Scottish Hospitals Inquiry

Witness Statement of

Dr Jonathan Coutts

WITNESS DETAILS

1. My name is Dr Jonathan Coutts.

2. I am a Consultant working in the Neonatal Unit at the Royal Hospital for Children (RHC) in Glasgow.

3. My Qualifications are MBChB, FRCPCH, FRCP.

4. Most of my clinical work is spent in neonatology. I also work as a paediatric respiratory consultant. I am based in the neonatal unit, but I have out-patient clinics in the RHC building.

PROFESSIONAL BACKGROUND

5. My senior paediatric training took place in Glasgow, Vancouver, and Hong Kong.

6. I was appointed as a Neonatal Consultant in 1995 in the Queen Mother's Hospital which was part of the Yorkhill Hospital site. I was appointed Clinical Director for Neonatology in 2006.

7. I worked at the old Yorkhill Hospital site in neonatal and respiratory paediatrics. The neonatal unit had a dual role. We provided standard neonatal

care for babies from our maternity unit but also acted as a regional and national referral unit for babies requiring the specialist services available in the children's hospital. This included babies that were born with congenital problems or those with complications arising from their prematurity.

OVERVIEW

8. The new Neonatal Unit on the old Southern site opened in 2010 before the new children's hospital was built. As the neonatal Clinical Director, I chaired the group that helped design the new neonatal unit with the architects. This was a completely new build next to the existing maternity and gynaecology building. The labour suite was placed on the ground floor and the neonatal unit on the first and second floors. Therefore, I can speak to the following themes: the benefits of triple co-locating services, what links exist between the neonatal unit and the other buildings on the QEUH campus, issues with the water supply within the neonatal unit, the Serratia infection outbreak in the neonatal unit in 2015/2016 and other issues relating to HAI reporting.

NEW NEONATAL UNIT AND PROPOSALS TO TRIPLE CO-LOCATE SERVICES

9. Clinical services previously located on the Yorkhill site closed at different times. The maternity hospital (QMH) closed in January 2010 and relocated to the new maternity building on the current QEUH site to join the maternity service previously provided as part of the old Southern General Hospital. Children's services stayed until 2015. I think it was on 10 June 2015 that everything started to move over to the new children's hospital.

10. Therefore from 2010 neonatal services were based on three sites. The new maternity building on the current QEUH site, the Princess Royal and from 2010 up to 2015 in the RHSC based at Yorkhill. Once the RHSC closed the

neonatal beds on this site moved into the new building on the current QEUH site.

11. Before and during the reconfiguration of neonatal services I was in a Clinical Director role. This is mostly a clinical role, but I was acting as the link between the clinical team and the hospital managers. I attended meetings to give both an insight from the clinical side and then to help the management team deliver clinical "targets." In this role my line manager was the associate Medical Director, who is now known as the Chief of Medicine.

12. As a clinician I am an advocate for the best care for neonatal patients and families, which sometimes would conflict with the Health Board policy. Just before I became the Clinical Director there was a disagreement about the plans for maternity service reconfiguration in Glasgow. The initial Health Board policy was to relocate the maternity service away from Yorkhill but to delay building a new children's hospital for another ten to twenty years and to keep the RHSC open. The neonatology team did not want to have a stand-alone children's hospital as this is not a good model for families. If mum and baby are both ill at the same time but the care they require is situated in two different hospitals then you need to separate families so they can both get optimal treatment. Triple co-located services means that we are not splitting families up therefore it is the best model of care for the families. After a long campaign we persuaded the Health Board to plan for triple co-location though there was a delay of four or five years to implement this with the building of the new children's hospital next to the new maternity and adult hospital on the QEUH site.

13. At the start of the process of reorganisation the RHSC at Yorkhill was an independent NHS Trust with our own identity and management structure. When NHS Trusts were abolished in Scotland and services reconfigured as NHS Health Boards, we lost our very effective management team and

became a small part of a large adult orientated structure. One example of the change in our structure was the resources we had allocated in RHSC to our clinical governance unit, which were subsequently redistributed around the Health Board.

