as whether a wider, robust, consistent and reliable person-centred approach to engagement has been evident. In addition, it is examining the organisational duty of candour and other key review processes, such as the Significant Adverse Event Review policy. It has been chaired by Professor Craig White, Divisional Clinical Lead in the Healthcare Quality and Improvement Directorate of the Scottish Government.

The Terms of Reference for the Oversight Board and its supporting Subgroups are presented in **Annex A**.

4. The Oversight Board and the Subgroups have been aided by a number of special reports commissioned to examine specific issues relating to NHS GGC. Of particular importance for this Interim Report is the **Peer Review of IPC**: led by Lesley Shepherd (national professional advisor to the Scottish Government) and Frances Lafferty (Senior Infection Control Nurse in NHS Ayrshire and Arran), this examined key IPC systems and processes in NHS GGC and how national policy on IPC has been implemented. Its terms of reference are set out in **Annex B**.

5. Lastly, the work of the Oversight Board was supported by several key individuals appointed to work alongside and within NHS GGC on improvement:

- Professor Marion Bain (Deputy Chief Medical Officer, Scottish Government), who was appointed as the Executive Lead for Healthcare Associated Infection within NHS GGC in December 2019 to set the strategic direction for IPC improvement;
- Professor Angela Wallace (Nurse Director, NHS Forth Valley), who was appointed in February 2020 to work with and succeed Professor Bain as the Health Board's Interim Operational Director for IPC; and
- Professor Craig White, who was appointed by the Cabinet Secretary for Health and Sport in October 2019 to work with the families to address communication issues within NHS GGC (and subsequently, to chair the Communication and Engagement Subgroup).

Their insights informed the Oversight Board's conclusions and their work to date will be set out here and in the Final Report.

6. In parallel, the Cabinet Secretary for Health and Sport commissioned a **Case Note Review** in her statement to Parliament on 28 January 2020. The Case Note Review is examining the individual case documents of the children and young people in the haemato-oncology service from 2015 to 2019 who had a gram-negative environmental pathogen bacteraemia and/or selected other organisms. It is overseen by Professor Marion Bain and a panel of independent external experts led by Professor Mike Stevens (Emeritus Professor of Paediatric Oncology at the University of Bristol). The work of the Case Note Review is continuing and so does not form part of this Interim Report, though there is an update on progress. It is expected to report in early 2021, and its conclusions will be included in the Oversight Board's Final Report.

7. In addition, the Oversight Board has acted alongside to, though separate from the **Independent Review**. On 5 March 2019, Dr Andrew Fraser and Dr Brian Montgomery were appointed by the Cabinet Secretary for Health and Sport to lead an Independent Review with the aim of: "*establish[ing] whether the design, build, commissioning and maintenance of the QEUH and the RHC has had an adverse impact on the risk of Healthcare Associated Infection and whether there is wider learning for NHS Scotland*." The Independent Review's report was published on 15 June 2020.[2] At various points in this Interim Report, the Oversight Board references issues that have been addressed by the Independent Review, but the latter's report is independent of the work of the Oversight Board. NHS GGC and the Scottish Government have both acknowledged the Independent Review's report and are planning action in response to the recommendations.

8. As with other aspects of public sector activity, the Covid-19 pandemic has proven disruptive to the Oversight Board. From mid-March 2020 onwards, it was not possible to hold regular meetings, as many of its members had vital roles in the NHS Scotland response to the pandemic. This delayed the final stages of the Oversight Board's programme, but it did not substantively alter what was done to reach the findings and recommendations set out here.

9. Following this introduction, the Interim Report consists of several sections:

- **Background and approach**: the context for the establishment of the Oversight Board and the infection issues within the QEUH and the RHC and the way the Oversight Board has been taking forward its work;
- **Infection prevention and control**: a review of the issues that gave rise to escalation to Stage 4, particularly the processes/systems and approach to improvement of IPC in NHS GGC, as well as a description of the remaining work for the Final Report;
- **Governance and risk management**: the full findings on IPC governance will be made in the Final Report, but an update on the work is provided here;
- **Technical review**: the full findings on the technical review will be set out in the Final Report, but a progress update is provided here;
- **Communication and engagement**: a review of the way in which the Health Board communicated and engaged with patients and families and an update on the work to be done for the Final Report;
- **Case Note Review**: an update on progress of this independent examination of the individual children and young people and infection incidents; and
- **Interim Report findings and recommendations**: the findings and initial Oversight Board recommendations of this Interim Report.

10. In addition, there are several annexes:

A. the terms of reference for the Oversight Board and its Subgroups;

B. the terms of reference for the IPC Peer Review;

[2] https://www.queenelizabethhospitalreview.scot/queen-elizabeth-university-hospital-review-review-report/.

C. the stages of escalation in the NHS Scotland Board Performance Escalation Framework; and

D. the Key Success Indicators identified by the Oversight Board

Background and Approach

Context for Escalation

11. On 22 November 2019, the decision was taken by Malcolm Wright, Director-General for Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland, to escalate NHS GGC to Stage 4 of the NHS Scotland Board Performance Escalation Framework. In a statement about the establishment of the Oversight Board, the Cabinet Secretary for Health and Sport, Jeane Freeman, said:

> "*Families deserve to have confidence that the places they take their children to be cared for are as safe as they possibly can be. That means their engagement with their Health Board must be open, honest, and rooted in evidence. This is even more important in the tragic circumstances where a child's life is lost. It is, in my view, simply cruel for the grief of a parent to be compounded by a lack of clear answers… I want now to set out the action and steps we are taking to give parents, families and patients the answers they legitimately seek and to, step by step ensure that we are working on evidenced data, putting in place all the required infection prevention and control measures and by doing so secure the confidence of clinical teams, patients and families*."

12. Escalation came against a background of a series of infection issues affecting children and young people in the paediatric haemato-oncology service at the QEUH and the RHC over a number of years. A handful of cases of children and young people with infections occurred in 2016 and 2017, but concerns mounted between January and September 2018 when the number and diversity of type of infections increased. According to Health Protection Scotland (HPS), there were at least 23 cases, involving 11 different organisms. Water testing in Ward 2A in 2018 identified contamination of water outlets and drains, and as a result, control measures were put in place, including sanitisation of the water supply to Ward 2A and installation of point-of-use filters in wash hand basins and showers. Despite these measures, concerns remained and in September 2018, more drastic steps were taken when Wards 2A and 2B in the RHC were closed and the children and young people were moved to the main QEUH building. Concerns about the water supply led to installation of an enhanced water-testing regime and a chlorine dioxide dosing system, first operating across the RHC in late 2018, then the QEUH in 2019.

13. An additional series of infections in 2019 in Ward 6A in the QEUH heightened concerns, and eventually led to the temporary closure of that ward to new patient admissions. Media reports claimed several deaths of patients were linked to infection in the hospital, raising further concerns among patients and families about safety. There was increasing dissatisfaction among some families at the level and quality of communication by NHS GGC throughout this period, leading to the appointment of Professor Craig White by the Cabinet Secretary for Health and Sport in October 2019 as a lead contact and facilitator for the families. In addition, internal NHS GGC reports came to light that suggested that some of the problems with the QEUH site had been identified as early as 2015, but did not appear to have been acted upon at the time (although they were at a later stage).

14. This occurred against a background of concerns that had been consistently raised by several clinicians at the QEUH about the potential environmental risks of the building and the link to emerging infections. Some of these concerns dated back to the period of the completion and handover of the new building. Some of the clinicians did not feel that their concerns – particularly about water and ventilation and the risk of their contribution to infection of such a vulnerable patient population – were being effectively addressed, and in some cases, formal whistleblowing procedures were triggered. These issues were raised in correspondence with the Cabinet Secretary for Health and Sport and featured in evidence submitted to the Scottish Parliament's Health and Sport Committee. The Oversight Board has reviewed this evidence.

15. Finally, there were a number of relevant reports by external bodies over the period that underlined these various concerns. This included the report commissioned by the Chief Nursing Officer and undertaken by HPS, which was invited to examine the infection incidents by the Health Board. Its report – *Queen Elizabeth University Hospital/Royal Hospital for Children: Water Contamination Incident*[3] – was published in February 2019. As well as setting out a number of recommendations for NHS GGC and for national action, the report recognised that the environmental risks of the hospital could not be discounted.

16. Escalation of NHS GGC to Stage 4 was set within the procedure for assessing NHS Board performance. The NHS Scotland Board Performance Escalation Framework lays out the triggers and actions when Health Boards are unable or hindered in taking forward their essential responsibilities. The Framework outlines a guide to inform action, and what steps are needed following the decision to escalate, depend on the 'stage' on the framework. Stage 5 is the most serious stage; Stage 4 is defined as "*significant risks to delivery, quality, financial performance or safety, (and) senior level external transformational support (is) required*." It is applied where the Scottish Government believes that a Health Board's capacity or capability requires enhancement to address local issues, and additional direct management or transformation support may be required. **Annex C** describes the five stages of escalation.

17. The decision to move a Health Board to Stage 4 is made on the advice of the Health and Social Care Management Board of the Scottish Government. In the case of escalation to Stage 4, consideration of the Health Board's position within the Escalation Framework would normally be prompted by the identification of significant weaknesses in particular areas considered to pose an acute risk to the following issues: financial sustainability; reputation; governance; and quality of care or patient safety (or in some cases, by a Health Board failing to deliver on the recovery actions agreed at Stage 3).

18. Action typically takes the form of a transformation team led by a Scottish Government Director, Board Chief Executive or other responsible person appointed by the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland to support the delivery of

[3] https://www.gov.scot/publications/qe-university-hospital-royal-hospital-children-water-incident/.

sustainable transformation. The Health Board Chief Executive continues to act as Accountable Officer and be responsible for matters of resource allocation to deliver any transformation plan. The Board Chief Executive and the executive team are expected to work in conjunction with the appointed transformation Director to construct required plans and take full responsibility for delivery.

19. In the case of the escalation of NHS GGC to Stage 4, the transformation Director is Professor Fiona McQueen, the Chief Nursing Officer for Scotland. She has been supported in the programme of transformation by the Oversight Board, and individuals appointed to work within and with NHS GGC, notably Professors Bain, Wallace and White.

20. In February 2020, NHS GGC was escalated again to Stage 4 for a range of issues *beyond* IPC, governance and communication and engagement; these included performance management on waiting times, the Board's out-of-hours service and financial matters. Work on these escalation issues is overseen by a separate Performance Oversight Group, chaired by John Connaghan (interim Chief Executive of NHS Scotland), thought it has had to suspend work as a result of the pandemic. Its programme of work has not informed this Interim Report, although the Oversight Board has been careful not to duplicate areas being covered more thoroughly by this companion group.

The NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital Oversight Board

21. The purpose of the NHS GGC/QEUH Oversight Board has been to ensure NHS GGC takes the necessary actions to restore and enhance public confidence in safe, accessible, high-quality, person-centred care at the QEUH and RHC with respect to the matters on which the Health Board was escalated. It will advise the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland when steps have been taken – as set out in the Cabinet Secretary's statement in November 2019 – to restore "*confidence that the places families take their children to be cared for are as safe as they possibly can be*." In particular, the Oversight Board aimed to:

i. ensure appropriate governance is in place in relation to infection prevention, management and control;

ii. strengthen practice to mitigate avoidable harms, particularly with respect to infection prevention, management and control;

iii. improve how families with children and young people being cared for or monitored by the haemato-oncology service have received relevant information and been engaged with;

iv. confirm that relevant environments at the QEUH and RHC are, and continue to be, safe;

v. oversee and consider recommendations for action further to the review of relevant cases, including cases of infection;

vi. provide oversight on connected issues that emerged;

vii. consider the lessons learned that could be applied across NHS Scotland; and

viii. provide advice to the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland and Scottish Ministers about the escalation status of NHS GGC.

22. This Interim Report sets out the Oversight Board's view on the Health Board's progress in addressing several (but not all) of the issues that led to escalation, and the work that remains to be done. This is a 'first phase' report; it does not give a final summation of the Oversight Board's activity and conclusions, which will come in the Final Report, and address the overarching questions posed about the Health Board's 'fitness for purpose' on these specific matters. In particular, the Oversight Board has not been able to conclude its work on point **v** in the list above, as the Case Note Review is vital to this, and the Review will not conclude its work until early next year. As a result, the Oversight Board will not examine individual cases or incidents, as these are being covered by the Case Note Review.

23. There are other areas the Oversight Board is not reviewing, particularly where they are being addressed by other processes. In particular, a full accounting of the issues around the building of the hospital is the responsibility of the **Hospitals Public Inquiry**. The Inquiry is chaired by the Right Honourable Lord Brodie QC PC. Its Terms of Reference have now been published[4] and the Inquiry has formally started. The Oversight Board is not pre-empting this work, but has necessarily covered similar territory in some instances as part of its own remit. It has done so with the intention of collecting sufficient evidence to take a view on assurance on NHS GGC's *current* systems, and thereby set out the actions that should be taken to achieve any necessary improvements.

24. Care has also been applied when considering issues raised as part of whistleblowing procedures, which have been activated by some clinicians within NHS GGC in relation to these infection incidents. Much of the substance of the issues raised has been necessary for the Oversight Board to review, and we are particularly thankful for the generous support and courage of those clinicians in raising them to the Cabinet Secretary and to the Scottish Parliament. It has been important that the Oversight Board's work does not cut across these whistleblowing processes, and for that reason, the Oversight Board does not offer a view on any specific internal matters directly relating to these procedures.

Key Working Relationships

25. The Oversight Board established three Subgroups with necessary experts and other participants, with the Scottish Government providing the Secretariat. It commissioned a number of key reports to support its programme of work. Overall, the Oversight Board met on nine occasions between December 2019 and March 2020, when meetings were temporarily suspended because of the Covid-19 pandemic. Further meetings took place in September and October to review all of

[4] https://www.gov.scot/publications/inquiry-into-the-construction-of-the-qeuh-glasgow-and-the-rhcyp-dcn-edinburgh-terms-of-reference/.

the relevant materials and agree the Interim Report. Each of the Subgroups had a similar calendar of meetings.

26. Relationships with key groups and communities have been vital for the work of the Oversight Board. This has been essential with respect to the families affected by the infections. Representatives of the families have been part of the Oversight Board itself (and the Communication and Engagement Subgroup in particular). In addition, extensive use has been made of the 'closed' Facebook page (described in more detail in the Communication and Engagement chapter below) to update patients and families on the Oversight Board's progress. Professor Craig White provided a central communication role as historical and new concerns were raised during the course of this work.

27. The Oversight Board also established a positive and constructive relationship with NHS GGC – a critical element to ensure that there was joint investigation of relevant issues and common agreement on how to improve. NHS GGC has worked with the Oversight Board to develop and deliver improvement plans, working through the appointments of Professors Bain and Wallace. NHS GGC staff helped to source and provide a significant amount of information to support Oversight Board and Subgroup discussions, for which the Oversight Board has been particularly grateful. In this context, special mention should be made of the dedicated and highly responsive Programme Management Office set up in NHS GGC to coordinate participation of the Health Board and requests for information. The Programme Management Office offers a good model of how to coordinate and expedite the provision of information, analysis and engagement for such external review processes. Its work – and the support from relevant staff across the Health Board – has been significant, and should be particularly acknowledged in light of the huge health challenges during the pandemic.

28. NHS GGC staff took part in several meetings of the Oversight Board and its Subgroups as invited participants, although the Health Board representatives were not formally part of these groups. Provision was also made for private discussions by the Oversight Board and the Subgroups where appropriate. The findings and recommendations of this Interim Report are the Oversight Board's alone, though in several cases, they reflect and reinforce actions already being taken by the Health Board. Discussions have been held with the Health Board and extensive feedback provided on the development of the Interim Report.

Governing Principles

29. The work of review and direction in these circumstances can be highly challenging, and given the nature of the subject, sensitive and emotionally charged for the children, young people, families and staff involved. The Oversight Board has adopted a values-based approach, based on NHS Scotland values. These governed the behaviours of the Oversight Board, both individually and collectively to:

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

30. Above all, the Oversight Board has been focused on opportunities and requirements for improving existing systems and behaviours. While that needs an understanding of what has happened in the past and how processes operated at different points in the period since the opening of the QEUH, it has all been in the service of assessing the quality and impact of processes in place now. 'History' has been important in reflecting the NHS GGC's own capacity to learn lessons, make any necessary improvements and track the implementation and adequacy of those changes going forward. The Oversight Board has aimed to ensure that learning is captured and implemented locally as well as nationally. It has also highlighted improvements already put in place by the Health Board.

31. The work of the Oversight Board has largely related to a specific patient community within the QEUH, but its focus has widened where larger implications are important to acknowledge. For example, the problems with building the hospital and its links with IPC have potential consequences for other vulnerable patient groups across the site, so assurance has been sought that appropriate actions have been taken on the learning arising from what happened with the paediatric haemato-oncology service.

Priority Issues to Be Examined

32. The Oversight Board has concentrated primarily on structures and procedures and not specific individuals and isolated incidents. These have been central to its role of considering the extent to which assurance can be provided about the Health Board's capability and capacity to deliver on the key areas highlighted in escalation. For the Final Report, the Oversight Board will review the narrative of key milestones to understand the circumstances that gave rise to escalation and provide the essential context for an emerging, progressively more complex set of circumstances. For the key areas it was examining – IPC, governance, and communication and engagement – the Oversight Board set out what 'good looks like' through a set of key success indicators (the full set of indicators is described in **Annex D**). The aim has been to concentrate on a set of principles for each area that governed how the Oversight Board and its Subgroups pursued investigation and recommendation. These principles have been applied through a focus on a set of overarching questions:

- ***To what extent can the source of the infections be linked to the environment and what is the current environmental risk?***
- ***Are IPC functions 'fit for purpose' in NHS GGC, not least in light of any environmental risks?***
- ***Is the governance and risk management structure adequate to pick up and address infection risks?***
- ***Is communication and engagement by NHS GGC sufficient in addressing the needs of the children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?***

33. These questions are threaded through the issues considered in the Interim Report. This report does not make final conclusions on these questions, but a full assessment will be included in the Final Report. The questions also link the key areas that the Oversight Board has been tasked to review in the context of these infection incidents:

- **IPC**: the processes, structures, relationships and behaviours in place to ensure that there is effective identification of infections, management of outbreaks and incidents, and appropriate preventative and improvement work around these issues;
- **governance**: the framework and systems in place for the issues and risks associated with infections to be raised and actioned, and the assurance secured within the organisation's senior management that this is happening; and
- **communication and engagement**: how the issues and implications of incidents and outbreaks are communicated with the children, young people, families and the wider public in line with the person-centred principles of NHS Scotland.

34. The issues are inter-locking. Robust IPC procedures should highlight major issues and risks through the structure of governance and risk management. Strong governance will give clear direction and resourcing to IPC across the organisation and ensure a culture of transparency and responsiveness to patient, family and public concerns. Good communication and engagement should ensure that the decisions with governance and the actions taken forward through the IPC Team are clearly presented to those affected by them.

35. Each set of issues required dedicated assessments. For **IPC**, the Oversight Board considered NHS GGC practice in light of the infection incidents, focusing on the QEUH (and where appropriate, across the Board), with reference to two key principles, as set out in its key success indicators:

- *There is appropriate governance for infection prevention and control in place to provide assurance on the safe, effective and person-centred delivery of care and increase public confidence.*
- *The current approaches that are in place to mitigate avoidable harms, with respect to infection prevention and control, are sufficient to deliver safe, effective and person-centred care.*

36. Similarly, for **communication and engagement**, the key success indicators that the Oversight Board have used are that:

- *Families and children and young people within the haemato-oncology service receive relevant information and are engaged with in a manner that reflects the values of the NHS Scotland in full.*
- *Families and children and young people within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHS Scotland in full.*

The Oversight Board's findings and recommendations should be seen through the 'lens' of these key success indicators.

37. As noted above, the findings and recommendations will be reported across two reports: this Interim Report; and a final Report. Different issues relating to escalation will be covered by the Interim and Final Reports: the table below sets out what issues will be covered by which report. Each set of themes arose from continuing exploration of the escalation issues, an iterative process that led to the emergence of matters requiring investigation at different points in the work programme (as the Terms of Reference note: "*(to) provide oversight on connected issues that emerge*"). Throughout, the Oversight Board has been careful to ensure that it avoids duplication with other review processes, as outlined above.

Escalation issue	**What is covered in this Interim Report**	**What will be covered in the Final Report**
Infection prevention and control	• Assurance on a selection of IPC processes/systems in NHS GGC following Peer Review • Review of approach to improvement in IPC in NHS GGC • Findings and recommendations on the above set of issues	• Review of how the infection incidents were addressed by NHS GGC and wider mitigation/responses • Review of how different staff have worked together in support of IPC in the QEUH • Review of the organisation of IPC leadership • Findings and recommendations on the above set of issues and the overarching question of the 'fitness for purpose' of IPC within the Health Board
Governance	• Update on work IPC governance	• Review of how infection incidents were escalated and addressed by the NHS GGC governance structure • Assurance on how IPC issues are currently escalated and addressed within NHS GGC • Review of NHS GGC risk management in light of the infection incidents • Findings and recommendations on IPC governance issues, and the overarching question of the 'fitness for purpose' of IPC governance within the Health Board

Escalation issue	**What is covered in this Interim Report**	**What will be covered in the Final Report**
Related technical issues	• Update on refurbishment of Wards 2A/2B in the RHC	• Assurance on NHS GGC's water testing and safety policy in the RHC/QEUH • Assurance on plans to address any remedial works relating to infection arising from infrastructure issues on the QEUH site
Communication and engagement	• Review of how communication and engagement was undertaken by NHS GGC with the children, young people and families affected by the infection incidents – including findings and recommendations	• Review of how the Health Board engaged with families through formal review processes, notably the organisational duty of candour and the Significant Adverse Events Review policy for these infection incidents – including findings and recommendations
Case Note Review	• Update of the work of the Case Note Review	• Summary of findings and recommendations of the Case Note Review
Review of escalation to Stage 4		• Advice on whether/how de-escalation should take place

38. The Oversight Board is conducting its work through the review of key documentation and direct inquiry with NHS GGC involving the experts who took part in the Oversight Board and its Subgroups. For the Interim Report, evidence included:

- the papers and material presented by NHS GGC to the meetings, including minutes of the Board, relevant committees (such as the Board Infection Control Committee and the Clinical and Care Governance Committee) and Incident Management Teams (IMTs), relevant action plans, special presentations and 'situation, background, assessment, recommendation' papers (SBARs);
- material provided previously to the Cabinet Secretary for Health and Sport and the Health and Sport Committee of the Scottish Parliament by several clinicians;
- specially-commissioned, topic-specific SBARs from external experts and statements on specific issues, such as water testing and the progress of refurbishment of Wards 2A and 2B in the RHC; and
- key external documents, such as the Health Facilities Scotland (HFS) report, *Water Management Issues Technical Review: NHS Greater Glasgow and Clyde – Queen Elizabeth University Hospital and Royal Hospital for Children* (finalised March 2019), and 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 NHSScotland* (published February 2019).

39. There was no programme of comprehensive interviewing or evidence gathering from individuals and organisations, apart from what was undertaken for commissioned work such as the Peer Review described above. However, specific clarifying discussions were held with some QEUH clinicians that had previously raised concerns about the Health Board, representatives of the affected children, young people and families, and NHS GGC representatives throughout the Oversight Board's programme of work.

Infection Prevention and Control

40. Long before the recent incidents at the QEUH, IPC procedures in hospitals had been under a spotlight. Following an outbreak of *Clostridium difficile* infection at the Vale of Leven Hospital within NHS GGC, which led to the deaths of 34 patients, the Scottish Government established an Inquiry under Lord MacLean to investigate not just *C. difficile* infection, but all deaths at the hospital associated with this infection in the period between 1 December 2007 and 1 June 2008. Its final report was published in November 2014[5], and found, amongst other things, that:

- governance and management failures within NHS GGC had created an environment in which patient care was compromised and the approach to IPC was inadequate;
- there were significant deficiencies in IPC practices and systems which had had a profound impact on the care provided to patients in the hospital; and
- strong management was lacking, which contributed to a culture unsuited to a caring and compassionate hospital environment.

41. NHS GGC accepted the recommendations, which included the following of particular relevance to the Oversight Board's work (not all directed exclusively at the Health Board, but across NHS Scotland more widely):

- *In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment, should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular review s of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.*
- *In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.*
- *Health Boards should ensure that IPC policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart;*
- *Health Boards should ensure that all those working in a healthcare setting have mandatory IPC training*;
- *Health Boards should ensure that the Infection Control Manager (ICM) has direct responsibility for the IPC service and its staff*;
- *Health Boards should ensure that the ICM reports direct to the Chief Executive or, at least, to an executive board member*;

5 https://webarchive.nrscotland.gov.uk/20170401011220/http://www.valeoflevenhospitalinquiry.org/report.aspx.

- *Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings*;
- *Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time*; *and*
- *Health Boards should ensure that IPC groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.*

42. The Vale of Leven Inquiry provides important context here. Not only did the Health Board set out plans to implement all the relevant recommendations, but the recommendations as a whole helped to shape the development of national standards and the current framework for IPC across NHS Scotland. This culminated with the issuing of the key guidance letter, DL (2019) 23 in December 2019[6] by the Chief Nursing Officer of NHS Scotland. This set out the mandatory Healthcare Associated Infection (HCAI) and Anti-microbial Resistance (AMR) policy requirements for all NHS Scotland healthcare settings. As the letter noted:

> "*Despite the progress made over recent years, reducing HCAI and containing AMR remains a constant challenge. Therefore, it is important at both a national and NHS Board level and beyond, that there is ongoing and increased monitoring for accurate, and, as far as is possible, real time assessments of current and emerging threats.*"

43. This background of increasing sensitivity to the need for ever-more robust IPC procedures and the drive for improvement form an important backdrop for the Oversight Board's work. In its terms of reference, the Oversight Board recognised that there would be key points of learning and need for improvement for both NHS GGC individually as well as for NHS Scotland as a whole. In this context, it is important to understand the distinctive circumstances of what took place in the QEUH.

- **The unique circumstances of a modern, large hospital**. There was little precedent for the challenges arising from a large, newly-built hospital complex such as the QEUH – not least in understanding the scale and nature of the infection issues and the diversity of organisms that appeared. This manifested itself in the limited experience that NHS GGC – and NHS Scotland more widely – could draw upon to fathom the particular issues relating to infection in the context of a modern hospital such as the QEUH. Indeed, there are few comparators whose experience on which the Health Board has been able to draw. This context is by no means justification for any of the actions taken – or not taken – as standards should rightfully be expected to be met in all healthcare settings. However, it is essential for understanding how NHS GGC had to adapt to an often novel, and in many respects, 'non-textbook' situation. Recognition of this is important, not least from the perspective of the national learning the Health Board's experience can provide going forward.

[6] https://www.sehd.scot.nhs.uk/dl/DL(2019)23.pdf.

- **The scale of the Health Board**. The issue of NHS GGC's unique scale as the largest Health Board in Scotland (and one of the largest in Europe) is relevant, as the sheer size and expanse of the Health Board were defining features for some of its approach to these issues. For example, IPC responsibilities are divided between a number of different geographical teams, each covering a mixture of hospitals and other healthcare settings. The Oversight Board's comments are largely focused on the operation of processes at the QEUH. At no point was the issue of scale ever offered as a mitigating or explanatory factor for how the Health Board should have fulfilled its responsibilities in the circumstances under review. However, it was cited as a factor at points in how the Health Board did and could have responded to the circumstances and what might be improved going forward.
- **Focus on selected aspects of IPC**. Throughout the Oversight Board's work, there were many good examples presented of a range of IPC functions in NHS GGC. As a result, it is important to separate out issues that applied specifically to the particular infection incidences under review – both in terms of the specific site (the QEUH) and the specific patient group (those in the paediatric haemato-oncology service) – and those which applied more widely to how IPC was pursued across NHS GGC as a whole. For example, the Oversight Board did not set out to examine the experience, responsibilities and processes in place for dealing with the bulk of gram-*positive* infections, and the steps that the IPC Team and other staff had taken to eradicate their transmission (such as approaches to hand cleanliness). This is especially important in understanding the Oversight Board's focus on IPC in the context of environmentally-related infections (which includes both gram-negative and positive organisms). Consequently, the Oversight Board did not examine the full range of IPC functions in NHS GGC, only those directly relevant to these particular incidents.

44. At the same time, there is a **historical context** that should be understood. While not delving into these issues, as already noted, the Oversight Board recognised that there were significant shortcomings in: the construction and handover of the QEUH; and how NHS GGC responded to emerging and related problems. These include the concerns that were raised by a number of clinicians at an early stage as well as how 'warning signals' about potential problems were – or were not – acted upon over the years. The Oversight Board discussed these issues, but they have only been highlighted where they: remained a continuing and current factor that would compromise any assurance on the issues relating escalation; or were corrected and led to improvements that are important to acknowledge. It is recognised that relationships and trust were impacted as part of these historical issues, resulting in the early decisions to appoint Professors Marion Bain and Angela Wallace in key positions within the Health Board to take forward urgent work.

45. Ultimately, the Oversight Board has sought assurance that current IPC processes within NHS GGC are 'fit for purpose': in terms of national standards and good practice and in light of how they addressed the infection incidents of the last few years. In this respect, the Oversight Board has measured Health Board IPC against the key success factor: "*the current approaches that are in place to mitigate avoidable harms, with respect to IPC, are sufficient to deliver safe, effective and*

person-centred care" (see **Annex D**). Consequently, the Oversight Board commissioned a range of work. As part of this programme, the Oversight Board has:

- commissioned a detailed description of the timeline of infection incidents between 2015 and 2019 and formal meetings to address the incidents (this will be presented in full in the Final Report);
- commissioned a system-wide Peer Review of current IPC systems and processes and associated governance scheme of delegation and escalation mechanisms against relevant national standards and guidance;
- commissioned bespoke SBARs on particular issues, such as the use of HIIATs by the Health Board;
- received reports from key individuals placed within NHS GGC, particularly Professors Bain and Wallace; and
- assessed if there were any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to operational delivery of IPC, including staffing/resourcing, minimum skills and joint working between relevant units.

46. As noted already, some work could not be done in full due to curtailment caused by the Covid-19 pandemic. Nevertheless, the Oversight Board amassed sufficient evidence to set out a series of findings in the following key areas:

- **Processes and systems**: the degree to which specific IPC processes and systems have been aligned with national standards and good practice and their effective and reliable implementation; and
- **Approach to improvement**: the extent to which the IPC Team has demonstrated a sustained commitment to improvement, and acted as an agent for improvement in infection management across NHS GGC.

Other IPC issues – and overall view of the efficacy of IPC within the Health Board – will be set out in the Final Report.

Processes and Systems

47. A critical element of the work of assurance by the Oversight Board is IPC processes and procedures within the Health Board. National compliance is important, not least given the efforts in recent years to codify good practice in IPC in the wake of the Vale of Leven Inquiry. There is a recognisable balance between compliance in national standards with flexibility in applying local innovation/ improvement, but as with much healthcare, fidelity in crucial areas is important.

48. To examine in greater detail the way that IPC operated within NHS GGC, a Peer Review was commissioned by the Oversight Board to explore some processes and procedures in more forensic detail. This exercise was designed to gain an understanding of how IPC systems and processes were embedded. The objectives of the Review were to:

- investigate the ways in which IPC at NHS GGC is operationalised across the system; and
- determine the ways in which national policy has been implemented within NHS GGC, identifying areas where this was carried out and where it could be improved.

The focus has been on the current operation of these processes.

49. Several areas of focus were originally identified for the Review, but owing to the restrictions caused by the Covid-19 pandemic, only the following could be taken forward:

- implementation of the National IPC Manual (NIPCM);
- implementation of Healthcare Associated Infection Systems for Controlling Risk in the Built Environment (HAI-SCRIBEs);
- audit;
- surveillance; and
- the use of the Healthcare Infection Incident Assessment Tools (HIIATs).

Action on two other areas – outbreak and incident investigation, and water safety – could not be taken forward through this Peer Review as planned, but are still recommended to be examined at some stage.

50. A team comprising members of the IPCG Subgroup was established to undertake the Peer Review. The Peer Review was undertaken on 16 March 2020 by Lesley Shepherd (national professional advisor to the Scottish Government) and Frances Lafferty (Senior Infection Control Nurse in NHS Ayrshire and Arran). Additionally, the Oversight Board requested Anti-microbial Resistance and Healthcare Associated Infection (ARHAI) Scotland to undertake an assessment of NHS GGC reporting of Healthcare Infection Incidents, specifically relating to the QEUH site. The focus of the SBAR was on how HIIATs were used.

Application of the National IPC Manual

51. As set out above, over the last few years there has been significant work nationally to set a common approach to improvement and standards in IPC. Central to this has been the NIPCM. Published in 2012[7], the National Manual sets out the standards, good practice and resources for improvement for IPC across NHS Scotland. Alignment between Health Board practice and the NIPCM reflects a Health Board's commitment to a recognised, consensus set of practices associated with 'what good looks like' for IPC. The NIPCM aims to:

- facilitate the effective application of IPC precautions by appropriate staff;
- reduce variation and optimise IPC practices throughout Scotland;
- improve the application of knowledge and skills in IPC;
- reduce the risk of HAI; and

[7] http://www.nipcm.scot.nhs.uk/.

- help alignment of practice, education, monitoring, quality improvement and scrutiny.

52. The National Manual is central to the Health Board's approach to IPC – indeed, NHS GGC placed the NIPCM as a link on the IPC Portal on its intranet site. In addition, the IPC Team has developed a series of new 'Standard Operating Procedures' (SOPs) to supplement national guidance for the Health Board – NHS GGC described these as a way of 'operationalising' the NIPCM, making it easier for frontline staff to understand the Manual.

53. However, as the aim of the NIPCM has been 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 has developed so many SOPs. These typically require regular updating based on the current scientific evidence reviews within the NIPCM. The SOPs do not provide contradictory information – they reflected national advice – but given that this work has already been undertaken as part of the NIPCM, the production of the SOPs seems to be unnecessary, if not redundant.

54. Moreover, the NHS GGC IPC Portal does not differentiate between local SOPs and the NIPCM. This is likely to cause confusion as to what constitutes national policy and what, local guidance. Moving forward, NHS GGC must ensure that staff are directed initially to the NIPCM and that SOPs should only be provided where there is a clear, compelling justification for their added value.

55. Nevertheless, there are some SOPs that *should* be developed going forward. In particular, disease-specific SOPs or aide-memoires would be a useful tool for facilitating easy access to key IPC information supported by the NIPCM. This could be important for novel and emerging pathogens which were linked to significant outbreaks of infection. The NIPCM includes information around transmission-based precautions required for specific pathogens/conditions within its Appendix 11, but there is a national need for extra guidance. It would be appropriate for some additional disease-specific, evidence-based SOPs/aide memoires to be produced nationally for inclusion within the NIPCM as part of national work.

<u>Use of Healthcare Associated Infection Systems for Controlling Risk in the Built Environment</u>

56. HAI-SCRIBE implementation was chosen as part the Peer Review to illuminate the wider issues of IPC governance being considered by the Oversight Board. HFS published the Scottish Health Facilities Note (SHFN) 30[8] in January 2007 to support Health Boards to manage IPC in the built environment. The guidance comprised:

- <u>Part A</u> – the National Manual, which provides information for teams to support decision making so that identified risks can either be eliminated or successfully managed; and

[8] file:///C:/Users/u206386/Downloads/1509104776-SHFN%2030%20Part%20A%20-%20HAI-SCRIBE%20Manual%20information%20(1).pdf.

- 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.

The main aim of the guidance is to ensure that IPC 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.

57. The Peer Review team found that while this process is largely adopted within NHS GGC, there are inconsistencies. When both the Facilities and Estates staff and Lead Infection Control Nurses (LICNs) were asked if there was a consistent and systematic approach to HAI-SCRIBE risk assessment across NHS GGC, their answers differed: Facilities and Estates representatives stated that there was, while the LICNs said there was not. Moreover, a review of a selection of completed HAI-SCRIBE documents highlighted:

- inconsistencies in approach regarding levels of work, patient risk categorisation and subsequent control measures required to mitigate risk to patients;
- evidence of involvement of the IPC Team in compiling the document, when it was often the responsibility of the relevant Estates Manager;
- 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; and
- an impression that several had been 'cut and pasted' from previous HAI-SCRIBE documents.

58. Good practice is clear that this should be a joint responsibility between Facilities and Estates and IPC Team staff, ensuring that the approach to reporting does not become siloed and relevant expertise and judgement is systematically and appropriately deployed.

Approach to Audit

59. In 2018, HPS issued the National Monitoring Framework for Safe and Clean Care Audits[9], which provides an agreed, recommended minimum approach to auditing for all Health Boards. This gives a set of principles for the quality assurance of all Safe and Clean Care auditing while supporting a Quality Improvement (QI) approach for compliance and improvement. The Framework clearly defines where the responsibility for undertaking audits, developing action plans and taking forward actions to address any issues lies. It stresses that IPC within Health Boards is *not* the sole responsibility of IPC Teams, but also falls to local teams, and is underpinned by organisational governance structures which ensure strategic oversight.

[9] http://www.nipcm.hps.scot.nhs.uk/resources/audit-tools/.

60. 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 staff's ability to undertake good IPC practice, such as staffing levels and patient acuity. The dashboard can show a breakdown of information by each individual clinical area. Senior Charge Nurses have access to the dashboard for monitoring quality within their area and are owners of their local improvement plans, a good example of the Health Board finding ways to strengthen responsibility for improvement at local levels.

61. Audits employing IPC Audit Tools (IPCAT) are undertaken using a collaborative approach to enable the appropriate individuals to take ownership of relevant actions and respond accordingly. Facilities and Estates 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. NHS GGC reported that the IPCAT audit report and action plan are shared with ward staff, and discussed during ward huddles

62. IPCAT audits reflect a point in time and give a snapshot of IPC policy. The audit alone does not improve compliance – this must be achieved through a change in behaviours, adaptations to practice or processes and, where required, repairs/alterations to the built environment. Investigatory management beyond the immediate correction/action is essential if sustained change is to be achieved. Action plans arising from IPC need to use a quality improvement approach with local teams reviewing current systems and processes and agreeing, testing and implementing change ideas with improvement progress regularly assessed via local data collection.

63. It is not evident from either the IPCAT strategy or discussion with the IPC Team how local improvement is measured other than by undertaking a re-audit at set intervals based on the RAG status. The use of audits to drive improvement does not appear to be fully embedded in the relevant action plans, suggesting that there is a disconnect between the process of audit and follow up and the wider goals of improvement those processes should be supporting.

<u>Approach to Surveillance</u>

64. Surveillance is crucial in order to gather intelligence to identify HAIs and outbreak clusters, and facilitate rapid action to address them. National guidance sets out a requirement that organisations have a surveillance system to ensure a rapid response to HAI.

65. NHS GGC uses the IPC clinical surveillance platform, ICNet, to record surveillance data. ICNet is designed to enable a comprehensive approach to clinical surveillance, outbreak management and anti-microbial stewardship, and is customisable to the specific requirement of the user. Having used the system for a number of years, it appears that the system is effective in NHS GGC. The IPC Team in NHS GGC includes data analysts, who support data collation and outputs of

surveillance enabling the Infection Control Nurses (ICNs) to focus on their clinical remit.

66. During the Peer Review, issues were raised about how regularly the triggers and organisms in ICNet system are updated regularly. For example, Appendix 13 of the NIPCM[10] is a nationally-agreed minimum list of alert organism/conditions with the purpose of alerting Health Board IPC Teams and Health Protection (HP) Teams of occurrences which may require further investigation. Unless otherwise stated, a single case would require an IPC or HP Team review to advise that the correct IPC 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 of the NIPCM is not exhaustive and specialist units – such as bone marrow transplant or cystic fibrosis – will also be guided by local policy regarding other alert organisms pertinent to these areas.

67. The Peer Review team understood that despite previous infection outbreaks within NHS GGC, the only additional environmental alert organisms added to their ICNet system (other than those within Appendix 13) were *C.pauculus* and *Cryptococcus*. This meant that the IPC Team had been purely reliant on laboratory surveillance alerting them to the presence of other environmental gram-negative isolates within patient specimens. Given the history of outbreaks, the diversity of environmental organisms seen and the rare nature of some of the organisms, a more pro-active approach to surveillance would have given a more systemic early-warning system given the recurrence of infections.

68. HPS/NSS conducted an '*External peer review of NHSGG&C processes (infection surveillance) related to Appendix 13 of the National Infection and Control Manual*' in January 2018 (at the IPC Team's request), which found that:

> "*the processes around response to MRSA, SAB and C difficile were highly developed and extremely thorough. However, the processes for response to some of the other infectious threats highlighted in Appendix 13 are less well developed and further consideration needs to be given as to how to ensure consistent and equitable response to all of these infectious threats by the local team*."

The Oversight Board Peer Review suggests that this further consideration is still required.

Use of Healthcare Infection Incident Assessment Tools

69. The NIPCM sets out the requirements for NHS Boards to assess all healthcare infection incidents using the HIIAT. An early and effective response to an actual or potential healthcare infection incident or outbreak is crucial. The local Health Board's IPC and HP Team should be aware of, and refer to, the national minimum list of alert organisms/conditions set out in Appendix 13 of the NIPCM. Within hospital settings the IPC Team normally take the lead in investigating and managing any incidents with support from the HP Team. Every healthcare infection incident in any healthcare setting should be assessed using the HIIAT.

[10] http://www.nipcm.hps.scot.nhs.uk/media/1365/2017-06-19-appendix-13.pdf.

70. In reviewing the HIIATs reported to ARHAI Scotland (formerly part of HPS), particular attention was given by the review team to 'green'-rated incidents. Incidents reported as 'green' have been provided to HPS/ARHAI Scotland 'for information only' with no escalation required to the Scottish Government. These are all reviewed by a Senior Infection Control Nurse within ARHAI Scotland and further information has been sought from the reporting Health Board where the assessment and scoring of the incident appears inconsistent with the HIIAT tool guidance.

71. A number of the 'green' incidents reported by NHS GGC over the period had been challenged by HPS/ARHAI Scotland. There were questions raised about whether the 'green' ratings were appropriate and how the recurrence of environmental infections within the QEUH site had been factored into the rating. HIIAT assessments rely on individual review and judgements that are necessarily subjective. Indeed, the ARHAI Scotland review of QEUH HIIATs for the Oversight Board noted some variation between different assessments across all Health Boards. But with respect to NHS GGC, several HIIAT assessments did not seem to take sufficient account of previous incidents within the same hospital site. Assessment should not focus exclusively on individual occasions of infection, but take into consideration wider backdrop issues. Indeed, there had been cases when HPS/ARHAI Scotland requested the Health Board to reassess an incident, taking into account previous incidents, although NHS GGC often chose not to change its initial assessment.

72. ARHAI Scotland concluded that there is a need for national as well as local learning here. *Context* should be a key element in the application of this alert system, a recognition that incidents may assume a different significance when considered in light of any potential pattern of infection incidents faced by the Health Board and the possibility of links to the environment. Opportunities for intervention by the Health Board as a consequence of taking a wider view of infections may have been lost. As a result, there is need for a deeper investigation of how NHS GGC continues to rate its infection incidents in the QEUH going forward.

Approach to Improvement

73. A systematic approach to healthcare improvement and better IPC have been ever more closely linked in recent years. Indeed, the Scottish Patient Safety Programme, which has embedded a more comprehensive improvement ethos across NHS Scotland, was in large part a response to the implications of the Vale of Leven Inquiry. Health Boards should not only be fulfilling current operational duties with respect to IPC, but ensuring that actions are taken to support improvements in their approach.

74. Improvement is explicitly highlighted within the overarching IPC guidance in NHS GGC, but it is not a responsibility lodged in a single part of the organisation. As set out in the Health Board's own Governance and Quality Assurance Framework for IPC Services, the IPC Team is responsible for, amongst other things:

- ensuring advice on IPC is available;
- in liaison with other relevant staff preparing, reviewing and updating evidence-based policies and guidelines in line with relevant UK Department of Health notifications and/or guidelines, when available and applicable;
- ensuring the provision of appropriate education to all grades of staff working within the scope of the policy; and
- providing specialist advice to key committees, groups, departments or individual staff members in relation to IPC practice.

Consequently, the role of the IPC Team is not standalone, but part of the wider conduct of Health Board responsibilities, recognising that IPC can only be successfully carried out when it is embedded across NHS GGC and driven by a commitment to continuous improvement. The IPC Team has the central role in this process of mainstreaming – in effect, ensuring that IPC is not just the responsibility of the IPC Team.

75. Based on 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 (for example, 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. 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 is confident that the process change is improving *outcome* (and this is clearly monitored and verified), then and only then, should wholesale local implementation commence.

76. As an agent of Board-wide improvement change, there are excellent examples of this kind of change in NHS GGC. One good example is the quality improvement project to reduce the central line-associated bloodstream infection (CLABSI) rate in the paediatric haemato-oncology population.

Quality improvement to reduce the CLABSI rate in paediatric haemato-oncology

From 2017, the Health Board undertook an exercise to improve infection rates and infection prevention behavior in the paediatric haemato-oncology unit. Surveillance data showed fluctuations in CLABSI rates in the Schiehallion Unit. Before de-canting to QEUH wards in September 2018, Ward 2A in the RHC was a haemato-oncology unit and housed the National Bone Marrow Transplant Unit as well as the Teenage Cancer Trust. Ward 2B was the daycare component of Ward 2A. Staff began researching evidence on the topic and found benchmarking guidance from the Cincinnati Children's Hospital in the US. This led to a Quality Improvement Project using the Model for Improvement and a focused test of change to reduce the incidence of CLABSI in the haemato oncology population. Elements of the project included introducing unified line insertion protocols as well as staff and family education around line care and maintenance.

The methodology was applied with a specific, measurable target: to reduce the number of CLABSIs in Schiehallion Unit patients to 1 per 1,000 total line-days. This was supported by a clearly-defined driver diagram with primary and secondary drivers defined by tailored measurements, and a set of successful outcomes.

Key outcomes

- An issue identified and acted on using QI methodology locally led with support and reporting through Health Board structures
- CLABSI rate reduced and stabilised: from a rate of 6.33 in June 2017 to just over 1 by the start of 2020
- Almost 80 percent reduction from peak phase and just under 60 percent reduction from baseline
- Benchmarking 'like-for-like data' challenging, however, best in country when compared to similar paediatric units
- Going forward – focused on improvement of services continuous improvement, shared learning

77. Across NHS GGC as a whole, there are other instances of IPC focusing on improvement. For example, with respect to gram-*positive* infections, there is notable performance against national expectations. The Clinical Outcomes Review commissioned by the Chief Executive as part of a trio of stocktaking reports on the QEUH, and which reported to the Board at its meeting in October 2019, concluded: "*both internal and external review of available data indicates the QEUH and the RHC are not outliers in terms of rates of Healthcare Associated Infection (HAI) or practice*."[11] Timeous and effective action across NHS GGC was also evident in responding to individual infection issues, as the Oversight Board saw in the case of the 2019 *Stenotrophomonas maltophilia* outbreak at the Royal Alexandria Hospital in Paisley.

[11] www.nhsggc.org.uk/media/257579/item-14-int-review16decfinal.pdf.

2019 infection outbreak at the Royal Alexandria Hospital

A number of instances of *Stenotrophomonas maltophilia* were identified at the Royal Alexandra Hospital in Paisley in early 2019. Infections in previously healthy patients are typically unusual. Nosocomial infections (ie. originating in a hospital) has been increasingly recognised, and usually only occur in those with significantly-impaired immune defences, such as severely immuno-compromised patients. This can cause bloodstream, respiratory, urinary and surgical-site infections. Risk factors pre-disposing a hospitalised patient towards infection include prior exposure to anti-microbials (especially broad-spectrum antibiotics), mechanical ventilation and prolonged hospitalisation. It may also affect the lungs of patients with cystic fibrosis.

S. maltophilia is resistant to many antibiotic classes. This means that treatment options are relatively limited. However, most strains remain susceptible to co-trimoxazole which is regarded as the drug of choice for treating infections. In January 2019, the IPC Team was informed of three instances related to *Stenotrophomonas*, which led to an IMT being convened by the end of the month. The Board was updated via the Healthcare Associated Infection Reporting Template (HAIRT) in February, and further updates were provided to the Care and Clinical Governance Committee, the Board Infection Control Committee and the Acute Infection Control Committee in March.

When the outbreak took place, a robust structure was in place which meant the incidents were managed timely and effectively at all stages. The key outcomes were:

- timely management of the incident and establishment of multidisciplinary team improves outcomes and communication;
- strict adherence to IPC procedures to reduce the risk of transmission of infection;
- communication with patients and families was pursued as a central part of incident management and managed by the clinical team with support from the IMT;
- a recognition that roles and responsibilities in environmental sampling needed to be clarified; and
- information flow from Reference labs needed to be streamlined.

78. What was notable in the above incident was the highlighting of the ‘lessons learned’ and the determination that relevant improvements were made in the local IPC Team. The Oversight Board saw abundant evidence of the hardworking and diligent nature of the staff in this area, with commitments to improving outcomes and ensuring patient safety and better care.

79. It is clear that the Health Board could learn from the experience of its infection incidents and adjust accordingly its approach, structures and actions, especially from 2018 onward. This was notable in several key developments (as discussed in more detail in the Final Report): the establishment and active work of a Technical Water Group to provide a targeted response to the set of 2018 infections; the updating of

NHS GGC's Water Safety Policy in 2018; and the development of a single IPC Assurance and Accountability Framework from a set of separate documents.

80. Nevertheless, these instances did not appear to be part of a more systematic approach to learning led by the IPC Team. Apart from a handful of commendable but seemingly isolated examples, there did not appear to be a sustained approach to IPC improvement across the Health Board. It was a recurring theme of the issues examined by the Peer Review and the approach taken to HIIATs discussed above.

81. For example, as part of the work of the Peer Review, the investigating team asked NHS GGC for examples of how local surveillance data was used to inform quality improvement work. The IPC Team has been involved in much of the quality improvement work that was cited, including development of Peripheral Venous Cannula (PVC) care plans which supported frontline staff in undertaking the correct, evidenced-based care of PVCs. This work was led by the IPC Team without apparent implementation of the model for improvement – consequently, ownership of the required improvement was not taken up by the clinical teams or services. There was no evidence of a structured use of quality improvement methodology and a focus on outcomes. Importantly, it was not evident that the relevant local teams were leading this work. Put simply, improvement work was too often siloed within the IPC Team without sufficient mainstreaming across other teams.

82. Similarly, the role of the IPC Team in producing guidance and policy raised concerns. In addition to the individual standard infection control and transmission-based precautions, there were a number of other SOPs that seemed to have been produced principally by the IPC Team. One example was a SOP Team for the insertion and maintenance of urethral urinary catheters – as catheter insertion and maintenance is typically the role of local bowel and bladder teams, the role of the IPC Team in leading the drafting of this SOP was confusing. Whilst the IPC Team should support and advise this work, it is inappropriate for them to lead. Indeed, it was not clear whether the local bowel and bladder reference group was involved in this work.

83. This does not reflect an IPC service which is integrated and collaborative. It appears to be one that provides a standalone service rather than advises and works towards the mainstreaming of IPC improvement. The ethos of improvement should be to work together across existing professional and organisational boundaries when the opportunity to find better ways of delivering shared outcomes can be achieved, and to focus on outcomes. That approach was inherent in the CLABSI work described above and should be more systematically pursued across the IPC Team.

84. In this context, the new IPC improvement collaborative being established through work led by Professor Angela Wallace is welcomed. This collaborative should encompass explicit learning from the QEUH infection incidents, not least with respect to handling gram-negative bacteria infections and working against the background of a potentially-compromised building. The recent refocusing of Executive responsibilities within NHS GGC around a 'Gold Command' structure – led by the Health Board's Chief Executive – and the creation of a new strand of transformation activity on 'Better Safe, Clean Clinical Environment' under the leadership of the Interim Deputy Director for IPC, the Chief Operating Officer and the

Director of Facilities and Estates is an opportunity to drive such improvement. If this strand of work is rooted in a comprehensive review of processes and performance issues for IPC, informed by the findings and recommendations made through the Oversight Board and other review processes, this could prove a powerful vehicle for delivering a change in approach to improvement.

Remaining Work

85. As already stated, this Interim Report does not cover all aspects of the Oversight Board's review of IPC. Several critical aspects are still being examined and will feature in the Final Report, including:

- Responsiveness: how responsive were IPC functions in identifying and taking appropriate action with regards to the children and young people in these infection incidents – not just in terms of addressing the incidents themselves and learning quickly from the experience, but also the efforts to understand the source of infections and take appropriate preventative measures;
- Joint working in IPC: effective IPC within a Health Board depends not just on the strength of the IPC Team, but how that Team link with other key functions across the organisation – this will review how well cooperative working to support IPC was evident in the QEUH, particularly between key staff with a responsibility for undertaking IPC such as Facilities and Estates and microbiologists; and
- Leadership: the strength of the current structure of responsibilities for the IPC Team in NHS GGC, and whether those divisions of responsibilities are best suited in these circumstances.

86. While recommendations on the aspects of IPC discussed here are made at the end of this Interim Report, the full conclusions of the Oversight Board on IPC will be made in the Final Report. This will include assurance on IPC within NHS GGC in the context of the infection incidents in the QEUH.

Governance and Risk Management

88. The second set of escalation issues which the Oversight Board is examining is IPC governance. Its importance has been captured in the Blueprint for Good Governance for NHS Scotland[12], which sets out key principles Health Boards should embody, including the ability to:

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

This is supplemented by the descriptions of good governance and the approach all Health Boards should take towards quality planning and management in key documents by HIS[13].

89. With respect to IPC, that covers a range of important areas, such as the way in which infection incidents and corresponding actions have been escalated, scrutinised, endorsed and monitored by the governance structure within a Health Board. It also includes how IPC and associated risks are identified, reviewed and overseen by relevant Committees (as well as the Board itself). Consequently, the Oversight Board is reviewing in detail:

- how infection incidents from 2015 onwards were identified and escalated through the governance structures of NHS GGC;
- how risk management was used and adopted accordingly,
- how well the relevant Committees and groups provided direction, monitoring, scrutiny and assurance about the handling of individual incidents, the way in which staff responded, how people were kept informed about what was happening, any weaknesses identified in the building/environment as a result, and the actions taken to address those weaknesses and prevent further problems in future; and
- the overall leadership shown in acting effectively in response and with foresight in dealing with the complicated challenges highlighted by the building.

[12] https://www.sehd.scot.nhs.uk/dl/DL(2019)02.pdf.
[13] http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=e4e2a8ce-342e-4e5c-b998-1f81859b282f&version=-1.

Progress Update

90. Assessment of these issues has also been led by the IPC and Governance (IPCG) Subgroup for the Oversight Board. This includes the following specially-commissioned work:

- a ‘timeline’ of infections and the Health Board’s responses between 2015 and 2019;
- detailed analysis of the minutes and papers of the IMTs, various groups and Committees about how the issues were reported, escalated, actioned and reviewed within the governance structure; and
- a specific peer review of IPC governance, taking account of the recent changes introduced within the Health Board following the appointments of Professors Bain and Wallace.

91. All of this work is still to be finalised so the Oversight Board will set out its findings and recommendations on IPC Governance in the Final Report.

Technical Review

92. Part of the Oversight Board's role has been to provide assurance not just on practice, but – as far as possible – the relevant physical environment of the QEUH and the Health Board's approach to inspecting and maintaining that environment. The Technical Issues Subgroup was established to provide advice on key aspects of this, including:

- assurance that the relevant environments at the QEUH and the RHC are, and continue to be, safe;
- progress on the refurbishment and reopening of Wards 2A and 2B in the RHC, following its closure in September 2018, so that children and young people can return to the Unit specially designed for their needs;
- how appropriate action plans have been developed and taken forward to address any technical issues highlighted by competent authorities such as the Health and Safety Executive, HPS and HFS; and
- lessons learned that could be shared more widely across NHS Scotland.

Progress Update

93. The work of the Subgroup is continuing and will be set out in full in the Final Report. Given its technical focus, there have been difficulties arising from the Covid-19 pandemic in progressing this work as quickly as desired. Nevertheless, working closely with NHS GGC, the Subgroup is currently undertaking reviews of:

- NHS GGC's water safety policy, with specific attention given to its water testing regime and how testing results are being used as part of IPC and the key water and ventilation infrastructure in light of the infections across the hospital site; and
- NHS GGC plans to review the impact of the chemical dosing system introduced from late 2018 to address water system contamination, especially any potential implications for the existing water infrastructure.

Refurbishment of Wards 2A and 2B in the RHC

94. The Subgroup has also reviewed progress on refurbishing Wards 2A and 2B in the RHC. Originally, when the children and young people were first de-canted from the wards, it was hoped that the work would be relatively limited. However, as further investigation was conducted on the state of the wards, it was clear that significant additional work would be required to redress shortcomings in the original building work, particularly with respect to ventilation issues.

95. The completion date for Wards 2A and 2B has now shifted to May 2021. The principal reason for the delay has been Covid-19, which has had an impact in an number of areas, including the procurement of relevant plant and equipment, essential staff being furloughed, social distancing being enforced (which has affected timescales) and the site needing to be shut down on one occasion following a

positive Covid-19 test result. In addition to these issues, as it has been upgrading the ward, NHS GGC has identified additional problems with mould, fire stopping and insulation in external walls which have all needed to be rectified and that has added time to the programme of work.

Communication and Engagement

96. The Oversight Board was established against a background of increasing dissatisfaction and distress among families of the children and young people in the paediatric haemato-oncology service, reacting to how NHS GGC had been communicating the continuing issues around infection in the hospital. In November 2019, the Cabinet Secretary for Health and Sport met with several families, which led to a set of 71 issues and questions about the hospital and the infections being posed to NHS GGC. The issues on which families felt frustrated in getting information from the Health Board included (but were not limited to):

- assurances on the current safety of the water system and the wider clinical environment for the children and young people;
- progress with key remedial work on different wards, including 2A and 2B in the RHC from which the Schiehallion Unit had been de-canted in 2018;
- issues relating to the current location of the children and young people in the haemato-oncology services in Ward 6A in the QEUH;
- the adequacy of IPC measures in place;
- conflicting messages in the communications given to patients and families as the infection incidents had progressed; and
- a perceived lack of compliance with the organisational duty of candour.

Responses to those questions were provided to families and subsequently posted by NHS GGC on its website, and the issues raised helped to set the remit of this Oversight Board.

97. Discontent with NHS GGC's communication was also evident in the survey conducted by Professor Craig White of this group of families in December 2019. Twenty responses were received, with the majority of respondents saying they were not satisfied with the level of communication about the ongoing issues by the Health Board, with clear dissatisfaction expressed about NHS GGC's performance in this regard. The issues experienced by families were many and varied: some were individual and personal matters relating to their own children, while others reflected a more common set of concerns about how the Health Board was engaging with them.

98. Supporting patients and families in the midst of a prolonged crisis would have been challenging to any Health Board. It was made particularly complex for NHS GGC by the difficulties in providing the children, young people and families with certainty and clarity about what has happening, as will be seen below. Nevertheless, the experience of some patients and families pointed to problems of the Health Board in its approach to communication, and the view by some that the Health Board was failing to exhibit the essential person-centred principles to communication that are the cornerstone of NHS Scotland.

99. The strength of feeling among several families highlighted the importance of engaging with families throughout the Oversight Board's work. A dedicated Communication and Engagement Subgroup was established, chaired by Professor White and with membership including communication experts from other Health

Boards as well as representatives of the families themselves. It provided a forum for direct exchange of views and discussions between the Health Board and family representatives.

100. The Oversight Board set two key success indicators for NHS GGC in its approach to reviewing communication and engagement. Patients and families within the paediatric haemato-oncology service should receive relevant information and are engaged with – and are treated with respect to their rights to information and participation – in a culture that reflects the values of NHS Scotland in full. That should be seen in the following.

- *Families and children and young people within the haemato-oncology service receive relevant information and are engaged with in a manner that reflects the values of the NHS Scotland in full.*
- *Families and children and young people within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHS Scotland in full.*

101. In its work, the Subgroup concluded that evidence of this kind of success should be seen through the following:

- priority is placed on communication and information provided to patients and families with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered);
- the Health Board ensures there is an appropriate Communication and Engagement Plan with a person-centred approach, including a clear Executive Lead for implementing and monitoring; and
- a review is conducted of key materials, policies and procedures in NHS GGC with respect to the organisational duty of candour and Significant Adverse Event Reviews, and identification of any national learning/lessons learnt.

102. Not all of the work carried out for the Oversight Board through the Subgroup is set out in the Interim Report. NHS GGC's approach to its organisational duty of candour and how it addressed Significant Adverse Event Reviews are key elements of how a Health Board should engage with patients and families when death or harm occurs within a hospital setting. They are processes that are governed by legal, regulatory and guidance frameworks, and the Oversight Board's findings here will be set out in the Final Report.

103. The Interim Report focuses on the extent to which communication and engagement by NHS GGC has reflected consistent delivery of the overarching principles outlined above, rooted in the NHS Scotland approach to person-centred care. These issues are considered under the following headings:

- the strategic approach to communication in NHS GGC;
- application of this approach in IPC, and the issues experienced by patients and families through this period; and
- scope for improvement.

Strategic Approach to Communication

104. The principles of good communication in healthcare settings have been clearly expressed nationally. The Director-General of Health and Social Care in the Scottish Government's and Chief Executive of NHS Scotland's letter of 22 February 2019[14] stressed the importance of appropriate communication:

> "*Our learning so far from the degree of public interest in these issues makes very clear that communication is always better done directly with those most closely affected first. We should, as far as possible, be alerting staff, patients and families before making any public statements and the service and Scottish Government should work closely together in our communications with the public.*"

105. NHS GGC's own stated objectives for person-centred care are set out in it 2019-23 Healthcare Quality Strategy[15]. This represents a level of aspiration – and a means of measuring how well NHS GGC currently operates – that the Oversight Board endorses. Responding to what patients and families wanted, the Strategy aims for a high-quality service that:

- takes time with patients and listens to them;
- takes care of people, looks after them and makes sure they get the right treatment;
- communicates well with patients by explaining all they need to know and involving them in decision making;
- is knowledgeable, safe and trustworthy;
- is efficient;
- is caring, compassionate and shows empathy;
- has friendly, kind, competent and professional staff; and
- communicates with the people who matter to them regarding their progress and condition.

106. The Health Board has recognised the kind of communication and engagement that should be expected for these patients and families in its description of 'Person-Centred Care' with the following series of commitments in that document.

- *We will enable people to share their personal preferences, needs and wishes about their care and treatment and include these in their care plan, care delivery and in our interactions with them.*
- *We will involve the people who matter to them in their care in a way that they wish and that meets the requirements of the Carer's Act (2018).*

[14] https://www.sicsag.scot.nhs.uk/hai/_docs/HCAI-DL-2019-23-Dec-2019.pdf.
[15] https://www.nhsggc.org.uk/media/253754/190219-the-pursuit-of-healthcare-excellence-paper_low-res.pdf.

- *We will develop further the person centred approaches to visiting throughout NHS GGC.*
- *We will make sure people experience care, which is coordinated and that they receive information in a clear, accurate and understandable format, which helps support them to make informed decisions about their care and treatment.*
- *We will give people the opportunity to be involved and/or be present in decisions about their care and treatment and include the people who they want to be involved in accordance with their expressed wishes and preferences.*
- *We will provide training and education, to enable staff to treat people with kindness and compassion, whilst respecting their individuality, dignity and privacy.*
- *We will inform people about how to provide their feedback, comments and concerns about their care and treatment. We will review our approach to collecting and managing feedback to make sure it is fit for purpose.*
- *We will make sure there is a collaborative and consultative approach in place to enable staff to actively listen, learn, reflect and act on all care experience feedback received and to ensure continual improvement in the quality of care delivered and the professional development of all staff.*
- *We will continue to identify and build opportunities for volunteers to help improve the health and wellbeing of patients, families and carers.*
- *We will engage with people, communities and the population we serve to deliver high quality services to meet their needs.*

107. The centrality of these communication principles is reflected in other NHS GGC strategies. In particular, the Health Board developed a dedicated communication strategy for infection issues: *Healthcare Associated Infection Communications Strategy*[16], published in 2015 (and due for review in 2019). The Strategy stressed "*the importance of a culture of openness, transparency and candour*". It acknowledged the need to learn from incidents such as the Mid Staffordshire NHS Foundation Trust Public Inquiry as well as the impact of the Vale of Leven Hospital outbreak of *C. difficile* and the recommendations from Lord Maclean's Inquiry.

108. The Strategy set out the principles of communicating infection diagnosis and risks, and included key actions to be taken forward in individual cases such as (but not limited to) the following:

- every patient should be informed of the risk of infection and the actions being taken to prevent healthcare associated infection;
- if a patient is diagnosed with an infection, the diagnosis should be discussed with the patient by one of the members of the clinical team if possible; and

[16] https://www.nhsggc.org.uk/media/243043/hai-communication-strategy-july-2015.pdf.

- the Health Board should ensure that if a patient dies with an infection which is either the primary cause of death or a contributing factor, families are provided with a clear explanation of the role played by the infection.

109. The Strategy presented a clear baseline of principles against which the actions with respect to the QEUH infection incidents can be considered. As noted, the Strategy is several years old and is due to be updated; in light of recent experiences with the QEUH, and the recommendations set out here (and in the Independent Review), there is a strong impetus for a new, revised version of the Strategy to be produced and issued.

Communication in the Context of Infection Prevention and Control

110. While a statement of principles and standards is vital, what matters most is how strategic aspiration is translated into action. Good practice was clearly evident. When reviewing how the Health Board responded to the unfolding circumstances of infections, the Oversight Board noted evidence of improvement already at work within the Health Board. It is important to highlight this, not least as practice that could support national learning.

111. Throughout the incidents, there was generally a recognition (not least by the children, young people and families themselves) of good communication at the point of care. At ward level, communication was often effective and sensitive, displaying the Health Board's person-centred values in how it responded to individual patients' and families' circumstances. Direct communication by the clinical and medical staff have been highly regarded by the children, young people and families throughout, not least when it related to the individual care of patients.

112. Communication to patients and families individually at the point of care was undertaken with compassion, care and support by the relevant staff, especially in the Schiehallion Unit. Ward staff were often the key means by which major, and often unsettling news was conveyed, such as the decision to de-cant Wards 2A and 2B in September 2018 (as discussed more fully below). As noted by one respondent in the December 2019 survey of families:

> *"Clinical staff provide timely and relevant information on… treatment. Someone is always available when we have questions. When I was stressed about a delay to surgery, nursing staff picked up on that and arranged for consultant to contact me*."

Despite the pressures to provide regular communication on the infections and the impact that they had on day-to-day operations, the focus on providing a high-quality service was never lost in the engagement with the children, young people and families. The Oversight Board commends that commitment by staff in the hospital to keeping patients and families directly informed.

