Written Statement

Janice MacKenzie

Introduction

1. My name is Janice MacKenzie. I retired from NHS Lothian in 2019. In my last post before retiring I was involved in supporting input from clinicians to the Royal Hospital for Children and Young People ("RHCYP") and the Department of Clinical Neuroscience ("DCN") ("the Project"). I provided clinical input in relation to the design, planning and construction. I have been asked to provide a written statement to the Scottish Hospitals Inquiry ("SHI") in relation to my involvement in the Project, and in particular decisions to design the RHCYP and DCN to include multi-bed rooms. I have been provided with a list of questions from the SHI and a bundle of documents from the SHI. NHS Lothian have provided me with additional documents for review. This statement seeks to answer the list of questions to the best of my recollection. Some of the events I've been asked about occurred fifteen or so years ago and, given the passage of time, I cannot recall all of the details of all the events.

Background

2. I started my General Nurse training in 1978 and qualified in 1981. After qualifying I worked as a staff nurse at the Victoria Infirmary, Glasgow for just under a year before going to Edinburgh to complete my children's nurse training. When I qualified as a registered children's nurse I went to London in 1983 and worked at Great Ormond Street Hospital for Children for 15 years in a variety of different roles, initially as a Staff Nurse and then as a Ward Sister before becoming a Nurse Manager/Senior Nurse.

3. I came back to The Royal Hospital for Sick Children Edinburgh (RHSCE) in 1998 as the Senior Nurse for Quality and Professional Development. I was in this role for 3 years before being promoted to the post of Principal Nurse for Children's and Associated Services and Operational Manager for Children's Community Services. I held this post for 4 years when in 2005 I was appointed as Chief Nurse for acute and community Children's Services in Lothian covering RHSCE and St John's Hospital

Children's Services. In the Chief Nurse role, I directed and managed the provision of all the nursing services and was part of the Children's Services Clinical Management Team, which had responsibility for the operational management of Children's Services and the core team comprised of the Director of Operations, Service Manager, Medical Director and myself. A key element of my role was to ensure that patients and their families received patient centred, safe and effective care. I worked closely with the Medical Director to ensure the effective working of the clinical governance framework.

4. In 2011, I was asked to join the project team for the RHCYP project on a part-time basis to provide clinical input. This was because the previous Project Director, Isabel McCallum, and one of the senior clinicians, Dave Simpson, had left the Project and the new Project Director, Brian Currie, recognised the need for direct clinical input and expertise within the project team. As well as working on the Project I continued to undertake the Chief Nurse role but on a part-time basis. As the Chief Nurse and a member of the Clinical Management Team, I was already involved in the Project and did provide clinical advice and supported staff in their involvement. In 2012 I became full-time on the project as Clinical Director until I retired in 2019. The key responsibilities of my role were to provide professional and clinical leadership and advice to a range of people including the project team, technical advisers and architects. I led the clinical input into the design of the new hospital working with a wide range of clinical and professional teams to ensure the clinical design of the wards/departments met the clinical requirements.

<u>Patient Focus and Public Involvement</u>

5. In 2006 the Project established a number of Project Groups: PG1 Core Project Team; PG2: Clinical Redesign; PG3: Steering Group Design & Construction; PG 4: Workforce; and PG5: Children & Young People's Advisory Board. These groups reported to the Project Board.

6. In the Chief Nurse role, I was asked by the then Project Director, Isabel McCallum, to lead on Patient Focus and Public Involvement and co-chair PG5 with a parent from the RHSCE Family Council. PG5 had its first meeting in October 2006, meeting monthly for the first 14 months and continued to meet until April 2009. The purpose of the group

was to ensure that there was effective consultation and engagement with patients and families and charity organisations for the planning of the new hospital. PG5 membership included staff, charity and parent representatives. The Family Council, which was already established, and Young People's Advisory Group (YPAG) which was formed in 2007, linked into PG5.

7. PG5 co-ordinated many consultation events and activities, including issuing questionnaires, to seek the views of children, young people and their families about a number of key elements in relation to the planning of the new hospital. A Record of Involvement was maintained and updated which shows the activities undertaken and who was consulted. The Record of Involvement (Bundle 4; Document number 2; Page 9) was updated regularly to allow us to demonstrate to the Scottish Health Council (SHC), which was established by the Scottish Executive, that we were meeting the Patient Focus and Public Involvement requirements. The SHC had an open invitation to attend the PG5 meetings, which a representative did on a few occasions, and they received agendas and papers for the meetings.

