Scottish Hospitals Inquiry
Witness Statement of Questions and Responses
Professor Angela Wallace

This statement was produced by the process of sending the witness a questionnaire with an introduction followed by a series of questions and spaces for answers. The introduction, questions and answers are produced within the statement.

Personal Details

1. Full name

A. Angela Wallace

Background

2. Please state your name and professional qualifications, including qualification in any specialities.

A. My name is Professor Angela Wallace. The qualifications I hold are RGN, MBA and FRCN. I do not have any specialist qualifications in Infection Prevention and Control.

3. Please provide a summary of posts held by you and/or an up-to-date CV.

A. I enclose my CV **(A49689031 – Appendix C)**. Please see a summary of my posts below:

2022 to Present - Executive Director of Nursing, Midwifery & Allied Health Professionals and Health Care Scientist

2004 to 2022 Executive Director of Nursing, Midwifery & Allied Health Professionals
NHS Forth Valley - (2020 to 2022) Interim Director of Infection Control and HAI Executive Lead – NHS GGC

2003 to 2004 - Director of Nursing, Forth Valley Acute Operating Division

2002 to 2003 - Interim Director of Nursing
Forth Valley Acute Operating Division

2001 to 2002 - Deputy Director of Nursing
Fife Acute Hospitals NHS Trust

2001 to 2002 - Acting Director of Nursing, Quality, Therapies & Rehabilitation
Fife Acute Hospitals NHS Trust

1999 to 2001 - Directorate Nurse Manager – Medicine, Rehabilitation & Care of the Elderly
Fife Acute Hospitals NHS Trust

1996 to 1999 - Nursing & Quality Adviser – Senior Nurse Quality & Audit
South Glasgow University Hospitals Trust

1991 to 1996 - Charge Nurse – Intensive Care & Coronary Care Units
Victoria Infirmary, Glasgow

1983 to 1991 - Nurse Training & Staff Nurse Post
Victoria Infirmary, Glasgow

4. What is your current role?

A. I am currently the Executive Director of Nursing and Midwifery for NHS Greater Glasgow and Clyde (NHS GGC) with strategic leadership for, Allied Health Professions and Healthcare Scientists. I am the Executive Lead in NHS GGC for Quality, Public Protection, Infection Prevention and Control, Healthcare Safe Staffing Act, People Delayed in their Discharge.

Involvement with QEUH/RHC before the Oversight Board was set up

5. Did you have any involvement with QEUH/RHC before the creation of the Oversight Board and taking up your role as Interim Operational Director for IPC? Please give details e.g. when your involvement began, and what was your involvement?

A. I had no involvement with QEUH/RHC before the creation of the Oversight Board and taking up my role as Interim Director for Infection Prevention and Control.

Role as Interim Operational Director for IPC (IODIPC)

6. What were the full circumstances around your appointment? e.g. who suggested the appointment, how were you recruited, who approved the appointment?

A. I was approached by the then Chief Nursing officer (CNO) for Scotland Ms Fiona McQueen. She explained that Prof Marion Bain of Scottish Government was supporting NHSGGC in respect of Infection Prevention and Control (IPC) as Healthcare Associated Infection (HAI) Executive Lead. Prof Bain had requested a senior colleague to direct IPC at a strategic and operational level. The CNO asked if I would consider taking this interim post in support of Prof Bain and the Scottish Government Oversight arrangements. There was no recruitment process, there were discussions between Fiona McQueen CNO, the Scottish Government colleagues, NHS Forth Valley Chief Executive and GGC about this ask and my capacity to cover my role in NHS Forth Valley and the Interim Director of Infection Prevention Control. My understanding is that this was then jointly approved by the 2 organisations and Scottish Government Colleagues.

7. Why did you agree to take up the appointment?

A. As a senior NHS Scotland leader and director, we are required to deliver on a national and regional priority within our annual organisational and professional objectives as part of the national performance appraisal system. This ask of

me would sit within this space and I would therefore not take on additional regional and national areas during my term as Interim Director of Infection Prevention and Control. The initial secondment was for 6 months, 2.5 days per week. I agreed to take up this role as I was asked to by Scottish Government colleagues. It was explained that my significant leadership experience managing complex situations would provide additional leadership capacity at this time. In working in NHS Scotland for 40 years I continue to be driven by service and wanted to help colleagues if I could with the aim of supporting them as they continued to provide safe, person-centred care.

8. What was the brief you were given on taking up the role? Was this in writing? What was your understanding of what the role involved?

