SCOTTISH HOSPITALS INQUIRY

CLOSING STATEMENT

on behalf of the

SCOTTISH MINISTERS

relating to the hearing commencing on 26 February 2024

1. The Scottish Ministers are grateful for the Chair's invitation to submit this closing statement. They have no areas of disagreement, other than points of detail noted in paragraph 2, to express with the closing statement of Counsel to the Inquiry as regards:

   (1) the themes that emerged from the evidence, so far as relevant to the Terms of Reference of the Inquiry;

   (2) the proposed explanations of and answers to each of the topics listed in the List of Topics;

   (3) the proposed answers to the questions posed in Terms of Reference 1 to 12.

2. The Chair is invited to note the following points of detail in relation to topics 4.10 and 4.14:

   (1) Topic 4.10, and paragraph 218 of the closing statement of Counsel to the Inquiry—NHSL's escalation to level 3 was for a number of reasons as set out in the letter to it dated 12 July 2019 (bundle 7, Vol 1, p339).

   (2) Topic 4.14, paragraph 226 of the closing statement of Counsel to the Inquiry—any such consideration suggested by Counsel would require to be undertaken in the context of the existing statutory framework and the respective functions, powers and duties of the Scottish Ministers and Health Boards respectively.

3. The Scottish Ministers wish to highlight the following additional points, framed by reference to the potential recommendations suggested by Counsel to the Inquiry.

A) General

4. The Scottish Ministers welcome the suggestion of a symposium or round-table meeting, and agree that it is best considered after the Inquiry has heard all of the evidence in relation to the QEUH.

5. The Scottish Ministers also welcome Counsel to the Inquiry's acknowledgment of the significant reforms since the RHCYP/DCN opened, and the large extent to which they have addressed problems. In that regard, the Scottish Ministers invite the Chair to note that NHS Scotland Assure is in its infancy and that it has set up robust processes for continuing improvement, learning, and challenge.

B) Recommendations considered suitable for an interim report

6. **Risk assessment** The Scottish Ministers agree that the rationale for decisions as to the suitability of existing work following a change of funding model or procurement route should be formally recorded. So far as it is suggested that that should take any particular form, they would respectfully suggest that the decision and form of record should be context-sensitive: it may be unwieldy—and, even to the extent successful, create a false sense of certainty—to attempt to capture all of the possible relevant aspects of existing work in a single format.

7. Relatedly, as to paragraph 458, the Scottish Ministers welcome Counsel to the Inquiry's recognition that the decision not to open the RHCYP/DCN was based on the evidence and justifiable. Indeed, as Counsel to the Inquiry submit at paragraph 170, it was rational, reasonable, appropriate, and in line with a consensus agreed by experts.

8. They agree, in line with the above remarks, that any decision should be context-sensitive. Noting, however, the importance of patient safety, they would

respectfully disagree with any suggestion that in urgent and sensitive situations there ought to be any prescribed form of risk assessment.

9. Rather, as Counsel to the Inquiry acknowledge at paragraphs 313–15, plans for the creation of NHS Scotland Assure were formed immediately so as to enable future decisions by the Scottish Ministers to be given robust assurance about healthcare construction projects from an early stage, reducing the likelihood that they will be identified at a later, costlier point in the process. They respectfully endorse the suggestion at paragraph 322 that the manner and scope of NHS Scotland Assure's involvement represents 'a reasonable compromise on grounds of cost and practicality', and as to paragraph 325 note that a project must come to CIG for approval when the cost exceeds a board's delegated limit.

10. **Derogations** The Scottish Ministers do agree that it would be workable and desirable to have a standard form for derogation from guidance, as that concerns an inherently circumscribed decision.

11. Relatedly, the Scottish Ministers would endorse what appears to be implicit in Counsel to the Inquiry's Closing Statement at paragraph 155: it would not, in their view, have been necessary or proportionate to have stalled the project at the stage of SA1 to require a full technical audit by a third party of all of the aspects concerned (of which there were around 80, as noted at paragraph 183).