113. There was also evidence that the Health Board was capable of learning to address the challenges of maintaining complex and often prolonged communication with patients and families in difficult circumstances. A good example of this was the development of the 'closed' Facebook page for patients and families, as described in

more detail in the box below. This Facebook page has been a critical means of alerting patients and families to key developments and issues as well as enabling them to raise important issues with the Health Board – indeed, the value of the mechanism has extended beyond the immediate infection issues for the patients and families, and developed into a means of supporting the group of families, children and young people for other issues. For example, it has become an important means of identifying and acting on issues affecting this group of patients during the Covid-19 pandemic. Although the key to its value is ultimately the responsiveness of the Health Board to the issues raised on the page, it was an innovative and useful tool that highlights the capacity of the Health Board to improve.

'Closed' Facebook page for patients and families

The decision to develop a customised Facebook page for the Schiehallion Unit patients and families emerged from the experience of using the existing social media services. In the first few months of 2019, public and media attention on the problems of the QEUH was particularly acute, increasing the need for families to find a way to express and discuss their concerns, seek and receive information, and engage with the Health Board on the continuing implications of the infections for their children.

In January, it was agreed that a 'closed' Facebook page would be established for the benefit of patients and families – a decision that was endorsed by the Board itself, commendably demonstrating the importance of improving patients' and families' communication within NHS GGC. A form of 'gate-keeping' of the page's membership would be provided by NHS GGC itself to protect the privacy of the discussions, but the forum was allowed open and full access to members.

The Facebook Group was launched in September 2019 for patients and families associated with their paediatric haemato-oncology service. Initially, the number of members was approximately 50, but over time, membership increased significantly; currently around 180 members are listed. It has the potential to become a central mechanism for parents to engage collectively with NHS GGC clinical leaders within the ward and the Board's staff who support corporate communication and engagement activity. Executive-level responsibility for engaging with patients and families has now been placed with the Health Board's Nursing Director – the first time a Board member was explicitly and visibly put forward in such a way.

Since escalation, families have expressed positive feedback about how the Facebook page keeps them informed of statements from Scottish Government Ministers as well as the work of other key reviews (and indeed, the work of the Oversight Board). There are some encouraging recent examples of this being used effectively to support dialogue with patients and families who have expressed concerns about (for example) the quality of the food in Ward 6A, including engagement on an event involving parents who wish to work with staff on improvement planning. While discussions on the pages are sometimes critical of NHS GGC, it represents a willingness by NHS GGC to support constructive debate and challenge for those most affected by the continuing problems and decisions taken by the Health Board, though it must continue to be used pro-actively and there remains work to ensure that this is done consistently.

114. NHS GGC has also undertaken work to ensure that individual children, young people and families have relevant communication/information specific to their needs and relevant of their histories. Not all patients and families have wanted the same level of engagement and information with the Health Board, and it was important to recognise their different circumstances and preferences. Given the sensitivities arising from the experience of many of these children and young people, it was also important that Health Board communications did not appear unnecessarily generic, but recognised a history of communication with particular families, and indeed, reflected the often difficult circumstances of their children that lay behind individual communications.

115. This led to the development of a specially-commissioned database to facilitate improved engagement with concerned patients and families and how they preferred to be contacted; the box below describes this in more detail. This as an important development that would be of value across NHS Scotland more widely. It has enabled communications to be formulated in a way that respects communication and engagement preferences, and clearly embeds a person-centred approach.

Database of contacts and communication preferences for patients and families

A database of contacts with the Scottish Government and NHS GGC was commissioned following the escalation of NHS GGC to Stage 4 in the NHS Scotland Performance Framework in November 2019. Based on the existing communication with over 400 families, the database compiles key information on preferences. It uses NHS National Office 365 SharePoint to capture the history of communication with particular patients and families. It has strict permissions settings in place and is sharable with colleagues in NHS GGC and Scottish Government links. The database supports improved oversight, makes it manageable to incorporate enhancements and changing requirements, and to add users. Its protocols can potentially be adapted to support future oversight requirements if/when Scottish Government/NHS Scotland coordination and comprehensive overview is required.

There is scope for improving the value of the database further. This tool could be supplemented by enhancing the existing family ‘induction’ packs with clear information on where patients and families could go for information about continuing issues such as the infection incidents. It also has applicability that goes beyond the paediatric haemato-oncology service, but could be deployed usefully whenever there is prolonged communication between the Health Board and a particular patient/family group.

116. Nevertheless, where communication and engagement went beyond the ward level – particularly with respect to ‘corporate’ communications on behalf of NHS GGC as a whole – there were a number of deficiencies. Such corporate communication has an essential role, as ward staff were not always the most appropriate channels for information, particularly when it involved a wider communication effort, targeted not just at the children, young people and families but staff and the wider public and media. In this context, the approach to communication and engagement by the Health Board did not consistently match the person-centred principles of its strategies.

117. This can be highlighted when considering how communication operated at specific points over the period. Key milestones in the timeline of infections spotlight how the Health Board acted:

- the decision to de-cant Wards 2A and 2B in the RHC in 2018;
- the introduction of a comprehensive water dosing system in 2018;
- the series of new infections in QEUH wards in 2019; and
- recent issues in the wake of the announcement of legal action.

All provided critical points when communication with patients and families was particularly sensitive, and are worth examining in detail.

Decision to De-cant Wards 2A and 2B in 2018

118. The decision to de-cant the children and young people from Wards 2A and 2B in the RHC to Wards 6A and 4B in the QEUH in September 2018 was one of the most visible and public milestones in the development of the infection incidents. Closing the wards would inevitably be regarded as an admission of the seriousness of the series of infection issues and open up the Health Board to potential accusations that it was not in full control of the situation. Consequently, good handling was vital.

119. The decision came on the back of a resurgence of infections within the RHC wards, leading to the restoration of the IMT after it had been stood down twice since March of that year. It was made relatively quickly, reflecting an urgency around the need to investigate the source of infections in the wards more thoroughly and mounting concerns by staff on the wards and families around the safety of the environment. It was also made at a point when concern, investigation and speculation had resulted in substantial disruption in the care of this group of children and young people. There was a significant physical/logistical challenge in ensuring that the new wards were altered to provide appropriate care for these vulnerable children and young people and manage the movement of patients on 26 September, but there was an equally important challenge in communicating the key information and the rationale to patients and families, addressing their questions while providing reassurance around the continuity and security of care.

120. The news was put out in a number ways on 18 September and the days that followed. For those on the wards, much of his was done through face-to-face briefing by the Chief Nurse and General Manager, supported by a written briefing for families. A hand-out, dated 18 September, set out the details of the de-cant. It highlighted the need for further invasive exploratory work on the source of infections, involving the drains as the primary reason for moving the children and young people, and emphasised the priority of their safety and care. The statement – which formed the basis of a media release the same day – did not offer details of where most children and young people in the Schiehallion Unit were moving to in the adult hospital (arguably a singular omission, given that the location had already been discussed in planning with senior management). On its own, the lack of detail on the nature and duration of the move would not have given sufficient reassurance to the children, young people and families. Nevertheless, the communication work – particularly through the direct support of those *in situ* on the wards – seems to have

been effective in managing a sudden and sensitive change of circumstances for the patients and families. The challenge for the Health Board was not made easier by false information carried in news outlets that the de-cant had already taken place, resulting in distress in some families on which swift and targeted action was taken by senior managers within NHS GGC.

121. The de-cant was originally envisaged as a short-term move, and presented as such to patients and families. As the investigation of Wards 2A and 2B revealed a succession of environmental deficiencies, going back to the original construction of the wards, it became clear in the succeeding months that it was unlikely that the children and young people would be restored to the original wards soon, and the stay in Wards 6A and 4B would be prolonged. However, the communication of this to patients and families appeared to be faltering. No formal updates on the work on Wards 2A and 2B seemed to have been made to the patients and families through October and November 2018, and it was evident that staff were reluctant to discuss the changing work timetable until a fuller picture of the problems in the wards was known (in particular, staff were waiting on key external reports on ventilation before providing an update). The absence of corporate updates in this period would have not been reassuring to those already experiencing considerable distress and uncertainty. The decision seemed to have been taken that it was better to 'have something to say', but this lack of communication was not reflective of the Board's strategic commitment to person-centredness. It compromised the confidence and trust that families with ongoing concerns and unanswered questions had in the Health Board.

122. When an update was forthcoming in December, it downplayed the emerging environmental issues emerging from the investigations of the wards. Briefing to patients and families on 6 December 2018 cast the further delays as an 'opportunity' to upgrade the ventilation. This suggested a lack of transparency about the emerging scale of issues encountered on Wards 2A and 2B. While communications should be mindful of causing unnecessary alarm, the approach seems to have contributed to a deepening suspicion among some families that the Health Board was 'covering up' issues relating to the hospital building. While there is no evidence of deliberate concealment of any such information, throughout 2019, the formal updates to patients and families about progress with Wards 2A and 2B seemed intermittent and not transparent about either the real difficulties experienced with the programme of work or the delay to a return of the children and young people to the RHC. It was known in January 2019 that any prospective return to Wards 2A and 2B was unlikely to occur before the end of that year, but this does not appear to have been fully and openly communicated to patients and families likely to be affected by these decisions.

123. This apparent omission might be indicative of the highly reactive environment that the Health Board faced, not least in the early part of 2019, as there were a number of immediate communication issues on which action needed to be taken. But it reinforced an impression that NHS GGC was not forthcoming about key information regarding the situation with the building, leading to an avoidable increase in distress and subsequent deterioration in the relationship between some families and the Health Board.

Introduction of the Water Dosing System in 2018 and 2019

124. The installation of a site-wide, water dosing system was a decisive step taken by the Health Board to address what seemed to be mounting environmental risks in 2018. The decision was not taken lightly, but followed extensive options appraisal by the specially-created Technical Water Group and careful planning to manage its introduction with minimum disruption to staff, children, young people and families. The option was raised quickly by the newly-established Group in the early stages of the 'water incident' in the first half of 2018; by the end of the year, the implementation of dosing was completed for the QEUH and extended to the RHC through 2019. It represented the most emphatic action by the Health Board to address the risks of widespread water contamination, a significant achievement in terms of the speed and scale of response.

125. From a communication perspective, the use of comprehensive chlorine dioxide dosing has several important dimensions. It demonstrated the responsiveness of the Health Board and its willingness to 'do what was necessary' to mitigate risks to patient safety and provide assurance to patients, families and the wider public about hospital safety. At the same time, it needed to be explained carefully to ameliorate any concerns (not least among patients and families) that might have arisen about having to treat the water with 'chemicals' and the impact that could have on patient health. Moreover, there was a risk it could be framed by some as a Health Board admission that there was widespread water contamination in the hospital and the impossibility of removing the source of the contamination without such dosing action. There were communication implications that went beyond the paediatric haemato-oncology patient group, as the water dosing would affect a wider number of patients. As a result, careful handling of information and messages with patients and families was critical.

126. Dosing for the adult hospital was agreed in early November 2018, and a communication was to be issued as soon as the timeline for the work was finalised. It was not clear how this was widely communicated, either in the lead up to the point at which the adult hospital dosing system was put in place (28 November) or in the period afterwards through information presented to patients and families. In mid-January 2019, apparently following complaints made by some families directly to the Scottish Government about the more general quality of information being provided by the Health Board, briefing was provided about the dosing. However, the written information was opaque:

> *"It is also important to note that the additional measures to ensure water quality have been put in place for the whole site (QEUH/RHC) and these have been successful. Our rigorous water quality testing is demonstrating good results alongside the ongoing use of water filtration devices."*

A fuller description of the chemical dosing system and its implications did not appear to be forthcoming in the following months, though references were made in subsequent briefings to patients and families. It further highlights what seems to be a different approach between what was communicated on the ward – where there would have been opportunities for direct questions from those patients and families present – and what was communicated through corporate channels.

New Infection Incidents in Wards 6A and 4B in 2019

127. The de-canting of the children and young people into Wards 6A and 4B should have been seen as an end to a period of severe anxiety about environmental risks. Consequently, the appearance of new infection incidents in the QEUH wards in 2019 caused renewed, if not higher levels of distress and raised further questions about the capacity of the Health Board to manage IPC. The new series of infections from June presented the Health Board with new communication challenges. At this point, the issues had features that were not present before. It carried a strong risk of suggesting that whatever action had been taken before had 'not worked' and that NHS GGC was not 'in control of the situation'. This was compounded by the difficulties that the IMT in the second half of 2019 faced in identifying the source of the new infections. As with the 2018 'water incident', strong IPC measures were required such as the closure of Ward 6A to new patients for a period, which led to disruption for the children and young people. The potential for undermining trust in NHS GGC was acute.

128. During that period, the Health Board endeavoured to keep patients and families updated on what was going on at different points. Verbal and written briefings continued to be provided after each IMT meeting, and a new dedicated Facebook group/page was established. While there was significant (and arguably inevitable) repetition of information across the different updates, the fact that they were being made was evidence of the Health Board recognising the importance of maintaining the flow of information to patients and families.

129. However, there seemed little open recognition of potentially deeper issues with regards to the environment. By this stage, the notion of widespread water contamination was becoming increasingly accepted – while the pathways and sources of infection eluded detection, the idea that the water system may have been contaminated at some stage in the construction/commissioning of the hospital was present in the HPS report on Wards 2A/2B and the accompany HFS report. The briefings to patients and families did not acknowledge these issues, but instead emphasised that "*we have undertaken extensive testing of the ward environment and at this stage no link has been detected between the infections and the ward environment or our infection control practices*" (as set out in an October 2019 briefing, but presented in similar phrasing in other briefings at that time). Patients and families were, of course, increasingly aware of the wider issues relating to the building, which meant that through this period there may have been a widening divergence between what several families understood from other sources and what they were being told by the Health Board.

130. Statements by the Health Board, of course, must be factually accurate. There is a risk in conveying perceived risks about the environment without fully understanding what is happening. Nevertheless, as more infections occurred in 2019, uncertainty around the environment would not go away, and communication efforts should have adapted to recognise and respond to that uncertainty. The lack of reference to these wider risks seems to have exacerbated a perception that the Health Board was increasingly focused on 'managing' rather than providing information. It reflected what appeared to be a greater priority on reputation management than regular, pro-active and supportive communication more explicitly

informed by the perspective of patients and families. This approach to communication – one that provided messages that were supportive of the organisation but did not consistently respond to individual patient concerns – seemed to have diminishing returns with an (understandably) increasingly vocal and expanding group of families that were unhappy about the lack of transparency in what was going on. By not openly acknowledging more readily what was *not* known about the infections, the Health Board created the impression that it was simply hiding something that was alleged to be known about the building. This potential trap is perhaps most tellingly demonstrated in the following more recent milestone.

Recent Issues Following the Announcement of Legal Action by NHS GGC

131. Since the Oversight Board was established, NHS GGC has announced that it was launching a legal case against the QEUH builders, Multiplex. As a result, the Health Board has become notably more sensitive to communication that could have a bearing on the conduct of the legal case, and as a result, has become increasingly reluctant to comment or discuss aspects of the infection incidents and the related issues, citing the risks of compromising the forthcoming legal case. This featured recently in its responses to the Independent Review's report on the commissioning, design, construction and handover of the hospital complex and a BBC Scotland Disclosure documentary on the QEUH (which aired in June 2020), when the Health Board was notably limited in its response to the issues raised. This has exacerbated a sense among several families that the Health Board had continued not to pursue a policy of transparency and sensitivity to the affected children, young people and families.

132. The Oversight Board appreciates the legal sensitivities facing the Health Board, particularly where it is likely to be made on the back of internal legal advice, but considers that continuing reluctance to be more open on many of these issues is exacerbating rather than resolving the fundamental concerns on communication and engagement that gave rise to escalation to Stage 4. This is particularly relevant given that the timescales for the legal action are not clear at this point, but could last for a prolonged period. A better balance about engaging on the challenges and history of addressing the problems of the QEUH is needed if there is to be restoration and trust in the Board's commitment to, and delivery of pro-active, transparent, compassionate and supportive communication and engagement where patients and families express concerns or ask questions. This should be irrespective of the number of families involved or any perceptions regarding their 'representativeness' with respect to the wider group of affected families.

Observations

133. All of the incidents described above show strong direct communications, but problems with corporate communication to the wider group of patients, families and ultimately, the public. There seems to be several recurring themes.

134. First, there was a lack of timely information on what was known about the infection issues and what actions were being taken as a result. Points raised by some families included:

- a widespread feeling that the Health Board was slow to respond to specific queries put to them about their children's care (for example, concerns in respect of the time taken to respond to the issues later reflected in the summary of 71 questions and issues that were put to the Cabinet Secretary for Health and Sport by family representatives in late 2019), and that communication with patients and families could sometimes 'lag' official press releases on media stories;
- suggestions that patients and families were hearing about key information through the media and press releases by the Health Board, rather than directly, adding to an impression of too often being 'kept in the dark'; and
- in a few cases, allegations that the Health Board was not answering questions "*properly or truthfully*", as one of the respondents to the family survey noted.

135. Such comments have been persistent across the period. For example, suggestions that there was a lack of transparency by the Health Board were made by some families at the start of the 'water incident' in March 2018. They have continued through to more recent discussions and the reaction of families on the Facebook page to the BBC Disclosure Scotland documentary in June this year. Across the period, communication did not always demonstrate to these families a clear, person-centred tone in addressing such sensitive issues. The work by Professor Craig White as 'family liaison' to support the way NHS GGC was drafting its public messages from late 2019 also highlights the need of the Health Board to develop more person-centred language in how it reacts to critical media stories.

136. Several families, particularly those with prolonged and continuing engagement with the Health Board because of the care and circumstances of their children, felt that the Board was often reluctant to provide direct answers to their questions and information about the hospital. This reluctance was fed by a sense of sluggish responses to questions posed, a strong impression of information being partial or misleading and a belief that the Health Board would not admit any mistakes that might have been made regarding the environment of the building or the care of their children. These views were not shared by the Health Board, and it was occasionally suggested that the responses reflected a minority of families that were explicitly expressing their views. Nevertheless, it was clear that the views of several families became more entrenched over the period, and that any communication and engagement efforts by NHS GGC to address distrust and lack of confidence in the Health Board did not fundamentally shift this sense of distrust. The obligations of the Health Board to respond openly, compassionately and supportively to any patient or family who raises concerns has not been consistently evident in the thinking, decision-making or actions of senior staff.

Scope for Improvement

137. While the Health Board has strived to learn from the unique situation it faced, there remains a continuing need for improvement in how communication, engagement and information provision takes place. Part of this requires a fuller understanding of the challenges facing the Health Board with respect to

communication, not least in terms of national learning to be gained from how to respond to infection outbreaks.

138. One key challenge was how to communicate a complex set of issues where uncertainty would not go away. This uncertainty had different dimensions to it. The exact source of infections was not clear throughout the period –- this proved a complex problem for the Health Board through 2018, where the picture of what was taking place developed incrementally. Knowing what and how to communicate with children, young people and families in this situation was not relatively straightforward. This was complicated with the difficulties of engaging with patients and families who were no longer in regular contact with the service. In particular, the timing of when to update patients and families was often hard to determine, not least in an environment of significant media scrutiny. Providing timely, full information to families was not always easy. Social media was a particularly complicating factor, as it could convey stories more quickly than the Health Board was accustomed to responding act as an amplifier – if not in some cases, a distorter – of some of the concerns being expressed. At the same time, the Health Board was seen as slow to take advantage of social media as a means of communicating with patients and families, and indeed, the wider public, about key developments, or addressing any misconceptions being disseminated.

139. Nevertheless, while these challenges made communication decisions more difficult to take forward, there are several areas where NHS GGC must take action to ensure the delivery of necessary improvements:

- the communication responsibilities of IMTs;
- coordination between different teams/services in communication;
- communication with staff;
- visibility and approach of senior management in communication; and
- the role of external bodies in supporting communication.

<u>Incident Management Team Responsibilities</u>

140. In line with national practice, the responsibility for communication decisions is typically lodged with IMTs – what to communicate, when and through what media – with communication advisors providing support and IMT Chairs with a key role in taking decisions. Throughout 2018 and 2019 in particular, IMTs were clearly active in response to communicating the infection incidents.

141. IMTs are often necessarily focused on specific outbreaks. While understanding a wider context of infection can be critical for determining the source and mitigation, the idea of a *communication* context to outbreaks seems less well appreciated. For the children, young people and families affected, a series of infections may appear part of a single continuum of events, potentially marked by escalating anxiety and disruption. This perception of a continuing ‘crisis’ did not seem to inform the approach to communication across the period, where actions were regarded typically in terms of addressing short-term issues. The IMT process, while useful for these more incident-based situations, was potentially less effective for a prolonged scenario when a number of incidents could be linked together by

patients and families (and as became the case in 2019, in the eyes of the media, politicians and the public).

142. A better process should be identified to allow for infection incidents to be more explicitly considered within that broader context. This should take full account of previous communications, consistency in messages where appropriate and the recognition that the audiences of these communications have changing expectations of what they want to know from the Health Board as the 'crisis' develops (particularly if initial questions about the source of infections cannot be quickly addressed). The learning for NHS GGC here would have a clear national dimension as well. Such a process may involve shifting some communication responsibilities away from the individual IMTs when it becomes clear that the incidents are being seen in a larger context. This would need to have clearly defined triggers, roles and responsibilities. This was particularly evident in relation to the responsibilities for developing and issuing press releases, as it was not clear to the Oversight Board where full responsibility was being exercised and the extent to which this was led by IMTs in practice.

Coordination of Communications

143. Infection issues can draw in the work of several services within the Health Board, including clinical staff, the IPC Team, Facilities and Estates, and senior managers. Clear coordination and a common approach to information, messages and the culture of communication is essential.

144. NHS GGC was not consistently integrated in its communication in this context. Key messages, especially when delivered directly on wards, would have often benefited from a more systematically joined-up approach, particularly between the IPC Team and facilities/environment personnel. Some families had reported that while ward-level communication was delivered compassionately and usually at the right time, that communication would have been more effectively delivered if they were made with the visible involvement of other staff who have a clear link to what was being communicated.

145. This was particularly highlighted for issues relating to changes in the estate and the physical environment as a result of the incidents – whether local changes such as the use of water filters on taps in rooms or wider changes, such as the de-canting of the whole of Wards 2A and 2B. Assurance would have been more strongly communicated to patients and families had these messages been more regularly undertaken jointly by clinical and Facilities and Estates staff.

146. Overall, the Health Board's corporate messaging needed to be more joined up in terms of recognising the range of activity that was taking place at any one time. The issuing of single-narrative corporate briefing points to NHS GGC's recognition of the importance of a common message. But as these briefings sometimes needed to be supplemented with questions directly posed by the families, it resulted in ward staff sometimes appearing not fully informed enough to address the concerns presented to them. This was particularly true in 2019 with the new series of infections in the QEUH wards, when many of the families' questions related to more technical, environmental subjects that were best addressed by Facilities and Estates

staff. As a result, the consistency of the information and messages across different levels of the organisation was not evident across the period, adding to the frustration experienced by some families and putting more pressure on ward staff.

Communications with Staff

147. This chapter has focused on communication and engagement with patients, families and the public, but there was an equally important need to provide regular information and reassurance to staff as well. This was important because of the duty of care of the Health Board to its staff, recognising their concerns about working in a potentially 'unsafe' environment as well as their natural compassion for their patients. It was also critical given the vital role that staff – especially those on the wards – played in providing information to patients and families. Communication with staff was another aspect of wider engagement with the public.

148. Staff concerns were evident throughout this period. While the concerns about the risks of the building tended to be expressed by individuals before 2018, from the 'water incident' onwards it became a continuing source of anxiety for groups of staff. For example, in September 2018 (before the de-canting), staff in Wards 2A and 2B were reported to have been visibly upset and anxious at a staff information event, and some approached their union for advice about the safety of their patients remaining within the ward. Specific decisions could raise concerns, such as the blanket use of anti-fungal prophylaxis as part of the IPC measures – in December 2018, some medics expressed concerns about the prescription of prophylaxis, as several children had experienced severe reactions. Moreover, when the *Cryptococcus neoformans* infection was drawing intense media scrutiny in early 2019, staff were reporting their own respiratory problems that they felt might be linked to ventilation /infection issues.

149. The Health Board responded actively to these concerns: there were regular briefing updates to staff (often weekly during the most intense periods), face-to-face meetings with senior hospital managers and active engagement by the IMTs through the Lead Infection Control Doctor. The commitment to keep staff up-to-date and supported through this period was evident, and there is no suggestion that the Health Board was not forthcoming to its staff about what was happening.

150. Nevertheless, while the regularity of such communications may have allayed anxieties, they could not remove them, for the same reason that some families remained dissatisfied with Health Board communication efforts. The prolonged uncertainty around what was causing the infections and the risks associated with the building could not disappear, forming an ever-present background to healthcare operations on the site. Moreover, as set out already, the apparent reluctance of the Health Board to be more forthcoming about the risks and issues around water contamination was making this issue of how to be open about what was known, and what was not known, as critical for staff as it was for the children, young people and families.

Role of Senior Management in Communication

151. While frontline staff were seen as important communicators, especially by the patients and families, it was not always appropriate for them to communicate on issues related to more corporate responsibilities, and where high-level decisions (such as de-canting or temporarily closing wards) were being taken. The perception of some families was that frontline staff were 'unfairly' put in the position of communicating 'difficult' messages.

152. Moreover, there was a strong feeling among some families that senior management in NHS GGC were not sufficiently and consistently visible in speaking/communicating with them at an early stage. While acknowledging that communication roles were rightly placed at different management levels within such a large Health Board, the nature of the incidents, particularly when such disruptive steps such as de-canting had to be taken, required a clear and unequivocal demonstration of senior leadership in communication. Its perceived absence was regarded as a key factor in undermining family confidence in NHS GGC to address these issues.

153. Senior management in NHS GGC did remain close to the development of the issues at different stages, but the importance placed on what was happening to the children, young people and families was not always communicated widely and effectively by those with Executive responsibilities. There was a gap between the perception of some families that senior Board management in NHS GGC were not closely involved with the emerging infection issues and the evidence that they were being regularly monitored by the Executive team within NHS GGC. This appeared to be an issue of visibility in many cases, and in retrospect, there were missed opportunities to highlight the priority with which this was being considered at senior levels within NHS GGC. As the issues became more prominent in the media, several families commented that more direct engagement with more senior staff within NHS GGC at an earlier stage would have helped to bolster confidence, and defuse much of the tension that has continued to play out publicly.

154. Senior leaders within NHS GGC did become directly involved, with letters to families from the Chief Executive being issued later in this period (including a letter of apology in early 2019) and opportunities extended for families to meet with them. In this context, the Oversight Board welcomes the identification of the Nursing Director as the key Executive for communication with families by the Health Board. It further suggests that more visible senior leadership in communication with the public and with the children, young people and families at an earlier stage should be systematically considered to inform future practice.

Support from External National Bodies

155. The Health Board admitted that the complexity of the communication challenges meant that it could have benefitted from greater external support and advice in how to handle patient, family and public expectations. That support was not perceived to be present for much of the period, and indeed, it is not clear that this kind of support is regularly provided and coordinated across NHS Scotland. As a result, there is national learning to be gained in the external support and positioning

around Board communication. The role and coordination of messaging by external bodies, particularly HPS and the Scottish Government, could also improve to ensure that these issues are not regarded as exclusively local.

156. In this respect, the difficulties faced by NHS GGC should not be regarded as exclusive to it, but potentially something that can be shared by other Health Boards facing similar situations and acting within the existing expectations and approaches to communication. Just as there are national bodies on hand to provide centralised specialist expertise to the Health Board in terms of the IPC challenges, similar national consideration should be given to having analogous expertise and advice on communication and engagement as well.

Remaining Work

157. As well as a general responsibility to inform patients, families and the wider public through the infection incidents, the Health Board is subject to a series of specific duties to investigate, inform and enter into dialogue when harm occurs in hospital settings. These duties are governed by a range of legislative, regulatory and guidance frameworks, but they all require compliance of Health Boards in the fulfilment of defined actions. They include:

- the organisational duty of candour: this is a legal duty which sets out how organisations (such as Health Boards) should tell those affected that an unintended or unexpected incident appears to have caused harm or death, and which requires the organisations to apologise and meaningfully involve those affected in a review of what happened – the Communication and Engagement Subgroup has undertaken work on this area, but that work will need to be linked into the wider assessment of reviews set out below;
- reviews of Significant Adverse Incidents: a national framework now exists to provide an overarching approach for best practice in how care providers effectively manage adverse events; and
- morbidity and mortality reviews: the reviews of patient deaths or care complications are designed to support organisations improve patient care and provide professional learning.

158. It is important that the Oversight Board can provide assurance that these obligations and commitments to good practice were met during these incidents. The Oversight Board is continuing to review these matters and will report its findings in the Final Report.

Case Note Review

Background to the Case Note Review

159. As part of the work of the Oversight Board, the Cabinet Secretary for Health and Sport set out plans for a Case Note Review in a Parliamentary statement on 28 January 2020. The Case Review team would review the case notes of paediatric haemato-oncology patients in the QEUH and RHC from 2015 to 2019 who had a gram-negative environmental pathogen bacteraemia (and selected other organisms) identified in laboratory tests.

160. The Case Note Review is currently reviewing the clinical records of all children and young people diagnosed with qualifying infections and who were cared for at the QEUH and RHC between 1 May 2015 and 31 December 2019. It is focusing on several key aspects: the number of patients (in particular, immuno-compromised children and young people) who may have been put at risk because of the environment in which they were cared; and how that infection may have influenced their health outcomes. Such work will be vital in determining the number and nature of the children and young people affected, providing assurance and identifying improvement actions, not just for NHS GGC, but more widely across NHS Scotland. It is also an important element in improving the communication and engagement with the affected children and young people and their families.

161. The Review will consider the balance of probability on the following set of specific questions:

- *How many children in the specified patient population have been affected, details of when, which organism etc?*
- *Is it possible to associate these infections with the environment of the QEUH and RHC?*
- *Was there an impact on care and outcomes in relation to infection?*
- *What recommendations should be considered by NHS GGC – and, where appropriate, by NHS Scotland, more generally – to address the issues arising from these incidents to strengthen IPC in future?*

162. There are two specific sets of outputs:

- reporting to the Oversight Board; and
- specific feedback to patients and families (including responses to questions raised by individual families).

<u>Reporting to the Oversight Board</u>

163. The independent Expert Panel will be responsible for providing a Final Report to the Oversight Board, which will include:

- a description of the approach and methodology to the Review;
- a description of the children and young people included in the Review;

- a description of the cases according to specified data types;
- analysis to answer the questions set out above; and
- observations on any prior NHS GGC internal reviews of individual episodes of care
- recommendations for NHS GGC and NHS Scotland, based on this analysis.

Individual case details will not be set out in the Report and the cases will be anonymised. This Report will be published.

Reporting to Patients and Families

164. The Expert Panel will provide individual private reports to patients and families that have requested details of the results of the reviews on the experiences of the individual children and young people.

Progress Update

165. As with the work of the Oversight Board, the Case Note Review's timescales have been affected by the impact of the pandemic – however, its work has progressed, albeit at a slower pace. The Expert Panel has agreed a classification of relevant infecting organisms, and the case notes of all children and young people defined as follows:

- those with a gram-negative environmental bacteraemia (bloodstream infection) – most patients fall into this group;
- other environment-related infections – there are a few other types of infection which may be associated with the environment (such as *M. chelonae*), but this includes only a small number of cases, some with bloodstream infection and some with similar infections found at other sites; and
- a smaller number of individual children and young people identified for inclusion for special reasons, where concerns have been raised that are related to the issues affecting the QEUH/RHC.

Currently, 85 children and young people have been identified, and whose clinical records will be reviewed (some have had more than one 'qualifying' infection episode).

166. The Expert Panel has estimated that it will complete its review of the instances of infection and be presenting its report in early 2021.

Interim Report Findings and Recommendations

167. The core of the Oversight Board's work has been the issue of assurance. Escalation has arisen from a history of complex issues since at least the opening of the QEUH, but the primary matter that gave rise to escalation to Stage 4 was a question of the 'fitness for purpose' of NHS GGC relating to: how IPC is conducted; the way that governance operates with respect to infections; and the communication and engagement approach to these events. Understanding the history of what has happened to the children, young people and the families in the paediatric haemato-oncology service and the clinicians that have supported them has been essential for the Oversight Board. Knowing this history is critical in ensuring that the right lessons have been learned and in further considering the current fitness of the structures and functions of NHS GGC within the Oversight Board's terms of reference.

168. Ultimately, the main question before the Oversight Board has been whether NHS GGC should be 'de-escalated' from Stage 4. As this is an Interim Report, the Final Report will provide a final assessment of all the issues that gave rise to escalation, the contributory factors, the learning and improvement evident to date from the Health Board – and ultimately, assurance on the issues on which NHS GGC were escalated. Notwithstanding that this remains work in progress, this Interim Report has already identified a number of areas where improvement needs to take place for that assurance to be robust. This forms the basis for the findings and recommendations set out in this chapter. The Final Report will set out the conclusions from the rest of the Oversight Board's work, taking account of the Case Note Review, and provide the full list of recommendations.

Findings

169. Findings are given for each of the different issues that led to the Health Board being escalated to Stage 4. Of the three areas for escalation, one – governance – is not examined in detail in the Interim Report. In addition, the work of the Technical Issues Subgroup has not been finalised for this report either, as noted above. Consequently, the findings (and recommendations) here focus on major elements of the two following areas: IPC; and communication and engagement.

Infection Prevention and Control: Processes, Systems and Approach to Improvement

170. Expectations around the scope and pursuit of IPC have changed over the last few years, reflecting, amongst other things, the impact of the Vale of Leven Inquiry. The Inquiry had a major impact on NHS GGC, of course, but it has changed the national context for ensuring that there are consistent, good-practice and evidenced approaches to effective, safe IPC. This has not been a single point of national transformation, but a continuing drive for improvement, one that will continue with the creation of a national centre of expertise for healthcare built environments. The constant evolution of a Scotland-wide agenda in IPC highlights both the challenges that the Health Board faced in addressing the infection incidents in the QEUH site – which presented complexities and unexpected issues that were far from recognised

experience in Scotland – as well as the opportunities for using NHS GGC's learning to support NHS Scotland as a whole.

171. What has become clear is the importance of all Health Boards to balance a commitment to these national standards and the codified processes that they set out, rooted in evidence-based good practice, with the flexibility and professional judgement to go beyond set processes where required. Practice has been captured in national guidance and standards with clearly-established reporting and monitoring regimes. Finding that balance has been essential to be able to respond to the new situations and developments in infection control, as indeed, the current pandemic is exemplifying to an alarming degree.

172. NHS GGC showed itself capable on repeated occasions of achieving that balance. Outside of these infection incidents, the recognition of the need to drive improvement was present in its work on CLABSI (and more widely, *Methicillin-resistant Staphylococcus aureus* (MRSA)). In the series of gram-negative infection outbreaks, the Health Board could respond innovatively and positively, with examples including specific responses to incidents (such as the establishment of the Technical Water Group in response to the 2018 'water incident', which will be discussed in more detail in the Final Report). That work is continuing through the recent reforms put in place in NHS GGC through a new 'Gold Command' structure and the formation of a dedicated programme of work to support improvement in IPC with joint executive leadership from the IPC Team, hospital operations, and Facilities and Estates.

173. However, these instances were not sufficiently consistent to provide assurance. An improvement-based learning approach – vital in addressing circumstances as novel and challenging as the environmentally-based infections in the QEUH – did not appear to be mainstreamed across the organisation. A structured use of quality improvement and good learning in one area did not seem to be systematically mainstreamed across the organisation. The IPC Team was seen as remaining too siloed and not fulfilling its role as the service that embeds improvement and mainstreams good IPC across the Health Board. Recognising recent progress, the Oversight Board welcomes the NHS GGC's creation of a new IPC work programme, and believes that one of its early priorities must be how improvement principles can be deepened in its work.

174. Through the work of the Peer Review, the Oversight Board highlighted a number of specific processes where improvement was required.

- Health Board compliance with the NIPCM was translated through a profusion of additional local guidance and interpretations of national standards, which ran the risk of promoting a 'GGC way of doing things' rather than nationally-endorsed standards.
- HAI-SCRIBEs were not pursued with full diligence and fidelity to process. Too often there seemed to be 'shortcuts' being taken in how HAI-SCRIBEs were put together that suggested a lack of understanding behind the good practice captured in the NIPCM.

- Audit and surveillance showed an inconsistent approach to improvement overall, with insufficient follow-through actions on audits and the absence of a pro-active approach to additional environmental alert organisms in surveillance.
- The scoring of HIIATs raised some concerns that the Health Board was not giving full (and in the Oversight Board's view, necessary) consideration to the wider context of infection at the QEUH site when rating infections. Elements of this issue have a national dimension, and the Oversight Board recognises the opportunity to improve practice across all Health Boards. But in the context of the environmental risks in the QEUH, the approach to HIIATs may indicate an underestimation of the wider infection risks facing the site.

175. The Interim Report has focused on how the IPC Team tackles different aspects of IPC. The Final Report will focus on how the Health Board handled the specific incidents, and what that reveals of the way IPC is conducted by the Health Board.

Communication and Engagement

176. It is hard to imagine a group of children, young people and families for whom the principles of person-centred communication would be more relevant in a healthcare setting. Within the paediatric haemato-oncology service, families were experiencing the sustained impact of the problems in the clinical environment on their children, including significant disruption and uncertainty. Given the nature of the patients, there were high-risk consequences of the issues remaining unresolved – communication and engagement through regular, sensitively-presented and clear information was vital.

177. The Health Board seems to understand this. It espouses person-centred principles in its overarching communication strategies. Indeed, throughout its work, the Oversight Board was presented with a lot of good evidence of a compassionate approach to communication within NHS GGC, especially by staff at the point of care. Families singled out the medical and nursing staff for their support, not least in how they kept themselves and their children as well informed as they could, a clear reflection of the person-centred approach to discussing individual care with patients and families. At this level, transparency and sensitivity seems to be regularly balanced in a way that patients and families regard positively – albeit sometimes limited and constrained by the problems with corporate and senior management communication referred to in this report.

178. However such an approach is inconsistently applied across the organisation. When it comes to communication that goes beyond ward level, too many patients and families feel that it has not been actioned, timely or fulsome, and that they are too often the last to know. This sense accumulated over several years, and it currently strains relationships between some families and the Board (and in a few cases, contributed to those relationships breaking down). Several families have felt that the Board has been too slow, if not reluctant, to provide them with answers to their questions, and have developed a deepening view of a Health Board that cannot admit to mistakes – or even, simply acknowledge uncertainty – about the environment of the building or the care of their children. Wherever the causes lie with

this, the results demonstrate a clear failure of the goals of communication for this group of children and young people and their families as a whole. Indeed, the appointment of Professor Craig White, in part a response to the gaps that had appeared between families and the Health Board, has been an acknowledgement of this.

179. From the Health Board's perspective, it is important to understand the challenges facing NHS GGC with communication.

- There was long-term uncertainty in how to explain the infection incidents, especially over the source of infections and the picture of environmental risk that started to appear.
- At some points over the period (notably in the aftermath of the *Cryptococcus neoformans* infections in early 2019), media coverage was experienced as a 'siege', heightening wariness of how public communication was managed. This created some logistical challenges in ensuring children, young people and their families were given correct information before any misleading or false news spread through the media.
- Those challenges were particularly acute in providing consistent and timely communication with patients and families no longer in regular contact with ward-based staff.

180. The Health Board mainstreamed a commitment to tailored and sensitive responses to individual patients and families through a database to reliably note individual family communication and information preferences. The creation of the closed Facebook page recognised that communication was not simply between individual patients and families with the Health Board, but amongst each other, as part of a community sharing the common experience of a child or young person in contact with the service and concerned by the impact of infection issues on their child's care experience and outcome.

181. The gradual unfolding of the scale of problems at the QEUH, with the emergence of hypotheses relating to the environment and building that could not be quickly verified or discounted, presented particular challenges in communication. The responsibility for decisions in respect of communication about incidents and outbreaks is typically lodged with IMTs, with communication advisors providing support for discussions to inform decisions by IMT chairs. While IMTs were active through this period in response to the infections, the IMT process itself – useful in more incident-based situations – was potentially less effective for a continuing 'crisis'. A new, or at the very least, enhanced process may need to be identified to address this with national support.

182. The recent legal action against the builders of the QEUH complex seems to be complicating the ability of the Health Board to be as open and responsive as patients and families need. There is a risk of the Health Board becoming increasingly reluctant to comment or discuss aspects of what has happened in relation to the infection incidents, citing the risks of compromising the forthcoming legal case. This has exacerbated a sense among several families that NHS GGC has not been pursuing a policy that gives primacy to transparency and sensitivity to the affected children, young people and families. While the Oversight Board appreciates the legal

issues facing NHS GGC and the force of legal advice, it considers that alternative approaches were and are possible and that the current continuing silence on many of these issues will not address fundamental concerns on communication and engagement that gave rise to escalation to Stage 4.

183. Lastly, there is a national dimension to this as well. Just as with other aspects of healthcare, there is a clear value in pooling experience and practice in NHS Scotland to address complicated communication challenges and developing national expertise. External bodies such as HPS and others did not have the expertise to providing NHS GGC with advice and support in this area. While the responsibilities may fall locally to NHS GGC, the implications are Scotland-wide, and deserve the same approach to improvement and learning found in other areas of healthcare.

Recommendations

184. The recommendations of the Oversight Board are rooted in the findings described above. As noted earlier, there are important lessons for NHS Scotland as a whole as well as specifically for NHS GGC – indeed, the unusual experiences of the Health Board could provide important lessons for Scotland. The Oversight Board has been well aware of the novelty of the challenges faced by the Health Board, the absence of national guidance in some areas and the importance of making an assessment that is not distorted by hindsight. They have been driven by the importance of ensuring that there is learning and change to address any similar set of challenges in future, whether within NHS GGC or across NHS Scotland more widely.

185. The recommendations are based on what needs to be done by NHS GGC and others to provide assurance and address escalation. In terms of the Key Success Indicators of the Oversight Board, they identify the changes that are required to satisfy the Oversight Board that these success indicators will be met and assurance restored, at least for the areas reviewed in the Interim Report. The recommendations are grouped according to each set of escalation issues: IPC; and communication and engagement. National recommendations are set out in the **green** boxes below.

<u>Infection Prevention and Control: Processes, Systems and Approach to Improvement</u>

186. The Interim Report recommendations cover the following key areas:

- the degree to which specific IPC processes in the QEUH have been aligned with national standards and good practice; and
- the extent to which the IPC Team has demonstrated a sustained commitment to improvement in infection management across NHS GGC.

Recommendation 1: With the support of ARHAI Scotland and Healthcare Improvement Scotland, NHS GGC should undertake a wide-ranging programme to benchmark key IPC processes. Particular attention should be given to the approach to IPC audits, surveillance and the use of Healthcare Infection Incident Assessment Tools (HIIATs).

187. With support from ARHAI Scotland and Healthcare Improvement Scotland, NHS GGC should undertake a comprehensive programme of work to address the shortcomings identified here. This should build on the existing Peer Review process, led from within its IPC Team but drawing on external expertise. It should also fit into the existing programme of work being taken forward as part of the Silver Command workstream in the Health Board. The scope and terms of reference should be agreed with the Scottish Government by March 2021.

188. This exercise should be undertaken as soon as feasible (acknowledging the pressure of other circumstances, not least the pandemic), and completed by the end of August 2021. The recommendations of that work should be jointly presented to the NHS GGC Board and the Scottish Government, and the former should authorise an action plan to implement any relevant recommendations.

189. This should include a review of audit programmes to ensure consistency in RAG rating and a stronger link to a continuing culture of improvement. This would help to confirm that there is an organisational approach to safe care auditing, in particular ensuring that it is not the sole responsibility of the IPC team. This should be done in the context of existing Quality Framework for improvement and planning as set out by HIS and involve the latter in a support role.

190. As seen above, the rating of HIIATs for the relevant infections in the QEUH raised concerns about consistency for the Oversight Board. A more in-depth and wide-ranging review needs to be undertaken by NHS GGC, looking at the local criteria and judgements applied to ratings for infection incidents related to the QEUH. Attention should focus on how known environmental risks in the hospital, especially with respect to potential water contamination, are explicitly factored into assessment.

Recommendation 2: With the support of ARHAI Scotland, NHS GGC should review its local translation of national guidance (especially the National Infection Prevention and Control Manual) and its set of Standard Operating Procedures to avoid any confusion about the clarity and primacy of national standards.

191. NHS GGC has not applied the NIPCM as fully and transparently as it could. Moreover, there was a view that not all guidance in the NIPCM was appropriate for NHS GGC. Consequently, NHS GGC should conduct a review of its guidance portal so that clinical staff are referred to the NIPCM and all relevant national guidance (as set out in DL 2019 (23)) more clearly as a single 'point of truth'. This should build on progress already made to feed into national structures, minimising the development of new local guidance. This exercise should set clear, consistent principles for the

development of local translations of national guidance, as well as the responsibility for developing, implementing and overseeing the relevant set of standards/guidance. This should be completed by end April 2021 and the results presented to the Scottish Government.

Recommendation 3: ARHAI Scotland should review the National Infection Prevention and Control Manual in light of the QEUH infection incidents.

192. Surveillance issues need to be addressed at national level as well. ARHAI Scotland should review the NIPCM to consolidate and prioritise content in relation to alert organism surveillance. In particular, Appendix 11 and the A-Z guidance list of organisms of the national manual should be enhanced as required so there is national consistency to any aide-memoires developed for clinical staff to use locally. The guidance could benefit from additional disease-specific evidence-based SOPs or aide-memoires for some novel pathogens to be produced nationally. This review should be taken forward in collaboration with the Scottish Government and completed by end August 2021.

Recommendation 4: With the support of Health Facilities Scotland, NHS GGC should undertake an internal review of current Healthcare Associated Infection Systems for Controlling Risk in the Build Environment (HAI-SCRIBE) practice to ensure conformity with relevant national guidance.

193. NHS GGC should undertake an internal review of current HAI-SCRIBE 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 IPC Team to take account of level of risk, as well as the scale of the project; the level and nature of the required input from the IPC Team for projects which are deemed smaller; and the overall use of HAI-SCRIBE and the consistency of use across NHS GGC, including consistency training for those undertaking HAI-SCRIBE. The review should be undertaken in cooperation with HFS and the results presented to the Scottish Government by end August 2021.

Recommendation 5: Health Facilities Scotland should lead a programme of work to provide greater consistency and good practice across all Health Boards with respect to the use of HAI-SCRIBEs.

194. HFS should work with Health Boards across Scotland to develop a governance system for ensuring HAI-SCRIBEs are completed consistently across and within all Health Boards. This should entail the establishment of a national forum to enable better sharing of design issues and lessons learned, with plans and a timetable for the forum to be agreed with the Scottish Government by March 2021.

This should be supported by a review of the current HAI-SCRIBE guidance across all Health Boards, which should be led by HFS in cooperation with the Scottish Government and completed by end August 2021.

Recommendation 6: ARHAI Scotland should review the existing national surveillance programme with a view to ensuring there is a sustained programme of quality improvement training for IPC Teams in each Health Board, not least with respect to surveillance and environmental infection issues.

195. IPC teams 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 Oversight Board recommends 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, such as those who are isolating multi-drug resistant organisms; and
- provision of training for IPC teams regarding quality improvement, utilising the data and intelligence from both audit and surveillance to ensure better outcomes for patients.

ARHAI Scotland, working with the Scottish Government, should set out plans for the required programme of work before the end of August 2021, potentially using the national forum referenced in Recommendation 5 above to develop and monitor the work going forward.

Recommendation 7: ARHAI Scotland should lead on work to develop clearer guidance and practice on how HIIAT assessments should be undertaken for the whole of NHS Scotland.

196. The review of HIIATs found that national improvement is needed. All Health Boards should be encouraged to report all infection-related incidents in an open and transparent manner. To support this nationally, by the end of August 2021:

- ARHAI Scotland should further develop the HIIAT assessment and reporting tools to allow service, ARHAI Scotland and the Scottish Government to visualise easily all incidents within a healthcare facility over time;
- ARHAI Scotland should coordinate a working group through the NIPCM steering group to consider the HIIAT assessment more generally, including a standardised scoring system to provide a more robust risk assessment of infection-related incidents within care systems;
- a programme of work to improve national guidance and good practice should be drawn up to ensure NHS Boards and other organisations IMT consider

previous incidents and any possible links when assessing all new infection-related incidents;

- a programme of work to develop education tools nationally to assist staff responsible for assessing and reporting infection-related incidents across NHS Scotland; and
- the Scottish Government should consider the communication and escalation process for all incidents, including a 'green' HIIAT.

Recommendation 8: A NHS GGC-wide improvement collaborative for IPC should be taken forward that prioritises addressing environmental infection risks an ensuring that IPC is less siloed across the Health Board.

197. The Oversight Board welcomes the development of a new improvement collaborative for IPC, and suggests that it takes forward early priorities that address the findings and recommendations set out here. As part of this, to ensure that IPC is more effectively mainstreamed across the different parts of the organisation, a cross-NHS GGC exercise should be undertaken to develop a plan for ensure IPC operates in a less siloed fashion across different service/functions in the Board. That exercise should consider the role of the IPC Team and the aspects of IPC that should be the responsibility of other parts of the organisation and other teams. It should undertake any necessary benchmarking with other Health Boards. The results of the work should be considered by the Board Infection Control Committee and the Clinical Care and Governance Committee. Monitoring arrangements for implementing the plan should be clearly set out as part of this.

198. The scope of the work should be agreed with the Scottish Government and the Health Board by end March 2021 and the work completed by end August 2021.

Communication and Engagement

199. Recommendations are set out below with respect to the overarching question: ***is communication and engagement by NHS GGC adequate to address the needs of the children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?*** Issues relating to how the Health Board formally reviewed these incidents and engaged with patients and families, particularly decisions not to activate the statutory organisational duty of candour procedure and the implementation of review processes such as Significant Adverse Event Reviews, will be considered in the Final Report.

Recommendation 9: NHS GGC should pursue more active and open transparency by reviewing how it has engaged with the children, young people and families affected by the incidents, in line with the person-centred principles of its communication strategies. That review should include close involvement of the patients and families themselves.

200. The particular problems of communicating information on HAI in the paediatric haemato-oncology service – when key information remains uncertain, or at best, nuanced – was acknowledged by the Oversight Board. It was challenging for NHS GGC to balance assurance in its approach to addressing the infection incidents when there was continuing, longer-term uncertainty on the sources of infection. Nevertheless, the focus should remain on transparency and this did not appear to be consistently applied by NHS GGC.

201. In that context, it is vital that there is clear and widespread consistency of messages and information shared in these situations. Similarly, it is critical that the Health Board undertakes a more transparent approach in its communication against any similar background of uncertainty, even if it leads to NHS GGC admitting its inability to answer key questions immediately. Expressing uncertainty should not be seen as detracting from providing reassurance. The Health Board should be more open about what is known and what can be said.

202. This should form the governing principles of a NHS GGC review of how it undertook communication with the affected children, young people and families of the infection incidents and what learning should be taken and mainstreamed. That review should closely involve the families themselves and be presented to the Scottish Government by end June 2021, not least as a source of national learning for other Health Boards. It should focus on the transparency and timeliness of how information was presented and communication experienced by patients and families.

Recommendation 10: NHS GGC should ensure that the recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy and an accompanying work programme for the Health Board.

203. NHS GGC should review and renew its existing HAI Communication. A revised strategy – taking account of the learning set out in this report and the actions identified in the recommendations – could become the basis of an exemplar to other Boards, or a plan modelled on national strategic and IPC requirements. This should be completed by end August 2021.

204. Communication and engagement activities were being brigaded together under a ‘Silver Command’ strand in the new ‘Gold Command’ structure. As the ‘Better Together’ work strand develops, there should be a priority in developing a revised version of the strategy with an accompanying action plan and commitment to undertake the reviews set out in these Interim Report recommendations.

Recommendation 11: NHS GGC should make sure that there is a systematic, collaborative and consultative approach in place for taking forward communication and engagement with patients and families. Co-production should be pursued in learning from the experience of these infection incidents.

205. The experience of the communication regarding infections in the paediatric haemato-oncology service has highlighted the need for deploying a range of approaches. This should be routinely pursued through collaborative work with families with direct experience of how best to navigate the complexities of making contact when an organisational or public interest matter may require that. A partnership approach should be explicitly recognised by NHS GGC and actively pursued as part of the 'Silver Command' work programme and reflected in the HAI Communication Strategy referenced in the previous recommendation.

Recommendation 12: NHS GGC should embed the value of early, visible and decisive senior leadership in its communication and engagement efforts and, in so doing, more clearly demonstrate a leadership narrative that reflects this strategic intent.

206. Leadership in addressing the challenge of communication on these infections was clearly demonstrated in much of the response to the emerging issues by senior staff within the hospital. But more senior leadership within the Health Board was not always presented visibly or experienced positively by the children, young people, their families and the public as the situation unfolded in the public eye. The lack of consistency in the approach was a significant issue for some families.

207. NHS GGC should review its approach to ensuring the right tone and sensitivity in handling is pursued in future, especially for its corporate communication, and determine if guidance or training is required to embed the Health Board's learning in this context. There should be more systematic assurance by the Health Board that this is happening across the organisation. This should also ensure that the views and experiences of patients and families remain central to how excellence in healthcare is pursued. Regular reviews of patient experiences and the use of Care Opinion is good, but opportunities for a more targeted review of communication in key incidents by relevant patients and families should be considered. This should build on the recent work led by the Executive Nurse Director as presented to the Board's Clinical and Care Governance Committee. This could take the form of some form of regular monitoring/review on the quality and effectiveness of communication in IPC as part of the revised HAI strategy. The results of that review should be regularly presented to the Care and Clinical Governance Committee, and, where appropriate, the Board.

208. The Health Board should present a proposal for putting these measures in place to the Scottish Government by the end of March 2021 so that it can feed into the development of a revised HAI Strategy.

Recommendation 13: The experience of NHS GGC should inform how all of NHS Scotland can improve communication with patients and families 'outside' of hospitals in relation to infection incidents.

209. There was a challenge for NHS GGC in communicating when it was not person-to-person. That challenge should be explicitly recognised and addressed pro-actively by the Health Board in preparation for any similar future challenges by ensuring its communication infrastructure has a strategic emphasis that recognises and plans and delivers on these principles. This includes due recognition of the role of strategic intent, leadership, skills and culture.

210. That should include learning from and establishing as routine practice the establishment of specific communication channels for patients and families. The example of the 'closed' Facebook page has already been cited, and while it remains a 'work in progress', it has been a key element in restoring good communication with many of the families including a significant uptake in participation. There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communication group in the first half of 2021.

Recommendation 14: The experience of NHS GGC in systematically eliciting and acting on people's personal preferences, needs and wishes as part of the management of communication in these infection incidents should be shared more widely across NHS Scotland.

211. To ensure that people remain at the centre of communication and engagement efforts and that they are listened to, special attention should be placed on ways of capturing communication preferences. This is particularly critical in particular operational services such as paediatric haemato-oncology service. NHS GGC demonstrated useful learning in this context, particularly through the development, updating and use of its database of communication preferences for affected patients and families. There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communication group. It should share learning of the use of the shared database (both software and approach) as well as the mechanism they developed to have single list of all those across service elements receiving care.

Recommendation 15: NHS GGC should learn from other Health Boards' good practice in addressing the demand for speedier communication in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.

212. The impact of social media on amplifying speculation was presented by NHS GGC as a key challenge, often overwhelming messages, narrative, and the ability to reassure families and present clear information. The Health Board should consider how it can provide more adept and quicker confirmation of lines and messages in this context, guarding against any harmful lag in communication, and how best to make positive and effective use of social media in this context. There is good practice that can be learnt from other Boards around the use of social media in this context, particularly around the value of different types of social media in different contexts. This is an excellent opportunity for national learning, and should be pursued through the NHS Scotland strategic communication group in the first half of 2021.

Recommendation 16: NHS GGC should review and take action to ensure that staff can be open about what is happening and discuss patient safety events promptly, fully and compassionately.

213. Good communications with the staff is important to ensure that staff are well informed and can contribute to supporting the children, young people and their families. This only works if there is a good flow of information from the Board to the point of care, without internal organisational boundaries becoming barriers. Key factors to support this include active, transparent and consistent communication across different, relevant parts of the Health Board. This is also likely to involve empowering and supporting 'clinical voices' to lead, shape and deliver public-facing communication reflecting transparent, respectful and compassionate communication, including the improved use of clinical expertise and voices in corporate responses to media enquiries and briefings.

214. NHS GGC is invited to review its the experience of the communications on HAI in the paediatric haemato-oncology service, and where lessons learned can improve staff communication in future. Plans for taking this forward should be presented to the Scottish Government by end March 2021.

Recommendation 17: The Scottish Government, with Healthcare Improvement Scotland and ARHAI Scotland, should review the external support for communication to Health Boards facing similar intensive media events.

215. While communication and engagement in these circumstances can and should be the responsibility of individual Boards, there are points where there is a clear role of other key bodies in supporting messaging and the flow of information. That role was not clearly and consistently acted upon in these circumstances. Scottish Government, HIS and ARHAI Scotland should review how other bodies should support and engage with individual Boards in similar situations in future, through the NHS Scotland strategic communication group. The Scottish Government should ensure any plans for improvement are developed by end August 2021.

Annex A: Terms of Reference for the Oversight Board and its Subgroups

Oversight Board

Authority

The Oversight Board for the 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 NHS Scotland, 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 Oversight Board.

Purpose and Role

The purpose of the Oversight Board 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 Oversight Board 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 and young people 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 of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland about potential de-escalation of the NHS GGC 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 and Social Care and Chief Executive of NHS Scotland 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 Oversight Board will agree a programme of work to pursue the objectives described above. In this, it will establish subgroups with necessary experts and other participants. The remit of the subgroups 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 subgroups.

In line with the NHS Scotland escalation process, NHS GGC will work with the Oversight Board 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 Oversight Board.

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

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 Oversight Board 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 NHS Scotland are:

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

The Oversight Board Members will endeavour to adopt the NPF and NHS Scotland 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 Oversight Board is focused on improvement. Oversight Board members, and subgroup members, will ensure a lessons-learned approach underpins their work in order that learning is captured and shared locally and nationally.

Meetings

The Oversight Board 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 Oversight Board 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 Board are to:

- improve the provision of responses, information and support to patients and families;
- if identified, support any improvements in the delivery of effective governance and assurance within the Directorates identified;
- provide specific support for infection prevention and control, if required;
- provide specific support for communication and engagement; and
- oversee progress on the refurbishment of Wards 2A/B and any related facilities and estates 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 Oversight Board work establishes a significant link to the issues set out above.

In order to meet these objectives, the Oversight Board 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 NHS Scotland. 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 Oversight Board will be chaired by the Chief Nursing Officer, Professor Fiona McQueen, and will report to the Director General for Health and Social Care.

Membership

Member	Job Title
Professor Fiona McQueen (Chair)	Chief Nursing Officer, Scottish Government
Keith Morris (Deputy Chair)	Medical Advisor, Chief Nursing Officer's Directorate (CNOD), Scottish Government
Professor Hazel Borland	Executive Director of Nursing, Midwifery and Allied Health Professionals and Healthcare Associated Infection Executive Lead, NHS Ayrshire and Arran
Professor Craig White	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Dr Andrew Murray	Medical Director, NHS Forth Valley and Co-chair of Managed Service Network for Children and Young People with Cancer
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, CNOD, Scottish Government
Carole Campariol-Scott/ Jim Dryden/ Calum Henderson/ Phil Raines (Secretariat)	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 Facilities and estates, Director of Communications, Board Chair and Chief Executive; and representatives from HPS, HFS, HIS, HEI and HSE.

Stakeholders

The Oversight Board 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 Scottish Parliament;
- the Scottish Government, particularly the Health and Social Care Management Board;
- the Board of NHS GGC and the senior leadership team of NHS GGC; and
- 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 Communication and Engagement Subgroup.

Infection Prevention and Control, and Governance Subgroup

Purpose and Role

The Infection Prevention and Control Governance (IPCG) Subgroup for the NHS GGC Scottish Government Oversight Board is a time-limited group which has been convened to work with NHS GGC to:

- determine whether appropriate Infection Prevention and Control Governance is in place across the organisation to increase public confidence; and
- make recommendations, if required and where appropriate, to strengthen current approaches to mitigate avoidable infection harms

The IPCG Subgroup directly reports to the Oversight Board, which is chaired by the Chief Nursing Officer, Professor Fiona McQueen. It has specific responsibilities for supporting the Oversight Board to ensure, where necessary and appropriate, improvements are made in the delivery of effective governance and provide assurance relating to infection prevention and control within and across NHS GGC.

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 and Social Care and Chief Executive of NHS Scotland 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 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 will focus on issues relating to infection prevention and control and associated governance that gave rise to escalation to Stage 4.

Approach

The IPCG Subgroup will take a values based approach in line with NPF and the values of NHS Scotland.

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 Oversight Board 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 NHS Scotland are:

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

These values will be embedded in the work of the IPCG Subgroup and will be informed by engagement work undertaken with key stakeholder groups.

The Subgroup is focused on improvement and as such the Subgroup members will ensure an evidence based, risk based, lessons-learned approach underpins their work in order that assurance can be articulated and learning is captured and shared both locally and nationally.

Meetings

The Subgroup will meet frequently for the first four weeks, with frequency thereafter to be determined as required. Video-conferencing or 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 Subgroup members, their PAs and relevant CNOD staff.

Objectives

The objectives for the Subgroup are to:

- carry out a system wide review of current systems and processes relating to the infection prevention and control and associated governance scheme of delegation and escalation mechanisms against relevant national standards and guidance;
- determine if there are any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to IPC risk management, audit, performance, compliance and assurance;
- provide support to the IPC Team within NHS GGC in the identification of measures for assurance as part of the review process and for future improvement/implementation; and
- make recommendations where appropriate to the Oversight Board on areas of learning for other Health Boards

In Scope

In order to meet these objectives, the Subgroup will retrospectively assess systems, processes and governance arrangements in relation to IPC management and control across the whole of NHS GGC. It will do so by reviewing:

- alignment of IPC and wider Board structures within the span of influence of NHS GGC; and
- a range of reports considered by the Board Corporate Governance Committees and the network of Operational Governance Groups and Committees including those reports presented to the associate Integrated Joint Boards.

Deliverables will be agreed in the early meetings of the Subgroup and with the Oversight Board.

Out of Scope

The Subgroup will not review:

- roles and responsibilities of individual staff members within NHS GGC; and
- aspects covered by either the Communication and Engagement or Technical Subgroups of the Oversight Board.

Governance

The Subgroup will be chaired by Diane Murray, and will report to the Chair of the Oversight Board.

Member	Job Title
Diane Murray (Chair)	Deputy Chief Nursing Officer, Scottish Government
Hazel Borland	Executive Director of Nursing, Midwifery and Allied Health Professionals and Healthcare Associated Infection Executive Lead, NHS Ayrshire and Arran
Professor Angela Wallace	Nurse Director, NHS Forth Valley
Professor Craig White	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Frances Lafferty	Infection Control Nurse, NHS Ayrshire and Arran
Martin Connor	Infection Control Doctor, NHS Dumfries and Galloway
Helen Buchanan	Executive Director of Nursing, Midwifery and Allied Health Professionals and Healthcare Associated Infection Executive Lead, NHS Fife
Christina Coulombe	Infection Control Manager, NHS Lanarkshire
Lisa Ritchie	Nurse Consultant, Health Protection Scotland, NHS National Services Scotland
Professor Marion Bain	Director for Infection Prevention and Control, NHS GGC (secondee)
Phil Raines	Chief Nursing Officer's Directorate (CNOD), Scottish Government

Sandra Aitkenhead	CNOD, Scottish Government (secondee)
Lesley Shepherd	Professional Nurse Advisor, CNOD, Scottish Government
Carole Campariol-Scott/ Jim Dryden/ Calum Henderson (Secretariat)	CNOD, Scottish Government

Associated Participant	Job Title
Sandra Devine	Infection Control Manager, NHS GGC
Pamela Joannidis	Infection Control Nurse, NHS GGC
Dr. A Leonard	Infection Control Doctor, NHS GGC
Dr. J Armstrong	Medical Director, NHS GGC
Elaine Vanhegan	NHS GGC Board Governance Lead

NHS GGC may have other officers in attendance dependant on the issue being discussed and agreed through the chair.

Technical Issues Subgroup

Authority

The Oversight Board for the QEUH and RHC, NHS GGC has been established at the direction of the Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland, further to his letter of 22 November 2019 to the Chairman and Chief Executive of NHS GGC.

A technical subgroup of the Oversight Board has been established to provide technical review, advice and assurance on the relevant technical matters relating to the built environment of the hospitals.

Purpose and Objectives

The purpose of the Technical Subgroup is to support the work of the Oversight Board, with a particular focus on the technical workings of the hospitals and any related technical reviews or reports. In particular the Technical Subgroup will:

- confirm that relevant environments at the QEUH and the RHC are and continue to be safe;
- oversee progress on the refurbishment and reopening of Wards 2A/B at the RHC and any related facilities and estates issues as they pertain to haemato-oncology services, such as Ward 6A at the QEUH;
- ensure that there are appropriate action plans in place to address any technical issues highlighted by competent authorities such as the Health and Safety Executive, Health Protection Scotland or Health Facilities Scotland and that these action plans are being delivered and provide oversight on connected issues that emerge;
- consider the lessons learned that could be shared across NHS Scotland; and

- provide advice to Oversight Board about potential de-escalation of the NHS GGC Board from Stage 4, in relation to these issues.

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 and Social Care and Chief Executive of NHS Scotland 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 Oversight Board is required to establish subgroups with necessary experts and other participants; this subgroup will address the requirement to ensure that relevant environments at the QEUH and RHC are and continue to be safe. To ensure delivery of that overarching objective, the Technical Subgroup will agree a programme of work to ensure that it complies with the purpose and objectives of the group.

The Oversight Board, and its subgroups, is focused on improvement. Members of this subgroup, will ensure a lessons-learned approach underpins their work in order that learning is captured and shared locally and nationally.

Governance/Accountability

The Subgroup will be chaired by the Alan Morrison, Health Finance and Infrastructure, Scottish Government and will report direct to the Oversight Board.

Membership

Member	Job Title
Alan Morrison (Chair)	Health Finance Directorate, Scottish Government
Tom Steele	Director of Estates, NHS GGC
Gerry Cox	Deputy Director of Estates, NHS GGC
Ian Storrar	Principal Engineer, Health Facilities Scotland
Lisa Ritchie	Nurse Consultant, Health Protection Scotland, NHS National Services Scotland
Sandra Aitkenhead	Chief Nursing Officers Directorate (CNOD), Scottish Government (secondee)
Phil Raines	CNOD, Scottish Government
Calum Henderson (Secretariat)	CNOD, Scottish Government

Additional involvement will be requested as necessary.

Communication and Engagement Subgroup

Purpose and Role

The Communication and Engagement Subgroup is a time-limited group to offer advice and assurance working with the Scottish Government and NHS GGC on:

- effective communication and engagement with patients and families; and
- robust, consistent and reliable person-centred engagement and communication.