A. I was not given a written brief for the role. My understanding was that, initially working alongside Prof Marion Bain, I would operationally direct IPC across NHS GGC and establish a director of IPC role, it was explained that further colleagues from NHS Scotland would be released to also assist our GGC colleagues, due to the significant additional pressures that the oversight arrangements would place on the IPC team. The release of colleagues did not occur.

9. Who did you report to, and who reported to you?

A. I reported to NHS GGC CEO Mrs Jane Grant. There were no direct reports initially but within my time in this role the arrangements changed and developed, this resulted in the Infection Control Manager (ICM) reporting to me during 2020. I had no planned regular meetings with the CNO but I regularly reached out to her and her team including SG policy unit colleagues.

10. What were you told about issues at QEUH/RHC before taking up the role?

A. It was explained to me that NHSGGC as part of the Scottish Government oversight arrangements in respect of IPC required additional leadership capacity. CNO Fiona McQueen shared that there were some microbiology colleagues within NHSGGC who had, and continued to, raise concerns regarding infections which they believed was connected to the QEUH and RHC building and environment. Although I understood that I would be the

liaison between the NHS Board and colleagues in Scottish Government and despite reaching out to those with concerns this raising of issues out with process continued and this pattern of behaviours was supported by colleagues in SG which left me in the unfortunate position of trying to manage the issues within process but at the same time the channels between the microbiologists and SG continued. I was trying to build relationships with the team and build trust and transparency and new ways of working but this continual questioning of processes hindered this process and undermined the position I was asked to fulfil.

11. Additionally, what were you told about:

(a) Incidence of infection and bacteraemia

A. CNO shared verbally that there were concerns re infections and bacteraemia that continued to be raised by the whistleblowers… despite the work that had been commissioned by SG and undertaken by ARHAI in 2019 **(A49689613 - HPS Report - Review-of-nhsggc-paediatric-haematooncologydata – Bundle 27, Volume 10, page 350)**.

(b) Specific incidents of infection and bacteraemia, including but not restricted to, Cryptococcus, Mycobacterium Chelonae, gram-negative bacteria

A. I was not told about specific incidents prior to taking up this interim role. I was however aware that there was significant media attention with regards to unusual incidents.

(c) Issues with the water system

A. I was not told about specific issues with the water system, but as stated above, CNO Fiona McQueen shared with me that there were concerns regarding building and environment which included the water supply in QEUH and RHC and I was aware from the media attention.

(d) The water incident of March 2018

A. No details were given on the water incident of March 2018 prior to taking up this role.

(e) Issues with the ventilation system

A. No details were given on concerns re ventilation system prior to taking up this role.

(f) Suitability of the ventilation system to deal with the Covid pandemic

A. The Covid-19 pandemic began within weeks of me taking up this role, therefore I cannot answer this question.

(g) Infection link with the water system

A. Please see (c) above for my response to this question.

(h) Infection link with the ventilation system

A. Please see (e) above for my response to this question.

(i) Decanting of wards

A. I was not aware of specifics in relation to wards that had been decanted but I was aware from my initial discussions with Prof Marion Bain that there were patients in RHC, oncology ward receiving care in the adult hospital QEUH.

(j) Risk to patients.

A. Please see (9) and (a) above for my response to this question.

(k) Culture and relationships within IPCT

A. It was explained to me by the CNO and Prof Marion Bain that the relationships between colleagues who had raised concerns and a range of colleagues within GGC were completely polarised to the point that I was extremely concerned that parts of the system were working in a space that was not psychologically safe. It was shared with me that NHSGGC had previously put plans in place to support colleagues in this respect however I considered this to be an extreme example of a fractured system. In my first meeting with CEO Jane Grant prior to accepting this interim role, Jane explained that a key commission would be to design a new organisational development (OD) approach to again support team working and build relationships. Prof M Bain shared with me she had an objective a part of her

role to “re-integrate” colleagues who had raised concerns back into the organisation, however, despite my best efforts in became apparent quite quickly that this may not be possible.

