Scottish Hospitals Inquiry

Witness Statement of

Jennifer Rodgers MBE

PERSONAL DETAILS

1. My name is Jennifer Rodgers. My current role is Deputy Nurse Director for Corporate and Community Services across NHS Greater Glasgow and Clyde Health Board (NHSGGC). I am based at the Board Headquarters at JB Russell House.

2. I provide strategic professional leadership to develop and support the delivery of the Board's objectives for nursing within NHSGGC's corporate and community services.

3. This position is within the Executive Nurse Director's Team. My line manager is the Executive Nurse Director, Professor Angela Wallace.

PROFESSIONAL BACKGROUND

4. I became a Student Nurse in March 1993 and qualified as a Registered Nurse in 1996.

5. I worked in various Staff Nurse roles, first in Glasgow, then Australia and New Zealand before returning again to Glasgow Yorkhill Hospital as an E Grade Staff Nurse. I later moved into a Senior Staff Nurse and then Senior Charge Nurse position within Paediatrics at the Royal Alexandra Hospital (RAH) in Paisley.

6. Following this, and on completion of the Scottish Patient Safety Fellowship, I undertook a wider role across NHSGGC Paediatrics and Neonates focussed

on Quality Improvement and patient safety at the Royal Hospital for Sick Children (RHSC) which at that time was situated at Yorkhill. It was during this time we designed and implemented a hospital safety huddle which was focused on safety, protection and flow. The huddle was successfully embedded in Yorkhill, and we then worked with colleagues across Scotland to share our approaches. We implemented various other improvement approaches during this time including utilising a ‘What Matters to me’ tool which I had previously introduced within the RAH paediatrics. This is a person centred approach asking children and families what matters to them as a standard part of care. Rather than focussing on what is the matter, we were flipping the perspective to instead ask what matters to patients and families. Children would draw a picture or write a list about what mattered most to them and then further discussions and care planning could be influenced by that. This was embedded across paediatrics and then adult settings.

7. I later become Lead Nurse prior to moving into the Chief Nurse role, covering all paediatric and neonatal nursing services across Greater Glasgow and Clyde.

8. In November 2020 I began my current role as Deputy Nurse Director, NHSGGC.

9. My professional academic qualifications are: MSc with Distinction; Nursing; BSc with Distinction; Health Studies; Advanced Paediatric and Neonatal Health Assessment with Distinction (Standalone module, M Level); Nurse Independent/Supplementary Prescriber (Standalone module, Level 9); and Diploma in Nursing.

10. I have undertaken a number of leadership and development programmes, these are detailed in my CV alongside further professional activities and awards.

WOMEN AND CHILDREN'S DIRECTORATE MANAGEMENT STRUCTURE

11. The senior management team for Women and Children's report to the Director of Women and Children's Services. The senior team include the Chief of Medicine, Chief Nurse, Director of Midwifery, Head of Finance, Head of HR, Organisational Development Lead, and the General Managers for Paediatrics, Obstetrics and Gynaecology.

12. My role within that structure was the Professional Lead for Nurses within hospital paediatrics and neonates. This included over 1000 registered nurses and around 300 healthcare support workers.

13. As Chief Nurse my line manager was the Director of Women and Children's Services, Kevin Hill. My professional lead was the Executive Nurse Director, Dr Margaret McGuire at the time, until August 2019 when a Deputy Nurse Director for Acute Services was appointed and my professional line switched to Angela O'Neill.

14. Professional clinical roles may have a direct line manager that is not a clinician, in which case they will also have a professional clinical lead. This is described in organisational structure charts by a solid line to the direct manager and a dotted line to the professional lead.

15. Given the size and scale of NHS GGC, the acute services are managed through a number of sectors and directorates. Each of these has its own director and senior management structure. The Women and Children's Directorate covers services for midwifery, gynaecology, hospital paediatrics and neonates.

16. The Director of Women and Children's Services reports to the Chief Operating Officer, which was Jonathan Best, now William Edwards. The Chief Operating

Officer reports to the Chief Executive, Jane Grant. The Executive Nurse Director also reports to the Chief Executive.

17. There are now two Deputy Nurse Directors in the Board, the Deputy Nurse Director for Acute Services and my new role as the Deputy Nurse Director for Corporate and Community Services.

18. In my current role, I provide professional leadership to the six Chief Nurses within the six Health and Social Care Partnerships across the GGC locality, which are Glasgow City, Inverclyde, Renfrewshire, East Renfrewshire, West Dunbartonshire and East Dunbartonshire as well as the corporate nursing team.

ROLE AS CHIEF NURSE

19. The Chief Nurse role spanned hospital paediatric and neonatal services across NHSGGC inclusive of a 256 bed tertiary paediatric centre, three neonatal units, two of which are level two, holding 50 and 28 cots, and the third a level three unit with 16 cots. The directorate also covers a range of national and regional paediatric and neonatal services including renal dialysis and transplant, ECMO (extracorporeal membrane oxygenation) and Cardiac surgery.

20. The Chief Nurse plays a key role in the planning and delivery of the strategic direction of the directorate as part of the Senior Management Team, informing and professionally influencing operational decision making. I provided visible, professional leadership to the nursing workforce.

21. I led and monitored nursing workforce planning within Hospital Paediatrics and Neonates ensuring application of workforce tools, national policy, principles of safe staffing legislation and ultimately the nurse staff plans to enable the delivery of safe, person centred and high quality care.

22. I worked to ensure that high standards of nursing care, professional governance and standards were met and matched to policy and professional principles through scrutiny, assurance and improvement in all areas of business. I would ensure that nurses were registered, complete revalidation and undertake appropriate education and training for their roles.

23. The Chief Nurse role did not have any direct reports, however I was Professional lead to four (latterly five) Lead Nurses.

24. In the context of my role, I am supporting and advising colleagues, including Director Kevin Hill, on professional nursing matters and aspects requiring consideration in any decision making.

25. My corporate responsibilities included Professional Lead for Person Centred Care and Chair of the Acute Child Protection Committee.

26. I provided support to the Executive Nurse Director and deputised for her as required.

27. The role included being part of the acute on-call executive director rota.

MEETINGS

28. The senior management team for the Women and Children's Directorate met informally every week and formally once a month.

29. Monthly Lead Nurse/Chief Nurse meetings were an open, safe space forum for professional issues.

30. There were regular one to one meetings between Lead Nurses and Senior Charge Nurses. Professional topics such as nursing assurance audits undertaken to monitor and continuously improve the delivery of safe, person-centred, effective high quality nursing care would be discussed at these meetings.

31. There was a further combined monthly meeting for the Senior Charge Nurses and this was chaired by the Lead Nurses. As Chief Nurse, I attended those meetings for particular agenda items and the Lead Nurses would update me on matters arising from the rest of the meeting.

32. Chief Nurses from all sectors and directorates met regularly for one to one meetings with the Executive Nurse Director and as a team to discuss professional business including care quality with the Executive Nurse Director.

33. Hospital paediatrics and neonates held a monthly infection control meeting which included Senior Charge Nurses, local Facilities and Estates. I chaired the group with the Lead Infection Prevention and Control Nurse for hospital paediatrics and Neonates. The group set to ensure that all areas were updated on policy changes, audit and inspections, any current/ emerging themes, shared learning and was also an opportunity for Senior Charge Nurses to raise issues and concerns.

34. The Infection Control Team would provide expert advice to clinical staff. They are subject experts in their field. I had good relationships with all the Lead Infection Prevention and Control Nurses for hospital paediatrics and neonates and worked with them very closely. I met with them at least every month as well as on a one-to-one basis to discuss any arising infection control issues. .

35. I attended a number of regular meetings as part of the Board's Governance Framework including: Women and Children's Clinical Governance Group; Child Protection Acute Group; and the Acute Infection Control Committee.

36. I would not be a standing member of NHSGGC Board level committees. However if requested, I would attend to present papers on a requested topic. For example, I presented a paper to the Board Infection Control Committee about the CLABSI (Central Line Associated Blood Stream Infection) quality improvement work.

37. Depending on the meeting, I could attend and give updates on behalf of hospital paediatrics and neonates. Equally, if there was information coming to

me from that meeting, I would go back and update my own local group as appropriate, so there would be feedback both ways. The majority of groups would work like that.

NEONATAL & PAEDIATRIC FACILITIES AT QEUH CAMPUS

38. The Royal Hospital for Children (RHC) is a 256-bed hospital. It is a national and regional centre for paediatrics services. In terms of regional, this means that children from the west of Scotland will utilise this service. National services are for the whole of Scotland. For example, any child in Scotland that requires a kidney transplant will come to the RHC.

39. The neonatal unit which is situated on the QEUH campus is one of the biggest in the UK. The unit is within the Maternity building, which is part of the retained estate and is not part of the new hospital buildings.

40. At the time I was Chief Nurse the RHC Outpatient Department saw around 100,000 children a year.

LAYOUT IN THE ROYAL HOSPITAL FOR CHILDREN (RHC)

41. I began working at the new RHC in September 2015. The offices of the senior management team were on the ground floor next to each other. We were a small team and all had good working relationships.

42. Also in the same area were the Clinical Service Managers, the Director of Midwifery and the Lead Nurses, so we were all easily accessible for each other.

43. The building has a beautiful atrium area. If you watch children walking in for the first time you would see their eyes light up, which was inspiring.

44. The families fed back that they really liked the single rooms. There were many more single rooms than in the old Yorkhill Hospital, and the parents liked that because it gave more privacy.

45. The rooms had en-suite bathrooms, whereas in the previous Yorkhill, the parents' bathroom would be shared between the whole ward. That was a big advantage for the families and carers who were staying.

46. The Medi-cinema is impressive and there is an added benefit to being co-located with the adult hospital in that we could run sessions for adults which was a service they did not previously have.

47. I felt that was important because there were some families where the adult would be in hospital for a long period of time, sometimes this would be at the end of their life. They could have a special movie session with their family in a 'what matters to you' approach.

48. The teddy hospital is incorporated into the main atrium, close to family support. Both are a great resource for families.

49. The Emergency Department design was also an improvement from Yorkhill. At Yorkhill there was a single entrance, meaning that if an ambulance arrived and a child was brought in, everybody would be sitting in the waiting room looking at the child and family as there was only one small corridor. In the new RHC ambulances arrive at their own specific entrance so privacy was enhanced. Also, the visibility of patients for clinical staff was improved in the design in the new RHC.

50. The resuscitation area is much larger in the RHC. It has four large resuscitation areas to accommodate all the equipment and staff required for a paediatric resuscitation or major trauma situation.

51. The majors and minors areas have staff bases in the middle and then all around them are the spaces for patients such that the clinical staff have excellent visibility at all times of all of the patients.

52. The live donor kidney transplant service also benefited. Live donors can often be from a child's parent. Previously, the parent would have had the operation in a different hospital and the kidney would then have to be transported across to Yorkhill. Now at RHC it is all done on the same site and the family are able to see each other more quickly following surgery. If, for example, the father is donating the kidney then the mother can go easily between both the child and the father, and the dad can come over and see the child when they are well enough.

RHC: BENEFITS OF THE NEW SCHIEHALLION UNIT

53. Benefits in the new RHC for the Schiehallion Unit included the TCT (Teenage Cancer Trust) area which previously was in a separate ward in Yorkhill to the paediatric haemato-oncology ward. Integrating these meant it was improved both for the young people and their families as well as the clinical team.

54. Single rooms were also an advantage for families' comfort and privacy. Previously there had been some shared rooms in the old Schiehallion.

55. There are more outdoor play areas in the new RHC than they had previously, so there is a much better scope at the new hospital for outside play for children and their siblings.

NURSING REPORTING STRUCTURES

56. The majority of registered nurses are Band 5 nurses, who provide care within the wards and departments. Band 6 nurses in acute services are Charge Nurses or deputies to the Senior Charge Nurses. The Senior Charge Nurse is a Band 7, similar to the old ward sister role. They are in charge of the overall management of their ward.

57. The haemato-oncology unit has more Band 6 nurses due to the level of acuity of their patients. Other areas will also have differing staff levels due to their acuity.

58. The Senior Charge Nurses report to the Lead Nurses. The Lead Nurse are Band 8A. Each Lead Nurses is responsible for their own areas, for example neonatal services.

