

NHS Greater Glasgow & Clyde	Paper No. 21/03
Meeting:	Board Meeting
Date of Meeting:	23rd February 2021
Purpose of Paper:	For Noting
Classification:	Board Official
Sponsoring Director:	Mrs Jane Grant, Chief Executive

Paper Title

Queen Elizabeth University Hospital and Royal Hospital for Children Update

Recommendation

The Board is asked to:

- Note the update on the related work streams in respect of the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC).
- Note the Interim Oversight Board Report published in December 2020.

Purpose of Paper

To ensure the NHS Board is kept abreast of the varying issues relating to the QEUH and the RHC.

Key Issues to be considered

- The current position in respect of the escalation to Level 4 of the NHS Scotland Performance Management Framework and the Interim Oversight Board Report – which is attached at Appendix 1.
- The position regarding the recommendations of the Independent QEUH Report.
- The Scottish Hospitals Public Inquiry
- The position in relation to the pursuit of legal action for loss and damages in relation to the QEUH and RHC.
- The work the Board is progressing regarding the Health and Safety Executive investigation.

Any Patient Safety/Patient Experience Issues

Core to the work underway.

Any Financial Implications from this Paper

No defined costs at this stage however varying elements will be of significance over time.

Any Staffing Implications from this Paper

Nil specific

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Any Equality Implications from this Paper

None

Any Health Inequalities Implications from this Paper

None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

Not applicable

Highlight the Corporate Plan priorities to which your paper relates

Improving quality, efficiency and effectiveness.

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Date: 14th February 2021

**Queen Elizabeth University Hospital and Royal Hospital for
Children Update – February 2021**

1.0 QEUH/RHC and Performance Escalation

1.1 NHS GGC remains on Level 4 of the NHS Scotland Performance Management Framework in respect of what was described as on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) and the associated communication and public engagement issues.

1.2 As Board members are aware, as part of that process, an Oversight Board was established, chaired by Professor Fiona McQueen, with three sub groups reporting to the Oversight Board namely; Infection Prevention and Control Governance, Communication and Engagement and a Technical group.

1.3 NHS GGC has worked closely with the Scottish Government team throughout, providing significant amounts of evidence over the months to the sub groups, reviewing and commenting on draft reports.

1.4 On 8 December the Finance Planning and Performance Committee received a presentation outlining the findings of the draft Interim Oversight Board Report. Feedback on factual accuracy and comment on conclusions was provided to the Scottish Government in December 2020, with the Final Interim Oversight Board Report published on 21 December 2020. The Interim Report focuses on Infection Prevention and Control: Processes, Systems and Approach to Improvement and Communication and Engagement. Updates are also provided on the other strands of work. The final report will consider IPC governance, structure, responsiveness and leadership, the timing of which yet to be confirmed.

1.5 Since receipt of the final version of the Interim Oversight Board Report, an Action Plan has been developed to ensure progress against each of the recommendations. Dialogue continues with the Scottish Government to confirm what is exactly expected in respect of some of the recommendations, particularly around communication and engagement. This is being overseen by the internal Executive Oversight Group, chaired by the Chief Executive. The Finance Planning and Performance Committee will receive a further update in due course.

1.6 We continue to support the work of the casenote review which is considering all haemato-oncology paediatric patients from 2015 to 2019 who had a gram-negative bacterium identified in laboratory tests. This is being undertaken by an expert panel who are providing oversight and analysis. This work is nearing completion with the draft report expected for review and fact checking by the last week in February. Final reporting timescales are yet to be confirmed, however are likely to be aligned to the Oversight Board Final Report publication.

1.7 Work continues on Wards 2A and 2B of the RHC, which were closed in September 2018. Timescales were updated when work began on the wards and the practicalities of addressing the range of works required were more fully understood. Acknowledging the further impact of COVID-19 with cessation of activity for some weeks, the programme plan required to be updated to recognise the various mitigation measures which needed to be in place to ensure safe working, adherence to social distancing, PPE and the enforcement of these measures. The current timescale for completion is May 2021, but this is dependent on no further disruption due to the COVID situation.

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1.8 Further work continues internally to address the issues associated with the Performance Escalation. An internal Oversight Board continues to meet regularly to overview progress with GP OOHs, Unscheduled Care and Scheduled Care.