12. What were you told about any risk assessments being done and any steps being taken in respect of the issues?

A. I was not told about any risk assessments that I can recall.

13. What were the key areas of focus in your role?

A. In taking up the role, I believed I had a unique opportunity to look at the context of the NHSGGC IPC from an independent perspective. I realised that this phase of independence may not have longevity therefore my initial focus was to seek to understand. Immediately prior to my role commencing, I spoke to colleagues mentioned in Scottish Government, CNO and Prof Bain including Scottish Government HAI Policy Unit, colleagues in ARHAI and NHS Healthcare Improvement Scotland (NHS HIS), NHS GGC Directors, acute colleagues. In taking up my role I immediately met with GGC colleagues beginning with the Infection Control Manager (ICM), lead infection control doctor, senior leader colleagues. In addition, I spoke to the people I knew across other boards and the royal college of nursing to gain insights, perspectives and gain any learning from their experiences of the current context that GGC colleagues were facing. I was asked to meet with Prof Marion Bain, and two microbiology colleagues, Dr Christine Peters and Dr Teresa Inkster who had raised concerns and continued to raise concerns. Simultaneously, I was utilising a Swot Analysis (Strengths, weaknesses, opportunities and threats) to compare IPCT approaches and performance internally (other hospital sites) and externally (Other NHS Scotland Boards). **(A49689091 - SWOT- PESTLE V1.docx Final – Bundle 27, Volume 10, page 202)**

14. What initial steps did you take on taking up the role? What key relationships did you form?

A. Please refer to my answer to Question 12 above and the approach to my role in the update provided to Oversight Board IPC and Governance

subgroup.**(A49689717 - QUEH IPCG Sub Group.pptx Draft Presentation.pptx Version 9 – Bundle 27, Volume 10, page 205)**.

Improvements to GGC Infection Prevention and Control

Please see: **(A49690639 - Email Chain - Angela _ Penelope _ Terri – Bundle 27, Volume 10, page 346) (A34187812 – QUEH Oversight Board – QEUH IPC and Governance Subgroup meeting Presentation – 17 December 2020 – Bundle 27, Volume 10, page 172) (A34187812 – QEUH IPCG Sub Group.pptx Draft Presentation.pptx Version 9 – Bundle 27, Volume 10, page 174)**

15. Please discuss the proposed improvements to GGC IPC e.g. provide a summary of the proposals, the intention behind them, who was responsible for implementation, have the proposals been implemented, how effective have they been, what is outstanding?

A. This report describes an update to the IPC and Governance Subgroup of the QEUH Oversight Board. This report was not titled GGC IPC improvements but provides an outline of my approach to understanding the current system, listening to the current context and aspirations of the colleagues in the system, applying my experience in delivering the Interim Director of Infection Prevention and Control role. The update follows the discovery and immediate assessment of this new system including internal and external stakeholder experiences and the findings of a Strengths, Weaknesses, Opportunities and Threats (SWOT) and Political, Economic, Sociological, Technological, Legal, and Environmental. (PESTLE) analysis to guide the focus of my interim role. The update shares the key areas and actions designed to enable IPC colleagues to move forward from the current context. The report touches on the exceptional situation that GGC IPC and wider colleagues were facing at a level of intensity that I had never encountered so far in my career. The intentions of my approach were to immediately support all colleagues equally, through my additional capacity, stabilise and take some of the unacceptable challenge, scrutiny and continual judgement from colleagues to allow them to focus on their roles unhindered and with non-negotiable respect. Furthermore,

the intention was to create the conditions, working with GGC IPC colleagues and wider teams, to plan a future state that they would wish for their patients, services and fellow colleagues.

16. What can you tell us about the Action Plans for the Paediatric Intensive Care Unit (PICU) and Infection Prevention and Control (IPC) dated May 2020? e.g.

(a) What do the Action Plans involve?

A. The Action plan had several components. I have added below who was responsible for each action:

NHSGGC confirm the validation results for the singe bed wards in PICU.- D.Conner/H Brown.

NHSGGC Consider options for increasing the dilution ventilation rate in the transitional corridors. - D.Conner/A Gallagher.

NHSGGC should assess any risk to patients as a result of keeping the solution as is currently implemented.

NHSGGC undertake annual validation/verification checks on all ventilation systems within PICU as per SHTM 03-01 should be recorded and noted on the corporate risk register together with appropriate mitigations in place - A.Gallacher.

IPCT should continuously monitor alert organism in line with appendix 13 NIPCM within this area – S.Devine/J.Redfern. **(A42378956 - NIPCM - NHS NSS - Version last updated 4 October 2021 (contains references to a relaunch on 11 July 2022 and the copy being generated on 2 February 2023) - Bundle 27, Volume 4, page 165).**

(b) Who is responsible for implementing them?

A. Please see my response to question (a).

(c) Have the plans been implemented in full? If not, why not?

A. The Action Plan/improvement plan was fully implemented. The improvement plan was returned to ARHAI on 30/07/2021 by email response sent on 30/07/21 (**A50589594 - Email Chain from Sandra Devine to Laura Imrie and others re PICU Improvement Plan - 29 July 2021 - Bundle 27, Volume 14, Page 55**) as follows: "I will update Chief Nursing Officers Directorate that you have shared the improvement plan and that we are content this will address the recommendations". The completed action plan was issued to members of the Board Infection Control Committee in August 2021 and can be found at **(A49690064 - PICU SBAR IMP PLAN UPDATED 300721 FINAL (1) - Bundle 27, Volume 10, page 233)**.

