Scottish Hospitals Inquiry
Witness Statement of
Mr James Redfern

WITNESS DETAILS

1. My name is James McDonald Redfern. I am known as Jamie.

2. I am the Director of Women and Children's Services within NHS Greater Glasgow and Clyde (NHS GGC). I was appointed to this post in 2021. I am based at the Royal Hospital for Children (RHC), which is situated within the Queen Elizabeth University Hospital (QEUH) campus in Glasgow.

PROFESSIONAL BACKGROUND

3. My qualifications are a degree in Economics and Quantitative Analysis, from Paisley College. I also hold a Postgraduate Diploma in Information Economics from the University of Strathclyde. Following my education, I commenced a management trainee role in 1992 working at Royal Hospital for Sick Children (RHSC), Yorkhill, working under Gerry Marr, the Director of Children's Services at that time. During my trainee period I worked in a rotation of departments, including periods of secondment to Care for Elderly, NHS Board Head Quarters, Estates and Facilities, Corporate Planning and Finance.

4. Following my rotation as management trainee, in 1994 I was successful in securing a position at the RHSC. This was as an Information Manager in Community Child Health Services. This new role involved working with databases, spreadsheets and other applications. I worked closely with senior clinicians from a range of specialities. It was through this work and the relationships that I built with the clinicians that I gained a broad clinical knowledge of Community Child Health. After about a year, I was promoted to Business Manager within the Community Child Health Directorate. This role being more of a direct support to clinical directors.

5. From 2000 to 2007, I held the post of General Manager for Medicine, Community and Child Health, and Children and Young People Psychiatry. Again this post was based at the RHSC. Following the introduction of the Community Health Partnerships there was a review of the organisation management structures.

6. I was part of that review. After participating in it, I was successful in retaining a General Manager post but with slight change in remit. The role changed to General Manager for Acute Hospital Paediatrics and Neonatology. In summary, I dropped community services and widened responsibility from medical acute specialties to that of surgery and anaesthetics as well as neonatology. Again, the post was based at the RHSC although I had extended responsibilities to paediatrics in Clyde.

7. The role of General Manager has a responsibility that covers clinical governance, staff governance, financial governance and performance. The position I held reported directly to the Director of Women and Children's Services (Mr Kevin Hill). The Director of Women and Children's services reports to the Acute Division Chief Operating Officer who in turn reports to the Board Chief Executive Officer.

8. In June 2015 and then again in June 2020, I was appointed to the role of Interim Director for the Women and Children's Directorate (W&CD) covering extended periods of absence for Mr Kevin Hill. In April 2021, I was appointed formally to the Director role when Mr Kevin Hill retired. Following this, Ms Melanie Hutton was appointed as General Manager.

9. The Director of Women and Children's covers Maternity, Obstetrics, and Gynaecology (MOG) as well as Hospital Paediatrics and Neonatology (HPN). The Directorate has a General Manager each for the aforementioned MOG and HPN. It also has a Chief of Medicine, Chief Nurse, Chief Midwife, Head of Finance, Head of People and Change, as well as Organisational Development and Planning managers. These individuals form the W&CD senior

management team. At time of my appointment as Director in 2021, I reported to the Chief Operating Officer (Mr Jonathan Best).

10. Functioning under General Managers are Clinical Service Managers. They in turn directly manage Lead Nurses/Midwives and Heads of Service (Audiology, Physiotherapy etc). The General Managers will also work closely with Clinical Directors and Lead Clinicians.

OVERVIEW

11. I am going to speak about my experience as a General Manager and also as Director of Women and Children's Services in NHS GGC from 2015 to the current date specifically in relation to infection control.

12. I have no responsibility for water provision to the hospital or the ventilation systems. Nor do I have direct responsibility for the maintenance of wider hospital environment. These are all matters that are the responsibility of the Estates and Facilities departments across the NHS Board. Similarly, I have no responsibility for domestic cleaning, catering and hotel services. Again, they are all part of the Facilities Directorate.

13. I have responsibility for the operational delivery of clinical services across all specialties formed under MOG (when becoming Director) and HPN (both as General Manager and then Director).

14. For example, I was directly involved in:
    - The decant from ward 2A/2B RHC to Ward 6A/4B QEUH in September 2018.
    - The decant from ward 6A to the Clinical Decisions Unit (CDU) in January 2019.
    - The decision to close ward 6A to new admissions in 2019, followed by reopening in November 2019.
    - Communications to patients and families, and staff over all these periods. I provide my reflections on this experience below.
    - The delivery of service under all these circumstances.

- The return of services from Ward 6A/4B to Ward 2A/2B in Spring 2022.

NHS GGC: Acute Division

15. I will now summarise the structure of the Acute Division of which Women and Children's Services is a part of.

16. There is, as I have mentioned, a Chief Operating Officer who is supported by a Deputy Medical and Nursing Director. The Acute Division also has its own Director of Finance and Director of People and Change.

17. The Division consists of three sector Directorates: North (GRI and other hospitals), South (QEUH and other hospitals) and Clyde (RAH and other hospitals). There is also a Regional Directorate (Beatson Oncology, Institute of Neurosciences) and Diagnostics Directorate (Laboratories and Radiology) as well as Women and Children's. Each Directorate is similar in structure.

MY ROLE: DIRECTOR OF WOMEN AND CHILDREN'S SERVICES

18. The difference between Director and General Manager in Women and Children can be described as follows:
    - Director role extends across MOG and HPN.
    - There is a more senior level of reporting – Chief Operating Officer.
    - There is less day-to-day operational management duties with greater focus on strategic aspects of service.

19. At an operational level I will still have oversight of the services I manage and this is primarily reported daily through the following:
    - Morning hand over report circa 6am.
    - Morning huddle report 8am.
    - 12:30 huddle report.
    - 3pm huddle report.
    - 7pm situational awareness report.
    - 12 midnight situational awareness report.

20. For each of these, a structured reporting format is used. Also a structured circulation list used with clear responsibilities around escalation. These reports will predominantly focus on staffing, hospital flow and any exceptional operational matters across Emergency Department, Wards, Intensive Care, Outpatients, Theatres and Departments. They cover both MOG and HPN. Technology is widely used to support the reporting described (Microsoft Teams and wider Office 365).

21. These reporting processes exist through to Chief Operating Officer and above.

22. The Directorate has a series of formal meetings weekly/monthly covering all areas of responsibility. Formal Directorate Management Team, Clinical Governance, Financial Governance, Staff Governance including Partnership and Performance. These meetings are sourced with standard reports and work to specific Key Performance Indicators (KPIs). Using these structures the Directorate has a standard Performance Review meeting with the Chief Operating Officer. Other mentioned Directorates function similarly.

23. The Directorate has embraced the use of technology to develop patient and staff engagement. A series of new websites are in place. A more structured approach to social media is growing across a range of platforms. A SharePoint site has been established with easy to navigate links to senior management team and who people are.

24. This is all supported by the senior management team doing regular walkabouts across the different hospitals. Beside this there is a strong focus on one to one discussions between employee and line manager, open door management, developed decision making, and focus on wellbeing and celebration of success/joy in the workplace.

25. Recent developments are Schwartz Rounds, Peer Support Networks and a Review of Estate linked to Well Being.

26. There is a developing culture of empathetic leadership and as a Director I am very clear about setting the organisations values and leadership traits.

27. Clinical Governance takes many forms and includes child protection, patient safety and quality improvement, staff engagement (including complaints), risk management, infection control, significant adverse event and clinical/non-clinical incident reporting).