59. The Lead Nurse reports to a Clinical Service Manager. There are two Clinical Service Managers in Paediatrics and Neonates.

60. Both Clinical Service Managers report to the General Manager who then reports to the Director.

61. From a professional perspective, as Chief Nurse, those Lead Nurses had a professional line to me.

62. Having worked as a Senior Charge Nurse and Lead Nurse previously, the communications between both your direct line manager and professional lead in my view worked well.

63. If there was a professional issue the Lead Nurses would escalate this to me. It was a small team and there would be good communication between operational and professional management.

NURSE STAFFING LEVELS AND RECRUITMENT:

64. When I started as Chief Nurse at the RHC on 7th September 2015, the hospital had only just moved in June that year and we changed from being a hospital that was around 30 per cent single rooms to having 80 per cent single rooms. This was more resource intensive for example in undertaking nursing observations and general duties.

65. It quickly became clear that we required additional nurse resource. To address this, I wrote an SBAR to the Executive Nurse Director, around October 2015. I worked with the workforce planners to look at the children's workforce.

66. At the time there was a national shortage of paediatric nurses, but we actively worked to recruit as many as possible within RHC. We were advertising widely. The issue was escalated through the Executive Nurse Director and that year in October 2015 a larger paediatric nurse student recruitment to universities was put in place. This meant that in October 2018, when these new nurses qualified, we would be in a better position. This was a challenging period for everyone in terms of being not able to recruit paediatric nurses.

67. When I first took on the role, it was identified there were staffing issues specifically in Wards 2C (Acute Receiving), Ward 3A (long term ventilation and neurosurgery), Ward 3B (surgery), and Ward 3C (renal and orthopaedics). Following the SBAR in October 2015, we maximised recruitment targeted to these four areas. This was supported by the Executive Nurse Director and the Director of Women and Children's.

68. Initially, Ward 2A was not specifically highlighted as an area of concern in terms of nursing workforce. However, this began to change with patients undergoing increasingly complex treatment regimens which often required more intensive nursing input. Alongside that, Ward 2A had a significant maternity leave pressure.

69. We use a triangulated approach to workforce planning. This involves utilising a workforce tool SCAMPS (Scottish Children's Acuity Measurement in Paediatric Settings), a validated tool for workforce planning within paediatrics, alongside professional judgement and quality measures.

70. Quality outcome measures will include data such as feedback/ complaints, pressure ulcers and Datix (e.g. medication errors).

71. Also considered in workforce planning is context, such as maternity leave, changes in service, whole time equivalent in post compared to budget, use of additional staffing, and percentage of planned absence allowance. This is calculated at 22.5 percent, with 1 percent factored for maternity leave. However, 2A had circa 5.5 percent maternity leave affecting staff availability. Following the issues coming to light we kept ward 2A's workforce closely under review and proactively recruited to the department.

72. As Chief Nurse, I would meet with Senior Charge Nurses, Lead Nurses and Operational managers to review their workforce together aiming to ensure it was fit for purpose.

73. Areas will roster their workforce matched to their activity as much as possible. For example, Ward 3B undertake cleft lip palate procedures on certain days, so they will put an additional nurse on those days. They will have good knowledge of what is required in their service and they will make sure their roster matches that.

74. On a day to day basis, there are a range of actions and mitigations in place should there be short term staffing pressures on a particular day.

75. This is escalated through the hospital safety huddles, workforce is central to the safety component of the huddle.

76. Each Senior Charge Nurse will make a Declaration of Safety at the huddle as to whether they are safe to start. If an area declared themselves not safe to start, the reasoning would be discussed and action taken to resolve it. This encourages a collective ownership of risk and to finding solutions.

77. Supplementary staffing is used in advance if staffing gaps are known about. This could be excess hours, staff bank and occasionally overtime or Agency.

INVOLVEMENT IN DESIGN AND BUILD OF RHC/QEUH: PRE-2015

78. I was not involved in the preplanning of the new hospital. I was also on maternity leave from October 2014 until my return in September 2015 so was not involved in the run up to, or the hospital move.

79. Prior to November 2012 I was based in the RAH children's ward which was not included in the move plans regards to Yorkhill. I therefore was not required to sign off ward drawings or plans.

80. I did visit the new hospital on one occasion prior to October 2014. It was very much a building site but the size and scale was very different to what we had at Yorkhill.

81. When I returned to work it was to the new hospital in September 2015.

PERIPHERAL ISSUES IN WARD 2A RHC: SEPTEMBER 2015

82. When I began working in the new building, I was aware there was a list of snagging issues, however I was not involved directly in discussions or managing any of the building / snagging repairs. I would not be able to describe the issues or programme of works.

83. From what I can remember I was not aware of any great impact on patients or families with the exception of the blinds. The blinds were cited as an issue and I recall operational and estates colleagues doing a programme of work to replace the blinds.

84. There was a period where if the blinds in patients' rooms did not work, the nurses, if able to, may have moved the family to a different room and request the blinds were fixed.

85. If anything impacted upon families, we would look to act on it and make sure that whatever the issue, it was reported to Estates. There is an online

reporting system called ‘FM (Facilities Management) First’ where nursing staff log issues into a system which then get picked up and addressed by Estates. Estates issues were generally not reported on to me in my role at the time.

CLABSI WORK – INFECTIONS

86. A central line is a plastic tube that goes into a major vein. Central lines pose an infection risk even in a relatively well person and you are at additional risk if you also have low immunity. Children with oncology conditions are more vulnerable to line infections as they also have low immunity and can be very ill from both their condition and treatment.

87. Children, simply due to their age and stage, may pose further risk of lines pulling or becoming contaminated for example children with nappies, or toddlers crawling around the floor, or pulling on their lines or not able to follow hand hygiene process.

88. Routinely we carried out audits in ward 2A/6A to ensure all staff were undertaking line care and infection control precautions properly.

89. We undertook additional, enhanced audit processes in the unit to ensure we were minimising any risks and nurses were accessing lines to best practice standards.

90. In 2016, there was a spike in line infections flagged to us by our Lead Nurse for infection control. It was thought to be attributed at the time to change of the type of central line from Bard to Vygon. Additional education was put in place and the issue seemed to resolve.

91. Subsequently the rate increased in early 2017, at that point the surgeon and I met and discussed adopting a quality improvement approach. We struggled to find data from comparable UK centres against which to benchmark our own data and so sought information from paediatric hospitals further afield. Mr

Bradnock, myself and others engaged with Cincinnati Children's Hospital who had undertaken a similar QI project.

92. Cincinnati Children's Hospital is widely recognised as one of the safest children's hospitals in the world. We held a conference call with them to discuss their published CLABSI QI work, and designed our quality improvement project based on their approaches.

93. We began working on improvements immediately and the project was presented at the Paediatric Quality Improvement group in March 2017. The focus was to reduce CLABSI rates within the paediatric haemato-oncology population. It would include all our haemato- oncology population with central lines that were inserted at RHC. This included outpatients and day-care patients as well as inpatients.

94. The first CLABSI QI meeting was May 2017. At that time, we had just started collecting the CLABSI rate, backdated to November 2014. Our median was 3.25 per thousand total line days.

95. It is important to have a denominator to enable us to track our own data improvement over time regardless of the actual and fluctuating number of patients included, also to benchmark with world centres and measure ourselves against the Cincinnati aim.

96. We generated a CLABSI graph for this population in order to track our position and improvement. At that time our data points were above the median.

97. CLABSI includes all types of microorganisms which cause line infections. The work was based on the CDC classification. A CLABSI is a primary bloodstream infection in a patient that had a central line, however, some blood stream infections (BSIs) are secondary to other sources other than the central line, e.g. mucositis that may not be easily recognised. A CLABSI is a laboratory confirmed bloodstream infection where a CVC is in place for ≥ 2

calendar days prior to a positive culture and is also in place the day of or day prior to culture and there are no other possible sources of infection. The CLABSI surveillance definition may overestimate the true incidence of CLABSI.

98. Mucositis is experienced in this population due to their treatment; children will get inflammation of their mouth and gastric tract. It is unpleasant and painful and can also lead to increased risk of infection.

99. The QI group comprised ward staff, senior charge nurse, surgeons, anaesthetists, intensivists, radiologists, oncologists, infection control nurses, nurse educators, Paediatric Oncology Outreach Nurse Specialist (POONS) managers and quality improvement experts.

100. Our aim was to reduce our CLABSI rate to the ‘best in class’ rate of Cincinnati’s less than one per thousand line days. We agreed on four key work streams and we set out four subgroups to work on these. They were line insertion, line access and maintenance, staff education, patient and family education & engagement. Each group set out to review evidence based best practice for their topic and then devise tests of change to implement that best practice in our context. It was a very open forum, there was open challenge, any idea was welcome, that was the ethos of the group.

101. From a line insertion point of view, we adopted a closed theatre model, so only essential staff were allowed to be in that theatre for the line insertion, we also mandated that everybody would wear masks. Strict guidance was adopted to ensure patients were washed within 24 hours prior to the surgery. The line insertion bundle was updated and monitored. There was also a specific theatre line list commenced.

102. In terms of access and maintenance, the tissue viability nurse led a change of dressing to a superior product. We introduced port protector caps, which are alcohol impregnated caps which cover the needle free device at the end of the line. We had discussed this with Cincinnati, it was to mitigate the risks to lines

becoming contaminated. Staff and family training was undertaken regarding the caps.

103. We reviewed central line access, ensuring people were appropriately trained and using a non-touch technique. We held a session to discuss line access with the nursing team to enable open discussion regards to their view on the subject and the non-touch technique approach. Organisational Development chaired the session, we talked to the staff about practice, about what they thought, about any barriers, about what could be done to make things better. It was an open, safe space to try and delve down into the discussion. It was a positive session. We also ensured everyone had the right training for lines and supervision and support in accessing lines. We also looked at the number of times we accessed lines and looked to adopt strategies to minimise access.

104. In terms of staff education, this included education on how to use the port protector caps (introduced in August 2017) for all staff in 2A, 2B, theatres and CT, continued aseptic non-touch technique education, and continued infection control education. We also carried out central line care audits.

105. In terms of parent and family education, we undertook parent and patient engagement sessions on infection control practices and how to look after your child's line including the protector caps. This is important as families spend time at home whilst their children have central lines in place. New posters were designed and put in all the rooms.

106. This work started prior to any issues raised about water but the data and actions the group were taking did feed into subsequent IMTs.

107. The CLABSI rate started to drop as the interventions were implemented. There was a spike in March 2018, which was at the time of the IMT associated with the water. After that the data continued to improve.

108. The Medical Director, Dr Jennifer Armstrong, asked me to attend the Board Infection Control Committee (BICC) in November 2017 and presented a paper

on the CLABSI work. I returned to the BICC around May 2018 to provide a further update.

109. Several of us attempted to seek comparable UK data to benchmark our CLABSI data, via their UK networks. I did not receive responses to the requests I sent. Therefore, we maintained to work to the internationally acknowledged aim of less than one per 1000 line days.

110. Since the end of 2019 the median rate has been less than one per 1000 total lined days, this met our aim.

AUDIT

111. We had existing audit processes which were increased in frequency during this time. We were undertaking frequent line care audits, routine hand hygiene and also SICPs (Standard Infection Control Precautions) Audits carried out by the senior charge nurses in their own or a peer ward. These are usually 6 monthly but wards 2A/6A were undertaking them monthly. IPCAT (Infection Prevention and Control Audit Tool) audits are also part of a standard IPCT audit cycle across the board undertaken by the infection control team. These were unannounced and areas are audited on their infection control practices, hand hygiene, environment and staff knowledge. An action plan is generated with a timetable for actions to be completed and these are monitored. As Chief Nurse, a link to this information would be automatically sent to my email address. These would be followed up locally and also monitored through our formal Senior Management Team processes from the service perspective.

112. There were also Care Assurance Audits undertaken using our paediatric care assurance tool. These would be undertaken by Lead Nurses and peer Senior Charge Nurses and include focus on practice in areas including infection control, patient centred care, pain management, child protection, palliative care, food, fluid, and nutrition. The result will trigger an action plan and also the frequency of the next audit.