(d) How have the plans advanced since 2020?

A. The plan was completed and actions in place and the routine surveillance reporting continues today.

(e) How effective have the plans been?

A. PICU is and continues to be a challenging environment due to the vulnerability and complexity of the patient cohort. Therefore, PICU continues to be a focus and robustly managed, supported and monitored.

(f) What work remains to be done regarding the Action Plans?

A. Please see my response to questions (d) and (e) above

<u>Queen Elizabeth University Hospital / NHS Greater Glasgow and Clyde Oversight Board</u>

Please see **(A34187835 – Email from Angela Wallace to Philip Raines re Oversight Report - 28 August 2020 - Bundle 14, Volume 3, page 243)**

17. What was your role in relation to the Oversight Board? e.g. Were you a member of the Board? Did you make recommendations? Were you involved in decision making?

A. Prior to my Interim Director of Infection Prevention Control role (DIPC), I was invited to be part of the patient/public experience subgroup. After taking up the post of DIPC I was asked to attend the IPC and Governance subgroup. I was not a formal member of the QEUH oversight board but was asked to attend as part of my new role. I did not make recommendations, nor was I involved in the Oversight Board decision making.

18. To whom did you report and how often?

A. I reported to NHS GGC CEO, I had access to the CEO when required and had regular check ins with her. I also initially met with Prof M. Bain until she demitted her GGC role. I informally checked in with CNO, and SG policy colleagues, with regular meetings with Lesley Shepherd (Professional Nurse Advisor HAI Policy Unit) to establish effective communication. I presented the HAIRT to the board every 2 months.

19. What form did the reporting take?

A. I had one to one meetings with the CEO, who made considerable time for me when required, on site and ad hoc by telephone or Microsoft teams. I attended the Strategic executive group (SEG), the NHS GGC pandemic gold command structures and presented the HAIRT to the board every 2 months, as explained above.

20. What was the intention of the reporting?

A. The reporting allowed me to have access to the CEO at every opportunity to share work progress and update her on progress with regards to the brief given to me upon taking up this interim role and any planned changes. She also sought to understand how I was on an individual pastoral basis given the 2 roles and the complexities facing both organisations.

21. To whom did you owe any duty of care/candour?

A. Although this role was appointed by SG in response to oversight via CNO, I reported to GGC CEO. It was crucial that I maintained an open and inclusive approach and both GGC CEO and the CNO expected that candour.

Greater Glasgow and Clyde Health Board

22. Did you attend any meetings of GGC Board?

A. From the onset of my appointment, I attended NHS GGC Board meeting to present HAIRT.

23. What was your role at the meetings?

A. My role was to present the HAIRT which is mandated by SG and which all Territorial Boards have to report from. This report **(A50590012 - South Glasgow Paediatrics Sector Report - 03 July 2020 - Bundle 27, Volume 14, page 78; A50589610 - IPC Sector Report - Clyde - July to August 2020 - Bundle 27 Volume 14, page 62)** demonstrates individual boards performance with respect to the Scottish government infection indicators. In addition this report contains other IPC activities ongoing across the board including summaries of incidents and outbreaks and the presentation provides assurance and opportunities for NHS board members to test the information contained within it. The NHS board is a public meeting.

Queen Elizabeth University Hospital / NHS Greater Glasgow and Clyde Oversight Board: Final Report (March 2021)

24. Were you involved in preparing the Interim Report or the Final Report of the Oversight Board? If so, what was your involvement?

A. No, I was not involved in this.

25. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of Infection Prevention and Control?

A. Yes.

26. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of Governance and Risk Management?

A. Yes.

27. Have you read the Interim Report and/or Final Report of the Oversight Board and noted its local recommendations in respect of Communications and Engagement?

A. Yes

28. What steps have been taken by GGC to implement each of separate recommendations of the 'Local Recommendations' of the Oversight Board, when they were taken and to what extent does the witness considers the implementation to have been effective?