28. Under Infection Control I receive various daily, weekly and monthly reports. The Directorate has an Infection Control Group which reports to the formal Directorate Management Team and also Clinical Governance Forum. Notification of any Problem Assessment Groups (PAGs)/Incident Management Team meetings (IMTs) are reported immediately and reviewed to conclusion through formal reporting structures used by the Directorate. As a General Manager I would expect to attend Incident Management Groups.

CHRONOLOGY OF EVENTS

THE NEW RHC – DESIGN, PLANNING AND TRANSFER OF HOSPITAL

29. The plans for the new Children Hospital were developed through the following:
    - Board Steering Group
    - Paediatric and Neonatal Steering Group (chaired by Director W&CD)
    - Paediatric redesign groups that were:
        - clinically led;
        - worked to standard terms of reference and reporting schedules; and
        - multidisciplinary in membership.
    - Supported by the New Children Hospital Planning Team
    - Cross cutting themes like estate, infection prevention control and communication were all managed centrally but with W&CD clinical/ managerial involvement as necessary.

30. I was predominantly involved in the Paediatric and Neonatal Steering group and subgroups. In designing the hospital, the paediatric management team were interested in clinical functionality such as size (wards, beds/cots, theatres, outpatients, Emergency Department etc), adjacency/flow, use of technology, staffing arrangements and support services. We did not have input into technical specification of systems such as water and ventilation.

31. There was a strong focus on patient engagement with particular emphasis on the voices of young people. There was specific engagement expertise such as parent facilities in Ward 2A as one example.

32. As we moved closer to the final design, again clinical teams were engaged in signing off final drawings with the new children hospital capital planning team. Director and General Manager signed off the final papers.

33. Snagging sign off was the joint responsibility of the planning and clinical teams. This was very much based on the expected functionality described in the approved drawings.

34. At that time, my communications with the new children's hospital planning team would have been with Project Manager, Project Director, Morgan Jamieson Medical Director, Nursing Director and Patient Community Engagement lead.

35. I became a member of the "On the Move" steering group. This was the group which had key operational responsibility for:
    a) the decant from old Royal Hospital for Sick Children; and
    b) opening and use of the new Royal Hospital for Children.

36. This required close liaison with various clinical teams. The Scottish Ambulance Service (SAS) and other key stakeholders were also involved in the process.

37. In lead up to the transfer from old to new, the elective program was slowed down so a minimum number of children had to be moved. A schedule of moves was planned. The key stakeholders were paediatric anaesthesia, intensive care, neonatology and emergency department consultants and nurse staff working in these areas. The sequence of moves was clinically led. Timing of the move was scheduled for the summer to avoid winter pressures/respiratory illness in children.

38. Command centre teams were set up in the new children's hospital and in the existing RHSC. The sequence of moves were progressed as mentioned, ward by ward and department by department.

39. Close communication of leave/receive arrangements with SAS and command centres were as stated, in place. Various risk strategies were also in place underpinning all of this.

40. Command centres had responsibility for the start up of service delivery in the new hospital and closing down in the old hospital. A successful restart program was initiated with emergency department, theatres, wards, intensive care and outpatients starting immediately.

41. Across the design plans of the new children's hospital and the on the move plans, communication with staff and patient engagement were prioritised key performance indicators.

42. Prior to the move there was clinical concern raised primarily on office accommodation. Offices for staff working in the new children's hospital were located in a separate building. On call bases were provided for clinical staff in the hospital across all the different teams as were offices for anaesthesia and intensive care staff. Following the move there was a general consensus that the concerns around the office block were unfounded. The Haematology Oncology team however wish we had greater emergency on call space in the hospital. This has now been provided.

43. Prior to the move taking place, site visits were allowed for staff. There was strong health and safety arrangements in place to ensure these ran smoothly. This was for both clinical and managerial teams. These were very well received. This was part of the final sign off at clinical level.

44. Also ahead of the move there was various structured discussions about staff amenities (changing facilities for example), public transport and car parking (particularly again for on call teams).

45. My own perception overall was that the campus was of breath-taking scale and modernity when considering the hospitals, laboratory building, university facilities and administration/office block.

46. The hospital management team are now located on the ground floor of the Royal Hospital for Children. They use a hot desk approach with focus on flexibility, use of technology and mobile working. This became essential during COVID-19.

47. The design and move of the new children's hospital to my mind was considered a success. That is not withstanding the subsequent infections that followed which remain under review as to the cause and for which I am again very sorry for all those involved.

THE NEW QEUH – VENTILATION IN THE ADULT BMT UNIT: JUNE/JULY 2015

48. When RHC moved to the QEUH campus in June 2015 I did not have any real knowledge of what was happening in the QEUH hospital in relation to the adult bone marrow transplant (BMT) service/Ward 4B. This was not a service under my management responsibility and there was very little interface between it and the paediatric service.

THE NEW RHC – VENTILATION AND FILTERS IN WARDS 2A/2B - JUNE 2015

49. On taking ownership of the RHC it was identified there was an issue with filters. They had not been fitted. A supply of the required product was

immediately secured from a supplier based in Ireland and fitted successfully prior to the restart of the paediatric BMT program on the new site.

THE NEW RHC –THE PAEDIATRIC BMT UNIT WARD 2A RHC: SEPTEMBER 2015

50. There were various checks ongoing in the RHC Ward 2A when we moved into the hospital. These were carried out by Estates or third party vendors working with Estates. An issue was identified where there was a break in the sealing in one of the cubicles and affecting pressure/circulation.

51. There was a series of meetings arranged. For example, I attended a meeting on 7 September 2015 and a minute of that meeting (**A40364499 - Minutes of Meeting to discuss BMT Unit RHC dated 7 September 2015 – Bundle 6 – Page 20**) has been shown to me.

52. There were a number of senior members of staff present. The final agreements were for:
    - All rooms to be checked and resealed where appropriate.
    - An appropriate testing program would continue routinely to ensure performance of the rooms maintained.
    - 4 cubicles would have enhanced work carried out on them. This was based on benchmarking analysis from other units carried out by Estates colleagues. A program for taking this work forward would be developed/implemented.

53. My role was to measure the impact all of this had on service and in particular the restart of the paediatric BMT service. Close links with the senior medical team were in place and essential.

54. A risk assessment was completed by Dr Alan Mathers (Chief of Medicine) and Dr Teresa Inkster. It was signed off by Dr Armstrong and others. This allowed the paediatric BMT service to restart. (**A38694847- Email from Alan Mathers dated 15 September – SBAR re paediatric BMT unit – Bundle 4 – Page 13**). There was, from memory, one urgent patient who needed treated and

with the timings and what would be involved, it was considered very difficult to find an alternative provider and the patient received treatment on Ward 2A.

55. There was at least one meeting I attended where Prof Brian Jones (Microbiologist) and David Loudon (Director of Facilities) amongst others discussed the estates/ventilation in Ward 2A/2B. David Loudon was explicit that all installed equipment met the statutory building requirements of that time.

IMT MEETING - 5 AUGUST 2016

56. (**A37987226 - Incident Management Meeting Minute, dated 5 August 2016, relating to Aspergillus Infections in Schiehallion Unit – Bundle 1 – Page 22**).

57. I have been asked about my recollection of an IMT on 5 August 2016. I do not specifically recall this IMT. The minutes describe the trigger for this meeting.