113. The Lead Nurses would provide me with a monthly update both in a one to one meeting and also when Care Assurance Audits were undertaken and improvement actions. This was formulated into a report for the wider nursing care assurance meeting I attended alongside Chief Nurses in the other sectors and directorate. The Senior Charge Nurses would also discuss this in their professional meeting to pick up shared learning and themes.

114. In summer 2017, Jamie Redfern and I completed a weekly update to the Medical Director, Jennifer Armstrong, at the end of each week. It included updates from 2A on infection control, service, Estates and Facilities. This was to ensure Jennifer had awareness of issues and actions, as she was the infection control executive lead. We received feedback from Jennifer about these reports, for example on 2 July she got back to me thanking me for the information. I also had acknowledgements from Kevin Hill and Sandra Devine.

115. The reports included a variety of information such as training updates, service updates, results of audits, Safe to Start position and information from Estates about physical repairs both required and completed. An example of an issue raised on one report was around 'clutter' in patient's rooms. A child and carer will essentially live in a single room for a long period of time so toys, clothes and personal belongings build up. We purchased additional units for the rooms to store people's belongings, and educated staff and families to ensure cleaning of the rooms could be undertaken.

CLADDING WORKS – 2017/2018

116. I was not involved in the cladding works as Chief Nurse. It was Estates and operationally led with IPC linked in. I recall the signage and the change of entrance. Estates and Infection Control teams would be able to talk about that in more detail.

CONCERNS RELATING TO THE WATER SUPPLY - MARCH 2018

117. I first became aware of the Lead Infection Control Doctor's (LICD) concerns around the water in 2A on, 1 March 2018. I remember this clearly as it coincided with the snowstorm on, 28 February 2018. A number of us stayed in the hospital overnight into, 1 March 2018 to ensure we managed the staffing and other challenges brought about by people not being able to travel to and from the hospital.

118. On that day, I was the only member of the children's senior management team onsite as others were unable to travel to work due to the weather conditions.

119. About 1 p.m. that day, I was informed by Teresa Inkster there was an issue with the water, Cupriavidus had been isolated in water testing.

120. In the hospital, water is routinely tested as part of legionella monitoring, but Teresa had found this through undertaking some specific tests due to a case of infection she was investigating. She said we must stop immunocompromised patients in 2A being exposed to the water, so we agreed on a plan to enact that that day. We achieved this under her instruction within a few hours.

121. We discussed this by phone. I recall the contingency plan we put in place. We agreed that I would send her an email afterwards with the points we had discussed, which I did. I have a copy of it, the email is timed at 13:55 on the 1 March 2018, here is what I said:

122. "Following on from our phone call, we have agreed the following actions to be taken today:
   (1) Stop patients using showers. Parents, carers are okay to use showers;
   (2) If staff/patients' families wash hands in sink, they must use hand gel afterwards;
   (3) Use bottled water for washing and brushing teeth;
   (4) If no bottled water for brushing teeth, do a dry brush (although we did have bottled water at the time so this wasn't an issue);

(5) Ian Powrie is linking with the company DMA to arrange Silver Hydrogen Peroxide dosing as soon as possible.

(6) Sinks / showers can be used 2-4 hours after dosing.

(7) Sinks in treatment and prep areas are ok to use.

(8) Await information on potential to use an outlet which has tested negative.

(9) Tests are underway to find the source".

The email noted that there is no current risk to healthy staff / families but we are being cautious for patients.

123. These were the initial measures put in place. Teresa then emailed me back saying: "Thanks, Jen. Agree all below. I will clarify with the estates re two-to-four-hour period post dosing." I have then replied "Thanks Teresa. Kevin has contacted Comms."

124. There were limited people on all sites that day, however the actions were triggered as noted. The Infection Control Lead Nurse was communicating actions and plans with various teams including consultants and estates teams. The Paediatric Lead Nurse worked to update and support the ward staff and families. We will have updated people in terms of the situation and measures being taken. At that point the view was that this would be a case of dosing the water to resolve.

125. We take subject expertise advice from infection control and Teresa was the lead doctor on the Board for infection control. Teresa informed us of the risk and action required; my part alongside the wider team including estates and facilities was in making sure we were putting those risk mitigations in place.

126. The next day on 2 March 2018, there was an IMT meeting held.

<u>IMT MEETING - 2 MARCH 2018</u>

(A36690451 - Incident Management Meeting Minute, dated 2 March 2018, relating to Cupriavidus bacteraemia and Water Dosing – Bundle 1 – Page 54)

127. I attended the Incident Team Management Team meeting on 2 March 2018. My role within the IMT is professional nurse leadership, so I would be present to input to the IMT from a nursing service position and to support any team actions. I would also be there to support the nurses in ensuring everything was in place that should be in terms of what the IMT was discussing. I was also there as part of the SMT and to relay information to the relevant directors.

128. I was always aware of other people's roles at IMTs, introductions were always made. Even if there was one person there who was not familiar with the group, we would all do introductions, so it would be clear from the introductions what everyone's role was at that IMT.

129. I had attended IMTs before for various outbreaks including for example, diarrhoea and vomiting bugs as it would be appropriate to have an IMT when a number of children in an area develop norovirus, rotavirus or astrovirus or similar infections.

130. The IMT meeting on 2 March 2018 was the first IMT I attended in terms of the water.

131. Everyone around the table was doing their best to resolve the incident as quickly as possible with the patients at the centre of that decision making. This is the experience I have had with all IMTs, people around the table contribute to the solutions from their different areas of expertise.

132. This particular IMT was very focussed, it was managed as well as I think it could have been given the circumstances. We moved through actions as quickly as we could, and you will see from the papers that there were many of actions undertaken at that time.

133. There is an action in the 2 March IMT minutes accredited to Teresa and me which says, "Create staff and patient information." At this point, Teresa would most likely have written the brief and I may have added to it.

IMT MEETING – 9 MARCH 2018

(A36690458 - Incident Management Meeting Minute, dated 9 March 2018, relating to Water Taps in Ward 2A – Bundle 1 – Page 60)

134. There is an entry on the IMT from 9 March 2018 which records me asking Facilities to contact other health boards with other similar high risk patients to consider what taps they use. Infection Control took the lead on that with Facilities.

135. During the course of the IMTs, Teresa, as IMT chair, contacted people who she recognised as being international experts such as Peter Hoffman and others. There was a proactive attempt to ask, 'Who knows about this in the world? Who's been through this situation before? Who can help us?' that was the sense of the IMTs.

136. I cannot specifically say in what way these people helped, as I was not directly liaising with them. Teresa or the infection control team would be best to ask about the microbiology and credibility of the input received. In terms of HPS, they attended all the meetings from early to mid-March, they regularly inputted as was appropriate.

137. HPS inputted to the IMTs as the national experts. They led the debrief for the water incident which was helpful for the team. Later, they supported the 'Review of NHSGGC paediatric haemato-oncology data' in October 2019, which was also helpful.

IMT MEETING – 12 MARCH 2018

(A36690457 - Incident Management Meeting Minute, dated 12 March 2018, relating to Water Incident in Ward 2A – Bundle 1 – Page 63)

138. At the IMT Meeting on 12 March 2018 it is noted that portable handwashing sinks were being brought onto ward 2A.

139. The direction we were given from our LICD was to stop exposure to water for this vulnerable population. In stopping this exposure portable sinks were one of the agreed actions.

140. This was to meet the needs of children and families in providing warm water whilst keeping everyone safe, ensuring they were not exposed to the mains water. The practicalities of the portable sinks were challenging.

141. The sinks took up space within the room, however they provided a water supply for the families in their rooms for washing and brushing teeth. While not ideal, this was a balance of risk deemed to be appropriate by the IMT, mitigating against what our IMT Chair was clearly articulating was a bigger risk. Once the filters were installed and testing confirmed the water (from point of use filters) met the appropriate standard, we were able to remove the portable sinks and resume use of sinks with point of use filters on taps.

142. During this period we rostered an additional nurse to specifically communicate with everybody, families, staff, and communication through Estates, as we had so many different activities and work going on. This was helpful and acknowledged in the HPS Debrief. Nurses in this role would have changed over time, it would not have been the same nurse every day because they tend to work 12-hour shifts, three days or four in a week, so we would have tried to have kept this as consistent as possible.

IMT MEETING - 29 May 2018

(A36706508 - Incident Management Meeting Minute, dated 29 May 2018, relating to Enterobacter cloacae in Ward 2A – Bundle 1 – Page 91)

143. I attended an IMT on 29 May 2018. Reading the minutes of this meeting, I see it is noted that, “Some discussion took place around the environment of Ward 2A and the restrictions of the design. SD queried progress of finding an alternative room for the treatment room bed currently in the prep room. JR advised that she has discussed this with Jamie Redfern and finding a solution to the problem involved a larger scale investment and movement of some internal ward services. JR will continue to chase this.”

144. This relates to the treatment bed being in the same room as where the nurses prepared medication. This area was not frequently used for patients, however it should have been located in an entirely separate room. Discussions had been ongoing and I had escalated the issue to the operational General Manager requesting a review based on this being a potential IPC issue. Operational management, the Lead Infection Control Nurse and the Senior Charge Nurse did a walk round of the ward to seek a potential solution. We considered the pharmacy room, however it would require to move elsewhere within the ward. To enable this, larger scale work was required. Several room purposes would have to be relocated, which meant for example built in kit and cupboards, so would involve Estates work.

145. Whilst this was ongoing, mitigations were put in place including additional cleaning and that no-one in addition to those required used the room when a patient was there. This was addressed in the redesign of 2A; there are now separate rooms for prep and treatment.

IMT MEETING - 6 JUNE 2018

(A36690461 - Incident Management Meeting Minute, dated 6 June 2018, relating to Drain Measures in Ward 2A – Bundle 1 – Page 99)

146. Looking at the minutes for the IMT meeting on 6 June 2018, I can see it says, "HPS are keen to understand what the difference is between the new RHC and the old Yorkhill site. They will look at epidemiology of patients, staff, current policies in use. At the moment there is no scope of reference but HPS will be in contact with Great Ormond Street and Alderhay Hospital who deal with a similar patient population. Annette Rankin will write this up and give a copy to Dr Inkster who read over this for factual accuracy before being submitted to the government. Jamie Redfern and Jenn Rodgers have asked for a formal timeline and scope of this review from Annette Rankin."

147. We will have asked for the scope and timeline so we would be able to undertake any associated actions required and to communicate with the relevant teams.

148. The IMT was closed on 21 June 2018.

SEPTEMBER 2018

149. Around 5 September 2018, IMTs were reconvened and had a focus on drains. This was not straightforward as drains by their purpose are not 'clean' and therefore it was challenging to interpret swab results and there was also no available guidance to help. This was more complicated than, for example, analysing water results as there would be an expectation to find bacteria in drains, e.g. we wash bacteria from our hands to prevent infection and by doing this the bacteria goes down the drain.

150. The drain IMT progressed through September, various actions were undertaken including chemical dosing of drains. By this point, there was growing anxiety and concern in the IMT given this had come soon after the water IMT.

151. The IMT group were grappling with questions such as 'Are children getting infections because of the environment? Are we doing enough? Are the things that we are doing working? If they are not working, what do we need to do?' That was when the conversation started around potentially moving wards.

IMT MEETING - 5 SEPTEMBER 2018

(A36629284 - Incident Management Meeting Minute, dated 5 September 2018, relating to X3 Gram negative bacteraemia in Ward 2A – Bundle 1 – Page 149)

152. I attended an IMT on 5 September 2018. Under the heading "Other relevant reports" there is a paragraph that begins "ES raised concerns in relation to HCSW staff being pulled from the area."

153. Emma Somerville, as the Senior Charge Nurse, is rightly raising her concerns, given this added IMT process was underway. The paragraph continues, "TI shares these concerns and wanted to be reassured that staffing will not result in a drop of standards. KT explained that staff were pulled to cover other

areas based on a risk assessment. JR reiterated that the SMT absolutely support nursing staff workforce to support quality and safety in ward 2A and 2B".

154. This will be linked to risk mitigation across our wider system. Potentially this decision will have been made at the Hospital Safety Huddle to support another area due to potentially short notice sickness or increased activity. Another area may have required immediate resolve and this ward assessed as the area best able to provide that assistance. On checking the records from the time, I can see that the ward had on average 10 registered nurses and 2 or 3 healthcare support workers (HCSW) on each day, they were generally in a 'safe to start' position and on some days staff were moved from other areas to support ward 2A.