14. Our feeling as paediatricians at the time of the re-organisation was that despite the appearance of listening to different working groups the Health Board had already decided on their preferred model. We were pleased when the Scottish government developed an interest in our campaign.

15. We really did not care where the actual site of paediatric services was going to be, only that it should be a triple co-location model. It was a fairly last-minute decision to build the Children's Hospital on the Southern site. I remember talking to Alan Seabourne, who I knew from his previous role at Yorkhill, when he was asked to change his plans for the building at the QEUH site to include a new children's hospital.

16. We thought that it would be beneficial to building the hospitals at the same time. At the time, I raised a specific concern for the Risk Register about what would happen if the neonatal unit moved whilst construction work was continuing on the Southern site. A baby within the neonatal intensive care unit is vulnerable to infection and I was concerned that if buildings were being demolished nearby, then the babies in the neonatal unit would be placed at risk of environmental infections. There are clinical papers that report premature babies getting fungal infections such as Aspergillus during adjacent building works. Therefore, we proposed that initially we should keep the QMH open to enable a delay in the transfer of services to take place once all the building work was completed.

17. Whilst we did not have any preference for a location of the new hospital, just a preferred model of care the fact that the new hospitals were built beside the

sewage works seemed odd. When I worked in the old neonatal unit at the Southern, I would often be aware of the smell from the sewage works. Sometimes there was a smell; sometimes there was not. It did not impact us as such, we just thought it was odd.

Link between the RHC and Neonatal Unit

18. When the RHC was built, a corridor was installed to link it to the neonatal unit which was already on site. You can easily walk through to the RHC from the maternity building, but initially we had hoped that the buildings would be physically joined and not linked through a corridor. I think the only physical connection, apart from the hospital corridor in the bridge is the vacuum tube system for blood samples.

EVENTS INVOLVING WATER SYSTEMS

19. In the neonatal unit we originally had water fountains to provide cold drinking water. It is important for the doctors and nurses to stay well hydrated in the warm working environment that exist in critical care areas. During one of the infection control meetings, it was decided that we had to get rid of all the fountains. I do not think they ever grew any organisms from these, but there was a theoretical risk to keeping them in place. This is why we all have our own bottles of water now as opposed to the piped drinking water supply.

20. I cannot remember when the water fountains were removed and if this was as a response to the Serratia infections.

21. For hand hygiene we always had these trough sinks rather than the particularly small sinks that they have elsewhere. Trough sinks are long sinks, like surgical hand washing sinks. Over time the taps have been changed

because they now have these filters attached to the bottom of them. I cannot remember exactly when this occurred.

22. During the infection control meetings, we discussed the design of the taps because there would be a little bit of standing water or something similar when the taps were switched off. I think at the time the sampling had picked up contamination while they had been doing checks. That is possibly why the filters were put on.

SERRATIA INCIDENT

23. We had a number of babies colonised with Serratia on the neonatal unit in 2015/2016. Colonisation is not the same as infection. All of us are colonised on our skin with bacterial organisms, and it is therefore normal that all babies in the neonatal unit will also have skin colonisation with one or more bacteria. As a routine we swab our babies in the neonatal unit regularly to look for the bacteria that have colonised them. We do this so that we are aware which organisms an individual baby has on their skin so that if they become unwell, we can give appropriate antibiotics. Every day on the neonatal unit we have a discussion with the microbiologists to plan which antibiotics we should be using if a baby develops sepsis. We also like to track certain bacteria which have the potential to cause more severe illness and spread between babies, and Serratia is one of these organisms. We know that if an intensive care unit is busy with a lot of activity, then there is a higher chance of skin bacteria passing between babies. The neonatal unit at the Southern has regular admissions of babies from other neonatal units around Scotland. Some of these babies will have been hospital inpatients for a prolonged period of time before transfer, which increases the chance of them acquiring “problem” bacteria on their skin in their local neonatal unit. But because it is not normal practice for other neonatal units to perform routine bacterial swabs, we are often unaware about the colonisation history of these patients prior to transfer

and admission. At this time, the number of babies colonised with Serratia was increasing, with Infection Control tracking who had it, was it the same type of Serratia, and which bedspace was the baby located in. They were looking to see if there was an environmental issue to explain the increased colonisation or was it just that the unit was very busy with children receiving multiple antibiotics because they have chronic conditions.