58. As per all IMTs commissioned by NHS GGC:
    a) It normally follows a Problem Assessment Group (PAG).
    b) Discusses recent infection of patients.
    c) Seeks a working hypothesis for what the cause(s) might be for infection.
    d) Identifies solutions for how to resolve any problems identified, commissions actions to implement solutions and tracks progress to completion.
    e) All IMTs are normally chaired by a senior clinician from IPC, and involve a range of people from different clinical, professional and managerial backgrounds. There is instruction on this within the National Infection Prevention & Control Manual (NIPCM).
    f) The incident is scored at the end of the meeting, utilising the Healthcare Infection Incident Assessment Tool (HIIAT) per the NIPCM, which depending on the result triggers series of actions the Board must follow.

g) As a General Manager of service I would expect to attend IMTs or have a suitable depute if I was unable to attend.
h) The working hypothesis will determine whether there is or is not a concern the infection is linked to the hospital environment.

59. From looking at the minutes of that IMT meeting I can see that Ian Powrie from Estates had provided background information relating to the environment pertaining to BMT rooms with focus on condensation. There had been identified breaches in the ventilation ducts, which had needed to be re-sealed. A number of other potential environmental issues were raised by those in attendance and a number of investigations/actions agreed on. These included air sampling of the air handling unit, inspection of the unit for water damage, inspection of chilled beams, upgrading of filters to HEPA filtration and Diagnostics to expedite reporting for ongoing surveillance. Generally, this is my experience of an IMT. A range of potential causes are proposed/discussed and either confirmed as working hypothesis or ruled out.

60. The summary of current Infection Prevention Control (IPC) reporting from a W&CD perspective is and has been:
    a) Review of weekly report circulated by IPC. Normally this is between myself, the Chief Nurse and the Lead IPC Nurse.
    b) As above, a monthly report by IPC. This is noted in Clinical Governance reports issued by the Directorate including the Directorate Infection Control Committee, Clinical Governance Forum, and Directorate Formal Management meeting.
    c) Throughout the month, the escalation of any PAG/IMT is noted and tracked to completion.

INFECTIONS – SURVEILLANCE AND MONITORING – CLABSI PROJECT 2017

61. I have been asked to summarise my understanding of the above project, which was clinically led but sponsored by the Chief Nurse at this time, Jen Rodgers.

a) RHC identified an increase in infections linked to haematology-oncology patient group.
b) Working hypotheses through a multidisciplinary quality improvement (QI) group were identified and changes proposed/implemented.
c) In working through the hypotheses, international research had been carried out by the QI group with focus on Cincinnati Children's Hospital (as identified best in class to learn from).
d) Over time, infections were monitored through standard run charts and improvements were reported.
e) Presently the RHC CLABSI run rate, I think, is on a par or better than that reported by Cincinnati. This QI work stream was demonstrated to be highly successful and to this day continues to show appropriate safety measures in place highlighted by such good results.
f) Achieving this showed the culture of safety operating across W&CD which is important moving forward through 2017 – present day.

CLADDING – 2017/2018

62. In June/July 2017 investigations into the cladding of the new hospital building commenced as a result of what happened at the Grenfell tower.

63. A series of communications were issued by the Board, I cannot remember specific communications but I remember that there was communication on cladding. I have been shown some Core Briefs from June 2017 – August 2017 but I cannot recall these.

64. A cladding group was established and my role was to ensure across the RHC, when changes were being made, there was a clear understanding of how we maintained as near as possible business as usual. This required information on when work would start/finish, how it would be completed and what the impact on service would be including patients and families attending hospital. Noise and access points were two important aspects of this.

65. Specific focus was on the haematology – oncology patient group. This was significant estate work on site, with the risk of infection to this group when attending. Monitoring such estates work is managed through a standard HAI-SCRIBE process agreed by service, Estates, third party vendors and IPC/Microbiology.

66. Signage was placed around the children's hospital to show the alternative entrances (**A38845827- Additional signage for the children's hospital when cladding works ongoing – Bundle 5 – Page 89**). This followed concerns raised by Dr Inkster about skips located at the main hospital entrance.

67. An email chain from 16 August 2018 to 23 August 2018 was presented to me on this matter (**A38845806 - Email chain between nurses, management staff and microbiology subject "update for parents" dated 16 August 2018 to 23 August 2018 – Bundle 5 – Page 91**). On the 17 August 2018, I emailed Melanie Hutton and Kathleen Thomson to liaise with the ward 2A/2B clinical teams as to how we implement Teresa's advice which was the alternative route, antifungal prophylaxis and surgical masks if required. On 20 August 2018, Melanie contacted Teresa to ask for information on prophylaxis cover, this was to give the team some background for a briefing for patients. Final communications would always follow authorisation from the Corporate team.

68. I have been shown a Media Statement dated 27 August 2018 (**A38845825- Media Statement titled "NHS GREATER GLASGOW AND CLYDE STATEMENT" by NHS Greater Glasgow and Clyde Health Board in dated 27 August 2018 – Bundle 5 – Page 100**) which addresses the response to the cladding works. Teresa Inkster is quoted as stating that "The most important measures are to offer high risk patients antifungal prophylaxis and to divert them away from the work". On 4 September 2018 there is an email from me to Kevin Hill requesting an update on the communication for parents of 2A/2B (**A38845807 - Email chain between nurses, management staff, communications team and microbiology in**

response to a parent feedback form and subject "update for parents" dated 28 August 2018 to 5 September 2018 – Bundle 5 – Page 97). I have been shown a document dated 7 of September 2018 which looks like a communication about the mitigations for the cladding works addressed to the parent/carers of ward 2A patients (**A38845769 - Cladding briefing prepared by NHS Greater Glasgow and Clyde Health Board for paediatric haemato-oncology inpatients dated 7 September 2018 – Bundle 5 – Page 101**). This would have been standard briefing noting concerns previously raised for this patient group.

EVENTS RELATED TO THE WATER SUPPLY ON WARD 2A/2B RHC – 2018

69. I have tried to summarise the events around infections in the paediatric haematology-oncology patient group from 2018 onwards.

70. I have been provided with a copy of an email chain from Jennifer Armstrong (**A38662162 - Email chain including notes and actions from teleconference involving NHS GGC, HPS HFS & Public Health England and subject "18/03/18: midday call for updated on RHC water incident:" dated 18 March 2018 – Bundle 5 – Page 116**).

71. Regarding the IMTs underpinning this position I refer to my previous comments. I would add at this time Health Facilities Scotland (HFS) and Health Protection Scotland (HPS) were actively involved in these meetings and updating Scottish Government. Normal escalation processes through the Chair of the IMT and service via myself were in place ultimately to Chief Operating Officer/Executive Officer and Medical Director (Board Lead for Infection Control).

COMMUNICATIONS TO STAFF - 28 MARCH 2018

72. An example of communication to staff is an email dated 28 March 2018 to senior nurses titled "Water Incident Update 2018". (**A39123924 - Email from Angela Johnson, Senior Infection Prevention and Control Nurse subject "RE: Water Incident update 28.3.18" dated 28 March 2018 - Bundle 5 –**

Page 132). The email provides an update and there are two attachments to this email. I am a copy addressee of that email. We were telling staff (a) what we were doing and (b) giving them a reassurance that we were dealing with this problem. The documents could be used as an aide memoire for staff. The different attachments are for patient groups with different clinical presentations.

73. Over time Jen Rodgers and I would routinely go round the Ward and with SCN and/or Consultant deliver the brief for parents and allow them the opportunity to ask us questions. This would be to all families on the ward.