155. Kathleen Thomson was the Lead Nurse for 2A and some other areas. The Lead Nurses would chair the safety huddles and with input from others make staffing decisions.

156. It is noted that we were committed to supporting the nursing workforce and were working up an evidence base to support a case for further posts.

157. We looked closely at the 2A workforce, reviewing the various aspects around 2017. Workload had increased, there was a large maternity leave pressure and there were issues with recruitment. During this ongoing period, it was important the ward had the additional staff they needed; as well as trying to recruit this was sometimes supplementary staff or staff moved from other areas, and HCSW roles.

158. There is a line in the IMT minute that states, "AR advised that these most recent cases will become part of the public domain." I do not know what information Annette Rankin had in regard to that.

<u>DISCUSSIONS TO DECANT WARD 2A RHC - 11 TO 14 SEPTEMBER 2018</u>

159. It was probably around about 11 September 2018 that the IMT began to raise decanting as an option. There had also been a few meetings outside the IMTs with the consultant group.

160. At this time, we also reiterated to everyone that handwashing sinks were for handwashing only as Teresa raised a concern that people were putting coffee, milk or other things down the sinks which could be creating a biofilm. When the drains were investigated small toys had also been found.

161. Posters were in place at sinks to that effect. These were put up at sinks and displayed a message along the lines of – Handwashing sink only - please do not put anything else down the sink. I do not recall the IMT instructing for signs to be made at the sink ever saying, ‘Do not drink the water’.

162. We met the clinical team in the morning of the 14 September 2018 and then we had an IMT, which is where we discussed Phase 1 and Phase 2. Phase 1 was the current measures that we had in place including new patients going to Edinburgh, case by case assessment for treatments, and some satellite care with DGHs. Phase 2 was the decant.

163. We met the 2A staff in the Medi-cinema at 08:30 to describe the situation. We agreed we would have the IMT and then meet the staff again later on in the day.

164. We had no new cases that day and we had five patients in total. Also, the IMT chair and HPS had contacted experts from other areas as the IMT were seeking advice at this point.

165. On the afternoon on 14 September 2018, Jamie met the 2A team, whilst Kevin and I went to the laboratory building and had a meeting with Jane Grant, some of her team, and others from the IMT where we discussed the decant, the options, the work so far and the general situation.

166. I went along to that meeting to support Kevin as the Director in my role as Chief Nurse.

167. I cannot recall all the people present, the Chief Operating Officer was there, as were Estates leadership.

168. We had a discussion which centred on the drains. I think Estates were looking to interrogate some of the information from a technical perspective. The Chief Exec was seeking detail around the decant options and how we would operationalise that. The focus was mostly about Estates and also working up the detail of decant options.

169. Jamie, with input from others, pulled together the options decant paper. There was a meeting with the consultants from haemato-oncology who went through a risk-based discussion on all of the options in that paper.

170. The Beatson was considered but discounted as they did not have a paediatric intensive care unit which was deemed essential for these children. It would not be an acceptable position for them to deteriorate and have to get an ambulance to cross the city.

171. Other wards in the RHC were considered, but Teresa was not content with the sinks in RHC and associated risks, noting the sinks in QEUH were larger and thus did not have the same risk of splash. The RHC was discounted as the LICD said the risk was too great.

172. We also looked at a potential porta-cabin ward on site but there was a 12 week lead time, which was deemed too long, and this could not be fast tracked.

173. There was also the option of closing and sending the patients to Edinburgh or Aberdeen, but I understood that neither of those sites could undertake the national BMT service or had the capacity to look after Glasgow’s patient population in addition to their own.

174. Then there was the option of considering centres in England, but that was deemed unfair for families as well as a capacity issue for those centres.

175. The criteria we measured options against were; the impact on paediatric bone marrow transplant, paediatric haemato-oncology, hospital at night, clinical teams, support services, adult services, clinical staff, patients and families, and also the timings of when we could operationalise the move.

176. At that time I have documented in my notes a list of points we would need to consider in terms of decant. I gave this list to the clinical service manager who then inputted to a spreadsheet and developed it further with colleagues; this became the decant operational log.

IMT MEETING – 17 SEPTEMBER 2018

(A36629315 - Incident Management Meeting Minute, dated 17 September 2018, relating to Water Testing and Drain Cleaning in RHC – Bundle 1 – Page 169)

177. There was an IMT on the 17 September 2018. It was discussed and decided at that IMT meeting to continue to recommend a decant as there were ongoing concerns about the general environment, there had been one positive case over that weekend.

IMT MEETING – 18 SEPTEMBER 2018

(A36629310 – Incident Management Meeting, dated 18 September 2018, Ward 2A, RHC, Bundle 1 - Page 175)

178. In the IMT on 18 September 2018, there were no new cases. The drain cleaning was undertaken. I remember Grant Archibald, the COO, also came to this meeting and the decant was agreed. We still had not yet identified a ward, but had agreed it would be within the QEUH.

179. After that IMT, a communication was generated with the communications team, Teresa and others. I then went to the ward to update families to tell them a decision had been made in regard to a decant.

180. Jamie, Teresa and I with others had an open offer to talk to families. This meant some families who Jamie and Teresa had spoken to the day before had already discussed a decant as a possibility. I had not been involved in that conversation, but I remember Teresa and Jamie noting that.

181. We had another meeting the next Friday with a broader clinical team from across Hospital Paediatrics and Neonates that included paediatric intensive care doctors, anaesthetists and a broad range of people from across the hospital. I am not sure if HPS were there or not. Their input was mostly via the IMT.

182. I would expect HPS to advise on infection control matters, measures and mitigations in place rather than the operational move. The IMT agreed the QEUH as the decant site. HPS were present and part of that decision making. From an infection control perspective the new ward was signed off by Teresa Inkster as the LICD and by Estates. The Lead Nurse for IPC also signed off the ward as ready.

PREPARATION FOR THE DECANT

183. In preparation for the decant, nurse and medical staffing was an important area in terms of planning. Considerable planning was undertaken to ensure we would have the correct level of nursing staff for the ward in QEUH to cover days, nights and weekends. We met with the clinical directors and discussed ensuring the hospital at night team had additional staff to support the decant ward in QEUH as well as for ward 4B. The hospital at night team cover the medical needs at night. This was eight days before moving and we were going into a bank holiday weekend.

184. I ensured the Royal College of Nursing were aware and linked in for support.

185. A request to the Director of the South Sector was made to handover a ward to be used for the decant ward which was close to ward 4B. Bone marrow transplant patients would be cared for in ward 4B, the adult unit.

186. The Director came back with ward 6A, it was agreed at that point. Existing adult patients in 6A were then moved to another area.

187. The Hospital paediatrics team worked together to progress this in a short timescale. Jamie, as the General Manager, the Clinical Service Manager and I undertook a lot of the planning work. Lynne Robertson, who is now retired, was the keeper of the operational decant log.

188. The Director, Kevin Hill, was very much involved in this also. We were updating Kevin on all aspects, and Kevin was updating us on anything additional we needed to know or do.

189. We worked to ensure we had pathways and processes for deteriorating patients. The resuscitation team led this, wrote a standard operating procedure (SOP) and worked with paediatric intensive care consultants, anaesthetists and ward teams to undertake mock resus situations. This was once we knew the decant wards were 6A and 4B.

190. The resus team set up a mock resus, from Ward 6A to paediatric intensive care and from Ward 4B to paediatric intensive care. They considered the equipment required. They wrote all of this into a SOP.

191. For the decant we also considered any practice which may be different because it was a different location, any situational awareness factors that may have an impact on the way you are able to deliver care. As part of that the team looked at their current SOPs to ensure they would still fit in to the new ward. We looked at child protection and safeguarding, particularly as we were going into a ward within an adult hospital.

192. Child protection colleagues advised us around our safeguarding plan. They provided a brief which we worked to. For example whilst there were no adult patients or staff from adult wards in ward 6A, we set to ensure the doors were swipe entry so people could not cut through the ward. This formed part of the

safeguarding plan. We also installed a new lock on the back of the door of the unit and made sure that was locked so nobody could access the ward. All of this was considered and actioned.

193. In terms of pharmacy, we worked to ensure we had appropriate storage facilities for the medications and the correct medications in place ready for the move.

194. The Rights of The Child was embedded in the plan. For example we purchased parents' beds as in the children's hospital there were fold down beds for parents, but the QEUH did not have these. This is an important children's right to have their parent / carer with them, so we very quickly purchased over 20 parents' beds.

195. We also ensured there was a play area, however we had to set this up within the corridor dooket. It had small tables, books and small toys. We had play staff covering every day, seven days per week, and additionally our activities coordinator for young people.

196. We purchased some wall art / glamour for the walls to make it a more child friendly environment.

197. We also worked to ensure we had the correct equipment within the ward.

198. We also arranged additional storage that we needed for children's hoists and special beds or baby baths. We needed to think through space and storage space for these things, so they were handy for the clinical team when they needed them, including the ward supplies and sundries. We required space and planning around procurement for stock supplies.

199. From an e-health perspective all the e-health was transferred over to Ward 6A, for example Trakcare system.

200. The floor plan had to be transferred because when we put Ward 2A and Ward 2B into Ward 6A, some of those beds were inpatient beds and some of them were day care beds, so all of that had to be arranged from an IT perspective. This enables us to work our patient record systems and admit and discharge people. Switchboard also updated the numbers on their system.

201. We also had to ensure people had the correct access enabled within their ID badges to access the areas they needed to in the adult hospital.

202. There was also work done to ensure the special feeds kitchen, who make up certain milks and certain products the children require, were aware of the move and had appropriate processes for 6A and 4B. This, alongside the children's menu, food choices, catering etc. had to be the same as in the children's hospital.

203. Estates had undertaken work in 6A beforehand, ensuring the area had the drains cleaned and filters fitted. I remember them doing some touching up work, as well as other requests infection control had asked for, but they should have the list of those actions.

204. We also planned routes from all the patient journeys children were likely to make. If you were a patient travelling from theatres, what is your route? If you are travelling in, what is your route? If you are travelling to radiology, what is your route? We put new signs up and communicated these with the staff and with the wider staff in the children's hospital and with other peers that we work with.

205. Planned procedures, including bone marrow transplant, were scheduled to coincide with the completion of actions required within the log.

206. We completed these changes in around 8 or 10 days. It was a lot to do but we worked through it methodically, as systematic and risk based as we possibly could at the time. I do think that the team should be commended for what they did and how they managed that move.

207. The team safely decanted one of Scotland's highest risk paediatric populations from one place to another in a very short space of time and did it safely, without incident and did it well. We took patients out of an area that the Lead Infection Control Doctor was saying was not a safe area and moved them to an area deemed safe. At the centre of this for us all was keeping children safe and well.

208. It was the right thing to do from the information and advice we were given at the time from our Lead ICD and national advisors HPS. It was organised and it was thought through, albeit it was in a very short space of time. Time criticality was important given the concerns at the IMT of any potential new cases, so it had to be at pace.

209. We worked as a team, sought advice from experts such as child protection, and resus officers, we used all our teams and collective knowledge, continually asking ourselves if there was anything else we should consider.

210. We met many times prior to the decant, considering each element with the wider team, including infection control, Facilities, Estates, nursing, and medical. People worked together with the shared purpose of getting the children moved safely and enabling IPC and Estates to take stock.

STV NEWS BROADCAST- 18 SEPTEMBER 2018

211. On 18 September 2018, around 6.15pm, while I was in the ward office preparing to go around the ward and talk to families of 2A, Brenda Gibson came in and told me the ward was on the news on television. STV played a piece which I think indicated the ward was going to be moved or closed. I did not see it.

212. This created quite a bit of tension and anxiety. I was in the ward to tell families about the situation and the move and then it came on the TV. I went around the unit speaking to the parents and giving them the briefing I had. Some had

seen the STV piece, some had not. Most parents at that time were okay when I spoke to them that night and understood the sequence of communication had not worked out as planned.

213. Our intention was to tell the families first, talk to people, also give the brief and then put out external communications.