24. Our patient population would be considered vulnerable to complications of infection. Because of our specialist nature we have patients with a mixture of conditions in the unit. In addition to premature babies, we care for babies with surgical conditions who often will require a stoma operation and subsequently will often be in the hospital for a long time before discharge. We have other complex patients who tend to stay for months in our unit. This is in comparison to other neonatal units in the UK who are restricted in mostly caring for premature babies, with only one or two older ones. We have a significant workload of older patients that would be in a PICU in other parts of the country since most neonatal units are located outside a children's hospital. A lot of our patients tend to have abnormal gut bacterial colonisation and they tend to have multiple courses of antibiotics because they often require to have central lines for prolonged periods of time which can then get infected. As I mentioned previously it is a bit unusual in that we screen all our babies routinely, we actually look to see what germs they have even in the absence of any concerns. I thought it interesting that when the team from the HPS decided to help with our local infection control process they asked whether we had a higher rate of Serratia colonisation than other comparable neonatal units. We suggested that they should try to find a unit to compare us against, but they were unable to identify a unit in the UK with a similar policy. Most neonatal units will only get a report from swabs saying something along the lines of “It's not MRSA, it's not an antibiotic resistant organism,” but that is as far as it goes.

25. Our microbial surveillance was a continuation of our practice from Yorkhill. When the service relocated, we continued our usual practice. We have a daily visit from Microbiology to review our results and obtain their advice. Should we just give an individual baby our usual antibiotics or do we need to give them different antibiotics? We find it extremely helpful, and we will identify if we have a pattern of organisms in our unit that other places would be unaware of. They will often only identify an organism such as Serratia if they suddenly get an outbreak of invasive infection with babies developing sepsis. In that situation they may resort to a period of routinely swabbing babies, whereas we are doing it all the time. I again stress that our practice had identified increased Serratia colonisation in well babies rather than increased invasive infection.

26. The more testing routine swabs that happen, the more we identify organisms in the unit which the clinicians find helpful. There was a bit of disquiet, I think, from the HPS staff who questioned this practice, but it has been our routine for many years, and it is a clinically sound practice.

27. I cannot remember the exact dates of the Serratia outbreak, but it was shortly after we combined the neonatal units. The regular meetings created a lot of work for the unit and at the time we queried whether it was a real priority because babies were not getting invasive infections and we were just identifying the colonisations because of our routine swabbing process. Having said that we wanted to understand if there was a real underlying problem and at the end of the process, we wanted more efficient environmental cleaning.

28. We suggested that the increased colonisation could be linked to the change in the local patient population. Until the neonatal units combined, we looked after mostly little premature babies at the QEUH site, but following the move we became much busier with a different patient population. Complex cardiac, ENT and surgical patients were now admitted to the unit. However, the unit

cleaning did not really change much. There was a slight increase, but this only took account of the increased number of patients but took no account that now we had a marked increase in footfall of staff into the unit. The new babies were often looked after by multiple teams, they needed more X-rays performed, and visits from other new staff members such as dieticians. Each of these babies was getting far more people coming to see them compared to previously when we only had little premature babies in the new unit. So clearly, we needed more cleaning, and this had to occur more often because we now were a different unit due to the change in our patient population.

29. We would regularly have the unit hand hygiene compliance checked. That has always gone on and mostly we score reasonably highly. We had to emphasise to visiting specialists the need to be extra careful with their hand hygiene which they were happy to engage with as it was in their interest to improve. We needed more environmental cleaning and any temporary increase needed to be maintained with now and again a deep clean.

30. The unit is terribly busy compared to other UK neonatal units. For example, our workload is about four times greater than the Princess Royal which would be considered as a reasonably large and busy neonatal unit in the UK. There is always a pressure to admit babies that are referred. We cannot say “Sorry, but we’re closed.” We cannot close, which may seem odd to some clinicians who will think that we must shut if we are full. However, since we are the largest neonatal service in Scotland and provide specialist services that are not replicated elsewhere the consequence of our unit closing is that some complex babies would end up going to the south, across the border to England. Therefore, it would be a very difficult decision to refuse a referral and therefore all the staff work hard to ensure that this does not happen. For example, we have some ability to put an intensive care patient upstairs in our special care and we keep all options available of moving patients around a bit, but it is difficult to close the unit.