2.0 Independent Review – Update

2.1 Work continues to review the actions arising from the report of the independent review of infection control concerns at the Queen Elizabeth University Hospital and the Royal Hospital for Children by Dr Andrew Fraser and Dr Brian Montgomery.

2.2 This is being progressed in accordance with the action planning methodology recommended by the Scottish Government. Progress is being monitored by QEUH Gold Command with input from appropriate Directors. All recommendations and actions relevant to NHS GGC are either complete or are fully in place with on-going monitoring.

2.3 Gold Command will receive a further update on the Action Plan in April 2021. The GGC Action Plan will also be further developed in future to incorporate the developments and outcomes of the Report recommendations being progressed by National Agencies and link, where appropriate, to Oversight Board recommendations. The Finance Planning and Performance Committee will also receive an update in respect of these recommendations.

3.0 Scottish Hospitals Public Inquiry

3.1 The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. This was a 'soft launch' with time taken to build an inquiry team and become established. On 19 January 2021 Lord Brodie announced timescales for 2021 and on the 1 February issued core participants with formal evidence requests. The content of the request is significant and is focussed on the below priorities.

- Adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care
- Governance and Project Management - as far back as 2002
- Effects of the issues identified on patients and their families

3.2 The timescales announced on the 19 January noted that an initial meeting is scheduled for Thursday 18 March which is intended to be an initial gathering of legal representatives of core participants at which Lord Brodie will explain the progress of the Inquiry and the likely programme going forward.

3.2.1 The first formal hearing of the Inquiry will take place on Tuesday 22 June. This will be a procedural hearing to confirm arrangements for the first substantive hearings in September.

3.2.2 The first substantive hearings of the Inquiry will commence on Monday 20 September and will last for three weeks. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families and it is those patients and families who will form the core of those called upon to give evidence in person at those hearings.

3.2.3 It is likely that the next set of hearings will be scheduled for late first quarter/ early second quarter of 2022, with a procedural hearing ahead of those either end 2021/ early 2022. Further details of what will be covered and the programme for the hearing will be published in due course.

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3.3 We continue to work with the dedicated team from the Central Legal Office on all issues connected to the QEUH/RHC. Supported by the CLO, NHS GGC has instructed both Senior Counsel and 2 Junior Counsel to act on the Board's behalf throughout the Inquiry.

3.4 The Programme Management Office (PMO) continues to manage the day to day requirements of the Public Inquiry in terms of administration and document flow. As a formal process is established by the Inquiry Team, the resources required are likely to increase to ensure we respond in a timely manner. The Executive Oversight Group, established, in November 2020, continues to ensure effective and transparent decision making across the process at this stage. It is important to note that some of the issues under consideration in respect of the Inquiry are directly related to those detailed in the legal claim updated below, and hence oversight of both elements is critical moving forward.

4.0 Legal Proceedings

4.1 Further to the approval of the Board in January 2019 to raise Court Proceedings against the parties responsible for delivering the QEUH/RHC construction project, the Board engaged MacRoberts LLP to act on its behalf. Court summons were served on the main contractor for the hospital project, Multiplex, and the Health Board's advisors, Currie & Brown UK Limited and Capita Property and Infrastructure Limited.

4.2 Throughout 2020, the Board continued to engage with the appointed legal team within MacRoberts. The process of seeking expert opinion against the 11 Heads of Claim was undertaken which included site visits and preliminary reports from the independent experts to assist on the question of liability.

4.3. In private session on January 2021, the Board considered the position in respect of the claim and the Board approved that NHS GGC instruct MacRoberts LLP to lodge the action for calling. This was completed on Wednesday 25th January.

4.4 Further legally privileged information will be considered in the private session of the Board on the 23rd February.

5.0 HSE Investigation

5.1 Board members will be aware that on the 24 December 2019, the Health and Safety Executive (HSE) served on NHS GGC an Improvement Notice in relation to the ventilation system for Ward 4C. Legal advice was sought and we appealed the Improvement Notice on the grounds that there was no basis in fact for the Improvement Notice to have been served.