214. Most of the families I spoke to that night were satisfied with the discussion.

215. I did not speak to every single family because we split the ward. I think myself, the consultant and the Senior Charge Nurse (SCN) were all there. When I spoke with families, I would give the families as much time as they needed to talk and answer the questions they had. That varied, you could be in with a family for 20 minutes or half an hour.

216.

REASONS FOR THE DECANT FROM WARD 2A/2B RHC

217. As I understood it at the time, the decant had been made necessary by the work that needed to be done on the sinks (linked to drains) and the wider sense of concerns about the environment requiring a closer look. The hypothesis was that the filters were potentially too close to the drains, causing the water to splash up, aerosolise and then re-contaminate your hands. In terms of risk, the IMT Chair, our Lead ICD, clearly said there was a risk of children getting infections due to aerosolisation from the drains.

218. Work to replace the sinks would not have been possible with immunocompromised patients in the ward. There was also a sense of a need to ‘get to the bottom of it’. The IMT wanted to mitigate as much risk as possible and so an empty ward would enable a close review of everything.

Teresa wanted to have a good look in the ward with no patients in the area. The initial time period was thought to be about 12 weeks, at that point we thought we would be back for Christmas.

219. The plan at that point was that the IPC team, microbiology and Estates would assess the ward, make it good, and then we would move back within a few months.

220. At that point, the filtered water samples were testing clear, so the filters were working. That was good and reassuring. The problems were noted to be the drains due to their proximity to the filters.

221. The initial water IMT had been closed off and a Water Technical Group was set up to continue the related work. I was not on that group, but know that one area they focused on was the chlorine dioxide dosing plant that we now have. The IMT closed late November / early December 2018. By that time chlorine dioxide dosing had commenced and the ward had moved.

STAFFING IMPLICATIONS FOLLOWING THE DECANT FROM 2A/2B

222. We moved children from one inpatient ward to two inpatient areas, 4B and 6A. This created a challenge in terms of a diseconomy of scale in nurse staffing. We rostered staff onto additional hours to ensure we had both areas covered with paediatric nurses. It was always paediatric nurses who cared for the children in 4B and 6A.

223. In order to ensure 4B and 6A had the staff they required, we booked additional nursing hours in advance, we collected the detail each week so we were clear about the extra due to the decant.

224. Additional hours could have been from bank nurses or the ward's own staff undertaking excess hours if they were part time or additional bank.

225. Staffing was still generally challenging at that time for the reasons stated above, but we were getting close to the new graduate recruitment of 2018, which had been the larger 2015 intake.

226. We were still advertising proactively all across the UK, trying to pull people in from London for example.

227. We also transferred paediatric inpatient facilities from the RAH, with that came around 16 WTE (Whole Time Equivalent) nurses who were able to join the wider team at RHC.

228. It was critical that 4B and 6A had the staff they required and everything was done at the time to support that.

STAFF MORALE FOLLOWING THE DECANT FROM 2A/2B

229. All the staff team were working incredibly hard through difficult circumstances at the time of the decant. It had an impact on everyone, as you would expect.

230. It felt a little better when the decant had taken place and the team and families started to settle into 6A/ 4B. In the first couple of weeks when I would go up, people said they liked the brightness and the straight design of the ward.

231. We thought at that time we would only be there for a few months. The move had taken place and they were managing okay between 4B and 6A. The decant was really hard, the IMTs were really hard, but there was a short period around October/November, where it seemed fairly settled considering all the factors. People were getting on with their jobs and were supported by the additional hours planning and now just awaiting Estates to inform them when they could return to 2A.

232. The Senior Charge Nurses of the ward and day-care worked closely and supported each other. The first couple of months seemed to be going okay.

CRYPTOCOCCUS IMT - DECEMBER 2018/JANUARY 2019

233. The next significant event was the Cryptococcus IMT.

234. [redacted] one case of Cryptococcus. There had been another case in an adult area in QEUH.

235. [redacted]

236. On 4 January 2019, I met the family of [redacted] who had Cryptococcus. There is a minute of the meeting.

237. I met with the family with Brenda Gibson, Teresa Inkster and Jamie Redfern. Teresa explained that the lab had found a Cryptococcus infection and she described that Cryptococcus came from soil and from pigeons. Teresa noted she did not know how or where [redacted] had got it.

238. At this IMT, air sampling was planned and undertaken and children were started on prophylaxis. At this point, there was not an understanding of how the patients had contracted Cryptococcus.

239. The anxiety of the whole IMT and clinical team was very high. People were very worried and saddened about what happened and were trying to understand what actions were required. They had already moved ward; this was a very difficult time.

240. Again, I believe everybody sitting around that table were focused on doing their best to keep children safe. We had a meeting on 7 January with consultants. I recall there being positive air samples, but it was not Cryptococcus neoformans, it was a different type of Cryptococcus from that in the patient cases.

241. There was a decision at the IMT on 9 January to install portable HEPA filters into 6A. A communication was drafted for families, however that evening it was decided that staff would receive an aide memoire to assist with the consistent communication and to clarify the points because it was fast moving.

242. We wrote an aide memoire which had about six bullet points to outline the position and actions. This included the deployment of HEPA filters and that HEPA filters scrub the air. Everybody was briefed on that including families.

243. The HEPA filters were installed in the ward on the 10th and the families were updated verbally based on the aide memoire briefing.

244. On 12 January 2019, which was a Saturday, I received a call informing me some families had gone to the Scottish Government as they were worried about the HEPA filter installation and the environment in general.

245. The Chief Executive set up the conference call on the Sunday morning. I joined this call and was asked to go to the ward to talk to the families with a written brief.

246. I went to the ward and was emailed a brief by the communications team to discuss with families. Brenda Gibson was also there. I went around every family present with the nurse in charge and spent time speaking with them.

247. Afterwards I emailed the senior team to tell them I had spoken to all the families and that they appreciated the communication. I emailed this to Jennifer Armstrong, Jane Grant, Ally McLaws, Kevin Hill and Claire Cook from the communications team. The wording on the email is as follows:

248. “Hi, Jennifer. I can confirm (accompanied by the nurse in charge) I spoke to all the families individually who were present on the ward today. They appreciated the written brief and the chance to ask questions. All of the families I spoke to were content with the process and the discussion. The

nurse in charge and consultant team have the brief and will share it with families not present. Many thanks, Jen."

249. I received a response from Jennifer Armstrong "Thanks for the update. Helpful feedback, no doubt reassuring for both the staff and the patients to have you there today." She sent that at around 7.20pm that evening, I sent my original email at around 7pm.

HEPA FILTERS WARD 6A - DECEMBER 2018/JANUARY 2019

250. HEPA filters were deployed in both the corridors of 6A and the single rooms as part of the Cryptococcus IMT. Estates later installed them into the ceilings of the bathrooms.

251. The HEPA filters are commonly described as 'air scrubber units', the HEPA filters essentially clean the air.

252. Air samples were taken to measure whether the HEPA filters were effective; this was complicated as people were coming and going in the ward which impacts on particles in the air. I understand from microbiology this was not an exact science.

253. This aside, the IMT were progressing to put in all measures that would improve the environment and therefore supported the deployment of HEPA filters.

ONGOING IMT 17 JANUARY 2019

254. At the 17 January 2019 IMT, I remember one of the suggestions Teresa made was that we may need to clean all the air vents in the hospital with HPV (Hydrogen Peroxide Vapour), which would have meant evacuating the entire QEUH ward stack. This was a challenging conversation in terms of people discussing all of the risks and impact on patient safety. Cryptococcus neoformans had not been found in air sampling.

255. By then we had HEPA filters in place for a week. Teresa thought that would mean that the air particles would be reduced, although there was not an exact measurement system to gauge it against. The bathroom air samples were higher than what Teresa thought they should be.

256. That is when the issue was picked up within the shower area, a small black line at the join. This was explored and mould was found to be under the shower floor due to water ingress. It was concluded that was the reason the air particles were higher than Teresa hoped they would have been.

257. It was not Cryptococcus, it was an issue underneath the floor. Work started to investigate the issue and it quickly became clear we could not do that work with immunosuppressed patients in the ward. Some higher risk patients were moved to 4B.

258. To enable the work to happen the patients again had to relocate. We resurrected the operational decant log and planned a decant to CDU in the children's hospital. That was a real low point for staff, the wider team and families, it was a really difficult time for everyone.

259. We were planning the move, talking to families, working to reassure staff and the media were printing very negative articles about the hospital with large pictures of pigeons. The media at the time impacted on the stress families and staff felt.

260. I recall there were media reports at the time which portrayed the move as due to Cryptococcus, but the move was due to the incidental finding in the bathroom of water ingress and resulting remedial works. We did describe that in a brief, and I remember several of those IMTs continuing until around nine o'clock at night.

261. Several members of the Board executive team came to the QEUH at that point, including the Chief Executive and Medical Director. They attended a

post IMT meeting with the consultants to listen to them and discuss the situation.

262. Consultants were able to speak about their concerns at that meeting directly to the Medical Director. There was a lot of anxiety about the move and the media.

263. Many of the nursing team were also anxious. Some of the staff were beginning to say they had rashes and were wheezy and wondering if it could have been the air. I contacted Occupational Health, who supported them from an OH perspective. I also brought in the Royal College of Nursing, again for additional support as well as offering psychology sessions to the team. Lead Nurses were also visibly present supporting every day. It was a low ebb and we tried to support wellness of the team though these approaches.

264. In terms of support for myself, Kevin, my line manager, Jamie and I were a solid team. We worked closely and were a good support for each other.

265. I cannot recall whether I was specifically offered any psychological support, but had I wanted it, I would have been able to arrange it. I would take responsibility for that myself.

WATER INGRESS IN THE BATHROOMS

266. The issue was raised with Estates who were responsible for the repair. They work with infection control to ensure they have an HAI-SCRIBE. They require to have an assessment of the works and mitigations in the form of the HAI-SCRIBE approved by IPC. In this instance it was deemed the work was too extensive for the children to stay in the ward.

267. The children moved safely to CDU and then, in February 2019, they moved back to 6A. As the work in 6A progressed, the Estates team updated the operational managers and clinical team to enable services to be managed accordingly.

268. The move was not because of Cryptococcus neoformans, rather the remedial work required for the bathroom flooring. It was very unfortunate and a difficult experience for everyone.

DECANT FROM WARD 6A TO CDU – JANUARY 2019

269. It was short notice and it was hard for the staff who had just been through the fairly recent move to 6A and now to be presented with this scenario of moving again. However the remedial work on the bathroom floors could not have been undertaken with the children in the ward.

270. For the decant from Ward 6A to the CDU we followed the same sort of structure as before. Some elements were relevant and some were not, because we were moving to a children's area. The operational log has the detail for this move.

271. We knew it would be a short-term move until the remedial works were complete. We also knew the filters worked in terms of water. CDU was prepared, the team there moved to another area, the Estates and Facilities team sanitised all the drains in CDU and, alongside infection control, they deep cleaned and prepared the area. High risk patients went to 4B rather than CDU.

272. The decision to move was again made as a recommendation by the IMT. Haemato-oncology patients already follow a pathway through CDU so it was not an entirely new place for them.

273. There were already paediatric patients in 4B so this number was extended. Staffing was challenging, the diseconomy of scale became even more of an issue as we had inpatients in 4B and CDU and day-care patients in the surgical day unit.

274. The complicated staffing model exacerbated the low staff morale as the team were split up into smaller teams across different areas. They also would support aspects of care for patients if they were for example in PICU or a surgical ward.

275. The service moved back to 6A in February 2019. The team were glad to get back. However, the period of time they were in 6A was now clearly extending beyond expectations. The move back had thought to be around Christmas 2018 but now we were in February 2019.

276. I was not involved in any of the groups who discussed the ongoing work in 2A. There was wide representation, including nurses, doctors and operational managers and the IPC team.

CABINET SECRETARY JEANE FREEMAN'S VISIT – JANUARY 2019

277. Jeane Freeman, the Cabinet Secretary, visited on 22 January 2019 and then later I remember showing her the parents' kitchen towards the end of 2019. This was when we were reopening the ward after the autumn 2019 IMT.

278. During her 22 January visit, we met the Cabinet Secretary within the RHC. From the Board there was John Brown, Jane Grant, Jennifer Armstrong, Tom Steele, Kevin Hill, Jonathan Best and myself. The communications team were present on the visit but not in the meeting. From Scottish Government there were Jeane Freeman, Jason Leitch and Fiona McQueen present.