12. They welcome Counsel to the Inquiry's recognition at paragraph 184 that any suggestion to the contrary would be made with hindsight, and as regards paragraph 226 would add (consistently with their observations above) that decisions of the sort concerned raise important and multi-faceted issues of resources which must take account of the possibility that greater demands on resources may occur if other routes are pursued.

13. The Scottish Ministers agree with the proposals as to timing in paragraph 186. They have provided documentation to the Inquiry and will be happy to assist the Inquiry further at the hearings yet to come in relation to the QEUH.

14. **Duplication of procedures** In line with the observations above, the Scottish Ministers agree that procedures should exist (and co-exist) to ensure patient safety with the minimum of duplication. They are neutral as to how any streamlining is best achieved, which appears to be for other Core Participants to consider in the first instance and refer to their observations above as to the benefits of the creation of NHS Scotland Assure.

15. **Information about common errors** The Scottish Ministers would welcome observations from NHS National Services Scotland as to any ways in which the 'lessons learned' process might usefully be supplemented.

16. In that regard, they recall that the Strategic Facilities Group ('SFG') has now been running for many years. It consists of NHS Directors of Facilities and Estates (several of whom oversee the delivery capital projects and manage ventilation systems and other critical building systems) and allows for informal discussion of a wide variety of estates and facilities issues across NHS Scotland. Mr Morrison would update the SFG on what was happening and share learning on development of Health Facilities Scotland/NHS Scotland Assure as one of many routes to sharing that learning across the NHS throughout Scotland.

17. **Role specifications and skills** On 2 May 2024, the Chief Nursing Officer issued a Directors' Letter outlining the main responsibilities for health boards in relation to their infection prevention and control ('IPC') services (a copy of the letter is produced at Appendix A to these submissions). The letter includes role specifications for IPC specialists across Scotland. These role specifications are recommended rather than mandatory. They were developed from an initial draft created by NHS Education for Scotland ('NES'), based on current job descriptions for IPC posts across Scotland and England, following consultation with NHS Scotland IPC staff representatives, Healthcare Associated Infection (HAI) Executive Leads and professional advisers to the Scottish Ministers. It is envisaged that the membership, structure, and scope of an IPC team should reflect the geography, function, size, and complexity of the health board it serves, in the

context of workforce planning in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

18. The Chief Nursing Officer Directorate commissioned NES, as part of the Strategic Plan for an Infection Prevention Workforce for 2022–2024, to create an Antimicrobial Stewardship generalist education framework and an IPC specialist education framework. These frameworks will map the training requirements of IPC staff as they progress through their IPC careers by providing guidance as to available and appropriate training. The Healthcare Associated Infection and Antimicrobial Resistance Policy and Strategy Unit, a policy division within the Chief Nursing Officer Directorate constituted by civil servants, IPC professional nurse advisers and an Associate Chief Nursing Officer, meets 6-weekly with NES. At these meetings NES provide updates as to, amongst other things, the development of the NES framework and all other tasks and workstreams associated therewith.

19. In line with Objective 7.1 of the Scottish Ministers' Scottish Healthcare Associated Infection Strategy for 2023–2025, NES are also working with NHS Scotland Assure to continue the delivery and implementation of the National Learning and Development Strategy for the Specialist Healthcare Built Environment Workforce (2021–2026). This includes a Learning and Development Knowledge and Skills Framework for the healthcare built environment, which is reviewed annually.

C) Recommendations considered suitable after the evidence about the QEUH

20. The following are preliminary observations which the Scottish Ministers reserve the right to revisit following the evidence about the QEUH.

21. **Legislative intervention** As Counsel to the Inquiry acknowledge, the decision not to open the RHCYP/DCN because of its non-compliance with safety guidance was correct. Whether in a particular situation patients' interests are best furthered by opening a hospital or postponing that opening must depend on the particular guidance in question and the ways in and extent to which there is a departure from

it. It does not appear to the Scottish Ministers that it follows from the fact that not opening the RHCYP/DCN was correct that guidance should always have the force of law.