MEDIA STATEMENT – 5 JUNE 2018

(**A38662060 - NHS GREATER GLASGOW AND CLYDE STATEMENT" by NHS Greater Glasgow and Clyde Health Board in response to Evening Times enquiry dated 5 June 2018 – Bundle 5 – Page 140**)

74. The standard process for delivering these briefs was a. sign off at Corporate management level, b. issue to Jen and I, c. we would visit the ward and hand out the brief to all parents, d. go through the content of the brief and e. try to answer any questions.

75. There is a quote from Dr Teresa Inkster within this statement. In such matters it would be normal for clinician to be quoted. Dr INKSTER at all times would be asked if she was happy with the quote.

76. In the paragraph second from the bottom of the statement, it states, "We've also taken the extra precaution of prescribing antibiotics to a few patients." That was a clinical decision. There is a risk when providing prophylaxis and you balance the risk between giving or not giving it. The clinical decision to prescribe prophylaxis would be made by the child's doctor but with advice from the microbiologist. The doctors and microbiologists would meet routinely to discuss such matters.

IMT MEETING – 6 JUNE 2018 (**A36690461 - Incident Management Meeting Minute dated 6 June 2018, relating to Water System Incident – Bundle 1 – Page 99**)

77. At the IMT meeting on 6 June 2018, there were further discussions about drains and sinks and I was seeking assurances from both Teresa Inkster and Estates that the filters were a functioning solution to the agreed hypothesis.

78. The solution was to refit taps and filters and then re treat the water supply. Note at this time, the NHS Board was seeking advice from a variety of UK experts.

79. HPV cleaning is mentioned in the minute. This is an additional level of deep cleaning by the external supplier. Standard Operating Procedures are in place for how this type of cleaning is to be administered.

80. There is a note under "Assurances moving forward, " and there is reference to a group chaired by Kevin Hill. It was subsequently decided that this group was not needed. Noting it was just the same people talking about the same thing as in the IMT.

81. The minute includes that Professor Gibson notes the impact of Ciprofloxacin on certain patients. This was a prophylaxis.

IMT MEETING – 14 JUNE 2018 (**A36690460 - Incident Management Meeting Minute, dated 14 June 2018, relating to Water System Incident – Bundle 1 – Page 123**)

82. I attended and chaired an IMT on 14 June 2018 due to Dr Inkster's unavailability. At this time we were keen to ensure the IMT was functioning appropriately. This included involvement from HPS colleagues, who at all times were actively involved in discussion and decision making, as well as the standard remit of feeding back to Scottish Government.

83. In the minute under the heading “Assurance moving forward,” I am noted as confirming that that the NHS Board were looking for the IMT to act as a key organisational governing structure for advising and overseeing implementation of the issues and actions.” This would be considered standard. It was important the NHS Board had confidence in the IMT processes.

84. More generally, for IMTs 2018 onward I would make the following observations:

    a) Infections were identified in Spring 2018.
    b) There was involvement from an array of experts to try to identify hypothesis and solutions.
    c) There was full escalation of the issue to senior Executive level.
    d) The hypothesis was that these infections may have come from the taps and two solutions were implemented to resolve.
    e) Filters added to the taps.
    f) Water cleansed through technical agreed regime.
    g) Continued testing of the water as well as standard checks on infections through IPC continued.
    h) Throughout the IMT there was close liaison with the Water Technical Group.
    i) I did ask what contingency plans were available to us if these solutions did not work. There was no other solutions but I did get a confidence from experts that the solutions would work.
    j) The routine checks and maintenance of filters seemed robust. As did the process for what would happen if a problem with filter occurred.
    k) The commercial company supplying the filters were very confident in the efficacy of their product and were regarded as international experts in this area.
    l) Interim arrangements until solutions were identified and implemented had been very unsatisfactory for patients, parents and staff (using bottled water and temporary sinks) and for that, I am really sorry.
    m) Standard communication at this time was opt-in. If a patient/parent wished to speak to senior management about anything relating to

infections or ward environment then they should seek arrangement via the ward team and normally Professor Gibson, Dr Inkster and I would attend. As part of standard IMT process any child with an infection and under review should have been updated via their named consultant.

n) There were throughout this period a number of other actions taken by the IMT including ongoing review of staff IPC practice, domestic cleaning/extended HPV, Estate management and close links between clinical teams and microbiology (particular clinical review of Ciprofloxacin as a prophylaxis).
o) Scottish Government as previously stated were getting updates on all infected patients under review by IMT.
p) Throughout this period, myself and Dr Inkster would try to speak to staff and answer queries/provide reassurance and note concern. I do recall there being discussion about the case definition being used by the IMT.

WATER EVENT WARD 2A/2B RHC - SUMMER 2018

85. After a reduction in infections, for what I recall was a period of 6-8 weeks, new infections started to occur. Further IMTs were called to review matters and again understand potential hypothesis and solutions.

86. My apologies for the non-technical use of terminology others more specialist might use. The summary of events from my recollections around this were:
    a) The filters were continuing to do their job and there was no problem with the water.
    b) However, there was a close adjacency between the filter and the sink drain, which may be creating a splashing effect which was leading to contamination/risk of infection.
    c) Noting that the filter product could not be changed there was a decision to remove all sinks and replace with a different version which would avoid this problem.
    d) It was noted that such sinks which would avoid splashing were in location across the adult hospital.

e) To implement the change in all sinks across wards it was agreed that the service had to relocate from Ward 2A/2B to another location.

CLOSURE OF WARDS 2A/2B (SCHIEHALLION) AND MOVE TO WARD 6A & 4B: SEPTEMBER 2018

87. In September 2018, we took the decision to close Ward 2A/2B (Schiehallion) and move patients to another location. This decision was taken at the IMT on 17 September 2018.

OPTIONS PAPER – 17 SEPTEMBER 2018

88. Working with the clinical team, Estates, infection control and HPS we agreed the following criteria needed to be achieved for any decant of service to work.
    a) Close proximity to RHC Theatres, Radiology, Paediatric Intensive Care and other support services in the children's hospital including Hospital at Night (HaN).
    b) Appropriate bed numbers to accommodate all aspects of the service. All matters of child protection, and other associated services to be considered.
    c) Appropriate clinical IPC conditions for patient safety and in particular for the Haematopoietic Stem Cell Transplant (HSCT) service.
    d) An ability to scale up at the earliest opportunity.
    e) Protection of specialist services, most importantly the national HSCT program.

89. Due to points 1, 2, and 4, the Beatson Oncology Unit was ruled out. Due to point 2, there was no scope to decant the full service to an alternative provider and a split across a range of services was considered inappropriate. Due to point 4, a new modular build was not possible. Due to points 2 and 3, the RHC was ruled out.

90. The preferred solution was agreed, across all involved, as a combination of space in the adult QEUH hospital for service including the HSCT service. This position was escalated to Kevin Hill and Jonathan Best who in liaison with

Jane Grant/Jennifer Armstrong reached decision for Ward 6A to be freed up as well as 4 specialist transplant beds in Ward 4B (where adult HSCT service was located).

91. Once this decision was reached staff were freed up to progress a full decant in a systematic way. This program was led by the Clinical Service Manager Lynne Robertson. A successful decant plan was fully implemented. There was regular communication across all stakeholders including staff and patients/families. Prior to the move some minor refurbishment was carried out in Ward 6A and a defined space was identified in Ward 4B.