279. At the meeting we discussed the Cryptococcus situation and the move to CDU because of the remedial bathroom work. We discussed the issues and actions. We discussed the Independent Review, which she would announce would take place.

280. There will not have been many patients in 6A at that point as we were relocating to CDU. We also visited 2A and 2B to see the works being done there.

281. I have a copy of a letter that the Cabinet Secretary sent to the Board and was sent on by the Chief Executive to thank the teams for their efforts.

282. There was a press release from Scottish Government following the meeting. They quoted the Cabinet Secretary saying she had visited the ward and spoken to a family and was also reassured that the Board were doing everything that they should be doing under the circumstances. The Independent Review was also announced.

283. The Cabinet Secretary would visit the campus for other business around that time, for example a few weeks later she visited to meet the team and hear about the work in NICU (Neonatal Intensive Care Unit).

MEETING WITH JONATHAN BEST AND CONSULTANT GROUP - 2 SEPTEMBER 2019

284. There was a meeting with Jonathan Best, the 2A Consultant group on 2 September 2019. I cannot recall the exact detail but in general terms it was the unit's consultants seeking clarity on whether there is an issue and if so what was the extent of the issue. There was discussion around what work had been completed to date and some discussion about seeking external independent view on the situation.

IMT MEETING - 6 SEPTEMBER 2019

(A36591637 - Incident Management Meeting Minute, dated 6 September 2019, relating to SBAR for Ward 6A – Bundle 1 – Page 394)

285. In the meeting on 6 September, the SBAR Emilia had received was discussed.

286. On the minute from this IMT, it says, "On the SBAR, it states that there's a build-up of dust on the chilled beams which typically harbours skin organisms."

287. Domestics undertake regular cleaning of the general environment to avoid build-up of dust. The chilled beams were separate to this. There was a cleaning schedule for them via Estates which was increased beyond the manufacturer's guidance to 6 weekly on advice of the IMT.

288. After this IMT, I have noted that I have been around the ward and spoken to families from around half past five to half past seven.

MEETING 9 SEPTEMBER 2019 – CLINICIANS' LETTER

289. There was also a meeting on 9 September 2019, which was triggered by a letter the clinicians sent to the Medical Director. They were seeking assurances in regard to environmental safety. The meeting was again listening to the clinicians concerns and discussing mitigations and the way forward.

290. I do not recall the detail of the meeting but have noted actions which included: Brian Jones, another microbiologist will review cases, Estates to undertake a peer visit to GOSH (Great Ormond Street Hospital) and plan for an IMT this week or early next week.

291. The same day at two o'clock, the Chairman visited RHC. I met him and took him to the ward where he met the Senior Charge Nurse. We went to one of the single rooms where Estates colleagues described the improvements and modifications that had been made and then he met several of the nursing and domestic staff. It was a supportive visit to 6A.

IMT MEETING - 13 SEPTEMBER 2019

(A36591627 - Incident Management Meeting Minute, dated 13 September 2019, relating to Epidemiology data for RHC – Bundle 1 – Page 360)

292. The IMT minute notes, "Dr Kennedy introduced his epidemiological data with commentary from Prof Brian Jones and Prof Alistair Leanord". It also states,

"Since moving to the Ward 6A the patterns of environmental gram-negative organisms are the same compared to the counts when the ward was at the old Yorkhill hospital" and "Senior microbiologists Prof Brian Jones and Prof Leanord both agreed that, from a microbiology point of view in their opinion Ward 6A, QEUH was microbiologically safe at this present time and IMT members accepted this position".

293. Dr Iain Kennedy showed us a table of the different organisms which had been identified within RHC, the new hospital, and whether they had also been found in Yorkhill when he reviewed retrospectively.

294. This IMT had been ongoing for several months with mitigations in place. Case by case children were sometimes being cared for elsewhere if appropriate. The IMT's concern was around the type rather than number of infections. The IMT was now presented with data to say the infection types were not in fact unusual. This information was new to the IMT and took time to process.

295. Everyone then went away to consider the data. There were meetings scheduled to follow.

296. The other completion of the actions agreed in the action plan continued as planned.

<u>IMT MEETING - 18 SEPTEMBER 2019</u>

(A36591629 - Incident Management Meeting Minute, dated 18 September 2019, relating to SBAR for Ward 6A – Bundle 1 – Page 365)

297. There was an IMT meeting on the 18 September 2019 where it became apparent there were differing views between Brian Jones and Annette Rankin. HPS remained of the view we had an outbreak and Brian Jones said in his view we did not. My understanding was that he meant this had been treated like an outbreak, but we did not have an actual outbreak in the sense of a single type of infection, a source and patient cases specific to that. It was hard for people to take this in, it was a different view from a different microbiologist.

298. There was discussion about risk, if there was no outbreak then children being cared for in other centres would be better returning to their base centre.

IMT TELECONFERENCE - 20 SEPTEMBER 2019

(A37992136 - Minute of Teleconference to discuss Ward 6A Status, dated 20 September 2019 – Bundle 1 – Page 370)

299. On the 20 September there was an IMT teleconference. The data was discussed at that teleconference and that was the meeting where the group agreed to recommend the full reopening of the ward based on the data.

300. That dataset was updated, and people discussed and agreed to move forward with a re-opening plan. The group included Alan Mathers, Chief of Medicine; Scott Davidson, Deputy Medical Director; Pamela Joannidis, Consultant Nurse IPC; Iain Kennedy, Public Health; Sandra Devine, Associate Nurse Director for Infection Control; Annette Rankin and Laura Imrie, who are both Nurse Consultants with Health Protection Scotland.

IMT MEETING – 8 OCTOBER 2019
(A37992136 - Minute of Teleconference to discuss Ward 6A Status, dated 20 September 2019 – Bundle 1 – Page 373)

301. HPS were undertaking a review, comparing RHC to Aberdeen and Edinburgh's Children's Hospital. The review outcome was required in order to inform the position to fully reopen. The CNO would make the final decision as to whether the ward would fully reopen.

302. The other sites are not directly comparable (e.g. only RHC carries out Allogeneic Bone Marrow Transplants) but they looked at similar patient populations within the Scottish context as much as was possible. We received the review in late October / November. Essentially they found for the current period of time - gram negative infection rates in RHC were the same as the other centres and for gram positives RHC were better.

303. This was positive, however still challenging for everyone and still a complex process towards recovering and reopening fully the ward.

MEETING WITH FAMILIES - 2 NOVEMBER 2019

304. On 2 November 2019, we had a meeting with the families. We sent a letter to almost 400 families to invite them to the meeting and around 17 families responded. Some said it was not relevant to them, they did not require to attend, and some were complimentary about the service.

305. Of the 399 letters sent, 9 families attended the meeting on the 2 November.

306. The families that attended were understandably upset and at some points angry. The Chairman and the Chief Executive began the meeting with an apology and then a presentation. This was followed by the families talking about their perceptions.

307. I spoke at the meeting when questions came up about nursing. There were several questions about nursing, such as staffing and other points. I completed an action plan following that meeting for the nurse-related items. I wanted to ensure I had picked up all the families' points, listened to what they had said, and undertook appropriate actions.

308. Much of the points were ongoing but it was important to note work that was either ongoing or newly progressing. I submitted that to the Executive Nurse Director, Dr Margaret Maguire and also then to the Chief Nursing Officer.

309. One of the points they raised, which as far as I can remember was the first time I had heard this to be an issue, was in regard to the lifts. The issue raised was that the lift was also used by the adult population (as it was the QEUH building), therefore they were unhappy about this. Following quite a bit of complicated work and planning with Estates and the QEUH team, we secured the families their own lift. Out of the three available lifts, one was cordoned off for use only by the paediatric haemato-oncology families.

IMT MEETING - 5 NOVEMBER 2019 (P125 OF BUNDLE)

(A36591709 - Incident Management Meeting Minute, dated 5 November 2019, relating to Sequencing Results of the Enterobacter blood stream infections – Bundle 1 – Page 392)

310. The next IMT after the meeting with the families was on 5 November, which discussed the Enterobacter sequencing results. Prof Alistair Leanord had begun his genome sequencing work by then. This felt like ground-breaking science at the time, which drilled down further into the samples in terms of their relation to each other. Prof Leanord presented some of his work on genome sequencing in relation to Enterobacter, which concluded there was no link between the cases.

PLANNING TO FULLY REOPEN WARD

311. Jamie and I created a reopening bundle. This described robust and ongoing actions so that assurances were in place to help navigate us back to full reopening.

312. The reopening bundle was a type of action plan. It detailed the actions required including, for example, the bathroom HEPA filter installation.

313. We started a group called the 'Clinical Review Group' (CRG). It included representation from the Consultants, Brenda or Dermot would always be there or one of the other haemato-oncology Consultants. There would be the Lead Nurse for service, Senior Charge Nurses, Lead Nurse for Infection Control, Estates Lead and Facilities Leads.

314. The group would systematically go through each area of the business. Each person would update for example, how the service was, staffing, cleaning, SCIPs and supervision results.

315. At the CRG we would pick up any issues, for example, if they had a problem recruiting a housekeeper, we would look to allocate actions. In terms of

facilities we would discuss items such as how the floor cleaning was, if they were managing the deep cleaning, if there had been any complaints about cleaning.

316. Estates would update on any works that were ongoing, they would update us on the chilled beam cycles and Hyacin drain cleans. The meeting took place every week as part of the reopening bundle to navigate back out of that situation.

317. Infection control undertook a root cause analysis on every new gram negative case. IPC would feedback on the Root Cause Analysis (RCA) to the CRG. We continued with enhanced supervision and weekly assurance checklists and these would be emailed to the group and discussed at the CRG.

318. We also ensured the Lead Nurse continued to be visible, in the unit every day providing general support, checking the staff and families had everything required and that there were no new emerging issues.

319. We recruited an additional Band 7 SCN. Normally there would be one SCN in a ward. The second SCN would have an extended remit on the additional infection control work. Both had overall IPC responsibilities, however this created capacity for the additional work and to support the existing SCN. The work on staff wellbeing continued and was included within the reopening bundle.

320. We worked to ensure families were aware of progress and that we were communicating fully; part of that was through our closed Facebook Page.

321. We were building our Facebook communication for positive news and innovations as well as a vehicle for patient engagement, communication and working together.

322. We used Facebook to set up focus groups around catering, to listen to feedback and aim to make improvements on the food options. As part of this

we introduced a deli cart. The page was also useful during the pandemic, for sharing information and working together with families on initiatives such as photo picture stickers of nurses smiling as the children could not see their faces because of their masks. Families helped design the stickers.

323. We moved from bottled water to tap water as part of the reopening bundle. We put in additional portering for pharmacy and housekeeping hours.

324. The reopening bundle was a useful in navigating us towards full reopening. The CRG maintained a robust focus and engagement from all those involved. During this period everybody continued to work together to ensure a safe reopening.

EXPERIENCE IN THE NEW WARD 2A/2B – SPRING 2022

325. In Spring 2022, the paediatric haemato-oncology ward moved back into the refurbished 2A/2B in the RHC

326. I was no longer in the Chief Nurse role when the ward moved back to 2A/B. As far I am aware there are no concerns with the environment.

THE CULTURE OF IMTS

327. Reflecting on the experience of events regarding IMT culture, in March 2018 the IMT focused on the water, completely focused on safety. It was closed with the acknowledgement that if any issues came up it would be recalled.

328. The IMTs were always focused on keeping children safe, this ultimately led to the decant. The IMT in March 2018 was effective and robust based on the hypothesis of the LICD. Tests and actions were taken quickly. It was closed in a relatively short space of time. In relation to the drains IMT, this was more complex, however from an IMT management and culture point of view I do not recall any issues.

329. Although people had different points of view, from my perspective it was constructive and people could raise a different point of view if they wished. The IMTs were focused on the job in hand and doing what was advised by the LICD and the external advisors, HPS and HFS.

330. In June 2019, the M. chelonae and gram negative IMTs commenced. This began as a M. chelonae IMT, then became a M. chelonae and gram negative IMT, the M. chelonae part was then closed and it became only gram negative. It was at that time things became more difficult within the meetings.