8. Around the time of the consultation events, I was aware through the Project Team that there were ongoing discussions at Scottish Government level about the benefits of single rooms in hospitals. PG5 were asked by the Project Team to seek the views of children, young people and their families about whether the patient areas should be all single rooms or a mixture of single rooms and 4/6 bedded bays. We therefore included this question in questionnaires ("Questionnaire score 1 to 5") (Bundle 4; Document number 3; Page 17) developed for children, young people and families to complete. YPAG in 2008 also provided their views on single room accommodation YPAG feedback on SRA131108 (Bundle 4; Document number 4; Page 19).

9. The feedback from the majority of children, young people and families who completed the questionnaires was that they would not always want to be in single rooms and that they felt that there should be a mixture of single rooms and bedded bays. At the same time the Project team sought the views of clinical staff who felt strongly that having 100% single rooms was not appropriate in a Children's Hospital for a variety of reasons.

This included patient safety, the need to be able to closely observe specific patients dependent upon their clinical condition, the impact on feelings of isolation and lack of social interaction. Many young children in the hospital also have respiratory conditions like bronchiolitis. From a patient safety perspective, the clinical view was that cohorting of patients with bronchiolitis in a 4 bedded bay was preferable as it allowed for greater observation. Also from a practical perspective, young children can't press a nurse call button and not all children have a parent/family member with them all the time. Children are generally more dependent on nursing staff than adults, particularly younger children and a high proportion of children in hospital are under 2 years of age. These were the main reasons for proposing a combination of single and multiple bedded rooms as the preferred option. There was however a recognition that the new hospital required more single rooms than it had at the existing RHSC hospital.

10. The outcome of the consultation is recorded in a paper called the Single Room Accommodation Report, which I drafted. The Single Accommodation report is Appendix 6.3 of the 2008 OBC (Bundle 3; Volume 1; Document number 12; Page 426).

11. It is also relevant to note that Infection Prevention and Control issued regular HAI reports for adult and children's services detailing HAI rates. On the basis of these reports and rates it was also acknowledged that hospital acquired infection rates amongst children at RHSCE were significantly lower than within adult services.

12. The proportion of single rooms within new builds was also discussed at the Association of Chief Children's Nurses, a group of Chief Nurses and Heads of Nursing for children's hospitals/units in the UK. Their remit was to shape and influence policy and share best practice. I was a member of the group and attended the meetings which occurred every few months. At the time that RHCYP was being planned there were also plans for new Children's Hospitals in Glasgow, Manchester and Liverpool and they were not planning to have 100% single rooms. This was a topical issue for senior children's nurses at this time. I would say that generally there was a consensus amongst the senior nurses that there should be a combination of single rooms and multi-bedded bays in children's units/hospitals.

13. There was also a wider consultation around 2007 by the Scottish Executive Nurse Directors Group, the NHS Lothian Board's Nurse Director was part of this group as were all the NHS Board Nurse Directors. This resulted in the Single Room Provision in Scotland Draft Nursing Report. I am aware that there were several draft versions of this report. The first version didn't specifically mention children. However, we were asked for input and the fifth version of the report (Bundle 4; Document number 5; Page 20) included NHS Lothian's findings in terms of children, young people and families and clinical views which were sought as part of the consultation for the new hospital (see page 5 of the report which is headed up "Children's Services") (Bundle 4; Document number 5; Page 25). I wasn't part of the Scottish Executive Nurse Directors group, but they did take extracts from the report I produced in 2007. I cannot recall who provided them with my report but the normal process for this would have been through either NHS Lothian's Nurse Director or the Project Director. As far as I was made aware this group seemed open to our findings and there was a recognition that children have differing needs from adults.

Single Room Policy

14. I do recall seeing the Scottish Government's Interim Guidance for NHS Scotland Provision of Single Room Accommodation dated 15 December 2006 (the Interim Guidance) (Bundle 3; Volume 1; Document number 5; Page 152) and have reviewed it for this statement. I note that it allowed for beds to be provided in an arrangement of 50%, 75% or 100% single occupancy rooms.

15. I do recall seeing the Guidance on the Provision of Single Room Accommodation in November 2008 (CEL 48) (Bundle 4; Document number 1; Page 5) and have reviewed it for this statement. I note that CEL 48 stated that for all new-build hospitals there should be a presumption that all patients will be accommodated in single rooms, unless there are clinical reasons for multi-bedded rooms to be available.

16. I do recall seeing a letter issued by the Scottish Government's Health Finance Directorate in July 2010 (CEL 27) (Bundle 4; Document number 10; Page 144) and have reviewed it for this statement. I note that that the presumption is that there should

be 100% single rooms in future hospital developments (CEL 27), unless there were clinical reasons for different arrangements.