92. The solution was not ideal for various reasons:
    a) We were located in an adult hospital environment and in a general ward not specifically built for paediatric haematology oncology client group.
    b) The clinical team were managing across two floors (diseconomies of scale were a challenge).
    c) Proximity to key RHC facilities were further away.
    d) Space was limited particularly in Ward 6A where acute inpatients (Ward 2A) had been merged with day care (Ward 2B).

93. An array of Standard Operating Procedures (SOPs)/working arrangements had to be formalised to try and implement as close to a business as usual model in place.

COMMUNICATION – DECANT TO WARD 6A/4B QEUH – 17 SEPTEMBER 2018

94. I have been shown a media statement from 17 September 2018 (**A38662124 - Media Statement titled "NHS GREATER GLASGOW AND CLYDE STATEMENT" by NHS Greater Glasgow and Clyde Health Board dated 17 September 2018 – Bundle 5 – Page 148**). The media statement describes the need for the temporary move and what would happen. A statement from Dr INKSTER is included. It was important parents were also

aware of why we were moving, how we would do it and what would happen once we had moved. I am not aware of any issues emerging during the move and personally viewed it as a smooth transition with strong operational governance around it.

95. There were various briefings for patients and carers. For example (**A38662122- Update for Parents in Wards 2A and 2B regarding cleaning and sink drains dated 18 September 2018 – Bundle 5 – Page 149**) Again this would have been a standard communication to inform parents of what was happening and why.

96. It was important parents were not only aware of what we were doing but had confidence in why and what would happen once implemented. Confidence in the water supply was important noting Ward 6a is sourced by same supply as Ward 2a.

WORK IN WARD 2A/2B RHC – AUTUMN 2018

97. At this time we were informed by the new Director of Facilities that, as the ward had been decanted, there was an opportunity for the replacement of a new ventilation system to be implemented in Ward 2A/2B and that this would be progressing while we were on decant.

98. The timeline would extend from weeks to months for us to work out of temporary relocation. However, we were advised that on completion we would have a state of the art ventilation system in situ. It would also allow for some further refurbishment work on the wards.

99. I was tasked in pulling together a capital planning group to oversee the project. This is part of the standard capital planning/finance instructions for projects of this scale and cost. We worked to standard terms of reference. We reported to the Acute Capital Planning parent group and also through own service/function report lines.

100. In essence the group was challenged with coming in budget and on time. If there was any variation to either aim then there was a clear audit trail for decision making and reason.

101. The group had representation from clinical team, capital planning design/finance, external project management, microbiology/IPC and Estates.

102. Prior to the group being set up a specification for the new ventilation system was agreed and costed with an appropriate procurement exercise completed. I was not formally involved in the technical aspects but kept aware of progress and outcome. Again, Estates, Capital Planning and HFS were the key stakeholders moving forward. Through the project duration thereafter, links with the main contractor and subcontractors were managed through Capital Planning and Estates. Our group was only updated on matters of progress/concern. As the project commenced we obviously ran into COVID which caused significant disruption to the timeline.

CRYPTOCOCCUS EVENT - DECEMBER 2018 TO JANUARY 2019

103. We were notified of two cases of Cryptococcus around the turn of the year 2018/19. This was suggested as very rare. [redacted] Relevant SAERs were conducted into both cases. Concurrent to this an IMT was set up which I was involved in.

104. On 4 January 2019 I attended a meeting [redacted] Brenda Gibson, Jen Rodgers and Teresa Inkster were also present. [redacted]. It was a really challenging time for the family. They were so upset in the meeting. There is a minute from the meeting. (**A41501445- Minutes of meeting between NHS Greater Glasgow and Clyde Health Board [redacted] on 4 January 2019 – Bundle 5 – Page 159**).

105. At the meeting [redacted] were informed that [redacted] had contracted Cryptococcus. They were told that there had been two cases in

the hospital and that it was a very rare infection. As mentioned, it was a very sad and challenging meeting. At this time there was no understanding of where the infection had been contracted. At the meeting we confirmed that there would be a Significant Clinical Incident Review (SCIR).

IMT – 7 JANUARY 2019 (A36690566 - Incident Management Meeting Minute dated 7 January 2019, relating to Cryptococcus neoformans – Bundle 1 – Page 255)

106. I attended an IMT meeting on 7 January 2019. My recollection of that meeting is as follows.
    a) It was very busy and went on for a significant amount of time. Note there were colleagues from adults and paediatrics present as well as the standard IMT membership.
    b) There was significant discussion on the working hypothesis. Dr Inkster did think environment was a risk and both the plant room and helipad adjacencies to clinical areas/pathways were considered a risk.
    c) To my mind, we never agreed a working final hypothesis with changes that had significant difference in reducing the risk of this infection if indeed there was a risk. There were changes implemented however including a program for reduction of pigeons on site to be implemented.
    d) My understanding now is that Dr John Hood has a written document that indicates neither patient is likely to have contracted this infection from hospital environment. I am not aware of any further IMT being called similar to this one for this type of isolated infection.

MOVE FROM WARD 6A TO CDU – JANUARY 2019

107. In January 2019 I was informed of an estates problem in Ward 6A. Following inspection by Dr Inkster and colleagues from the clinical team a HAI-SCRIBE was put in place to manage remedial works. However during works it became evident the problem of mould was significantly more concerning than first envisaged. Dr Inkster was clear that there was a need for decant to be considered.

108. Ultimately a decision was taken to decant inpatients from Ward 6A to CDU with day care services being provided from Ward 1A. Both these locations in the RHC. Again, considerable work had to be carried out on the decant to these areas and again, after escalation/agreement to proceed through very detailed planning this was successfully completed.

109. A decision on displacement of services from CDU had to be considered and again this was managed internally at operational level within the Directorate.

110. At the early stages of this I do recall spending a full weekend on site and walking across the hospitals speaking to parents and families to inform them of these planned changes and why. There was also close discussion with staff at this time. This engagement continued routinely through the stay in CDU until moving back to Ward 6A. No changes during this time were made to plans we had in place for HSCT patients and use of Ward 4B.

COMMUNICATIONS – JANUARY 2019

111. I have been provided with an email,(**A39355087 - Email from Lorraine Dick, Senior Media Relations Officer regarding the Herald and Evening Times running articles, which includes a statement titled NHS GREATER GLASGOW AND CLYDE STATEMENT ON TAP WATER AT QEUH and subject "Herald Article" dated 28 January 2019 – Bundle 5 – Page 252**). Within the email it is stated, "Claims that children are not allowed to drink the tap water are totally untrue. We have not instructed staff or patients not to drink the tap water at the Royal Hospital for Children (RHC) or any other building on the QEUH campus." Again, the message to parents following this article was assurance on the safety of the water supply.

112. I have seen another email chain (**A39123940 -Email chain between nurses, communications and facilities regarding ward 3C being under the impression that tap water was not appropriate for consumption and subject "RE: Herald Article" dated 28 January 2019 to 27 March 2019 –**

Bundle 5 – Page 261). It states, "I can confirm that the IMT have previously advised that the water is drinking water quality. This position has been notified to all wards and departments by the RHC management team." Again, it was important that staff and patients were reassured on this matter.

STENOTROPHOMONAS INCIDENT IN 2017 AND SBAR - MARCH 2019

113. I cannot recall being involved in the Stenotrophomonas patient incident in 2017.

114. I became aware later on and retrospectively I became involved when Professor Gibson asked Dr Chaudhury to carry out an audit of patients and there was a concern around three particular cases identified. This work was taken through W&CD Clinical Governance via Dr Mathers, Chief of Medicine.