331. By its nature, the IMT was harder for people to understand as there was not a marked increase in infection numbers. There had been some unusual infections that Teresa had been worried about. There was a large number of environmental swabs and samples being undertaken but nothing was being found that linked back to the children.

332. IMTs usually work around managing a specific infectious agent, COVID for example. If we know how it is transmitted then we can block the transmission, then infection rates go down and we install a permanent solution if possible. In this way the incident will be brought under control, monitored and closed.

333. This IMT was not able to follow the same process as there was no single type of infection and no clear source. We had mitigations in place including controlling admissions on a case by case basis and newly diagnosed children going to Edinburgh Children's Hospital. This was difficult for families who lived this side of Scotland and the further separation from their family units.

334. We were undertaking as many actions as possible but the hypothesis was unclear as that IMT progressed.

335. The group began to consider if it could be other sources rather than the ward environment but the Chair then presented us with slides noting that just because we had not found anything in the environment, it did not mean it was not there. To that end we continued and put in a whole range of mitigations.

336. At the IMT meeting on 14 August, there were some difficult conversations and challenge around views. An additional Infection Control Doctor was present who had a more confrontational approach. People were undertaking the mitigations but simultaneously struggling to understand the problem.

337. The two Senior Charge Nurses from 2A and 2B came to see me afterwards. They said they had found the IMT difficult and unhelpful. I discussed with Teresa Inkster what they said. To try and improve this, pre-meetings were arranged. Stakeholders such as Estates were getting information at the IMT and so had no time to consider it prior to the meeting. There may have been a couple of pre-meets prior to this but Teresa agreed that we would introduce them as standard at that point. However, Teresa did not chair the IMT again after that.

338. The meeting at Glasgow Royal Infirmary on 20 August 2019 was an open discussion seeking views and comments from those who attended the IMT. I remember people speaking openly. There is a minute which reflects the discussion. I recall that the recommendations were to have an independent chair and pre-meets.

CONTACT WITH OTHER AGENCIES THROUGH IMT MEETINGS

339. HPS and HFS were closely involved in the IMTs. I occasionally took HPS or Scottish Government colleagues around to enable them to see the facility. They were not involved in the operational running of the service.

340. HFS would link with the Estates and Facilities team outwith IMTs.

341. I did not have any involvement with Scottish Water, that would have been Estates again and microbiologists.

342. We worked closely with our Facilities and Estates teams. For example, when we moved to CDU, our colleague from Estates was Kerr Clarkson. The team

would give him lists of Estates tasks and he would make sure this list of actions was completed for every room. Infection Control would link with Kerr also.

343. When we undertook the HPV cleaning in 2A in June 2018, we had an Estates colleague in the ward at all times, working through the process with us each day.

344. From Jamie's and my perspective, we would speak to Tom Steele, or people in his team, regularly. They would update us on works and we could raise any concerns. From my perspective our relationship with Estates was good.

345. In relation to our liaison with the Scottish Government, we would be regularly communicating around updates, questions or queries from Scottish Government.

346. HPS who were at the IMTs also would update Scottish Government. The IPC team would also submit Hospital Infection Incident Outbreak Reporting Tool (HIIORT) reports to HPS.

347. From November 2019 following on from when the Board went on Level 4 escalation, we started updating Scottish Government on a daily basis. The daily brief for 6A/4B collated items including Estates work, any infection control issues, test results, and family communications. It would be approved by the COO and Executive Nurse Director and the PMO would send it to Scottish Government by midday each day.

348. Communication outwith the daily updates at that time included supporting the Case Note Review and working with Professor Craig White in regard to communication and, for me, the Communication Subgroup of the Oversight Board.

349. Scottish Government questions could arrive through various routes, for example via the corporate governance team, communications team, infection

control or nursing. Reponses would be pulled together by the appropriate team, approved and submitted back to Scottish Government.

HOSPITAL ACQUIRED INFECTION AND HEALTHCARE ASSOCIATED INFECTIONS

350. A hospital acquired infection (HAI) is an infection that has manifested whilst the patient is in hospital. It is defined as a positive sample from a patient who has been in hospital for at least 48 hours. Depending on the type of infection, the incubation period can be longer, for example COVID, but based on national definitions it would be a HAI on the 48-hour rule.

351. A healthcare associated infection (HCAI) is where a patient has been in contact with any healthcare system in the previous 30 days.

352. These definitions would be used within the IMT process. People’s infections would be commonly referred to as, ‘HAI,’ or, ‘HCAI,’ or community. The information would be listed in the IMT documentation.

353. These terms are widely used and understood and did not change throughout the IMT process. The case definition evolved, but HAI and HCAI are nationally understood definitions.

354. The case definition describes the type of cases which will be included in the IMT. For example, an IMT could start with a specific infection such as Enterobacter and then the IMT would then increase the case definition to include any gram-negative potentially associated with the environment. Therefore, the case definition would be extended to include more cases. Review of case definition does happen as part of IMTs and is specific to the IMT.

355. IMTs could be called for a single case of a particularly unusual infection or two or more cases of the same infection.

356. The water IMT was focussed on any infections that could be potentially linked to the water.

357. The Cryptococcus IMT was one child and one adult, so the number was small but the infection was considered to be rare.

358. The later 2019 IMT was focussed on unusual types of infection rather than numbers of infections. Our data had improved by that point in terms of the CLABSI rate.

RENAMING OF INFECTIONS

359. At each IMT, the status of patient cases and types of infection would be covered. Names or the ‘renaming’ of infections would be something to discuss with the microbiologists or IPC team who would be expert in that area.

360. Bacteria causing infections may belong to an overarching group of bacteria which will also have sub types. In previous years we may not have known or used the names of the subtypes.

361. There was some discussion about naming of infections within the IMTs but, in general, everyone was agreed that the purpose of the group was to ensure all actions were undertaken to stop infection spread / transmission from source.

COMMUNICATION WITH PATIENTS ABOUT INFECTION

362. Patients will receive information at the start of their hospital admission in regard to infection control and infection risk. This would be a standard ongoing discussion with their clinician specific to their care.

363. A patient’s doctor will normally discuss with them or their family if they find the patient has an infection. They will discuss potential causes and also treatment. The clinician has an understanding of the patient’s condition and would be able to describe any impact on their wider treatment or answer any

questions the family might have. This could be the consultant or another member of the team.

364. Managers would not be able to speak to that as they do not have the detailed clinical picture for each individual patient, and nor should they. This is for the clinical expert team caring for the patient.

PROPHYLACTIC MEDICATION

365. I was not involved in decision making in regard to prophylactic medication. This was a recommendation by the Lead ICD in discussion with consultants.

366. At various points across this period, based on microbiology advice and discussion with the consultant group, prophylactic medication was prescribed to at-risk patients. The prescriber or another appropriate member of the care giving team will normally discuss with the family the new medication.

367. The microbiologist might advise the consultant and they would make a clinical decision based on the patient's risk factors, their immunity, their condition, their contra-indications and their allergies.

368. Some of the communications briefs referred to this in general terms, such as some at risk patients will be prescribed prophylactic medication. If this was included in a brief with a family, I would not discuss their individual child's prescription as that would be something for their clinical team.

COMMUNICATIONS FOLLOWING IMT

369. Initially in the water IMT, a lot of the communication was verbal, although there was also some written communication. As the IMTs progressed we undertook to do more written as well as verbal briefs. In the Cryptococcus IMT and through 2019, we utilised more written communication and we still accompanied this with face to face discussions.

370. From the start of the water and the subsequent related IMTs, the offer was always included for families to speak with Infection Control and Teresa always made herself available as the Lead Infection Control Doctor.

371. A representative from the communications team would be present at IMTs as part of the IMT core membership. Communication is a standing item on the IMT agenda. They would advise on communications as the subject expert. They would help advise and guide the IMT around potential content. The final decision about press release would normally sit with the Chair of the IMT.

372. As the IMTs went on, we developed a written brief to go alongside our verbal updates. This could be used by staff and families and also be given to those in out-patients or day care areas. Incidents were fast moving and dynamic making it difficult for people to remember the detail, so written briefs were a useful tool.

373. We were trying to support consistency within staff to family communications and family to family communications. This was an attempt to ensure accurate information was provided within the context of substantial external media reporting, which was not always portraying the same information as our briefings.

374. Following an IMT there would often be staff communications, inpatient families' communication and external communications. The communication team had a central role to play in formulating all the communication briefs and releases. They would receive input from subject experts, whether these were infection control, microbiology or estates.

375. We developed a process where after every IMT we would go to the ward and update the staff, then join with a consultant or senior nurse to update the families individually. That would be Jamie or I and a clinical person, and we would talk to every family. We would give them the brief, discuss it with them and answer any questions.

376. When giving the briefs to families we created space for questions and discussion. I invited questions and always noting if we did not know the answer we would find out and get back to them.

377. I did not post any briefing documents under a room door, if a family were not available we would leave the briefing with the clinical team to update them when they returned or became available, noting we would be happy to come back and discuss / answer any questions.

378. Families told me they appreciated the information and conversations. I felt empathy and compassion for the set of circumstances the families found themselves in and now with this additional stress, it was very difficult for them and for the staff caring for them.

379. We updated families in an open and honest way, sharing the information we had been given.

380. We did the same with staff as it was important they knew the detail. We would talk to them in small groups, go through the brief and give them opportunities to ask questions. We would continue this until all the staff had been updated in the ward, often 2 or 3 groups each time.

381. IMTs often did not finish until the afternoon, it then took time for a communication to be written and agreed and approved. Thereafter, it would come to Jamie and I who would then go to the ward and begin the update process. This meant it was often late afternoon or early evening.

382. The communications team is managed as part of the corporate function in the Board; it does not sit within the sectors or directorates.

383. Alongside relevant others, the IMT Chair would input to and approve communications briefs written by the communications team.

384. IMTs have delegated accountability to make decisions and recommendations in regards to the incident, including the communications elements. Being part

of the IMT I saw part of our role as keeping the staff and inpatient families informed.

385. I very much imagined myself in the families' position and tried to always provide face to face opportunities to answer any questions and have conversations that were helpful for people.

386. The entire inpatient ward was directly impacted by the changes such as cleaning regimes, HPV and HEPA filters, so it was important we spoke to everyone and not only those families impacted by infection.

387. It would not have been normal practice following standard IMTs for members of the senior management and infection control teams to speak to every family on a ward after each IMT. This however was required over the course of these incidents.

388. Whilst we developed to do this well for inpatients, it was more challenging to communicate in a person centred way to the hundreds of patients' families who were at home attending only occasionally as inpatients or outpatients.

389. At many points we had IMTs every day. Things were moving daily and to attempt to communicate this quickly changing position with outpatient families was a growing challenge.

390. We became aware of a narrative that some families were feeling they were not being kept updated. It emerged that this was mostly feedback from people who were not in hospital but had a child who potentially could be admitted if their condition changed i.e. families currently in the community but perhaps using outpatient services.

391. To try and begin to address this challenge, Teresa and I stationed ourselves at the clinics in outpatients and asked the consultants to let their patients know we were there and that we would be happy to discuss the situation with them. Teresa and I spoke to a number of families within outpatients. I

regularly went to day care and spoke to families there. We gave out briefs in both day care and outpatients.

392. The organisation sent letters when larger pieces of news were to be shared. Some families responded asking to opt out of the letter process as they did not feel it was relevant to them. We wanted to be person centred in our approach and, with letters being sent to around 400 families, this was more challenging to achieve.

393. Outpatient families could get in touch and arrange to meet with us when they came for their appointment. We had long meetings with people in the outpatient area, but we still were not capturing all the families.

394. We then created a Facebook page which assisted us in reaching this cohort. It also meant people could choose whether to opt in or not as we knew some people were keen to be engaged and others less so.

395. We attempted to undertake face to face communication with the people directly involved. Talking to families on the ward alongside senior nurses and doctors, that was part of all our roles.

396. At the same time families would receive communications via wider media channels, social media, and a private Facebook page organised by families for peer support.

397. Social media moves very quickly so misinformation could travel quickly through those channels, which the organisation had no control of. That was a big challenge and I often found myself in discussions with families correcting things they had read elsewhere.

398. I always set out to communicate well and talk to families openly and honestly. The challenge was when those families were not there to have those discussions with and they had heard other information. The Board's closed Facebook group definitely helped us with that.