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 and Social Care and Chief Executive of NHS Scotland 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 Communication and Engagement Subgroup will take a values based approach in line with the NPF and the values of NHS Scotland. 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 work of the Subgroup 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 NHS Scotland are:

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

These values will be embedded in the work of the Communication and Engagement Subgroup, and this work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives, respecting the importance of specific values informed actions linked to personal context and experiences.

The Communication and Engagement Subgroup is focused on improvement. Subgroup members, will ensure a 'lessons learned' approach, as well as respecting the experience of families must underpin and inform the identification of improvements for dissemination both locally and nationally.

Meetings

The Communication and Engagement Subgroup will meet fortnightly initially and then at a frequency to be determined thereafter. Tele-conferencing will be provided. A range of communication and engagement mechanisms will be agreed to enable patients and families to feed into the work of the Communication and engagement Subgroup.

Full administrative support will be provided by officials from Scottish Government. The circulation list for meeting details/agendas/papers/action notes will comprise Oversight Board members, their PAs and relevant CNOD staff.

Outcomes

The Outcomes for the Communication and Engagement Subgroup are to:

- positively impact on patients and their families in relation to how complex infection control issues and all related matters are identified, managed and communicated;
- demonstrate a pro-active approach to engagement, communication and the provision of information; and
- identify what has worked well and where the provision of information, communication and engagement could have been and could be enhanced and improved.to ensure that the outputs from the group are disseminated to key stakeholders and any wider learning points or recommendations are shared nationally.

In order to achieve these outcomes, the Subgroup will retrospectively assess factors influencing the approach to communication and public engagement associated with the infection prevention and control issues and related matters at the QEUH and RHC.

Having identified these issues, the Subgroup will 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 good practice as well as lessons learned across NHS Scotland.

Deliverables

The Deliverables for the Communication and Engagement Subgroup are:

- a prioritised description of communication and information to be provided to families, with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered);
- development of a strategic Communication and Engagement Plan with a person-centred approach as key. This should link to and be informed by consideration of existing person-centred care and engagement work within the Board, to ensure continued strong links between families and NHS GGC. Specific enhancements and improvement proposals should also be clearly identified and should consider how the proposals from parent representatives on an approach that identifies and supports the delivery of personalised actions through the 'PACT' proposal can inform further work;
- a description of findings following a review of materials, policies and procedures in respect of existing practices with regards to communication, engagement and decision-making arising from corporate and operational communication and engagement, linked to infection prevention and control and related issues. This will include consideration of organisational duty of candour, significant clinical incident reviews, supported access to medical records (including engagement, involvement and provision of information to families in relation to these processes); and
- a description of findings and recommendations to: (a) NHS GGC; (b) Health Protection Scotland; (c) NHS Scotland; and (d) Scottish Government on learning to support any required changes and improvements for communication and public engagement relating to the matters considered by the Subgroup.

Governance

The Communication and Engagement Subgroup will be chaired by Professor Craig White, and will report to the Oversight Board. The Oversight Board is chaired by the Chief Nursing Officer, Scottish Government and reports to the Cabinet Secretary for Health and Sport. Members and those present at Subgroup meetings should ensure that they circulate information about the work of the Subgroup to colleagues and networks with an interest, contribution and perspective that can inform the work to be undertaken. It has been agreed that this must include clinical/care staff in relevant operational services, as well as senior management/corporate staff in NHS GGC.

Membership

Member	Job Title
Professor Craig White (Chair)	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Lynsey Cleland	Director of Community Engagement, Healthcare Improvement Scotland
Andrew Moore	Head of Excellence in Care, Healthcare Improvement Scotland
Professor Angela Wallace	Nursing Director, NHS Forth Valley
Jane Duncan	Director of Communications, NHS Tayside
Professor John Cuddihy	Families representative
[redacted]	Families representative (until March 2020)
Suzanne Hart	Communications, Scottish Government
Phil Raines	Chief Nursing Officer's Directorate (CNOD), Scottish Government
Calum Henderson (Secretariat)	CNOD, Scottish Government

In addition to these members, other attendees may be present at meetings based on agenda items, for example: Chair of Infection Prevention and Control and Governance subgroup; relevant Directors and senior staff from NHS GGC and communication staff from Scottish Government.

Stakeholders

The Subgroup recognise 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 and their families;
- the general public;
- the Scottish Parliament;
- Scottish Government, particularly the Health and Social Care Management Board;
- the staff of NHS GGC, Trade Unions and professional bodies; and
- the senior leadership team of NHS GGC and the Board.

Annex B: Peer Review Terms of Reference

Purpose and Governance

The Infection Prevention and Control Governance (IPCG) Subgroup of the NHS GGC Scottish Government Oversight Board has examined an array of documentation from NHS GGC which outlines the form and function of governance regarding 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.

Approach

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

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, facilities and estates, senior charge nurses as well as local IPC teams.

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; and
- 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 five areas of focus:

- implementation of HAI-SCRIBE;
- implementation of the National IPC Manual;

- audit and surveillance;
- outbreak and incident investigation (including escalation/de-escalation); and
- 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 the IPC Team and Facilities 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.

Peer Review Team Members

Member	Job Title	Review area
Frances Lafferty	Senior IPC Nurse, NHS Ayrshire and Arran	Implementation of HAI-SCRIBE
Lesley Shepherd	Professional Nurse Advisor, HCAI/AMR, Scottish Government	Audit Surveillance National IPC Manual

Annex C: Stages of Escalation in NHS Scotland 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. The Chief Executive of NHS Scotland is aware.
Stage 4	Significant risks to delivery, quality, financial performance or safety; senior level external support required	Transformation team reporting to the Chief Executive of NHS Scotland.
Stage 5	Organisational structure/configuration unable to deliver effective care.	Ministerial powers of Intervention.

Annex D: Key Success Indicators of the Oversight Board

Outcome	Action	Example of evidence
Infection Prevention and Control and Governance		
There is appropriate governance for infection prevention and control (IPC) in place to provide assurance on the safe, effective and person-centred delivery of care and increase public confidence.	Carry out a system wide review of current IPC systems and processes and associated governance scheme of delegation and escalation mechanisms against relevant national standards and guidance.	• Confirmation of current/sustainable effective governance with respect to: HAIRT Reports; Care and Clinical Governance Committee and Audit and Risk Committee Reports; AOP and Corporate Objectives and Performance Reports; IPC Inspection and Escalation Reports; IPC Audit Reports and Action Plans; relevant Antimicrobial Management/ Infection Control/ Decontamination/ Water Safety/ Education and Training/ Surveillance/ Outbreak Preparedness and Management/ Audits/ Policy and Procedures/ Inspection and Action Plans/ IPC Escalation Reports/ SBARs/ Research and Development and Voluntary Action Plan Updates; and IPC Risks. • Active action plans to address recommendations/action on relevant HPS/ HEI/ Internal reports since 2015 with clear timelines, monitoring, action responsibility and appropriate oversight.
	Determine if there are any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to IPC risk management, audit, performance, compliance and assurance.	• Report setting out gaps in national standards/guidance and provision of NHS GGC action plan to address issues and monitoring arrangements for action plan. • Report setting out wider learning with regards to IPC risk management, audit, performance, compliance and assurance for consideration by DG Health and Social Care, SG Ministers, and NHS Chairs and NHS Chief Executives fora (as part of wider Oversight Board reporting).

Outcome	Action	Example of evidence
The current approaches that are in place to mitigate avoidable harms, with respect to infection prevention and control, are sufficient to deliver safe, effective and person-centred care.	Conduct a detailed review of relevant individual instances of infection and identify actions on individual cases and systemic improvements.	• Clear methodology for identifying and undertaking review of all relevant cases, validated by external experts. • Identification of general issues relating to the IPC governance issues and provision of NHS GGC action plan to address issues and monitoring arrangements for action plan. • Identification of individual issues relating to specific cases and NHS GGC action plan to communicate and engage with relevant families/patients and monitoring arrangements for action plan.
	Ensure that the physical environment to the relevant wards in QEUH and RHC support the delivery of safe, effective and person-centred care with respect IPC, particularly in the delivery of any refurbishments/physical improvements.	• Action plan setting out identification of key issues in Ward 6A in QEUH and implementation of how they have been dealt with. • Assessment setting out completion of refurbishment works in Wards 2A/2B in RHC and how identified issues were addressed. • Confirmation of action plan and assessment above by HPS.
	Determine if there are any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to operational delivery of IPC, including staffing/ resourcing, minimum skills and joint working between relevant units.	• Evidence of full implementation of mandatory national HCAI and AMR policy requirements as set out in DL (2019) 23. • NHS GGC action plan to identify staffing/ resourcing gaps in IPC operations with respect to putting in place policy requirements in DL (2019) 23, address the identified gaps with clear actions/ timetables and monitoring arrangements for delivery.

Outcome	Action	Example of evidence
Communication and Engagement		
Families and children and young people within the haemato-oncology service receive relevant information and are engaged with in a manner that reflects the values of NHS Scotland (NHSS) in full.	Prioritise communication and information provided to families and patients with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered).	• Compilation of outstanding questions by families and publication of responses on NHS GGC website. • Published process for responding to questions in future as part of NHS GGC Communication strategy. • All additions/revisions/updates to questions previously answered have been made as soon as additional information has been received and/or reviewed.
Families and children and young people within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHSS in full.	Develop and implement a strategic NHS GGC Communication strategy with a person-centred approach, including a clear Executive Lead for implementing and monitoring.	• Publication of relevant NHS GGC Communication strategy with evidence of co-production with families. • Identification of Executive Lead to implement strategy with monitoring arrangements and measures of implementation and measures of effectiveness in place.
	Review key materials, policies and procedures in respect of existing practices with regards to communication, engagement and decision-making regarding consideration of the organisational duty of candour similar reviews (including engagement, involvement and provision of information to families in relation to these processes), and identification of any national learning/ lessons learnt.	• Report setting out gaps in compliance, opportunities for improvement, recommendations for action and provision of NHS GGC action plan to address issues and monitoring arrangements for action plan. • Identification of individual issues relating to specific cases and NHS GGC action plan to communicate and engage with relevant families/patients. • Reporting setting out wider learning with regards to organisational duty of candour and other review processes and management of IPC activities for consideration by DG Health and Social Care, SG Ministers, and NHS Chairs and NHS Chief Executives fora (as part of wider Oversight Board reporting). • Clear description of how communication, engagement, information provision and support dimensions of Oversight Board case reviews will integrate family involvement and engagement in accordance with best practice case reviews and individual family preferences.

PART 2

Papers considered at NHS Greater Glasgow and Clyde Oversight Board Communication and Engagement Subgroup Meetings

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SCOTTISH GOVERNMENT
HEALTH AND SOCIAL CARE DIRECTORATES

COMMUNICATION AND ENGAGEMENT SUB-GROUP QUEEN ELIZABETH UNIVERSITY HOSPITAL AND ROYAL HOSPITAL FOR CHILDREN, NHS GREATER GLASGOW AND CLYDE (NHSGGC)

TERMS OF REFERENCE

Purpose and role of group

The Communications and Engagement Sub-Group for Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), NHS Greater Glasgow and Clyde (NHSGGC), is a time limited group to offer advice and assurance working with Scottish Government and NHSGGC on:

- Effective communication and engagement with patients and families.
- Robust, consistent and reliable person-centred engagement and communication

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 Communications and Engagement Sub-Group will take a values based approach in line with the National Performance Framework (NPF) and the values of NHSScotland (NHSS).

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 work of the Sub-Group individually and collectively:

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

The values of NHSS are:

- Care and compassion

- Dignity and respect
- Openness, honesty and responsibility
- Quality and teamwork

These values will be embedded in the work of the Communications and Engagement Sub-Group, and this work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members / patient representatives, respecting the importance of specific values informed actions linked to personal context and experiences.

The Communications and Engagement Sub-Group is focused on improvement. Sub-Group members, will ensure a 'lessons learned' approach, as well as respecting the experience of families must underpin and inform the identification of improvements for dissemination both locally and nationally.

Meetings

The Communications and Engagement Sub-Group will meet fortnightly initially and then at a frequency to be determined thereafter. Tele-conferencing will be provided.

A range of communication and engagement mechanisms will be agreed to enable patients and families to feed into the work of the Communications and Engagement Sub-Group.

Full administrative support will be provided by officials from Scottish Government. The circulation list for meeting details/agendas/papers/action notes will comprise Oversight Board members, their PAs and relevant Chief Nursing Officer Directorate (CNOD) staff.

Outcomes

The Outcomes for the Communications and Engagement Sub-Group are:

- to positively impact on patients and their families in relation to how complex infection control issues and all related matters are identified, managed and communicated.
- to demonstrate a proactive approach to engagement, communications and the provision of information.
- to identify what has worked well and where the provision of information, communication and engagement could have been and could be enhanced and improved.
- to ensure that the outputs from the group are disseminated to key stakeholders and any wider learning points or recommendations are shared nationally.

In order to achieve these outcomes, the Communications and Engagement Sub-Group will retrospectively assess factors influencing the approach to communication

and public engagement associated with the infection prevention and control issues and related matters at the QEUH and RHC.

Having identified these issues, the Sub-Group will work with NHSGGC 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 good practice as well as lessons learned across NHSScotland.

Deliverables

The Deliverables for the Communications and Engagement Sub-Group is to:

- A prioritised description of communications and information to be provided to families, with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered).

- Development of a strategic Communications and Engagement Plan with a person-centred approach as key. This should link to and be informed by consideration of existing person-centred care and engagement work within the Board, to ensure continued strong links between families and NHSGGC. Specific enhancements and improvement proposals should also be clearly identified and should consider how the proposals from parent representatives on an approach that identifies and supports the delivery of personalised actions through the PACT proposal can inform further work.

- Describe findings following a review of materials, policies and procedures in respect of existing practices with regards to communications, engagement and decision-making arising from corporate and operational communications and engagement, linked to infection prevention and control and related issues. This will include consideration of organisational duty of candour, significant clinical incident reviews, supported access to medical records (including engagement, involvement and provision of information to families in relation to these processes).

- Describe findings and make recommendations to (a) NHSGGC, (b) Health Protection Scotland (c) NHS Scotland and (d) Scottish Government on learning to support any required changes and improvements for communications and public engagement relating to the matters considered by the Sub-Group.

Governance

The Communications and Engagement Sub-Group will be chaired by Professor Craig White, and will report to the Oversight Board.

The Oversight Board is chaired by the Chief Nursing Officer, Scottish Government and reports to the Cabinet Secretary for Health and Sport.

Members and those present at Sub-Group meetings should ensure that they circulate information about the work of the Sub-Group to colleagues and networks with an interest, contribution and perspective that can inform the work to be undertaken. It has been agreed that this must include clinical and care staff within relevant operational services, as well as senior management and corporate staff within NHSGGC.

Membership

Member	**Job Title**
Professor Craig White (Chair)	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate
Professor John Cuddihy	Families representative
Ms Lynsey Cleland	Director of Community Engagement at Healthcare Improvement Scotland
Mr Andrew Moore	Head of Excellence in Care for Healthcare Improvement Scotland
Professor Angela Wallace	Nursing Director, NHS Forth Valley
Ms Jane Duncan	Director of Communications, NHS Tayside
Mr Phil Raines	CNOD, Scottish Government
Mr Calum Henderson (Secretariat)	CNOD, Scottish Government

In addition to these members, other attendees may be present at meetings based on agenda items, for example: Chair of Infection Prevention & Control and Governance sub-group; relevant Directors and senior staff from NHSGGC and communications staff from Scottish Government.

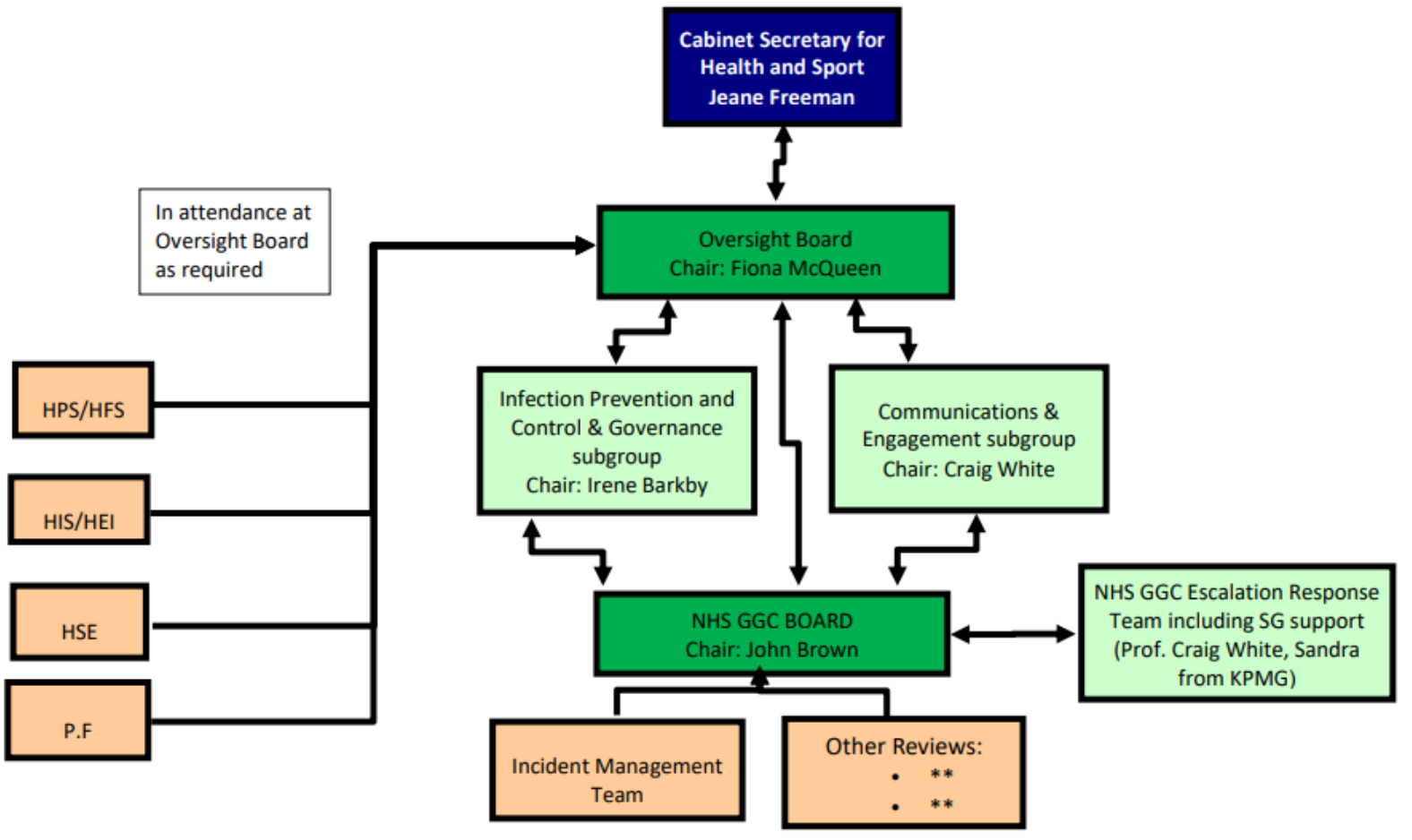
Stakeholders

The Communications and Engagement Sub-Group recognise 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 and their families
- The general public
- The Scottish Parliament
- Scottish Government, particularly the Health and Social Care Management Board
- The staff of NHSGGC,Trade Unions and professional bodies
- The senior leadership team of NHSGGC and the Board

Scottish Government
14 January 2020

Governance Structure Diagram



Request for Feedback from Families in Contact with Paediatric Haemato-Oncology Service at NHSGGC

19

Total Responses

19 Completed Responses

0 Partial Responses

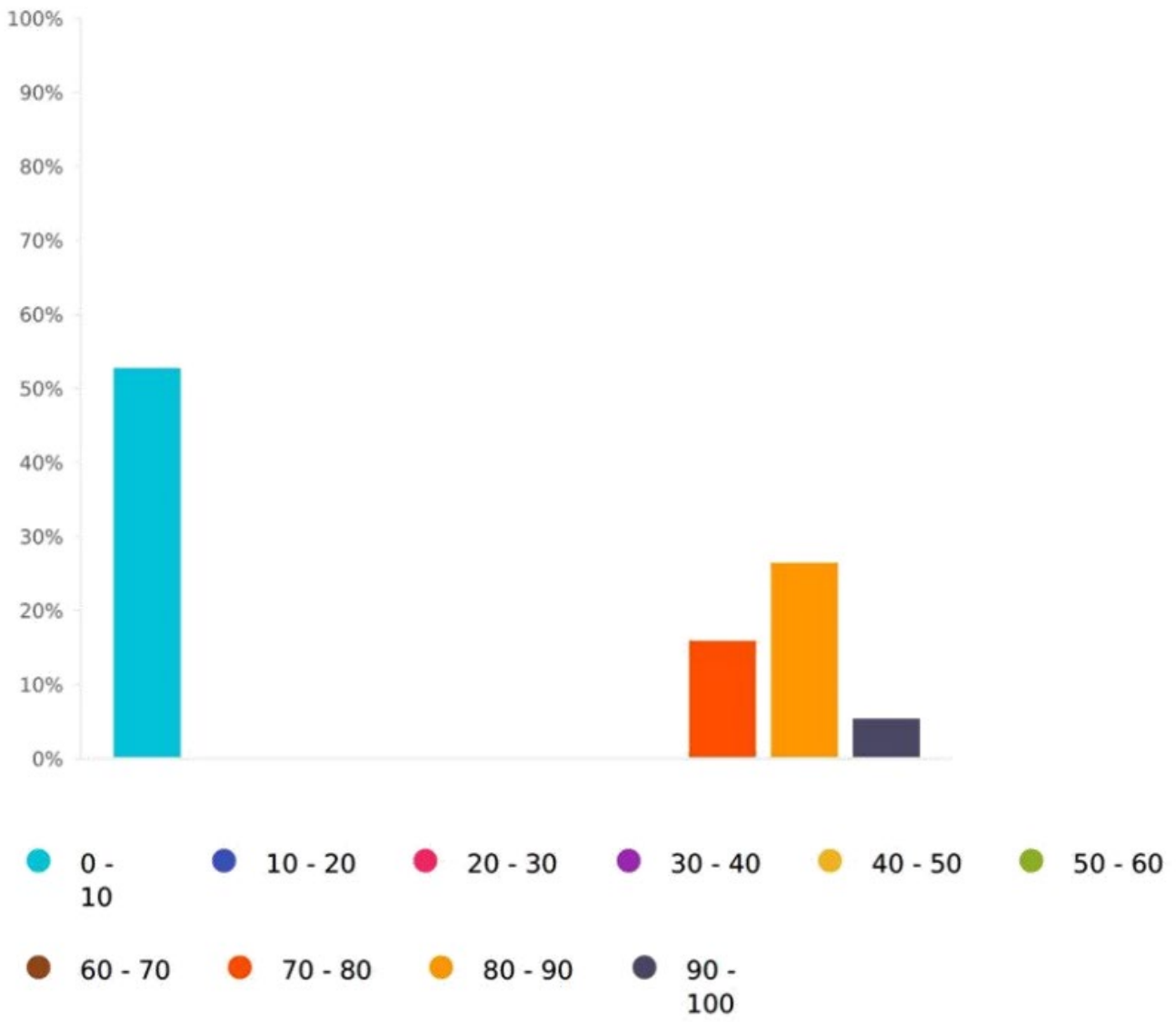
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Survey Visits

Q1

How satisfied have you been personally with the provision of information provided on matters of concern to your child’s health, care, treatment and support? (0 is not at all satisfied and 100 is completely satisfied)

Answered: 19 Skipped: 0



Choices	Response percent	Response count
0-10	52.63%	10
10 - 20	0.00%	0
20 - 30	0.00%	0
30 - 40	0.00%	0
40 - 50	0.00%	0
50 - 60	0.00%	0
60 - 70	0.00%	0
70 - 80	15.79%	3
80 - 90	26.32%	5
90 - 100	5.26%	1

Q2

What has worked well in your experience of the way in which NHS Greater Glasgow and Clyde has provided information, support and responses to any concerns and questions ?

Answered: 19 Skipped: 0

1. Nothing at all, as the information provided always occurs after the press and media have got a hold of info. There are no responses to questions raised on the Facebook page set up but the NHSGGC themselves. They seem to have no compassion whatsoever in regards to parents who are desperatly seeking answers.
2. Nothing, I find getting reports, information and clarification is like getting blood from a stone in most cases. There is a real reluctance to share information such as official reports and test results with parents in any way other than verbally.
3. It would have been helpful if that had provided ANY information however there had been NO communication from them
4. One to one correspondence between doctor and [redacted]/parents.
5. I think it was useful appointing someone to act as a parent liaison, however it would have been more beneficial if this person was a medical professional who had answers to questions asked. That is the only thing I think that has been done well thus far.
6. Last to know. Even the results of [redacted]scans have me worrying on edge for 6weeks when they were completed after 2 weeks. Needless anxiety. Then the lies about the air and water. Not being told the truth about anti fungal medicines. You've no idea how all this snowballs to near breakable levels
7. Nothing as far as I'm concerned the silence has been deafening
8. Speaking to medical professionals
9. The health boards response was well covered in the media and I received sufficient mail in post. I was offered an opportunity to ask any questions.
10. At the moment nothing considering a board meeting was held 4weeks ago and I'm still waiting on answers to questions that where raised.
11. Nothing. We have not had any luck receiving answers at all. As parents we learn what is happening to our children and the environment via the media. It’s not good enough. We ask questions yet have to wait for answers. Those answers never come. Once parents have been notified by the media of any serious cases or happenings on the ward, there is absolutely no support. The NHS would come around and give out a letter which is basically the press release. There is no after-care, there is no support, and there is no comfort for parents.
12. Nothing at all they do not answer any questions properly or truthfully
13. Nothing.
14. Appointing a direct contact for families to liaise with
15. Clinical staff provide timely and relevant information on [redacted] treatment. Someone is always available when we have questions. When I was stressed about a delay to surgery, nursing staff picked up on that and arranged for consultant to contact me. From my perspective, any issues of wider concern (for example, the recent infection issue) are communicated promptly by staff and by letter/Facebook
16. Clinical staff are attentive not only to [redacted] needs but also to those of her parents. They are always open in discussions about her treatment. They always take the time to provide useful, informative, background information when required when discussing [redacted] treatment.

17. Senior staff on ward have been extremely professional. NHSGCC have been proactive at providing updates.
18. Usually quick to answer
19. I haven't really had much information regarding the water contamination and had to really be assertive to get any answers to anything while in the hospital a lot of mistakes made abd I was trusting the professional

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Q3

What could have been better in the way that NHS Greater Glasgow and Clyde provided support, information or responses to your questions ?

Answered: 19 Skipped: 0

1. A start would be acknowledgement on behalf of the NHSGGC, as a parent who's child is still going through treatment i am fuming in regards to the media having information about the safety of the hospital before i do.
2. Email contacts with all consultants. Better access to test results. Written reports issued after verbal discussion. A secure patient portal with access to certain details would be ideal in future.
3. If they had been honest and actually responded when it was needed and not only when parents found out
4. N/A h[redacted]n a patient for just over 2 weeks with most of my questions/concerns being addressed. We have received letters by hand and through the post in relation to the issues being raised.
10. Everything.
11. Honest timely answers. The poor nurses are affronted being asked questions they should never have to answer. I speak to a wide variety of staff in that hospital and every one of them advised not to drink the water.
12. Face to face meeting or at least some sort of communication which we didn't get
13. The press reporting issues before parents being told
14. Maybe a chance to ask questions at a clinic if we had concerns.
1. Answer then openly honestly and with complete transparency.
2. Open and transparency. Honesty. Health board and infection control that we can trust to give us the honest truth and not covered up any significant incidents in the hospital. Open communication as to why children have to take medication. A timely response to any questions parents ask
3. Being truthful and communicating with all families, we find everything out by the press!
4. If management and the board had come and spoke to us parents themselves
5. The Facebook page was set up with good intentions, but does not seem to allow for discussion between parents and the board
6. I can't think of anything at this time
7. For those of us not on Facebook it can feel as if we sometimes miss out on the timely release of information and have to rely on others to let us know when information is released.
8. There is an element of ‘blame avoidance’ in some communications, e.g. recent letter to parents from Jeane Freeman. This is not constructive (and not the point).
9. Being open and honest..conflicting stories and information is not acceptable
10. Been more truthful about things

Q4

Are there any issues that although not directly affecting your child have resulted in you having cause for concern ?

Answered: 19 Skipped: 0

2. Yes definitely the fact is that multiple children have now unfortunately passed away due to the infections in the hospital. This causes great concern not only to me but im sure every single parent of a child going through treatment. The communication between staff, parents and the health board for the my child [redacted]ndergone treatment has been less than acceptable. Nobody wants to listen to parents concerns and no action up until now has been taken.. This is disgraceful.
7. Yes, the contaminated water concerns me. The building works, the cleanliness of the hospital as a whole...security of the hospital given it directly links to adult services. .....the fact our ward is STILL closed and we are in the adult hospital.
8. My child has been affected severely by the negligence
9. No
10. Again everything. The lack of communication has been my biggest concern.
11. The care we give is close comfort. Holding our child when they are in pain and giving constant reassurance things will be ok. The health board knew things weren't ok for a considerable time so I was unwittingly lying to my . The showe[redacted] the room have a sign saying run for 5 minutes.....when you are covered in sickness or something else we dont have 5minutes to wait to be clean. Did parents take that infected water back into their child's bed after a shower? ?

10. Plenty the whole situation has been handled wrong. Our kids are at their most Vulnerable and we have to worry about ward/hospital safety on top of this

11. The high number of infections that have be isolated to ward 2a, 2b then 6a. Why have there been such a high increase in children contracting These infections who were given the same treatment when yorkhill was opened . I am also extremely worried That the sick children’s in Edinburgh was not allowed to open due to issues found , are these the same issues affecting the Glasgow children’s hospital but we are being told the hospital is safe to use .

12. I have no concerns only sympathy for newly diagnosed children in South West Scotland to have to travel that bit further north to Aberdeen rather than Glasgow albeit resolved now.

16. Yes
17. The whole environment is causing a concern. As parents we have sleepless nights thinking that our children might have to go into hospital. With the winter coming up there is no doubt that we will spend time in the hospital ward but we are scared. We do not have trust that the ward is safe. I do not want to lose my child through a hospital acquired infection.

18. The hospital is a huge concern, the board have to be sacked or leave, there has to be a new board who can and will answer parents truthfully, not lie and hide important information like this board have been.
19. I have no faith in the people that run the hospital as they made myself and my son feel stupid and lied to our face when we complained about the water, they told us there was nothing wrong when there clearly was
20. I am concerned for newly diagnosed families, that their confidence in the hospital will be shaken at the time they need it most. I am also concerned for the Schiehallion team, although they have remained professional at all times these issues must have placed them under immense pressure when their job is already so demanding.

15. Clearly the media speculation and political manoeuvring is unsettling at this time. I remain confident that the clinical staff only have best int [redacted]nd treatment at the core of their actions

17. We have found the negative tone of the media coverage to be very unhelpful as it generates conversations with wider family/friends groups who are worried and ask questions of us about the infections. Having to have these conversations is a distraction
that I would rather not have, instead I would rather stay focused on care. For th [redacted]idance of doubt I have no concerns about the skill, professionalism, or resourcing of the Schiehallion ward.

1. I am extremely concerned by the lack of hygiene I witness on a daily basis within the hospital ; particularly in public areas. Cleaning staff do not appear to be being supported to do their jobs effectively. There appears to be no managerial oversight. Staff wear uniforms and shoes that they have used outside the hospital. There is inadequate CLEAN space for staff to change in. Some examples of hygiene challenges include: lifts, floors, tables/chairs in main atrium of adult hospital. etc. Ward 6A is immaculate, however, and the staff on this ward take pride in doing their jobs professionally (including domestic staff). This is different to other wards we have had the unfortunate experience of. Examples include: mould in bathrooms in 3B

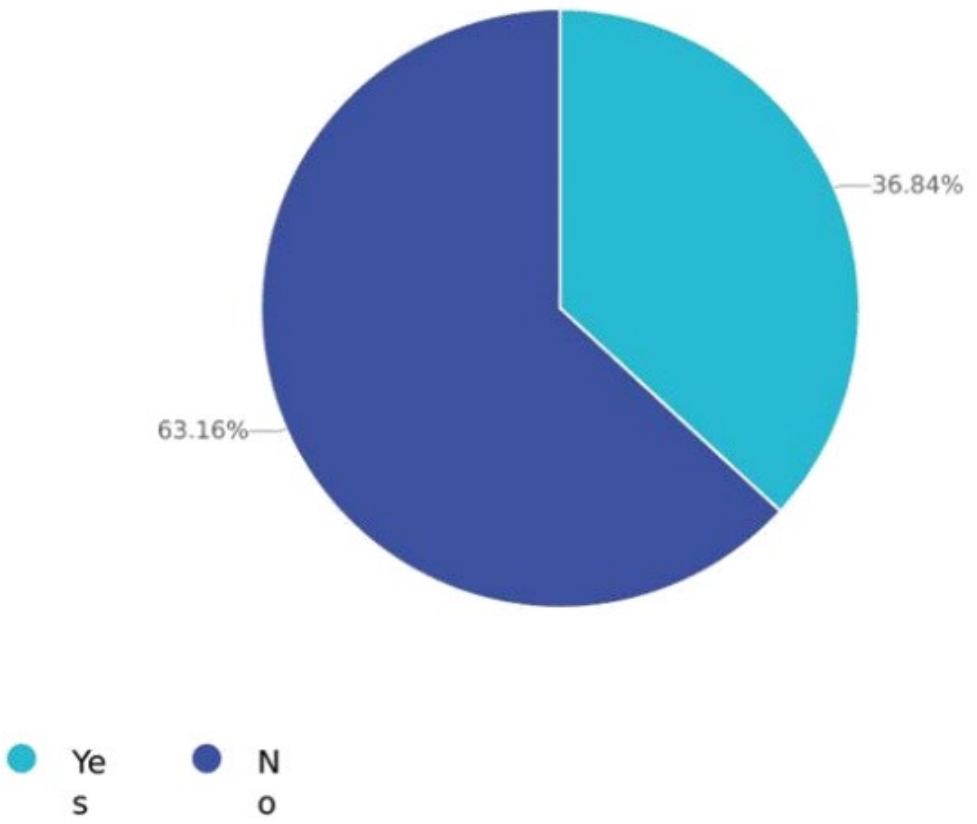
2. The mass hysteria that has come about regarding infections and information given to parents regarding it.

3. Yes there were a few but they did affect my child

Q5

Have you had any contact with Professor White through meetings, telephone or email?

Answered: 19 Skipped: 0



Choices	Response percent	Response count
Yes	36.84%	7
No	63.16%	12

Q6

What has worked well in respect of the Cabinet Secretary for Health and Sport's appointment of Professor White as a point of contact for families ?

Answered: 18 Skipped: 1

10. As far as im led to believe from conversations with other parents there seems to be good communication between parents and Professor Craig White, although i have yet to speak wirh him personally.
11. Unknown, I have had no contact with Prof White although I am hopeful he will do his best to be transparent and thorogh
12. He has a direct contact to and questions
13. Not sure what has worked well as I have not been involved personally.
14. It is helpful to be able to email any questions I have when I think of them.
15. Nothing
16. Only had one letter to complete this survey
17. A named person dealing with all enquiries is always good.
18. At the moment not a lot as Professor White often cant answer the questions and has to wait a long time for them to be answered If at all.
1. At least our questions are being acknowledged.
2. Nothing as he also can't answer questions so really no point contacting him.
3. Nothing as he hasn’t replied to my emails
4. As above, having a real person to contact directly is very helpful. I also have confidence that Professor White has our best interests at heart and responds in a compassionate manner.
5. Hasn't affected me
6. I don't know enough about Professor White to answer that question meaningfully.
7. Not able to comment at this stage.
8. Plenty of contact now
9. Havent had much on this

Q7

What could be improved in support of Professor White's involvement as a point of contact with patients and families ?

Answered: 17 Skipped: 2

10. As I have said I have yet to speak with Professor Craig White so couldn't comment.
11. N/a
12. If the board responses with the truth
13. not sure as I have said above .
14. Question 9 states Professor White is ‘a’ point of contact and this question states he is the single point of contact. That is confusing. However I think it would have been helpful if the point of contact knew the answers to any asked questions.
15. Sack the Health Board and get some some professionals with experience of this matter in place
16. To be completely unbiased when dealing with issues ,
17. He may need counselling when it’s all over and then possibly knighted.
18. The board to answer the questions in a quick and efficient manner.

1. Personally I think Professor White should have more powers to enforce answers. At this point it’s pretty much we ask him, he will ask somebody else, and we never get any answers. There should be a definite timeline in which these answers are provided. For example, I’ve asked a list of questions on the 16th of November via email. Today is the 3rd of December and I’ve still not received the answers
2. I don't see a point as he has to go back to others to ask them and then he doesn't get the proper answers so therfore can't answer parents questions properly.
3. The board to be honest with him and answer his questions
4. Don't know
5. More information about Professor White and his remit/contact details would be good.
6. I would welcome the opportunity to speak with Professor White to discuss.
7. I'm unsure if anyone can feel that information is now truthful
8. Not sure

Q8

If there is anything further you want to ask, suggest or request then please use the space below to do so:

Answered: 16 Skipped: 3

3. I would like to know why it has taken so long for action to be taken, why as a parent do i and many others have to find out important information about the safety of the hospital and children through either social media or newspapers, why has it been deemed acceptable for our kids to be put in the position where they are already on life saving treatments, to then have to worry about life threatening illnesses being contracted in a 'super hospital' why were we and still are beimg told the hospital is safe when evidently it is not. Why have patients and parents been lied to. Why has there been no alternative to cipro put into place yet? To be honest i have many questions but whether i ever get an answer or not is a different matter.

2. [redacted] and had contact with the ward in the past 2yrs. Only my [redacted] ever recieved a letter to speak to anyone about it. Why was that? My [redacted] actually [redacted] accessed the ward more than her.

6. I think it would be huge protection to all the children in Scotland if the existing board were replaced with people who knew what their job description entailed if they knew how to tell the truth if they had empathy and care towards the sickest children in Scotland and if they knew how to engage with patents when something does go wrong instead of protecting their own jobs without a second thought for the lives of the children in that hospital!

7. No.

5. I want to know why in 201[redacted]y was diagnosed no [redacted]at down and explained to me there was a problem and what it was. I want to know why no one told me my son could have been at risk.
I want to know why if the building is safe, is my son still being prescribed prophylactic antibiotics.

10. What is the Planned Maintenance System the hospital incorporates? Surely signatures and timestamps show who checks these failings and who they report to? Were the kids sent home as a matter of course early after teeatment to prevent them catching infection on the ward? We were told daily it would be the infection that would kill our children not the cancer. That's what makes this so disgusting . The hospital was aware before opening things were not safe but recklessly pursued their course towards the rocks regardless. Leaving parents with horrendous guilt and mental health scars for the rest of their lives. Shame on who is responsible.

11. The need to look into concerns over the building pre opening . I have seen on many forms builders who worked on the hospital claiming concerns were raised re water / ventilation . Ifthis has gone on deaf ears some one must be held accountable

12. I can only suggest that in future when large public purchases like hospitals, schools etc are allegedly complete and ready to open; then can the government employ a suitably qualified individual to test water supply, ventilation, cladding, parking, staffing before any keys are handed over and not to agree any unrealistic opening dates. We should learn from previous mistakes of late in this country and maybe not build Europe’s largest hospital next to a sewer.

13. Question 4 I would say isn't correctly worded as I have a score of 90 for clinicians but for the board I'd say 0

1. I want to us that the current board needs to step down. They have failed our children miserably. There is no excuse good enough for children who lost their life. In order to restore trust in parents these people need to leave. Communication forms need to be set up for parents to have a place where they can come and have an open discussion. The hospital should stop trying to meet people on a one-to-one basis unless it is to discuss a one-to-one case. It is hard enough for parents to go through this treatment without having to feel like they are being victimised. Also we would like to ask if NHS GGC could stop monitoring for parents Facebook profiles.

2. I strongly suggest you replace the board, if this was a private sector they would be facing criminal convictions, this board needs removed, for parents and staff to feel better about this hospital. The stress us parents and the staff is under is disgusting, we need a safe place for our kids, I would like my daughters medical records

3. I feel the board and management need to remove themselves as I don't think anyone has faith in them and will never trust what they say or do. I know I never will

4. Not at this time.

5. As per point 10.

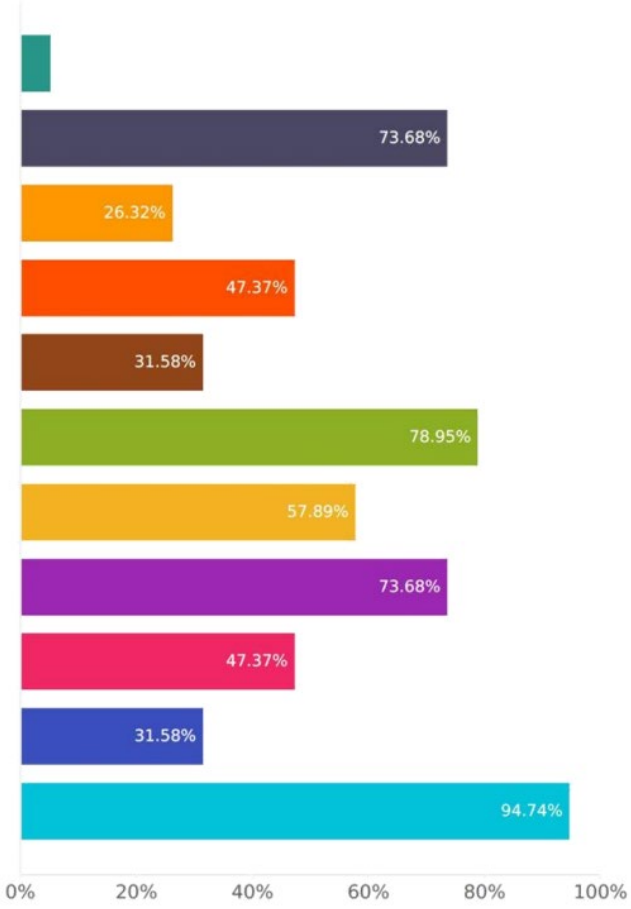
6. I am in the process of seeking my sons medical records. He was in ward2A from [redacted] 201[redacted] only a few nights at home!!..we were in source due to numerous infections but we were never really informed of what these infections were or how they can about..many occasions we were just informed unknown reason!!

16. Was my child one of the children affected by the contaminated water ?

Q9

If you have answered ‘Yes’ above – what information or contact would you like to receive in relation to the work being undertaken on communication and engagement with patients and families?

Answered: 19 Skipped: 0



- Periodic updates on the work being undertaken by NHSGGC to rebuild confidence in the service
- Joining the Oversight Board Communication and Engagement Sub-Group
- Joining a Parents and Families Reference Group
- Dates and times of focus groups and group meetings being arranged
- Details of who I can speak to about questions and concerns specific to my child's care and treatment
- Minutes of the Oversight Board Communication and Engagement Sub-Group
- How to arrange a meeting with the Chief Executive and Chairman of NHS Greater Glasgow and Clyde
- How to provide feedback or make a complaint relating to my experience of services provided
- How to arrange a meeting with Professor Craig White
- Information on establishment of the public inquiry

Other (Please specify)

Choices	Response percent	Response count
Periodic updates on the work being undertaken by NHSGGC to rebuild confidence in the service	94.74%	18
Joining the Oversight Board Communication and Engagement Sub-Group	31.58%	6
Joining a Parents and Families Reference Group	47.37%	9
Dates and times of focus groups and group meetings being arranged	73.68%	14
Details of who I can speak to about questions and concerns specific to my child's care and treatment	57.89%	11
Minutes of the Oversight Board Communication and Engagement Sub-Group	78.95%	15
How to arrange a meeting with the Chief Executive and Chairman of NHS Greater Glasgow and Clyde	31.58%	6

How to provide feedback or make a complaint relating to my experience of services provided	47.37%	9
How to arrange a meeting with Professor Craig White	26.32%	5
Information on establishment of the public inquiry	73.68%	14
Other (Please specify)	5.26%	1

Q10

Any Other Comments

Answered: 7 Skipped: 12

1. N/A
2. If you take by my answers that I am very unsatisfied with the way things have been handled. The questions in this survey were indirect, and unhelpful. The questions you should have been asking you don't want to know the answers too.
3. We will not be "got to" individually and will support each other as a group moving forward. The other parents are all in our corner during this fight. The Health Board appear to be in infection/cancer corner and its shameful. The grammar used in this form is unclear and although I check the consent boxes I am unsure what this is exactly being used for and to what gain or effect.
   [redacted]
4. Good luck and merry Xmas to all the hard working and under paid staff of nhs Scotland.
5. Replace the board ASAP Contact me by email or telephone. Start giving us honest answers and the proper information before we have to read it in papers or on Facebook!
6. Overall, I have every confidence in the staff and resources available in the Schiehallion ward to treat my daughter. The standards of cleanliness I have observed in that ward are amongst the best I have seen anywhere in the hospital.
7. Something must be done about the on-site smoking. This makes the hospital dirty and noxious (for staff, visitors and patients). Furthermore, the fungus in tobacco and tobacco ash is likely to compound the

infection risk within the wards - and may be an infection risk (particularly when traipsed into wards on people’s shoes).

Action Tracker

Action	Action Owner	Progress
Secretariat to consider the timings and frequency of the meetings	CH	Complete
Secretariat to produce a draft Terms of Reference to share with group by 13 December	CH	Complete (Final Version to be confirmed by the Sub Group 9/1)
Scottish Government to consider how we can engage with the families for the next meeting and for those that want to be part of the reference group who will support the work of the Sub Group	CW/PR/ CH	Complete
The Sub Group Chair to discuss with the Chair of the Oversight Group around the expectations of the outputs of the Oversight Group	CW	Complete
The group will consider which documents it would be helpful to review - for example the business continuity plan and any strategic communication, engagement and person-centred/public focus plans	All	Ongoing
Scottish Government to amend the minute to reflect additional action. The Addition of member of Schiehallion Unit	CH	Complete
Scottish Government will invite additional members with regards to expertise in Communications and Public Engagement	CH	Complete Angela Wallace and Jane Duncan have both been invited to next board Meeting.

NHS Greater Glasgow and Clyde to invite Jen Rodgers to Sub group	CH	Complete
Scottish Government to confirm the plans for the parent reference group at the next meeting	CH/CW/ JR	Ongoing The SG and GGC to consider further planning of the event
NHS Greater Glasgow and Clyde to review website content and circulate suggested pages on Ward 6A for Sub Group members comment	SB	Complete Shared with Oversight Group on 20 December. 9/1 Website content will be discussed at Sub Group
NHS Greater Glasgow and Clyde to provide responses to Professor Cuddihy's questions	EV/MM	The questions were sent to GGC by CH on 23/12. GGC to provide direct response to Professor Cuddihy
Sub Group members to provide the questions from families that remain unanswered to CH to allow us to coordinate responses an provide the necessary answers.	All	Ongoing (No additional Questions received by Sub Group Members)
NHS Greater Glasgow and Clyde to undertake a review to understand the number of patients who may not have received the letters.	MM/EV	Ongoing
NHS Greater Glasgow and Clyde to share draft letter with the Sub Group that will go to families regarding prescribing in Haemato-oncology patients.	MM	Complete A letter was agreed to be not the best form of communication. NHS GGC have created a implementation Group to introduce recommendations of the SBAR.
Minute of 18 to be updated. Secretariat to consider the minute to ensure	CH	Complete

constituency with Oversight Board.		
Sub Group to provide further comments on Terms of Reference	All	Complete
Proposed Website content to be shared with JD, AW. Scottish Government to provide comments on Oversight Board content in advance of the site going live on Monday 13 January	CH	Complete
NHS to bring Service Family Masterlist to the next meeting.	NHS GGC	Ongoing – to be brought to Sub Group on 4 February
NHS GGC to provide a collection of documentation around policies and procedures as a paper for the next Sub group meeting.	NHS GGC	Complete
NHS GGC to make a person centred review which families should receive the PI letter. CW to take forward any communication if the Board recommends it would be more appropriate for him to do so	JR/EV/CW	Ongoing
Action tracker to be shared	CH	Complete
Scottish Government to take proposal to next Oversight Board around publication of minutes.	CH	Ongoing – OB takes place on 6 Feb.
CW to review the process used by the clinicians around the decisions taken with regards to appropriateness of communication.	CW	Ongoing

The NHS Greater Glasgow and Clyde to bring paper to meeting on 4 February, to breakdown the subsets of the master list	NHS GGC	Ongoing - Paper tabled for 4 Feb
The action tracker to become standing item on the agenda.	CH	Complete
Scottish Government to consider wider action list bringing together all actions from Sub Groups and Oversight Board.	CH/PR	Ongoing
Scottish Government and NHS Greater Glasgow and Clyde to take forward discussions around information Governance	SG/ NHS GGC	Ongoing
Final amendments to be made to Terms of Reference by 30 January	CH	Complete
Scottish Government to table at Oversight Board on 6 February for clearance.	CH	Ongoing – OB takes place on 6 Feb.
The Scottish Government to take forward action to find best approach for information sharing.	CH	Ongoing
The Scottish Government to consider comments shared by Angela O'Neill and Mags Maguire as part of the draft workplan.	PR	Ongoing
The secretariat to share HPS Manual in advance of 4 February meeting.	CH	Ongoing

SB to bring a case-study of the Cryptococcus incident from 2018 for the 4 February meeting.	SB	Paper tabled at 4 February
NHS Greater Glasgow and Clyde to share presentation with Professor White in advance of 4 February meeting	NHS GCC	Ongoing
CW to reflect on how to ensure appropriate confidentiality in Sub Group discussions and will consider steps to address this in advance of the next meeting.	CW	Ongoing
CW to utilise the master list to identify another family representative and reflect on how best they can participate in the work.	CW	Ongoing
It was asked going forward that relevant communication between members of the Sub Group should be shared widely to help support discussion.	All	Complete

Various policies and strategies by NHS GGC

Provided as separate documents.

HEALTH AND SOCIAL CARE DIRECTORATES
NHS GREATER GLASGOW AND CLYDE OVERSIGHT BOARD

COMMUNICATIONS AND ENGAGEMENT SUBGROUP

29 January 2020

COMMUNICATIONS AND ENGAGEMENT SUBGROUP: POTENTIAL WORKPLAN

Purpose

The following paper proposes a potential workplan for the members of the Subgroup to agree.

Discussion

With the final terms of reference being agreed for the Subgroup, the agreement of a set of success indicators by the Oversight Board and the preparation of a Programme Plan for all the different workstreams underway, it is timely for the Subgroup to agree a provisional workplan. The value of planning ahead is that it starts to map the work required to achieve the deliverables in the Terms of Reference, and helps members and NHS GGC to plan for forthcoming meetings.

The following schedule reflects the objectives set out in the Terms of Reference and the issues that have been raised in the Subgroup discussions to date. It will, of course, remain flexible, as the Subgroup may need to reprioritise issues for discussion, or spend longer on particular topics. However, it is a framework that will support planning for the meetings: in particular, it can be used to enable NHS GGC to provide relevant papers/materials for forthcoming meetings at least a week in advance of specific meetings, so they can be distributed quickly to members.

Date of meeting	**Proposed key topics for meeting**
29th January	Discussion of Relevant Policies and Procedures: As set out in the agenda – this could be used as an initial discussion of the range of documentation provided by NHS GGC, and an opportunity for members of the Subgroup to indicate where particular issues should be explored in more in-depth. It would inform that workplan. Workplan: As set out in the agenda, this would be a discussion based on this proposal.
4th February	Approach to engaging families on case review: The approach to undertaking the case review would be discussed by the Subgroup, and its views on how different families should be communicated and engaged with over the approach discussed, with actions agreed. Overview of Board strategic approach to communications and engagement in case of infection: This would be the opportunity for an overview of the Board's overarching approach to communications and engagement in these circumstances, with a particular focus on: • the Board's strategic commitments and supporting policies, procedures and implementation support resources in relation to communication and engagement at all levels from Board to point of care; and • the governance processes in place to ensure that strategic commitments and policy/procedural requirements in support of communication and engagement and how they should be delivered consistently and impactfully. Example of this strategic approach in action: An example showing how this works in practice would be valuable, particularly if it was a positive example that can act as a benchmark/exemplar. The example of the 2019 outbreak of stenotrophomonas at the Royal Alexandria Hospital, used in the IPCG Subgroup, would be good for cross-referencing.
18th February	Organisational duty of candour: A meeting dedicated to this issue would be valuable, given the importance that many families have placed on this. The format might be: i) a description of the policy/strategy and how it is monitored/reviewed through the governance structure; ii) an example of that policy in action; and iii) questions from the Subgroup about how that policy applied in the cases related to Wards 2A, 2B and 6A.
3rd March	The same format for 18th February – policy overview, case-study description, and examination of policy in the situations that led to escalation to Stage 4 – could be applied to addressing the following two specific topics. • Significant clinical incident reviews: This would give particular focus to how feedback from families affected by infection incidents had been collected and how this has supported continuous improvement. • Supported access to medical records: This would also give an opportunity to discussion how the PACT principles could be applied to support families.

Date of meeting	**Proposed key topics for meeting**
18th March	Review of strategic communications and engagement plan in relation to paediatric haemato-oncology patients: A key deliverable is development (or review/refinement of) a strategic communications/engagement plan. Work on this might usefully be commissioned at the 18th February meeting, and involve some of the Subgroup members working closely with NHS GGC representatives on preparing a draft for this meeting. Development of recommendations for Oversight Board: This would be the meeting where the Subgroup might reflect on its collected 'findings' through the previous meetings with a view to agreeing a set of draft recommendations for the Oversight Board. This should address the following questions: • What have the positive impacts of the actions undertaken to date and what factors have been contributory to the times when the impact of communication and engagement have not had the desired positive impact? • A description of the proactive actions taken to deliver person-centred approaches to engagement, communication and the provision of information and, where this has not been implemented as intended, what may have contributed and what are the possible improvement/learning actions? • What national standards in respect of communication and engagement in a person-centred have been useful and/or where might there be improvements made in the future? • What are the key strategic commitments that will address the dissatisfaction of families, continue to support the positive feedback from other families and together influence learning from recent work and discussion?
Further meetings	To be agreed by the subgroup

Recommendation

The Subgroup is asked for its views on the provisional workplan.

Scottish Government
January 2020

NHS GGC paper on communications with families

NHS GGC
Acute Division
Women and Children Directorate
Hospital Paediatrics and Neonatology

1. **Context and Introduction**

   There has been well documented infection incidents occur within the paediatric haematology oncology patient group treated in the Royal Hospital for Children (RHC).
   During these incidents there has been criticism of the NHS Board's communication plan for updating patients and families.
   The Scottish Government has targeted this as an area of expected improvement moving forward.
   This is reflected in the Infection Control Oversight Board commissioning a sub group under the Chair of Professor Craig White with specific mandate to implement change in this area.

2. **Introduction to the paper**

   In making sure the Board has a robust communication plan in place and is being delivered to patients and families it must:
   - Understand the different types of communication content which might be circulated?
   - Who amongst the patient and family group would wish to receive such communication?
   - Identify the grouping of patients and families that exist across paediatric haematology oncology?

   This paper sets out to answer these three questions.

   It then describes how it would deliver the right communication to the correct group.

   And also provide a confidence within these arrangements no family would be missed.

3. **Types of communication the NHS Board / Scottish Government might wish to circulate to Paediatric Haematology Oncology families**

   In simplified format and for the purposes of this paper there are three types of communication:

- Here and now (inf1)
- 2015 to November 2019 (inf2)
- Future including return to Ward 2a/ 2b & moving forward (inf3)

4. Patient and Family Groups

In simplified format and for the purposes of this paper there are three groups of patients:

- Treated in the RHC but are above the age of 18 (group 1)
- Treated in the RHC but have died (group 2)
- Treated in the RHC and likely/ potentially to be treated again (group 3)

5. Who would want what information?

There has to be a degree of sensitivity around what is communicated to group 2. Clinical opinion has articulated that a blanket communication ongoing to this group is not appropriate.
To date, NHSGGC have therefore taken the position that communication should not go out to these families. It is noted that there has been criticism of this decision by at least one family.
We would reaffirm the difficulties in judging who would want what information in such circumstance and as such suggest this base position is considered.
A process for ongoing communication on a case by case basis based on the preference of individual families could be considered. This would require some initial communication with each family.
Group 1 might be interested in inf2. They are unlikely to be interested in inf1/3.
Group 3 might be interested in all of inf1/2/3.

6. Processing information to families

It will be impossible in an individual family basis understand what information they might want and what they might not.
The groupings and rules in sections 3-5 simplify the challenge and focus best attempts on making sure everyone is appropriately informed.
It is for the sub group to decide how it uses this information and who eventually gets what.

7. Number of patients per group as at Jan 2020

Using appendix 1 (master list JR1.2)

- Group 1 – 19 patients

- Group 2 – 61 patients

- Group 3 – 434 patients

8. Data sources and keeping master file updated.

Due to concerns that previous communications had missed specific patients the provision of an active master list was created by searching:

- the active Leukaemia, lymphoma, stem cell transplant and oncology databases
- all inpatient, day case and outpatients treated under haematology oncology code period April 18 to November 19
    - In this second search there had to be a manual extraction of all benign haematology / haemophilia patient groups

A standard operating procedure is now in place to update the master file (appendix1) with two objectives:

- Ensure patients are aligned to the appropriate group
- Track all new patients

Extra safety checks will be placed in making sure Group 2 is accurate.

9. Differences to what was done previously

Previously the master file was created by taking a look forward over 6 week period and identifying patients on active treatment. This approach was quick to procure but not sensitive to the challenges that have been identified moving forward in terms of effective communication across inf1-3.

10. Further Comment

This paper acknowledges there have been, and continue to be written correspondence, individual and group meetings with a number families from all of the above categories. An additional database has been established to support these active communications. This includes families who have contacted Scottish Government, the closed Facebook Group, local teams or the NHS Board with queries relating to this situation. The approach embodies the principles of openness and person centeredness.

Jamie Redfern
General Manager Hospital Paediatrics and Neonatology Paper v1.1 31-1-2020

NHS GGC presentation on Infection Prevention and Control and Cryptococcus case study

Provided as a separate document.

HEALTH AND SOCIAL CARE DIRECTORATES
NHS GREATER GLASGOW AND CLYDE OVERSIGHT BOARD

Communications and Engagement Subgroup

4 February 2020

CASE REVIEW: COMMUNICATIONS AND ENGAGEMENT WITH FAMILIES

Purpose

The following paper proposes options for communicating and engaging with families on the Case Review.

Background

In her statement to Parliament on the Queen Elizabeth University Hospital on 28 January 2020, the Cabinet Secretary for Health and Sport set out details of an independent, rigorous and robust review of individual cases to answer key questions by the families affected. These include:

- how many haemato-oncology paediatric patients have been affected since the opening of the hospital;
- which gram-negative infections have been contracted; and
- when these infections occurred.

At the same time, the review aims to ascertain:

- whether infections were associated with the environment or other sources;
- what infection prevention and control measures were in place and how they affected the outcomes; and, most importantly,
- the impact on quality of care and outcomes for the children

Consequently, the Case Review team will examine the case notes of all haemato-oncology paediatric patients from 2015 to 2019 who had a gram-negative bacterium identified in laboratory tests. In particular, it relates to patients cared for in Wards 2A/2B in the Royal Hospital for Children, as well as haemato-oncology paediatric patients with a gram-negative bacterium cared for in other areas of the Royal Hospital for Children and Queen Elizabeth University Hospital over that time period.

To ensure rigour and robustness the Case Review will employ two main approaches:

- an epidemiological review which will be validated by microbiologists and epidemiologists and use international infection definitions to identify all gram-negative infections in the selected group. The epidemiology review will clearly define the frequency of the infections and their distribution by person, place and time. It will be led by Health Protection Scotland; and
- the use of the Paediatric Trigger Tool Review, an internationally-validated approach which will identify impact on outcomes in relation to infections and the care of haemato-oncology paediatric patients in hospital during this time.

Infection prevention and control measures, their use and effectiveness will also be assessed in relation to the outputs of the Case Review.

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 – will provide guidance on the use of the Tool for this purpose and the augmentation of the tool as required for this cohort of patients.

The Case Review process will be overseen by Professor Marion Bain, the newly-appointed head of healthcare-associated infection at NHS GGC. An expert panel will provide oversight and final analysis, which will include national expertise from:

- Professor Mike Stevens, Emeritus Professor of Haemato-oncology from the University of Bristol;
- Gaynor Evans, Clinical Lead for the Gram-negative Bloodstream Infection Programme at NHS Improvement England; and
- Professor Mark Wilcox, Professor of Medical Microbiology, University of Leeds.

As this review covers a significant time period and number of cases and complexities the review team have agreed the approach will require to be segmented.

The first segment to be reviewed will be the cases from 2017. That segment will be completed by March, and the whole review completed by June 2020. The report of this review will be published.

Options for Communications and Engagement

To progress with the Case Review, engagement with families must begin as soon as possible. The following approach is suggested:

- preparing a short, clear description of the Case Review, its purpose, how it would be conducted and timescales, outputs and what families can expect from it (potentially based on the background section set out above, and completed by 7 February);
- identifying which families would want to be contacted directly about the Case Review using which method of communication, based on the 'Families Masterlist' developed by NHS GGC database (subject to the identification of cases for the first stage of review, by 7 February);
- agreeing a draft letter for all those likely to be covered by the Case Review which can be sent out to all families, subject to preferences recorded in the Families Masterlist (by 7 February); and
- enabling those favouring more direct, private engagement to make arrangements directly with Professor White.

We should also consider an event for those families wishing to hear about the Case Review in more detail from those who will be conducting it, so their questions can be answered. We should also consider how to use the closed Facebook page for families as part of this work.

At the conclusion of the work, in addition to the general oversight report by the expert panel, individual families will be offered opportunities for discussion of the results of their individual case reviews with members of the expert panel.

Recommendations

The Subgroup is asked to agree on how to engage with families over the Case Review.

Secretariat
Communications and Engagement Subgroup
February 2020

Statutory Duty of Candour Update for

Communication and Engagement Subgroup (Friday 14th February 2020)

Introduction

The Communication and Engagement Subgroup raised a query about the role of the statutory Duty of Candour as it related to the occurrence of gram negative infections in children who had been cared for within haemato-oncology services at The Royal Hospital for Children in 2017 and 2018.

The statutory Duty of Candour came into force on 1st April 2018. There was no instance in which the occurrence of a gram negative blood stream infection, reported in a patient receiving care from the haemato-oncolgy service, was deemed to be a notifiable patient safety incident between 1st April and 31st December 2018.

Application of the statutory duty of candour

The duty candour requirements are considered by every meeting of an IMT, which was informed by the guidance provided by the Board's policy document. The service management teams have a responsibility to also consider the duty of candour policy requirements irrespective of an active IMT.

The occurrence of an infection in many of these patients is not an unexpected event. Families and children understand during consent to treatment, that vulnerability to infection is a recognised complication of treatment. Ongoing support is provided to them to minimise this risk but it is recognised as a known risk and complication of care. The following extract from the Scottish Government website refers to these circumstances.

How will the duty of candour deal with the fact that is well established in medicine that there are known risks and complications? There are some events that occur entirely predictably during the course of medical interventions and procedures – it is completely impractical to suggest that an organisational duty of candour might be applied to these surely?

Duty of candour is very specific and only applies where there has been an unexpected or unintended consequence that causes harm or death to an individual (as defined by the Act) that is not as a consequence of the condition for which they are being treated.

https://www2.gov.scot/Topics/Health/Policy/Duty-of-Candour/FAQ accessed 29/01/20

To ensure that GG&Cs application of organisational Duty of Candour was in line with other Scottish Health Boards, we recently checked with a number of other Boards

regarding their views on the application of the duty with respect to a variety of infection related events and were assured that our practice is consistent with the other large Boards in NHS Scotland.

There was significant awareness and training during 2017, in the run up to the statutory Duty of Candour becoming live, which continued beyond the policy launch in April 2018. There have been a number of bespoke training events, as well as promotion of duty of candour requirements via routine meetings for services and teams. NHS GG&C staff were presenters and attended the nationally provided training events. NHS GG&C staff were development partners and make use of the NES modules on duty of candour. There is a significant level of guidance in the policy document along with additional templates on the NHS GG&C Intranet. The NHS GG&C clinical risk team provide guidance on an as requested basis on the application of the Duty of Candour policy.

Communication and Engagement Sub Group
NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital Oversight Group

Note for Stocktake Process

Introduction

1. The following note is in response to the commission of the Oversight Board for the emerging findings and remaining key issues of the work of the Communications and Engagement Subgroup. It reflects the progress of the work to date and while it should not be read as a final expression of the Subgroup's recommendations to the Oversight Board, it both captures where the Subgroup believes tentative conclusions can be made and provides specific comments on where its work will be focused for the remainder of this phase of the escalation process. The conclusions may be revised following further work in the coming meetings, and for that reason, these should not be read as early recommendations but observations that will support the identification of recommendations in the closing stages of this phase of the Oversight Board's work.

2. The conclusions have been derived from a method of working in the Subgroup that has encouraged open, respectful inquiry, challenge and collaboration on identifying recommendations. Improvement and learning have been the cornerstone principles of the Subgroup's work and a recognition that the different viewpoints of all taking part in the Subgroup – including NHS Greater Glasgow and Clyde (NHS GGC) representatives, family representatives, professionals from other health Boards and Scottish Government officials – have been crucial in reaching these tentative conclusions. The Subgroup considered a range of information – including survey feedback from families, relevant strategic, policy and guidance from NHS GGC, and consideration of the communication and engagement dimensions through a specific infection incident,

3. The workplan of the Subgroup to date and its activity, as well as the significant written and presented contributions by NHS GGC colleagues, are set out in Annex A.

Emerging Findings

4. The Subgroup recognised several overarching issues in identifying its findings to date, which set the context for the examination of the communication and engagement issues that gave rise to escalation to Stage 4.

- The communications challenge of the continuing uncertainty around the contributory factors to infections in these incidents – recognising the contextual influencing factors occurring at the Queen Elizabeth University Hospital (QEUH) site – was in many respects unprecedented. NHS GGC was continually learning (and continues to learn) from the particular difficulties of balancing the different requirements of communication and engagement with different audiences in these circumstances.

- While the focus of the work is on communication and engagement arising from the particular issues initially arising from the Royal Hospital For Children and the haemato-oncology paediatric patient population and their families, the issues that have been raised and the wider learning that has surfaced has wider application in the workings of the Board as a whole. The Subgroup has observed and recognised that strategic commitments to communication and engagement, leadership narratives, clinical engagement and culture significantly influenced the nature and extent of communication and engagement actions during the incidents of infection being considered.
- The communications challenges of addressing infection prevention and control should also be understood in the context of the efforts to ensure that effective and high-standard service and support was maintained throughout to this particular patient population and their families.