5.2 After an initial hearing in the Employment Tribunal relating to the Board's appeal against the HSE Improvement Notice, it was agreed that the legal representatives of the HSE and Board would meet. Due to COVID-19 there was a suspension of activity. A preliminary hearing was held on 3 Sep 2020 with a further preliminary hearing on the 23 Nov 2020. The Court has provided a timeline for the appeal to proceed, with a hearing scheduled for around October 2021.

6.0 Summary

6.1 The many issues described in this paper represent a significant amount of work over the coming months, and indeed years in respect of the Public Inquiry. The resource requirements of the senior leadership team and supporting elements, such as the PMO, are currently being reviewed with a view to increasing the level of resource during February and March 2021.

6.2 The senior leadership team are committed to support the programmes of work described, ensuring swift action and implementation of recommendations with robust action plans. A process is being established to ensure a monitoring framework is created to track progress and ensure any required improvements are realised.

INTERIM REPORT

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

Findings

Progress

November 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, clinical 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 – particularly 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.

The Interim Report 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.

The Final Report will set out findings and recommendations for the remaining IPC issues, particularly: clinical governance; the responsiveness of the Health Board's IPC to the infection incidents; the responsibilities and structures of the IPC Team; working culture and relationships with the IPC Team; and the way in which leadership has been organised for IPC.

Local recommendations

- With the support of the Scottish Government and ARHAI Scotland, NHS GGC should undertake a wide-ranging benchmarking of key IPC processes through a more comprehensive Peer Review exercise.
- 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.
- With the support of Healthcare Improvement Scotland, NHS GGC should undertake a review of its programme of audits relating to IPC, in line with the national Healthcare Improvement Scotland framework for quality planning and improvement.
- With the support of ARHAI Scotland, NHS GGC should undertake a review of its approach to Healthcare Infection Incident Assessment Tools (HIIATs) to ensure that risks and incidents are being properly and consistently identified and communicated.
- 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?*

Further work is being undertaken on communications and engagement. 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). 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), clinical 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 and Clinical Governance was (and is 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 the technical workings of the hospitals in question, with a particular focus on key infrastructure issues. It has been chaired by Alan Morrison, Deputy Director for Health Infrastructure in the Scottish Government.
- **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 2020.¹ 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.

¹ <https://www.queenelizabethhospitalreview.scot/queen-elizabeth-university-hospital-review-review-report/>.

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 clinical 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;
- 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 noted that there had been several deaths of children and young people linked to infection, 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 were coming 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.

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.

15. Finally, there were a number of relevant reports by external bodies over the period that underlined these various concerns. This included the report 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*² – 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. Indeed, with the publication of the HPS report, there was extensive media reporting that ‘widespread contamination’ of the water supply had been found, though the specific link to individual infection incidents remained elusive.

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 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.

² <https://www.gov.scot/publications/qe-university-hospital-royal-hospital-children-water-incident/>.

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, clinical 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/QEUEH 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 QEUEH 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 will:

- 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 QEUEH 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 emerge;
- 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. 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 published³ 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. 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 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

³ <https://www.gov.scot/publications/inquiry-into-the-construction-of-the-qeuh-glasgow-and-the-rhcy-dcn-edinburgh-terms-of-reference/>.

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.

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 in line with the values of NHS Scotland. These values 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, clinical 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;
- **clinical 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 clinical 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 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.

<u>Escalation issue</u>	<u>What is covered in this Interim Report</u>	<u>What will be covered in the Final Report</u>
<i>Infection prevention and control</i>	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Review of how the infection incidents were addressed by NHS GGC and wider mitigation/responses Review of the roles, resourcing, organisation and related culture and leadership issues of the IPC Team for the QEUH Findings and recommendations on the above set of issues
<i>Clinical governance</i>	<ul style="list-style-type: none"> Update on work on Clinical Governance 	<ul style="list-style-type: none"> 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 Clinical Governance issues
<i>Related technical issues</i>	<ul style="list-style-type: none"> Update on refurbishment of Wards 2A/2B in the RHC 	<ul style="list-style-type: none"> Assurance on NHS GGC's water testing policy in the RHC/QEUH Assurance on plans to address any remedial works relating to infection arising from infrastructure issues on the QEUH site
<i>Communication and engagement</i>	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Review of how the organisational duty of candour, the Significant Adverse Events Policy and related review processes operated for these infection incidents – including findings and recommendations
<u>Escalation issue</u>	<u>What is covered in this Interim Report</u>	<u>What will be covered in the Final Report</u>
<i>Case Note Review</i>	<ul style="list-style-type: none"> Update of the work of the Case Note Review 	<ul style="list-style-type: none"> Summary of findings and recommendations of the Case Note Review
<i>Review of escalation to Stage 4</i>		<ul style="list-style-type: none"> 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 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 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 2014⁴, 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 reviews 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;*