INFECTIONS

31. We did not have any concerns that infections in the neonatal unit were linked to the building. Initially as I mentioned we had concerns about the risk of fungal infections due to ongoing building works, but we did not see any fungal infections as aresult.

COMMUNICATION

32. Because of my previous management role, I tend to read all the email communications from the Board. I know some people delete them because of the huge number of emails that we all receive but I try to read them all. There has been a change in how the Health Board communicates to their staff. When I was the Clinical Director things happened that do not happen anymore, and whilst I recognise that not all change is bad, I do not think that the current communication policy is as effective. In the past I would go with all the other Clinical Directors and other service managers to the Health Board headquarters, then at Charing Cross, on a regular basis. We would all sit round this huge table, and not only did we get information, but we were able to share information with the Health Board. One example of this was when I explained that the requirements for IT services that I was planning for in the new neonatal unit would overload the out-of-date system that existed at the Southern site. It was clear that this information had not yet been shared with the Health Board by the IT department.

33. At a lower level we would also meet in a separate Women and Children's meeting. Again, that meeting was effective for information sharing down from the senior management team and upwards from the staff. There would be people there from all the services. This type of meeting slowly stopped happening.

34. One result of the change in communication I can think of was seen when the Health Board were taken by surprise when they first held meetings about the new hospital. The most important thing concerning staff was about parking and travel issues. The Health Board just had not realised that this was a problem because they had stopped having their previous style of meetings and at a high level just had not thought about how staff were going to get to this new hospital which had no transport links and very limited parking. If they had continued to have their old style in person meetings, the staff side representatives would have pointed that this was a concern right at the very start.

35. Currently when you get the email communications you think, “Why are they talking about that? That is not important.” However, they do not realise this, and they think they are communicating effectively with their emails since they have no way of getting communication back up the system from their own staff. That is a problem.

36. I think emails are part of the problem because people email everything to everybody. We all get a lot of useless emails sent on “For your information.” You often get more than one copy of these useless emails as it is much easier to hit the “Send to all” than to think about who actually needs a copy. A lot of what we are sent by email is irrelevant. Therefore, people tend to switch off when they are sent too much irrelevant information. When I go on holiday, I can come back to 500 emails.

37. We all receive a Core Brief and generally I will read all the Core Briefs. Having said that, I do not recall seeing anything recently about the cladding being removed from the adult hospital. There is a lot of information within the Core Brief that is irrelevant. In contrast to this corporate communication, we have good local communication in neonatology. For example, every Wednesday,

the neonatal Consultants have a meeting where we go through an agenda, and we speak about patient problems and staffing issues. But we also discuss social things too, holidays, for example and we generate an excellent team spirit. We have other separate unit meetings to discuss complex problems. For example, this afternoon we will hold our Neonatal Unit management meeting. Internally, we have quite good communication as well and every shift, one of the senior nurses will be going around each room , giving key messages face to face to the nurses on shift.

38. I would definitely say the Health Board have changed the way they manage communication and I think they have lost sight of some things. There is not that bottom-up chat now. I recognise that the organisation is huge and complex, but it has always been huge and complex. If you are only surrounding yourself with a small group of people, you lose out on what is going on elsewhere. An example of that would be my earlier reference to the IT system. If I had not raised that at Health Board meeting, the wider group of attendees would not have known it was an issue. It has an impact on relationships too. It is far easier to ask someone something in a meeting than to send an email, which may not be read. Those meetings gave you the chance to form relationships and find out what each person does within the hospital.

39. I cannot think of an exact timescale when it changed though. I stopped being the Clinical Director about ten years ago, but I suspect that my successor Morag did not have the same experience of access to the Health Board managers.