22. Account must also be taken of the difficulties posed by transposing guidance into even secondary legislation, which is inherently less adaptable, less readily amended, and (by its binding nature) less apt to allow for nuance in the degree to which it requires to be followed. As Counsel to the Inquiry observes at paragraph 489, NHS guidance is (in the Scottish Ministers' view, justifiably) neither mandatory nor definitive in all circumstances, and they refer to their endorsement of Counsel to the Inquiry's proposed response to the Remit at paragraph 334.

23. The Scottish Ministers are also conscious of health boards' needs to develop context-sensitive and cost-effective projects, which need must entail their being afforded discretion (subject to risk assessment and appropriate oversight) as to the particular technical specifications to be adopted in a given case.

24. In addition, and with paragraph 242 of Counsel to the Inquiry's closing statement in mind, the Scottish Ministers would observe that in the case of the RHCYP/DCN it was relevant that compliance with the guidance had ostensibly been contractually—and so legally—required. As Counsel to the Inquiry observe at paragraph 231, NHS Lothian fully agreed with the Scottish Ministers' decision to postpone the opening of the hospital.

25. **NHS Scotland Assure** The Scottish Ministers would welcome the perspectives of Counsel to the Inquiry and other Core Participants following the close of evidence.

26. **Funding models** The Scottish Ministers welcome and adopt Counsel to the Inquiry's submission at paragraph 191 that the revenue-funding model was not an operative cause of the delay in opening the RHCYP/DCN, for the reasons they give. They would further observe at this stage that no hospital is currently being developed on the revenue-funding model. They agree that the choice of funding model is important and its benefits must be considered in relation to its drawbacks

in a given instance. They would also observe that those benefits and drawbacks engage acute questions of macroeconomic policy and the (in)ability of Scottish Ministers to fund capital-funded projects which questions are likely to exceed the Inquiry's Terms of Reference.

Ruth Crawford K.C.

Stephen Donnelly, Advocate

Counsel to the Scottish Ministers

Appendix A

Directorate of the Chief Nursing Officer, NHS Scotland
Anne Armstrong, Interim Chief Nursing Officer

Scottish Government
Riaghaltas na h-Alba
gov.scot

Dear Colleagues,

NHS SCOTLAND INFECTION PREVENTION AND CONTROL (IPC) ROLES AND RESPONSIBILITIES, INCLUDING IPC TEAM (IPCT) AND SPECIALIST IPC ROLE DESCRIPTORS.

This letter replaces the previous HDL (2005) 8 and builds on evidence and lessons learnt following: The Vale of Leven Hospital Inquiry Report (2014), The Queen Elizabeth University Hospital Review (2020) and The Queen Elizabeth University Hospital/ NHS Greater Glasgow and Clyde Oversight Board: Final Report (2021) . It outlines the main responsibilities for Boards in relation to the infection prevention and control (IPC) service and introduces the team and specialist IPC role descriptors.

The Role of the Chief Executive

The Chief Executive is ultimately responsible for ensuring successful prevention and control of infections within their NHS Board area. This accountability requires that the Chief Executive:

- Is aware of their legal responsibilities to identify, assess and control risks of infection in the workplace,
- Appoints an Executive Lead to be the Healthcare Associated Infection (HAI) Executive Lead,
- Appoints either a Clinical Lead and/or Infection Control Manager to have responsibility for the IPC service with sufficient resource to provide IPC support and advice and is able to demonstrate clear lines of governance throughout the organisation, and
- Ensures that prevention and control of infection is a core part of their organisation's clinical governance and patient safety programmes.

From the Interim Chief Nursing Officer

Anne Armstrong

02 May 2024

DL (2024) 11

Addresses

For action

NHS Scotland Chairs,
NHS Scotland Chief Executives,
Chief Officers Health and Social Care Partnerships,
Local Authorities,
HR Directors,
Medical Directors,
Nurse Directors,
Primary Care Leads,
Directors of Pharmacy,
Directors of Public Health,
Directors of Dentistry,
Optometric Advisors,
All Independent Contractors (Dental, Pharmacy, General Practice and Optometry),
Infection Control Managers,
Infection Control Doctors,
Infection Control Nurses.