17. I have been asked how I was made aware of CEL 48 (Bundle 4; Document number 1; Page 5) and 27 (Bundle 4; Document number 10; Page 144) Guidance when they were introduced. Guidance would normally be disseminated through the management line, it would have gone to the Board initially from the Scottish Government and the Board Executive Directors would cascade it down through the organisation to their management teams. I don't recall who I received it from but it would have come through one of three channels: either the project team; University Hospitals Division's Director of Nursing; or, the General Manager for Children's Services but I cannot say for certain which one it was.

18. I have been asked about the Scottish Government's Single Room Steering Group, the Delphi Consultation and the introduction of the Single Room Policy. I was not part of the Steering Group or the Delphi Consultation and cannot say why they were formed. I was not involved in the development of the single room policies CEL 48 (Bundle 4; Document number 1; Page 5) or CEL 27 (Bundle 4; Document number 10; Page 144). Similarly, I do not know whether the introduction of CEL 48 or CEL 27 lead to a review and update of the technical guidance. Those were matters for the Scottish Government.

19. I would have been involved in the decisions about the proportion of single rooms in each ward in the RHCYP from the perspective of giving my clinical nursing opinion. I remember being involved in many of the discussions with the different clinical teams that the project team led as well as discussions with my senior nursing team about this issue. I recall we considered the different clinical specialities and what the proportion of single rooms should be based on the clinical needs of the patients. This is an important point; it was not the same for every ward. It varied with each speciality depending on the children's clinical needs.

20. For example, taking account of the clinical needs the recommendation was for 100% single rooms within the Oncology ward and Child and Adolescent Mental Health Unit. In addition, the proportion of single rooms within the two medical wards, which admit

both planned and emergency admissions of children with a range of medical conditions, e.g. general paediatrics, respiratory, gastro-intestinal, diabetes, rheumatology and nephrology, was higher than within the surgical wards, due to the clinical conditions that children and young people admitted to these wards had, e.g. cystic fibrosis. The surgical wards, also admit both planned and emergency admissions for children requiring both general and specialist surgery, e.g. orthopaedics, trauma, ear, nose and throat, spinal and plastic surgery. The proposals for each ward came from the meetings and discussions between clinical teams and the project team.

21. To reach the decision about this issue a number of factors were considered which would have included clinical risks, patient mix of condition/disease, patient dependency, observational needs and age range of patients. This then allowed the clinical staff to consider the appropriate ratio of single rooms and four bedded bays within a ward area. At that time, as was still the case when I retired, a significant number of children admitted to hospital were under the age of 2. Children, especially younger children, feel isolated and alone when in a single room, they need social interaction as part of the mental and physical development and this is more difficult to achieve when in a single room particularly if a parent is not resident with the child and they are in hospital for longer period of time. Also, young children cannot raise an alarm or call for a nurse when they need help or are upset. Another important factor is that a child's condition can often deteriorate more quickly than an adult and many due to their age are not able to indicate this to staff. So the ability to closely observe children who are unstable is a key issue for clinical staff. Each child's needs are assessed on an individual basis with some children requiring one to one nursing care. The level of observation required is dependent upon the clinical condition of the child, and determines the ratio of patients to one nurse.

22. I would add that, in practice, clinical assessments involving Infection Prevention and Control are always made in relation to which patients should be admitted to a single room and which patients should be cohorted in a multi-bedded bays. NHS Lothian has its own guidance on this, namely Patient Isolation Prioritisation and Assistance with Isolation Prioritisation Risk Assessment (Bundle 4; Document number 6; Page 42) which took account of the National Infection and Prevention Control Manual, appendix

11 which details Best Practice and Optimal Placement in terms of room type (Bundle 4; Document number 7; Page 50).

Approval re Proportion of Single Rooms for July 2008 OBC

23. I have been asked whether the Chief Medical Offer and/or the Chief Nursing Officer was consulted in relation to the decision taken about the proportion of single rooms in the RHCYP both in the 2008 OBC (Bundle 3; Volume 1; Document number 12; Page 272) and any subsequent decision.

24. In my role as Chief Nurse I would not have been involved in discussing this with the Chief Medical Offer and/or the Chief Nursing Officer. My recollection is that NHS Lothian got approval from the Chief Medical Officer in relation to the proposals to have a mixture of single rooms and multi-bedded bays prior to the submission of the 2008 OBC (Bundle 3; Volume 1; Document number 12; Page 272). I cannot recall a specific conversation about it but think I would have been told this by either the Project Director, Isabel McCallum, and/or Project Sponsor, Jackie Sansbury. I knew that the Single Bed Accommodation Report was in the OBC (Appendix 6.3) (Bundle 3; Volume 1; Document number 12; Page 426) and I don't think that this would have been included if it hadn't been discussed with Scottish Government representatives prior to submission of the OBC. I believe that Jackie Sansbury in her role as Project Sponsor should be able to confirm the position. As I was not in the Project team at this stage I would not have expected to see any paperwork or documentation confirming approval.