5. With that context in mind, the following sections sets out the Subgroup's findings to date, noting issues that have been concluded satisfactorily in the workplan ('what worked well') and where scope for improvement – both by NHS GGC and potentially by other Boards and nationally – have been identified. These are set out under a series of key themes/headings:

- communications and engagement with individuals;
- communication and engagement with the public; and
- the organisational duty of candour.

Communications and engagement with individuals

6. When incidents of this nature take place, there is a priority need to ensure that patients and their families receive timely and accurate information and advice from the Board. This needs to ensure that what is communicated is clear and reflects what is known at that time and is communicated in a way that considers fully the sensitivity and exceptional circumstances of this patient population and their families. This is particularly true of those patients who are in active receipt of the service, where emerging issues might have a potential impact on their care, while understanding that the service extends to those who were not in the operational area where the infection occurred. While maintaining consistency of message, it must be highly attuned to the different communication needs and preferences of individual families beyond the operational area where infection(s) were identified and so must be person-centred and reflect core NHS Scotland values.

7. What worked well:

i. ***Processes in place***. The haemato-oncology paediatric service had processes in place for continuing communications and engagement with patients and families, rooted in the relationships between clinical and medical staff on the ward and those patients. Those processes valued the importance of face-to-face and sensitive communications with patients, adapted to the particular needs of each patient and family.

ii. ***Integration at the point of care***. There was recognition of the effectiveness and sensitivity of these communications processes at ward level, particularly in how highly person-centred it was to reflect individual patients' and families' circumstances. Communications with the clinical and medical staff has been highly regarded by families throughout this process.

iii. ***Evidence of compassion, care and support of the management team***. The focus and urgency with which the senior management team gave to communications throughout these incidents has been evident, although their involvement was not always strongly communicated and the leadership on the issue was not consistently experienced by families as it should have been.

8. <u>What could benefit from learning and improvement</u>:

i. ***Improved content of mechanisms of support/information for families***. Families noted that their questions were not all timeously or fully addressed, not least in the closed Facebook page. The importance of timely responses was consistently emphasised – that did not mean families always expected answers, but a recognition of the importance of their questions even when full answers could not always be given. Staff in key communication roles were not always aware of important context in providing the answers that families were required. The admission of uncertainty for some issues – such as the source of infection in several cases – did not appear to be consistently forthcoming from the Board.

ii. ***Establishing new mechanisms for communication***. There was evidence of recognition of the need to address the challenges of maintaining complex and often prolonged communications with families and patients. Establishing the closed Facebook page for families was viewed positively in this context, although it was emphasised that key to its value is the responsiveness (both with respect to timeliness and content) of NHS GGC to issues raised by families. Ensuring that the Facebook page addressed families' questions in particular seemed to have been an early and in some cases, damaging challenge to the health Board.

iii. ***Consistency of positively received action with all, particularly with respect to wider service and with respect to historical service issues***. Not all the communications were as effective as more direct ward communications, particularly for patients and families not currently engaged with the service and where engagement was historical and where reflections have acknowledged several missed opportunities. They were sometimes characterised as being overly defensive, undermining the appearance that the Board was taking a full grip of the situation. It was acknowledged that a key challenge facing the Board was how to communicate on a complex issue where uncertainty was prolonged – notably the source of infections – with individuals who were no longer in regular contact with the service.

iv. ***Timeliness of some communication, which could often be more 'reactive' than 'pro-active'***. Communications were sometimes seen as lagging, responding 'late' to stories and issues that were circulating without official NHS GGC comment for an extended period.

v. ***How connected corporate messaging was***. Communications did not always reflect actions or work across the organisation, leasing to a fragmented picture of how issues were being addressed.

vi. ***How well integrated were estates/facilities functions into communications and engagement***. It was noted that key messages, especially when delivered directly on wards, could have sometimes benefited from a more joined-up approach of IPC and facilities/environment personnel.

vii. ***The strength and consistency of compassion and transparency in the tone of written communications***. There was seen to have been variation in the 'person-centredness' of the communications by the organisation, so that not all correspondence or direct engagement appeared to reflect the sensitivity and compassion that was apparent in, for example, the direct ward-based communications cited above.

viii. ***Value of new mechanisms to capture information on communications preferences***. The development of the specially-commissioned database facilitating improved engagement with concerned families and how they preferred to be contacted was cited as a good example of learning in the face of the challenges faced by the Board. It was suggested that this tool could be supplemented by enhancing the existing family 'induction' packs with clear information on where families could go for information about continuing issues such as the infection incident(s). Further work was identified to find effective ways of supporting coordination and communication of the various ways in which families can raise and have their questions (about point of care or wider organisational issues) responded to.

Communications and engagement with the public

9. Communications in incidents such as this serve a wider purpose to the public and wider audiences. It must provide reassurance that issues of public interest have been identified and acted upon, maintaining clarity and transparency while reflecting drive and focus in seeking solutions to issues. In a febrile and heightened media environment – characterised by a focus on critical issues, a simplifying of potentially complex situation and a pace of transmission through a variety of channels (including social media) – that public commitment presents health Boards with particular challenges.

10. What worked well:

i. ***Strategic framework***. NHS GGC had a strategic framework for its communications and engagement across all of its activities, set out in a regularly-updated strategy with clear and responsive priorities. Infection issues were clearly highlighted in these overarching documents, and there has been a dedicated healthcare-associated infection communications strategy for the Board, though it is currently in need of updating.

ii. ***Senior engagement***. The focus of senior management on the issues was acknowledged, but the importance placed on the was not always communicated more widely and effectively to the public.

iii. ***Management focus on service provision/business continuity maintained***. Despite the 'crisis management' that continued for some time, the focus on providing a high-quality service was maintained.

iv. ***Staff impact and wellbeing considered***. The impact of the media 'storms' on staff was understood and acted upon within the Board. Communications with staff – both in terms of letting them know what was happening at different stages but also in recognition of their role in communicating to patients and families – was fully recognised as an essential part of this process.

11. <u>What could benefit from learning and improvement</u>:

i. ***Need for a range of methods for communicating***. It was acknowledged that a range of channels and voices for communicating by the Board was important. In particular, clinical voices should be deployed in messaging more often, and if there were skills/training issues about expertise and confidence in media engagement, the Board should address these. Having a visible face and clear leadership in communications was vital, and it was felt that this was not evident in how the Board addressed these incidents.

ii. ***Clarity of narrative in corporate responses***. The consistency of the information and messages across different levels of the organisation was not always evident across the period. The variations in tone/information did not seem to always reflect differences in audience or changing circumstances, but potentially a lack of coordination in how messages should be universally communicated by the organisation.

iii. ***Consistency of compassionate, person-centred tone in communications***. Again, communications did not always demonstrate a clear, person-centred tone in addressing such sensitive issues among families. The willingness to recognise the nature of concerns, apologise for their impact and take decisive action in the face of unknown issues – particularly the decision to de-cant Wards 2A and 2B – would have strengthened some of the communications effort and reduce the mistrust that appeared to build in some families.

iv. ***Impact of social media***. The role of social media as an accelerator and echo chamber for messages was not initially well understood, and difficult to adjust to. Developing better and more rapid responses to fast-moving communications messages was recognised as an emerging need for Board communications activity. The Subgroup has highlighted that the ability of Boards to respond to this was a national development challenge.

v. ***Challenge of maintaining communications in 'slow-burn crisis' scenario***. The gradual unfolding of the issue, with the emergence of hypotheses relating to the environment of the QEUH that could not be quickly verified or discounted, presented a particular set of difficulties in communications. It was agreed that the IMT process, while useful in more boundaried, incident-based situations, was less effective for a continuing 'crisis' where a number of incidents were linked together in media terms. A new process may need to be identified to address this (and applied nationally, as well as locally to the Board).

vi. ***Challenge of maintaining communications where ambiguity is high***. Related to the point above, the demand for clear answers and causation in the media – and indeed, at times politically – jarred with the necessary uncertainty as the Board was trying to understand the source of a complex, and at times, resolutely unsolvable set of issues. This was more difficult to deal with given concerns about competing considerations of confidentiality and transparency.

vii. ***External support and positioning around Board communications***. The role and coordination of messaging by external bodies, particularly NHS Health Protection Scotland (HPS) and the Scottish Government, was not always clear during the period. Further national work needs to be done to be clear about respective roles and the importance of consistency and support across NHS Scotland as a whole, where that is appropriate.

Organisational duty of candour

12. The organisational duty of candour, now enshrined in legislation, is a critical role for health Boards to undertake where harm, or worse, may have come to patients. The application of the duty of candour in these circumstances was a key part of the Subgroup's discussions, and these have not been concluded as yet, with further work on remaining issues to be done. It has been recognised that several of the issues identified below may involve national work on how the duty of candour is applied systematically across Scotland, and the Oversight Board's final recommendations will inform this national improvement work as appropriate.

13. What worked well:

i. The duty was actively considered during the period, although it was not formerly activated for any of the instances of infection within the paediatric haemato-oncology service.

14. What could benefit from learning and improvement:

i. While implementation of the duty in these circumstances has particular challenges, it is clear that the legislation does not require a view on causation to be determined in deciding whether to activate the duty (though this appears to have been the prevailing understanding of the legislation by senior staff in NHS GGC).

ii. Ensuring that the possibility that an event or incident could result in harm should consistently be given full consideration.

iii. Actual or potential harm outcomes are not restricted solely to patient safety events and physical harm.

Ongoing activity

15. The Subgroup has several continuing and commissioned actions underway, addressing further points raised above and examining new issues. They include the following:

i. work to explore the process of communication and supportive care around a child's death (taking account of decision-making and links with external agencies such as COPFS);

ii. further review of the NHS GGC application of the duty of candour;

iii. further work to develop a process within Boards to address 'slow major incidents'; and

iv. a more active consideration of the recommended roles of key external bodies – such as NHS HPS and the Scottish Government – to make their responsibilities in these incidents more clear.

Annex: Annotated Workplan

The Subgroup has held seven meetings to date. Particular issues and work undertaken by NHS GGC and others are set out below.

5 December 2019

- Discussion of the Subgroup's approach to the escalation issues and its ways of working
- Discussion of the results of the survey conducted by Professor Craig White of families affected by the incidents

18 December

- Discussion of terms of reference for the Subgroup
- Discussion on the families' engagement with the Subgroup
- Discussion of workplan for the Subgroup

9 January 2020

- Discussion of the families' key questions with the Board, responses to date and engagement through the Facebook pages
- Review of the dedicated web-pages for the affected patients and families by NHS GGC

29 January

- A discussion of the relevant policies and procedures on communications issues within NHS GGC, including the range of applicable strategies and plans, based on information provided in advance by the Board
- Review of the communications and engagement approach to supporting families in the Case Note Review

4 February

- A detailed examination of how the NHS GGC communications strategic approach operated in the context of the 2017-19 infection incidents in the RHC and QEUH
- A presentation on the NHS GGC strategic approach to communications in the context of infection incidents, with a focus on the overall strategic approach (including the communications strategy for healthcare associated infection), the different media/messaging employed, and a case-study of the 2018-19 cryptococcus incident, with the learning that was gained

- A discussion of the key issues/challenges that arose in the case-study, including the challenges of balancing patient/family confidentiality with the surrounding media pressures, the context of situations where ‘conjecture drives narrative’, and the difficulties of addressing a fast-moving social media communications environment

18 February

- A detailed examination of how the organisational duty of candour was applied by NHS GGC in the context of the 2017-19 infection incidents in the RHC and QEUH
- A discussion paper on the application of the duty of candour by the Board in the context of infection incidents, prepared by NHS GGC, with oral comments provided by other members on the Subgroup following a commissioned review of the NHS GGC approach
- A discussion of the key issues/challenges that arose with respect to the duty of candour and transparency more generally

3 March

- Full discussion on emerging findings and key remaining issues as part of the stocktake process for the Oversight Board

NHS Greater Glasgow and Clyde
Comments on findings/recommendations
of the Communications and Engagement Subgroup

1.0 Introduction

1.1 NHSGGC representatives welcomed the opportunity to attend the meetings of the Communications and Engagement Subgroup to be able to contribute to its considerations and, in particular, to hear from the two parent representatives on the group. We are grateful to Professor John Cuddihy and to [redacted] for sharing their personal experiences with us. The opportunity for learning from this process will benefit both NHSGGC and the wider NHSScotland.

1.2 We are grateful for the opportunity to comment on the report prepared by Professor Craig White, chair of the Subgroup, and Phil Raines, Secretariat, Scottish Government.

1.3 A number of the issues covered within the report are recognised as having been considered by the Subgroup and NHS Greater Glasgow and Clyde has already applied learning from this process to our engagement with families and to our wider communications, including the tone of our communications and developing personalised approaches that meet the needs of individual patients.

1.4 There are a number of observations on the draft report, which we provide here with additional detailed comments provided in Appendix 1. In addition, a timeline of communications and engagement in connection with Incident Management Team meetings held in 2018 and 2019, up to the Ward 6A incident, has also been prepared for reference. This is shown at Appendix 2.

2.0 Main areas to note

2.1 The views and experiences of families of patients under the care of the haemato-oncology paediatric service were central to the process of gaining feedback on NHSGGC's communications. There were a number of ways in which views were obtained: the contribution of the two family representatives on the group; comments from families who engaged with the Cabinet Secretary for Health and Sport and Scottish Government officials; and, finally, responses to a questionnaire issued to all families by Professor White.

2.2 Whilst the insight from the feedback from these parents and carers was invaluable, these were views representing a small number of families. For instance, of a total of more than 400 questionnaires issued to families, 20 were returned, with 10 expressing a positive experience and 10 a negative experience of engagement with NHSGGC. This mirrored the experience of NHSGGC when the Chairman and Chief Executive of NHSGGC wrote to more than 400 families offering the opportunity to meet and nine families took up the offer and met the senior NHSGGC team.

2.3 This observation is not to undermine the important feedback from those families who had a negative experience and we want to treat everyone individually and

fully understand the importance of individualised information. However, for balance, we would ask that it be acknowledged in the final report that the majority of families did not offer a negative view about our engagement with them.

2.4 The findings describe a lack of senior leadership visibility. The report also acknowledges the scale of NHSGGC. Whilst we fully recognise there was perhaps limited visibility from the corporate management team, we would wish to highlight the high levels of visibility and ongoing regular communication from the Chief Nurse and the General Manager for Hospital Paediatrics who personally visited the unit after each Incident Management Team (IMT) meeting to update families and answer their questions. The Chief Nurse and General Manager are members of the Senior Management Team of the Women and Children's Directorate which has responsibility for managing the Royal Hospital for Children. Within NHSGGC these are senior management posts.

2.5 The main other area that we would ask to be considered for inclusion in the final report is the important role of the IMT in assessing and determining the communications response to an outbreak or incident and the national framework within which Boards manage such outbreaks, including their HAI communications.

2.6 This is a national process which NHSGGC follows in the management of infections and outbreaks. Appendix 2 provides a timeline of infection incidents managed over the course of 2018-19 and the communications response to each incident.

2.7 The authority of the IMT to determine whether a Board should make a public statement on an infection incident or outbreak enables an independent, impartial assessment to be made by those managing the incident of the communications that should take place with patients, the public and the media. A communications advisor sits on this group but decisions on whether to be proactive are made by the IMT chair, with the agreement of the team, on the basis of the overall assessment of the incident from the IMT based of a rating of red, amber and green (evidence of this is included at Appendix 2).

2.8 The Subgroup heard from NHSGGC about a number of difficulties with this process through a presentation of one incident, the Cryptococcus investigation. This included the challenge of balancing openness and transparency with the need to maintain patient confidentiality and the risk of deductive disclosure when sharing information about a small number of cases with other families. These issues were central to the dilemmas faced by NHSGGC in our wider communications and engagement. We believe there is potential national learning on the approach to be taken in communicating healthcare acquired infections from these experiences and would ask that consideration be given to this for the final report.

2.9 The report highlights the importance of good communications with staff to ensure that staff are well informed and can contribute to supporting families and patients. There is no doubt that this was a prolonged period of uncertainly and anxiety for families and staff alike. There were significant efforts to ensure that staff were

kept informed, as is shown in Appendix 2, however this is an important area that we will continue to focus on going forward.

3.0 Conclusions

3.1 We are grateful for the opportunity to respond to the draft report as we hope that this experience will help NHSScotland continue to evolve and develop its communications response to outbreaks and incidents.

3.2 We would hope the comments offered are helpful in producing a final report that will provide a useful opportunity to learn from our experience. At this time more than ever, it is important for NHSScotland to consider how it remains open and transparent about outbreaks but seeks to avoid unnecessary alarm or anxiety.

Appendix 1

Concern	Page No	Report comment	NHSGGC comment
1.	Pg 1	*Recommendation 1.* *The Board should learn from the challenges of communicating against a background of certainty and where a critical situation is "slowburn" by pursuing more active and open transparency.*	This is a challenging recommendation as, by virtue of the issues emerging over a period of many months, many of the issues related to the lack of certainty and clarity over the precise nature of the situation, rather than the issue of transparency. The challenge of transparency was really complex when we did not have a clear and full understanding of the position due to its unique complexity.
2.	Pg 1	*The Board should continue to ensure that key and sensitive communications with patients, families – and indeed, the wider public – are undertaken by individuals with particular 'credibility', not least clinical voices*	Immediate face to face communication is our primary approach for ensuring effective, timely and efficient, person centred communication with patients and families. Incident Management Team communications are led by the IMT chair, who is generally a clinician, and the Chair is the spokesperson for all public statements. Clinical spokespeople are also used in media handling, including broadcast interviews as appropriate but this area will be further developed.
3.	Pg 3-4	*While not focusing on these issues, the Subgroup recognized that there were significant shortcomings in: the construction and handover of the QEUH; how NHS GGC responded to emerging problems that appeared to be related to that construction and handover; and the corporate resource and approach in support of person-*	This remains under review, awaiting the conclusions from the Independent Review and the Public Inquiry. It is also the subject of a significant legal claim by the NHS Board and, thus, at this stage to state "there were significant shortcomings in

		centred communication. The Subgroup noted that any historical shortcomings relating to treatment of these issues, particularly the construction and handover of the QEUH, would be addressed by the Independent Review of Dr Andrew Fraser and Dr Brian Montgomery, and the forthcoming Public Inquiry by Lord Brodie.	the construction and handover of the QEUH" may be regarded as prejudicial and it may not be helpful to include this statement at this time.
4.	Pg 4	While these principles were agreed after the concerns underpinning the communications and engagement work arose, for how 'person-centred care' should be conducted by the Board itself are set out in the Annex to this paper and underpin the recommendations set out below.	The meaning of this paragraph is not entirely clear as the principles outlined were included in the Quality Strategy which was approved by the NHS Board in early 2019 and was in development prior to that time, rather than the principles emerging after the communications and engagement work commenced.
5.	Pg 6	Timeliness of some communication, which could often be more 'reactive' than 'proactive': communications were sometimes seen as lagging, responding 'late' to stories and issues that were circulating without official NHS GGC comment for an extended period.	This was a highly complex situation with a number of conflicting narratives, for example, within clinical teams, whistle blowers, tabloids and wider media, social media, political, government and opposition parties which all required to be handled. Whilst there were attempts to be proactive there were very significant challenges in managing and pre-empting these various commentaries. It would be helpful if this high level of complexity could be acknowledged.
6.	Pg 6	Consistency of compassionate, person-centred tone in communications: again, communications did not always demonstrate a clear, person-centred tone in addressing such	This is very similar to the 4th bullet point on pg 6.

		sensitive issues among families. The willingness to recognise the nature of concerns, apologise for their impact and take decisive action in the face of unknown issues – such as the decision to de-cant Wards 2A and 2B – would have strengthened some of the communications effort and reduce the mistrust that appeared to build.	

Points Raised in respect of Independent Review & Subsequent BBC Disclosure Scotland Program

This is a very useful summary of key issues that have been subject to various reviews recently. The answers to these questions will come from different sources, but to expedite getting answers, we have annotated below who is best placed to address the questions, and will commit to ensuring these questions are put before the required individuals as soon as possible. In addition, where it is possible to provide answers, we have done so.

Craig White/Phil Raines
Scottish Government

Unless otherwise indicated below, the questions in this section would be for the Independent Review to address. We will forward these questions to the Review Secretariat.

1.Initial Questions for Independent Review Team (additional questions reflective of each chapter will follow)

Chapter 1:- Introduction, Terms of Reference, Remit & Method

To establish whether the design, build, commissioning and maintenance of the Queen Elizabeth University Hospital and Royal Hospital for Children has had an adverse impact on the risk of Healthcare Associated Infection and whether there is wider learning for NHS Scotland. **(Fraser & Montgomery March 2019)**

High Level Findings

In the course of the Review, through examination of documentation, listening to witnesses, discussion with experts and input from the Review's expert advisers, and site visits, we have not established a sound evidential basis for asserting that avoidable deaths have resulted from failures in the design, build, commissioning or maintenance of the QEUH and RHC;

The QEUH and RHC combined now have in place the modern safety features and systems that we would expect of a hospital of this type. The general population of patients, staff and visitors can have confidence that the QEUH and RHC offers a setting for high quality healthcare.

(Fraser & Montgomery, Independent Review June 2020)

1. In respect of your two high level findings, detailed above, do you consider that these findings reflect the intended scope and intention of your inquiry?

2.Your 'emergent findings' caused you to focus on defined groups of potentially vulnerable patients and their families (Page 4, para 2). In the course of your review have you established any basis for asserting ***that avoidable healthcare associated infections, within the vulnerable patient group within paediatric haemato-***

oncology, have resulted from failures in the design, build, commissioning or maintenance of the QEUH and RHC?

This question is crucial in ensuring completeness of your remit and your statement on page 23: 1.5.2 ***'the review is an investigation into alleged deficiencies in a system which allowed clinical risks in treatment and care to arise which may have caused harm to numbers of patients.'*** **(the term *'numbers of patients'* is assumed to extend beyond those who have sadly passed away**)

3.Recognising that you would rely on Professor Craig White as a conduit of information to/from this vulnerable patient group and their families, how many did you speak to or reference questions/concerns from, via Prof White within your review?

4. Did you find their 'evidence' to be credible & reliable and as such accepted into your review? If so, why is this group not referenced in your review?

5.Whilst the '*general population of patients'***(Fraser & Montgomery, Independent Review June 2020)** can have a confidence as a result of your findings; how can those potentially vulnerable patients expect to have the same level of confidence when you make no direct reference to them in your high-level findings despite being an aspect of your remit?

6..With the designated paediatric haemato-oncology wards (ward 2A and ward 2B) currently undergoing extensive renovation, as detailed in principle finding 1, resulting in the displacement of vulnerable patients to another ward, how can you conclude with your statement that " ***The QEUH and RHC combined now have in place the modern safety features and systems that we would expect of a hospital of this type'?***

7. Indeed, as detailed in principal finding 5 ***'the level of independent scrutiny and assurance throughout the design, build and commissioning phases was not sufficient'***, how can you be satisfied, and indeed state publicly, as to the current application of such scrutiny and assurance relative to those aspects of the major renovation, including air ventilation, water systems and associated infrastructure within those wards, when this work remains incomplete?

8. Moreover, how can you be satisfied that such major renovations will reduce such risk to those vulnerable patients when they have not been completed, scrutinised or commissioned in accordance with current technical specifications, infection control and wider guidelines, which cater for the needs of immunocompromised patients?

9. Has your review, described on page 23, 1.5.2, '.. ***as an investigation into alleged deficiencies in a system, which allowed clinical risks in treatment and care to arise, which may have caused harm to numbers of patients…'*,** enabled any conclusion as to whether this is indeed the case?

10. In relation to your document review you state

i) *A further matter which became evident in sourcing reports, both published and unpublished, is the* ***lack of availability of large bodies of documentation relating***

to who took decisions, whether the decisions were implemented properly, whether the planned building systems worked as intended and were free of complications and specifically, free of contamination or risk of contamination (page 26:1.6.9);

ii) ***We conducted limited literature searches to explore matters such as the risk thresholds for air change rates, chilled beam technology and infection risk, and material relating to environmental health and environmental health monitoring***.(page 26:1.6.11);

iii) *We undertook several site visits and inspections to the Queen Elizabeth University Hospital and a further matter which became evident in sourcing reports,* ***both published and unpublished****, is the* ***lack of availability of large bodies of documentation relating to who took decisions, whether the decisions were implemented properly, whether the planned building systems worked as intended and were free of complications and specifically free of contamination or risk of contamination***.(page 27:1.6.17).

If you have a lack of such crucial information relative to risk contamination and have limited your literature review relative to infection risk,

(a) what trust can we have they you have demonstrated depth and appropriate research to enable you to make detailed, informed, high level findings and operate within the faith of your remit, providing assurance to the Cabinet Secretary and to address public concern?

(b) what steps did you take to fill those gaps in critical knowledge around matters such as risk and have you made allowances for the limitations in your knowledge?

11. In support of question 4, you have identified *'around 40 interviewees'*, some of whom were interviewed more than once resulting in an estimated 100 hours of interview material. Can you confirm exactly how many interviewees there were, breaking down their respective role, to reflect those groupings identified by you, namely

i) Family members of those whose deaths were linked to allegations about the building, and unusual potential sources of infection;
ii) Whistle-blowers within NHS GG&C;
iii) Senior individuals who have led reviews and inquiries, who have been leading investigations and preparing reports on aspects of the hospital and other relevant subjects;
iv) Those closely involved with infection control in the QEUH/RHC;
v) Clinical staff with management and leadership roles, and senior clinicians specialising in infection and haematology;
vi) Representative groups for staff and management at NHS GG&C;
vii) Senior managers responsible for project decision-making, and management of the QEUH/RHC building including Estates and Facilities managers; and
viii) General Managers and senior post-holders in organisations responsible for the planning, construction and operation of both hospitals.

Note- there is no mention with the groupings of family members/patients whose HAI were linked to allegations about the building and usual potential sources of infection.

This will assist in understanding the depth and detail explored, in the absence of such crucial information as detailed at question 4, especially in the context of your remit and overall public trust.

12. Can you confirm if the interviews conducted filled any of your knowledge gaps as detailed in question 4a and 4b?

The questions below relate to the Communications and Engagement Subgroup as a whole. We will share these questions with members of the Subgroup to secure their views. Initial responses from the Chair and the Secretariat to questions are presented below, but do not, of course, reflect the views of the Subgroup as a whole.

2.Questions to be considered specifically by Communication & Engagement Sub-Group

1.Do you believe that the conduct of NHSGGC has been within the faith of the agreed terms of reference of the Communication & Engagement Sub-Group, commissioned by Scottish Government?

The conduct of NHSGGC with respect to communications and engagement is, of course, the subject of the Subgroup's inquiries, as set out in its terms of reference. The view of the Subgroup on NHSGGC in this context will be set out in the Subgroup's summary report, which it will present to the Oversight Board to consider for its Final Report.

2.Do you believe that the conduct, pre and post publication of the BBC Disclosure Scotland program, of NHSGGC has further eroded trust and confidence with paediatric haemato-oncology patients, their families and the wider public?

The Subgroup meeting of 1 July 2020 covered these issues, where concern about NHSGGC actions in the wake of the programme were clearly expressed (and recognised by NHSGGC representatives). That meeting's discussions will inform the final set of judgements by the Subgroup in its summary report.

3.With the sub-group being created as a consequence of NHSGGC being placed into special measures, what steps can be taken by Scottish Government to hold to account NHSGGC for their failings to communicate and engage and thus adhere to the measures imposed on them?

The Oversight Board will consider and advise on this for all its recommendations as part of its Final Report.

4.Do you believe there is value in paediatric haemato-oncology patients and their families engaging with the Communication & Engagement Sub-Group?

The participation of representatives of the community of patients and families has been essential. The Cabinet Secretary for Health and Sport has been clear about this consistently in Parliamentary statements, including the announcement of the establishment of the Oversight Board in the first place. Communication with families through Professor Craig White has been critical in identifying key issues and concerns to shape the work, not just of the Communications & Engagement Sub-Group, but the Oversight Board as a whole.

5.The Fraser & Montgomery Independent Report stated in relation to Communication:- ***"Communication about QEUH and its problems since opening has been variable ranging from appropriate and effective in relation to clinical communication with patients and families, to inadequate and reactive in relation to external communication about serious problems with the building and possible links to infectious disease events."*** **(Principal Finding 9)**

Do you consider that this is a true reflection of communications within NHSGGC?

The assessments of the Independent Review should be read in the context of its terms of reference, which focused on the commissioning, design, building and handover of the QEUH. The Oversight Board was set up to drive improvement in a range of areas as they are at present. The Communications & Engagement Sub-Group assessments of communications by NHSGGC, when they are presented in their summary report, should be seen in the context of a focus on the current nature of communications, as informed by how the health Board has dealt with the recent history of infection incidents at the QEUH. As a result, we do not think it valuable to compare assessments, as they do not necessarily refer to the same thing.

6. Do you think that NHSGGC have learned anything from this review, when you reflect on their conduct of late?

The Sub-Group will reflect on recent conduct by the health Board when finalising its findings and recommendations advice to the Oversight Board. When it presents its Final Report, the Oversight Board will be focusing on what the health Board needs to improve from now, not simply from the point when the Oversight Board was established.

7.Do you consider that the scope and depth of the IR was sufficient in showing an accurate representation of the thoughts and opinions of patients and families? (only two families of deceased; one parent of patient treated within paediatric haemato-oncology and less than 40 individuals in total. No-one from Multi-plex was interviewed and, as detailed in the Independent Review, there was a lack of accessible documentation with limited research conducted)

The Scottish Government has been clear that it is not appropriate to comment on the IR's processes, so this is not a matter on which the Oversight Board, and its Sub-Groups, can comment.

8. Should paediatric haemato-oncology patients and their families trust NHSGGC to act in their best interest?

The Sub-Group cannot answer that question. The Oversight Board as a whole was established with respect to a defined set of issues on which NHSGGC was escalated, so on those matters, the Oversight Board can offer its views about how well NHSGGC has acted and what needs to change, and will set those views out in due course with its Final Report. What is clear is that the expectations on health Boards with regards to patients and their families are clearly set out, and Board are held to account when those expectations are not met (not least through the process of escalation that gave rise to the Oversight Board in the first place).

9. Has NHSGGC treated paediatric haemato-oncology patients and their families with respect, providing them with timely and accurate information following the Independent Review?

The Sub-Group has not systematically reviewed all the information provided to families – collectively and individually – following the Independent Review. It has equally noted the restrictions on the health Board to comment on some issues – both because of the pending legal case as well as because of individual patient confidentiality – and the concerns expressed by families at the way communications and engagement have been conducted in the wake of the Review report's publication and the BBC Disclosure programme. The meeting of 1 July 2020 of the Sub-Group highlighted these issues in detail, and those discussions will inform the Sub-Group's summary paper.

10.Can you provide a timeline as to when individual case reviews will be completed?

We have asked Professor Mike Stevens, the independent expert heading up the Expert Panel of the Case Note Review which the Cabinet Secretary for Health and Sport announced in January this year, to provide an update note to cover the answer to this and several of the questions below. We expect this update to be published on the closed Facebook page as soon as possible.

11.From the Independent Review and indeed reiterated on the Disclosure Scotland program by Dr Montgomery- "***'…evidence of contamination of the water almost from the point of the hospital opening..',*** can you confirm that, in addition to reviewing cases individually there will be an overview of infections during the time period 2015 onwards, whilst applying retrospectively, the case definition constructed during the 2018 incident outbreak, thus making sure **all cases** of infection have been identified?

Please see the answer to question 10 above.

12. Can you confirm that the individual case reviews will be conducted with the full picture and environmental risks in mind and not simply due to underlying health conditions?

Please see the answer to question 10 above.

13. In instances where water sampling was NOT conducted at the time, can you confirm what scientific basis the review team will use to determine matching between a patient's infection and the environment? It is requested that the reviewer state within each of the reviews whether water sampling was conducted at the time and if not, why

not with due regard to **Management of Public Health Incidents: Guidance on the roles and responsibilities of NHS led Incident Management Teams and associated literature/reports.**

Please see the answer to question 10 above.

14. In instances where water samples, air ventilation samples, drain samples and associated environmental sampling were not taken at the time, but taken during the time period that wards 2A and 2B were closed, will those samples be considered within such scientific or circumstantial case review?

Please see the answer to question 10 above.

15. Can there be assurance provided that such samples as detailed in question 11, together with physical samples of the air-ventilation, water, drainage and associated infrastructure/ environment are retained together with any photographic/video and audio recorded evidence of the physical condition of the infrastructure and fabric of the wards to enable independent scrutiny?

Please see the answer to question 10 above.

16. NHSGGC are taking legal action against the contractor involved with the construction of the hospital. We will be told that, for legal reason, NHSGGC are unable to discuss this. However, one would assume that there is legal a basis for doing so, founded upon evidence in possession of the NHSGGC. Does NHSGGC possess such evidence that would support the allegation that there was increased risk of ***avoidable healthcare associated infections, within the vulnerable patient group within paediatric haemato-oncology, resulting from failures in the design, build, commissioning or maintenance of the QEUH and RHC?***

This question should be answered by NHSGGC.

17. From information in the public domain, yet to be established as evidence, NHSGGC made the decision to open the hospitals, without considering the needs of a vulnerable patient group, in the knowledge that there were significant increased risks and separately numerous, seriously ill children have contracted infections requiring of major clinical interventions. With the decision to proceed despite concerns about the ventilation system, water system and taps being raised should patients and their families consider that both NHSGGC and the contractor are complicate in increasing the risk of ***avoidable healthcare associated infections, within the vulnerable patient group within paediatric haemato-oncology, resulting from failures in the design, build, commissioning or maintenance of the QEUH and RHC?***

This question should be answered by NHSGGC.

18. If NHSGGC have taken legal action against the Contractor does this mean that a counter claim may be made against NHSGGC for seeking to “cover-up” such action? Is it the case that patients and families should progress legal action against NHSGGC?

This question should be answered by NHSGGC. Any decision by patients and families on legal action would need to be made by the individuals in question themselves.

19. When meetings have been held with hospital staff to discuss our children's cases with regards to the infections they have contracted. Were these staff able to access all historical documentation and information in order to obtain the full picture for us or are certain documents and information not within the 'public domain' and therefore not accessible to staff?

This question should be answered by NHSGGC.

20. Have any of the senior staff on ward 2A/2B/6A known there was a problem, but have been unable to speak out, for fear of their job and reprisals?

This question should be answered by NHSGGC.

As highlighted, these are questions for NHSGGC to answer. There are a few which appear to be better channelled towards the Independent Review and the Scottish Government, and these are highlighted below.

3.Questions to be considered specifically by NHSGGC

1.Why did NHSGGC fail to communicate proactively with the patients and families prior to the publication of the Disclosure Scotland Program?

2.Why did NHSGGC fail to proactively engage with the patients and families, providing them with the pre-prepared statement supplied to BBC relative to the Independent Review by Fraser & Montgomery?

3.Following the Disclosure Scotland Program and those allegations made throughout, why did NHSGGC not proactively support patients and families?

4.Can NHSGGC explain the rationale for not appearing on the program, instead providing a pre-prepared written statement?

5.Does NHSGGC consider that the high-level findings satisfy the remit and terms of reference of the Independent Review?

6.Does NHSGGC believe that there is no evidence ***that avoidable healthcare associated infections, within the vulnerable patient group within paediatric haemato-oncology, have resulted from failures in the design, build, commissioning or maintenance of the QEUH and RHC?*** If so, what is the basis for this belief?

7.Can NHSGGC confirm that ***The QEUH and RHC combined now have in place the modern safety features and systems that we would expect of a hospital of this type. The vulnerable patient group of immunocompromised paediatric haemato-oncology patients, staff and visitors can have confidence that the QEUH and RHC offers a setting for high quality healthcare?***

8.Can NHSGGC provide the basis for the decision to close ward 2A and ward 2B of RHC in 2018 and what risks NHSGGC believed existed in respect to the paediatric haemato-oncology patients treated within those wards?

9.Following the closure of wards 2A and wards 2B of the RHC, what sampling and environmental testing has been conducted within the wards, especially in respect of the air ventilation system; water supply, drainage and associated infrastructure?

10.Following such sampling and environmental testing, what bacteria or fungus has been identified within ward 2A and/or ward 2B?

11.In instances where water samples, air ventilation samples, drain samples and associated environmental sampling were not taken at the time, but taken during the time period that wards 2A and 2B were closed, will those samples be considered within such scientific or circumstantial case review?

12. Can there be assurance provided that such samples as detailed in question 11, together with physical samples of the air-ventilation, water, drainage and associated infrastructure/ environment are retained together with any photographic/video and audio recorded evidence of the physical condition of the infrastructure and fabric of the wards to enable independent scrutiny?

13.Following sampling and environmental testing, what bacteria or fungus has been identified within ward 6A during the time between the point of transfer of patients from ward 2A and now?

14. During 2019 it was reported that the “kitchen facility” in ward 6A had developed a water leak that was subsequently investigated by Infection control and Health Protection Scotland. Can you advise patients and parents of the extent of this water leak and as to whether there was mould/fungus found during such examination?

15. During the summer months of 2019, patients within ward 6A were moved from room to room allegedly to facilitate cleaning. However, it has been reported by some that water leaking from the ceilings was the actual reason, caused by ‘chilled beams’ (condensing during warm weather, causing condensation and water droplets) within the ceiling space. Can you confirm if this was indeed the case and what risk was posed to patients and their families?

16 Following sampling and environmental testing, what bacteria or fungus has been identified within ward 4B- (the area used for paediatric patients)?

17.What measures have been taken during the major renovations to wards 2A and 2B especially in relation to air-ventilation, water supply and drainage?

18.When are wards 2A and 2B expected to re-open and ready to receive patients?

19.During the course of the Disclosure Scotland Program, the Cabinet Secretary for health, Jeane Freeman stated, in respect of the hospital facility in Edinburgh that she

took a decision that said, " ***I cannot be confident that this hospital is safe, so we are not opening it***". How confident are you that the QEUH and RHC is safe?

20.Dr Montgomery stated in the BBC Disclosure Scotland Program- "... *we have also found that the way that things were progressed there are a small number of* ***very vulnerable patients whose needs were not fully taken account of*** *and that's because* ***we do feel there were errors in the way aspects, in which the building was designed, built, commissioned or maintained***…. "
Do you agree that those *very vulnerable patients* are those treated within the paediatric haemato-oncology wards 2A and 2B and associated wards?

21. Dr Montgomery further states "… ***we found problems with both the ventilation and water***…" What comment do you have for paediatric haemato-oncology patients and their families who had been told by NHSGGC that there was no problem with the water or ventilation?

22. Dr Montgomery also discusses "***ambiguity around guidelines***" and that '***compromises were made along the way***'. d)What measures did you take to add clarity to this ambiguity? e)What compromises did you make? f) Did your clarity or comprise mitigate or exacerbate the risk to paediatric haemato-oncology patients? g) did you record such risk in your risk register and if so when?

23. Dr Montgomery states ***'…evidence of contamination of the water almost from the point of the hospital opening...'*** When were NHSGGC aware of this contamination and what was done about this?

24.Dr Montgomery disclosed '…***we were not looking for evidence***…(relative to a connection between such identified issues with ventilation, water and taps and paediatric haemato-oncology patients). Are you satisfied with this statement?

25. If the independent review team had a remit ***To establish whether the design, build, commissioning and maintenance of the Queen Elizabeth University Hospital and Royal Hospital for Children has had an adverse impact on the risk of Healthcare Associated Infection and whether there is wider learning for NHS Scotland.*** **(Fraser & Montgomery March 2019).** Do you consider that they have fulfilled this remit?

26. If the independent review team were not looking for evidence, what were they looking for? Indeed, if they are not looking for such evidence, who is?

This would appear to be a question for the Independent Review, so we will forward the question to its Secretariat.

27. When rare infections bacteria/fungus are 'evidenced', particularly within the context of patient, place and time, what additional measures are put in place to prevent a recurrence within the patient group? (both in terms of investigation of the incident and protection of the wider patient group)

28. If the IR team were not looking for such evidence, despite their own remit indicating otherwise, how can you be satisfied that the vulnerable patient group, as identified by

Dr Montgomery, were not at increased risk of contracting ***avoidable healthcare associated infections, within paediatric haemato-oncology, resulting from those identified failures in the design, build, commissioning or maintenance of the QEUH and RHC?***

29.How does NHSGGC intend to respond to this failing?

30.Dr Montgomery stated in relation to the QEUH and RHC '… ***accepted (QEUH/RHC) in a less than fit state…".*** What does NHSGGC have to say about this decision and did such a decision, expose vulnerable immunocompromised patients, increase the risk of contracting avoidable healthcare associated infections and in so doing, place their lives at risk?

31. Why were those in a position of authority in NHSGGC not as 'decisive' as Cabinet Secretary, Jeane FREEMAN MSP when she stated, in respect of the Royal Hospital for Children, Edinburgh " ***I cannot be confident that this hospital is safe, so we are not opening it***".

32.Acknowledging that many of the infrastructure design features of the Royal Hospital for Children in Edinburgh and RHC in Glasgow are shared, indeed it has been said that one was the blue print for the other, why has such decisive action been taken in respect of one hospital and not the other?

This would appear to be a question for the Scottish Government, and we will come back with an answer.

33.Is there a greater risk to paediatric haemato-oncology patients attending the facility in Edinburgh rather than Glasgow?

Please see the answer to question 32.

34. Are the paediatric haemato-oncology patients treated in RHC, Glasgow, less vulnerable to infection than if they were to be treated within the new facility in Edinburgh, in its current state?

Please see the answer to question 32.

35. What do you have to say to paediatric haemato-oncology patients and their families to reassure them following the Disclosure Scotland program?

36.Acknowledging that ward 2A and ward 2B are closed and in light of information currently in the public domain, are you satisfied that between the period of time the wards were opened in 2015 and then closed in 2018, the level of risk and potential exposure and exploitation of vulnerable paediatric haemato-oncology patients, associated with the RHC and those wards was acceptable?

37.As a Board, were NHSGGC aware of those increased risks, as identified by the Fraser and Montgomery Review relative to air-ventilation, water supply and taps and if so, when were the Board aware and were such risks detailed within your risk register?

38. ***"One unanswered matter is the placing of the water system on the IP&C risk register in 2018, and not at the point of first raising concerns – at the time of opening of the hospital when the Legionella report was submitted by the outside contractor.***" **(Fraser & Montgomery Report 2020, 8.17.4)**. Why did the board wait **three years** to place such a high risk onto the Risk Register when in the words of Dr Montgomery ***'…evidence of contamination of the water almost from the point of the hospital opening...'*** **(Disclosure Scotland program June 2020)**?

39. How many vulnerable paediatric haemato-oncology patients were needlessly exposed to such high risk and what measures did you take to inform them and their families that concerns existed?

40.Does NHSGGC believe in the Communication & Engagement Sub-Group?

41.Why did NHSGGC not follow the agreed process of proactive communication and engagement with paediatric haemato-oncology patients and their families?

42.Why did NHSGGC not proactively provide a statement, designed to support paediatric haemato-oncology patients and their families, that would assist mitigate the high level of anxiety, anger and concern felt as a consequence of the BBC Disclosure Scotland Program?

43.How does NHSGGC expect to build trust with the paediatric haemato-oncology patients, their families and wider public, when they continually demonstrate that **safety, respect, dignity and justice are but mere concepts and not a reality?**

44.This crisis has placed enormous stress on extremely vulnerable patients and their families. The trauma experienced has been immeasurable, intense, and at times unbearable. How does NHSGGC intend to support such patients and their families, now and in the future?

45.The copy of the NHSGGC statement to BBC, supplied to paediatric haemato-oncology patients and their families in respect of that provided prior to the Disclosure Scotland Program; does this reflect all written communications with BBC?

46.Why should parents continue to engage with the Communication & Engagement Sub-Group when NHSGGC treat the group and those they represent with contempt?

47. Within the Patient Charter as detailed under The Patient Rights (Scotland) Act 2011, you state '… ***commitment to our patients and our community is as an open, accountable and responsive organisation that fosters patient and public involvement***.' In light of your continuing failure to communicate and engage with paediatric haemato-oncology patients and their families, which has also been commented upon in the Independent Review, how can you honestly defend such a statement?

48. NHSGGC are currently at stage four of NHS Scotland Performance Escalation Framework meaning there are ***"significant risks to delivery, quality, financial performance or safety"*** with ***"senior level external support required".*** In all the

circumstances, should this be escalated to stage 5 meaning that the organisational structure in a NHSGGC is prohibiting effective care?

49. NHSGGC are taking legal action against the contractor involved with the construction of the hospital. We will be told that, for legal reason, NHSGGC are unable to discuss this. However, one would assume that there is legal a basis for doing so, founded upon evidence in possession of the NHSGGC. Does NHSGGC possess such evidence that would support the allegation that there was increased risk of ***avoidable healthcare associated infections, within the vulnerable patient group within paediatric haemato-oncology, resulting from failures in the design, build, commissioning or maintenance of the QEUH and RHC?***

50. From information in the public domain, yet to be established as evidence, NHSGGC made the decision to open the hospitals, without considering the needs of a vulnerable patient group, in the knowledge that there were significant increased risks and separately numerous, seriously ill children have contracted infections requiring of major clinical interventions. With the decision to proceed despite concerns about the ventilation system, water system and taps being raised should patients and their families consider that both NHSGGC and the contractor are complicate in increasing the risk of ***avoidable healthcare associated infections, within the vulnerable patient group within paediatric haemato-oncology, resulting from failures in the design, build, commissioning or maintenance of the QEUH and RHC?***

51. If NHSGGC have taken legal action against the Contractor does this mean that a counter claim may be made against NHSGGC for seeking to “cover-up” such action? Is it the case that patients and families should progress legal action against NHSGGC?

52. In their report, Dr’s Montgomery and Fraser discuss the processes and procedures adopted within the IMT and specifically aspects of alleged bullying and conflict. It is known that information from two specific IMT, intended to inform parents in relation to the vulnerability of their child, was withheld and indeed, it is alleged that ‘lies’ were told in respect of the parents being updated, when in fact they had not. It is further alleged that staff were unwillingly, engaged in a series of lies, which resulted in communication with the General Medical Council such was the concern. How can patients and their families have trust and confidence in the governance of the IMT, the very body commissioned to investigate outbreaks of infection, when at the heart of it are lies and cover-ups?

53. When meetings have been held with hospital staff to discuss our children’s cases with regards to the infections they have contracted. Were these staff able to access all historical documentation and information in order to obtain the full picture for us or are certain documents and information not within the ‘public domain’ and therefore not accessible to staff?

54. Have any of the senior staff on ward 2A/2B/6A known there was a problem, but have been unable to speak out, for fear of their job and reprisals?

NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital Oversight Group

Findings/Recommendations of the Communications and Engagement Subgroup

Summary: Recommendations

1. The health Board should learn from the challenges of communicating against a background of uncertainty and where a critical situation is slowly evolving by pursuing more active and open transparency by undertaking a review of how it engages with families in line with the principles of its communication strategies. That review should include close involvement of the families that were affected by the infection incidents.
2. The health Board should embed the value of early, visible and decisive senior leadership in its communications and engagement efforts and in so doing more clearly demonstrate and communicate a leadership narrative that reflects this strategic intent. That should be manifested in consistent communications by senior leaders in the health Board with families in such circumstances.
3. To ensure that a person-centred approach is embedded in all of its official communications – corporate to point of care – and that patients and families are responded to in a timely manner, the health Board should ensure that the Executive leads for communications and for person-centred care jointly, regularly and systematically review the quality of their communications with family representatives, and report on this to the Executive team of the health Board.
4. The health Board should make sure that there is a systematic collaborative and consultative approach in place for taking forward communications and engagement with families and patients. Co-production should be pursued in learning from the experience of this challenge. The priority should be on reliable and consistent delivery of this in a way that empowers clinical leaders and directors across professions. The review of communications noted previously could provide recommendations that would enable this to be embedded in the health Board's operations going forward**.**
5. The health Board should ensure that the principles of direct, person-centred and compassionate communications on the ward with patients and families be applied in a way which ensures consistency of experience across all patients and families. While this was reflected in the experience of some patients and families, it was not widely experienced by all of them, particularly those with ongoing question and concerns about infection prevention and control.
6. Finding the right ways of communicating to patients and families who are 'outside' of the hospital is a key challenge that health Boards must address when faced with these circumstances. The experience of NHS GGC should inform national learning on how this can be improved across NHS Scotland in future.

7. The health Board should systematically elicit and reliably act on people's personal preferences, needs and wishes, particularly in circumstances where longer-term communication with patients and families is taking place. An action plan setting out how the learning from the communication challenges of Healthcare Associated Infections in the paediatric haemato-oncology service within NHS GGC will inform that approach going forward should be presented to the Scottish Government by NHS GGC. This should also support national learning.
8. The health Board should learn from other health Boards that have developed good practice in addressing the demand for speedier communications in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.
9. The health Board should review and take appropriate action to ensure that there is an environment where staff are open about what is happening and can discuss patient safety events promptly, fully and compassionately.
10. The recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy for the health Board, and indeed, the wider strategic culture and approach of the health Board, with a view to forming the basis for wider national learning.
11. The Scottish Government, with Health Improvement Scotland and Health Protection Scotland, should review the external support for communications to Boards facing similar intensive media events.
12. Given that organisational duty of candour was considered, but not formally activated, in these circumstances, NHS GGC should review its approach to ensure that it is not simply focused on patient safety incidents and circumstances where causality is clear.
13. The national challenges around the application of the organisational duty of candour highlighted by these events should be explicitly considered and acted upon by the Scottish Government and NHS Scotland.

Introduction

The following note sets out the findings and recommendations from the Communications and Engagement Subgroup of the NHS Greater Glasgow and Clyde (NHS GGC) and Queen Elizabeth University Hospital (QEUH) Oversight Board. That work has been set within the framework of the Subgroup's (and the wider Oversight Board's) Terms of Reference and governed by the Key Success Indicators agreed by the Oversight Board. Given the impact of Covid-19 on the ability of the Oversight Board and its Subgroup to take forward this work as originally planned, the findings set out here have been compiled to inform the final Oversight Board report.

The note is based on:

- the papers and material presented by NHS GGC to the Subgroup's meetings, including the presentations and papers provided;

- discussions at the Subgroup meetings, both with NHS GGC colleagues and amongst the Subgroup members; and
- the experience of operating the new processes put in place in response to the infection issues, such as the 'closed' Facebook page for families and the NHS GGC database capturing communication preferences for families.

The note sets out findings and recommendations under two key issues that were highlighted in the escalation to Stage 4 and which were the focus of the Subgroup:

- communication issues: this relates to how the health Board communicated and engaged with individual families and patients affected by the infection issues at the QEUH, as well as the wider public; and
- organisational duty of candour: this relates to how the health Board carried out its legal obligations under the organisational duty of candour in the context of the issues that gave rise to escalation.

Under findings, the note will highlight possible areas of assurance ('what has worked well') and areas for improvement ('what needs to improve'). Under recommendations, it will draw out where national learning may be relevant.

The Subgroup also acknowledges the positive changes that have already been made within NHS GGC since the escalation of the health Board to Stage 4. Such progress has been taken into account and reflected in this report, but notes that there appears to be key learning that has yet to be fully embedded.

The Subgroup's Terms of Reference are set out in Annex A.

Context Setting

The Oversight Board recognised in its Terms of Reference that there would be key points of learning, and need for improvement, for both NHS GGC individually but equally, for NHS Scotland as a whole. In this context, the Communications and Engagement Subgroup acknowledged that its understanding of what took place in response to the series of infection incidents in the QEUH (and the Royal Hospital for Children) should be framed within the context of a series of key issues.

- The unique circumstances of a new, large-scale hospital. There was little precedent for the challenges – not least in understanding the scale and nature of the infection issues – arising from a large, newly-built hospital complex such as the QEUH. This manifested itself in the limited experience NHS GGC – and NHS Scotland more widely – could draw upon to fathom the particular issues that became somewhat clearer over the period. This context can by no means ever be justification for complacency over any actions that were taken – or not taken – by the health Board or the speed with which they were understood and addressed, but the context is important in understanding how the health Board had to adapt to a novel, emerging situation, not least from the perspective of the national learning the health Board's experience can provide.

- Size of the health Board. The issue of NHS GGC's unique scale arose at different points in the Subgroup's deliberations, as the sheer size and expanse of the health Board were defining features for some of its approach to the issues presented to the Oversight Board. While the focus was on the specific issues as they related to the haemato-oncology paediatric services, the issue of scale was considered. It was cited as a factor at points in how the health Board did and could have responded to the circumstances and what might be improved going forward. Indeed, it was argued at points in the Subgroup meetings that the size of NHS GGC could not only allow the health Board access to potentially unique resources and some greater flexibility in how resources were deployed, but presented an opportunity for the health Board to develop into a national exemplar in how it had dealt and learnt from the challenges it faced.

The work of the Subgroup was carried out in the knowledge of a historical context that needed to be understood and which served to inform the work of improvement. The Subgroup was aware of the issues raised about the construction and handover of the QEUH, how NHS GGC responded to emerging problems that appeared to be related to that construction and handover and the corporate resource and approach in support of person-centred communication. However, it was equally clear that issues relating to the building and environment were being addressed by the Independent Review by Dr Andrew Fraser and Dr Brian Montgomery, and indeed, be covered in the forthcoming Public Inquiry by Lord Brodie. They are also subject to ongoing legal proceedings raised by NHS GGC. Consequently, the findings and recommendations of this note do not cover these issues directly.

The findings and recommendations were developed with a view to supporting the health Board's own stated objectives for person-centred care, as set out in it 2019-23 Healthcare Quality Strategy[1]. Responding to what patients and families wanted, the Strategy aimed for a high quality NHS that:

- takes time with patients and listens to them;
- takes care of people, looks after them and makes sure they get the right treatment;
- communicates well with patients by explaining all they need to know and involving them in decision making;
- is knowledgeable, safe and trustworthy;
- is efficient;
- is caring, compassionate and shows empathy;
- has friendly, kind, competent and professional staff; and
- communicates with the people who matter to them regarding their progress and condition.

The principles of how 'person-centred care' should be conducted by the health Board are set out in the Annex B to this paper and underpin the recommendations set out

[1] https://www.nhsggc.org.uk/media/253754/190219-the-pursuit-of-healthcare-excellence-paper_low-res.pdf.

below. They are the principles that the Subgroup have held uppermost in mind when considering the communication and engagement responses of NHS GGC to the infection issues of the QEUH, particularly with respect to the patients and families in the haemato-oncology paediatric service.

In addition, relationships with key groups and communities have been vital for the work of the Subgroup. This has been essential with respect to the families affected by infections, as the Cabinet Secretary made clear when the Oversight Board was established, that their participation in the work of assurance and improvement was critical. For that reason, representatives of the families were part of the Subgroup, and extensive use was made of the closed Facebook page (as described below) to improve communications with the families (and elicit their views) to support the work of the Subgroup.

Communications

Findings

What has worked well

ii. *Good communication at point of care*. Communications at ward level has largely been seen as effective and sensitive, particularly in how highly person-centred it has been to reflect individual patients' and families' circumstances. Communications with and by the clinical and medical staff has been well regarded throughout this process, though their communication roles has not always been seen as appropriate, as discussed further below.

iii. *Establishing new mechanisms for communication*. There was evidence that the health Board was capable of learning to address the challenges of maintaining complex and often prolonged communications with families in difficult circumstances. Establishing the closed Facebook page for families was viewed positively in this context, although it was emphasised that key to its value continues to be the responsiveness of NHS GGC to issues raised by families. Similarly, the development of a database that captured communications preferences of families and enabled more sensitive, targeted communications was seen as an important innovation.

iv. *Senior engagement on communication issues* The focus of senior management on the importance of communicating with patients and families was acknowledged, but the importance placed on the issue was not always communicated widely and effectively by the health Board throughout the period.

v. *Management focus on service provision/business continuity maintained*. Despite the 'crisis management' that continued for some time in the face of the continuing infection issues in the QEUH, the focus on providing a high-quality service was never lost by the health Board, nor the priority on the individual care and needs of the patients and their families.

vi. *Staff impact and wellbeing considered*. The impact of the media 'storms' on staff could be dispiriting. This was understood and acted upon within the health Board.

What needs to improve

vii. *Several families reported a consistent lack of transparency in the communications by the health Board, creating an impression that there was 'something to hide' in terms of what might lie behind the infection incidents*. Several families, particularly those with continuing engagement with the health Board because of the care and circumstances of their children, felt that the Board was often reluctant to provide them with answers to their questions and information about the hospital. This reluctance was fed by a sense of sluggish responses to questions posed, a strong impression of information being partial or misleading, and a belief that the health Board would not admit any mistakes that may have been made regarding the environment of the building or the care of their children. Clearly, these were impressions that were not shared by the health Board, and it was occasionally argued that the responses reflected a minority of families that were explicitly expressing their views. Nevertheless, it was clear to the Subgroup was these feelings became more entrenched over the period, and that any communications and engagement efforts by NHS GGC to address distrust and lack of confidence in the health Board did not fundamentally shift opinions. Indeed, the views of the minority could not be viewed as unrepresentative of a larger group of families, who might not have chosen to express their views vocally.

viii. *Frustration by families at the health Board's reluctance to address questions about the infection incidents and their background has been heightened by NHS GGC's current difficulties in discussing some issues because of the pending legal case*. Since the Oversight Board was established, NHS GGC announced that it was launching a legal case against the QEUH builders, Multiplex. As a result, the health Board seems to have become increasingly reluctant to comment or discuss aspects of what has happened over the last few years in relation to the infection incidents, citing the risks of compromising the forthcoming legal case. This featured recently in its responses to the Independent Review's report on the commissioning, design, construction and handover of the hospital complex and a recent BBC Scotland Disclosure programme on the QEUH (which aired in June 2020). This has exacerbated a sense among several families that the health Board was not pursuing a policy of transparency and sensitivity to the affected patients and families. The Subgroup appreciated the legal issues facing the health Board, but considered that continuing silence on many of these issues will not address fundamental concerns on communications and engagement that gave rise to escalation to Stage 4.

ix. *Families did not always feel that communications with them was the priority for the health Board, as opposed to communication with other groups or the wider public*. Some families, particularly those active with the haemato-oncology paediatric service at the time, did not feel that the health Board consistently prioritised their information needs over other groups, or the wider public. Finding out about key decisions via media statements – as was reported by some, for example, on the decision to decant Wards 2A and 2B – suggested to some that families were occasionally 'afterthoughts'. This might reflect the

complex challenges faced by the health Board in ensuring all patients and families received the relevant information quickly and timeously, but it was clear that there was an ingrained lack of faith in the health Board's ability to prioritise their needs among some families. This was particularly demonstrated in the results of the survey of families through the closed Facebook page by Professor Craig White, where several respondents reported this.

x. *Consistency of compassionate, person-centred tone in communications*. Where there were communications, they did not always demonstrate a clear, person-centred tone in addressing such sensitive issues among families. The willingness to recognise the nature of concerns, apologise for their impact and take decisive action in the face of unknown issues – such as the decision to de-cant Wards 2A and 2B – would have strengthened some of the communications effort and reduce the mistrust that appeared to build. While this was often evident, it was not consistent.

xi. *Consistency of positively received action with all, particularly with respect to wider service and with respect to historical service issues*. Not all the communications were as effective as more direct ward communications, particularly for patients and families not currently engaged with the service and where engagement was historical and where reflections have acknowledged several missed opportunities. They were sometimes characterised as being overly defensive. It was acknowledged that a key challenge facing the health Board was how to communicate on a complex issue where uncertainty was prolonged – notably the source of infections – with individuals who were no longer in regular contact with the service.

xii. *Timeliness of some communication, which could often be more 'reactive' than 'proactive'*. Communications were sometimes seen as lagging, responding 'late' to stories and issues that were circulating without official NHS GGC comment for an extended period. Again, the health Board could not always produce comment quickly, but the perception of delay tended to aggravate family concerns.

xiii. *'Management' was perceived as using frontline staff to communicate 'difficult' messages relating to the health Board more generally*. While frontline staff were seen as important communicators, it did not always seem appropriate that they were the channel for communicating issues that related to more corporate responsibilities. The perception by some families was that frontline staff were 'unfairly' put in this position and that account was not being taken of the clear communication role of senior managers within the QEUH. There was a strong feeling among some families, that senior management in the health Board were not sufficiently and consistently visible in speaking/communicating with them at an early stage.

xiv. *How well integrated were estates/facilities functions into communications and engagement*. Key messages, especially when delivered directly on wards, could have sometimes benefited from a more joined-up approach of infection prevention and control (IPC) and facilities/environment personnel. Given the complex nature of the information that often had to be communicated – including both environmental issues, their link to infection, and the impact on individual care – it because clear that key information from a variety of different personnel needed to be brought together more quickly and effectively when

conveyed to patients and families.

xv. *Value of new mechanisms to capture information on communications preferences.* The development of the specially-commissioned database facilitating improved engagement with concerned families and how they preferred to be contacted was rightly cited as a good example of learning in the face of the challenges faced by the health Board. It was suggested that this tool could be supplemented by enhancing the existing family 'induction' packs with clear information on where families could go for information about continuing issues such as the infection incident(s). Further work was identified to find better ways of supporting coordination and communication of the ways in which families can raise and have their questions (about point of care or wider organisational issues) responded to. As a whole, the Subgroup endorsed the person-centred principles of communication which prioritised the need to give weight to all views and the need to respond to all views in an appropriate, and where possible, customised way.

xvi. *Improved content of mechanisms of support/information for families*. Families had noted that their questions were not all timeously or fully addressed, not least in the closed Facebook page during the initial period when NHS GGC was escalated to Stage 4.

xvii. *Clarity of narrative in corporate responses*. The consistency of the information and messages across different levels of the organisation was not always evident across the period.

xviii. *Impact of social media*. The role of social media as an accelerator and 'echo chamber' for messages was clear throughout the period, but not initially well understood, not least the difficulties in adjustment required. Developing better and more rapid responses to fast-moving communications messages was recognised as an emerging need for Board communications activity.

xix. *Challenge of maintaining communications in a 'slowburn crisis' scenario*. The gradual unfolding of the issue, with the emergence of hypotheses relating to the environment of the QEUH that could not be quickly verified or discounted, presented a particular set of difficulties in communications. The responsibility for decisions in respect of communication about incidents and outbreaks is typically lodged with Incident Management Teams (IMTs), with communication advisors providing support and a key role in taking decisions by the IMT chairs. It was clear that relevant IMTs were active through this period in response to the infection incidents. However, it was agreed that the IMT process, while useful in more incident-based situations, was potentially less effective for a continuing 'crisis' where a number of incidents could be linked together in media terms. A new process may need to be identified to address this (and applied nationally, as well as locally to the health Board).

xx. *Challenge of maintaining communications where ambiguity is high*/. Related to the point above, the demand for clear answers and causation in the media – and indeed, at times politically – jarred with the necessary uncertainty as the health Board was trying to understand the source of a complex, and at times, resolutely unsolvable set of issues. This was more difficult to deal with given concerns about competing considerations of confidentiality and transparency.

xxi. *External support and positioning around Board communications*. The role and coordination of messaging by external bodies, particularly NHS Health Protection Scotland (HPS) and the Scottish Government, was not always clear during the period, and did not provide a consistent source of support or advice to the health Board in addressing the communication challenges faced by NHS GGC.

Recommendations

1. The health Board should learn from the challenges of communicating against a background of uncertainty and where a critical situation is slowly evolving by pursuing more active and open transparency by undertaking a review of how it engages with families in line with the principles of its communication strategies. That review should include close involvement of the families that were affected by the infection incidents.

- The particular difficulties of communicating information on Healthcare Associated Infections (HAI) in the paediatric haemato-oncology service when key information remains uncertain, or at best, nuanced, was acknowledged. It was challenging for the health Board to balance assurance in its approach to addressing the infection incidents when there was continuing, longer-term uncertainty on the sources of infection. Nevertheless, the focus should remain on transparency and it was clear to the Subgroup that this was not consistently applied by NHS GGC, while recognising that the pressures of the shorter-term need for answers could not be easily reconciled against the longer-term work to secure those answered.
- In that context, it was vital that there was clear and widespread consistency of messages and information shared. Similarly, it was critical that the health Board undertake a more transparent approach in its communications against a background of uncertainty, even if it led to the health Board admitting its inability to answer key questions immediately.
- This should form the governing principles of a health Board review of how it undertook communications with the affected patients and families of the infection incidents and what learning should be taken and mainstreamed. That review should closely involve the families themselves and be presented to the Scottish Government, not least as a source of national learning for other health Boards.

2. The health Board should embed the value of early, visible and decisive senior leadership in its communications and engagement efforts and, in so doing, more clearly demonstrate and communicate a leadership narrative that reflects this strategic intent. That should be manifested in consistent communications by senior leaders in the health Board with families in such circumstances.

- Leadership in addressing the challenge of communications on HAI in the paediatric haemato-oncology service was clearly demonstrated in much of the response to the emerging issues by senior staff within the QEUH. But more

senior leadership within the health Board was not always presented visibly or experienced positively by patients, families and the public as the situation unfolded in the public eye. The lack of consistency in the approach was a significant issues for some families. • The Subgroup recognises and acknowledges the important role of the IMT in assessing and determining the communications response to an outbreak or incident; and the national framework within which Boards manage such outbreaks, including their HAI communications. However, there is also a need to point to the need for a mechanism to manage a critical incident supported by more prominent and transparent strategic leadership, governance, public engagement and input. • This highlighted the importance of the health Board showing leadership early, decisively, visibly and consistently in such situations as soon as they arise.

3. To ensure that a person-centred approach is embedded in all of its official communications – corporate to point of care – and that patients and families are responded to in a timely manner, the health Board should ensure that the Executive leads for communications and for person-centred care jointly, regularly and systematically review the quality of their communications with family representatives, and report on this to Executive team of the health Board.
• A caring, compassionate and empathic approach to communication was not always evident in how the health Board responded to the circumstances. Too often communications appeared to be inappropriately reactive and defensive. • The health Board should review its approach to ensuring the right tone and sensitivity in handling is pursued in future, especially for its corporate communications, and determine if guidance or training is required to embed the health Board's learning in this context. • There should be more systematic assurance by the health Board that this is happening across the organisation. Joint Executive responsibility by the two leads should be accompanied by a visible approach to reviewing key communications and engagement incidents going forward. • This should also ensure that the views and experiences of patients and families remain central to how excellence in healthcare is pursued. Regular reviews of patient attitudes and the use of Care Opinion is good, but opportunities for a more targeted review of communications in key incidents by relevant patients and families should be considered. • On the specific issue of addressing the 71 questions set out by families, it was noted that, following escalation, the health Board did address and publicise its responses.

4. The health Board should make sure that there is a systematic collaborative and consultative approach in place for taking forward communications and engagement with families and patients. Co-production should be pursued in learning from the experience of this challenge. The priority should be on reliable and consistent delivery of this in a way that empowers clinical leaders and directors across professions. The review of communications noted previously could provide recommendations that would enable this to be embedded in the health Board's operations going forward.