115. In March 2019 Dr Mathers produced an SBAR for Jennifer Armstrong. (**A39243760 Email chain dated 4 March 2019 containing an SBAR by Alan Mathers sent to Jennifer Armstrong dated 1 March 2019 – Bundle 4 – Page 151**). I was not directly involved in this including ongoing communication.

116. I do recall being asked why there was not a Significant Adverse Event Review/Significant Clinical Incident commissioned. In speaking to Haematology Oncology, Cardiac and Extra Corporeal Life Support teams none thought there was a need for this although the case was reviewed through their local mortality and morbidity governance structures.

WARD 6A CLOSED TO NEW ADMISSIONS – APRIL 2019 TO OCTOBER 2019

117. From April 2019 to October 2019, we continued to hold more IMTs. These continued to be chaired by Dr Inkster.

118. My recollection from these IMTs is as follows.
    a) The concern was that we were experiencing a strange array of infections.

b) The overall number of infections were not pushing us over the control lines however, given the variety Dr Inkster was concerned.
c) It was very difficult through this program of meetings to agree a working hypothesis or identify solutions to resolve matters.
d) Due to point 3, a decision was taken to close the ward (Ward 6A) to new admissions and specific types of inpatient elective chemotherapy work. I think this was at the beginning of August 2019.
e) Aberdeen and Edinburgh clinical and managerial teams were notified of this again after escalation and approval.
f) This arrangement remained in place until October 2019.
g) To avoid overuse of the two other external sites, extra space was negotiated in Ward 4B for some patients to be managed. Again, remembering that Ward 4B was not part of the IMT review (restricted to infections in Ward 6A).
h) We also used the Beatson Oncology Unit for age appropriate cases.
i) Throughout this period, August to October 2019, we had regular multidisciplinary team meetings with clinical and managerial hospital teams.
j) As matters progressed, it became clear patients and families did not want to be seen outwith Glasgow. We still had no hypothesis/solutions. Aberdeen/Edinburgh were struggling to cope with the demands being placed upon them. The pressure with use of Ward 4B beds was starting to grow.
k) As we moved closer to October two things happened:
    a. Dr Inkster was replaced as chair of the IMT with Dr Crighton; and
    b. Dr Brian Jones (Microbiologist) became involved in reviewing our situation and feeding updates to the clinical team and ongoing IMT.
l) Dr Jones general feedback, from memory, was conflicting with that applied by Dr Inkster. He indicated we did not have a problem. We were not out of control lines and the infections were not rare.
m) Ultimately the IMT made a decision to lift the restrictions of access. Dr Crighton also decided to close the IMT down. This was completed

under strict condition that a Clinical Review Group (CRG) was established.

n) This was also around same time when benchmarked data on infection rates between the main paediatric units in Scotland was shared and it was reported independently that Glasgow infections were comparable if not better than those of Lothian/Grampian.

o) I set up the CRG and chaired it. This group met weekly and followed a set agenda with structured involvement from management, clinical, IPC/Microbiology, Estates and Domestics. Primarily the group reviewed infection/infection risk. It also monitored IPC practice and outcome, and reviewed any other situational awareness linked to infections and where necessary trigger escalation of concern. This extended to environmental test reviews by exception for example.

p) The CRG was very successfully implemented and since its introduction there has been superb teamwork across the represented areas, building on what was already a very strong platform. There have also been no significant issues with repeat or new infections for the remaining period in Ward 6A and since the move to the refurbished Ward 2A.

119. In response to point 11 (a) above, I can confirm that I was called to a meeting at the Glasgow Royal Infirmary chaired by Linda de Caestecker, who was Director of Public Health. The meeting was held on 20 August 2019 and the minute is (**A36591680 - Meeting re functioning of IMT dated 20 August 2019 – Bundle 6 – Page 70**). Dr Teresa Inkster was not present at the meeting and her apologies are recorded. Following this meeting I have not worked with Dr Inkster on matters of infection.

120. I prepared an SBAR (**A38694861 - SBAR by Jamie Redfern dated 14 November 2019 – Bundle 4 – Page 202**) where the recommendation was that the restrictions on admissions be lifted with immediate effect. The ward did re-open and we have not had any issues since as previously stated.

WARD 2A/2B REOPENS – APRIL 2022

121. Following completion of the project to return to Ward 2A/2B, the wards re-opened in April 2022. This decision was taken after broad agreement with all key stakeholders that the works had been completed and signed off. All checks had been completed independently and organisationally. There had been full consultation with the clinical team. A successful decant plan for the move was implemented. I would say the decant was again very successfully managed, this time led by Melanie Hutton with strong engagement from all stakeholders. This work extended into a settling in period and again I would say this has been very successful with infection rates within control levels, and the HSCT restarted and the MIBG specialist service started.

122. Operationally at Directorate level we took the opportunity to undertake some service redesign. This included provision of an age 8-12 dedicated play area. Mirrored on the age-appropriate template of the Teenage Cancer Unit. The vision and funding for this led by two families and two former patients in particular (Molly and Sara). Working with these young women on the project was both humbling and inspirational. It is also a template for patient-user engagement/service redesign that I would seek to replicate and build on moving forward.

123. We also took the opportunity to develop office space adjacent to the ward and address some space issues for pharmacy. Other aesthetic improvements in the ward most importantly lighting is also impressive.

124. Staff feedback since returning to the ward has also been very positive.

THE NEW RHC – BUILT ENVIRONMENT/STANDALONE ISSUES

125. I have an awareness of room issues being raised by patients and families such as room temperature, blinds and televisions not working. The reporting process for issues on a ward or within a room is for the Senior Charge Nurse to report it to the relevant department, such as Facilities or Estates, who may invite a third-party contractor in to sort the matter, however it would depend on the issue and if it is time critical. For example, if there was a problem on a

ward that meant we could not take a burns patient, dialysis patient or it meant cancelling a bone marrow transplant then this would be escalated immediately.

126. With the issues on Ward 2A (Schiehallion) and Ward 6A (QEUH) the Estates reporting became daily with staff.

THE NEW HOSPITAL BUILDING – REFLECTIONS

127. Generally, from an operational perspective, the building serves its core purpose. It has got enough beds, it has got enough theatres, it has got enough outpatient space, it delivers day-to-day care very successfully. It is a successful hospital.

128. If I could go back in time and plan another hospital, of course there are certain things that you would wish you had done differently, that you probably did not know at the time. For example, I do think more could have been done around staff amenities such as creche, gym, changing rooms etc. We could also benefit from expanded meeting space. These are all areas we are looking at as part of ongoing modernisation program for the build including learning from other centres such as in Utrecht and Helsinki. An exciting piece of work we are developing is in paediatric theatres.

129. I am in conclusion truly sorry for the experiences and sad outcomes for some of the children and families attending RHC since it opened.

130. I was not aware of any issues faced as we moved into the hospital and started services. In particular, this relates to water supply and any other environmental challenge of the new build.

131. I worked very hard with our clinical team and management colleagues to manage the various situations we faced with trying to minimize disruption to service, gain positive experience/outcome for children, young people and families, and maintain staff morale as best we could. I walk through Ward

2A/2B as part of my routine visibility. On these walkabouts I talk to staff and parents and I am thankful to see generally smiling faces as they carry out their daily function often still in challenging circumstance. No one will ever forget the difficult and extremely harrowing experiences faced and nor should we. However, a successful platform has been built to move forward for a service and hospital we can be proud of.