Further Enquiries

Scottish Government Directorate for Chief Nursing Officer

Email: cno@gov.scot

Role of Healthcare Associated Infection (HAI) Executive Lead

The HAI Executive Lead holds delegated accountability for the IPC service function within their portfolio answering directly to the Chief Executive in line with the Board's internal scheme of delegation. HAI Executive Leads are responsible for:

- Annual workforce planning to establish an IPCT appropriate to the size and complexity of the Board, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019,
- Responsible for the management of any IPC associated risks which have been escalated to ensure appropriate mitigation steps are taken,
- Ensure the IPC service can provide the function required and have an appropriate work programme which supports provision and continuous improvement, and
- Responsible for chairing the NHS Healthcare Associated Infection Executive Committee (HAIEC)/ Infection Control Committee (ICC)
- Oversee and ensure relevant and required IPC/ healthcare associated infection (HCAI) reports are published and/or sent to the appropriate National Board/Scottish Government.

Infection Control Manager and/or Clinical Lead

The Infection Prevention Workforce: Strategic Plan (2022-2024) and accompanying CNO letter states that both the complexity and size of the Board should be considered when determining whether there is a need for a dedicated IPC Clinical Lead.

The Clinical Lead role **may not be required in all boards** and is distinct from the role of the HAI Executive Lead which will retain the delegated accountability within the Board for HAI.

Team and Specialist IPC Role Descriptors:

The Infection Prevention and Control Team (IPCT)

The function of the IPCT is to advise on the prevention,

surveillance, investigation, and control of infection across health and care settings in collaboration with other key service partners. The IPCT works collaboratively with microbiology, virology and other services and departments, including operational and senior management teams, health protection teams, care home providers and the health and social care partnerships , to provide infection, prevention, and control (IPC) subject matter expertise, safe, effective, and person-centred communications and advice and support to help reduce the risk of infection to patients, service users, staff and visitors.

The membership, structure, and scope of an IPCT should reflect the geography, function, size, and complexity of the NHS Board it serves.

A descriptor of an IPCT can be found in ANNEX A.

IPC Specialist Role Descriptors

Since the publication of the Infection Prevention Workforce Strategic Plan 2022- 2024 in December 2022, the Healthcare Associated Infection (HCAI) and Antimicrobial Resistance (AMR) Policy Unit has been engaging with national and territorial Boards to produce a Clinical Lead role descriptor for Scotland and update the existing Infection Control Manager (ICM) descriptor within HDL(2005)8.

During the first stage of engagement with IPCTs from across Scotland, the HCAI/AMR Policy Unit was asked by key stakeholders to develop role descriptors for Infection Control Doctors, Nurses/Practitioners and Infection Control Support Workers.

ANNEX B holds role descriptors for all of the aforementioned team members. It is recognised that some staff may have additional responsibilities based on local need which would not necessarily be considered as a core responsibility for that role across Scotland, and therefore such responsibilities are not included within the descriptors.

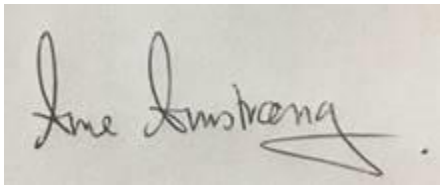
The individual role and team descriptors outline the main responsibilities for IPC specialists across Scotland. The individual role descriptors were developed with an initial draft created by NHS Education for Scotland, based on current job descriptions for IPC posts across Scotland and England, which was followed by consultation with

NHS Scotland IPC staff representatives, HAI Executive Leads and Scottish Government Professional Advisors**.**

All descriptors emphasise that IPC teams are responsible for the provision of IPC advice to other areas and departments, noting that this does not mean they are accountable for IPC practice in those areas.

The IPCT and team member descriptors **are not mandatory**. They have been developed as a support tool and guide for Boards to refer to when reviewing local roles or IPCT structures as part of workforce planning in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

Yours sincerely,



Anne Armstrong
INTERIM CHIEF NURSING OFFICER

Annex A – IPCT DESCRIPTOR

IPC Team Descriptor ANNEX A.docx

Annex B – SPECIALIST ROLE DESCRIPTORS – CROSS READ TABLE

Role Descriptors - Cross Read Table ANI