Approval re Proportion of Single Rooms for 2012 OBC

RHCYP

25. In 2012 NHS Lothian had to submit an addendum to the July 2008 OBC to include DCN as part of the Project. I was asked to review the Single Room Accommodation Report which was at Appendix 6.3 of the July 2008 OBC (Bundle 3; Volume 1;

Document number 12; Page 426) to check that the assumptions we had made then were still valid.

26. I have been shown an email chain over 24, 25, 26 and 27 October 2011 (Bundle 4; Document number 14; Page 167) with colleagues in that regard. In that correspondence, I confirm that, whilst the paper was written in September 2007 and is 4 years old, the views expressed by staff at that time overall had not changed. I noted that we had not done any further consultation with children, young people and their families on this issue. I state that the paper is still relevant as the clinical reasons were still sound and the ability to cohort specific groups of children was very important.

27. I have been shown an Action Plan dated 29 November 2011 (Bundle 4; Document number 15; Page 171) relating to the Scottish Futures Trust ("SFT") Independent Design Review. Prior to being shown this paper I did not recall it, but on reading it I do now remember a design review being undertaken around this time and that I was involved in responding along with other members of the project team to some of the recommendations made. Point 5 of the Action Plan refers to a short paper explaining the rationale for the ratio of single bed provision.

28. I have been shown the paper the Rationale for the Proportion of Single Rooms (Bundle 4; Document number 16; Page 180) which is what is being referred to in the Action Plan, which I drafted. The clinical nurse managers along with their clinical teams were asked to review each of the wards and the proposed split of single rooms and 4 bedded bays and to confirm if there was any clinical justification for changing this. I then drafted that paper for submission to the Scottish Futures Trust. The rationale paper refers to the CEL 48 (Bundle 4; Document number 1; Page 5) and CEL 27 (Bundle 4; Document number 10; Page 144) Guidance and indicates that there was no change of view between 2007 and 2012 as regards the proportion for single room accommodation within RHCYP. This Rationale Paper (Bundle 4; Document number 16; Page 180) related to RHCYP only.

29. At the time of the 2012 OBC (Bundle 3; Volume 2; Document number 61; Page 672) I was not directly involved in the planning for DCN, this was being led by one of the Project Managers, Fiona Halcrow, and Project Clinical Lead, James Steers, for DCN. I was aware that as this was an adult facility it would have 100% single rooms. I was not involved in the discussions with the clinical teams in DCN about deviating from a 100% single rooms, this was led by the DCN Project Manager and Clinical Lead. I did review the paper that was produced providing the rationale for requesting two 4 bedded bays and supported the decision to seek a derogation in 2013 called the "Rationale for request for 2 x 4 bed ward and 16 Isolation/single bedrooms and en-suites within the new DCN Acute Ward" (Bundle 4; Document number 17; Page 182). At the time this paper was written I wasn't directly involved on a day to day basis with DCN but I did have an overview of what was happening in DCN as the Project Team worked very closely together. The Project Manager asked me to review the paper given my involvement with RHCYP in relation to single bedrooms and 4 bedded bays. I was informed that the derogation from the guidance had been approved by the Chief Medical Officer and Deputy Director (Capital and Facilities), Scottish Government and was aware of the email that was sent on 16th July 2013 (Bundle 4; Document number 19; Page 189).

SHTM 03-01

30. I have been asked about SHTM 03-01, Table A1 (and its predecessor SHTM 2025). At the time of the planning for the new hospital I was aware that there were a number of technical guidance documents which would have included ventilation, but I did not have the expertise or knowledge of them. Any considerations as to ventilation or other technical requirements would be a matter for the engineers and technical advisers and I do not specifically recall having any discussions with engineers or technical advisers prior to the commencement of the procurement exercise.

STATEMENT OF TRUTH [to be signed by witness once statement is finalised]

I, Janice MacKenzie , confirm that:

(i) The contents of this statement is the truth to the best of my knowledge and recollection;

(ii) I am willing for this statement to form part of the evidence before the Scottish Hospitals Inquiry.

(iii) I am willing for this statement to be published on the Scottish Hospitals Inquiry website.

Signature: Janice Mackenzie

Date: 20th April 2022