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<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 2019⁵ 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.

⁵ [https://www.sehd.scot.nhs.uk/dl/DL\(2019\)23.pdf](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 in the QEUH 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.

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 on the QUEH site. The focus of the SBAR was specifically 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 2012⁶, 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
- 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

⁶ <http://www.nipcm.scot.nhs.uk/>.

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.

Use of Healthcare Associated Infection Systems for Controlling Risk in the Built Environment

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) 30⁷ in January 2007 to support Health Boards to manage IPC in the built environment. The guidance comprised:

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

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:

⁷ [file:///C:/Users/u206386/Downloads/1509104776-SHFN%2030%20Part%20A%20-%20HAI-SCRIBE%20Manual%20information%20\(1\).pdf](file:///C:/Users/u206386/Downloads/1509104776-SHFN%2030%20Part%20A%20-%20HAI-SCRIBE%20Manual%20information%20(1).pdf).

- 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 Audits⁸, 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.

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.

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

⁸ <http://www.nipcm.hps.scot.nhs.uk/resources/audit-tools/>.

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.

Approach to Surveillance

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 NIPCM⁹ 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.

Use of Healthcare Infection Incident Assessment Tools

⁹ <http://www.nipcm.hps.scot.nhs.uk/media/1365/2017-06-19-appendix-13.pdf>.

68. 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.

69. 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.

70. 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 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.

71. 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

72. 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.

73. 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.

74. 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, then and only then, should wholesale local implementation commence.

75. 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 project focused on simple changes for better patient outcomes and on a hospital-wide Quality Improvement Collaborative (QIC) set on reducing the incidence of CLABSI across the hospital. Elements of the QIC included giving staff across the unit responsibility of management of line incidence reporting within 48 hours and unified central line insertion protocols.

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

76. 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.*”¹⁰ 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.

2019 infection outbreak at the Royal Alexandria Hospital

A number of instances of *Stenotrophomonas maltophilia* were identified at the Royal Alexandria 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,

¹⁰ www.nhsggc.org.uk/media/257579/item-14-int-review16decfinal.pdf.

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.

77. 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 (although there was no evidence presented that these lessons learned were shared across the different IPC teams in the Health Board). 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.

78. 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 elsewhere in this Interim Report and 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; the development of a single IPC Assurance and Accountability Framework from a set of separate documents; and the new SOP relating to the identification of new environmental organisms agreed in November 2018.

79. 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.

80. 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 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 importantly, it was not evident that the relevant local teams were leading this work. Put simply, improvement work appeared to be siloed within the IPC Team without sufficient mainstreaming across other teams.

81. 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.

82. 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. That approach was inherent in the CLABSI work described above and should be more systematically pursued across the IPC Team.

83. 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

84. 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;
- Responsibilities and structures: the roles, resourcing and organisation of the IPC Team in the QEUH, as well as relations with other parts/functions of NHS GGC;
- Culture: how well did the IPC Team work internally and with other key staff, with a particular focus on the working environment and how this might have affected NHS GGC's overall effectiveness in IPC; 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.

85. 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.

86.

Governance and Risk Management

87. The second set of escalation issues which the Oversight Board is examining is Clinical Governance. Its importance has been captured in the Blueprint for Good Governance for NHS Scotland¹¹, 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 clinical governance and the approach all Health Boards should take towards quality planning and management in key documents by HIS¹².

88. With respect to IPC, that covers a range of important areas, such as the way in which infection incidents and corresponding actions are escalated, scrutinised, endorsed and monitored by the clinical 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.