COMMUNICATION

132. The general approach to communication with patients and families was an opt-in approach. Families were offered the opportunity to speak to senior management, infection control and clinicians if there were any concerns. This could be a general invitation based on concerns or queries they had on what was happening. This might be triggered by concerns at what was being experienced at ward/outpatient level or what they were reading in the media. Following an IMT any patient with an infection would again be offered a similar meeting.

133. Various families took this up with attendance regularly from myself, Dr Teresa Inkster and the child's consultant (often Professor Gibson). Over time, routine briefings were offered to all inpatient families with normally Jen Rodgers (Chief Nurse) and myself with the Senior Charge Nurse visiting to hand over a written brief and answer any questions. These included updates on the commission of a Public Inquiry and feedback on media stories circulating including TV programs such as the BBC Disclosure programme.

134. Separate communication and briefings were issued to staff as well as group Q&A sessions with again Jen Rodger's and I attending. The offer of individual one to one meetings was also made.

135. Through the work of the Communication groups set up under NHS Board escalation by Scottish Government there were various briefings circulated to all patients and families, to those who had used paediatric haematology

oncology services prior to the move to the new hospital and those who had used the service after the move.

136. I was not part of the communication groups set up under escalation although I am aware Jen Rodgers was. I did work very closely with key stakeholders involved in these groups to implement their recommendations/instructions.

137. The process for statements to patients, families and staff say triggered following an IMT meeting were drafted by the Corporate Communications team. Clinical staff including those in Infection Prevention Control would be involved in working with the Communications team. Final sign off in any statement was at Corporate level.

138. Often the draft to sign off for statements took up many iterations over a number of hours. This could be challenging when looking to issue thereafter to parents and staff. Very often, the final copy would have a quote from clinical staff such as Dr Inkster.

139. Generally parents accepted the briefings without question. However there would be questions for example on why we had filters when stating the water was safe. The same questions were asked around the provision of antibiotics/prophylaxis.

140. Specific times when staff and parent/family briefings were issued included:
    - Update on infection control arrangements following IMTs.
    - Ward moves.
    - Closure to new admissions.
    - Media exposure.
    - Work of the Communications Group.
    - Public Inquiries.
    - Reinforcement of hospital safety – drinking and using water to wash etc.

141. The written briefs associated with infection control matters would try to explain the issue, update on what was happening to resolve incidents and how further communications would follow during incident. An example might be explanation of estates work to be carried out on a ward.

142. It was always particularly challenging when there was no working hypothesis as to what was causing infection or how they would be resolved. It was also challenging when you were answering questions on infection which were not water related but parents and families would revert to this as the issue/ cause.

143. Briefings would be predominantly for staff and patients, parents and families associated with the paediatric haematology oncology service. I am aware however that wider teams were updated through briefings and if necessary Q&A sessions held. Specific examples were on Ward 3C and renal team and theatres/ general surgery.

144. Generally, the rest of the hospital remained interested but unaffected by what was happening. Core Brief was the mechanism for corporate updates to wider staff groups. There is a standard approach to the production and issue of Core Brief. It is prepared by the Corporate Communications team, signed off by the Chief Executive and then sent out by email but with a hard copy provided. Topics for Core Brief could be general updates, positive news stories as well as updates on matters like the Public Inquiry and media speculation.

145. There would be an occasional parent who would indicate they did not want to attend for treatment (e.g. surgery). In these situations I or a colleague would speak to parent, explain situation and normally resolve it amicably.

146. I have been shown an email chain (**A39123941 - Email chain between nurses, communications and facilities regarding ward 3C being under the impression that tap water was not appropriate for consumption and subject "RE: Herald Article" dated 28 January 2019 to 30 January 2019 – Bundle 5 – Page 254**). I have been directed to one of the emails in this chain

where Prof Tom Steele states “Can you review beforehand? Less is more here with Ben.” I have been asked what Prof Tom Steele meant by this. I do not recall this communication. My view was the message needed to be concise and reinforce that the water was safe.

147. I have been provided with a briefing that was issued to parents, (**A39123907 - Briefing for parents and carers regarding the measures taken to enhance the ward and subject “150819 update briefing for Parents in” dated 16 August 2019 – Bundle 5 – Page 338**) and (**A39123898 - Briefing for parents and carers regarding the work that has taken place to the ward and subject “060919 Update Briefing for Parents” dated 6 September 2019 – Bundle 5 – Page 345**). It was important that again we fully communicated with parents and families, to ensure hat they were aware of decisions taken and why. Equally that we were actively listening to challenges faced and trying to improve the temporary stay.

148. I have been provided with another media statement, (**A39123908 Media Statement titled “NHS GREATER GLASGOW AND CLYDE RESPONSE” by NHS Greater Glasgow and Clyde Health Board dated 9 September 2019 – Bundle 5 – Page 361**).

149. Effective communication is an important key performance indicator with staff and patients, families and parents. We have an active SharePoint site. We use technology to support local team briefs. We promote visibility with regular walkabouts and Q&A sessions as well as aforementioned technology use.

150. The quality of briefings is important – what we say, how we present it, how we encourage involvement. All are essential ingredients to success.

151. A number of new exciting opportunities are routinely presenting. Effective generation and handling of patient feedback is critical to what we do. Learning from experience is vital. Especially in use of Care Opinion, complaints etc.

152. Generally I was confident in what I was communicating and how I was doing it. I am not aware of any direct criticism aimed at me in this regard. I do recall one incident which was very emotionally challenging with a particular patient/parent. I often reflect on this.

LETTER FROM THE CHIEF NURSING OFFICER (CNO) TO CHIEF EXECUTIVES - FEBRUARY 2019

153. I have been shown a copy of a letter dated 11 February 2019, which was sent from the Chief Nursing Officer to Infection Control Managers, HAI Leads, Chief Executive Officers and NHS Scotland (**A32248275 – Chief Nursing Office letter – HAI Guidance – Bundle 6 – Page 44**).

154. Within this letter it states: "If you have a red HIIAT, or an amber HIIAT, score at your IMT, and if a proactive media statement is planned, then this has got to be undertaken in consultation with HPS and the Scottish Government."

155. My understanding is this was standard practice anyway and followed by the NHS Board/ delegated to the IMT chair and the wider communications team. But the IPC team/ Communications team would be able to speak to this better.

SPECIFIC EVENT - COMMUNICATION - MEETING WITH JOHN CUDDIHY – AUGUST 2019

156. Professor Cuddihy's daughter Molly had contracted Mycobacterium chelonae in 2018. She was considered a case of interest alongside the patients under incident review. Dr Inkster had explained this in an earlier meeting with Professor Cuddihy noting that it was based on national infection control standards.

157. In 2019 there was an IMT commissioned which included review of a potential second case of Mycobacterium Chelonae. I attended the IMT dated 25 June 2019 **(A36591622 - Incident Management Team Meeting minutes dated 25 June 2019 – Bundle 1 – Page 325).** The intention was to update Professor

Cuddihy of this development and this is ref lected in the minutes of this meeting.

158. My understanding was that later it was confirmed the cases were not related.

159. I have been shown an email email dated 17 July 2019. **(A34364657 - Email from Professor Cuddihy to Jamie Redfern dated 17 July 2019 – Bundle 6 – Page 55).** This email clearly highlights the Professor's unhappiness about not being formally updated of this second case. The unhappiness is clearly directed to me.