399. Looking back, the sense of this as a growing issue was in 2019. It was raised in IMTs and that started the process of creating a Facebook page as well as attending clinics and making ourselves as accessible as possible to anybody that wanted to speak to us.

400. As far as the content of the briefs, the communications team could speak more about that. Essentially, they would draft a communications briefing, key stakeholders would input to it or maybe draft it with them, depending on what the communication was, and then it would go through an approval process, starting with the key contributors being content.

401. In October 2019, following the appointment of Professor Craig White, once communications were agreed internally they were then sent on to Professor White for approval. From November 2019, external communications and media statements were also cleared by the CNO and Cabinet Secretary.

402. Once the communication brief was approved, Jamie and I would take it to the wards, speaking to staff and families in 6A/ 4B and sometimes other locations if a haemato-oncology patients happened to be in another area such as 3B or PICU.

403. The communication team are also contacted by external media for statements or comments. There were times when we were not aware beforehand of external media running stories. This was a challenge as we did not have the opportunity to update staff and families in advance of all publications.

404. The Cryptococcus IMT was particularly challenging in terms of media. Stories were running in the media, but we had a duty to the family and were concerned about the risk of deductive disclosure. This meant our communications were limited as the Board were protecting the families' right to confidentiality.

405. This population nationally is very small and the concern was that if any detail had been provided then people may have worked out who the family were. I

remember when I was going round talking to the parents and families at that time, some were asking who it was. We were trying to protect the confidentiality of that family. This is why the Board's communication sometimes read as high level, we were concerned always about patient confidentiality and deductive disclosure for individual patients.

406. Following that and a visit from the Cabinet Secretary, there was a release I think from the Procurator Fiscal and Scottish Parliament referring to the death of a [redacted]. The Board had not given an age or gender which made it appear less open, rather they were protecting confidentiality of the family.

407. I believe Jamie and I consistently going round the ward was the right thing to do in the circumstances.

DUTY OF CANDOUR

408. Duty of candour is a standing item in the IMT agenda. If a new case was noted at the IMT, the Consultant present will usually confirm that either they or their colleague will discuss this with the family. It would not be normal practice for managers to be involved in those conversations however we did offer support during the difficult periods as the IMTs progressed, as did Teresa.

409. During the IMT meetings, the Consultant would confirm that they were going to speak to one of their patients and Jamie, infection control and I would offer support if required. Usually they would prefer to discuss this with the families themselves but sometimes we were part of these discussions.

410. Normally if a patient has an infection and they are in hospital, their clinical team will talk to them/ their family and let them know they have an infection and the plan to treat that infection. That conversation would happen with the clinical team, which should be recorded in the notes, and the treatment would be started.

411. In an IMT situation, that would still happen and the clinicians would speak to the individual patients about their infection and treatment.

COMMUNICATION WITH FAMILIES

412. During the course of the first IMT, it was mostly Teresa Inkster and Jamie Redfern who spoke to the families who took up their open offer of a management / infection control discussion. A fair number of families spoke with Teresa and Jamie at that point. Then, when we moved into the next IMT, it was similar, but with more written briefs added and a constant offer to speak with the infection control team and managers, including Jamie and me.

413. We tried to update as a team. Clinicians were also at the IMTs and required to know the detail in order to discuss with families if there were questions within their routine interactions. If information was required for a newly admitted patient late at night, the staff that are physically there at that time would discuss with the family as appropriate. Further detail could be picked up thereafter with IPC or managers if they wished.

414. There was an emphasis on visible leadership, including Lead Nurses and Clinical Service Managers, being present on the ward, supporting the team and coordinating specific projects such as the HPV clean in June 2018.

415. There was additional support required because of the nature of the environmental issues raised and reassurance around actions and also in terms of the very intense media interest.

416. One day I was talking to a mum of a patient in Ward 6A Day care, and she was telling me about the separate family Facebook page, on which the members were saying there were no managers in the ward and that the managers were never there.

417. I clarified that, as the Chief Nurse, I was part of the management team in the hospital. She said, “No, no, I don’t mean you, Jen, not you, I mean the

managers sitting up there, the Chief Exec.” This is the only parent that made a comment like this.

418. The management the parent referred to was Executive level, however within the structure we had responsibility as the directorate management team in such a large organisation. As I described earlier, the Board is split into sectors and directorates each with a management team having responsibility to manage their area.

419. There are I think some nuances around the term ‘Board’ and who they are. Jamie and I were communicating with families as part of the NHS GGC Health Board, but we are not members of the Board of NHS GGC. Jamie and I, with others in the clinical team, were communicating with families in the ward as part of that structure.

420. The majority of families welcomed our visits and were happy to speak to us and grateful for the update. I understand the outpatient families were not receiving as regular updates the same way and would have been receiving information from media outlets and social media and so some have felt they were not being communicated with directly. We worked to improve this as I described.

421. The Executive Nurse Director, Chief Executive and Chairman visited the ward as did the Chief Nursing Officer. There were various Scottish Government official visits. Kevin Hill, Jonathan Best and Grant Archibald were on the wards too. I do not know exactly how often, but they had been in the wards.

422. We were mindful this was a haemato-oncology ward so we do try to limit footfall and keep it as calm and well controlled as possible.

423. In that time, we probably had about 500 families through that particular service. The majority of families I spoke to in the hospital told me they were happy with the updates; I have described the issue with those that were not inpatients.

424. Information from the IMTs, including communication with families, was consistently communicated up the organisation to the Executive team.

425. On these visits families would often share things, for example I remember one family in particular. We were having the usual conversational update and the dad said he was annoyed as the mum was not allowing the child to have showers. This was 2019 and we knew the water was 'wholesome'.

426. I explained that the child had a central line and it was important they had good hygiene and were kept clean. I explained how important that was, but he said that some people on the Facebook page were saying they should not shower their child because the water was contaminated.

427. This progressed into a discussion between the mum and dad, him saying not to listen to that page, to listen to the staff and that the page was adding to her stress. Some families told me they had to come off the peer support Facebook page because it was causing them stress.

428. This was during the autumn IMT in 2019, so it raised a concern that perhaps some children were not being showered and kept clean and this could itself pose a risk of infection. I spoke to the Senior Charge Nurse who ensured staff went round every patient each day, ensuring they were getting their showers and reinforcing that it was safe to do so.

429. I also thought about how families were living within the environment, rather than only the environment in isolation. Were they showering? How they were using the bottled water, given that bottled water is not sterile.

430. I raised this at the IMTs, ensuring again we were reinforcing and being clear that the water was safe.

431. We then acted on removing bottled water completely via the IMT and the reopening bundle.

432. In general terms, families receive a lot of information when they first become patients in the unit. There is the family information pack and 'Welcome to the Ward' pack. They also receive a lot of infection control information throughout their stay, and, as standard, patients around the hospital will receive information on laundry and handwashing.

CHALLENGES RELATED TO COMMUNICATION

433. The sequencing of information was challenging at times. I noted comments in the Closing Statement by Counsel to the Inquiry stating that people only got informed via the media. If media statements were to be released we aimed to ensure the ward staff and families were aware and saw and heard that information from the Board first. Unfortunately, this did not happen every time as some of this was out with our control. The communications team would be better able to describe these processes.

434. When there was a planned media statement or press release we would go round to the ward and talk to families and tell them about the release. This was to ensure the families had that first by a short window; it was very close in terms of timings.

435. Due to the extent and timing of press enquiries, sometimes a reactive comment would go out prior to us speaking with the families. The communications team would be better set to speak to this, but they would receive a significant amount of media requests for comments.

436. There was recognition and discussion about the need to sequence the information to try to make sure parents and staff in the ward were updated first and did not get a shock from a media report. This was aside from or sometimes added to the IMT verbal and written updates. We continued to give updates that were unrelated to media.

437. In the Closing Statement by Counsel to the Inquiry there was a comment about the ward being closed in April 2018. This was a norovirus / rotavirus

outbreak, which is not unusual within paediatric wards. An IMT would have put standard restrictions in place, for example restrictions on visiting and closure of communal areas to stop the transmission of this virus. Information would have been shared with families at the time regarding this.

438. There is a reference also to communication at the time of the water dosing in Ward 2A. In terms of communicating that the water would be switched off for a period whilst dosing would take place, the Lead Nurse informed me they had told families about the switch off and had ensured parents had time to have showers prior to this happening. I had asked them to ensure all the families were aware and they confirmed that.

WAYS TO REPORT FAULTS WITHIN THE HOSPITAL

439. From a nursing point of view, if there was a fault found, for example with the floor, they would escalate this through the Estates management system (FM First). RHC also has a Hospital Huddle and Estates / Facilities are represented at this and would also note and ensure faults were actioned.

WHISTLEBLOWING

440. Nurses can raise concerns through their nursing structure. In a ward, this would be to their Charge Nurse or Senior Charge Nurse. If they have a concern about something ongoing they can raise this with their Senior Charge Nurse.

441. If the issue requires further escalation, the Senior Charge Nurse would raise it with the Lead Nurse. The Lead Nurse could bring that to either the Clinical Service Manager or Chief Nurse, depending on whether it is a professional or operational issue. It may then make its way to the Senior Management Team and further professional line depending on the issue.

442. If there is an issue a nurse does not want to raise through these structures, they may talk to their union, usually the Royal College of Nursing (RCN)

representative. They could talk to their RCN representative who could raise it directly with the Chief Nurse.

443. That has happened on a few occasions, not related to this, regarding other general professional issues which were managed. I had a good relationship with the union representatives and we were able to work through anything that was being raised and ensure we sat down and talked and listened to the people who were raising concerns and that we then addressed these issues.

444. The whistleblowing policy is another route staff would have. I did not receive any whistleblowing alerts raised by nurses. As far as I am aware no nurses went down that route. Nurses spoke to the Senior Charge Nurse, Lead Nurse or me directly about concerns. Nurses did raise their anxieties with me, specifically I recall around Jan 2019, which was a particularly challenging time.

445. The team were worried about the environment, the IMTs were ongoing there was a lot of media at that time. We involved the RCN and Occupational Health and tried to support wider wellbeing. Nothing was raised from a whistleblowing point of view.

446. I was asked to go to a meeting as part of a whistleblowing investigation. It was around October 2019 and I was asked to attend JBR where I was interviewed by Linda de Caestecker, who was the Public Health Director and also had a role in whistleblowing. She interviewed me about a particular IMT.

CONCLUDING COMMENTS

447. In terms of the expectations I had relating to my job and the reality of it professionally, working through a situation like this you learn a huge amount and take that learning with you going forward.

448. Healthcare is dynamic, you do not always know what you are going to face and you have to be prepared for that.

449. We approach any situation with a view to do the best we can for the patients, staff and people around us, no matter how challenging that feels at times.

450. We focussed on supporting teams. Although I know additional audits and scrutiny sometimes provoked additional stress, we had to undertake these processes to provide ourselves, our families and our staff with ongoing assurance around our systems and practice.

451. In terms of being involved in all the reviews and the Public Inquiry, there have been around seven external reviews, including the Independent Review, the Health and Safety Review and the Case Note Review. I tried to support and guide nurses through those to focus on what you can control and what your job is and your responsibility in caring for your patients.

452. Providing input to the reviews as well as the business as usual was time-consuming and stressful for the staff. It required a lot of additional focus and work for the teams. However, everyone wanted to fulfil their part and wanted to contribute and glean any learning.

453. Similarly with the media, I tried to support staff through some of the difficulties, as the anxiety around that for staff and families was a real challenge. There were points where their ward was constantly in the media, every day, and this impacted families and staff morale.

454. We were in a position as a local management team to work through each scenario, undertaking what was required. I would update the Executive Nurse Director, Margaret McGuire, and Kevin Hill, my line manager, both of whom were supportive.

455. There is no doubt it was a difficult time and had an impact on us and the teams. Jamie and I worked as a leadership team to attend all the IMTs, update families, support staff who were upset and worried and undertake IMT actions as well as the wider work.

456. While we could not immediately expedite the move back to 2A, we did other things to support the team as I have described, including RCN support, massages, psychology drop-in sessions for staff, providing additional staff, and enriching skills mix. We worked to respond to what was needed. Many of us worked long hours, weekdays and weekends to ensure we were doing all we could to mitigate risk to children and improve the situation.

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