Progress Update

89. 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;

¹¹ [https://www.sehd.scot.nhs.uk/dl/DL\(2019\)02.pdf](https://www.sehd.scot.nhs.uk/dl/DL(2019)02.pdf).

¹² <http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=e4e2a8ce-342e-4e5c-b998-1f81859b282f&version=-1>.

- 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 Clinical Governance structure; and
- a specific peer review of IPC governance and the recent changes introduced within the Health Board by the IPCG Subgroup.

90. All of this work is still to be finalised so the Oversight Board will set out its findings and recommendations on Clinical Governance in the Final Report.

Technical Review

91. 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

92. 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

93. 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.

94. 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

95. 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.

96. 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.

97. 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 happened, 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.

98. 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.

99. 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.*

100. 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.

101. 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.

102. 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

103. 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 2019¹³ 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.”

104. NHS GGC's own stated objectives for person-centred care are set out in its 2019-23 Healthcare Quality Strategy¹⁴. 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.

105. 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).*
- *We will develop further the person centred approaches to visiting throughout NHS GGC.*

¹³ <https://www.sicsag.scot.nhs.uk/hai/docs/HCAI-DL-2019-23-Dec-2019.pdf>.

¹⁴ https://www.nhsggc.org.uk/media/253754/190219-the-pursuit-of-healthcare-excellence-paper_low-res.pdf.

- *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.*

106. 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*¹⁵, 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.

107. 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
- 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.

¹⁵ <https://www.nhsggc.org.uk/media/243043/hai-communication-strategy-july-2015.pdf>.

108. 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

109. 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.

110. 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.

111. 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 on the ward to keeping patients and families directly informed.

112. 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 2018 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.

113. 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.

114. 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.

115. 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.

116. 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

117. 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.

118. 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.

119. The news was put out in a number of ways on 18 September and the days that followed. For those on the wards, much of this was done through leafletting. 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.

120. 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.

121. 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.

122. 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

123. 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.

124. 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.

125. 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

126. 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.

127. 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.

128. 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.

129. 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

130. 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.

131. 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

132. 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.

133. 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.

134. 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.

135. 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

136. 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.

137. 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.

138. 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.

Incident Management Team Responsibilities

139. 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.

140. 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).

141. 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

142. 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.

143. 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.

144. 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.

145. 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

146. 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.

147. 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.

148. 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.

149. 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

150. 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.

151. 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.

152. 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.

153. Senior leaders within NHS GGC did become directly involved, with letters to families from the Chief Executive being issued later in this period 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

154. 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.

155. 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

156. 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.

157. 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

158. 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.

159. 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.

160. 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?*

161. 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).

Reporting to the Oversight Board

162. 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

163. 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

164. 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).

165. 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

166. 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 clinical 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.

167. 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 and the learning and improvement evident to date. Notwithstanding that this remains work in progress, this Interim Report has already identified a number of areas where improvement needs to take place. This forms the basis for the findings and recommendations set out in this chapter, which also includes areas where further investigation is necessary (for example, with respect to the Peer Review). 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 and advice on de-escalation.

Findings

168. 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 and risk management – has not been examined in detail in the Interim Report, so findings and recommendations are not presented for that set of issues. In addition, the work of the Technical Issues Subgroup has not been finalised for this report either, as noted above. Consequently, the findings here focus on major elements of the following areas: IPC; and communication and engagement.

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

169. 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.

170. 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.

171. 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’). 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.

172. 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.

173. 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 HIATs 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

QEUEH, the approach to HIIATs may indicate an underestimation of the wider infection risks facing the site.

174. The Peer Review could not be implemented in full by the Oversight Board because of the pandemic, and so the recommendations below recognise that there is further investigative work the Health Board should do for its IPC processes.

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, 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.

185. The recommendations are based on what needs to be done by NHS GGC 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.

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

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, NHS GGC should undertake a wide-ranging benchmarking of key IPC processes through a more comprehensive Peer Review exercise.

187. With support from ARHAI Scotland, NHS GGC should undertake a comprehensive Peer Review process, led from within its IPC Team but drawing on external expertise. The scope and terms of reference should be agreed with the Scottish Government by the end of January 2021, and should include elements that were not examined as part of the Oversight Board's Peer Review in March 2020, specifically outbreak and incident investigation, and water safety.