160. Following receipt of the email, I responded on 25 July 2019 and set up a meeting to speak to Professor Cuddihy. **(A34364663 - Email from Jamie Redfern to Professor Cuddihy dated 25 July 2019 – Bundle 6 – Page 58).**

161. I was instructed by Mr Hill not to speak to Professor Cuddihy as was Dr Inkster. My understanding was that communication with him was being managed through another route. I therefore took no further action and went on holiday. On return I received said email from Professor Cuddihy expressing concern and anger that I had not spoken to him about the second case. After discussions with various parties it was agreed that Dr Inkster and I should meet with Professor Cuddihy. At this meeting (8 August 2019) Dr Inkster informed Professor Cuddihy why no conversations/update had taken place. He was very unhappy and the meeting closed. Thereafter I had no further dialogue with Professor Cuddihy on the matter.

162. I do have a very good relationship with Professor Cuddihy since then. This has been built up through working with him, his daughter and his wife plus another family. This has focussed on fund raising and service redesign for an aged 8-12 appropriate room in Ward 2A, but now extended to other service areas including Ward 2B and paediatric intensive care.

163. I would refer again to parent questions on the use of prophylaxis. Again, concern that these drugs were being issued when the NHS Board were declaring the water as safe. Dr Conor Doherty (Immunology and Infectious Diseases doctor) reviewed our use of prophylaxis and made various changes. The agreed framework he established was used by the consultants moving forward.

THE CLOSED FACEBOOK GROUP – SEPTEMBER 2019

164. The Closed Facebook page was set up by NHS GGC.

165. Those joining had to answer two questions to be admitted to the group:
    - Are you a parent of child associated with Ward 2a?
    - Will you agree to accept the rules of the Group?

166. The intention of the group was to improve communication to families and patients, particularly those who were not attending the hospital regularly. Initially anything posted had to be approved by Professor Craig White/Scottish Government. This included posts relating to the BBC Disclosure Programme in June 2020. This would extend to briefings, but also good news stories associated with the service.

167. Administration was initially by Corporate Communications. However, it is now the responsibility of the W&CD.

168. As mentioned previously, the hospital now actively uses social media to promote positive news stories about staff and patients. This is across a number of platforms and has been and continues to be very successful.

CONCLUSIONS

169. I have been asked a number of questions about the challenges we faced and changes we have made to address them. There are I would say many of both. I will try to summarise these.

Challenges

170. Since the opening of the Royal Hospital for Children there have been many challenges we have had to manage with staff working in haematology oncology but also wider paediatric areas as well as patients and families attending the hospital.

171. These have been covered in this statement above and include:
    - Impact of moving ward and infection prevention control measures.
    - Scrutiny on infection prevention control practice including hand hygiene.
    - Extended patient concerns on infections.
    - Media reporting especially around focus of the various case reviews.
    - Impact of the Public Inquiry.

172. As a local management team, we tried to manage all of this through close links, visibility and question and answer sessions with staff. This was and has been very challenging.

173. It is certainly very difficult to describe such a challenge in words of this kind.

174. In relation to staff communication, it was very important to us that staff understood what was happening. Whether this has been updates following IMTs, to what is happening with the Public Inquiry, to hospital moves they have had to experience. It was especially important they were confident that no one was blaming them. It was important they could at ward level answer patient and family questions or know where to seek answers from.

175. Visibility is important to us as a local management team. By that I mean all staff know who we are and what our values are. That as well as organised drop in sessions we have when walking through wards chatting to staff and patients, they know they can ask us questions at any time. An open door policy between staff and management is in place.

176. Empowerment of local nurses, allied health professionals and medical leadership was important and we have tried to ensure they are involved in all key decision making.

177. Protecting staff morale and well being will always remain very important to us. The experiences of hospital infections then COVID has tested this.

178. It has been a daily challenge for a significant period of time. I do think again reinforcing the point of openness and effective communication and visibility have been essential in us managing this.

179. At the same time, it was important we improved communication with families. There was recognition that the NHS Board had been criticised on its communication strategy/plan during the infection periods with parents and families. My experience through the infection periods is that the organisation has been constantly learning from its experience.

180. Again visibility and openness with good communication has been essential. Walkabouts with the local management team and speaking to parents has been a positive step forward. Encouraging Q&A on any issues parents and families were experiencing vital. We have worked very hard in encouraging patient feedback whether positive or negative. Using such feedback as a mechanism for reviewing and developing service delivery. Care Opinion is an excellent tool for this as is formal complaints management.

181. We have a close relationship with the Corporate Patient Engagement team and look to sample targeted views of the patients and parents/families we serve. This work is ongoing and we believe evolving because of our commitment to it and opportunities technology continues to present.

182. Not only to staff working in haematology oncology but the wider hospital, a number of media stories have been very challenging. The senior management team with clinical teams have worked very hard to create a powerful narrative of all the good things the hospital has and continues to do/achieve. Social

media has become a very powerful tool in progressing this strategy. As has wider technology.

183. The purposes of this not to forget the significant challenges the hospital and patients families have faced since opening, but to encourage and motivate the way forward and learning from them.

184. We strive for everyone to feel part of a successful hospital team. Sharing staff and patient stories is very emotive and powerful in achieving this. We feel a positive staff group is easily identified by patients and families. We believe this is reassuring to them, better partnership working and ultimately a lead to enhanced safety and better outcome. Through all this we have on occasion had to reassure families that it is safe to attend the hospital. Growing this culture makes that easier.

185. I mentioned joy in the workplace and positivity as crucial outcomes of empathetic leadership. Of course we have and continue to have day to day challenges. We do not get everything correct all the time. However, we are very much as I have also said before, very much a learning organisation.

186. This then leads to the third focus we seek to progress. That is the education and development of our staff but linked very closely to innovation and a developing culture of excellence. Whether that be improvement in the physical environment, or the use of technology to redesign of how we do things. We work had to continue building our reputation to make paediatrics and neonatology in Glasgow an attractive place to work and a safe place for patients to be treated.

187. There is nothing more positive than walking around our hospitals, speaking to staff, sharing our ideas, focussing on our successes and learning from experience. Also though hearing from them about the challenges they face. The concerns they have. The importance of listening is so important.

Infection Prevention Control

188. The high level of ongoing frequency of infection prevention control monitoring that continues to this day and the excellent results that the team achieves is consistently recognised.

189. I always remember when Gaynor Evans visited the ward. She was the senior nurse who was part of the Case Note Review Panel and was from the Department of Health, and was the leading nurse for Infection Control in NHS England. Gaynor Evans visited Ward 6A (QEUH) and on carrying out checks at Ward 6A she told us that the ward was spotless and immaculate. I believe the efforts of the team at that time were outstanding and this was also recognised when the Independent Review team visited.

190. Complementing this there are great relationships across Service, Estates, Facilities, Infection Prevention Control and Management. This is reflected in the escalation and reporting of any issue no matter how minor affecting practice on the ward and solutions sought/ implemented. It is clear to me these relationships were always in place but somehow enhanced through the collective experiences faced.

191. There are many visiting clinical teams to the haematology oncology wards. These teams are consistently reminded of the high performance levels for IPC expected when in the ward, with staff fully empowered to challenge wherever they see any degree of concern.

192. The pride shown in IPC performance is clear and encouraging for ongoing staff morale. Some staff query why inspections continue noting consistently high performing results. This is a reasonable question to ask.

193. My personal response is always for us/them to showcase the high levels of performance to themselves and others.

194. I think this is an important point on which to conclude my statement.

195. 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.