- The experience of the communications on HAI in the paediatric haemato-oncology service has highlighted the importance of eliciting and responding to communication and support needs beyond a child's death, and the need for deploying a range of approaches. This should be routinely pursued through collaborative work with families with direct experience of how best to navigate the complexities of making contact when an organisational or public interest matter may require that. A partnership approach should be explicitly recognised by NHS GGC and actively pursued.
- In this context, the 'closed' Facebook page is a good example of this collaborative approach, as seen recently in how key information (and response to concerns and queries by families) has been disseminated in relation to the Covid-19 emergency.
- This is an excellent opportunity for national learning. It is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group. This could include what kind of training and peer support such individuals might require.

5. The health Board should ensure that the principles of direct, person-centred and compassionate communications on the ward with patients and families be applied in a way which ensures consistency of experience across all patients and families. While this was reflected in the experience of some patients and families, it was not widely experienced by all of them, particularly those with ongoing questions and concerns about infection prevention and control.

- The Terms of Reference for the Subgroup set out the intention to ensure that NHS GGC communications and engagement in this context demonstrated clear principles of person-centred care going forward. The Annex to this paper presents these principles in greater detail, notably with respect to:
  - *we will enable people to share their personal preferences, needs and wishes about their care and treatment and include these in their care plan, care delivery and in our interactions with them;*
  - *we will develop further the person centred approaches to visiting throughout NHS GGC; and*
  - *we will make sure there is a collaborative and consultative approach in place to enable staff to actively listen, learn, reflect and act on all care experience feedback received and to ensure continual improvement in the quality of care delivered and the professional development of all staff.*

- There was excellent evidence of these principles in operation with wards-based communications, and the staff of the haemato-oncology paediatric service were singled out for particular praise in their continuing approach to this.
- The practice apparent in the wards in this context should be mainstreamed in the health Board's wider approach to communications.

6. Finding the right ways of communicating to patients and families who are 'outside' of the hospital is a key challenge that health Boards must address when faced with these circumstances. The experience of NHS GGC should inform national learning on how this can be improved across NHS Scotland in future.

- It was acknowledged that there was a greater challenge for the health Board in communicating when it was not person-to-person. That challenge should be explicitly recognised and addressed pro-actively by the health Board in preparation for any similar future challenges by ensuring its communications infrastructure has a strategic emphasis that recognises and plans and delivers on these principles. This includes due recognition of the role of strategic intent, leadership, skills and culture.
- That should include learning from and establishing as routine practice the establishment of specific communications channels for patients and families. The example of the 'closed' Facebook page was cited at several points in the Subgroup's meetings, and while it remains a 'work in progress', it has been a key element in restoring good communications with many of the families including a significant uptake in participation.
- There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group.

7. The health Board should systematically elicit and reliably act on people's personal preferences, needs and wishes, particularly in circumstances where longer-term communication with patients and families is taking place. An action plan setting out how the learning from the communication challenges of Healthcare Associated Infections in the paediatric haemato-oncology service within NHS GGC will inform that approach going forward should be presented to the Scottish Government by the health Board. This should also support national learning.

- To ensure that people remain at the centre of its communications and engagement efforts and that they are listened to, special attention should be placed on ways of capturing communications preferences. This is particularly critical in particular operational services such as haemato-oncology paediatric service.
- NHS GGC demonstrated useful learning in this context, particularly through the development, updating and use of its database of communications preferences for affected families.

- There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group. It should share learning of the use of the shared database (both software and approach) as well as the mechanism they developed to have single list of all those across service elements receiving care.

8. The health Board should learn from other health Boards that have developed good practice in addressing the demand for speedier communications in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.

- The impact of social media on amplifying speculation was presented by the health Board as a key challenge, often overwhelming messages, narrative, and the ability to reassure families and present clear information.
- The health Board should consider how it can provide more adept and quicker confirmation of lines and messages in this context, guarding against any harmful lag in communications, and how best to make positive and effective use of social media in this context.
- There is good practice that can be learnt from other Boards around the use of social media in this context, particularly around the value of different types of social media in different contexts. This is an excellent opportunity for national learning, and should be pursued through the NHS Scotland strategic communications group.

9. The health Board should review and take appropriate action to ensure that there is an environment where staff are open about what is happening and can discuss patient safety events promptly, fully and compassionately.

- Good communications with the staff is important to ensure that staff are well informed and can contribute to supporting families and patients. This only works if there is a good flow of information from Board to the point of care, without internal organisational boundaries becoming barriers. Key factors to support this include active, transparent and consistent communications across different, relevant parts of the health Board.
- In this context, the health Board is invited to review how its staff could be better informed in future, based on the experience of the communications on HAI in the paediatric haemato-oncology service, and where lessons learned can underpin widespread good practice.
- This is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group.

10. The recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy for the health Board, and indeed, the wider strategic culture and approach of the health Board, with a view to forming the basis for wider national learning.
• It was noted that this was an important strategy for NHS GGC communications in these circumstances, and further, that the document is in need of updating. • While there was debate about whether it is valuable to develop bespoke strategies for communications and healthcare-associated infections, a revised strategy – taking account of the learning set out in this report and the actions identified in the recommendations – could become the basis of an exemplar to other Boards, or a plan modelled on national strategic and IPC requirements.

11. The Scottish Government, with Health Improvement Scotland and Health Protection Scotland, should review the external support for communications to Boards facing similar intensive media events.
• While communications and engagement in these circumstances can and should be the responsibility for individual Boards, there are points where there is a clear role of other key bodies in supporting messaging and the flow of information. That role was not clearly and consistently acted upon in these circumstances. • It is recommended that Scottish Government, Health Improvement Scotland and Health Protection Scotland should review how other bodies should support and engage with individual Boards in similar situations in future, through the NHS Scotland strategic communications group.

Organisational Duty of Candour

Findings

What has worked well

xxii. The organisational duty of candour was actively considered during the period, although it was not formerly activated for any of the instances of infection within the paediatric haemato-oncology service.

xxiii. There was evidence of clinicians involved with IMTs of taking actions to reflect their recognition of their professional duty of candour in respect of the incidents and outbreaks being considered, including the need to develop clarity on the actions required to respond to the incidents considered as part of the IMT process.

What needs to improve

xxiv. NHS GGC policy in support of organisational duty of candour legislation does not fully reflect the legislation and guidance – primarily in respect of the reliance placed upon harm being viewed to be avoidable and/or related to acts of omission/commission of the organisation. It is focused on the concept of a 'patient safety incident' – not a construct within the legislation and does not fully consider the legislation requirement to consider an unintended or unexpected incident that could result in harm (including actual or potential psychological harm).

xxv. While implementation of the organisational duty in these circumstances has particular challenges, it is clear that the legislation does not require a view on causation to be determined in deciding whether to activate the organisational duty of candour procedure and includes provision for unexpected events that have resulted or could result in outcomes included in legislation (including increases in treatment) to activate the organisational duty of candour procedure.

Recommendations

1. Given that organisational duty of candour was considered, but not formally activated, in these circumstances, NHS GGC should review its approach to ensure that it is not simply focused on patient safety incidents, circumstances where causality is clear and where events could result in death or harm.

- NHS GGC undertook benchmarking of its organisational duty of candour response to the infection incidents, which was done on what appeared to be an informal basis. The health Board is asked to undertake a review of its supporting policy and procedures to support implementation of the organisational duty of candour and provide feedback to the Scottish Government on areas where revisions to national non-statutory guidance would be helpful and how revised implementation support materials regarding the duty and multiple instances of healthcare associated infection might be developed through Healthcare Improvement Scotland.

2. The national challenges around the application of the organisational duty of candour highlighted by these events should be explicitly considered and acted upon by the Scottish Government and NHS Scotland.

- It was suggested that NHS GGC might not be unique in its ambiguous approach to applying the organisational duty of candour in situations where causality is not easily understood, and other Boards might be experiencing similar challenges in interpreting the legal duty. The Subgroup could not explore this in detail within the scope of its work, but flag that up as a consideration for the arrangements in place for review of the Annual Duty of Candour reports published by NHS Boards.

Phil Raines
Secretariat/ Scottish Government

Craig White
Chair

July 2020

Annex A

Terms of Reference

Purpose and Role

The Communications and Engagement Subgroup the QEUH and the RHC, NHS GGC, is a time limited group to offer advice and assurance working with Scottish Government and NHS GGC on:

- effective communication and engagement with patients and families; and
- robust, consistent and reliable person-centred engagement and communication.

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 and Social Care and Chief Executive of NHS Scotland 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 Communications and Engagement Subgroup will take a values based approach in line with the NPF and the values of NHS Scotland. 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 work of the Subgroup 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 NHS Scotland are:

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

These values will be embedded in the work of the Communications and Engagement Subgroup, and this work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives,

respecting the importance of specific values informed actions linked to personal context and experiences.

The Communications and Engagement Subgroup is focused on improvement. Subgroup members, will ensure a 'lessons learned' approach, as well as respecting the experience of families must underpin and inform the identification of improvements for dissemination both locally and nationally.

Meetings

The Communications and Engagement Subgroup will meet fortnightly initially and then at a frequency to be determined thereafter. Tele-conferencing will be provided.
A range of communication and engagement mechanisms will be agreed to enable patients and families to feed into the work of the Communications and Engagement Subgroup.

Full administrative support will be provided by officials from Scottish Government. The circulation list for meeting details/agendas/papers/action notes will comprise Oversight Board members, their PAs and relevant CNOD staff.

Outcomes

The Outcomes for the Communications and Engagement Subgroup are to:

- positively impact on patients and their families in relation to how complex infection control issues and all related matters are identified, managed and communicated;
- demonstrate a proactive approach to engagement, communications and the provision of information; and
- identify what has worked well and where the provision of information, communication and engagement could have been and could be enhanced and improved.to ensure that the outputs from the group are disseminated to key stakeholders and any wider learning points or recommendations are shared nationally.

In order to achieve these outcomes, the Communications and Engagement Subgroup will retrospectively assess factors influencing the approach to communication and public engagement associated with the infection prevention and control issues and related matters at the QEUH and RHC.

Having identified these issues, the Subgroup will 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 good practice as well as lessons learned across NHS Scotland.

Deliverables

The Deliverables for the Communications and Engagement Subgroup are:

- a prioritised description of communications and information to be provided to families, with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered);
- development of a strategic Communications and Engagement Plan with a person-centred approach as key. This should link to and be informed by consideration of existing person-centred care and engagement work within the Board, to ensure continued strong links between families and NHS GGC. Specific enhancements and improvement proposals should also be clearly identified and should consider how the proposals from parent representatives on an approach that identifies and supports the delivery of personalised actions through the 'PACT' proposal can inform further work;
- a description of findings following a review of materials, policies and procedures in respect of existing practices with regards to communications, engagement and decision-making arising from corporate and operational communications and engagement, linked to infection prevention and control and related issues. This will include consideration of organisational duty of candour, significant clinical incident reviews, supported access to medical records (including engagement, involvement and provision of information to families in relation to these processes); and
- a description of findings and recommendations to: (a) NHS GGC; (b) Health Protection Scotland; (c) NHS Scotland; and (d) Scottish Government on learning to support any required changes and improvements for communications and public engagement relating to the matters considered by the Subgroup.

Governance

The Communications and Engagement Subgroup will be chaired by Professor Craig White, and will report to the Oversight Board. The Oversight Board is chaired by the Chief Nursing Officer, Scottish Government and reports to the Cabinet Secretary for Health and Sport. Members and those present at Subgroup meetings should ensure that they circulate information about the work of the Subgroup to colleagues and networks with an interest, contribution and perspective that can inform the work to be undertaken. It has been agreed that this must include clinical and care staff within relevant operational services, as well as senior management and corporate staff within NHS GGC.

Membership

Member	Job Title
Professor Craig White (Chair)	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Lynsey Cleland	Director of Community Engagement, Healthcare Improvement Scotland
Andrew Moore	Head of Excellence in Care, Healthcare Improvement Scotland
Professor Angela Wallace	Nursing Director, NHS Forth Valley
Jane Duncan	Director of Communications, NHS Tayside

Professor John Cuddihy	Families representative
Suzanne Hart	Communications, Scottish Government
Phil Raines	Chief Nursing Officer's Directorate (CNOD), Scottish Government
Calum Henderson (Secretariat)	CNOD, Scottish Government

In addition to these members, other attendees may be present at meetings based on agenda items, for example: Chair of Infection Prevention and Control and Governance subgroup; relevant Directors and senior staff from NHS GGC and communications staff from Scottish Government.

Stakeholders

The Communications and Engagement Subgroup recognise 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 and their families;
- the general public;
- the Scottish Parliament;
- Scottish Government, particularly the Health and Social Care Management Board;
- the staff of NHS GGC, Trade Unions and professional bodies; and
- the senior leadership team of NHS GGC and the Board.

Annex B

The following sets the Strategic Intention by NHS GGC for its Healthcare Quality Strategy (2018-23) in relation to 'Person Centred Care'.

- *We will enable people to share their personal preferences, needs and wishes about their care and treatment and include these in their care plan, care delivery and in our interactions with them.*
- *We will involve the people who matter to them in their care in a way that they wish and that meets the requirements of the Carer's Act (2018).*
- *We will develop further the person centred approaches to visiting throughout NHS GGC.*
- *We will make sure people experience care, which is coordinated and that they receive information in a clear, accurate and understandable format, which helps support them to make informed decisions about their care and treatment.*
- *We will give people the opportunity to be involved and/or be present in decisions about their care and treatment and include the people who they want to be involved in accordance with their expressed wishes and preferences.*
- *We will provide training and education, to enable staff to treat people with kindness and compassion, whilst respecting their individuality, dignity and privacy.*
- *We will inform people about how to provide their feedback, comments and concerns about their care and treatment. We will review our approach to collecting and managing feedback to make sure it is fit for purpose.*
- *We will make sure there is a collaborative and consultative approach in place to enable staff to actively listen, learn, reflect and act on all care experience feedback received and to ensure continual improvement in the quality of care delivered and the professional development of all staff.*
- *We will continue to identify and build opportunities for volunteers to help improve the health and wellbeing of patients, families and carers.*
- *We will engage with people, communities and the population we serve to deliver high quality services to meet their needs.*

Subject: FW: Oversight Board Communication and Engagement - Feedback and Communication Links Established
Date: Monday, 13 January 2020 at 18:41:43 Greenwich Mean Time
From: Craig.White[redacted]
To: Craig White

From: John Cuddihy [redacted]
Sent: 13 January 2020 09:56
To: White C (Craig) [redacted]
Cc: [redacted]; Henderson C (Calum) [redacted]; Raines P (Philip) [redacted]; Margaret.Mcguire[redacted]; Elaine.Vanhegan[redacted]; Jennifer.Rodgers[redacted]; Sandra.Bustillo[redacted]
Subject: Re: Oversight Board Communication and Engagement - Feedback and Communication Links Established

Good Morning Craig

Thank you for your email; I hope the most recent meetings went well and look forward to reading the minutes and actions that have emerged.

In furtherance of your question relative to my communication with parents, please find some quick points

Social Media Platform- Closed facebook account owned by Hospital/ Closed Facebook account created by parents

I have updated on the fact that I was asked to undertake a position on the group and invited any comments that I could take forward on behalf of others. Following the first meeting of the Sub Group, I updated parents on matters discussed by way of an information sheet ahead of formal minutes, inviting comment. From feedback, this was received positively and highlighted that a number of families were still out with formal communication channels. I addressed this by confirming I would raise with the Chair and sub group members, which I did in both email and social media platform. I also asked that such matters be raised at the following meetings. Having identified the key themes of the initial meeting and proposals for a TOR, positive comment was received not only through those forums identified but also through private DM from parents not wishing to comment on open sites. I remain in contact with such parents who choose to communicate in this way.

It was important to note that updates on matters raised by me were responded to and posted by the Chair Craig White on closed facebook accounts. This provided a confidence that the communication channel was operating effectively and parents/patients were being listened to.

Indeed this continued ahead of the second meeting where I posted further updates inviting parents to identify concerns they wished raised on their behalf. One such matter was the decision by the Board to commence legal action which was disclosed in the media. This caused a number of parents to question how this would impact on them and their loved ones; this was communicated not only within the C & E forum but also by email direct to the Chair. Indeed, I have continued to update the Chair and secretary to the group on issues that emerge; increased requests to access medical records and the subsequent impact and implications of so doing.

Personal Messaging/ Email

This has been used by some parents who have not wished to comment on open forums and I have,

where I can, provide updates to their questions and sign-post them to appropriate services that can offer the support or answers they require. Peer support is hugely important and parents/patients can discuss concerns and experiences that are often shared.

Personal Contact- via ward/day care

The ward/day care are environments where parents/patients come together to discuss a variety of matters important to them; individually/collectively. Where appropriate the aims and objectives of the communication and engagement sub-group have been progressed with reference to the group as a forum to take forward their concerns. Again those parents have been encouraged to make contact with the chair and take up the offer of discussion. Indeed they have also been encouraged to take up the offer of discussion with the Chair and CEO where appropriate.

From my perspective many parents simply need a 'critical friend' accessible 24/7 or as soon as possible through the most appropriate medium at that time, as emerging issues cause significant challenge, often as a consequence of developing illness/matters in the media/discussions with staff/material on social media. Mothers speaking to mothers; fathers to fathers and patients to patients- each offer support to the other accused by those comfortable to do so. Some people are not conformable speaking with others, wishing to maintain a level of privacy however they still require access to the information required.

Having reviewed the most recent proposal for a open platform offering all manner of information, this should develop that interaction and communication, catering for the diverse needs of everyone involved.

Staff

From my perspective it has been hugely important to ensure that staff, where appropriate are updated on our interaction and that staff on the ward are held in the highest regard- it is important that they know and understand that we recognise the impact and implications for them and we appreciate everything that they have done and continue to do!

Third Party Contact

where appropriate I have signposted patients to other groups and/or statutory authorities which may offer support to them- this is not to replace the role of those within the hospital simply another way to sign post vulnerable patients/parents who may be overawed by the whole process.

Note

Another forum which is a source of information and one that is shared with me on occasion is the "patient forum" - young people live their lives on social media and chat about the many, many issues that are unfolding in their lives. They rely a lot on the likes of the TCT co-ordinator who is outstanding in his communication - personal, online. He often brings them together at social events that enable a 'safe space' to discuss concerns as they impact the group. Where appropriate I have learned from this forum, matters that may impact on families and/or others and look to tie them into emerging issues for the C & E sub group. One such example is the creation of the pre-teen social space which has gained considerable support and also the TCT "virtual space' which has increased in the absence of their unit.

I often think of the young people in the midst of all the issues as sometimes I believe we forget who this impacts on the most!!

From my perspective, communication and engagement is better than it has been and such forums and conduits of information provide a means to ensure that the needs of the patients/parents are considered.

Sorry for the random format of the response as I am just about to head off and can follow up once I

have more time. I am more than happy to develop any of the points raised should clarity be required.

Hope this helps.

PS

Once I receive the minutes from the most recent meeting, I will have those circulated on the various forums.

John

On 13 Jan 2020, at 07:22, <Craig.White[redacted]> [redacted] wrote:

Dear John and [redacted]

Thank you for your ongoing involvement with the Communication and Engagement Sub-Group of the Oversight Board.

I am currently reviewing the various channels of communications with parents and would appreciate it if you could provide me with details of the arrangements you have kindly taken forward to connect and feedback to parents following your attendance at prior meetings.

This will help me describe the various arrangements in place and ensure that the most effective ones inform and determine the ongoing requirements with the various families who have been in touch with Scottish Government and/or with NHS Greater Glasgow and Clyde. It is likely that there will be a need to target specific communications in the coming weeks and I anticipate your feedback assisting me to ensure that the right information gets to the right people at the right time.

Thanks in anticipation for any response and detail that you can provide. I would of course be happy to discuss this in person if that would be easier,

Best wishes

Craig W

Professor Craig White | **Divisional Clinical Lead**
Healthcare Quality and Improvement Directorate | Planning & Quality Division | DG Health and Social Care | Scottish Government| Room GE.06, St Andrews House | Regent Road | Edinburgh EH1 3DG |

T: [redacted] | M: [redacted] | E: [redacted] | Twitter: [redacted]



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06 June 2020

QUEH Independent Review – Request for Further Background on Reference to Organisational Duty of Candour

Situation

The Scottish Government was invited by the Co-Chairs of the QEUH Independence Review to consider their draft report in respect of criticism or implied criticism of Scottish Ministers and the Scottish Government.

The draft Review report makes reference to the organisational duty of candour legislation introduced by the Scottish Government and recognises the link to matters considered within the draft report, given the focus of this legislation on unexpected or unintended incidents and recognition of the relevance of this to the 'unusual events' (para 8.3.22) considered within the draft report.

This SBAR has been provided in request to a response for further background by way of explanation of the Scottish Government's initial feedback to the Co-Chairs that there is disagreement with the assertion in the draft report that the organisational duty of candour legislation does not cover the scenarios outlined in the draft report.

Background

The draft report includes the following content in respect of organisational duty of candour:

9.11.1 The organisational Duty of Candour provisions require NHS Boards by law to follow set procedures 'when there has been an unintended or unexpected incident that results in death or harm (or additional treatment is required to prevent injury that would result in death or harm)'.202Alongside the legal requirements, the Organisational Duty of Candour Guidance issued by Scottish Government in March 2018 outlines the issues organisations are to consider at each point in the procedure; the guidance suggests best practice, and provides a checklist of the steps to be taken to fulfil the duty.

9.11.2 Conventional expectations of the arrangements relate to single episodes of care when complications or adverse events occur, and for prompt disclosure so that patients and relatives are properly in the picture and vital information is shared with them by senior employees of the NHS Board.

9.11.3 NHS GG&C has an operational policy. It complies with the NHSScotland policy and sets out processes by which they discharge their corporate duty of candour – the duty may be assigned to a clinician or manager with responsibiliities but the duty is held by

the organisation. The Duty of Candour is to put across factual information, without speculation or conjecture.

9.11.4 In the case of patients undergoing treatment for haemato-oncological conditions such as leukaemias, their clinical course is normally prolonged, with setbacks and remedies; patients and families should be fully informed of the nature of this clinical course at the outset. The interventions are numerous, come in several episodes and are often subject to delays to plans if events or complications get in the way. The nature of this care is that it is spread over multiple episodes, with the potential for complications and unexpected setbacks.

9.11.5 In relation to the QEUH/RHC situation of individual episodes of infection and clusters of cases affecting haemato-oncology patients, clinicians with overall responsibility for the patients' clinical care shared the Duty of Candour with the ICD with responsibility for the area in which the care was provided. There is no specific mention or allowance for such an eventuality in the policy or its operation but the doctor's action was innovative and consistent with the duty.

9.11.6 This is an exacting task, as the very nature of investigation of a setback such as a serious infection with several possible causes is rarely certain. Conveying the uncertainty of the investigation that seeks to find a cause, and its possible outcomes, may be part of the Duty of Candour consultation. This is not a usual part of an ICD's duties, but is one that is part of an holistic service of care and in principle is commendable.

9.11.7 We have listened to accounts of the process of disclosure, and examined documents relating to the matter.203 Care is essential in avoiding speculation, and in not losing the main message within a great deal of detail. Associations of events and abnormal findings in a hospital and its surrounding environment, may or may not have a close link with a patient's care and consequences. If an event such as a pigeon or its excrement being found near an air ventilation inlet is one of several possible explanations without substantial evidence to support it, then such detail should be set aside to focus on the nature of the investigation and so arrive at the most likely explanation, with a commitment to provide an update once there is less uncertainty.

Finding

9.11.8 In common with whistleblowing, the legal provision applying organisational Duty of Candour to NHS Boards is a recently introduced procedure with local application, and has been in use as part of the events that this Review has examined. There is no provision in policy or guidance for the scenario of clusters of infectious disease events with uncertain cause, nor for the specific involvement of an Infection Control specialist.

Recommendation

9.11.9 Infection Control specialists should reflect as a group on the development of their role in Duty of Candour relating to HAIs. They should share examples in confidence as a learning process, with a view to sharing experience. As these events are unusual, such learning should be on a Scotland-wide basis, in a confidential setting. It may subsequently form a critical event for reporting and discussion in enhanced professional appraisal.

Those responsible for Duty of Candour Policy in NHS Boards and Government may wish to review their operational processes to allow for this eventuality. They should consider how to apply the Duty consistently relating to HAI, encompassing governance to acknowledge events that have triggered a Duty action, along with a review of any learning that might arise from the Duty investigation.

Assessment

SG disagree with the assertion that the organisational duty of candour legislation does not cover the scenarios outlined in the draft report.

The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 at section 21 states that a responsible person must follow the duty of candour procedure as soon as reasonably practicable after becoming aware that subsection (2) applies to a person who has received a health service, subsection (2) indicating that this applied when an unintended or unexpected incident occurred in the provision of a health service and that the incident appears to have resulted in or could result in and outcome mentioned in subsection (4) of the Act; requiring that the outcome relates directly to the incident rather than to the natural course of the person's illness. Subsection 4 (c) (i) includes 'an increase in the person's treatment'. This must be the opinion of registered health professional not involved in the incident.

The term 'incident' is not defined in the legislation. This is reasonably regarded to be an instance of something happening; an event or occurrence.

The draft report references, at paragraph 8.2.21, "….incidents of reporting infection but also risk and safety factors that predispose to future infection" and "clusters of cases" (paragraph 9.11.5) that resulted in "significant disruption to cancer treatment regimens and additional antibiotic treatment to clear infection" (para 8.2.25), occurring in the context where …."potential harm has already occurred (para 8.4.19).

Considering the organisational duty of candour legislation these instances, events and/or occurrences are recognised by the independent review to have resulted in an increase in treatment and could have resulted in other outcomes referred to in the legislation, on account of the disruption to cancer treatment.

The content of para 9.11.1 does not refer to the content of the legislation in respect of "appears to have resulted in our could result in ….."

The recognition at para 9.11.2 that "conventional expectations" relate to individual episodes of care needs to be considered in respect of obligations on responsible persons to ensure that decision-making in respect of legislative duties should be informed not by "conventional expectations" but on obligations as outlined in the Act, in this context the unexpected incident that occurred in the provision of a health service.

There is not a NHSScotland organisational duty of candour policy as stated at 9.11.3. The Scottish Government issued non-statutory guidance to support implementation of the organisational duty of candour legislation. While respecting the review's independence to offer a view in relation to NHSGGC's policy in respect of the legislation, there are elements of their policy which appear to emphasise causality and do not recognise the 'could result in' provisions.

Scottish Government policy is that responsible persons are expected to ensure that legislation on organisational duty of candour is applied to unexpected or unintended incidents of the sort referenced in the IR report and, for the reasons outlined below, could have reasonably been considered to apply to the instances of HAI being considered by IMTs – primarily on account of these being unexpected, that these resulted in an increase in treatment for some patients; and could have resulted in other outcomes referred to in the Act, including psychological harm as a result of the disruption to the care environment and experience for children, young people and their families.

It is not clear whether 9.11.5 is referring to organisational or professional duty of candour and whether the legislative provisions of the organisational duty of candour legislation in respect of considering the views of an independent registered health professional have been fully considered in drafting this section.

9.11.6 this would benefit from clarifying if this relates to the professional duty of candour applicable to various clinicians involved and/or legislative requirements relating to communication arising from the organisational duty of candour (recognising that NHSGGC decided not to activate the procedure for the unexpected events that occurred). The provisions of the legislation in respect of the reasonable opinion of a registered health professional not involved with the incident may also be relevant here in respect of infection control doctors having expressed a view that the instances of infection resulted or could result in the outcomes mentioned in Section 21 subsection (4).

At 9.11.8 it is not clear if this relates to NHSGGC policy or is referring to the legislation, regulations and supporting non-statutory guidance. The legislation, regulations and non-statutory guidance does not provide specific decision-making guidance across the range of services falling within the scope of the legislation, though the document 'Duty of Candour - examples including considerations for activating the procedure (v3.0)' (Healthcare Improvement Scotland) does consider HAI and includes an example of where an organisation may decide to activate the organisational duty of candour procedure when an unexpected incident can be regarded to be events impacting upon more than one patient. All NHS Board Chief Executives were written to by Healthcare Improvement Scotland on 05 April 2018, this letter including reference to the 'case scenarios' document referred to above.

9.11.9 does not refer to the guidance provided by Healthcare Improvement Scotland in support of NHS Board's consideration of their obligations in respect of the organisational duty of candour. The review may wish to refer to the HAI section of that document and the need to further consider unexpected incidents relating to the scenarios considered within the independent review report.

Recommendations

The Co-Chairs may wish to consider the following in respect of content of the draft report as this relates to criticisms or implied criticisms regarding the Scottish Government's introduction of organisational duty of candour legislation:

Distinguishing organisational duty of candour as distinct from the professional duty of candour, to ensure that where there is reference to 'duty of candour' it is clear which of these the report is making reference to

While it is recognised that interpretation of what constitutes the need for a responsible person to activate the organisational duty of candour procedure as outlined in the Act is a matter for responsible persons and their legal advisors; and that it is for the IR to offer a view on the potential for future changes to legislation and/or improvements in the scope of non-statutory guidance issued by the Scottish Government, reference to the resource developed by Healthcare Improvement Scotland (which includes HAI), supporting the implementation of the organisational duty of candour may be helpful in recognising their role in supporting NHS Boards with the implementation and application of the legislation.

Whether the findings and observations of the independent review in respect of organisational duty of candour might be more clearly articulated following consideration of the assessment offered in the 'Assessment' section of this document above.

The Co-Chairs note that this feedback is provided respecting and recognising that it is for them to determine what is included in their report – this feedback is provided with the intention of ensuring that any criticism or implied criticism of Scottish Ministers in respect of organisational duty of candour takes account of the provisions outlined in legislation and in recognition that the content of the draft report appears to acknowledge in earlier sections of the report that there was an occurrence of unexpected events which resulted in or could result in the outcomes referred to in the Act.

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NHSGGC Oversight Board Final Report – Comments Received from NHSGGC on Content relating to Organisational Duty of Candour

This paper outlines the points and themes made in the feedback in the draft Oversight Board Final Report in respect of the organisational duty of candour, with an overview in tabular form of the substantive points made in feedback from NHSGGC with proposed SG responses alongside this – followed by the content of the Draft Final Oversight Board report in respect of the organisational duty of candour and finally with a recommendation in respect of modifications to the content of the content of the report that could be made to reflect consideration of NHSGGC's response to the draft.

In preparing this review of the feedback received against the draft Oversight Board Final Report I have reviewed section 6.1 and also paragraph numbers 234, 276, 277 and 278.

Summary of Feedback and SG Response

Feedback from NHSGGC	Response
QEUH Independent Review opinion was supportive of the content of the NHSGGC policy	SG do not agree with the assessment of the QEUH independent review on this issue. Oversight Board have considered different and broader range of information in relation to this issue than the QEUH IR.
Duty of Candour policies of other NHS Boards	The Oversight Board have provided this feedback to NHSGGC on the basis of review of the incidents falling within the scope of our work and the method is not based on benchmarking with other NHS Boards but the provision of a view on areas where improvement activity can be focused.
Reference to content in HIS document	The HIS document makes it clear that it is for each responsible person to determine the application of the organisational duty of candour legislation to incidents. The HIS document includes content that relies upon information that may not be known at the time of the incident and will only be identified through review and is itself in need of improvement to take account of

	the issues where further implementation support is required.
Balance between emphasis on national work and recommendations for NHSGGC	The Oversight Board recommendations are focused on areas for potential improvements within NHSGGC, consideration of which will helpfully inform the ongoing and separate discussions with SG, HIS and NES about implementation support needs for NHS Boards more generally in respect of adverse events.
Reference to national discussions re learning from implementation of the Act	The notes referred to are notes of comments made in one of the breakout groups at this meeting and are not the SG's position which remains that it is expected that the legislative obligations are considered. SG understands that this is an area where learning and improvement should feature as an ongoing commitment of all NHS Boards in respect of the legislation.
Reference to media coverage re NHS Grampian reports	The legislation is interpreted by each responsible person in accordance with individual circumstances and, as explained at national meetings, it is accepted by SG that it is for Boards to be able to explain the approach to interpretation and application of the legislation. It is that interpretation and application of this in the context of the incidents falling within the scope of the Oversight Board's work that have informed the recommended learning and improvement actions for NHSGGC specifically, the outcome of which may be of use to other NHS Boards and their own continuous process of reviewing and learning from local interpretation and application of the legislation within their Board.
Unbalanced statements	The statements are based on the information considered by the Oversight Board in respect of the scope of their work and the specific circumstances considered in relation to the infection events within the paediatric haemato-oncology service at

	NHSGGC. The perception of unbalanced statements appears to have been derived from a misunderstanding that the Oversight Board are only providing feedback on the basis of a review of the interpretation of the legislation on incidents occurring in other NHS Boards.
Other Boards have similar policies	The SG has not reviewed or signed off on NHS Board policies in respect of organisational duty of candour. If other NHS Boards would find it helpful to review their policies and provide feedback on possible improvements to reflect the requirements of the legislation then this could be proposed through the national fora where these are discussed.
In all IMTs duty of candour is discussed	The Oversight Board has noted concerns about the operational effectiveness of IMTs within the scope of our work. The need to more clearly outline the delineation of professional duty of candour and the interface in decision-making with organisational duty of candour decision-making has been noted and has informed the proposed need to consider this as part of the recommended local review of interpretation of the legislation and associated decision-making.
November 2020 meeting included Boards setting out difficulties in interpreting policy	It was acknowledged at this event that this can be complex and it is for individual NHS Boards to interpret the legislation on a case by case basis (note that the legislation is the key determinant here, the policy that informed the development of the legislation not being relevant to the interpretation of the legislation itself).
Variation nationally is evidenced in the annual reports and approach is on national implementation	The Scottish Government have identified areas where there is variation in the content of annual reports, consistent with the legislative requirement that Scottish Ministers are informed when these reports are published.
DoC was never designed for clusters of infection events and all Boards need to	The legislation applies to events occurring in respect of NHS Boards provision of

work on this with further policy guidance and implementation	health services and as such there are no events that might occur in so doing that are outside the scope of the legislation. The need to ensure that learning from incidents that might involve a series of events and/or be associated with more than one episode of care is one that informed the Oversight Board's view that a review by NHSGGC has the potential to contribute to any enhancements or additional content that could be usefully added to the non-statutory guidance.

Content of the Draft Final Oversight Board Report

I have reviewed the content in this document with respect to organisational duty of candour and am content that the context in respect of the scope of the Oversight Board's work is reflected, as are the complexities and challenges in respect of the events relating to the episodes of infection, the issues NHSGGC acknowledge to have influenced their decisions about this in terms of balancing duties of confidentiality, the work by clinicians on the professional duty of candour and the acknowledgement of the ongoing national discussions about how best to continue to support dialogue about implementation support resources, learning and any need for revisions to the non-statutory guidance.

The Oversight Board's observations in respect of the focus on avoidable harm, consideration of the 'could result' element of the legislation and the fact that there is a requirement to consider psychological harm remain and are not changed by any of the feedback from NHSGGC. The report has acknowledged already NHSGGC's feedback based on their self-initiated review of the position as articulated by those contact in other NHS Boards and the discussions about this have already been initiated as per the commitment at para 278 in terms of the separate process of ensuring that the non-statutory guidance and implementation support through HIS and NES considers further work that may be required through their work on adverse events more generally.

Given the foregoing content in the paper, I propose that there is no need to change the wording of the document as it relates to organisational duty of candour. If NHSGGC would find it helpful to talk through the possible opportunities for learning and improvement that appear to the Oversight Board to exist in respect of their policy and approach to decision-making in respect of avoidable harm, the legislative requirement to consider events that could result in death or harm, psychological harm and/or the complexities of incidents that comprise more than one event and/or the interface with professional/organisational duties of candour and balancing other duties in respect of confidentiality I would be happy to support them with this thinking and planning actions (in the same way that I have with some of the clinical governance and quality management issues that I have recently discussed with the Executive Nurse Director following review and consideration of

organisational responses to complaints of affected families in respect of care experiences and quality of care).

Professor Craig White
Scottish Government
04 March 2021

From: White C (Craig)
Sent: 29 October 2020 08:51
To: Roberts A (Anncris); Nichols K (Kay)
Cc: Nicol L (Lynne)
Subject: FW: John Cuddihy correspondence on Mycobacterium Chelonae cases and organisational duty of candour

Hi

I am sharing this in confidence at this stage as am anticipating that we will want to pick up following next NHSGGC Oversight Board meeting which is on Friday this week.

Craig

Professor Craig White
Deputy Director, Covid 19 Test and Protect Portfolio
DG Health and Social Care | Scottish Government| M: [redacted] | E: [redacted] MS Teams: [redacted] |Twitter: [redacted]

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From: Raines P (Philip)
Sent: 29 October 2020 08:37
To: White C (Craig) ; McQueen F (Fiona)
Cc: Murray D (Diane)
Subject: RE: John Cuddihy correspondence on Mycobacterium Chelonae cases and organisational duty of candour

Craig

This is very helpful, and could be worth bringing into tomorrow's Oversight Board meeting, particularly the suggestion that this could be considered as part of our remaining work on the organisational duty of candour.

Thanks
Phil

Sent with BlackBerry Work (www.blackberry.com)

From: "White C (Craig)" [redacted]
Sent: 20 Oct 2020 14:09
To: "Raines P (Philip)" [redacted]; "McQueen F (Fiona)" [redacted]
Cc: "Murray D (Diane)" [redacted]

Subject: RE: John Cuddihy correspondence on Mycobacterium Chelonae cases and organisational duty of candour

Phil

The organisational duty of candour procedure was not activated for the events outlined, so consideration of the application of the organisational duty of candour obligations on NHSGGC does not come into play. In terms of the professional duty of candour that GMC and NMC registrants have, this is held with the individual practitioner and it would therefore be a decision for an individual regulated health professional to decide on actions when they believe that in order to discharge their professional duty a course of action should be taken (in this case Dr. Inkster's recommendation that information should be disclosed to a parent) – while a medical practitioner would be required to take into account any feedback or discussions in respect of what another colleague thinks (in this case a senior manager or the view of another medical professional, in this case the Medical Director (themselves bound by a professional duty of candour), the decision and accountability for professional duty of candour disclosures rest with the regulated healthcare professionals.

While it would be appropriate that any such professional duty of candour disclosures should not breach other professional or statutory duties (in this case) confidentiality, this would need to be informed by consideration of the ways in which the professional duty of candour might be discharged without breaching another professional or statutory obligation. For example, balancing the interests of the person(s) to be disclosed to with the possible impact of deductive identification that would then breach the rights of another person(s). I can think of scenarios where it might be possible to have discussions with other parties about these competing interests and gain consent for disclosure of information to one person/family if there has been a conversation with others, including consideration of whether in fact the information was already known in confidence through the close relationships and communications established in Units such as those the children were being cared for within.

In practical terms I wonder if this could be discussed and considered further through the further work planned on professional and organisational duty of candour as signalled in the Interim Report, providing an opportunity if appropriate for us to seek Dr. Inkster's recollections of her recommendation informed by the professional duty of candour and identify any learning and improvement opportunities for NHSGGC in terms of the balancing exercises/decisions that are necessary where there are competing professional obligations and or statutory duties ?

Hope this is helpful

Craig

Professor Craig White
Deputy Director, Covid 19 Test and Protect Portfolio
DG Health and Social Care | Scottish Government| M: [redacted] | E: [redacted] MS Teams: [redacted] |Twitter: [redacted]

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From: Raines P (Philip) [redacted]
Sent: 20 October 2020 12:16
To: White C (Craig) [redacted]; McQueen F (Fiona) [redacted]
Cc: Murray D (Diane) [redacted]
Subject: John Cuddihy correspondence on Mycobacterium Chelonae cases and organisational duty of candour

All

You will recall that John Cuddihy has provided a paper for the Oversight board on the Mycobacterium Chelonae (MC), in which (amongst other things) he made allegations regarding how he and his family were deliberately not kept informed about infections in the QEUH in 2019. The specific passage in his report reads:

"It is the case that those tasked with discharging this [duty of candour] 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.***"

I wrote back to ask if John could share with us the evidence he alluded to in his report, and John has now kindly shared the following documents with us (attached here). I've reviewed these, and offer the following comments.

- The exchange between John and Jane G/John B sets out reasons put forward by GGC for TI/KH being told not to talk to John and his family. These largely relate to the delays in establishing the typing of the second MC infection, whether there was a link to [redacted] infection in May 2018, and the desire to preserve the anonymity of the patient/family of the second MC case in June 2019. I'd welcome a view as to whether this, at the very least, skirts organisational duty of candour as set out by John – but on the surface of it, GGC's reasoning does not appear unreasonable (IMO).
- John focuses on reference in a summer 2019 IMT minute that says he and his family had been informed. This was clearly a mistake for which Jane G apologies in the correspondence. It's not clear how that mistake occurred, but there isn't evidence presented to suggest that there was a deliberate cover up (as opposed to a simple minuting mistake).

On balance, I'm not sure there's enough presented here for the OB to pursue usefully as part of its terms of reference (though there is in John's report more generally). However, others' views welcomed, not least as John will want to know what the OB will do with this.

Cheers
Phil

From: John Cuddihy [redacted]
Sent: 20 October 2020 10:50
To: Raines P (Philip) [redacted]
Subject: attached as requested.

Morning Phil

I provide this information in furtherance of your request and in support of my report to Oversight Board relative to Mycobacterium Cholonae and the lack of reports provided by GGC in this regard.

Please find attached a selection of correspondence relative to my concerns over the actions raised in IMT of June/July 2019; instruction given to the action owners, Jamie Redfern and Teresa Inkster; failure to discharge those actions; inaccurate reporting of those actions; their subsequent meeting with me at my instance and the disclosure at that meeting- 'tell him the truth'. I also have material from those at that meeting which provide me with information that does not accord with that provided by Jane Grant or John Brown, accepting that they may simply be reporting that which has been articulated to them. None the less, I am left to find on the conclusions within the Mycobacterium Cholonae report that I have already provided to you. Indeed, the events detailed led to a senior clinician raising those concerns with General Medical Council. I have additional reports following my meeting of 12 November 2019 with Jane Grant, John Brown and Jennifer Armstrong during which Jane Grant assured me she would look into my concerns; she was somewhat embarrassed when I mentioned that she had already, allegedly done so, as per her letter to me.

In addition, you will note that the email response from Jane Grant of 27 November makes reference to a member of staff being off sick and as such, unable to provide updates relative to an aspect of my earlier letter to her- that aspect was the IMT- I understand that the member of staff referred to may have been Teresa Inkster, whom, I understand, was NOT 'off sick'. I understand further that this member of staff may have been subsequently asked to review a letter intended for me, outlining circumstances surrounding this incident. I am also led to believe that a number of factual inaccuracies were recorded and articulated to GGC.

I have included a letter from 04 July from John Brown as this references, at a corporate level, my desire for an investigation into MC and the corporate response in this regard.

John

Letter from John Brown, dated 04 July 2019 in response to my concerns around reporting of Mycobacterium Cholonae

Letter to Jane Grant- sent by email, 30 August 2019

Holding Letter from Jane Grant, dated 04 September 2019

Letter from Jane Grant, dated 27 September 2019 responded to letter of 30 August

Letter from John Brown dated 27 September- (same day as response received from Jane Grant), following my email and letter dated 30 August

Letter from Jane Grant to Parents dated 21 November 2019

Email Response from me to Jane Grant, John Brown & SG dated 22 November, following her letter of 21 November 2019.

Email to Jane Grant dated 24 November 2019 and her response the same day.

Email response from Jane Grant, dated 27 November following my email of 25 November 2019- ***(attention is drawn to ref to member of staff being off-sick- highlighted in red for ease of reference)***

NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital Oversight Group

Findings/Recommendations of the Communications and Engagement Subgroup

Summary: Recommendations

1. The health Board should learn from the challenges of communicating against a background of uncertainty and where a critical situation is slowly evolving by pursuing more active and open transparency by undertaking a review of how it engages with families in line with the principles of its communication strategies. That review should include close involvement of the families that were affected by the infection incidents.
2. The health Board should embed the value of early, visible and decisive senior leadership in its communications and engagement efforts and in so doing more clearly demonstrate and communicate a leadership narrative that reflects this strategic intent. That should be manifested in consistent communications by senior leaders in the health Board with families in such circumstances.
3. To ensure that a person-centred approach is embedded in all of its official communications – corporate to point of care – and that patients and families are responded to in a timely manner, the health Board should ensure that the Executive leads for communications and for person-centred care jointly, regularly and systematically review the quality of their communications with family representatives, and report on this to the Executive team of the health Board.
4. The health Board should make sure that there is a systematic collaborative and consultative approach in place for taking forward communications and engagement with families and patients. Co-production should be pursued in learning from the experience of this challenge. The priority should be on reliable and consistent delivery of this in a way that empowers clinical leaders and directors across professions. The review of communications noted previously could provide recommendations that would enable this to be embedded in the health Board's operations going forward**.**
5. The health Board should ensure that the principles of direct, person-centred and compassionate communications on the ward with patients and families be applied in a way which ensures consistency of experience across all patients and families. While this was reflected in the experience of some patients and families, it was not widely experienced by all of them, particularly those with ongoing question and concerns about infection prevention and control.
6. Finding the right ways of communicating to patients and families who are 'outside' of the hospital is a key challenge that health Boards must address when faced with these circumstances. The experience of NHS GGC should inform national learning on how this can be improved across NHS Scotland in future.

7. The health Board should systematically elicit and reliably act on people's personal preferences, needs and wishes, particularly in circumstances where longer-term communication with patients and families is taking place. An action plan setting out how the learning from the communication challenges of Healthcare Associated Infections in the paediatric haemato-oncology service within NHS GGC will inform that approach going forward should be presented to the Scottish Government by NHS GGC. This should also support national learning.
8. The health Board should learn from other health Boards that have developed good practice in addressing the demand for speedier communications in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.
9. The health Board should review and take appropriate action to ensure that there is an environment where staff are open about what is happening and can discuss patient safety events promptly, fully and compassionately.
10. The recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy for the health Board, and indeed, the wider strategic culture and approach of the health Board, with a view to forming the basis for wider national learning.
11. The Scottish Government, with Health Improvement Scotland and Health Protection Scotland, should review the external support for communications to Boards facing similar intensive media events.
12. Given that organisational duty of candour was considered, but not formally activated, in these circumstances, NHS GGC should review its approach to ensure that it is not simply focused on patient safety incidents and circumstances where causality is clear.
13. The national challenges around the application of the organisational duty of candour highlighted by these events should be explicitly considered and acted upon by the Scottish Government and NHS Scotland.

Introduction

The following note sets out the findings and recommendations from the Communications and Engagement Subgroup of the NHS Greater Glasgow and Clyde (NHS GGC) and Queen Elizabeth University Hospital (QEUH) Oversight Board. That work has been set within the framework of the Subgroup's (and the wider Oversight Board's) Terms of Reference and governed by the Key Success Indicators agreed by the Oversight Board. Given the impact of Covid-19 on the ability of the Oversight Board and its Subgroup to take forward this work as originally planned, the findings set out here have been compiled to inform the final Oversight Board report.

The note is based on:

- the papers and material presented by NHS GGC to the Subgroup's meetings, including the presentations and papers provided;
- discussions at the Subgroup meetings, both with NHS GGC colleagues and amongst the Subgroup members; and

- the experience of operating the new processes put in place in response to the infection issues, such as the 'closed' Facebook page for families and the NHS GGC database capturing communication preferences for families.

The note sets out findings and recommendations under two key issues that were highlighted in the escalation to Stage 4 and which were the focus of the Subgroup:

- communication issues: this relates to how the health Board communicated and engaged with individual families and patients affected by the infection issues at the QEUH, as well as the wider public; and
- organisational duty of candour: this relates to how the health Board carried out its legal obligations under the organisational duty of candour in the context of the issues that gave rise to escalation.

Under findings, the note will highlight possible areas of assurance ('what has worked well') and areas for improvement ('what needs to improve'). Under recommendations, it will draw out where national learning may be relevant.

The Subgroup also acknowledges the positive changes that have already been made within NHS GGC since the escalation of the health Board to Stage 4. Such progress has been taken into account and reflected in this report, but notes that there appears to be key learning that has yet to be fully embedded.

The Subgroup's Terms of Reference are set out in Annex A.

Context Setting

The Oversight Board recognised in its Terms of Reference that there would be key points of learning, and need for improvement, for both NHS GGC individually but equally, for NHS Scotland as a whole. In this context, the Communications and Engagement Subgroup acknowledged that its understanding of what took place in response to the series of infection incidents in the QEUH (and the Royal Hospital for Children) should be framed within the context of a series of key issues.

- The unique circumstances of a new, large-scale hospital. There was little precedent for the challenges – not least in understanding the scale and nature of the infection issues – arising from a large, newly-built hospital complex such as the QEUH. This manifested itself in the limited experience NHS GGC – and NHS Scotland more widely – could draw upon to fathom the particular issues that became somewhat clearer over the period. This context can by no means ever be justification for complacency over any actions that were taken – or not taken – by the health Board or the speed with which they were understood and addressed, but the context is important in understanding how the health Board had to adapt to a novel, emerging situation, not least from the perspective of the national learning the health Board's experience can provide.

- Size of the health Board. The issue of NHS GGC's unique scale arose at different points in the Subgroup's deliberations, as the sheer size and expanse of the health Board were defining features for some of its approach to the issues presented to the Oversight Board. While the focus was on the specific issues as they related to the haemato-oncology paediatric services, the issue of scale was considered. It was cited as a factor at points in how the health Board did and could have responded to the circumstances and what might be improved going forward. Indeed, it was argued at points in the Subgroup meetings that the size of NHS GGC could not only allow the health Board access to potentially unique resources and some greater flexibility in how resources were deployed, but presented an opportunity for the health Board to develop into a national exemplar in how it had dealt and learnt from the challenges it faced.

The work of the Subgroup was carried out in the knowledge of a historical context that needed to be understood and which served to inform the work of improvement. The Subgroup was aware of the issues raised about the construction and handover of the QEUH, how NHS GGC responded to emerging problems that appeared to be related to that construction and handover and the corporate resource and approach in support of person-centred communication. However, it was equally clear that issues relating to the building and environment were being addressed by the Independent Review by Dr Andrew Fraser and Dr Brian Montgomery, and indeed, be covered in the forthcoming Public Inquiry by Lord Brodie. They are also subject to ongoing legal proceedings raised by NHS GGC. Consequently, the findings and recommendations of this note do not cover these issues directly.

The findings and recommendations were developed with a view to supporting the health Board's own stated objectives for person-centred care, as set out in it 2019-23 Healthcare Quality Strategy[1]. Responding to what patients and families wanted, the Strategy aimed for a high quality NHS that:

- takes time with patients and listens to them;
- takes care of people, looks after them and makes sure they get the right treatment;
- communicates well with patients by explaining all they need to know and involving them in decision making;
- is knowledgeable, safe and trustworthy;
- is efficient;
- is caring, compassionate and shows empathy;
- has friendly, kind, competent and professional staff; and
- communicates with the people who matter to them regarding their progress and condition.

The principles of how 'person-centred care' should be conducted by the health Board are set out in the Annex B to this paper and underpin the recommendations set out below. They are the principles that the Subgroup have held uppermost in mind when considering

[1] https://www.nhsggc.org.uk/media/253754/190219-the-pursuit-of-healthcare-excellence-paper_low-res.pdf.

the communication and engagement responses of NHS GGC to the infection issues of the QEUH, particularly with respect to the patients and families in the haemato-oncology paediatric service.

In addition, relationships with key groups and communities have been vital for the work of the Subgroup. This has been essential with respect to the families affected by infections, as the Cabinet Secretary made clear when the Oversight Board was established, that their participation in the work of assurance and improvement was critical. For that reason, representatives of the families were part of the Subgroup, and extensive use was made of the closed Facebook page (as described below) to improve communications with the families (and elicit their views) to support the work of the Subgroup.

Communications

Findings

What has worked well

- *Good communication at point of care*. Communications at ward level has largely been seen as effective and sensitive, particularly in how highly person-centred it has been to reflect individual patients' and families' circumstances. Communications with and by the clinical and medical staff has been well regarded throughout this process, though their communication roles has not always been seen as appropriate, as discussed further below.
- *Establishing new mechanisms for communication*. There was evidence that the health Board was capable of learning to address the challenges of maintaining complex and often prolonged communications with families in difficult circumstances. Establishing the closed Facebook page for families was viewed positively in this context, although it was emphasised that key to its value continues to be the responsiveness of NHS GGC to issues raised by families. Similarly, the development of a database that captured communications preferences of families and enabled more sensitive, targeted communications was seen as an important innovation.
- *Senior engagement on communication issues* The focus of senior management on the importance of communicating with patients and families was acknowledged, but the importance placed on the issue was not always communicated widely and effectively by the health Board throughout the period.
- *Management focus on service provision/business continuity maintained*. Despite the 'crisis management' that continued for some time in the face of the continuing infection issues in the QEUH, the focus on providing a high-quality service was never lost by the health Board, nor the priority on the individual care and needs of the patients and their families.
- *Staff impact and wellbeing considered*. The impact of the media 'storms' on staff could be dispiriting. This was understood and acted upon within the health Board.

What needs to improve

- *Several families reported a consistent lack of transparency in the communications by the health Board, creating an impression that there was 'something to hide' in terms of what might lie behind the infection incidents*. Several families, particularly those with continuing engagement with the health Board because of the care and circumstances of their children, felt that the Board was often reluctant to provide them with answers to their questions and information about the hospital. This reluctance was fed by a sense of sluggish responses to questions posed, a strong impression of information being partial or misleading, and a belief that the health Board would not admit any mistakes that may have been made regarding the environment of the building or the care of their children. Clearly, these were impressions that were not shared by the health Board, and it was occasionally argued that the responses reflected a minority of families that were explicitly expressing their views. Nevertheless, it was clear to the Subgroup was these feelings became more entrenched over the period, and that any communications and engagement efforts by NHS GGC to address distrust and lack of confidence in the health Board did not fundamentally shift opinions. Indeed, the views of the minority could not be viewed as unrepresentative of a larger group of families, who might not have chosen to express their views vocally.
- *Frustration by families at the health Board's reluctance to address questions about the infection incidents and their background has been heightened by NHS GGC's current difficulties in discussing some issues because of the pending legal case*. Since the Oversight Board was established, NHS GGC announced that it was launching a legal case against the QEUH builders, Multiplex. As a result, the health Board seems to have become increasingly reluctant to comment or discuss aspects of what has happened over the last few years in relation to the infection incidents, citing the risks of compromising the forthcoming legal case. This featured recently in its responses to the Independent Review's report on the commissioning, design, construction and handover of the hospital complex and a recent BBC Scotland Disclosure programme on the QEUH (which aired in June 2020). This has exacerbated a sense among several families that the health Board was not pursuing a policy of transparency and sensitivity to the affected patients and families. The Subgroup appreciated the legal issues facing the health Board, but considered that continuing silence on many of these issues will not address fundamental concerns on communications and engagement that gave rise to escalation to Stage 4.
- *Families did not always feel that communications with them was the priority for the health Board, as opposed to communication with other groups or the wider public*. Some families, particularly those active with the haemato-oncology paediatric service at the time, did not feel that the health Board consistently prioritised their information needs over other groups, or the wider public. Finding out about key decisions via media statements – as was reported by some, for example, on the decision to decant Wards 2A and 2B – suggested to some that families were occasionally 'afterthoughts'. This might reflect the complex challenges faced by the health Board in ensuring all patients and families received the relevant information quickly and timeously, but it was clear that there was an ingrained lack of faith in the health Board's ability to prioritise their needs among some families. This was particularly demonstrated in the results of the survey of families through the closed Facebook page by Professor Craig White, where several respondents reported this.

- *Consistency of compassionate, person-centred tone in communications*. Where there were communications, they did not always demonstrate a clear, person-centred tone in addressing such sensitive issues among families. The willingness to recognise the nature of concerns, apologise for their impact and take decisive action in the face of unknown issues – such as the decision to de-cant Wards 2A and 2B – would have strengthened some of the communications effort and reduce the mistrust that appeared to build. While this was often evident, it was not consistent.
- *Consistency of positively received action with all, particularly with respect to wider service and with respect to historical service issues*. Not all the communications were as effective as more direct ward communications, particularly for patients and families not currently engaged with the service and where engagement was historical and where reflections have acknowledged several missed opportunities. They were sometimes characterised as being overly defensive. It was acknowledged that a key challenge facing the health Board was how to communicate on a complex issue where uncertainty was prolonged – notably the source of infections – with individuals who were no longer in regular contact with the service.
- *Timeliness of some communication, which could often be more 'reactive' than 'proactive'*. Communications were sometimes seen as lagging, responding 'late' to stories and issues that were circulating without official NHS GGC comment for an extended period. Again, the health Board could not always produce comment quickly, but the perception of delay tended to aggravate family concerns.
- *'Management' was perceived as using frontline staff to communicate 'difficult' messages relating to the health Board more generally*. While frontline staff were seen as important communicators, it did not always seem appropriate that they were the channel for communicating issues that related to more corporate responsibilities. The perception by some families was that frontline staff were 'unfairly' put in this position and that account was not being taken of the clear communication role of senior managers within the QEUH. There was a strong feeling among some families, that senior management in the health Board were not sufficiently and consistently visible in speaking/communicating with them at an early stage.
- *How well integrated were estates/facilities functions into communications and engagement*. Key messages, especially when delivered directly on wards, could have sometimes benefited from a more joined-up approach of infection prevention and control (IPC) and facilities/environment personnel. Given the complex nature of the information that often had to be communicated – including both environmental issues, their link to infection, and the impact on individual care – it because clear that key information from a variety of different personnel needed to be brought together more quickly and effectively when conveyed to patients and families.

- *Value of new mechanisms to capture information on communications preferences.* The development of the specially-commissioned database facilitating improved engagement with concerned families and how they preferred to be contacted was rightly cited as a good example of learning in the face of the challenges faced by the health Board. It was suggested that this tool could be supplemented by enhancing the existing family 'induction' packs with clear information on where families could go for information about continuing issues such as the infection incident(s). Further work was identified to find better ways of supporting coordination and communication of the ways in which families can raise and have their questions (about point of care or wider organisational issues) responded to. As a whole, the Subgroup endorsed the person-centred principles of communication which prioritised the need to give weight to all views and the need to respond to all views in an appropriate, and where possible, customised way.
- *Improved content of mechanisms of support/information for families*. Families had noted that their questions were not all timeously or fully addressed, not least in the closed Facebook page during the initial period when NHS GGC was escalated to Stage 4.
- *Clarity of narrative in corporate responses*. The consistency of the information and messages across different levels of the organisation was not always evident across the period.
- *Impact of social media*. The role of social media as an accelerator and 'echo chamber' for messages was clear throughout the period, but not initially well understood, not least the difficulties in adjustment required. Developing better and more rapid responses to fast-moving communications messages was recognised as an emerging need for Board communications activity.
- *Challenge of maintaining communications in a 'slowburn crisis' scenario*. The gradual unfolding of the issue, with the emergence of hypotheses relating to the environment of the QEUH that could not be quickly verified or discounted, presented a particular set of difficulties in communications. The responsibility for decisions in respect of communication about incidents and outbreaks is typically lodged with Incident Management Teams (IMTs), with communication advisors providing support and a key role in taking decisions by the IMT chairs. It was clear that relevant IMTs were active through this period in response to the infection incidents. However, it was agreed that the IMT process, while useful in more incident-based situations, was potentially less effective for a continuing 'crisis' where a number of incidents could be linked together in media terms. A new process may need to be identified to address this (and applied nationally, as well as locally to the health Board).
- *Challenge of maintaining communications where ambiguity is high*/. Related to the point above, the demand for clear answers and causation in the media – and indeed, at times politically – jarred with the necessary uncertainty as the health Board was trying to understand the source of a complex, and at times, resolutely unsolvable set of issues. This was more difficult to deal with given concerns about competing considerations of confidentiality and transparency.

- *External support and positioning around Board communications*. The role and coordination of messaging by external bodies, particularly NHS Health Protection Scotland (HPS) and the Scottish Government, was not always clear during the period, and did not provide a consistent source of support or advice to the health Board in addressing the communication challenges faced by NHS GGC.

Recommendations

1. The health Board should learn from the challenges of communicating against a background of uncertainty and where a critical situation is slowly evolving by pursuing more active and open transparency by undertaking a review of how it engages with families in line with the principles of its communication strategies. That review should include close involvement of the families that were affected by the infection incidents.
• The particular difficulties of communicating information on Healthcare Associated Infections (HAI) in the paediatric haemato-oncology service when key information remains uncertain, or at best, nuanced, was acknowledged. It was challenging for the health Board to balance assurance in its approach to addressing the infection incidents when there was continuing, longer-term uncertainty on the sources of infection. Nevertheless, the focus should remain on transparency and it was clear to the Subgroup that this was not consistently applied by NHS GGC, while recognising that the pressures of the shorter-term need for answers could not be easily reconciled against the longer-term work to secure those answered. • In that context, it was vital that there was clear and widespread consistency of messages and information shared. Similarly, it was critical that the health Board undertake a more transparent approach in its communications against a background of uncertainty, even if it led to the health Board admitting its inability to answer key questions immediately. • This should form the governing principles of a health Board review of how it undertook communications with the affected patients and families of the infection incidents and what learning should be taken and mainstreamed. That review should closely involve the families themselves and be presented to the Scottish Government, not least as a source of national learning for other health Boards.

2. The health Board should embed the value of early, visible and decisive senior leadership in its communications and engagement efforts and, in so doing, more clearly demonstrate and communicate a leadership narrative that reflects this strategic intent. That should be manifested in consistent communications by senior leaders in the health Board with families in such circumstances.
• Leadership in addressing the challenge of communications on HAI in the paediatric haemato-oncology service was clearly demonstrated in much of the response to the emerging issues by senior staff within the QEUH. But more senior leadership within the health Board was not always presented visibly or experienced positively by patients, families and the public as the situation unfolded in the public eye. The lack of consistency in the approach was a significant issues for some families.

- The Subgroup recognises and acknowledges the important role of the IMT in assessing and determining the communications response to an outbreak or incident; and the national framework within which Boards manage such outbreaks, including their HAI communications. However, there is also a need to point to the need for a mechanism to manage a critical incident supported by more prominent and transparent strategic leadership, governance, public engagement and input.
- This highlighted the importance of the health Board showing leadership early, decisively, visibly and consistently in such situations as soon as they arise.

3. To ensure that a person-centred approach is embedded in all of its official communications – corporate to point of care – and that patients and families are responded to in a timely manner, the health Board should ensure that the Executive leads for communications and for person-centred care jointly, regularly and systematically review the quality of their communications with family representatives, and report on this to Executive team of the health Board.

- A caring, compassionate and empathic approach to communication was not always evident in how the health Board responded to the circumstances. Too often communications appeared to be inappropriately reactive and defensive.
- The health Board should review its approach to ensuring the right tone and sensitivity in handling is pursued in future, especially for its corporate communications, and determine if guidance or training is required to embed the health Board's learning in this context.
- There should be more systematic assurance by the health Board that this is happening across the organisation. Joint Executive responsibility by the two leads should be accompanied by a visible approach to reviewing key communications and engagement incidents going forward.
- This should also ensure that the views and experiences of patients and families remain central to how excellence in healthcare is pursued. Regular reviews of patient attitudes and the use of Care Opinion is good, but opportunities for a more targeted review of communications in key incidents by relevant patients and families should be considered.
- On the specific issue of addressing the 71 questions set out by families, it was noted that, following escalation, the health Board did address and publicise its responses.

4. The health Board should make sure that there is a systematic collaborative and consultative approach in place for taking forward communications and engagement with families and patients. Co-production should be pursued in learning from the experience of this challenge. The priority should be on reliable and consistent delivery of this in a way that empowers clinical leaders and directors across professions. The review of communications noted previously could provide recommendations that would enable this to be embedded in the health Board's operations going forward.

- The experience of the communications on HAI in the paediatric haemato-oncology service has highlighted the importance of eliciting and responding to communication and support needs beyond a child's death, and the need for deploying a range of approaches. This should be routinely pursued through collaborative work with families with direct experience of how best to navigate the complexities of making contact when an organisational or public interest matter may require that. A partnership approach should be explicitly recognised by NHS GGC and actively pursued.
- In this context, the 'closed' Facebook page is a good example of this collaborative approach, as seen recently in how key information (and response to concerns and queries by families) has been disseminated in relation to the Covid-19 emergency.
- This is an excellent opportunity for national learning. It is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group. This could include what kind of training and peer support such individuals might require.

5. The health Board should ensure that the principles of direct, person-centred and compassionate communications on the ward with patients and families be applied in a way which ensures consistency of experience across all patients and families. While this was reflected in the experience of some patients and families, it was not widely experienced by all of them, particularly those with ongoing questions and concerns about infection prevention and control.

- The Terms of Reference for the Subgroup set out the intention to ensure that NHS GGC communications and engagement in this context demonstrated clear principles of person-centred care going forward. The Annex to this paper presents these principles in greater detail, notably with respect to:
  - *we will enable people to share their personal preferences, needs and wishes about their care and treatment and include these in their care plan, care delivery and in our interactions with them;*
  - *we will develop further the person centred approaches to visiting throughout NHS GGC; and*
  - *we will make sure there is a collaborative and consultative approach in place to enable staff to actively listen, learn, reflect and act on all care experience feedback received and to ensure continual improvement in the quality of care delivered and the professional development of all staff.*
- There was excellent evidence of these principles in operation with wards-based communications, and the staff of the haemato-oncology paediatric service were singled out for particular praise in their continuing approach to this.

- The practice apparent in the wards in this context should be mainstreamed in the health Board's wider approach to communications.

6. Finding the right ways of communicating to patients and families who are 'outside' of the hospital is a key challenge that health Boards must address when faced with these circumstances. The experience of NHS GGC should inform national learning on how this can be improved across NHS Scotland in future.

- It was acknowledged that there was a greater challenge for the health Board in communicating when it was not person-to-person. That challenge should be explicitly recognised and addressed pro-actively by the health Board in preparation for any similar future challenges by ensuring its communications infrastructure has a strategic emphasis that recognises and plans and delivers on these principles. This includes due recognition of the role of strategic intent, leadership, skills and culture.
- That should include learning from and establishing as routine practice the establishment of specific communications channels for patients and families. The example of the 'closed' Facebook page was cited at several points in the Subgroup's meetings, and while it remains a 'work in progress', it has been a key element in restoring good communications with many of the families including a significant uptake in participation.
- There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group.

7. The health Board should systematically elicit and reliably act on people's personal preferences, needs and wishes, particularly in circumstances where longer-term communication with patients and families is taking place. An action plan setting out how the learning from the communication challenges of Healthcare Associated Infections in the paediatric haemato-oncology service within NHS GGC will inform that approach going forward should be presented to the Scottish Government by the health Board. This should also support national learning.