188. This Peer Review should be undertaken as soon as feasible (acknowledging the pressure of other circumstances, not least the pandemic), and completed before the end of March 2021. The recommendations of that Peer Review 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.

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.

189. 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 March 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.

190. 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 June 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.

191. 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 March 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.

192. 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 June 2021.

Recommendation 6: With the support of Healthcare Improvement Scotland, NHS GGC should undertake a review of its programme of audits relating to IPC, in line with the national Healthcare Improvement Scotland framework for quality planning and improvement.

193. A review of audit programmes should be undertaken 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. The scope of the review should be agreed with the Scottish Government and completed by end March 2021.

Recommendation 7: 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.

194. 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 June 2021, potentially using the national forum referenced in Recommendation 5 above to develop and monitor the work going forward.

Recommendation 8: With the support of ARHAI Scotland, NHS GGC should undertake a review of its approach to Healthcare Infection Incident Assessment Tools (HIIATs) to ensure that risks and incidents are being properly and consistently identified and communicated.

195. 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, with support from ARHAI Scotland, looking at the local criteria and judgements applied to ratings for infection incidents related to the QEUH. The results of the review should be presented to the Scottish Government by end March 2021.

196. Particular attention should be given to how known environmental risks in the hospital, especially with respect to potential water contamination, are explicitly factored into assessment. This should be part of a wider approach by the IPC Team to consider how the ‘history’ of environmental infections in the hospital site, particularly with respect to water contamination, can inform relevant IPC hypotheses and the work of IMTS more consistently going forward. The Health Board is invited as part of the review to set out how any change in HIIAT approach is mainstreamed across the wider approach to IPC, particularly in the QEUH.

Recommendation 9: 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.

197. 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 June 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 10: 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.

198. 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.

199. The scope of the work should be agreed with the Scottish Government and the Health Board by end January 2021 and the work completed by end June 2021.

Communication and Engagement

200. 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 the organisational duty of candour and review processes such as Significant Adverse Event Reviews will be discussed in the Final Report.

Recommendation 11: 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.

201. 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.

202. 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.

203. 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 March 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 12: 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.

204. 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 March 2021.

205. 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 13: 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.

206. The experience of the communication on HAI 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 14: 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.

207. Leadership in addressing the challenge of communication on HAI in the paediatric haemato-oncology service was clearly demonstrated in much of the response to the emerging issues by some 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.

208. 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 CCGC, and, where appropriate, the Board.

209. The Health Board should present a proposal for putting these measures in place to the Scottish Government by the end of January 2021 so that it can feed into the development of a revised HAI Strategy.

Recommendation 15: 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.

210. 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.

211. 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 16: 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.

212. 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 17: 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.

213. 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 18: 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.

214. 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.

215. 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 January 2021.

Recommendation 19: 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.

216. 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 June 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 clinical 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

<u>Member</u>	<u>Job Title</u>
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 (seconded)
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

<u>Member</u>	<u>Job Title</u>
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

<u>Member</u>	<u>Job Title</u>
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
Alfie Rawson	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

<u>Outcome</u>	<u>Action</u>	<u>Example of evidence</u>
<i>Infection Prevention and Control and Clinical Governance</i>		
<i>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.</i>	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.	<ul style="list-style-type: none"> Confirmation of current/sustainable effective governance with respect to: HAIRT Reports; 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.	<ul style="list-style-type: none"> 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).

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<u>Outcome</u>	<u>Action</u>	<u>Example of evidence</u>
<i>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.</i>	Conduct a detailed review of relevant individual instances of infection and identify actions on individual cases and systemic improvements.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.
<u>Outcome</u>	<u>Action</u>	<u>Example of evidence</u>
<i>Communication and Engagement</i>		
<i>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.</i>	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).	<ul style="list-style-type: none"> • 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.

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<p><i>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.</i></p>	<p>Develop and implement a strategic NHS GGC Communication strategy with a person-centred approach, including a clear Executive Lead for implementing and monitoring.</p>	<ul style="list-style-type: none"> • 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.
	<p>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.</p>	<ul style="list-style-type: none"> • 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.