40. When we were in Yorkhill, you would be able to just go into someone's office, for example, Jamie Redfern, and ask him a question. There was always somebody at the office you could speak to. However, there is a clearly defined management structure, and you need to stop people jumping straight to the

top of the service. It is best to feed things up through the management structure at Women and Children's.

41. It is not all negative. I thought the running of the Problem Assessment Group (PAG) meetings seemed to go well and they were always run in a very formal way. The meetings would involve all the relevant staff. There would be domestic managers, other professionals and doctors and nurses. They were usually held in the neonatal unit so it would be easy to get to them.

HIIAT Scoring and Infection Control

42. There were a couple of PAG meetings that I attended where HPS were also involved. These meetings were chaired by a senior figure from Infection Control and HPS would dial in. I was not clear as to why HPS were involved in these meetings, and I did not find their involvement helpful. They considered their role as maybe some kind of senior oversight and to consider their involvement as an important part of the process, but my assessment was that they did not understand the situation. For example, after a meeting one of the HPS participants said something along the lines of "Right, we now need to discuss are we going to close the unit?" as if this was a decision with no consequences. My immediate response to this question in the meeting was "We can't, and we are not going to." They had no idea of the consequences of closing our unit. As I mentioned previously if our unit closed a significant number of complex babies would have to travel long distances to units in England, it was not a casual decision to consider. The time and distance involved would adversely affect the health of children. At the time I thought, "You don't actually understand what we're talking about, but you think you are taking control." I did not find the involvement of HPS very helpful. Another example of was to do with our HIIAT scoring.

43. The HIIAT score is a tool that we use to score how serious we need to consider an outbreak of infection. Initially as a clinician I found it unhelpful since we did not at that time have an outbreak of infection, but an increase in colonisation with no actual episodes of sepsis in our babies. At the end of the PAG meeting the Chairperson of the infection control meeting would go through each part and we would agree the total score. There are different parts to the scoring system that need agreement.

44. At one point we had a baby that developed Serratia [redacted]. However, when we came to agree on the HIIAT score we reported as "Red" [redacted]. At the end of the following meeting when we agreed the HIIAT score, we scored "Green." At this point HPS interjected and disagreed saying "You cannot be green. You were red last time." The rest of the PAG meeting did not agree with this assessment because the score was obviously green. HPS then made a comment along the lines of "But you were red last time, we can't say that you've gone from red to green, the First Minister is copied into emails." I got a little bit irritated at this point and suggested that we had to be objective in our scoring and that "a minister maybe getting upset was not part of the HIIAT scoring system." In the end we were scored "Green acting as Amber" because HPS would not agree to the score changing from red to green because of political concerns. I felt this was not professional and sent an email to my line manager immediately after the meeting. I actually had a reply from one of the infection control staff saying, "Thank you for your input at the meeting. Sometimes clinicians like you can say things that we cannot."

45. I felt our local Infection Control team managed things very well. We had our own Microbiologists who were effective chairs. They were quite clear as to what we should be doing, and they would be robust in challenging the clinicians such as myself if they felt we were not managing the situation as we

should be. It was their job to do that. I did not see Health Protection Scotland adding anything to the process. They were acting like they did because they had issues with our infection control systems of which I was not aware.

46. There was a lot of anxiety in the Scottish Government Health Department about our outbreak of Serratia, even though there was obviously confusion about true infection versus colonisation. Using the term “Outbreak” infers you have an epidemic of disease whereas we just had babies who were growing Serratia and were mostly well. I agree that increased colonisation is important to review closely but it was not an outbreak of illness.

47. The press reports were not helpful. Professor Pennington apparently said we wash babies under the taps which was untrue. We cannot do anything about that, as that is just the press. You will have people on one page say how fantastic we are and then you will turn the page and see a different story saying how terrible we are.

48. The nurses find it upsetting. A lot of the nurses are on social media. I am not on social media as I do not have the time and I cannot be bothered. We need to understand that in the old days people talked about us in their homes without our knowledge. Now they talk about us on social media, it is the same thing. Some of us have decided to “listen in at their window” so we should not get upset about it, but a lot of the nurses do get upset.

49. I believe that the facts stated in this witness statement are true. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.