- To ensure that people remain at the centre of its communications and engagement efforts and that they are listened to, special attention should be placed on ways of capturing communications preferences. This is particularly critical in particular operational services such as haemato-oncology paediatric service.
- NHS GGC demonstrated useful learning in this context, particularly through the development, updating and use of its database of communications preferences for affected families.
- There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group. It should share learning of the use of the shared database (both software and approach) as well as the mechanism they developed to have single list of all those across service elements receiving care.

8. The health Board should learn from other health Boards that have developed good practice in addressing the demand for speedier communications in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.
• The impact of social media on amplifying speculation was presented by the health Board as a key challenge, often overwhelming messages, narrative, and the ability to reassure families and present clear information. • The health Board should consider how it can provide more adept and quicker confirmation of lines and messages in this context, guarding against any harmful lag in communications, and how best to make positive and effective use of social media in this context. • There is good practice that can be learnt from other Boards around the use of social media in this context, particularly around the value of different types of social media in different contexts. This is an excellent opportunity for national learning, and should be pursued through the NHS Scotland strategic communications group.

9. The health Board should review and take appropriate action to ensure that there is an environment where staff are open about what is happening and can discuss patient safety events promptly, fully and compassionately.
• Good communications with the staff is important to ensure that staff are well informed and can contribute to supporting families and patients. This only works if there is a good flow of information from Board to the point of care, without internal organisational boundaries becoming barriers. Key factors to support this include active, transparent and consistent communications across different, relevant parts of the health Board. • In this context, the health Board is invited to review how its staff could be better informed in future, based on the experience of the communications on HAI in the paediatric haemato-oncology service, and where lessons learned can underpin widespread good practice. • This is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communications group.

10. The recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy for the health Board, and indeed, the wider strategic culture and approach of the health Board, with a view to forming the basis for wider national learning.
• It was noted that this was an important strategy for NHS GGC communications in these circumstances, and further, that the document is in need of updating. • While there was debate about whether it is valuable to develop bespoke strategies for communications and healthcare-associated infections, a revised strategy – taking account of the learning set out in this report and the actions identified in the recommendations – could become the basis of an exemplar to other Boards, or a plan modelled on national strategic and IPC requirements.

11. The Scottish Government, with Health Improvement Scotland and Health Protection Scotland, should review the external support for communications to Boards facing similar intensive media events.
• While communications and engagement in these circumstances can and should be the responsibility for individual Boards, there are points where there is a clear role of other key bodies in supporting messaging and the flow of information. That role was not clearly and consistently acted upon in these circumstances. • It is recommended that Scottish Government, Health Improvement Scotland and Health Protection Scotland should review how other bodies should support and engage with individual Boards in similar situations in future, through the NHS Scotland strategic communications group.

Organisational Duty of Candour

Findings

What has worked well

- The organisational duty of candour was actively considered during the period, although it was not formerly activated for any of the instances of infection within the paediatric haemato-oncology service.
- There was evidence of clinicians involved with IMTs of taking actions to reflect their recognition of their professional duty of candour in respect of the incidents and outbreaks being considered, including the need to develop clarity on the actions required to respond to the incidents considered as part of the IMT process.

What needs to improve

- NHS GGC policy in support of organisational duty of candour legislation does not fully reflect the legislation and guidance – primarily in respect of the reliance placed upon harm being viewed to be avoidable and/or related to acts of omission/commission of the organisation. It is focused on the concept of a 'patient safety incident' – not a construct within the legislation and does not fully consider the legislation requirement to consider an unintended or unexpected incident that could result in harm (including actual or potential psychological harm).
- While implementation of the organisational duty in these circumstances has particular challenges, it is clear that the legislation does not require a view on causation to be determined in deciding whether to activate the organisational duty of candour procedure and includes provision for unexpected events that have resulted or could result in outcomes included in legislation (including increases in treatment) to activate the organisational duty of candour procedure.

Recommendations

1. Given that organisational duty of candour was considered, but not formally activated, in these circumstances, NHS GGC should review its approach to ensure that it is not simply focused on patient safety incidents, circumstances where causality is clear and where events could result in death or harm.
• NHS GGC undertook benchmarking of its organisational duty of candour response to the infection incidents, which was done on what appeared to be an informal basis. The health Board is asked to undertake a review of its supporting policy and procedures to support implementation of the organisational duty of candour and provide feedback to the Scottish Government on areas where revisions to national non-statutory guidance would be helpful and how revised implementation support materials regarding the duty and multiple instances of healthcare associated infection might be developed through Healthcare Improvement Scotland.

2. The national challenges around the application of the organisational duty of candour highlighted by these events should be explicitly considered and acted upon by the Scottish Government and NHS Scotland.
• It was suggested that NHS GGC might not be unique in its ambiguous approach to applying the organisational duty of candour in situations where causality is not easily understood, and other Boards might be experiencing similar challenges in interpreting the legal duty. The Subgroup could not explore this in detail within the scope of its work, but flag that up as a consideration for the arrangements in place for review of the Annual Duty of Candour reports published by NHS Boards.

Phil Raines
Secretariat/ Scottish Government

Craig White
Chair

July 2020

Annex A

Terms of Reference

Purpose and Role

The Communications and Engagement Subgroup the QEUH and the RHC, NHS GGC, is a time limited group to offer advice and assurance working with Scottish Government and NHS GGC on:

- effective communication and engagement with patients and families; and
- robust, consistent and reliable person-centred engagement and communication.

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 and Social Care and Chief Executive of NHS Scotland 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 Communications and Engagement Subgroup will take a values based approach in line with the NPF and the values of NHS Scotland. 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 work of the Subgroup 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 NHS Scotland are:

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

These values will be embedded in the work of the Communications and Engagement Subgroup, and this work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives, respecting the importance of specific values informed actions linked to personal context and experiences.

The Communications and Engagement Subgroup is focused on improvement. Subgroup members, will ensure a 'lessons learned' approach, as well as respecting the experience of families must underpin and inform the identification of improvements for dissemination both locally and nationally.

Meetings

The Communications and Engagement Subgroup will meet fortnightly initially and then at a frequency to be determined thereafter. Tele-conferencing will be provided.
A range of communication and engagement mechanisms will be agreed to enable patients and families to feed into the work of the Communications and Engagement Subgroup.

Full administrative support will be provided by officials from Scottish Government. The circulation list for meeting details/agendas/papers/action notes will comprise Oversight Board members, their PAs and relevant CNOD staff.

Outcomes

The Outcomes for the Communications and Engagement Subgroup are to:

- positively impact on patients and their families in relation to how complex infection control issues and all related matters are identified, managed and communicated;
- demonstrate a proactive approach to engagement, communications and the provision of information; and
- identify what has worked well and where the provision of information, communication and engagement could have been and could be enhanced and improved.to ensure that the outputs from the group are disseminated to key stakeholders and any wider learning points or recommendations are shared nationally.

In order to achieve these outcomes, the Communications and Engagement Subgroup will retrospectively assess factors influencing the approach to communication and public engagement associated with the infection prevention and control issues and related matters at the QEUH and RHC.

Having identified these issues, the Subgroup will 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 good practice as well as lessons learned across NHS Scotland.

Deliverables

The Deliverables for the Communications and Engagement Subgroup are:

- a prioritised description of communications and information to be provided to families, with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered);

- development of a strategic Communications and Engagement Plan with a person-centred approach as key. This should link to and be informed by consideration of existing person-centred care and engagement work within the Board, to ensure continued strong links between families and NHS GGC. Specific enhancements and improvement proposals should also be clearly identified and should consider how the proposals from parent representatives on an approach that identifies and supports the delivery of personalised actions through the 'PACT' proposal can inform further work;
- a description of findings following a review of materials, policies and procedures in respect of existing practices with regards to communications, engagement and decision-making arising from corporate and operational communications and engagement, linked to infection prevention and control and related issues. This will include consideration of organisational duty of candour, significant clinical incident reviews, supported access to medical records (including engagement, involvement and provision of information to families in relation to these processes); and
- a description of findings and recommendations to: (a) NHS GGC; (b) Health Protection Scotland; (c) NHS Scotland; and (d) Scottish Government on learning to support any required changes and improvements for communications and public engagement relating to the matters considered by the Subgroup.

Governance

The Communications and Engagement Subgroup will be chaired by Professor Craig White, and will report to the Oversight Board. The Oversight Board is chaired by the Chief Nursing Officer, Scottish Government and reports to the Cabinet Secretary for Health and Sport. Members and those present at Subgroup meetings should ensure that they circulate information about the work of the Subgroup to colleagues and networks with an interest, contribution and perspective that can inform the work to be undertaken. It has been agreed that this must include clinical and care staff within relevant operational services, as well as senior management and corporate staff within NHS GGC.

Membership

Member	Job Title
Professor Craig White (Chair)	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Lynsey Cleland	Director of Community Engagement, Healthcare Improvement Scotland
Andrew Moore	Head of Excellence in Care, Healthcare Improvement Scotland
Professor Angela Wallace	Nursing Director, NHS Forth Valley
Jane Duncan	Director of Communications, NHS Tayside
Professor John Cuddihy	Families representative
Suzanne Hart	Communications, Scottish Government
Phil Raines	Chief Nursing Officer's Directorate (CNOD), Scottish Government
Calum Henderson (Secretariat)	CNOD, Scottish Government

In addition to these members, other attendees may be present at meetings based on agenda items, for example: Chair of Infection Prevention and Control and Governance subgroup; relevant Directors and senior staff from NHS GGC and communications staff from Scottish Government.

Stakeholders

The Communications and Engagement Subgroup recognise 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 and their families;
- the general public;
- the Scottish Parliament;
- Scottish Government, particularly the Health and Social Care Management Board;
- the staff of NHS GGC, Trade Unions and professional bodies; and
- the senior leadership team of NHS GGC and the Board.

Annex B

The following sets the Strategic Intention by NHS GGC for its Healthcare Quality Strategy (2018-23) in relation to 'Person Centred Care'.

- *We will enable people to share their personal preferences, needs and wishes about their care and treatment and include these in their care plan, care delivery and in our interactions with them.*
- *We will involve the people who matter to them in their care in a way that they wish and that meets the requirements of the Carer's Act (2018).*
- *We will develop further the person centred approaches to visiting throughout NHS GGC.*
- *We will make sure people experience care, which is coordinated and that they receive information in a clear, accurate and understandable format, which helps support them to make informed decisions about their care and treatment.*
- *We will give people the opportunity to be involved and/or be present in decisions about their care and treatment and include the people who they want to be involved in accordance with their expressed wishes and preferences.*
- *We will provide training and education, to enable staff to treat people with kindness and compassion, whilst respecting their individuality, dignity and privacy.*
- *We will inform people about how to provide their feedback, comments and concerns about their care and treatment. We will review our approach to collecting and managing feedback to make sure it is fit for purpose.*
- *We will make sure there is a collaborative and consultative approach in place to enable staff to actively listen, learn, reflect and act on all care experience feedback received and to ensure continual improvement in the quality of care delivered and the professional development of all staff.*
- *We will continue to identify and build opportunities for volunteers to help improve the health and wellbeing of patients, families and carers.*
- *We will engage with people, communities and the population we serve to deliver high quality services to meet their needs.*

Queen Elizabeth University Hospital (QEUH)/Royal Hospital for Children (RHC) Advice, Assurance & Review Group (AARG)

Terms of Reference

Date Published: June 2021
Version: 3.0
Document Type: ToR
Review Date: **N/A**

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Document Status:	Draft
Author:	John Lewis
Owner:	Scottish Government
Approver:	Shalinay Raghavan, Team Leader

1.1.2 Approvals*:* *This document requires the following signed approvals:*

Name	Title	Date
Amanda Croft	Chief Nursing Officer	

1.1.3

1. Name of the Group
QEUH/RHC Advice, Assurance & Review Group (AARG)
2. Background
In response to concerns raised in relation to patient safety and healthcare associated infections at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), the previous Cabinet Secretary for Health and Sport commissioned a number of investigations into the built environment at the hospital and a review of clinical cases in relation to children who had been treated there. In November 2019 the then Cabinet Secretary escalated NHS Greater Glasgow and Clyde (NHS GGC) to Stage 4 of the NHS Board Performance Escalation Framework. The reports were commissioned between 2019 and 2020 and include: 1. The Independent Review conducted by Dr Andrew Fraser and Dr Brian Montgomery (published June 2020); 2. The Oversight Board (chaired by Professor Fiona McQueen) Interim Report (published December 2020); 3. The Oversight Board Final Report (published March 2021); 4. The Overview Report of the Case Note Reviews (published March 2021). The Independent Review, together with the Interim and Final Oversight Board reports, specifically identified a number of national recommendations to be taken

forward by different parties. The Case Note Review Overview Report provided insight on the issues encountered within NHS GGC, on the basis of which national recommendations were also drawn.

It has been agreed that a review and assurance process would need to be retained for NHS GGC beyond the Oversight Board Final Report. As part of this process, NHS GGC will draw up an action plan to address all of the recommendations highlighted across all four reports. It is envisaged that this would allow Scottish Government (SG) to assess and agree monitoring arrangements for NHS GGC's action plan in response to findings and context specific criteria for de-escalation.

The intention is to review the progress of NHS GGC (with regards to QEUH and RHC) in June 2021 and again in September 2021 with a view to determining if proposed actions had been progressed or completed and to consider whether conditions had been satisfied for de-escalation to be recommended. This would also provide opportunities for officials to provide support with particular risks in respect of issues known to take time to improve, specifically those relating to culture and leadership in relation to Infection Prevention and Control (not the whole NHS Board). It would also support any modifications in order to achieve more integrated strands of governance and interfaces.

3. Scope of work

Respecting the importance of the Chief Executive and her team to take operational decisions the QEUH/RHC Advice, Assurance & Review Group (AARG) will provide advice, assurance and review of all reports, recommendations and closed actions, based on NHS GGC's overarching action plan. This will include the following:

- Establish purpose of AARG; the make-up and of its core membership; the format and duration of meetings; the inclusion and role of invited guests; reporting arrangements of the review group; the timeline and agreement of the Final Review;
- Undertake an initial formal review of progress in first meeting of AARG;
- Implement the recommendations within the action plans and the reports relating to improvement;
- NHS GGC to establish an ongoing and regular monitoring process of the plan within the Board and update AARG accordingly;
- Provide advice regarding weekly progress meetings between SG Lead and NHS GGC, including on further interventions, if appropriate;
- Consider and provide advice to CNO in her discussions/liaison with SG colleagues;
- Undertake a timely formal review and produce a briefing with recommendations for the CNO to take to the Chief Executive of NHS Scotland/Director General of Health and Social Care regarding the level of escalation and any recommendations in relation to this;

- Progress that review with CNO and the Chief Executive of NHS Scotland/Director General of Health and Social Care to inform a meeting with the Cabinet Secretary.

4. Membership

The QEUH/RHC Advice, Assurance & Review Group (AARG) membership consists of:

- Amanda Croft, Chief Nursing Officer (CNO), Scottish Government (Chair)
- Jane Grant, Chief Executive of NHS Greater Glasgow and Clyde (NHS GGC)
- Jonathan Best, Chief Operating Officer, NHS GGC
- Tom Steele, Director of Estates and Facilities, NHS GGC
- Elaine Vanhegan, Head of Corporate Governance and Administration, NHS GGC
- William Edwards, Director of eHealth, NHS GGC
- Margaret McGuire, Nurse Director, NHS GGC
- Jennifer Armstrong, Medical Director, NHS GGC
- Sandra Bustillo, Director of Communications and Public Engagement, NHS GGC
- Irene Barkby, Associate Chief Nursing Officer, Scottish Government
- Craig White, Deputy Director, Scottish Government
- Marion Bain, Deputy Chief Medical Officer (DCMO), Scottish Government
- Angela Wallace, Nurse Director, NHS Forth Valley
- Shalinay Raghavan, Interim Head of QEUH Response Team, Scottish Government
- John Lewis, AARG Secretariat, Scottish Government

Other regular or invited attendees at the meeting will include:

- Christine Ward, CNOD Deputy Director, Scottish Government
- Others TBC according to theme discussed and area of expertise

5. Governance

The AARG will provide ongoing guidance and support to NHS GGC and also monitor activities to ensure progress and adequate responses are being made to the relevant recommendations.

6. Meetings

The AARG will meet initially on 7 June 2021 with additional meeting frequency TBC.

7. Outputs
• The AARG Chair will formally report on progress to the Cabinet Secretary in September 2021. • Additional reporting to the NHS GGC Board will occur, with briefing to the Chief Executive of NHS Scotland/Director General of Health and Social Care accordingly.

Chief Nursing Officer Directorate
Professor Amanda Croft, Chief Nursing Officer

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QEUH/RCH Advice, Assurance & Review Group (AARG)

Notes of Meeting

7 June 2021

Time: 13:30 – 15:30 (Microsoft Teams)

Attending:
Amanda Croft, Scottish Government (Chair) (AC)
Jane Grant, Chief Executive, NHS Greater Glasgow & Clyde (JG)
Jonathan Best, Chief Operating Officer, NHS GGC (JB)
Tom Steele, Director of Estates and Facilities, NHS GGC (TS)
Elaine Vanhegan, Head of Corporate Governance and Administration, NHS GGC (EV)
William Edwards, Director of eHealth, NHS GGC (WE)
Margaret McGuire, Nurse Director, NHS GGC (MM)
Jennifer Armstrong, Medical Director, NHS GGC (JA)
Sandra Bustillo, Director of Communications and Public Engagement, NHS GGC (SB)
Angela Wallace, NHS Forth Valley (AW)
Christine Ward, Scottish Government (ChW)
Irene Barkby, Scottish Government (IB)
Craig White, Scottish Government (CrW)
Marion Bain, Scottish Government (MB)
Shalinay Raghavan, Scottish Government (SR)
John Lewis, Scottish Government (Secretariat) (JL)

1. Welcome and Introductions – Chair

Welcome and introductions. **AC** noted that the purpose of the AARG is to have in place a system to work together and to ensure that Scottish Government can continue to support the progress that's being made, noting thanks to JG and her team for all of their substantive hard work on this. The aim of this meeting is high level discussion on the objectives and to seek assurance on systems, processes and improvement.

2. Terms of Reference – Chair / All

JG 3 changes suggested. Proposed changes were agreed.

3. Overview of the implementation plans and progress to date – JG / NHS GGC Team

JG CEO Summary/overview *(refer to slide 2, Oversightv3):*

JG confirmed an NHSGGC top priority is to fully implement the various reports' recommendations, and also to recognise the learning gained. Clear corporate and local ownership of recommendations across all 3 reports has been established. A Board-wide Action Plan is in place for oversight and project management. A Board-wide library of documents has been established containing NHSGGC

evidence of all associated work undertaken against each recommendation. By early June c.1/3rd of actions are complete, with majority likely to be completed September 2021. However, not all actions have to be completed for de-escalation.

This was followed by presentations from each of the NHSGGC team members, with detailed discussion and appropriate actions (in the table below).

Incident Management Process – AW *(Refer to slides 4-5, Oversightv3 for details):*

The presentation and discussion addressed the key points raised regarding the large volume of work carried out on NHSGGC's Incident Management Process, enabling a constant review of improvements.

Estates and Facilities – TS (refer to slides 6-7, Oversightv3):

The Group discussed the update on the 11 recommendations affecting estates and facilities as part of the overall Board Action Plan, which brought together common themes across the Reviews, particularly regarding the management of water systems and ventilation.

eHealth and Data Management – WE (refer to slides 8-10, Oversightv3):

This part of the presentation and discussion was driven by the Caseload Review work, which highlighted a number of systems and process improvements.

Governance and Risk – EV (refer to slide 11, Oversightv3)

The Group were given an update on and discussed the wide range of governance activity being undertaken across all levels of NHSGGC and how it is being aligned to the national work and implementation of 'Blueprint for Good Governance'.

Patient and Case Management – JB, SD (refer to slides 12-13, Oversightv3):

The 15 Recommendations across 2 reports and its complementarity to the Independent Review work (63 Recommendations, 40 of which NHSGGC has taken forward – and are completed or underway), was discussed.

The Group discussed each of the above areas in detail, including with respect to the National Recommendations and Actions set out in the Terms of Reference.

4. Communications and Engagement review – *SB* *(refer to AARG Communication and Engagement slides)*:

SB outlined in detail the activities and progress being made on NHSGGC's very comprehensive Communications and Engagement Review and the different approaches being undertaken to improve and enhance both communication and engagement and different roles within this activity. Further discussion took place on NHSGGC's exit strategy on the back of the Case Note Review Team finishing their work at the end of June.

5. AOCB and date of the next meeting – All

AC confirmed that the AARG has to report back formally in September and is engaging with the Chief Executive of NHS Scotland/Director General and the Cabinet Secretary's Private Office regarding this. Another meeting similar to this will take place in August (date TBC) followed by the formal session in September (date TBC) to complete the work of the AARG. The August meeting will provide NHSGGC with the opportunity to continue to provide continuous improvement updates and also to flag any risks ahead of the formal reporting stage in September.

Action Log		**Completed**
1	**JL** to make changes to ToR and circulate to Group	✓
2	**JG** and her team to take the request for **TS** to chair an e-Health oversight group away to discuss and respond to **IB** in due course	✓
3	**CrW** to move into an informal role to support communication and engagement work when requested	✓
4	**JL** to write up and distribute notes of the meeting for comment	✓
5	**AC** will confirm meeting dates for the August and September meetings and send out to the Group	✓
6	**JG** to provide Scot Govt with the updated Action Plans to look at the detail ahead of the August meeting	✓
7	**AC / ChW** to check with Scot Govt teams to formally note progress of NHSGGC work	✓

POLICY & PROCEDURE

DUTY OF CANDOUR COMPLIANCE

Lead Manager:	Director of Clinical and Care Governance
Responsible Director:	Medical Director
Approved by:	Board Clinical Governance Forum
Date approved:	
Date for Review:	Three years from date of approval
Version:	

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1. INTRODUCTION & PURPOSE

The organisational Duty of Candour procedure is a legal duty to support the implementation of consistent responses across health and social care providers where there has been an unexpected event or incident that has resulted in death or harm, or could result in death or harm, where the outcome relates directly to the incident rather than the natural course of the person's illness or underlying condition. Provisions in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 and the Duty of Candour Procedure (Scotland) Regulations 2018 set out the procedure that organisations providing health services, care services and social work services in Scotland are required by law to follow when such an incident has occurred.

Scottish Government guidance setting out how those provisions should be implemented was published in 2018 (available on StaffNet at SG DoC Guidance). This guidance document describes the different reporting structures for health, care services and social work services.

Under the Duty of Candour legislation, organisations must provide their employees with details of any services or support which may be able to provide assistance or support, taking into account the circumstances relating to the incident. Furthermore, organisations must provide patients and/ or their families with details of needs-based services or support, and through meetings and discussions, organisations should determine the impact of the incident on their health and wellbeing.

Organisations are required to apologise and to meaningfully involve patients and families in a review of what happened. When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement. They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen. Other than the situations outlined in Appendix 2, information should only be disclosed to others when the patient has given their expressed or implied consent.

The purpose of this policy is to:

- Improve the support, timeliness, quality and consistency of communication with patients and / or relevant persons when an unexpected or unintended incident occurs so that they receive prompt information to enable them to understand what happened; that a meaningful apology (defined as a sincere expression of sorrow or regret) is offered; and that patients and / or relevant persons are informed of the action the Health Board or Health and Social Care Partnerships (HSCPs) will take to try and ensure that a similar incident does not recur.
- Provide clear information to staff on what they should do when they are involved in an incident and the support available to them to cope with the consequences of what happened and to communicate with patient and / or relevant person effectively.

This policy has been informed by the requirements set out in:

- The Duty of Candour procedure, and regulations to be made using the power in the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016) for implementation in April 2018.

Creating the environment where staff are open about what happened and discussing incidents promptly, fully and compassionately with patients and / or relevant persons can:

- Help maintain trust and confidence necessary for an effective therapeutic relationship.
- Help patients and / or relevant persons cope better with the after-effects.

- Promote a thorough review into the incident including the patient's and / or relevant person's perspective.
- Provide patients and / or relevant persons with assurance that lessons learned will be implemented to help prevent a similar type of incident.
- Provide an environment where patients and / or relevant persons, healthcare professionals and managers feel supported when things go wrong.

2. SCOPE

It is the intention that this policy will support NHSGGC's ambitions to meet its Public Sector Equality Duty as per the Equality Act (2010). In order to achieve this, the policy must be considered alongside the existing repository of anti-discriminatory documentation including the Clear to All Policy and other communication support resources including the NHSGGC Interpreting Service (including telephone interpreting) and translation services. Uptake of the policy will be monitored through appropriate patient engagement methodology to capture disaggregated data by protected characteristic and inform any future development.

3. RESPONSIBILITIES & ACCOUNTABILITIES

3.1 Greater Glasgow & Clyde Health Board

NHSGGC Health Board will monitor that the processes in place with regard to Duty of Candour work effectively and is committed to promoting a culture of openness within services.

3.2 The Chief Executive

The Chief Executive has overall responsibility for ensuring integrated governance, including risk management and clinical governance within the Board which includes the Duty of Candour Policy. The Chief Executive delegates the responsibility for patient safety to the Board Medical Director.

3.3 Medical Director

The Medical Director is the designated board member responsible for reporting to the Board on patient safety and clinical quality issues. The Medical Director will be accountable for ensuring that the policy is adhered to and that the relevant staff have access to Duty of Candour training.

3.4 Directors and Chief Officers

The senior management team of Acute Division Sectors and Directorates and the Chief Officers and Clinical Leads in HSCPs are responsible for ensuring Duty of Candour principles are followed for their services and will have day to day responsibility for ensuring that the policy is implemented.

3.5 General Managers, Heads of Department, Clinical Managers, Lead Nurses or equivalent

All managers working within the organisation are expected to follow the Duty of Candour Policy and have a responsibility for ensuring that all incidents as defined by the Duty of Candour legislation are acknowledged and reported as soon as they are identified. To aid decision making worked examples can be found at Appendix 5.

They should be aware that an individual member (or members) of staff might require support during the review and provide the appropriate help and guidance for them which may in some cases come

from external agencies. This was highlighted in the Scottish Government First Year Review of the Duty of Candour Procedure.

3.6 Adverse event Review Commissioner / Complaints Investigating Officer

The senior manager responsible for managing the incident or complaint is responsible for ensuring that Duty of Candour is discharged in line with the policy.

They should ensure coordination of the communication with the patient and / or relevant person including that the opportunity being given to incorporate patient and / or relevant person questions in the review process. They must also ensure that the patient and / or relevant person's concerns and issues are addressed as part of the review and feedback of the outcome given.

3.7 All those with Managerial & Supervisory Responsibilities for Clinical Staff (Clinical Managers/Clinical Leads).

All members of clinical staff with patient contact should be familiar with the procedural aspects of this policy. They should follow the guidance to achieve openness with patients and / or relevant persons as well as healthcare partners and other healthcare organisations where applicable.

3.8 All Staff

All staff who have the potential to become aware of harm to patients require to be aware of the legal duty in relation to Duty of Candour. They should report any potential Duty of Candour cases to their line manager.

3.9 Independent Contractors

The Duty of Candour is the legal duty of any contractor, who must have arrangements in place which operate in accordance with the Act and any associated regulations or directions.

3.10 Director of Clinical and Care Governance

The Director of Clinical and Care Governance is the lead manager for NHSGGC. This involves a monitoring role, liaising with management teams to ensure that the need for Duty of Candour is recognised and implemented and documented as per the policy. The Clinical Governance Support Unit will provide support and guidance to those managers discharging Duty of Candour on behalf of the organisation.

The Director of Clinical and Care Governance and Deputy Medical Director, Corporate will also act as an arbitrator if any disagreements arise regarding the incident to ensure compliance with the Duty of Candour legislation.

3.11 Monitoring Committees

The Acute Services Division Clinical Governance Forum, Primary Care and Community Clinical Governance Forum & Mental Health Services Clinical Governance Group will receive reports from the Clinical Risk Team on Duty of Candour to monitor compliance and identify any areas of concern, taking action where appropriate.

The corporate oversight of policy implementation will be maintained by the lead Executive, i.e. Medical Director, via regular reports at the Board Clinical Governance Forum. The Forum will receive reports every four months relating to the Duty of Candour process and issues highlighted in order to provide assurance to the Board, or to raise concerns.

The Non-Executive oversight will be provided through an annual report to the Clinical and Care Governance Committee, which is a standing sub-committee of the NHS Board and will seek assurance of policy implementation.

4. POLICY & PRINCIPLES

4.1 Identifying the Need for Duty of Candour

Effective communication between staff who recognise an unexpected or unintended incident and their management team is vital in order to ensure that the Duty of Candour process is implemented from the outset. As soon as an incident is identified the top priority is to ensure appropriate clinical care is given. Whenever practicable, appropriate discussion and patient consent should be gained prior to providing any additional treatment that is required.

There can be very rare occasions when an incident has been declared a Duty of Candour incident and the management team responsible for the incident decide that it is inappropriate to disclose this to the patient and / or relevant person. This is usually on the grounds that it is felt to be in the best interests of the patient and / or relevant person as the disclosure would cause harm. The default is openness and transparency and any decision not to disclose must be exceptional. The decision, not to disclose must be escalated to the senior management team of the area the incident occurred (Sector, Directorate, HSCP) for agreement. If there is any disagreement between those involved in the management of the incident and the management team, the Director of Clinical and Care Governance and Deputy Medical Director, Corporate will act as an arbitrator for the final decision to ensure compliance with the Duty of Candour legislation. The reason disclosure has not been given would be recorded by the clinical risk team and monitored through governance structures.

It may also be the case that despite best efforts the organisation is unable to communicate with next of kin for a patient who has died as there may be no family who has been in contact with the patient for example. In these cases as long as effort has been made to implement Duty of Candour, it would not be recorded as a failure to follow the process.

If an incident is not reported at the time but is identified through a complaint the management of the service responsible should consider if the incident should be investigated as a Significant Adverse Event rather than a complaint. This will allow all the requirements of the organisational Duty of Candour procedure to be followed and recorded. This decision should consider the complexity of the review, the likelihood of organisational responsibility for the patient outcome and advice from complaints and clinical risk staff.

4.2 Principles of Duty of Candour Practice

Principles of practice can be found at Appendix 4. This must not be considered a ‘tick box’ exercise but as a way of working to ensure openness, trust and good communication.

5. PROCESS

Meeting the Duty of Candour is a process rather than a one-off incident. There are a number of stages in the process; the duration of the whole process depends on the incident, the needs of the patient and / or relevant person, and how the review into the incident progresses. The flowchart in Appendix 1 provides an overview of the Duty of Candour process.

6. TRAINING

It is very important that staff who are responsible for the implementation of the Duty of Candour legislation are fully aware of the regulations and the NHSGGC Duty of Candour Policy. It is acknowledged that clinical staff currently have a responsibility to ensure a professional Duty of Candour (generally being open and honest with patients regarding their care) and will already have a level of competence and understanding in this area which will facilitate implementation of this legislative Duty of Candour Policy.

For those staff who require additional training and support particularly with the interpersonal aspects of Duty of Candour Policy Implementation there are a range of programmes which can be accessed depending on the specific needs of staff groups or individuals. Clinical leads/managers may consider additional training in Duty of Candour an essential requirement for particular roles or jobs and can add the relevant programme or module to Role Specific Induction or refresher training as deemed appropriate. A full list of available training with a descriptor and suggested target group is available at Appendix 3. As a minimum it is expected that the NES online module is added to mandatory training for role specific staff.

This information will be promoted on HR Connect and through the Learning and Education calendar so that managers and staff will be able to easily access the required training and support. In addition the requirements of the Duty of Candour regulations are embedded in existing relevant policy based programmes for example Root Cause Analysis and People Management programmes.

7. MONITORING

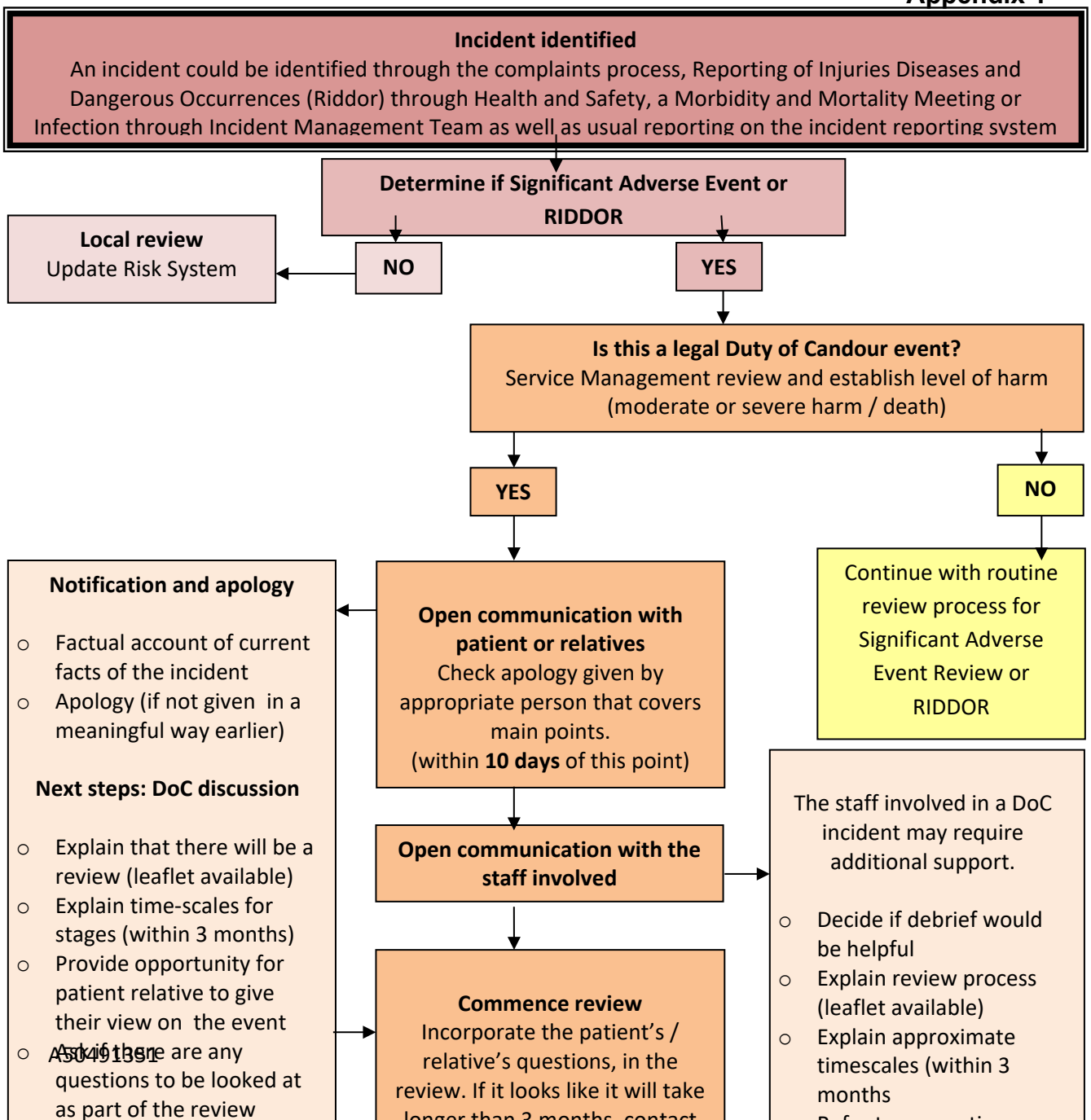
Services should review their Duty of Candour incident to be assured that they are complying with this policy. There is also a requirement for service to monitor completion of relevant training.

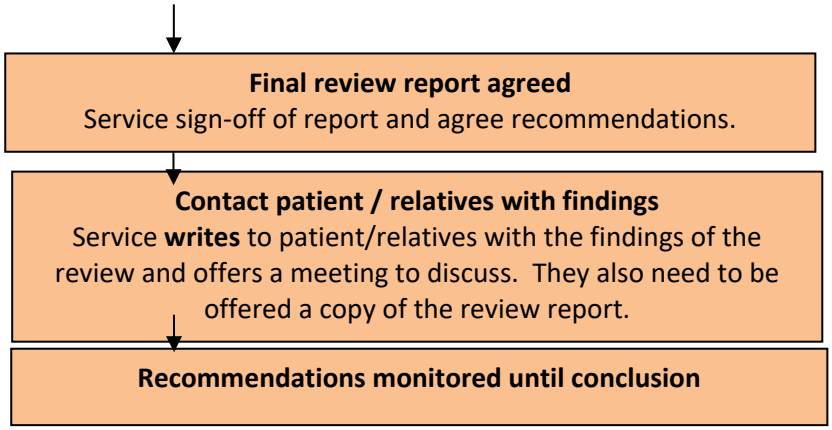
An annual Duty of Candour report will also be presented to the Board Clinical Governance Committee. The aspects of the policy listed below will be monitored by the Acute Services Division / Mental Health Services Clinical Governance Group / Primary Care and Community Clinical Governance Forum as part of the quarterly clinical risk report.

Monitoring requirements:

- The number of Duty of Candour incidents reported
- The patient and / or relevant person receiving an apology
- The patient and / or relevant person is/are informed of the review process and offered to contribute
- The patient and / or relevant person is/are given the report and feedback on the outcome of the review and offered a meeting to discuss the findings
- The completion of the review within 3 months of the Duty of Candour procedure being started for an incident
- Duty of Candour Procedure is commenced within one month of the incident, or a reason is recorded when this has not happened
- Maintain records of all communication with relevant persons including all individual correspondence and dates
- Completion rates of training

Appendix 1





Appendix 2

Particular patient circumstances that need to be considered in the Duty of Candour process

Other than the situations outlined below, information should only be disclosed to others when the patient has given their expressed or implied consent.

When a patient dies

When an incident as defined in the Act has resulted in a patient's death, the person acting lawfully on behalf of the deceased patient must be notified. It is even more crucial in these circumstances that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The patient's relevant person should be informed about the investigation process. They will also need emotional support. Establishing open channels of communication will allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

Children

Although there is no legal age of maturity for giving consent to treatment, it is accepted practice that a child over 12 years may have the capacity to give consent. However, it is still considered good practice to encourage competent children to involve their families in decision making. The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. This is sometimes known as Gillick competence or the Fraser guidelines. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the Duty of Candour process after a patient safety event. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought.

Patients with impaired capacity

Some individuals may have difficulty understanding what has happened to them. This may be as a result of a mental disorder such as mental illness, dementia or learning disability, or a physical disorder that impairs communication such as a stroke. The Duty of Candour still applies in these situations but the approach may need to be modified. In almost all cases, the individual should be told what has happened and be involved in discussions. The only circumstances in which it is appropriate to withhold incident information from a patient with mental health issues is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the patient. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the patient. In all instances where a decision not to disclose is made the requirements described in section 4.1 will also need to be followed.

Individuals with impaired capacity may need extra support in order to understand what has happened, and to participate in the process. This may include:

- Involvement of a supporter such as a family member, carer or friend of the individual's choosing.
- Involvement of independent advocacy. Individuals with a mental disorder have a legal right to advocacy.
- Involvement of Named Person as defined by the Mental Health (Care and Treatment) Scotland Act 2003.
- Advice on best ways to communicate from those who know the individual well. This may involve communication advice from a speech and language therapist.
- Involvement of a welfare proxy if one exists. A proxy would be a welfare guardian or attorney with appropriate powers relating to medical treatment. You can find out if there is a welfare attorney or guardian by calling the Office of the Public Guardian on [redacted].

It is never appropriate to discuss incident information with a carer or relative without the consent of an individual who has capacity. If the individual has insufficient capacity to understand and participate in the Duty of Candour process despite maximum support, the discussion should proceed with the welfare proxy. Where there is no such person, clinicians must consider who the most important person to involve is, taking account of the individual's wishes. This would usually be the primary carer or nearest relative. Even in this situation, the individual should be involved wherever possible and their wishes and preferences taken into account.

Patients with different language or cultural considerations

The need for interpreter service and advocacy services, and consideration of special cultural needs must be taken into account when planning to discuss incident information. Advice on culturally sensitive issues can be given by the chaplains or other specialists.

Patients with different communication needs

A number of patients will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs. Knowing how to enable or enhance communications with a patient is essential to facilitating an effective Duty of Candour process. This involves focusing on the needs of the patient and / or relevant person, and being personally thoughtful and respectful.

Patients who do not agree with the information provided

Sometimes, at the time of the decision to activate the procedure, despite the best efforts of healthcare staff or others, the relationship between the patient and / or relevant person and the healthcare professional breaks down. They may not accept the information provided or may not wish to participate in the Duty of Candour process. In this case, the following strategies may assist:

- Deal with the issue as soon as it emerges;
- Where the patient agrees, ensure their family or relevant person are involved in discussions from the beginning;
- Ensure the patient has access to support services;
- Offer the patient and/ or relevant person another contact person with whom they may feel more comfortable. This could be another member of the team or a manager with a higher level of responsibility;
- Consider a mutually acceptable mediator to help identify the issues between the healthcare organisation and the patient, and to look for a mutually agreeable solution;
- Write a comprehensive list of the points that the patient and / or relevant person disagree with and reassure them you will follow up these issues and demonstrate this is achieved;
- Ensure that the approach taken to engage includes the need to revisit, re-engage and better involve and/or use review methods that are more appropriate to the nature of their questions.

What are the implications if a claim for compensation is made once the decision to follow the Duty of Candour procedure is made?

Whilst it would not be appropriate for an organisation to try to prevent the relevant person from making a claim, organisations can suggest to the relevant person that they may wish to wait until the Duty of Candour procedure has concluded, when their case will have been investigated; they will have received an apology; their questions will have been answered and any actions to improve the quality of care and/or learning will have been identified. However, the patient also needs factual advice about the time-lines and outcomes in terms of ensuring that they do not suffer detriment if they wish to pursue a legal action.

If a relevant person mentions that they are considering making a claim, the Duty of Candour procedure should continue. If a relevant person makes a claim (i.e. the organisation receives an appropriate notification of this), then some elements of the Duty of Candour procedure may need to be paused until the legal process reaches a conclusion. For example, internal reviews could still proceed and organisations should still try to identify any potential improvement and learning actions.

Appendix 3

Training & Development Opportunities in support of Duty of Candour

Title/content	Staff group	Descriptor
NES E-learning module (Duration 45 mins) accessed via LearnPro: http://nhs.learnprouk.com/	Mandatory for senior clinical managers Open to all staff	This module covers the new organisational Duty of Candour on health, care and social work services. The module content includes ways of ensuring that staff and Organisations are open honest and supportive when there is an unintended or unexpected incident resulting in death or harm.
1/2 day Sage & Thyme Communication skills (accessed via L&E training catalogue) NHSGGC : Learning and Education Catalogue	Open to all staff	This 3 hour workshop is based upon evidence relating to core communication skills, psychological assessment and support. Attendees will learn how to use a structured approach for getting in and out of a conversation with someone who is upset or distressed, while providing basic psychological support. The workshop uses a mix of small group work, lectures and interactive rehearsals based on participant's scenarios to teach and demonstrate a structured approach to noticing distress, hearing concerns and responding helpfully.
1 Day Intermediate Communication Skills (accessed via Learning & Education training catalogue)	Registered Nurses, AHPs (experienced band 5 and above) and Doctors who are involved in complex / difficult /necessary conversations with patients and / or relevant persons.	The training provides a structured evidence based approach to communication skills. This interactive day will include a variety of teaching techniques for example, scenario based group work, DVD skills exercises and interactive discussion.
2 day Advanced Communication Skills (accessed via L&E training catalogue)	As above + Particularly useful for senior staff and managers who are involved in significant conversations for example, around the complexities of care, breaking bad news or decision making.	The training provides a structured evidence based approach to communication skills. Over the 2 days the training builds and expands on the models and theories taught during the 1 day intermediate training session. It allows participants to refresh and review their current experience of communication issues through scenario base role play, reflective practice discussions and group experiential learning techniques. Each participant will be given an opportunity to use the models and techniques, to further develop their communication skills enabling them to deal more effectively with challenging/difficult conversations.

Title/content	Staff group	Descriptor
1/2 day Duty of Candour (accessed by contacting Clinical Governance Support Unit)	Senior Clinical staff ; Clinical Managers, Clinical Service Managers, Lead Nurses	This half-day training session specifically looks at disclosure communication immediately following an incident and follow-up meetings (which would also be suitable for meetings following a complaint). The course aims to enhance the skills of the individual to facilitate a successful interaction. The training will provide tools and techniques to improve the confidence of the staff who can find this type of meeting stressful and intimidating.
Bespoke on request Training (Contact Clinical Governance Support Unit or Learning & Education)	Clinical staff or Teams likely to be involved in an incident or SAERs	Could range from Short 2 hour sessions to ½ day sessions and arranged by contacting the Clinical Governance Support Unit or Learning and Education
Managing Difficult Conversations (Part of the People Management programme) (accessed via Learning & Education training catalogue)	Any manager in NHS Greater Glasgow and Clyde who has responsibility for managing NHSGGC staff in their teams. This includes managers employed in integrated Health and Social Care Partnerships who are not directly employed by NHSGGC.	The course is designed for those responsible for leading teams by developing personal skills in handling difficult conversations with staff and peers. The course will also explore good practice approaches to effective management of challenge.

Appendix 4

Principle	Detail	Relevant regulatory requirements
Acknowledge	• Acknowledge and report unexpected or unintended incidents as soon as they are identified. • Concerns from the patient and / or relevant person must be taken seriously. • Denial of concerns will make future open communication more difficult.	Where it is not possible to contact an appropriate person, or they decline to be communicated with, a record of this must be kept. An explanation must be provided to the relevant person if the procedure is started more than one month after the incident. Supplementary guidance states it is best practice to inform the relevant person within 10 days of the procedure starting.
Truthfulness **Timeliness** **Clarity**	• An appropriate person should be nominated for the communication. • Information must be given in an open and truthful manner. • Communication should also be timely giving information as soon as is practicable, based solely on the facts known at that time. • Explain that new information may emerge as the investigation takes place. • Patients, their families and carers should receive clear information and be given a single point of contact for any questions or requests they may have.	The patient/representative should receive: • An account of the incident with the known facts to date • An explanation of the actions that will happen next • Where the procedure start date is later than one month after the date on which the incident occurred, an explanation of the reason for this • Communication should be a method preferable to the relevant person
Apology	• Patients, their families and carers should receive a meaningful apology (defined as a sincere expression of sorrow or regret) for the harm that has resulted from the incident. Saying sorry is not an admission of liability and it is the right thing to do. • Both verbal and written apologies should be considered. Verbal apologies are desirable because they allow face to face contact. A written apology, which clearly states the organisation is sorry for the suffering and distress resulting from the incident, must also be offered. Some circumstances relating to the incident dictate the best way to apologise. • The SAE Leaflet for Patients and Relatives gives expressions of regret therefore use of this leaflet	In addition to any apology provided at the time of an incident, the responsible person must offer the relevant person a written apology in respect of the incident and must provide one if the relevant person wishes it.

Principle	Detail	Relevant regulatory requirements
	assists the Duty of Candour process. • Openness and honesty towards patients is supported and actively encouraged by many professional bodies including the Medical Defence Union, the Medical Protection Society, the General Medical Council, General Pharmaceutical Council, the Nursing and Midwifery Council and the Health and Care Professions Council.	
Recognising Patient and Carer Expectations	Patients and / or relevant persons can reasonably expect to be fully informed of the issues surrounding an incident, and its consequences, in a face to face meeting with representatives from the organisation. • Patients and /or relevant persons should be advised on how to contribute questions or information for the review of an adverse event • They should be treated sympathetically, with respect and consideration and confidentiality must be maintained at all times. • Patients and / or relevant persons should also be provided with communication support in a manner to meet their needs. This may involve an interpreter. • Relevant information should be provided for example copies of SAER draft and final reports and access to case records.	In all cases, a meeting should be offered initially to provide the relevant person with information on the incident and the investigative process. They should be given the opportunity to ask questions about the incident for the review to consider. Following the meeting, a note should be provided to the relevant person. A copy of the written report (see below) should be provided
Staff Support	• This organisation aims to create an environment in which all staff feel encouraged to report incidents. • Staff will be supported throughout a significant adverse event review process. The SAE toolkit contains: • A leaflet explaining the SAE process • A leaflet for staff support • A reflective exercise template to help learning from the incident • Staff will be encouraged to seek support from Occupational Health • Counselling services are available to all NHS Greater Glasgow & Clyde employees. Face to face and telephone consultations are	The organisation must provide an employee who is involved in an incident with details of any services or support of which the responsible person is aware which may provide assistance or support to any such employee

Principle	Detail	Relevant regulatory requirements
	available. All appointments are confidential. Staff are also encouraged to seek help from their relevant professional bodies.	
Risk Management and Systems Improvement	• Root Cause Analysis methodology will be used to uncover the underlying causes of significant adverse events. This investigation will focus on improving systems of care, which will be reviewed for their effectiveness.	The regulations require a review of the circumstances which it considers led or contributed to the incident. This should be concluded within 3 months of the Duty of Candour procedure commencing. If this is not possible, the relevant person must be kept informed. Written report of the review should include a description of how the review is carried out, a statement of actions taken to improve the quality of service provision and sharing of learning within and external to the organisation. It should include a list of actions taken in accordance with the DoC regulations and the date they were taken.
Multi-Disciplinary Responsibility	• The Duty of Candour policy applies to all staff involved in patient care. Healthcare provision involves multi-disciplinary teams. This should be reflected in the way that patients and / or relevant persons are communicated with when things go wrong. • Both senior managers and senior clinicians must participate in the incident investigation process.	The organisation must ensure that all employees who carry out the Duty of Candour procedure on its behalf are aware of the Duty of Candour procedure; are able to provide relevant persons with the required information and receive relevant training and guidance on the Duty of Candour procedure and any services and support which may be available to relevant persons.
Learning organisation	• Structures are in place to disseminate the lessons and actions taken from adverse event reviews in order to reduce the likelihood of their recurrence. • The Service Senior Management Teams are accountable for ensuring that processes are in place at Sector/Directorate and speciality level to monitor compliance with action plans developed as a result of incidents	The report into the incident must consider sharing learning with other persons or organisations in order to support continuous improvement in the quality of health, care or social work services

Appendix 5

Duty of Candour outcomes and worked examples

The organisational Duty of Candour procedure is a legal duty to support the implementation of consistent responses across health and social care providers where there has been an unintended or unexpected event or incident that has resulted in death or harm, or could result in death or harm, where the outcome relates directly to the incident rather than the natural course of the person's illness or underlying condition.

The outcomes of the incident are listed below. Examples including considerations for activating the procedure can be found on StaffNet at http://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Clinical%20Governance/Clinical%20Risk/Duty%20of%20Candour/Duty%20of%20Candour%20-%20Examples%20(v2.0).pdf

The Act describes the patient outcomes that would be applicable to Duty of Candour as:

A. The death of a person.

B. Permanent lessening of bodily, sensory, motor, physiologic or intellectual functions (severe harm).

C. Harm which is not severe but which results in one or more of the following:

- An increase in the person's treatment
- Changes to the structure of the person's body
- The shortening of life expectancy of the person
- An impairment of the sensory, psychological, motor or intellectual functions of the person which lasted, or is likely to last, for a continuous period of at least 28 days.

D. The person requires treatment by a registered health professional in order to prevent:

- The death of the person, or
- An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned in B or C.

References

Gillick v West Norfolk and Wisbech AHA (1985) UKHL 7 British and Irish Legal Information Institute 1985

Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill (2016)

Healthcare Improvement Scotland Duty of Candour examples v2 2018

NHSGGC Management of Significant Adverse Events Policy 2020

Scottish Government Organisational Duty of Candour Guidance 2018

The Duty of Candour Procedure (Scotland) Regulations 2018 – SSI 2018/57

QEUH/RHC Advice, Assurance & Review Group (AARG)

Notes of Meeting

19 August 2021

Time: 09:00 – 11:00 (Microsoft Teams)

Attending:
John Burns, Scottish Government (Chair) (JB)
Jane Grant, Chief Executive, NHS Greater Glasgow & Clyde (JG)
Jonathan Best, Chief Operating Officer, NHS GGC (JB)
Scott Davidson, Deputy Medical Director for Acute Services, NHS GGC (SD) (attending with Jonathan Best)
Tom Steele, Director of Estates and Facilities, NHS GGC (TS)
Elaine Vanhegan, Head of Corporate Governance and Administration, NHS GGC (EV)
Margaret McGuire, Nurse Director, NHS GGC (MM)
Denise Brown, NHSGGC (DB) attending in place of William Edwards, Director of eHealth (WE)
Jennifer Armstrong, Medical Director, NHS GGC (JA)
Sandra Bustillo, Director of Communications and Public Engagement, NHS GGC (SB)
Angela Wallace, NHS Forth Valley (AW)
Christine Ward, Scottish Government (ChW)
Irene Barkby, Scottish Government (IB)
Craig White, Scottish Government (CrW)
John Lewis, Scottish Government (Secretariat) (JL)

1. Welcome, apologies and new Introductions – Chair

Welcome and introductions. JB introduced himself as the interim Chair following Professor Amanda Croft's departure. The following people gave their apologies due to alternative commitments: William Edwards, Director of eHealth, NHS GGC, Marion Bain and Shalinay Raghavan, Scottish Government. Denise Brown is deputising for WE.

2. Notes and Actions from previous meeting – Chair

- It was agreed that the Actions from the previous meeting are complete so there was no need to go over the detail:

Action Log		Completed
1	**JL** to make changes to ToR and circulate to Group	✓
2	**JG** and her team to take the request for **TS** to chair an e-Health oversight group away to discuss and respond to **IB** in due course	✓
3	**CrW** to move into an informal role to support communication and engagement work when requested	✓
4	**JL** to write up and distribute notes of the meeting for comment	✓

5	**AC** will confirm meeting dates for the August and September meetings and send out to the Group	✓
6	**JG** to provide Scot Govt with the updated Action Plans to look at the detail ahead of the August meeting	✓
7	**AC / ChW** to check with Scot Govt teams to formally note progress of NHSGGC work	✓

- All actions agreed as completed.

3. Implementation plans: evidence of progress / closure of actions – JG and QEUH Team – JG / NHS GGC Team

JG CEO Summary/overview (Refer to PowerPoint presentation, AARG Oversight Board, 19 August 2021 – slides 2-4, and AARG Briefing Note, 11 August 2021 for more detailed summary):

Progress against the actions plans since the AARG meeting on 7 June 2021 was discussed. The significant amount of work undertaken by the Board was acknowledged, as well as the recent helpful progress made in discussions held in preparation for this meeting, along with the opportunity for Scottish Government to review a number of documents that had been requested.

JG discussed that NHS Greater Glasgow and Clyde Health Board has made substantial progress on all of the recommendations from across the 3 reports into the QEUH and RHC, with actions delivered in an accelerated timescale of delivery. All actions at this point are either completed or are underway, with the Board on course to conclude 90% of all recommendations by the end of August 2021, and with further progress on actions due by the end of September 2021.

Internal review process to make sure progress is being made, overseen by JG.

This was followed by presentations from each of the NHSGGC team members, with detailed discussion and explanations.

***Infection Prevention and Control – Incident Management Process Update on Progress of the Oversight Report Recommendations* – AW** (Refer to slides 5-13):

AW presented an update across the recommendations which demonstrated that the work to achieve the 33 recommendations in relation to IPC processes were complete by August 2021. There were two areas that final external comments were awaited from ARHAI as key stakeholders in the work undertaken to achieve the recommendations. Within the presentation a key focus was the area of incident management teams (IMTs). A discussion followed with questions from Scottish Government members of the AARG in relation to the focus on developments progressed across the IMTs and it was recognised that the work in GGC would help inform practice and be shared nationally.

Members of the AARG noted the evidence submitted, the content of the presentation, the questions discussed by the group and recognised the significant progress across all recommendations. It was recognised NHS GGC's performance across the IPC AOP targets and that NHS GGC continues to demonstrate sustained improvements in these areas over time, and it was noted that this performance was not an outlier in any area in a national context. The whole system IPC improvement programme was noted as part of the ongoing work and AW highlighted that this work pre-dated the Oversight Board recommendations. The corresponding use of data, the development of the dashboard, including the communication internally and externally, was also highlighted by IB as positive developments and potential national exemplars.

Estates and Facilities – TS (Refer to slide 14):

The Group discussed progress against the recommendations affecting Estates and Facilities within the Board action plan, which brought together common themes across the Reviews, particularly regarding the management of water systems and ventilation, the planned re-opening dates of Wards 2A and 2B and data collection and assurance processes. The work that the Board has undertaken on Estates and Facilities has been impressive, with the appropriate use of experts to help them identify, address and continue to manage the substantial work that was required to be undertaken. The Board's Water Safety Group, along with an independent Authorising Engineer were charged with confirming all work, which was noted to be another exemplar of good practice. This has been used to bring them to a place where Wards 2A and 2B will be due to reopen. Additionally, NHSGGC have used their experience to contribute to the national response to IPC, through the Board's IPCT members' involvement in the Covid-19 Nosocomial Review Group (CNRG).

eHealth and Data Management – DB (Refer to slide 15):

This part of the presentation and discussion was driven by the Case Note Review work, which highlighted a number of systems and process improvements, including the development of a new database system and water and hard surface sampling. A full, end-to-end process review has been undertaken covering the sampling processes for water, environmental and clinical tests, which has informed a number of improvements and also the specification for the new completed database system. This has been achieved by working across teams and directorates (e.g. Estates, microbiology, labs) and the supplier of the estates management system, first to add additional mandatory drop down features into the system – this allows for the capture of precise locations associated with the maintenance activity. Additional fields have also been added to the water sampling request process, enabling the extraction of data into the database system to contribute to enhanced reporting. Hard surface environmental sampling data is extracted from the Telepath Laboratory System and put into the database (the latter of which was developed with colleagues across all disciplines). It was agreed that there was significant national learning from this innovative work and was unlikely to be in place elsewhere.

Duty of Candour and Datix – JA (Refer to slide 16-17):

This part of the presentation and discussion focused on the internal audit of Duty of Candour (DoC) at the Board, the consultation processes undertaken to address DoC issues and a robust review and implementation of policy to underpin these processes, along with the development of supporting guidance regarding DoC and Hospital Acquired Infections (HAIs). Sampling the testing of cases in the audit found that the incidents were consistently maintained in Datix and the appropriate mix of specialists was used to carry out the investigations in the DoC cases, finding that in the cases review appropriate engagement with patients and their families was carried out at all stages of the process. Through random sampling the audit found investigation reports were completed for all cases examined, setting out areas for improvement where relevant along with lessons learned. Relevant learning was also set out as appropriate in the reports. Policy on DoC was changed to make it much more consistent with the legislation in terms of unintended and unexpected incidents. Additionally, anonymised learning summaries are shared with the National Learning Summaries run by Health Improvement Scotland (HIS). Since 2021, this community of practice website is under review by HIS. The Board have made their roles and responsibilities clearer as well as the training – working with NES and the TURAS model. As part of external independent review, work has been ongoing with the IPC teams to look at how organisational DoC may apply – to be incorporated into the IPC accountability framework.

The utilisation of Datix in a consistent way was discussed and confirmation was given that the Datix metric report will be presented at the Divisional Clinical Governance Forums. The Board have developed a number of key metrics to ensure that the validity of the classification is audited in terms of risk categorisations – this will be looked at quarterly. It was recognised in the group that Datix reporting was an ongoing challenge nationally.

Patient and Case Management – JB, SD (Refer to slide 18):

This part of the presentation and discussion focused on initiatives and activities to improve staff engagement, including by consulting with and listening to and learning from others, leading to a review and redesign of processes. The importance of sharing information and increased collaboration across the different sectors and directorates in the Board was discussed, to ensure that this was supported through internal review and development of SOPs in order to embed a continuous improvement and quality assurance culture. A local performance review group is in place that meets monthly, covering clinical quality and governance, staff governance and reports up through the senior team and the Clinical Governance Forum. The use of a Balanced Score Card is reviewed on a weekly basis to identify any trigger safety checks for adverse events. Due process maps have also been developed to tie various threads together.

What has helped the Board to achieve this, is that they clearly recognised that a central requirement from the reviews was an understanding of the need for change. As such, their employment of

Organisational Development (OD) as a tool with which to engage constructively within and across professional teams has helped them facilitate organisational and cultural change.

Communications and Engagement review – SB (Refer to slides 19-20):

SB updated the group on progress since the previous AARG meeting, leading to discussion on the Board's HAI communications strategy, the development of 'best practice' guidance and the independent consultation with the families and young people, along with the development of a communications plan which was shared with the families regarding the reopening of Wards 2A and 2B. Appropriate communications in each Incident Management Team is being developed in consultation with IPC colleagues. Externally, the Board have co-opted the independent Consultation Institute to undertake further engagement with over 20 families, through a tailored approach to their initial engagement, supported by guidance and input from Scottish Government. As CrW has fulfilled his role in supporting the families' communications and engagement, particularly through social media, it was confirmed that as part of the agreed process he would no longer have access to the information on the families' group. They have also recently recruited a Deputy Director – Public Engagement to a newly created post, to continue to develop progress made.

Governance and Risk – EV (Refer to slides 21-22)

The Group were given an update on and discussed the wide range of governance activity being undertaken across all levels of NHSGGC. In terms of governance, the Board has demonstrated a coherent approach, which included the Royal College of Physicians Edinburgh (RCPE) Quality Governance Collaborative undertaking an external review of governance, and Board development sessions focused on the *Blueprint for Good Governance*. From the evidence provided and this discussion of it, the Board has consistently provided strong and robust responses to questions about their internal audit, planning processes and their approach to risk management, including how this informs their Audit and Risk Committee. The Board is about to establish a revised and enhanced approach to risk as part of its Active Governance Programme.

The Board has demonstrated through the evidence provided and at the AARG that they have instituted an approach to governance and risk that can be identified throughout their engagement with addressing the recommendations and the risk management strategy that they have established, including through their Datix work and through dialogue with the Board Development Sessions. Further, the Board is developing a programme of future projects with HFS/NHS Assure to plan future applications of the assurance process. New risk arrangements were discussed and it was noted that a new Senior Risk Officer was due to be imminently appointed.

Summary and Next Steps – JG, JB, All (Refer to slide 23)

It was confirmed that approximately 90%+ of actions will be completed by the end of August, with further progress expected by the end of September.

In summary, the Board has demonstrated that there is clear and substantial evidence of their progress. They have done so through their action plans, the specifically requested evidence by Scottish Government to support what they refer to in these plans, and through their presentation and comprehensive and assured articulation of the evidence during robust assurance and review questioning throughout this meeting. The Board has clearly demonstrated the high priority that they have given to addressing all of the recommendations made for them. In so doing, they have presented evidence of a robust approach to action planning and delivery against these actions, while creating a large electronic library database of evidence to support their progress. It was also noted that the action plan will be subject to an ongoing process of audit to ensure maintenance and sustainability of actions.

Scottish Government AARG members requested a specific sample of documentary evidence to review prior to that meeting, and has been both satisfied and impressed by the quality of the evidence and the Board's assured responses to questioning on it. JG confirmed that the Board would continue to work on this going forward.

The NHSGGC position in relation to the NHS Board Performance Escalation Framework would be under consideration by the Scottish Government. The Board would be updated at the relevant point.

5. AOCB – All

The Paediatric Trigger Tool (PTT) and the PTT Report was discussed, including the approach to be taken to communicate the report to the families.

JB thanked JG and the NHSGGC team for the work that they have undertaken in meeting the recommendations and noted that this has been done while the Board continues to have to manage the challenges of the pandemic.

JG thanked the group for the constructive, measured approach taken throughout the discussions in both previous AARG meetings.

Action Log		**Completed**
1	**JB** to work with CNOD/Scottish Government colleagues to take forward the work shared within the AARG and provide advice to the Director General Health and Social Care / Chief Executive NHS Scotland (DG-HSC/CE-NHS), particularly in relation to the Board's Stage 4 escalation status	
2	**JB** / CNOD to confirm if scheduled meeting with Cabinet Secretary will proceed following this AARG meeting and discussion with DG-HSC/CE-NHS	
3	**ChW** and CNOD team to work with Board team to agree a process for sharing the PTT Report with the families, while considering any Data Protection issues for patients and their families in the process	
4	**JL** to write up and distribute notes of the meeting for comment	

OFFICIAL:SENSITIVE
Yes

Paper no:	**HSCMB/100/2021**
Meeting date:	**15 September 2021**
Agenda item:	3

Substantive Items

Purpose:	To update HSCMB on the work undertaken by the QEUH/RHC Advice, Assurance and Review Group (AARG) regarding NHS Greater Glasgow and Clyde's (NHSGGC) escalation status; and based on the recommendation of the AARG, seek advice on the proposal to the Director General Health and Social Care / Chief Executive NHS Scotland (DG-HSC/CE-NHS) and to seek feedback on next steps.

Title:	**NHS GGC escalation review based on the outcome of the QEUH / RHC Advice, Assurance & Review Group (AARG)**

Background and Key Issues:	• Responding to concerns raised regarding patient safety and healthcare associated infections at the QEUH and RHC, the previous Cabinet Secretary for Health and Sport commissioned a number of investigations into the built environment at the hospitals and a review of clinical cases in relation to children who had been treated there. • On 22 November 2019 NHS Greater Glasgow and Clyde (NHSGGC) were escalated to Stage 4 of the NHS Board Performance Escalation Framework. • The reports from the investigations that were commissioned between 2019 and 2020 include: 1. *The Independent Review* conducted by Dr Andrew Fraser and Dr Brian Montgomery (published June 2020); 2. *The Oversight Board (chaired by Professor Fiona McQueen) Interim Report* (published December 2020)[1]; 3. *The Oversight Board Final Report* (published March 2021)[2]**;** 4. *The Overview Report of the Case Note Reviews* (published March 2021). • It was agreed that a review and assurance process would need to be retained for NHSGGC beyond the *Oversight Board Final Report*. NHSGGC drew up an action plan to address all of the 108 recommendations; Scottish Government (SG) were to assess and agree monitoring arrangements in response to findings and context specific criteria for de-escalation through

[1] Taken together as a single report for the purposes of the NHSGGC action plans.
[2] *Ibid*.

	the AARG. • NHSGGC provided evidence to support the work it has carried out to address the recommendations, with 91% of the actions completed, and outstanding actions to be completed by the end of September 2021 (those subject to third party inputs notwithstanding). • The SG *NHS healthcare standards: Board performance escalation framework*[3] allows for decisions on de-escalation to be considered based on the extent and robustness of the evidence provided by the Board in escalation, as well as the response of that Board to challenge from SG. The robustness of the evidence and standard of interrogation of it therefore requires professional objectivity and scrutiny, especially in terms of the decisions made by SG based on it. • Further detail on Key issues are set out in **Annex 1**.

Agreed with Directorate for Health Finance: Not Applicable

Summary of contribution to the Triple Aim:	Addressing the 108 recommendations across the reviews into infection prevention and control in the QEUH and RHC through an action plan of remedy, progress and lessons learned by NHSGGC, with advice, assurance and review provided through the AARG. This supports our work to embed the internationally recognised triple aim of quality, effective and safe care.

Summary of contribution to Recovery/ Renew:	The work supports and informs the delivery of the objectives set out by the Cabinet Secretary for Health and Sport in The Remobilise, Recover, Redesign: Framework for NHS Scotland.

Action Required:	HSCMB is invited to: • Consider the evidence provided by NHSGGC to the AARG and advise DG-HSC/CE-NHS that: ○ NHSGGC has substantially met and in some instances exceeded the evidential requirements against the overwhelming majority of the 108 recommendations, and will complete the rest by the end of September 2021; ○ NHS GGC be de-escalated from Stage 4 to Stage 2 and

[3] Scottish Government (2021) *NHS healthcare standards: Board performance escalation framework*, https://www.gov.scot/publications/nhs-healthcare-standards-nhs-board-performance-escalation-framework/ (10 June)

	this will be this will be in accordance with the Stage 2 definition in the 'framework' that there may be "some variation from plan; possible delivery risk if no action", with Scottish Government providing "advice and support" and increased surveillance and monitoring, if necessary; o As part of the ongoing assurance arrangements NHSGGC will provide a monthly exception report in respect of the action plan; o Additionally, the CNO and COO will meet quarterly with the Chief Executive and members of the senior team of NHSGGC; o These assurance arrangements will be kept under review.

Author: John Lewis **Date:** 8 September 2021	**Director:** John Burns **Date:** 8 September 2021

Annex 1

Background

In response to concerns raised in relation to patient safety and healthcare associated infections at the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC), the previous Cabinet Secretary for Health and Sport commissioned a number of investigations into the built environment at the hospitals and a review of clinical cases in relation to children who had been treated there. On 22 November 2019 the then Cabinet Secretary escalated NHS Greater Glasgow and Clyde (NHSGGC) to Stage 4 of the NHS Board Performance Escalation Framework.

The reports from the investigations that were commissioned between 2019 and 2020 include:

1. *The Independent Review* conducted by Dr Andrew Fraser and Dr Brian Montgomery (published June 2020);
2. *The Oversight Board (chaired by Professor Fiona McQueen) Interim Report* (published December 2020)[4];
3. *The Oversight Board Final Report* (published March 2021)[5];
4. *The Overview Report of the Case Note Reviews* (published March 2021).

The *Independent Review*, together with the *Interim* and *Final Oversight Board Reports*, specifically identified a number of national recommendations to be taken forward by different parties. The *Case Note Review Overview Report* provided insight on the issues encountered within NHSGGC, on the basis of which national recommendations were also drawn.

It was then agreed that a review and assurance process would need to be retained for NHSGGC beyond the *Oversight Board Final Report*. As part of this process, NHSGGC was tasked with drawing up an action plan to address all of the recommendations highlighted across the reports. It was envisaged that this would allow Scottish Government (SG) to assess and agree monitoring arrangements for NHSGGC's action plan in response to findings and context specific criteria for de-escalation.

The intention was to review the progress of NHSGGC (with regards to QEUH and RHC) in June 2021 and again in September 2021, with a view to determining if proposed actions had been progressed or completed and to consider whether conditions had been satisfied for de-escalation to be recommended. Accordingly, the QEUH/RHC Advice, Assurance & Review Group (AARG) was established for this purpose and to also provide opportunities for officials to provide support with particular risks in respect of issues known to take time to improve, specifically those relating to culture and leadership in Infection Prevention and Control (not the whole NHSGGC Board). It would also support any modifications in order to achieve more integrated strands of governance and interfaces.

[4] Taken together as a single report for the purposes of the NHSGGC action plans.
[5] *Ibid*.

The Role and Scope of the AARG

Respecting the importance of the NHSGGC Chief Executive and her team to take operational decisions the AARG's purpose was to provide advice, assurance and review of progress on all reports, recommendations and closed actions, based on the Board's overarching action plan. The AARG's role, therefore, was to:

- establish the purpose of the group, its core membership, reporting arrangements and the timeline and agreement of the Final Review;
- seek assurance that the recommendations within the action plans and the reports relating to improvement are implemented;
- seek updates from NHSGGC regarding ongoing and regular monitoring of the action plans within the Board;
- provide advice regarding progress, including on further interventions, if appropriate;
- consider and provide advice to CNO in her discussions/liaison with SG colleagues;
- undertake a timely formal review and produce a briefing with recommendations for the CNO to take to the Director General of Health and Social Care/Chief Executive of NHS Scotland (DG-HSC/CE-NHS) regarding the level of escalation and any recommendations in relation to this;
- ensure that the review is progressed by the CNO and the DG-HSC/CE-NHS to inform a meeting with the Cabinet Secretary on the decision to de-escalate, or not.

The Progress

AARG Meeting #1

The initial meeting of the AARG was held on 7 June 2021, with the format being two extended presentations which provided an overarching summary of the distance travelled by the Board in terms of addressing the 108 Recommendations from the aforementioned Reviews. NHSGGC established that one of their top priorities was to implement the recommendations fully within these reports, but also to recognise the learning that the Board has made from this work. The Board has identified where the cross-over in terms of recommendations across the three reports[6] exists and have aimed to streamline the implementation of the actions across all reports. They have taken clear corporate and local ownership of the recommendations across the reports and have in place a Board-wide Action Plan for oversight and project management. The Board Chief Executive, Jane Grant has taken the lead through regular senior management progress reviews, and Gold and Silver Command referenced in reports was also put in place. At the strategic level, Gold Command looks at actions with progress being made against them; Silver Command discusses more operational aspects required to address the recommendations.

NHSGGC has also established a Board-wide digital library of documents containing NHSGGC evidence of all associated work undertaken against each recommendation, should there be a need to draw on particular information and

[6] *Ibid.*

sources. By the time of the June AARG, the Board had completed approximately one-third of actions and confirmed that they would meet most of the remaining actions on the recommendations by August and September 2021. It was also confirmed that through conversations with Scottish Government officials and other colleagues that not all actions had to be completed in order to achieve de-escalation. However, the Board confirmed that they would complete most of the actions by September 2021, though perhaps a very small number going past this timescale.

AARG Meeting #2

The second meeting of the AARG was due to take place on 11 August 2021. However, due to NHSGGC submitting action plans in which evidence and progress were not clearly sighted, Scottish Government members of the group met with one of NHSGGC's Directors and the Chief Executive's Business Manager and had a positive, constructive discussion clarifying Scottish Government's expectations of what was required from the action plan and supporting evidence.

The reconvened meeting took place on 19 August 2021 and given the absence of the CNO was Chaired by John Burns, NHS Chief Operating Officer (NHS COO). The meeting discussed the revised action plan and corresponding evidence documents specifically requested by SG (see Annex A for list of action plans and documents submitted as evidence).

The AARG members view is that NHSGGC have provided a comprehensive, robust and evidence-informed overview of each of the areas in which the 108 recommendations from the reports have been, are currently being, or will soon be addressed. These were presented by NHSGGC under the following headings and summarised below:

- Infection Prevention and Control – Incident Management Process
- Estates and Facilities
- eHealth and Data Management
- Duty of Candour Recommendations
- Datix – Recommendation (Case Note Review)
- Operational Management – Acute
- Communication and Engagement
- Governance and Risk

Summary of NHSGGC's Assurance on Progress Against the 108 Recommendations

The NHSGGC Executive Team presented a comprehensive, robust and assured discussion to support the evidence they presented in their action plans and the additional documentary evidence specifically requested by SG to review in advance of the second AARG meeting. Angela Wallace (NHS Forth Valley), in her independent role as Acting Director for Infection Control at NHSGGC to assure the Board's progress against the recommendations, confirmed the robustness of the activities and evidence to support such.

Throughout the process NHSGGC have undertaken Chief Executive-led regular senior management progress reviews, utilising Gold and Silver Command arrangements to ensure comprehensive oversight and delivery against the recommendations. Throughout this process, the Board have undertaken a journey of continuous improvement to embed lessons that they have learned, and have established and maintained a Board-wide document library with evidence of completed work against each recommendation.

At the time of the second AARG meeting on 19 August 2021, NHSGGC had made progress against all of the recommendations, with approximately 86% of them having been completed, a significant progress from 33% having been completed at the time of the AARG meeting on 7 June 2021. At 31 August the Board had completed 91% of actions against the recommendations (subject to internal audit), and confirmed that they were on target to complete the remaining 9% of actions by the end of September 2021, necessary inputs by third-parties notwithstanding. This progress was broken down thus:

- **Independent Review:** 41 recommendations – 37 completed or in place (90.2%); the remaining 4 actions all underway, with 3 on course to be completed by 30 September 2021, and the remaining action being dependent on action concluding in the Oversight Board Plan.
- **Oversight Board Actions:** 24 recommendations – 20 completed (83.3%); the remaining 4 actions all underway (with 1 involving proceeding work with national partners); 3 are due to be completed by 30 September 2021.
- **Case Note Review:** at 19 August 43 recommendations – 38 completed (88.4%); the remaining 5 are all underway; 3 of which are eHealth programmes which are on track (1 is in place but with further Organisational Development work ongoing).
- **At 7 September 2021:** 91% of actions have been completed (subject to internal Board validation) all of the outstanding actions will be completed by 30 September 2021, notwithstanding any actions that require third-party inputs.

In summary, we would suggest that the Board have demonstrated clear and substantial evidence of their progress and learning. They have done so through their action plans, the specifically requested evidence by SG to support what they refer to in these plans, and through their presentation and comprehensive and assured articulation of the evidence during robust assurance and review questioning at the AARG meeting on 19 August 2021. From the evidence provided, we believe that the Board has clearly demonstrated the high priority that they have given to addressing all of the recommendations made for them. In so doing, they have presented evidence of a robust approach to action planning and delivery against these actions, while creating a large electronic library database of evidence to support their progress. SG AARG members requested a specific sample of documentary evidence to review prior to that meeting, and has been both satisfied and impressed by the quality of the evidence and the Board's assured responses to questioning on it.

Advice regarding where NHSGGC currently are in meeting the Recommendations

In considering the Board's escalation status, there is a need to undertake any decision from a balanced perspective, asking the following questions:

1. Where have they been? Where are they now? What have they learned from this process?
2. Who have they engaged with to bring them to their current place?
3. How committed are the Senior Leadership of NHSGGC?

1. Where have they been? Where are they now? What have they learned from this process?

As part of the assurance and review work of the AARG, from the detailed, evidence-informed action plans and corresponding evidence specifically requested by the AARG it is clear that NHSGGC have undertaken a substantial and unquestionable volume of work to meet the recommendations. In terms of the comprehensiveness of the 'outbreak management' work what the Board has achieved in terms of progress, is very good and in some ways may be defined as leading the way on a national level.

The work that the Board has undertaken on e-Health has served as an enabling function, ensuring that a full process review has been undertaken, covering processes for water, environmental and clinical microbiology sampling, helping to identify the improvements and incorporating these into a new database system. This has also facilitated the capture of precise data on the location of maintenance activities, for example, in the estates management system, as well as ensuring the capture of water sampling data.

In terms of their work on Duty of Candour, the Board presented impressive evidence, including the implementation of an internal audit process by their internal auditors, Azets, and a revision of their corresponding policy in light of the commentary they have received regarding their perceived insufficiency. **The connection of this Duty of Candour to the IPC issues – which helped lead to escalation – has also been made by the Board. The evidence and the external assurance provided to the AARG bears this out.**

Improvements in NHSGGC's Datix structures have also been evidenced, with the Board improving communication by the introduction of 'end-to-end' data sharing through their Divisional governance, including the use of forums, quarterly summaries and the use of reporters and reviewers. They have also demonstrated evidence of having established effective standard operating procedures (SOP) and a balanced score card as part of this process.

2. Who have they engaged with to bring them to their current place?

From the evidence and assurances provided, the work that the Board has undertaken on Estates and Facilities has been very good, with the appropriate use of experts to help them identify, address and continue to manage the substantial work

that was required to be undertaken. This has been used to bring them to a place where Wards 2A and 2B are due to reopen in October 2021. Additionally, NHSGGC have used their experience to contribute to the national response to IPC, through the Board's IPCT members' involvement in the Covid-19 Nosocomial Review Group (CNRG).

NHSGGC's independent Operational Director for IPC, Professor Angela Wallace (NHS Forth Valley), has provided the Board with robust external assurance, highlighting its "strong assurance, accessible data and strong practice" around IPC, confirming that the 33 recommendations which relate to IPC that were due to completed by the end of August. The evidence, confirmed by Professor Wallace, confirms that the Board has shown significant strengths in how they are engaging with their IPC, the strength of IPC measures, and their corresponding use of data, as well as the way that they are communicating with both their staff and externally. The Board also convened a Water Safety Group and employed an independent Authorising Engineer charged with confirming all work – another exemplar of good practice.

The Board have also established a Care Home team to provide the appropriate support. Further, on 6 August 2021 the National Support Framework for PICU in the RHC was stood down.

What has undoubtedly helped the Board to achieve this, is that they clearly recognised that a central requirement from the reviews was an understanding of the need for change. As such, their employment of Organisational Development (OD) as a tool with which to engage constructively within and across professional teams has helped them facilitate organisational and cultural change.

While IPC was one of the key themes for escalation, the Board's approach to governance and risk was the other. The Board has demonstrated through the evidence provided and at the AARG that they have instituted an approach to governance and risk that can be identified throughout their engagement with addressing the recommendations and the risk management strategy that they have established, including through their Datix work and through dialogue with the Board Development Sessions. Further, the Board is developing a programme of future projects with HFS/NHS Assure to plan future applications of the assurance process, while also appointing a new Senior Risk Officer. Through these activities and processes NHSGGC has shown that they have developed an appetite for risk discussions and that they have brought them into their Board, thereby building corporate knowledge and understanding in the process of doing so.

Additionally, in terms of governance, NHSGGC has demonstrated that they are using internal audit processes, the Royal College of Physicians Edinburgh (RCPE) Quality Governance Collaborative, and Board development sessions focused on the *Blueprint for Good Governance*. From the evidence provided and the discussion of it at the AARG meeting on 19 August, the Board consistently provided strong and robust responses to questions about their internal audit, planning processes and their approach to risk management, including how this informs their Audit and Risk Committee.

Externally, the Board have co-opted the independent Consultation Institute to undertake further engagement with families, through a tailored approach to their initial engagement, supported by guidance and input from Scottish Government. They have also recently recruited a Deputy Director – Public Engagement to a newly created post, to continue to develop progress made.

3. How committed are the Senior Leadership Team of NHSGGC?

The Senior Leadership Team (SLT) at NHSGGC have exhibited evidence of significant improvements in their approach to communication with frontline staff, instituting weekly meetings with the Board Nursing Ward Team and a variety of disciplines, with senior nurses being placed in charge of them. This allows the senior nurses in charge of Ward Teams to challenge on what is and what isn't working. This innovation isn't practiced in many Boards, so is demonstrative of good, innovative practice by NHSGGC, helping staff "speak up together"; a stark contrast to the earlier view expressed in the 'Reviews' of staff being reluctant to speak to each other or to speak up generally. This change suggests that the Board are fostering a more open, transparent and mutually trusting professionalism.

The Board also provided evidence of the fostering of a strong learning culture within and across all of the wards and teams, with the aforementioned senior nurse meetings and meetings with frontline staff. This demonstrates good engagement with people throughout the workforce, while listening, sharing and empowering staff as part of this learning process. This adds another dimension in terms of the depth of leadership that the Board is demonstrating – i.e. they're in the process of enabling and empowering their people.

The SLT has demonstrated a strong commitment to addressing all of the recommendations, even though addressing all of them was not a requirement. They have also sought to do so at pace, though carefully and comprehensively, while having to operate as the largest Health Board in Scotland in the midst of a global pandemic. These overlapping and comprehensive challenges need to be recognised, as does the progress NHSGGC has made in spite of them. The SLT – in terms of the action plans and requested corresponding evidence and in the way they have responded to challenging questions in the AARG – has presented a very coherent, coordinated, focused response to what has been demanded of them. They have responded with impressive clarity and precision to all of the questions asked of them, demonstrating quite clearly that they have developed and improved strong underpinning processes needed to ensure that they move out of and remain out of escalation.

The Criteria for NHS Board Escalation and De-escalation

The Scottish Government *NHS healthcare standards: Board performance escalation framework*[7] allows for decisions on de-escalation to be considered based on the extent and robustness of the evidence provided by the Board under escalation, as well as the response of that Board to challenging assurance and review questioning

[7] Scottish Government (2021) *NHS healthcare standards: Board performance escalation framework*, https://www.gov.scot/publications/nhs-healthcare-standards-nhs-board-performance-escalation-framework/ (10 June)

from Scottish Government officials and professional advisers. As such, the robustness of the evidence and the standard of interrogation of it will require to be professionally objective and open to scrutiny, as appropriate, especially in terms of the decisions made by Scottish Government based on it.

The purpose of escalation – regardless of the absence of any published clear objective criteria – is to ensure that a Board is monitored closely by Scottish Government while they seek to address the issues which have led to escalation in the first instance. If a Board has addressed the issues which led to escalation and the only objective measurement in which to determine this has been met – i.e. robust and verifiable evidence of meeting the recommendations set out in their action plans – then NHSGGC have been considered to have met the objective requirements for de-escalation, including to Stage 2 rather than Stage 3, as they have provided substantial evidence of good and in parts exemplary practice.

Risks for and against De-escalation

Risks for

- There is a risk that (TIART) we will be required to provide an objective justification for this and show underpinning evidence that such a decision will hold up to potential further scrutiny.

- TIART with the backdrop of the Public Inquiry due to begin on 20 September 2021, this brings possible suggestions that we're pre-empting or attempting to influence the outcome of the Inquiry.

- TIART such a decision is likely to be met with significant disquiet from some quarters – the media, Opposition MPs and families affected by the IPC issues at QEUH and the RHC.

Risks against

- There is a risk that (TIART) we will be required to provide an objective justification for this and show that the Board will have had to have demonstrated insufficient progress in addressing the actions arising from the 108 recommendations.

- TIART as there are no published objective criteria for either escalation or de-escalation in Scottish Government's own 'escalation framework', it would be extremely difficult for us to objectively justify the reasons as to why NHSGGC should not have been de-escalated.

- TIART this will draw attention to what objective criteria Scottish Government used to escalate NHSGGC in the first instance. The Board, having undertaken comprehensive work on addressing the actions relating to the 108 recommendations from the 3 Reviews, would likely have sought well-established objective criteria for such a decision, including a possible challenge against the initial decision to escalate them.

Additional Considerations

On 10 December 2019 the then Cabinet Secretary for Health and Sport, Jeanne Freeman made a statement to the Scottish Parliament on the escalation of NHSGGC to Stage 4, reflecting in her statement "the urgency of addressing concerns about infection prevention, control and engagement with patients and families with respect to the QEUH."

As the Cabinet Secretary announced in her statement to the Scottish Parliament that it would be kept abreast of the progress of the Oversight Board and its findings, a consideration for the current Cabinet Secretary of Health and Care is whether an updated statement should be made to the Scottish Parliament on the pending decision regarding the escalation status of NHSGGC.

Given the previous statement was made after NHSGGC was placed into Stage 4 escalation, it would be the presumption that any statement to the Scottish Parliament would follow at an appropriate juncture the decision being communicated to the Board.

Next Steps

- To consider how and when Cabinet Secretary be updated on the decision made by DG-HSC/CE-NHS' recommendation on NHSGGC's escalation status following HSCMBs advice.
- To liaise with Communications colleagues to develop and establish lines to take for subsequent media and public enquiries.
- A draft a briefing outlining the background and the decision for the Cabinet Secretary for Health and Care as well as briefing lines for FMQs.
- To draft a statement from the Cabinet Secretary for Health and Care on the decision made on NHSGGC's escalation status for the Scottish Parliament.

Conclusion

HSCMB are asked to consider and agree the AARG recommendation to the DGHSC/CE NHS that NHSGGC should be de-escalated to Stage 2 of the SG escalation framework.

ANNEX A – Supporting documents provided by NHSGGC

Greater Glasgow and Clyde (2021) *Copy of AARG – Master Independent Review Action Plan – Final 13th* (12 August 2021)

Greater Glasgow and Clyde (2021) *Copy of Copy of AARG – Master OB Action Plan – Final 13th* (12 August 2021)

NHS Greater Glasgow & Clyde (2020) *Standard Operating Procedure (SOP) 1.1.1 for Minimising the Risk of Pseudomonas Aeruginosa Infection from Water; 1.1.2 Applicable in All Adult And Paediatric Intensive Care Units and Neonatal Units (Levels 1, 2 and 3)*, Version 4 (Effective From October 2020 / Review Date October 2022)

NHS Greater Glasgow & Clyde Control of Infection Committee (2021) *Infection Prevention & Control Team (IPCT) Incident Management Process Framework* (www.nhsggc.org.uk/your-health/public-health/infection-prevention-and-control)

NHS Greater Glasgow & Clyde Control of Infection Committee (2020) *Audit Schedule and Process Infection Prevention and Control Audit Tool (IPCAT) Strategy* (https://www.nhsggc.org.uk/your-health/infection-prevention-and-control/) (Effective From November 2019 / Review Date November 2021)

NHS Greater Glasgow & Clyde (2021) *Ward 6A QEUH Enhanced Supervision Report, April 2020-March 2021* (Cn - 5.4 - Enhanced Supervision Report - Aon - 210611)

Greater Glasgow and Clyde (2020) *Outbreak and Incident Management Plan* (Version 4 Final) (February 2020)

Greater Glasgow and Clyde (2020) *Paediatric Line-Related Sepsis Management Guidelines*, Lead Authors [redacted], Consultant Microbiologist, QEUH, Dr Louisa Pollock, Consultant Paediatrician, RHC (Approved February 2020 / Review Date February 2023)

Greater Glasgow and Clyde (2021) *Case Note Review Actions 3.1 3.3 10.1 10.2 eHealth Actions Evidence Report* (Version 1.2) (22 July 2021)

Greater Glasgow and Clyde (2021) *Case Note Review Actions 3.1 3.3 10.1 10.3 Short Report* (Version 2.0) (22 July 2021)

Greater Glasgow and Clyde (2020) *Standard Operating Procedure: WQS-017 Procedures in the event of out of specification sample for Legionella and other monitored bacteria, moulds etc.* (Version 2) (19 August 2020)

Greater Glasgow and Clyde (2021) *Infection Prevention and Control Assurance and Accountability Framework* (Version 2) (April 2021) (Approved 21 April 2020 / Review Date April 2022)

Greater Glasgow and Clyde (2021) *Final 14 – Policy and Procedure: Duty of Candour Compliance* (Draft Policy) (OB - Final 14 - Duty Of Candour Draft Policy - JA - 210729)

HEALTH AND SOCIAL CARE MANAGEMENT BOARD
Minutes of Meeting held at 09:00 am on Wednesday 15 September 2021

Present:		
until 1000	Caroline Lamb	Chief Executive NHS Scotland and Director-General, Health and Social Care (Chair)
(Chair 10-11)	Richard McCallum	Director of Health Finance and Governance
	John Burns	Chief Operating Officer for NHS Scotland
	Gregor Smith	Chief Medical Officer for Scotland
	Jason Leitch	National Clinical Director Scotland
	Linda Pollock	Interim Director, Healthcare Quality and Improvement
	Donna Bell	Director of Mental Health and Social Care
	Richard Foggo	Director of Covid Public Health
	Christine McLaughlin	Director of Testing
	Iona Colvin	Chief Social Work Adviser
	Jonathan Cameron	Interim Director of Digital Health and Care
	Michael Kellet	Interim Director of Population Health
	Christine Ward	Deputy Director, CNOD
	David Miller	Chief People Officer, NHS Scotland (for Gillian Russell)
	Naureen Ahmad	Deputy Director General Practice Policy Division (for Tim McDonnell)
	Mairi Macpherson	Deputy Director, Improving Health and Wellbeing (for Michael Chalmers)
Apologies:	Tim McDonnell	Director of Primary Care
	Gillian Russell	Director of Health Workforce
	Michael Chalmers	Director of Children and Families
	Anne Armstrong	Mental Health Nursing Advisor
	Stephen Gallagher	Director of Vaccination Strategy and Policy
	Penelope Cooper	Director for Covid Coordination
	Rachel Jenkinson	Head of Corporate Assurance
	Stephen Lea Ross	Deputy Director, Health Workforce
	Jane Hamilton	Head of Business Management and EU Withdrawal
In Attendance:	Robert Kirkwood	Head, Office of the Chief Executive NHSScotland
	Gwen Nicholson	Office of the Chief Executive NHSScotland
	Jack Downie	Office of the Chief Executive NHSScotland
	Kevin Farquharson	Office of the Chief Executive NHSScotland
	Frances Conlan	DG HSC Support Office
	Julie Dick	DG HEC Support Office
	Kirsteen McColl	DG HSC Support Office
	Gavin Reid	Head of Portfolio Management Office
	Andrew Wilkie	Head of Corporate Communications
	Malcolm Summers	Head of Strategic Reform
	Carole Finnigan	Programme Officer, Strategic Reform
	Anita Morrison	Head of Health and Social Care Analysis
	Kim Walker	Programme Director, PgMS, NHS NSS
	Roa Johnstone	Programme Manager, PgMS, NHS NSS
	Irene Barkby	Professional Nursing Advice, Infection Prevention and Control
	Shalinay Raghavan	Head of QEUH Independent Review
	David Crossman	Chief Scientist
	Delina Cowell	Chief of Staff to CMO

Item 1: Welcome, Introductions and Apologies for Absence

1.1 The Chair welcomed attendees. Apologies were noted, as above.

1.2 The Chair advised that, whilst this Management Board meeting would focus primarily on the Care & Wellbeing programmes, as set out at the previous day's Directors Call, there was one item which would normally come to the Business agenda HSCMB meeting, which required to be taken at this meeting. To allow for as much time as possible to discuss the Care & Wellbeing Programmes (and because the Chair had to leave for a call at 10am), this item would be taken as the first substantive item. The Chair would hand-over to Richard McCallum, Director of Health Finance and Governance at 10am.

Item 2: Minutes of the Meeting of 25 August 2021

2.1 The minutes of the Meeting of 25 August 2021 were agreed as an accurate record.

2.2 A new HSCMB Action Log had been circulated with the papers. This had been designed to assist with more effective action tracking and Secretariat would ensure that it was regularly updated.

Item 3: NHS GGC escalation review based on the outcome of the QEUH / RHC Advice, Assurance & Review Group (AARG) (HSCMB/100/2021)

3.1 The Chair asked non HSCMB Members and those who were not usually in attendance to leave the meeting while this item was discussed, and to join again for their respective agenda items when prompted to do so by the Secretariat.

3.2 John Burns, Chief Operating Officer for NHS Scotland, introduced the paper which provided an update on the work undertaken by the AARG regarding NHS Greater Glasgow and Clyde's (NHS GGC) escalation status; and, based on the recommendation of the AARG, sought advice on the proposal to the Director General Health and Social Care / Chief Executive NHS Scotland (DG-HSC/CE-NHS) and feedback on next steps.

3.3 John Burns advised that he had chaired the last AARG meeting which had received assurance on the arrangements in place for infection control, assurance on the active governance of infection and control being enforced across the NHS GGC system, and the improvements in communications in place. Assurances had been received that the senior leadership team were engaged and fully committed.

3.4 On 22 November 2019, NHS GGC was escalated to Stage 4 of the NHS Board Performance Escalation Framework. HSCMB was invited to consider the evidence provided by NHS GGC to the AARG and advice to DG-HSC/CE-NHS that NHSGGC had substantially met, and in some instances exceeded, the evidential requirements against the overwhelming majority of the 108 recommendations, and would complete the rest by the end of September 2021. The recommendation was that NHS GGC be de-escalated from Stage 4 to Stage 2, in accordance with the Stage 2 definition in the escalation framework that there may be "some variation from plan; possible delivery risk if no

action", with Scottish Government providing "advice and support" and increased surveillance and monitoring, if necessary.

3.5 As part of the ongoing assurance arrangements, NHS GGC would provide a monthly exception report in respect of the action plan. Additionally, the Chief Nursing Officer and Chief Operating Officer would meet quarterly with the Chief Executive and members of the senior team of NHS GGC. These assurance arrangements would be kept under review.

3.6 The discussion included: seeking clarity on who gave assurance on the estate and facilities activity; reflection on how governance is assessed and that Richard McCallum would discuss with the Head of OCENHS; noting NHS GGC escalated for finance but not for workforce which is interesting when we see how critical workforce is now; Public Inquiry due to begin; escalation process and timing consideration for any de-escalation; consideration on the efficacy of the current escalation framework and what could be done to improve it; proving that extra layer of governance and assurance for Scottish Ministers for taking urgent action; estates and facilities – NHS Assure and Health Facilities Scotland working with Glasgow to develop a dashboard, a new level of brining intel together; scoping an HAI refresh for the country; applying learning from Vale of Leven and Covid-19; leadership of infection prevention and control; oversight and challenges; cognisance of the size of NHS GGC; action plan; progressing the strategy; looking at securing resource/workforce; saw the sea change, change of ownership and acceptance that things had to be done differently and demonstrate that; On governance, we asked and were given evidence – a key point; external engagement; important aspect is what we have learned from the situation in Glasgow, not just what Glasgow has done in response; need to be mindful of the impact escalation has on the Board and staff working in NHS GGC; sharing learning and linking with the National Planning and Performance Oversight Group (NPPOG) team on the work done and assessments made to inform the escalation framework.

ACTION No 73: Richard McCallum to pick up on the NHS GGC governance arrangements with Robert Kirkwood, OCENHS.

3.7 In summary, the Chair noted the common theme in the discussion of revisiting the escalation framework to ensure it was fit for purpose and the important piece on how we share the learning and the broader work that this has triggered. There was acknowledgement that NHS GGC had done an enormous amount of work. The Director-General took the advice of HSCMB and was supportive of de-escalating NHS GGC to Stage 2, acknowledging the work done and the action taken. The Director-General would reflect on the work involved in the next step of taking the recommendation to portfolio Ministers for a final decision. Thanks were offered to John Burns and the CNOD team for their work and for bringing the item.

3.8 HSCMB then discussed the upcoming Glasgow Public Inquiry, noting that an update on logistics, proceedings and support would be required for members, as some would be likely to be called as witnesses. CNOD was in dialogue with the Inquiry Team and briefing would be prepared and circulated.

ACTION No 74: CNOD to prepare and circulate briefing on the upcoming Glasgow Public Inquiry.

Care and Wellbeing Portfolio

4.1 The Chair introduced the Care and Wellbeing Portfolio section of the meeting. Following a discussion at a Directors call on Tuesday 14 September 2021, points for consideration included:

- what we are here to do;
- clarity on purpose and benefits; and
- maintaining a whole approach (not just Health), It was right that it was led from DG HSC, but it had been noted that cross-government working would be critical to the success of the programmes.

Item 4: Portfolio Mission and Outcomes (HSCMB/101/2021 Slide Presentation)

4.2 Richard Foggo, Director of Covid Public Health, introduced the item, expressing that the need for cross government coherence was critical for optimum outcomes and benefits and that there should be method behind it, and a logical structure that connects to ambition. The Care and Wellbeing portfolio was being set up to deliver the collective mission "after Covid, working together to improve Scotland's wellbeing" in order to improve population health and reduce health inequality.

4.3 Anita Morrison, Head of Health and Social Care Analysis, provided HSCMB with a short presentation, following on from a strategic session with the Cabinet Secretary for Health and Social Care on 4 August 2021.

4.4 The care and wellbeing programmes were in place to provide a coherent cross-cutting approach to systems and delivery. To ensure these best feed into our overarching vision for improving population health and to bring coherence and (in time) a tool for prioritisation, a Care and Wellbeing Outcomes Framework would sit above the four Care & Wellbeing programmes. The Framework would set out intermediate outcomes and key metrics to show performance against these outcomes.

4.5 There was a wealth of data, standards and outcomes used across health, and it currently felt fragmented. HSCMB was asked to consider whether better linkage from outcome to delivery was required starting with a mission and national outcomes, noting that key outcomes, such as population health, move very slowly. Nonetheless, Anita suggested that there is an important opportunity under the new portfolio arrangements to agree single overarching outcomes for the portfolio, aligned to the National Performance Framework (NPF), and to develop a stronger performance and governance framework around the 4 programmes.

4.6 To inform the discussion, the following questions were posed:

- This has been framed in terms of improving population health (and reducing inequality) as overall focus of portfolio. Is this the best framing? Is it both or do we concentrate on reducing inequalities?
- Do we have a good (and honest) sense of where we are now on achieving mission? How might DG/SG/PHS go about assessing Scotland's position on investments, legislation, interventions to achieve mission - what more, what pace, what scale?

- Do the examples provided offer a useful approach to link outcomes to delivery? What modifications would make them more useful?
- If the approach seems useful what would be the process and timeframe and how ready are the 4 programmes to be able to contribute?

4.7 The discussion included: interconnectivity and doing things in a different way; services being clustered around people; healthy weight and life expectancy; how best to structure; thinking more broadly to change culture; indicators in children's services; Some helpful new policies to tackle diet and access to outdoors beginning this year - commencement of Milk and Healthy Snack Scheme from 1 August 2021 and first tranche of £60m for play park renewal but impact will be long term; Family Nurse Partnership now spread Scotland-wide and a decade old. Starting to see real benefits particularly in school-readiness; having something around ACES which are both a symptom and a cause of inequalities which lead to health inequalities and allows us also to focus on children and their families in preventative and early intervention activities; looking at people as a whole; person-centred focus; supportive of developing a model to help map outcomes to delivery; recognition that if we don't set expectation in a measurable way, it probably won't happen; the focus today needs to be on the aim and what's going to galvanise; being accountable for actions to improve population health. We need to be accountable, but also create a system where that accountability is pervasive across our health & social care delivery system and beyond; if it doesn't contribute to the aim, not doing it; moving the agenda forward; improving population health and inequalities; recognition that systems were complex; recognition that people were supported by a number of communities.

4.8 Caroline Lamb handed over to Richard McCallum to chair the latter half of the meeting, before departing for her next meeting.

4.9 The discussion continued: model for improvement; formulating an aim; that analysis should not drive aim but be in service to it; long term activity; Getting It Right for Every Child (GIRFEC); structural challenges; learning and opportunities; whole context; driver diagrams; helping with the wider learning opportunities across the portfolio and across government; aim driven by desire for the people of Scotland to live healthier lives; important to remember not starting from scratch; thinking in terms of People and Place; looking at personae; looking at what works well; local community planning assumptions being variable across the country; and, opportunity to create a prototype, to test thinking.

Item 5: Programme Charter Themes (HSCMB/102/2021 Slide Presentation)

5.1 Following on from the previous, linked agenda item, Malcolm Summers, Head of Strategic Reform, introduced the item, expanding on the wider agenda point and setting the direction. Three broad portfolio objectives included coherence, sustainablity and outcomes.Coherence aims included: improved strategic coherence with alignment across SG and within the portfolio; and, improved delivery coherence, a genuine whole system strategy. Sustanability aims included: increasing sustainability through innovation and new working practices; redesigning the system around the citizen; and work across government focusing on people and place, planning expenditure on health and social care as an investment in communities, in employment and in the future health and wellbeing of all. The portfolio outcomes focus was on improving population health and reduce inequality, putting population health on the same footing as system efficiency and

prioritising prevention; and, supporting improved data to enable an understanding of pressures, performance, consistency & improvement not just in the acute sector but also making the connections to primary, community and social care and wider population health measurement.

5.2 Kim Walker, Programme Director, PgMS, NHS NSS, offered observations that the portfolio mission needed to be more visible and clearer, with outcomes that programmes could connect to; a communications and engagement strategy to raise awareness/visibility; and, portfolio infrastructure, decision making and reporting framework to provide assurance.

5.3 Observations gathered from baseline data included the need for: greater coherence between programmes and portfolio mission and SG and system; more emphasis on person-centred, prevention, whole system and interdependencies between programmes; clarity on requirements for enablers across programmes to support planning and prioritisation; and, balance between addressing current system pressures and sustainable whole system change.

5.4 Malcolm Summers then offered a high level summary of future opportunities and challenges for the four Care and Wellbeing Programmes - Place and Wellbeing, Preventative and Proactive Care, Integrated Planned Care, and Integrated Unscheduled Care.

5.5 The discussion included: having a clearer mission; how to move on; keen to hear from the Leads of the various programmes; picking up the links between the drugs mission and the care and wellbeing programmes; importance of sustainability; sustainability of services – change in demography and lifestyle, demand and need; stopping less useful workstreams; professional practice and influence; getting out of low value interventions; better allocation of resources; use of programme budgets at a local level to target approaches; requiring a vehicle to carry it forward; planning and unscheduled care; pathfinder projects; being ready to reset; enablers; components for success; considering what success looks like; timeframes and the need to be agile; cognisance that our world is changing all the time; recognising the changing environment; staffing; moving in a complex eco system; understanding what system leadership is required; discussions with NHS Board Chief Executives; requiring single system and professional leadership; levers and control; culture, practice and professional behaviours; collaboration across agencies and professions; not being driven by individual goals; Ministerial direction to work differently; opportunities to lead by example; recognition of people being in families and communities if we want to change the future; need to work cross government; expect Health Boards and Social Work to work together - what H&SC Integration all about; cognisance that new ways of delivering and performing came out of the pandemic; and, opportunity to lead and for new culture.

5.6 The discussion continued with: developing a practice model/driver diagram; setting different expectations; having a mission but needing a diagnosis for measurable change; needing enough clarity at all stages to prioritise; more work to be done; more that can be used for next iteration; SROs playing their part; all taking something away from the discussion; and, recognition that can't create it all at portfolio level; thinking about whole population approaches. Health visiting is a universal service but we provide more support in a tiered way where needed; central to this will be key political choices

about the extent to which excess deaths (including drug deaths), premature disability and long-term health inequalities are prioritised alongside many other competing demands on health and social care services; need to focus on whole population health but if we do not also have a focus on inequalities, then the gap will continue to widen and those with least will continue to have worst outcomes as will their children; it is important to see people in the context of their family and their community; a primary driver being politics and political will; Gold Command meeting for Digital immediately after HSCMB to prioritise demand, and address significant pressure on delivery partners; reflecting that Preventative and Proactive Care Programme (and Place and Wellbeing) feel very adult-centric. PfG commitment to £500m Whole Family Support (and preventative child health services like midwifery, school nursing and health visiting) should feature more strongly; PPC could be more comprehensive across the life cycle from a children and families perspective- this thinking is being done, but not fully reflected here; welcome engagement with PPC to understand any potential requirements for Digital - light in this area at the moment; Child health work is already in place and should feature - we have workforces who can play a strong role in GIRFEC; the family support work is part of P&P - recognition that we can't do everything immediately so have started there, happy to pick up offline; cautioning against placing as much stock on a mission - can refine (a clearer focus on population health is the refinement we are proposing); creating the conditions for change, culture and calling out some fundamental barriers; change of culture and refreshed purpose in existing workforces can unlock powerful preventative/proactive care. This won't happen on its own but we can think together about the role our workforces can play. New multi-disciplinary working approaches already showing results in local contexts where this is being tested; we need to know what we're trying to do - at the top and for each programme and how the programmes connect to help us deliver collectively; aiming for health life expectancy, even a reversal of falling life expectancy and narrowing of gender gap and socioeconomic LE gap.

5.7 The Chair thanked Anita Morrison, Malcolm Summers and Kim Walker for their presentations which generated a good discussion, recognising that there was lots to build on. There was scope to continue discussions at the Tuesday morning calls and Directors were encouraged to support that endeavour as it developed.

Item 6: Innovation Adoption Service

National Adoption, Scaling and Implementation Service (HSCMB/103/2021)

6.1 Christine McLaughlin, Director of Testing, introduced the paper which updated HSCMB on the creation of an adoption, implementation and scaling service at the Centre for Sustainable Delivery (CfSD) following discussion of paper HSCMB/090/2021 at the meeting of the 11 August 2021, and to seek approval for funding to establish a core service at the CfSD.

6.2 HSCMB was invited to:

- approve in principle, core funding (of up to £800K per annum, of which £370k was approved for 2021/22) to establish an adoption implementation, and scaling service at the CfSD and allow the recruitment of core resource;
- note that a workshop would be organised to define a clear commission for this new service, the outcomes of which would be reported back to HSCMB and through the Innovation workstream of the Care & Wellbeing Portfolio;

- note the identification of a current gap in strategic leadership, structures and resources to support the change required in our Health and Care services and the wider Scottish economy.

6.3 David Crossman, Chief Scientist, noted the links to the discussion for the previous agenda item. Recognising the positioning of CfSD in its innovation role, he recommended that HSCMB take a more overt commissioning role for the innovation pathway. Next steps would include arranging a workshop will all those involved in establishing this new service, including NSS, HIS and SHIP, to define a clear and formal commission to CfSD for the required outcomes of this work.

6.4 The discussion included: acknowledgement that the workstream needed to be progressed; support for the proposal, with caveats around who would commission CfSD, the conversations to be had, and the mapping required; noting the proliferation of innovation not necessarily being captured and need for clarity of roles of NSS, HIS – including SHTG; the need for integrated innovation; need to revisit commissioning from CfSD, to be sure what is required; the scale of implementation being key; support with these conditions from workforce perspective; supportive of CfSD tenancy approach; more work needed on Digital and how resources could be used on a regional basis to scale up; working with Universities involved in social work & care through the Social Work Education Partnership - part of this is looking at innovation and excellence in care - linking this work into portfolio; and, how this will inter-relate with CSO and the work they fund. It was noted it was important this work was directed by and reported back into HSCMB given the breadth of the connections.

6.5 HSCMB noted the recommendations and approved the funding request, as set out in the paper, noting the further work to be done. Christine McLaughlin thanked HSCMB for its comments and would progress with the Workshop on Innovation arrangements.

Item 7: Any Other Business (AOB)

7.1 AOB items included:

- Primary Care Debate in the Scottish Parliament on track;
- service pressures – focus on input and colleagues thanked for their input and ongoing support. Preparations were being made for Ministerial briefing;
- certification becoming a larger issue;
- Cervical Screening update in the Scottish Parliament;
- Covid-19 – a small uptick in cases noted and over 60s hospital admissions rising. Data being examined for over 70s and over 80s;
- COP26 – examining and learning from the modelling for the event and looking at the dynamics of the risks;
- Stakeholder management and a note for DG to raise at ET; and
- NHS Awards to be held on 4 November 2021 with some astonishing work having be recorded in the submissions which was truly inspiring.
- Conservative debate today on resumption of GP services including face to face appointments by a 'target date' in hand. Speeches and briefing with Ministers.

7.2 There were no other items of business. The Chair thanked attendees and closed the meeting.

The next Health and Social Care Management Board meeting (a Ministerial HSCMB) will be held on Wednesday 29 September 2021 at 9:00 am.

From: Ward C (Christine)
Sent: 25 November 2021 10:45
To: White C (Craig); Roberts A (Anncris); Barkby I (Irene); Birch J (Jason)
Cc: Nicol L (Lynne); Pollock LA (Linda); Burns J (John); Chief Nursing Officer
Subject: RE: Submission on aspergillus in the QEUH

Hi all

Just to confirm the version in the FM pack does not include the level of detail below so there should be no risk of incorrect reporting today. We will, of course, change the wording going forward.

Regards

Christine

Christine Ward | Deputy Director | Chief Nursing Officer's Directorate | Scottish Government
Tel : [redacted] **email:** [redacted]

From: White C (Craig) [redacted]
Sent: 25 November 2021 10:22
To: Roberts A (Anncris) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Birch J (Jason) [redacted]
Cc: Nicol L (Lynne) [redacted]; Pollock LA (Linda) [redacted]; Burns J (John) [redacted]; Chief Nursing Officer [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Hi, yes

Geraldine Jordan, Director of Clinical and Care Governance

See item-19dii-paper-ccgc-m-21_01-final.pdf (nhsggc.org.uk) for confirmation of same.

Craig

Professor Craig White
Deputy Director
DG Health and Social Care | Scottish Government| M: [redacted] | E: [redacted] |Twitter: [redacted]



From: Roberts A (Anncris) [redacted]
Sent: 25 November 2021 10:05
To: Barkby I (Irene) [redacted]; White C (Craig) [redacted]; Ward C (Christine)

[redacted]; Birch J (Jason) [redacted]
Cc: Nicol L (Lynne) [redacted]; Pollock LA (Linda) [redacted]; Burns J (John) [redacted]; Chief Nursing Officer [redacted]
Subject: RE: Submission on aspergillus in the QEUH
Importance: High

Hi all
Apologies I have been having IT issues this morning and have just seen this. I am happy with this from my perspective (assuming that Geraldine is the Director of Clinical governance)
Anncris

Sent with BlackBerry Work (www.blackberry.com)

From: "Barkby I (Irene)" [redacted]
Sent: 25 Nov 2021 10:00
To: "White C (Craig)" [redacted]; "Ward C (Christine)" [redacted]; "Birch J (Jason)" [redacted]
Cc: "Roberts A (Anncris)" [redacted]; "Nicol L (Lynne)" [redacted]; "Pollock LA (Linda)" [redacted]; "Burns J (John)" [redacted]; Chief Nursing Officer [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Thanks Craig this is helpful clarification.

Christine,

Conscious things are moving fast this am. Can the wording be amended to that which Craig has suggested?

Irene

Irene Barkby MBE
Associate Chief Nursing Officer – HAI/AMR/COVID Response
Chief Nursing Officers Directorate
Scottish Government
2 St. Andrews House,
Regent Road,
Edinburgh
EH1 3DG

[redacted]

Mobile Number: [redacted]

From: White C (Craig) [redacted]
Sent: 25 November 2021 09:51
To: Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Birch J (Jason) [redacted]
Cc: Roberts A (Anncris) [redacted]; Nicol L (Lynne) [redacted]; Pollock LA (Linda) [redacted]; Burns J (John) [redacted]; Chief Nursing Officer [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Morning Irene

The paragraph appeared in a paper submitted to the September AARG (author John Lewis, Director John Burns), though as previously stated at the meeting itself I asked NHSGGC colleagues for further details on this work and from memory their Medical Director confirmed that their review of the organisational duty of candour work was a desktop review that did not involve engagement with any staff or patients and families, nor look at outcomes – ie. it was an internal audit perspective based on review of documentation which may have included the Board's revised organisational duty of candour policy (though I don't know this for sure as I don't think the AARG was provided with a copy of the internal audit as such). I have searched for the minute of the meeting but don't think I have received this.

In terms of revised wording for any background briefing, I would suggest the following to be more accurate based on my recollection of the September AARG meeting at which the original document containing the "impressive evidence" and "perceived insufficiency" wording.

[proposed revision - start]

In terms of their work on organisational duty of candour, the Board commissioned a review by their internal auditors, Azets. This was a desktop review which considered changes in the Board's organisational duty of candour policy made following recommendations by the Oversight Board. The AARG encouraged the Board to ensure that their ongoing assurance work on these changes considered the effectiveness of implementation and took account of the impact on staff, patients and families. Officials have continue to engage with the Board's Director of Clinical Governance on Oversight Board recommendations on the application of the organisational duty of candour procedure to instances of hospital acquired infections.

[proposed revision – end]

Anncris, can you confirm you are content with the proposed revisions to reflect our engagement with Geraldine (NHSGGC) and Karon (NHS Lanarkshire) on the HAI/Covid guidance which is in part related to the Oversight Board's recommendations re organisational duty of candour.

Best wishes,

Craig

Professor Craig White
Deputy Director
DG Health and Social Care | Scottish Government| M: [redacted] | E: [redacted] |Twitter: [redacted]

From: Barkby I (Irene) [redacted]
Sent: 25 November 2021 09:18
To: White C (Craig) [redacted]; Ward C (Christine) [redacted]; Birch J (Jason) [redacted]
Cc: Roberts A (Anncris) [redacted]; Nicol L (Lynne) [redacted]; Pollock LA (Linda) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Morning Craig,

The statement below was lifted from a Briefing to Cab Sec on the proposal to deescalate GG&C. It is therefore already in SG documents as a statement of fact, although not sure who exactly crafted the statement. As far as I am aware that appendix is for info only for FM and not for stating.

Would you have alternative wording you would wish to suggest?

In terms of their work on Duty of Candour, the Board presented impressive evidence, including the implementation of an internal audit process by their internal auditors, Azets, and a revision of their corresponding policy in light of the commentary they have received regarding their perceived insufficiency. The connection of this Duty of Candour to the IPC issues – which helped lead to escalation – has also been made by the Board. The evidence and the external assurance provided to the AARG bears this out

From: White C (Craig) [redacted]
Sent: 25 November 2021 08:51
To: Ward C (Christine) [redacted]; Birch J (Jason) [redacted]
Cc: Roberts A (Anncris) [redacted]; Nicol L (Lynne) [redacted]; Pollock LA (Linda) [redacted]; Barkby I (Irene) [redacted]
Subject: FW: Submission on aspergillus in the QEUH

Morning Christine/Jason,

I note that this submission to FM refers to impressive evidence on organisational duty of candour - as far as I recall the Advice, Assurance and Review Group didn't review specific evidence on this and, to my knowledge neither have the policy team. I do recall asking some questions about this at an AARG meeting and was advised that the work of their internal auditors was limited to a desktop exercise and didn't consider staff or patient/families experiences.

In my opinion, there are risks in providing such a bold statement on this in an FM briefing and would recommend that this is revised.

Craig

Professor Craig White
Deputy Director
Health and Social Care Directorates
Scottish Government

M: [redacted] | E: [redacted] |

Working from home - I work core hours flexibly around caring responsibilities so there is no expectation of a response to any email sent when outside recipients working hours.

****Sent from iPhone which may account for brevity or typos****

Scottish Government
Riaghaltas na h-Alba
gov.scot

From: McKerron R (Rosie) [redacted]
Date: Wednesday, 24 Nov 2021, 11:41 pm
To: Birch J (Jason) [redacted], Fallis R (Russell) [redacted], First Minister [redacted], Chief Nursing Officer [redacted], Cabinet Secretary for Health and Social Care [redacted], Minister for Public Health, Women's Health & Sport [redacted], Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted], DG Health & Social Care [redacted], McMahon A (Alex) [redacted], Smith G (Gregor) [redacted], Chief Medical Officer [redacted], Leitch J (Jason) [redacted], Bain MB (Marion) [redacted], Armstrong A (Anne) (Health) [redacted], Burns J (John) [redacted], Barkby I (Irene) [redacted], Ward C (Christine) [redacted], Ross E (Elaine) [redacted], Allan L (Lara) [redacted], Hutchison D (David) (Special Adviser) [redacted], Hamilton E (Emma) [redacted], Shepherd L (Lesley) [redacted], White C (Craig) [redacted], Taylor M (Mark) [redacted], Aitken L (Louise) [redacted], Paterson M (Matt) [redacted], Powell L (Lisa) [redacted], Kerbalai S (Syed) [redacted], McPherson G (Grant) [redacted], Wilson L (Lee-Ann) [redacted] Graves-Morris C (Charlotte) [redacted], Nurse M (Molly) [redacted], Communications Health & Social Care [redacted], McAllister C (Colin) [redacted], Kay L (Louise) [redacted], Gregg N (Naomi) [redacted], Raghavan S (Shalinay) [redacted], Campariol-Scott C (Carole) [redacted], Sharp G (Gary) [redacted], Hegarty L (Lee) [redacted], First Minister FMQs [redacted], Chief Nursing Officer [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Jason, colleagues

Many thanks for the work on this especially given the lateness of the hour. Having discussed with Jason, I have sought to restructure some of this into lines for FM to deploy.

Davie – grateful for your views on the attached. I took some of the material from the timeline in the original FMQ (which FM has in her overnight pack – attached) to create the lines on pre-NHSGGC entering special measures. I'm not sure we need Annex B but will leave you to confirm.

As you know FM, wanted this info asap so I'm planning to have it on her desk by 8.30 tomorrow, so very grateful for views before then. I understand Christine will be online early tomorrow to pick up any further requests.

Thanks
Rosie

From: Birch J (Jason) [redacted]
Sent: 24 November 2021 22:42

To: Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; McKerron R (Rosie) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Rosie, Russell,

Further to the above, pleas find attached a separate FMQ as requested.

Regards

Jason

Jason Birch | Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | M [redacted] | [redacted]

From: Fallis R (Russell) [redacted]
Sent: 24 November 2021 19:59
To: Birch J (Jason) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole)

[redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; McKerron R (Rosie) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Jason

You spoke with my colleague Rosie on the FM's further asks on QEUH which she would like back later this evening – **ideally by 9.30pm.**

In a separate FMQ note (don't update the existing FMQ on QEUH as FM has this with her this evening), please can you include background and lines for FM to deploy on:

1) What we've instructed on the Andrew Slorance case – so, narrative of the information you've listed below but also including who in NHS Lothian has been instructed to take forward the external review and the timeframe attached.

2) A list of actions on infection prevention and control in NHSGGC/QEUH since:
(i) NHS GGC was escalated to stage 4 for infection control etc (examples of improvements that have been made)
(ii) a list of actions taken prior to that point in the preceding 12 months
(iii) what scrutiny measures HIS are taking in relation to cases of aspergillus (external review of cases etc)

I will need all of the above in one FMQ with clear separation of background material (if sensitive and for FM info only) and then lines to take so FM is able to narrate SG and HS action taken.

I understand Spads will feedback separately on the letter tomorrow.

Thanks
Rosie

Russell Fallis | Head of FMQ Team, Scottish Government | [redacted]

-------- Find out more on Preparing First Minister's Questions (FMQs) --------

From: Birch J (Jason) [redacted]
Sent: 24 November 2021 19:05
To: First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi)

[redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Fallis R (Russell) [redacted]

Subject: RE: Submission on aspergillus in the QEUH

Patrick,

Thank you for the message. In terms of the First Minister's points:

Professor McMahon has today written to NHS GG&C to confirm that there will be an external review of Mr Slorance's case notes by NHS Lothian. The Interim CNO has also written to NHS Lothian to request that this external assurance is carried out as a matter of urgency.

I have included draft text below for a letter to be sent to Mrs Slorance from the First Minister and I understand that you will have the contact details and therefore be able to confirm the message has been received by Mrs Slorance.

The independent external peer review of the case notes will consider the care and treatment including what and how this has been communicated with the patient and the family. In particular it will consider and seek assurance of the following areas which are covered by NHS GG&C's internal review:

- Pre-ICU Care summary
- ICU Care summary
- Patient journey through the Queen Elizabeth University Hospital
- Acquisition of COVID-19 by Mr Slorance
- Infection assessment
- Treatment given to Mr Slorance in relation to:

i. Covid-19
ii. Anti-fungal
iii. Communication with patient

In relation to the HIS inspections, there is an unannounced inspection of the QEUH in the upcoming HIS inspection schedule. We have also requested advice from NHS Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) in relation to data and evidence available on cases of Aspergillus.

I hope that this is helpful.

Kind regards

Jason

<u>Suggested draft letter from the First Minister to Mrs Slorance</u>

Dear Mrs Slorance,

I am writing to you to once more offer my heartfelt condolences on the loss of Andrew, at this especially difficult time in the lead up to the first anniversary of Andrew's death.

Andrew was a much valued and well respected colleague and he is sorely missed.

I wanted to tell you that NHS Greater Glasgow & Clyde are in the process of undertaking an internal review of Andrew's care and treatment and their communications through a case note review. The outcome of this review will be reported to the Interim Chief Nursing Officer, Professor Alex McMahon.

Professor McMahon has also commissioned a process of external assurance in relation to Andrew's care and treatment and how the details were communicated to you. This independent external peer review will be led by NHS Lothian's Medical Director and will provide further reporting directly to Professor McMahon.

I will of course keep you updated as these reviews proceed and I understand that Professor McMahon has asked NHS Lothian to undertake their part of the review as a matter of urgency. Should you have any further questions, please do not hesitate to get in touch.

Yours sincerely

Jason Birch | Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | M [redacted] | [redacted]

From: Crolla P (Patrick) [redacted] **On Behalf Of** First Minister
Sent: 24 November 2021 17:35
To: Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]; First Minister [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Birch J (Jason) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Fallis R (Russell) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Gayle,

The First Minister was grateful for the submission.

She wishes this issue to be progressed as follows:

- In relation to the question of a case note review of Andrew Slorance's specific case:
  - There should be a case notes review and it should be externally assured (external, that is, to GCC).

- It would be preferable for this review to be initiated by the SG (presumably by the CNO).
- We should communicate this news to Mrs Slorance in the course of tomorrow morning. Her view is that this is best done by a letter from the FM to Mrs Slorance and she would be grateful if this can be prepared as a matter of urgency.
- She would wish to have confirmation by 1130 that this letter has been successfully received by Mrs Slorance.
- She will require briefing on the review, it's process, who is conducting it etc that she can use at FMQ's. She will need this as soon as possible tomorrow and no later than 1000.

- In relation to a more general review of instances of aspergillus that Mrs Slorance has called for, the FM would like further clarity on what can be said on this point. For example, can she say that HIS will conduct a round of inspections as discussed at paras 11 and 12? If not, she is minded to confirm that we are considering a wider review. Again, she will need this as soon as possible tomorrow and no later than 1000.

Many thanks,

Pat

Patrick Crolla
Deputy Private Secretary
Office of the First Minister
5th Floor | St Andrews House | Regent Road | Edinburgh | EH1 3DG | [redacted] | [redacted]

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From: Williamson G (Gaye) [redacted] **On Behalf Of** Chief Nursing Officer
Sent: 24 November 2021 13:53
To: Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]; First Minister [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Chief Nursing Officer [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Birch J (Jason) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole)

[redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]

Subject: Submission on aspergillus in the QEUH

SENT ON BEHALF OF THE INTERIM CHIEF NURSING OFFICER

PS/Cabinet Secretary Health and Social Care

Please find attached a submission which provides an update on the issues connected with aspergillus at the QEUH, NHS GGC, for the Cabinet Secretary's urgent attention.

Kind regards

Gaye

Gaye Williamson *(she/her)* | Private Secretary to Chief Nursing Officer | Chief Nursing Officers Directorate | Scottish Government | [redacted] | [redacted] | Teams |
I am working from home

From: White C (Craig)
Sent: 29 November 2021 18:36
To: Roberts A (Anncris); Carson C (Catherine); Kay L (Louise)
Subject: RE: Submission on aspergillus in the QEUH - Response from Louise Slorance

Categories: Live Issue

Alex McM confirmed in a reply that Mrs Slorance had spoken the day before to NHSGGC Executive Nurse Director by telephone and that was her point of contact.

Professor Craig White
Deputy Director
Health and Social Care Directorates
Scottish Government
M: [redacted] | E: [redacted] |

Working from home - I work core hours flexibly around caring responsibilities so there is no expectation of a response to any email sent when outside recipients working hours.

****Sent from iPhone which may account for brevity or typos****

Scottish Government
Riaghaltas na h-Alba
gov.scot

From: Roberts A (Anncris) [redacted]
Date: Monday, 29 Nov 2021, 5:12 pm
To: Carson C (Catherine) [redacted], Kay L (Louise) [redacted]
Cc: White C (Craig) [redacted]
Subject: RE: Submission on aspergillus in the QEUH - Response from Louise Slorance

Hi Catherine
I see that Craig was copied in further down this chain and highlighted the importance of Mrs Slorance having a named contact in NHSGG&C . I can't determine whether that was communicated to her verbally as it didn't appear in the letter.
In terms of lines on organisational Duty of Candour…

- We recognise that if things go wrong during the provision of treatment or care, openness and transparency is essential. NHS Boards have a statutory responsibility under the organisational Duty of Candour regulations to provide that transparency.
- Fundamental to that is personal contact and engagement with those affected, [such as yourself], even if a review is ongoing and even if definitive answers cannot be provided.
- That is why we have asked NHS GG&C to ensure that [you] have a named person that you can contact when you are ready and able to do so.

- [This engagement should also be seen as helpful by the Board, because through it they will be able to understand your perspective on how things could have been dealt with better and thereby improve their services.] OR [We expect the Board to use their engagement with those affected to learn and to improve their services]
- If you would find it helpful, the Scottish Mediation Network may provide a route for you to discuss these matters with the Board, using an independent source.

I'm not sure how relevant these lines are to what Mrs Slorance raises in her email though.

Anncris

Anncris Roberts
Unit Head|Safety, Openness and Learning I DHQI: Planning & Quality I
Currently working from home
Mobile [redacted]

From: Carson C (Catherine) [redacted]
Sent: 29 November 2021 16:40
To: Kay L (Louise) [redacted]; Roberts A (Anncris) [redacted]
Subject: FW: Submission on aspergillus in the QEUH - Response from Louise Slorance

Good afternoon Louise, Anncris,
Linda Pollock suggested I contact you both for some input to a response needed for the FM.
Earlier today the FM received an email from Mrs Louise Slorance and I have attached to this email, CNO has suggested that we need a wider clinical response.
The case has been assigned to me on Micase for control and to ensure we have all the contributions before a final reply is sent.
Grateful if you could provide me with some lines for inclusion in respect to your policy areas.
You will be aware that there has been lots of media and polictical interest around this today and it is likely to be raised at FM question time this week, with that in mind could I have your contributions as soon as possible.
Please get in touch if you need any further information.

Catherine Carson
Business Support Team Leader | Chief Nursing Officer's Directorate| Scottish Government |Telephone [redacted] | Mobile [redacted]
mailto: [redacted]

From: McMahon A (Alex) [redacted]
Sent: 26 November 2021 07:56
To: Lamb C (Caroline) [redacted]; Chief Medical Officer [redacted]; Smith G (Gregor) [redacted]; Leitch J (Jason) [redacted]; Burns J (John) [redacted]; Ellis G (Graham) [redacted]; DG Health & Social Care [redacted]
Cc: Ward C (Christine) [redacted]; Birch J (Jason) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Chief Nursing Officer [redacted]
Subject: FW: Submission on aspergillus in the QEUH - Response from Louise Slorance

Colleagues
This response from Mrs Slorance to the First Minister, I think requires wider clinical and performance thought before we reply. I also think that there is a need for engagement with the Cabinet Secretary and SPADs potentially to before we reply. But I would welcome thoughts on how to handle this, this morning, although I appreciate many colleagues are on leave today but I do think there would be merit in a meeting to discuss how we frame the advice that goes back.
Welcome thoughts.
Alex

Professor Alex McMahon
Interim Chief Nursing Officer
Scottish Government
St Andrews House

Edinburgh
EH1 3DG

From: Dow L (Lynne) **On Behalf Of** First Minister
Sent: 25 November 2021 22:31
To: Kay L (Louise); Birch J (Jason); Hutchison D (David) (Special Adviser)
Cc: White C (Craig); McMahon A (Alex); Allan L (Lara); McKerron R (Rosie); Fallis R (Russell); First Minister; Chief Nursing Officer; Cabinet Secretary for Health and Social Care; Minister for Public Health, Women's Health & Sport; Minister for Mental Wellbeing & Social Care; FM Policy Team Mailbox; DG Health & Social Care; Smith G (Gregor); Chief Medical Officer; Leitch J (Jason); Bain MB (Marion); Armstrong A (Anne) (Health); Burns J (John); Barkby I (Irene); Ward C (Christine); Ross E (Elaine); Hamilton E (Emma); Shepherd L (Lesley); Taylor M (Mark); Aitken L (Louise); Paterson M (Matt); Powell L (Lisa); Kerbalai S (Syed); McPherson G (Grant); Wilson L (Lee-Ann); Graves-Morris C (Charlotte); Nurse M (Molly); Communications Health & Social Care; McAllister C (Colin); Gregg N (Naomi); Raghavan S (Shalinay); Campariol-Scott C (Carole); Sharp G (Gary); Hegarty L (Lee); First Minister FMQs; Chief Nursing Officer; Bain MB (Marion); Barkby I (Irene); Shepherd L (Lesley)
Subject: RE: Submission on aspergillus in the QEUH - Response from Louise Slorance

All
We have received the attached response from Louise Slorance this evening following the First Minister's letter sent earlier today.
Grateful for advice in the morning as to how this should be taken forward.
I have made the First Minister aware.
Thanks
Lynne

Lynne Dow
Deputy Private Secretary
Private Office to the First Minister | 5th Floor| St Andrew's House | Regent Road | Edinburgh |EH1 3DG

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From: Kay L (Louise)
Sent: 25 November 2021 10:32
To: Birch J (Jason); Hutchison D (David) (Special Adviser)
Cc: White C (Craig); McMahon A (Alex); Allan L (Lara); McKerron R (Rosie); Fallis R (Russell); First Minister; Chief Nursing Officer; Cabinet Secretary for Health and Social Care; Minister for Public Health, Women's Health & Sport; Minister for Mental Wellbeing & Social Care; FM Policy

Team Mailbox [redacted]; DG Health & Social Care [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]

Subject: RE: Submission on aspergillus in the QEUH

Davie, as discussed, further tweak on HIS. If you are happy with this we will include in the letter and FMQ

In addition, we have tasked Healthcare Improvement Scotland (HIS) to assess and determine if there are any broader concerns in the Queen Elizabeth University Hospital requiring action based on their review of data on aspergillus.

Louise Kay
☎ | [redacted] ✉ | [redacted]

From: Birch J (Jason) [redacted]

Sent: Thursday, 25 November 2021 10:20

To: Hutchison D (David) (Special Adviser) [redacted]

Cc: White C (Craig) [redacted]; McMahon A (Alex) [redacted]; Allan L (Lara) [redacted]; McKerron R (Rosie) [redacted]; Birch J (Jason) [redacted]; Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]; FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]

Subject: FW: Submission on aspergillus in the QEUH

Thanks – slight tweak.

Jason

Jason Birch | Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | M [redacted] | [redacted]

From: Hutchison D (David) (Special Adviser) [redacted]
Sent: 25 November 2021 10:14
To: White C (Craig) [redacted]; McMahon A (Alex) [redacted]; Allan L (Lara) [redacted]; McKerron R (Rosie) [redacted]; Birch J (Jason) [redacted]; Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Revised letter. We'll need to get this to FM within next 10 minutes so if there are any substantive changes needed pleas let us know.

Dear Louise,

I cannot begin to imagine the grief that you and your family have endured in the last year since Andrew's death. While I know there are not words I can express that can help ease that pain, I hope you know that you have my heartfelt condolences.

Andrew was a friends and colleague to a huge number of people across the Scottish Government and I can't tell you how much we miss him.

I want to set out some of the actions we have instructed to try and get the questions you have answered.

Our Interim Chief Nursing Officer, Professor Alex McMahon, has commissioned the Medical Director of NHS Lothian to provide an external review of Andrew's care and treatment and the communication of his care with your family. This is distinct from any internal process being carried out by NHS Greater Glasgow and Clyde. Both the external and internal case note review will be reported directly to professor McMahon and will, of course, be shared with you..

In addition, we have tasked Healthcare Improvement Scotland (HIS) to use data on aspergillus in the Queen Elizabeth University Hospital to assess and determine if there are any broader concerns requiring action.

We will of course keep you updated as these reviews proceed and I understand that Professor McMahon has asked NHS Lothian to undertake their part of the review as a matter of urgency. Should you have any further questions, please do not hesitate to get in touch.

I know that none of the steps outlined above will, of themselves, immediately resolve the issues you have raised - but I hope and believe that the action that will flow from this work can make a difference.

From: White C (Craig) [redacted]
Sent: 25 November 2021 10:03
To: McMahon A (Alex) [redacted]; Allan L (Lara) [redacted]; McKerron R (Rosie) [redacted]; Birch J (Jason) [redacted]; Fallis R (Russell) [redacted];

First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Thanks Alex, it was the draft FM letter I was commenting on. I noted Mags' engagement and the proposal re the mediation network, it was the former I thought might be helpful to refer to in the FM's letter though given they have now spoken by telephone that's probably not essential to include.

Best wishes,

Craig

Professor Craig White
Deputy Director
DG Health and Social Care | Scottish Government| M: [redacted] | E: [redacted] |Twitter: [redacted]

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From: McMahon A (Alex) [redacted]
Sent: 25 November 2021 09:59
To: White C (Craig) [redacted]; Allan L (Lara) [redacted]; McKerron R (Rosie) [redacted]; Birch J (Jason) [redacted]; Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs

; Chief Nursing Officer ; Bain MB (Marion) ; Barkby I (Irene) ; Shepherd L (Lesley)

Subject: RE: Submission on aspergillus in the QEUH

Margaret McGuire has written to Mrs Slorance and offer to meet with her, and that was followed up with a contact yesterday by phone. Mrs Slorance has stated that she wished to take some time to consider the offer of meeting. We should respect. We have also written to Jane Grant to say that when she does reach out to make contact the use of the Scottish Mediation Network might be very helpful for both parties. The FM is also writing to Mrs Slorance.

Thanks

Alex

Professor Alex McMahon
Interim Chief Nursing Officer
Scottish Government
St Andrews House
Edinburgh
EH1 3DG

From: White C (Craig)
Sent: 25 November 2021 09:54
To: Allan L (Lara) ; McKerron R (Rosie) ; Birch J (Jason) ; Fallis R (Russell) ; First Minister ; Chief Nursing Officer ; Cabinet Secretary for Health and Social Care ; Minister for Public Health, Women's Health & Sport ; Minister for Mental Wellbeing & Social Care
Cc: FM Policy Team Mailbox ; DG Health & Social Care ; McMahon A (Alex) ; Smith G (Gregor) ; Chief Medical Officer ; Leitch J (Jason) ; Bain MB (Marion) ; Armstrong A (Anne) (Health) ; Burns J (John) ; Barkby I (Irene) ; Ward C (Christine) ; Ross E (Elaine) ; Hutchison D (David) (Special Adviser) ; Hamilton E (Emma) ; Shepherd L (Lesley) ; Taylor M (Mark) ; Aitken L (Louise) ; Paterson M (Matt) ; Powell L (Lisa) ; Kerbalai S (Syed) ; McPherson G (Grant) ; Wilson L (Lee-Ann) ; Graves-Morris C (Charlotte) ; Nurse M (Molly) ; Communications Health & Social Care ; McAllister C (Colin) ; Kay L (Louise) ; Gregg N (Naomi) ; Raghavan S (Shalinay) ; Campariol-Scott C (Carole) ; Sharp G (Gary) ; Hegarty L (Lee) ; First Minister FMQs ; Chief Nursing Officer ; Bain MB (Marion) ; Barkby I (Irene) ; Shepherd L (Lesley)

Subject: RE: Submission on aspergillus in the QEUH

Morning Lara

Does Mrs Slorance now have a dedicated point of contact at NHSGGC for ongoing support and communication ? If so, should this be cross-referenced in this latter. As you know, this was one of the improvements that the Oversight Board Communication and Engagement Sub-Group encouraged NHSGGC to prioritise as part of their actions to deliver on the changes recommended by the Oversight Board.

Best wishes, .

Craig

Professor Craig White
Deputy Director
DG Health and Social Care | Scottish Government| M: | E: |Twitter:

From: Allan L (Lara) [redacted]
Sent: 25 November 2021 09:19
To: McKerron R (Rosie) [redacted]; Birch J (Jason) [redacted]; Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Hi Rosie

Please see updated letter below.

**

Suggested draft letter from the First Minister to Mrs Slorance

Dear Mrs Slorance,

I am writing to you to once more offer my heartfelt condolences on the loss of Andrew, at this especially difficult time in the lead up to the first anniversary of Andrew's death.

Andrew was a much valued and well respected colleague and he is sorely missed.

I wanted to tell you that NHS Greater Glasgow & Clyde are in the process of undertaking an internal review of Andrew's care and treatment and their communications through a case note review. The outcome of this review will be reported to the Interim Chief Nursing Officer, Professor Alex McMahon.

Professor McMahon has also commissioned a process of external assurance in relation to Andrew's care and treatment and how the details were communicated to you. This independent external peer review will be led by NHS Lothian's Medical Director and will provide further reporting directly to Professor McMahon.

I can also confirm that the Cabinet Secretary for Health and Sport has asked Healthcare Improvement Scotland (HIS) to carry out a review of aspergillus in the Queen Elizabeth University Hospital to determine if there are any broader concerns that can and should be addressed.

Following the outcomes of the independent expert review of Andrew's case and the work of HIS, these will help me assess if further external assessment of the wider infection prevention and control measures in place in NHS Greater Glasgow & Clyde are required.

I will of course keep you updated as these reviews proceed and I understand that Professor McMahon has asked NHS Lothian to undertake their part of the review as a matter of urgency.

Should you have any further questions, please do not hesitate to get in touch.

Kind regards

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

From: McKerron R (Rosie) [redacted]
Sent: 25 November 2021 08:48
To: Birch J (Jason) [redacted]; Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]; Allan L (Lara) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Morning all
Davie made some edits to this – see attached (this is now with FM). The main change is that the Health Secretary has asked HIS to look at data on aspergillus in QEUH – rather than waiting for outcome of the case note review of Andrew's case. **CabSec Health PO** – tba.
Jason – on the letter, could you update this based on latest in brief and send on asap pls? Spads keen to see so it can issue pre-FMQs.
Thanks
Rosie

From: McKerron R (Rosie)
Sent: 24 November 2021 23:42
To: Birch J (Jason) [redacted]; Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly)

[redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; Barkby I (Irene) [redacted]; Shepherd L (Lesley) [redacted]; Allan L (Lara) [redacted]

Subject: RE: Submission on aspergillus in the QEUH

Jason, colleagues

Many thanks for the work on this especially given the lateness of the hour. Having discussed with Jason, I have sought to restructure some of this into lines for FM to deploy.

Davie – grateful for your views on the attached. I took some of the material from the timeline in the original FMQ (which FM has in her overnight pack – attached) to create the lines on pre-NHSGGC entering special measures. I'm not sure we need Annex B but will leave you to confirm.

As you know FM, wanted this info asap so I'm planning to have it on her desk by 8.30 tomorrow, so very grateful for views before then. I understand Christine will be online early tomorrow to pick up any further requests.

Thanks

Rosie

From: Birch J (Jason) [redacted]

Sent: 24 November 2021 22:42

To: Fallis R (Russell) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]

Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; McKerron R (Rosie) [redacted]

Subject: RE: Submission on aspergillus in the QEUH

Rosie, Russell,

Further to the above, pleas find attached a separate FMQ as requested.

Regards

Jason

Jason Birch | Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | M [redacted] | [redacted]

From: Fallis R (Russell) [redacted]

Sent: 24 November 2021 19:59

To: Birch J (Jason) [redacted]; First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]

Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Camparil-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Chief Nursing Officer [redacted]; Bain MB (Marion) [redacted]; McKerron R (Rosie) [redacted]

Subject: RE: Submission on aspergillus in the QEUH

Jason

You spoke with my colleague Rosie on the FM's further asks on QEUH which she would like back later this evening – **ideally by 9.30pm.**

In a separate FMQ note (don't update the existing FMQ on QEUH as FM has this with her this evening), please can you include background and lines for FM to deploy on:

1) What we've instructed on the Andrew Slorance case – so, narrative of the information you've listed below but also including who in NHS Lothian has been instructed to take forward the external review and the timeframe attached.

2) A list of actions on infection prevention and control in NHSGGC/QEUH since:

(i) NHS GGC was escalated to stage 4 for infection control etc (examples of improvements that have been made)

(ii) a list of actions taken prior to that point in the preceding 12 months

(iii) what scrutiny measures HIS are taking in relation to cases of aspergillus (external review of cases etc)

I will need all of the above in one FMQ with clear separation of background material (if sensitive and for FM info only) and then lines to take so FM is able to narrate SG and HS action taken.

I understand Spads will feedback separately on the letter tomorrow.

Thanks

Rosie

Russell Fallis | Head of FMQ Team, Scottish Government | [redacted]

-------- Find out more on Preparing First Minister's Questions (FMQs) --------

From: Birch J (Jason) [redacted]

Sent: 24 November 2021 19:05

To: First Minister [redacted]; Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]

Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]

[redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Fallis R (Russell) [redacted]

Subject: RE: Submission on aspergillus in the QEUH

Patrick,

Thank you for the message. In terms of the First Minister's points:

Professor McMahon has today written to NHS GG&C to confirm that there will be an external review of Mr Slorance's case notes by NHS Lothian. The Interim CNO has also written to NHS Lothian to request that this external assurance is carried out as a matter of urgency.

I have included draft text below for a letter to be sent to Mrs Slorance from the First Minister and I understand that you will have the contact details and therefore be able to confirm the message has been received by Mrs Slorance.

The independent external peer review of the case notes will consider the care and treatment including what and how this has been communicated with the patient and the family. In particular it will consider and seek assurance of the following areas which are covered by NHS GG&C's internal review:

- Pre-ICU Care summary
- ICU Care summary
- Patient journey through the Queen Elizabeth University Hospital
- Acquisition of COVID-19 by Mr Slorance
- Infection assessment
- Treatment given to Mr Slorance in relation to:

i. Covid-19
ii. Anti-fungal
iii. Communication with patient

In relation to the HIS inspections, there is an unannounced inspection of the QEUH in the upcoming HIS inspection schedule. We have also requested advice from NHS Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) in relation to data and evidence available on cases of Aspergillus.

I hope that this is helpful.

Kind regards

Jason

<u>Suggested draft letter from the First Minister to Mrs Slorance</u>

Dear Mrs Slorance,

I am writing to you to once more offer my heartfelt condolences on the loss of Andrew, at this especially difficult time in the lead up to the first anniversary of Andrew's death.

Andrew was a much valued and well respected colleague and he is sorely missed.

I wanted to tell you that NHS Greater Glasgow & Clyde are in the process of undertaking an internal review of Andrew's care and treatment and their communications through a case note review. The outcome of this review will be reported to the Interim Chief Nursing Officer, Professor Alex McMahon.

Professor McMahon has also commissioned a process of external assurance in relation to Andrew's care and treatment and how the details were communicated to you. This independent external peer review will be led by NHS Lothian's Medical Director and will provide further reporting directly to Professor McMahon.

I will of course keep you updated as these reviews proceed and I understand that Professor McMahon has asked NHS Lothian to undertake their part of the review as a matter of urgency.

Should you have any further questions, please do not hesitate to get in touch.

Yours sincerely

Jason Birch | Unit Head | Directorate for Chief Nursing Officer | Scottish Government | St Andrew's House | Regent Road | Edinburgh | EH1 3DG | M [redacted] | [redacted]

From: Crolla P (Patrick) [redacted] **On Behalf Of** First Minister
Sent: 24 November 2021 17:35
To: Chief Nursing Officer [redacted]; Cabinet Secretary for Health and Social Care [redacted]; Minister for Public Health, Women's Health & Sport [redacted]; Minister for Mental Wellbeing & Social Care [redacted]; First Minister [redacted]
Cc: FM Policy Team Mailbox [redacted]; DG Health & Social Care [redacted]; McMahon A (Alex) [redacted]; Smith G (Gregor) [redacted]; Chief Medical Officer [redacted]; Leitch J (Jason) [redacted]; Bain MB (Marion) [redacted]; Armstrong A (Anne) (Health) [redacted]; Burns J (John) [redacted]; Barkby I (Irene) [redacted]; Ward C (Christine) [redacted]; Birch J (Jason) [redacted]; Ross E (Elaine) [redacted]; Allan L (Lara) [redacted]; Hutchison D (David) (Special Adviser) [redacted]; Hamilton E (Emma) [redacted]; Shepherd L (Lesley) [redacted]; White C (Craig) [redacted]; Taylor M (Mark) [redacted]; Aitken L (Louise) [redacted]; Paterson M (Matt) [redacted]; Powell L (Lisa) [redacted]; Kerbalai S (Syed) [redacted]; McPherson G (Grant) [redacted]; Wilson L (Lee-Ann) [redacted]; Graves-Morris C (Charlotte) [redacted]; Nurse M (Molly) [redacted]; Communications Health & Social Care [redacted]; McAllister C (Colin) [redacted]; Kay L (Louise) [redacted]; Gregg N (Naomi) [redacted]; Raghavan S (Shalinay) [redacted]; Campariol-Scott C (Carole) [redacted]; Sharp G (Gary) [redacted]; Hegarty L (Lee) [redacted]; First Minister FMQs [redacted]; Fallis R (Russell) [redacted]
Subject: RE: Submission on aspergillus in the QEUH

Gayle,

The First Minister was grateful for the submission.

She wishes this issue to be progressed as follows:

- In relation to the question of a case note review of Andrew Slorance's specific case:
  - There should be a case notes review and it should be externally assured (external, that is, to GCC).
  - It would be preferable for this review to be initiated by the SG (presumably by the CNO).
  - We should communicate this news to Mrs Slorance in the course of tomorrow morning. Her view is that this is best done by a letter from the FM to Mrs Slorance and she would be grateful if this can be prepared as a matter of urgency.
  - She would wish to have confirmation by 1130 that this letter has been successfully received by Mrs Slorance.
  - She will require briefing on the review, it's process, who is conducting it etc that she can use at FMQ's. She will need this as soon as possible tomorrow and no later than 1000.
- In relation to a more general review of instances of aspergillus that Mrs Slorance has called for, the FM would like further clarity on what can be said on this point. For example, can she say that HIS will conduct a round of inspections as discussed at paras 11 and 12? If not, she is minded to confirm that we are considering a wider review. Again, she will need this as soon as possible tomorrow and no later than 1000.

Many thanks,
Pat

Patrick Crolla
Deputy Private Secretary
Office of the First Minister
5th Floor | St Andrews House | Regent Road | Edinburgh | EH1 3DG | [redacted] | [redacted]

All e-mails and attachments sent by a Ministerial Private Office to any other official on behalf of a Minister relating to a decision, request or comment made by a Minister, or a note of a Ministerial meeting, must be filed appropriately by the recipient. Private Offices do not keep official records of such e-mails or attachments.
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From: Williamson G (Gaye) **On Behalf Of** Chief Nursing Officer
Sent: 24 November 2021 13:53
To: Cabinet Secretary for Health and Social Care ; Minister for Public Health, Women's Health & Sport ; Minister for Mental Wellbeing & Social Care ; First Minister
Cc: FM Policy Team Mailbox ; DG Health & Social Care ; McMahon A (Alex) ; Chief Nursing Officer ; Smith G (Gregor) ; Chief Medical Officer ; Leitch J (Jason) ; Bain MB (Marion) ; Armstrong A (Anne) (Health) ; Burns J (John) ; Barkby I (Irene) ; Ward C (Christine) ; Birch J (Jason) ; Ross E (Elaine) ; Allan L (Lara) ; Hutchison D (David) (Special Adviser) ; Hamilton E (Emma) ; Shepherd L (Lesley) ; White C (Craig) ; Taylor M (Mark) ; Aitken L (Louise) ; Paterson M (Matt) ; Powell L (Lisa) ; Kerbalai S (Syed) ; McPherson G (Grant) ; Wilson L (Lee-Ann) ; Graves-Morris C (Charlotte) ; Nurse M (Molly) ; Communications Health & Social Care ; McAllister C (Colin) ; Kay L (Louise) ; Gregg N (Naomi) ; Raghavan S (Shalinay) ; Campariol-Scott C (Carole) ; Sharp G (Gary) ; Hegarty L (Lee)
Subject: Submission on aspergillus in the QEUH

SENT ON BEHALF OF THE INTERIM CHIEF NURSING OFFICER
PS/Cabinet Secretary Health and Social Care
Please find attached a submission which provides an update on the issues connected with aspergillus at the QEUH, NHS GGC, for the Cabinet Secretary's urgent attention.
Kind regards
Gaye

Gaye Williamson *(she/her)* | Private Secretary to Chief Nursing Officer | Chief Nursing Officers Directorate | Scottish Government | | | Teams |
I am working from home

Organisational Duty of Candour Annual Reports Review

Situation

Linda Pollock asked me to review NHS Boards submission of organisational duty of candour reports published by NHS Boards and consider the way in which these might inform future work undertaken to support improvement in the quality of reports and consider how content could influence a more explicit contribution to the development and implementation of Directorate policy priorities.

Background

I have reviewed the information held in eRDM in respect of NHS Boards organisational duty of candour reports published since the publication of annual reports became a statutory obligation for NHS Boards on 01 April 2018. At the time of writing NHS Boards are required to have published organisational duty of candour reports covering 2018-19, 2019-20, 2020-21 and 2021-22.

This identified that not all of the NHS Boards reports were easily accessible within SG systems for this review, with several of the links to the reports in SG produced documents not functioning or linking with NHS Board weblinks that had been removed.

An initial priority action of sourcing as many of the NHS Board reports was therefore identified.

Assessment

The way in which NHS Board organisational duty of candour reports are filed and retained does not easily lend itself to review of the content of reports. URLs held within eRDM have been reviewed to access individual NHS Board reports. Several links were no longer functional or linked to other documents. Although it was then possible to locate copies of the individual NHS Board reports missing/inaccessible from the eRDM documents, web searches and review of emails to the [redacted] inbox archives was required to locate copies of the additional reports not accessible through information held on eRDM files.

The number of reports accessible through SG records or publically accessible sites has increased in reporting years 2018/19, 2019/20 and 2020/21 from 10 to 15 to 16 reports of a total possible 19 NHS Boards being available. Organisational duty of candour reports for the Scottish Ambulance Service, NHS Ayrshire and Arran and NHS Fife were not accessible for three of the four reporting years considered. Reports for NHS Borders, Dumfries and Galloway, Highland, Orkney, Western Isles, Golden Jubilee and NHS 24 were not accessible for two of the hour reporting years. A full and complete set of reports should be sourced before the recommendations for further action are considered. This is not likely to reflect Boards not having prepared or notified SG of publication as required by statute, though suggests that improvements in SG processes and NHS Board processes for publically accessible versions of their reports are likely required. Some NHS Boards such as NHS Tayside and NSS publish their reports for each reporting year on the same website e.g. https://www.nhstayside.scot.nhs.uk/YourRights/PROD_325453/index.htm

It is not clear from review of historical information what actions have been taken by officials when no notification of the publication of a report has been received (there were some Boards in some reporting years with no report or notification received or recorded in overview documents).

It seems unlikely that the content of each of the organisational duty of candour reports within and across NHS Boards has been considered fully by officials in respect of whether the report content reflects the minimum statutory obligations regarding what such reports should contain.

It is unlikely that the themes within and across Boards have been identified in order that any issues, risks and themes with the potential read across to policy commitments on openness, safety and learning or improvements in report content identified.

Although the SG commissioned analysis of the organisational duty of candour reports identified some reports that did not include content required by the Act, it is not clear if NHS Boards were provided with individual feedback on this to support improvements in future in respect of adherence to the requirements of the Act. This observation also applies to reports published after those included in the initial analysis report.

It is not clear whether policy teams and professional advisory groups outside of our Directorate have considered the content of organisational duty of candour reports by NHS Boards in ways that are aligned and integrated with their policy development, implementation support or advice to Ministers. For example, NHS Forth Valley report for 2020-21 included very generic information on changes made. The primary legislation in respect of reporting could be interpreted to only require publication of changes to policy and procedure in respect of the duty of candour provisions specifically, ie not the changes to policies and procedures in respect of changes and improvements arising from activation of the procedure.

> Section 21 (2) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 states:
>
> The report must set out in relation to the financial year -
>
> information about the number and nature of incidents to which the duty under section 21(1) has applied in relation to a health service, a care service or a asocial work service provided by the responsible person,
>
> an assessment of the extent to which the responsible person carried out the duty under section 21(1),
>
> information about the responsible person's policies and procedures in relation to the duty under section 21(1), including information about—
>
> procedures for identifying and reporting incidents, and
>
> support available to staff and to persons affected by incidents,
>
> information about any changes to the responsible person's policies and procedures as a result of incidents to which the duty under section 21(1) has applied, and
>
> such other information as the responsible person thinks fit.

Most reports provide details of a wide range of changes introduced following reviews undertaken after activation of the organisational duty of candour procedure. NHS Lanarkshire's reports are particularly impressive in this regard. Many reports refer to changes and improvements within NHS Boards that have the potential to inform national strategic safety priorities or processes also implemented within other NHS Boards. It is not clear what consideration or actions there have been by reporting NHS Boards on engagement, communication or discussion with other NHS Boards.

Reports from NHS Boards for the 2020-2021 report period refer to 95 people where there was an unexpected or unintended incident the resulted or could result in death.

The following are illustrative examples of report content with particular relevance to safety strategic priorities, the potential for national review and actions to mitigate potential clinical risks or support learning, change and improvement nationally. The potential relevance and questions raised in respect of national policy and strategic work on clinical risk management and quality management work is noted in parentheses in **bold.**

> Due to a delayed diagnosis of cancer, the relevant service has implemented high risk targeted queues on TRAK to focus capacity on urgency of procedure and reduce delays.
>
> **[Does this happen nationally as a result of this incident ?]**
>
> Following the delayed diagnosis of a condition which resulted in significant lasting harm, all patients who have been delayed in the emergency department for more than six hours have a ward round review where standard checks and care rounding documents are utilised
>
> **[Does this happen in all A&E Departments?]**
>
> Following staff not being aware of the photosensitivity side effects of a drug which resulted in a patient subsequently suffering a severe allergic reaction due to exposure to sunlight and admission to hospital overnight for observation and treated for burns, there has been a project to ascertain the side effects of all the commonly used drugs within the service, particularly looking to identify other medications which have photosensitivity side effects. This information has been displayed and shared across teams and is available on hard copy in each unit and was shared on the safety brief daily over the summer months.
>
> **[Would this have been reported nationally and then disseminated through pharmacy and medicines governance processes ?]**
>
> Following an incident, a policy for missing persons from acute hospital has been implemented, and the policy for missing persons in non-acute facilities has been amended to include patients on transfer to acute hospitals. An SOP for the transport of patients between facilities, including guidance to aid decision-making on escorts has also been implemented. The nursing notes in the patient information record system within acute wards will now include text to include risk assessments and this information is audited every two weeks.
>
> **[Would this inform SPSP Mental Health programme and were considerations given to how shared nationally ?]**
>
> Patients with unusually high opioid analgesic requirements following gall bladder removal should have a CT scan prior to discharge. Patients who are not discharged within 24hrs of surgery because of ongoing pain should have a CT scan to identify any bile leak or bleeding. There should be a single patient information leaflet for laparoscopic gallbladder surgery on both sites. This information leaflet should include information on how to have direct advice from the surgical team after discharge, rather than using NHS 24 or GP services.
>
> **[Is this change local only or now the national position based on the outcome of this duty of candour review ?]**

The examples above are not illustrative or exhaustive and included to emphasise the potential for systematic review of all content from reports to identify actions with significant potential to inform and/or assure optimal effectiveness of processes of communication, co-ordination and consideration of the necessary actions being taken to reflect a transparent and clearly articulated contribution to improving the content and quality of reports or national learning systems, both with the potential to contribute to reductions avoidable death and harm.

While it is presumed that monitoring of implementation and effectiveness of the changes introduced as a result of individual Board decisions to activate the duty of candour procedures will form part of NHS Board clinical governance processes, there is currently no means by which to provide assurance more widely or the extent to which the content of reports is considered through other processes within organisations such as Healthcare Improvement Scotland.

There is variation in the quality of the content of reports in respect of what has changed as a result of the activation of the organisational duty of candour procedure within NHS Boards. This presents an opportunity to provide further examples and implementation support for NHS Boards to consider how this content from reports informs local learning systems and openly and transparently communicates the impact of changes identified to improve the safety and effectiveness of health services provided.

It is not clear the extent to which changes made in individual Boards as a result of the activation of the organisational duty of candour procedure are considered by other Boards and/or considered when commissioning or designing national improvement programmes.

Recommendations

Collate all of the NHS Board individual organisational duty of candour reports and retain within a file structure that supports further analysis by report year across NHS Boards and by NHS Board over reporting years. (This has been actioned and the collated material is accessible at: [redacted]

Further work is required to consider the potential for organisational duty of candour reports to contribute to the continuous improvement in national learning and improvement systems. This should be framed in a manner that recognises the significance of the content of these reports as a wider part of Scottish Government's commitment to openness, learning and improvement. For example, 95 deaths in the reporting year 2021-2022.

This narrative could be informed by similar quantification across other reporting years and other harm outcomes, the purpose of which would be to ensure that there is a focus on each activation of the procedure reflects the death of a person or a life trajectory potentially significantly altered as a result of the unintended or unexpected incident.

Arrange meeting with Kay and Annalena in early January to consider possible further actions arising from this initial review of reports, this could involve consideration of:

- Preparation of an assessment template for review of the content of individual reports submitted and within and between Board analysis and comparison. This could be used to

inform revisions to non-statutory guidance for the completion of NHS Boards annual reports, emphasising content reflecting legislative and policy intentions and supporting an increase in the number of reports containing high-quality content of all the required components. This process of revising non-statutory guidance should also incorporate the work and dialogue relating to HAI, recently subject to discussion with SAMD Executive.

- Collation of all learning and improvement actions noted in reports to identify actions that could be taken by Healthcare Improvement Scotland and NHS Education for Scotland to consider how changes and improvements identified have influenced national learning, safe care inspections, QI support commissions, clinical risk management and relevant change and improvement policy work.

- This could involve working collaboratively with some NHS Boards to share details of the examples of learning and improvement resulting from implementation of the organisational duty of candour procedure, with significant potential to positively contribute to national strategic prioritisation and public assurance that the implementation of this legislation is positively contributing to policy objectives.

- Consideration of additional content for inclusion in updated revised non-statutory guidance on organisational duty of candour to support continuous improvement in the content of NHS Board reports and outlined how the work referred to in the reports contributes to strategic, policy, risk and improvement support work nationally.

All of the above recommendations to inform a standard operating procedure for officials considering the content and quality of future NHS Board organisational duty of candour reports . This should include how review of these should be approached and the potential actions required by officials following such review e.g. feedback to NHS Boards, assurance re consideration of national clinical risk management and/or improvement collaboration/focus.

Professor Craig White. MML PhD ClinPsyD CPsychol FBPsS FRCP
Scottish Government
Healthcare Quality and Improvement Directorate

09 December 2022

Queen Elizabeth University Hospital/Royal Hospital for Children

Case Note Review

Communications Plan

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1. Case Note Review - Background

As a result of continuing problems arising from infection incidents on the Queen Elizabeth University Hospital (QEUH) campus, on 22 November 2019, the Scottish Government's Health and Social Care Management Board escalated NHS Greater Glasgow and Clyde to 'Stage 4' of its escalation ladder. That stage represents a level where there are "*significant risks to delivery, quality, financial performance or safety, and senior level external transformational support [is] required*." As a result, a new 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.

As part of the work of the Oversight Board, the Cabinet Secretary for Health and Sport set out plans for a Case Note Review (CNR) in Parliamentary statement on 28 January 2020. The Case Review team would review the case notes of haemato-oncology paediatric patients in the Royal Hospital for Children (RHC) and the QEUH from May 2015 to December 2019. The cohort currently consists of 85 patients (and a larger number of infection episodes):

- children and young people with blood cultures of a Gram-negative environmental pathogen (including enteric pathogens associated with the environment) (there are 81 children that meet this inclusion criteria);
- children and young people with a M. chelonae (Acid Fast Environmental) infection (there are 3 children that meet this criterion – only 2 with bacteraemia, and 1 with a skin infection); and
- children and young people included for other reasons: this includes one child with a Gram-negative infection (not blood stream detected) and Aspergillus.

2. Communication Plan Purpose and Objectives

The Plan will support the Core Project Team and Communications Lead in communication and engagement with families and parents, NHS Greater Glasgow and Clyde (NHS GGC) clinicians, NHS GGC Board Senior Leadership Team and other NHS GGC staff, Scottish Government Ministers, Scottish Government officials, elected representatives, external stakeholders and, where necessary, the media.

The Plan outlines the main audiences and communication channels to be used throughout the project, and includes a narrative for each stakeholder group. It will be updated as the project moves forward. The Core Project Team is responsible for delivery of the Plan.

The Plan will provide stakeholders with consistent messages in a way that is open, honest and timely, encourage engagement and recognise the importance of ensuring support is provided throughout the course of the case note review.

The key communication objectives are aligned with different parts of this project:

Indicative Timeline	**Key objective**
February 2020-July 2020 **Planning/Data Collection**	Engage with patients, families, NHS GGC clinicians, NHS GGC Board Senior Leadership and Scottish Government stakeholders to communicate: • Patients included/not included in the review • The scope/case definition of the review • Set of questions the review will consider • Role and Remit of the Expert Panel • Panel review outcomes.
May 2020-December 2020 **Case Note Review process**	Engage with patients, families, NHS GGC clinicians, NHS GGC Board Senior Leadership, Scottish Government, elected representatives and stakeholders to communicate: • Progress regarding the end of data collection and the review underway.
Autumn 2020 **Interim report (emerging findings from review)**; **face to face meetings with the patients and families**	Engage with patients and families, Scottish Government, elected representatives, NHS GGC clinicians and NHS GGC Board Senior Leadership to communicate: • For the Cabinet Secretary – interim report including progress to date and estimated time of publication of the final report, comms and engagement plan; • For families – an update on when the report and any recommendations will be available;

	• The opportunity for patients and families to meet the Expert Panel and how this will work e.g given the current circumstances, most likely via a video call. This also includes considering individual communication preferences with parents where cases have been reviewed.
Early 2021 **Draft report**	Draft report issued to all stakeholders for comments. The primary audience will be parents and families. Specific approaches and family-specific actions will be considered when issuing the report to them.
Spring 2021 **Findings and Recommendations from the Report**	Engage with patients, families, NHS GGC clinicians, NHS GGC Board Senior Leadership, Scottish Government, elected representatives and stakeholders to: • Provide findings and recommendations • Outline how Scottish Government and NHS GGC will work collaboratively to monitor the implementation of any recommendations.
Spring 2021 **Publication of the findings of the case note review**	To provide transparency in drawing out key conclusions – and where appropriate, lessons – that can inform improvements in NHS GGC with respect to its escalation to Stage 4 for infection, prevention and control matters.
Spring 2021 **Face to face feedback with patients/families**	Still to be planned. This part of the Case Note Review will be the opportunity for patients and families to meet with the Expert Panel with a view to answering family/patient questions as far as can be accomplished through the CNR.
Spring 2021 **Lessons Learned**	As stated in the Terms of Reference, the work of the Case Note Review will be vital[1] in identifying improvement actions, not just for NHS GGC, but more widely across NHSScotland, including ARHAI and the Scottish Government. In particular, the findings will aim to identify and affirm elements of best practice, areas for further reflection and ways to improve some of the aspects of the processes used by NHS GGC that influenced care delivery and experiences, environmental and IPC data. Findings focused on improvement of relevant processes, including

[1] This may need reworded based on the outcomes of the case note review.

	any contributory factors in the impact on care delivery and outcomes in the context of IPC and technical issues will also be considered by the Oversight Board. Consideration will be given on best ways on how/when/who to communicate them to.

3. Communications Narrative

The communications narrative identifies the main audiences and communication channels, opportunities and mechanisms to engage with each stakeholder group throughout the CNR. It includes the different sets of messages that we need to communicate to different groups, and when we need to communicate them; with the understanding that these messages will vary over time, as the CNR progresses. Its key aim is to ensure clarity of communication and opportunities, where appropriate, for engagement in a way that is flexible, open and timely.

The narrative is informed by prior work of the Oversight Board Communication and Engagement Sub-Group; and the shared common interests across stakeholders of any system and process issues identified through the life of the CNR, with the expected outcome that such issues be articulated in support of organisational learning and improvement.

The communications narrative will:

- take a thorough, tailored approach to communicating such findings which will reflect the ongoing engagement with those groups where further engagement and support over the course of the review is essential;
- take into account the need to consider and respond to expectations across the different stakeholders groups.

It is expected that this approach will go some way towards mitigating any concerns / negative impact from specific stakeholders if these occur. In doing so it will be important to acknowledge that with any exercise such as this there will be different levels of understanding of the need for, approach to and validity of observations made about the interactions between care delivery processes, outcomes and the contribution at individual case level of acknowledged issues with the hospital environment and effectiveness of infection prevention and control procedures and process.

This approach could also provide useful observations for example in the case of improvement in respect the integration of structured case note review processes as part of quality management infrastructure work; as well as when looking at ways to influence culture and learning-focused organisational process.

3.1 Stakeholders

This section provides more detail on who the stakeholders are (acknowledging differences within each group); what they will want to know about from the CNR; the desired methods of communicating with them; and sensitivities that we should consider when doing so. It also acknowledges and includes those who have indicated their preferences to not receive communications from the review.

3.1.1 Children, Young People, Parents and Families

Addressing individual questions from children, young people, their parents and families is a key driver for the CNR. This section focuses on understanding individual circumstances and communicating them, as far as can be done, to the families in question.

There are different groups within this group – for example, some will not want to receive communications on this – and the sensitivity required to address the issues here, recognising that for some families, they continue to be affected by the death of their child, that for several families they have not previously felt 'heard' or that their outstanding and unresolved questions relating to their child's care were being considered in ways that instilled confidence or assured them that all dimensions of their dissatisfaction were understood and engaged with.

This section acknowledges the different stages to this communications work:

- introducing and setting out the CNR;
- contacting families and setting out the basis for case selection;
- providing families with the opportunity to highlight questions, issues or observations that they wished to make known to the CNR panel (please see **Appendix B** for further details);
- addressing individual questions about involvement; providing appropriate updates on overall progress; and,
- ensuring that preferences for updates and discussion of the CNR outcome for their child are elicited and delivered
- most importantly, communicating specific findings and responses to questions to those families/patients that wish to receive them.
- ensuring that the core narrative supporting this CNR are consistently reflected in communications and engagement – particularly reflecting Ministerial commitments to full, open, transparent and respectful engagement with parents and families, recognising that for some their levels of trust in public services have been and continues to be significantly challenged as result of their experiences.

Considerable engagement has already taken place with this group, in particular coming from NHS GGC and those working closely with the patients/families, supported by the Paediatric Haemato-Oncology Closed Facebook page. Engagement has also been supported through the Communications and Engagement subgroup.

These established communication and engagement processes will be essential when informing patients and families of the outcomes of the CNR and managing peoples' responses to these.

3.1.2 NHS GGC Clinical and Medical Staff

This area of communications and engagement has been recognised as a particular risk in the CNR. This group has been concerned with the appropriateness of the method applied for the CNR, and reassurance that the review is an opportunity for engagement lessons to be learned going forward. There are particular sensitivities with respect to any focus on the quality of care for these patients.

Steps have been taken to address the concerns of the medical and clinical staff as far as is realistically achievable, while recognising that an element of challenge from this group may be experienced as the CNR progresses. This includes regular meetings with the medical and clinical staff with the Chair of the Review and the Expert Panel Lead, with a view to providing opportunities to raise concerns and issues and subsequent responses from the Chair and Lead; access to the Terms of Reference for the review; and information on the methodology. This is expected to continue for the remainder of the review. It will be important to encourage reflection among the group on the benefits of the CNR processes as an embedded dimension of quality management infrastructure within learning focused systems and organisations, recognising that although recent experiences of scrutiny and media attention on the service has understandably triggered anxiety, there are possible ways in which interactions with the recognised problems with the hospital environment and organisational responses have impacted on care delivery which, considering exercises such as the CNR from other work and settings, are often more readily identified by those who are not 'too close to see'.

Messages will address the questions and concerns of medical and clinical staff about the scope and validity of the approach of the CNR. This will be further supported by further communication, information and engagement focused on learning from the review of systems and processes and specifically whether these have contributed to individual instances of infection for the children and young people's care that is being reviewed.

3.1.3 NHS GGC Board Senior Leadership

Messages will focus on engagement with senior staff on progress with the project; support in resolving any operational issues arising from the work; and communication of key findings; IPC system processes and actions to date; reflecting on past events, then focussing on whether the environment in which we provide care is safe for the future. This is also part of NHS GGC's wider communications and engagement work in this area.

This element will need to take account of comms to date with senior management and the relationship between the clinicians and the patients/parents and how that can continues positively through proactive communication and engagement. Action here will be led by the Core Project Team in partnership with NHS GGC staff.

3.1.4 Other NHS GGC staff
Actions here will follow the same process as per above section and will also be led by the Core Project Team with input from GGC staff.

3.1.5 Scottish Government/Ministers
Actions will include what we communicate and the timing of it - to the Cabinet Secretary and other Cabinet members; updates to the Scottish Parliament; and consider the interests of Scottish Government colleagues across the relevant policy areas, Scottish Government Communications colleagues.

Communications with this group will clearly reflect the Cabinet Secretary's priority around engagement with, and empathy for, the families affected by the Case Note Review and its findings, as per her recent communications with opposition parties and the media after the publication of the QEUH Independent Review report.

3.1.6 The media
We will discuss and agree what and when to communicate key messages with our SG Communications colleagues to provide accurate and timely updates to the media when needed. This will take account of the need for consultation with members of the Core Project Team and NHS GGC. NHSS GGC will be encouraged to prepare a communications plan in response to the publication of the report.

4. Governance
The source documents for this Communication Plan are the Case Note Review Project Initiation Document. (see **Appendix A** for governance chart).

The Core Project Team will approve this Communications Plan. It will also regularly review progress of the Action Plan.

4.1 Key Roles
Case Note Review (Project) Sponsor: Interim SRO Phil Raines, QEUH/RHC Support Unit Head

- Tasks as per the communication plan
- Final approval on all communication materials

Executive Lead: Professor Marion Bain

- Tasks as per the communication plan
- Final approval on all communication materials

Communications and Engagement Lead: Professor Craig White

- Tasks as per the communication plan
- Delegated final approval on all communication materials
- Provide communication support and advice where necessary
- Evaluation of the communication aspect of the Case Note Review

Core Project Team

- Final approval of communication plan
- Developing key messages for stakeholders

Programme Manager: Marie Brown

- Provide updates on communication plan progress to the Core Project Team
- Maps progress against milestones.

5. Engagement Action Plan

In addition to offering a standard template, the Engagement Action Plan will help to drive quality and provide a consistent application of best practice.. The planning process makes use of the iterative six-step Stakeholder Engagement Cycle.

Engagement Action Plan

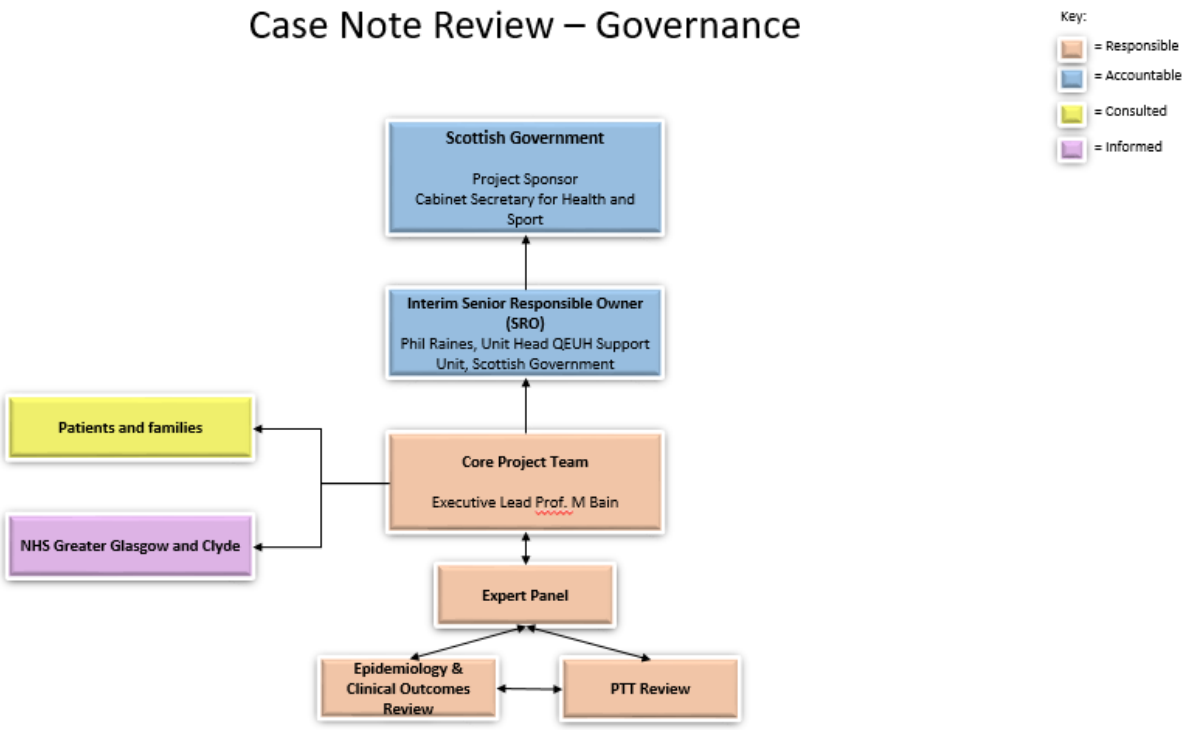
February 2020-July 2020 **Planning / Data Collection**						
Stakeholder Group	**Channel**	**Key message/ Action**	**When/ Frequency**	**Responsible**	**Measures of Implementation**	**Measures of Effectiveness**
Patients and Families	Letters	Engage to communicate: • Patients included/not included in the review • The scope/case definition of the review • Set of questions the review will consider	March 2020	Communication Lead	All families will have received communication outlining the rationale for inclusion and the opportunity to provide questions to the review team	Families who wish to submit questions will have done so and these will be consistent with the scope of the review
NHS GGC Medical and Clinical Staff	Video Call (Microsoft Teams)	Engage to communicate: • Patients included/not included in the review • The scope/case definition of the review • Set of questions the review will consider	April 2020, May 2020	Executive Lead	A video call will have taken place and will have been attended by range of staff	Staff will understand the rationale for the review and why the scope and method are being undertaken

May 2020-September 2020 **Case Note Review**						
Stakeholder Group	**Channel**	**Key message/ Action**	**When/ Frequency**	**Responsible**	**Measures of Implementation**	**Measures of Effectiveness**
Families	Letter from Chair of the Expert Panel to the families – 03/07/2020	Letter from Mike Stevens to the families of the patients who are part of the case note review, providing an update on the progress of the review, including the process and methodology involved and current provisional timescales for completion of the review and publication of the final report. Letter will be published on the closed FB Group and emailed to those families not members of the FB Group	TBC	Mike Stevens Craig White	All families will have received Professor Stevens' letter	All families will understand the progress made, the approach being undertaken and be clear on how to engage and communicate with the team.
Families	FB Group	The independence of the clinicians involved in this process will be confirmed in further communications to the families, acknowledging the concerns expressed through the Oversight Board Family Representative.	August 2020	Craig White	All families will have received the details of the members of the CRG	All families will understand the independence of the CRG members and have the opportunity to express further concerns.
Patients and Families	Email and attachment	Biographies of the Case Note Review members	August 2020	Craig White	All families will have received background information on	Families will have had reassurance of level of expertise and independent

					the Case Note Review members.	process used when establishing team and skills for the work involved in the case note review.
Autumn 2020 **Emerging findings from the Review (Interim report)**						
Stakeholder Group	**Channel**	**Key message/ Action**	**When/ Frequency**	**Responsible**	**Measures of Implementation**	**Measures of Effectiveness**
Patients and Families						
Cabinet Secretary for Health and Sport						
NHS GGC Medical and Clinical Staff						
NHS GGC Board						
Face to face meetings with patients and families **Interim Report**						
Stakeholder Group	**Channel**	**Key message/ Action**	**When/ Frequency**	**Responsible**	**Measures of Implementation**	**Measures of Effectiveness**
Patients and families						

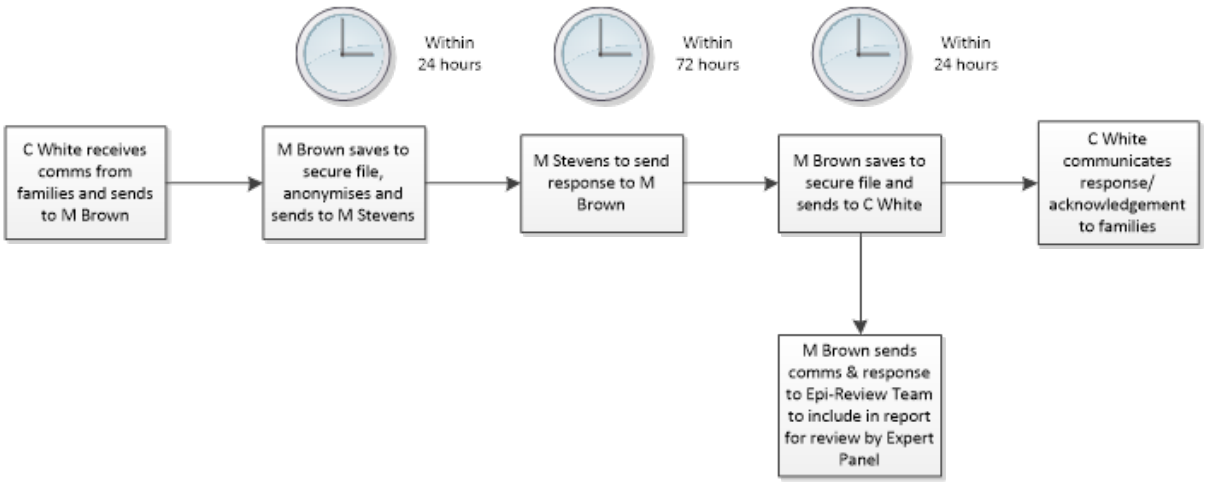
January 2021 **Draft report**						
Stakeholder Group	**Channel**	**Key message/ Action**	**When/ Frequency**	**Responsible**	**Measures of Implementation**	**Measures of Effectiveness**
Patients and Families						
Cabinet Secretary for Health and Sport						

Appendix A


Case Note Review – Governance
Key:
= Responsible
= Accountable
= Consulted
= Informed
Scottish Government
Project Sponsor
Cabinet Secretary for Health and Sport
Interim Senior Responsible Owner (SRO)
Phil Raines, Unit Head QEUH Support Unit, Scottish Government
Patients and families
Core Project Team
Executive Lead Prof. M Bain
NHS Greater Glasgow and Clyde
Expert Panel
Epidemiology & Clinical Outcomes Review
PTT Review

Appendix B

Procedure for responding to parental communications (agreed July 2020)



1 Document Control Sheet

Key Information

Title	Case Note Review Communications Plan
Date Published / Issued	
Date Effective From	
Version / Issue Number	V0.6
Document Type	Communications Plan
Document Status	Draft
Author	Marie Brown, Programme Manager
Owner	Professor Craig White
Approver	Core Project Team
Approved by and Date	
Contact	[redacted]
File Location	

Revision History

Version	Date	Summary of Changes	Name	Changes Marked
v0.1	15-Apr-20	Original Plan	Marie Brown Programme Manager	
V0.2	27-Apr-20	Accepted tracked changes and comments from Prof. Bain	Marie Brown Programme Manager	Y
V0.3	12-05-20	Slight updates from CW comments	Marie Brown Programme Manager	N
V0.4	05-06-20		Carole Campariol-Scott	Y
V0. 6	12-08-20	Finalised version	Carole Campariol-Scott	Y
V0.7	25-08-20	Further edits to finalised version	Carole Campariol-Scott	Y

Approvals

This document requires the following signed approvals:

Version	Date	Name	Role	Signature
V0.7	04/09/20	Marion Bain	Executive Lead	

Distribution

This document has been distributed to:

Version	Date of Issue	Name	Role / Area

RE: IMT Ward 6A, QEUH - 2nd September 2019

RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND)

Thu 29/08/2019 15:36

To: Lang Ann (NHS GREATER GLASGOW & CLYDE) [redacted]; Bowskill Gillian (NHS GREATER GLASGOW & CLYDE) [redacted]; Conner Darryl (NHS GREATER GLASGOW & CLYDE) [redacted]; Crighton Emilia (NHS GREATER GLASGOW & CLYDE) [redacted]; Davidson, Scott [redacted]; Deighan, Chris [redacted]; Dell Mark (NHS GREATER GLASGOW & CLYDE) [redacted]; Devine, Sandra [redacted]; Dick Lorraine (NHS GREATER GLASGOW & CLYDE) [redacted]; Friel Patricia (NHS GREATER GLASGOW & CLYDE) [redacted] alan.gallacher[redacted] <[redacted]; Gibson, Brenda [redacted]; Hackett Janice (NHS GREATER GLASGOW & CLYDE) [redacted]; Hamilton Pauline (NHS GREATER GLASGOW & CLYDE) [redacted]; Sandra.Higgins[redacted] [redacted]; Hill Kevin (NHS GREATER GLASGOW & CLYDE) [redacted]; Allyson.Hirst[redacted] [redacted]; Howat Angela (NHS GREATER GLASGOW & CLYDE) [redacted]; Hunter William (NHS GREATER GLASGOW & CLYDE) [redacted]; INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE) [redacted]; Joannidis Pamela (NHS GREATER GLASGOW & CLYDE) [redacted]; Kennedy Iain (NHS GREATER GLASGOW & CLYDE) [redacted]; Lang Ann (NHS GREATER GLASGOW & CLYDE) [redacted]; Macdonald, David [redacted]; Mallon John (NHS GREATER GLASGOW & CLYDE) [redacted]; Mcneil Elaine (NHS GREATER GLASGOW & CLYDE) [redacted]; Murphy, Dermot [redacted]; Office, Press [redacted]; phpu[redacted] [redacted]; Purdon Colin (NHS GREATER GLASGOW & CLYDE) [redacted]; Redfern James (NHS GREATER GLASGOW & CLYDE) [redacted]; Rodgers Jennifer (NHS GREATER GLASGOW & CLYDE) [redacted]; Rolls Gael (NHS GREATER GLASGOW & CLYDE) [redacted]; Sastry Jairam (NHS GREATER GLASGOW & CLYDE) [redacted]; Somerville, Emma [redacted]; Steele, Tom [redacted];

Cc: MacLeod, Calum [redacted]; Harkness Anne (NHS GREATER GLASGOW & CLYDE) [redacted]; RITCHIE, Lisa (NHS NATIONAL SERVICES SCOTLAND) [redacted];

1 attachment

IMT Ward 6A Gram Negative Blood Cultures 23 08 19 (2).doc;

Good afternoon,
Many thanks for the papers for next weeks IMT. I am unable to attend (Lisa Ritchie will attend) and as i have a number of comments i thought it would be helpful to share these before the meeting. Happy to discuss further before Monday if required

Annette

From: Lang, Ann [redacted]
Sent: 28 August 2019 09:55
To: RANKIN, Annette (NHS NATIONAL SERVICES SCOTLAND); Bowskill Gillian (NHS GREATER GLASGOW & CLYDE); Conner Darryl (NHS GREATER GLASGOW & CLYDE); Crighton Emilia (NHS GREATER GLASGOW & CLYDE); Davidson, Scott; Deighan, Chris; Dell Mark (NHS GREATER GLASGOW & CLYDE); Devine, Sandra; Dick Lorraine (NHS GREATER GLASGOW & CLYDE); Friel Patricia (NHS GREATER GLASGOW & CLYDE); alan.gallacher[redacted]; Gibson, Brenda; Hackett Janice (NHS GREATER GLASGOW & CLYDE); Hamilton Pauline (NHS GREATER GLASGOW & CLYDE); Sandra.Higgins[redacted]; Hill Kevin (NHS GREATER GLASGOW & CLYDE); Allyson.Hirst[redacted]; Howat Angela (NHS GREATER GLASGOW & CLYDE); Hunter William (NHS GREATER GLASGOW & CLYDE); INKSTER, Teresa (NHS GREATER GLASGOW & CLYDE); Joannidis Pamela (NHS GREATER GLASGOW & CLYDE); Kennedy Iain (NHS GREATER GLASGOW & CLYDE); Lang Ann (NHS GREATER GLASGOW & CLYDE); Macdonald, David; Mallon John (NHS GREATER GLASGOW & CLYDE); Mcneil Elaine (NHS GREATER GLASGOW & CLYDE); Murphy, Dermot; Office, Press; phpu[redacted] Purdon Colin (NHS GREATER GLASGOW & CLYDE); Redfern James (NHS GREATER GLASGOW &

CLYDE); Rodgers Jennifer (NHS GREATER GLASGOW & CLYDE); Rolls Gael (NHS GREATER GLASGOW & CLYDE); Sastry Jairam (NHS GREATER GLASGOW & CLYDE); Somerville, Emma; Steele, Tom
Cc: MacLeod, Calum; REMFRY, Lesley (NHS NATIONAL SERVICES SCOTLAND); Harkness Anne (NHS GREATER GLASGOW & CLYDE)
Subject: IMT Ward 6A, QEUH - 2nd September 2019

Good morning

Please find attached an agenda and the minutes from the last IMT regarding the Paediatric haematology/oncology Ward 6A, QEUH.

Also attached is an updated action plan.

The next meeting is being held on:

Date: Monday 2nd September 2019
Time: 14:00
Venue: Room L2007, Level 2, Teaching & Learning Building, QEUH

Can you please let me know of any apologies.

Kind Regards

Ann Lang
PA/Data Manager to Infection Control Manager
Admin Building
Level 2
Queen Elizabeth University Hospital

Tel: [redacted] *(internal* [redacted]*)*
Email: [redacted]

Incident Management Team meeting
Gram Negative Bacteraemia (GNB) – Paediatric Haem Onc
Friday 23rd August 2019, 10:00
Room L2005, Teaching & Learning Building, QEUH

Present: Dr Emilia Crighton, Dr Chris Deighan, Gillian Bowskill, Sandra Devine, Jenn Rodgers, Tom Steele, Darryl Conner, Dr Jairam Sastry, Pamela Joannidis, Dr Iain Kennedy, Prof Brenda Gibson, Dr Teresa Inkster, Annette Rankin, Emma Somerville, Colin Purdon, Lorraine Dick, John Mallon, Dr Dermot Murphy, Dr Milind Ronghe, Calum MacLeod (minutes)

Apologies: Alan Gallacher, Gael Rolls, Sandra Higgins, Jamie Redfern

Actions

Welcome, Apologies, Introductions

Dr Crighton welcomed everyone to the meeting, introductions were made and everyone was reminded of the confidentiality surrounding IMTs.

A clinician on behalf of t~~T~~he group asked why Dr Crighton was chairing this meeting and not Dr Inkster. Dr Crighton explained that she had been asked to chair the meeting by the Director of public health. Sandra Devine advised the group that a decision had been made following a request from Dr Inkster that she required support. Dr Inkster informed the group that she will no longer chair this meeting. Dr Inkster said that she was ~~asked to~~advised she was to ~~-~~demit the chair and this was following feedback from the last meeting from members of the IMT that they were unhappy with the chair. Dr Inkster stated she was happy to continue to chair and was not in agreement to demit this role.~~, Sandra Devine said that she had had a conversation with Dr.Inkster regarding the complexities of chairing this meeting and being an active participant and that in principle Dr Inkster was in favour of another chair, however, this conversation was informal and no decision was made at that time~~. Sandra Devine informed the group that in Dr Inkster's absence earlier this week and to ensure that the meeting went ahead she had contacted other ICDs but because of the complexity of the meeting they did not feel they could chair. Annette Rankin requested that there was assurance that due process and from a governance perspective that there was a clear decision making process justifying the change in chair. Sandra Devine advised that Jacqui Reilly nurse director NSS was aware of the decision making process. Sandra~~he ~~also commented that the board SOP states that the chair can be either an Infection Control Doctor or Public Health Consultant. This is also in keeping with national guidance.

Minutes of the last meeting

Minutes from the previous IMT held on 14th August were disseminated to the group and the following amendments were requested:

Page 3, Other Relevant reports, 2nd paragraph, last line - Detail of the hand hygiene audit should be gained from Angela Johnson and followed up with the team to ensure clarity and learning.

Page 4, Risk Management/Control Measures, 2nd paragraph, 2nd last line – In order for this to be effective high level dusting needs to be carried out so estates are to investigate of hyper static cleaning can be carried out before the HPV clean can be undertaken

Page 4, ~~Hypothesis~~ Hypothesis, should read - The primary hypothesis for the increase of gram negative bacteraemia are the chilled beams either leaking or dripping condensation onto patients.

The other hypothesis the group are working towards is the access to unfiltered water patients may have had out with Ward 6A.

Page 5, AOCB, last paragraph, 1st line – Tom Steele requested an alternative to photos being sent to the group due to the sensitivity of some of them. He requested that in future appropriate meeting rooms can be booked to enable the photographs to be shown.

Update on Actions:

Please see separate action plan.

Incident Update – General Situation Statement

Possible link to the unusual gram negative bacteraemia being found within Ward 6A and organisms found in water and chilled beam environmental samples.

The haematologist/oncologist clinicians require access to a safe environment to treat their high risk patients. The initial move of patients from Ward 2A/2B into Ward 6A QEUH was supposed to be short term but has become long term after a ventilation review was carried out while Ward 2A was empty and undertaking facility upgrades. Currently looking at March 2020 until patients can move back into Ward 2A but this could change as there has been some changes to the scope of works required.

Clarification regarding the case definition for this incident was discussed.

It was agreed that any patient with a bloodstream infection from an organisms whose source is water or soil i.e. environmental organisms.

Patients who have a positive BC and have contact with 6a or supporting services (excluding 4B) in the past month.

It was agreed that if no new infections are detected after 4 weeks then consideration ~~we~~ can ~~assume the control measures put in place are working and~~be given to lifting restrictions on admission would be considered.

Incident Update – Patient Report

To date there has been 11 cases of gram negative bacteraemia in 10 patients (1 patient had 2 separate episodes). 4 of these cases are Hospital Acquired Infections (HAI).

Out of the 10 patients, 3 remain as inpatients.

There were two previously reported possible cases. One of the patients who was under investigation as a possible case will not be included as patient did not have any contact with Ward 6A and acquired infection in Ward 4B (HAI) thought to be potentially linked to a previous sewage leak. Annette Rankin stated she would provide this information in her update to the policy unit to explain why the case was no longer being considered. The other possible case is still under investigation.

The last confirmed case was on 2rd August 2019. **J Mallon**

Incident Update – Microbiology Report

Dr Inkster informed the group of a recent environmental positive Stenotrophomonas sample taken in an area just outside the anaesthetic room of Ward 2a, RHC. It is thought this may be due to the domestic using water from the DSR. Water in this area is filtereds and has chlorine dioxide present but does not have point of use filters so organisms commonly found in potable water will still be present. Only with the introduction of point of use filters fitted to taps can you guarantee no organisms within the water. **Estates**

Numerous results have came through but require decoding of areas of where samples were taken is before a final report can be completed. John Mallon is going to create specific labels for all future water samples taken regarding this incident so that they can be easily identified and lab staff will know what to test for.

3 samples from chilled beams within Ward 6A are to be taken and compared against samples from another area within the hospital. Estates have said they have found issues in gaining access in other areas to carry this out so it was agreed samples can be taken from a clinic instead where access will be easier.

John Mallon commented that recent samples from chilled beams were negative for gram-negative organisms, yeasts and fungi.

Incident Update – Other Relevant Reports

This week enhanced supervision found few minor estates issues which have been rectified. Hand Hygiene audit score was 100% opportunity taken and 80% compliance. The general failure with the compliance was staff touching taps after hand hygiene and before patient contact. Gillian Bowskill said the failures were by a mixture of staff groups.

Dr Kennedy asked how can we demonstrate that we are dealing with improving hand hygiene scores as recent reports have seen opportunities taken not being 100%. Hand hygiene co-ordinator Stefan Morton is carrying out training for all groups of staff over the next few weeks.

Jenn Rodgers informed the group that a different external person carried out the central line audit of Ward 6A, Day Care & OPD area. Overall practice was good in all 3 areas.

Hypothesis Update

The primary hypothesis for the increase in gram negative bacteraemia are the chilled beams either leaking or dripping condensation onto patients and their surroundings.

The second hypothesis the group are working towards is the access to unfiltered water patients may have had out with Ward 6A, e.g. toilets in adult and children's atrium, school room, Clic sargent etc.

Dr Kennedy spoke about his epidemiology report where it outlines the number and nature of the organisms. Within his epidemiology you can see patterns which are similar to the old Yorkhill hospital. You can recognise the work which has been undertaken recently to drive down the Klebsiella rates. Discussion on what would be a reasonable rate of infection within the haematology/oncology paediatric population was discussed. Dr Inkster has obtained figures from Great Ormond Street Children's Hospital public annual report where they reported 4 gram negative bacteraemia within its entire patient population but none within the nature found during this incident. Dr Kennedy suggested that occupancy, which is higher in the new unit compared to the old facility and patient acuity should be taken into consideration when reviewing data. He also commented that all these types of infections had been seen

before in the unit in yorkhill hospital.

The group commented that we might not be seeing as many infections because we have diverted cases and most of the existing patients are being given ciprofloxacin prophylaxis. It also commented (by who?)that comparing GOS to the current ward was not appropriate as the current ward was a temporary location and comparisons when patients are located in the new unit may be more meaningful.

Risk Management/Control Measures - Patients

Patients are currently receiving Ciprofloxacin as a prophylaxis to prevent infections. Clinicians are reporting that patients are experiencing an increase of nausea, diarrhoea and vomiting due to this.

Gillian Bowskill and T Inkster

All new patients requiring treatment are being diverted to Edinburgh or Aberdeen children hospitals.

Pamela Joannidis asked if there was any admission screening carried out. Emma Somerville informed the group they only carry out screening on patients if they are symptomatic when admitted into hospitals. It was noted that to implement this would be a major undertaking for lab staff and would require excess funding. Pamela commented that being aware of what is in the patients GI tact on admission may lead to better prescribing choices and definitions of what is exogenous or endogenous infection.

Estates

Estates

Jenn Rodgers has requested an SOP should be written up by the IPCT outlining the requirements if a patient is moved out with Ward 6A for a period of time. This will give clear guidance for staff to follow and implement anything required before patient is moved.

Estates

Risk Management/Control Measures - General

Estates

A list of all the control measures that have been put in place and the date in which they started is to be compiled to outline the measures this group has taken.

Estates

Biocide dosing of the chilled beams is to be introduced next week. It was agreed that samples of the water within the chilled beams will be taken before and after the implementation of the biocide.

Estates

New mechanical connectors will be fitted to the chilled beams as soon as possible. It was originally going to be carried out during the next time the chilled beams clean was due but this has been brought forward.

Estates

A revised Standard Operating Procedure (SOP) regarding the cleaning of the chilled beams is to be sent to Dr Inkster

It was agreed that the public toilets outside Ward 6A including the disabled toilets are to be closed to prevent patients using them.

Estates

Increase the chlorine dioxide currently at 0.5 parts per million (PPM) to a dose of 0.7 PPM. Regular contact with water experts say that we are using the best technology available to deal with organisms in the water.

The current DSR sink within Ward 6A cannot have a point of use filter fitted to it so estates have ordered a new sink and IPS panel to accommodate a tap in which one can be fitted. In the meantime while awaiting on the delivery of these items estates are to come up with a plan on how domestics can get access to filtered water for cleaning within Ward 6A. **Estates**

HEPA filtration units are to fitted to the every patient en-suite. Tom Steele informed the group that these units are made to order and has requested confirmation on the final number required for Ward 6A. **Estates**

Further Investigations Required

Estates are working on a timeline of the event of when the boiler pressure was lost and also the increased condensation from the chilled beams and map this against the patient timeline.

Tom Steele has also asked for the unfiltered water within the DSR to be tested as well as the DSR within the PICU.

Tom Steele is to see if we have got a point of use filter fitted to the tap within the DSR within PICU, RHC.

Healthcare Infection Incident Assessment Tool (HIIAT)

Severity of illness – MODERATE
Services – MAJOR
Risk of transmission – MODERATE
Public anxiety – MODERATE

The group agreed on an HIIAT score of RED. **L Dick J Rodger**

The group discussed how they can justify why the Services section within the HIIAT is now a Major when it was reported as Moderate last week and there have been no new cases since 3rd August. The reason the group decided to change it was that the most vulnerable patients are being moved to hospitals across Scotland to obtain treatment as this has been going on since the start of August. The longer this is kept going the more pressure and impact other health boards and patients/families will incur.

Communications

Advice to Public

Lorraine Dick and Jenn Rodgers have been doing briefings to family and staff. A brief to update staff and patients is expected today and concern was given that they are giving them the same repetitive information. It was agreed that people still want information even if it is quite repetitive. Staff will require a briefing that is in written down so that they know what to say if asked by patients. **L Dick**

Duty of Candour

No new patients have been identified.

Advice to Professionals

Clinicians are in regular contact with Edinburgh and Aberdeen colleagues regarding admitting new patients who have been diverted from Glasgow.

Media — **E Crighton**

Lorraine Dick will create a holding statement for the media — **A Rankin**

HPS

Gillian Bowskill & Sandra Devine will complete the HIORT and send onto Annette Rankin from HPS.

AOCB

Dr Inkster suggested it may be helpful to have a peer review undertaken and suggested contacting Great Ormond Street. The group agreed that this would be a good way forward. A visit to Leeds hospital was previously planned however this has been delayed ~~a peer review should be carried out of Ward 6A from someone who works in a similar ward (Great Ormond Street or Leeds Children Hospital).~~ Dr Crighton will discuss this with Dr Jennifer Armstrong to see if this can be arranged as soon as possible. It was suggested that an estates representative could visit Great Ormond Street Hospital and see what they do in a technical aspect regarding their testing regime and see if it aligns with ourselves. In the interim Annette Rankin offered to have another nurse consultant (HPS) not involved in the incident ~~will organise for one of her colleagues from HPS to~~ carry out a walk round of Ward 6A from an environmental perspective .

The group discussed what was going to be the deciding factor for when they can open ward 6A back open to new patients. It was agreed that with the introduction of the biocide to the chilled beams, mechanical fittings to be added to the chilled beams and no new gram negative bacteraemia within the ward in 4 weeks then the group will consider re-opening up the unit for new patients. This will be discussed at the next IMT.

The next IMT is on Monday 2nd September at 1400 in Room L2007, Level 2, Teaching & Learning Building, QEUH

SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Oral hearings commencing from 19 August 2024 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 27 - Miscellaneous Documents - Volume 12