A. As part of the response to the recommendations, a QEUH/RHC Advice, Assurance & Review Group (AARG) was created to oversee the implementation of corrective actions. The group consisted of senior and executive leadership from Scottish Government and NHS Greater Glasgow & Clyde and met regularly throughout 2021. Corrective actions and subsequent evidence gathering has been ongoing since. Positive communication from Scottish Government has been received in the form of the de-escalation of NHS Greater Glasgow and Clyde from Stage 4 of the NHS Scotland Performance Escalation Framework in 2022. As part of the process to complete the Local Recommendations, each action was assigned an executive lead, along with an operational lead to implement the actions. An audit system was implemented in 2022 and is still currently live in 2024. The executive lead is requested to submit supporting evidence for each action and a review process is undertaken. To support and ensure effectiveness of each implementation, a monitoring audit report is completed with details of the recommendation, actions taken, and changes made. Documentation and other supporting material are also included. A summary of the audited area is recorded and logged with the Chief Executive's business manager. To oversee the effectiveness of this work and as part of robust governance, the progress of the AARG was first reported to the NHSGGC Board in February 2021, with regular updates at board meetings up until 2023. This allowed Board members to scrutinise plans and expected outcomes for assurance that the process would be effective. As part of the Oversight Board Local

Recommendations, all actions were considered for implementation, with evidence available where appropriate. Many of the actions which have taken place have built upon current processes in a continually improving manner. This has included updates to various strategies and published information including the Assurance Framework, the Duty of Candour policy and strategies which focus on risk management and communication and engagement with staff and patients. Infection control structures have also been adjusted and benchmarked against national guidance. This work has been undertaken between 2021 and 2023 and all policies, guidance and SOPs which have been updated have been published and implemented in an effective manner.

29. Can you point us to documentation that confirms your position in respect of whether recommendations have been implemented?

A. All completed action templates and supporting evidence is stored on our dedicated SharePoint site: Oversight and Case Note Review - Action Plan. Oversight and Case Note Review - Action Plan - Documents - All Documents (sharepoint.com) **(A37370185 - ARGG - Master OB Action Plan - Bundle 27, Volume 14, Page 25)**.

30. What recommendations, if any, remain outstanding? If recommendations are outstanding, why?

A. All recommendations of the Oversight Board have now been completed, as of August 2024.

<u>Queen Elizabeth University Hospital: Case Note Review</u>

31. Have you read the Case Note Review and noted its recommendations?

A. Yes

32. What steps have been taken by GGC to implement each of separate recommendations of the Case Note Review, and to what extent do you consider the implementation to have been effective?

A. A range of actions have taken place in terms of the Case Notes Review and all recommendations have been considered for implementation, with supporting evidence, where appropriate. The recommendations of the Case Note Review are subject to the same scrutiny as outlined in the response to the Local Recommendations of the Oversight Board recommendations as outlined in question 27. An executive lead was assigned to each action, with an ongoing audit process in place to monitor progress and changes made. The NHSGGC Board were regularly updated on progress with the opportunity to scrutinise progress for assurance that the actions would be effective. Many of the completed actions have focused on developing current systems as part of regular continuous improvements efforts. This has included enhancements to IT and recording systems, process reviews for some clinical procedures and the expansion of infection control information gathering including audits and benchmarking.

33. Can you point us to documentation that confirms your position in respect of whether recommendations have been implemented?

A. All completed action templates and supporting evidence is stored on our dedicated SharePoint site: Oversight and Case Note Review - Action Plan. Oversight and Case Note Review - Action Plan - Documents - All Documents (sharepoint.com) **(A37370185 - ARGG - Master OB Action Plan - Bundle 27, Volume 14, Page 25)**.

34. What recommendations, if any, remain outstanding? If recommendations are outstanding, why?

A. I refer you to the sharepoint in the above question. As far as I am aware all actions are now complete.

Queen Elizabeth University Hospital Independent Review (June 2020)

35. Have you read the Independent Review and noted its recommendations?

A. Yes

36. What was done to implement the recommendations of the Independent Review?

A. A range of actions have taken place in terms of the Independent Review and all recommendations have been considered for implementation, with supporting evidence, where appropriate. The recommendations of the Case Note Review are subject to the same scrutiny as outlined in the response to the Local Recommendations of the Oversight Board recommendations as outlined in question 27. An executive lead was assigned to each action, with an ongoing audit process in place to monitor progress and changes made. The NHSGGC Board were regularly updated on progress with the opportunity to scrutinise progress for assurance that the actions would be effective.

37. Who led on the implementation?

A. The CEO designed the approach to implementation with a programmed approach to delivering the actions and to achieve timescales. The then Acute services Chief Operating Officer (COO) J. Best presented progress at the Gold Command Better Every day that I attended.

38. What was your involvement in implementation?

A. I was involved in ownership of some areas of action and as part of the oversight internally in GGC, then externally reporting as part of my attendance at the SG Oversight Board.

39. At the BICC on 5 October 2020, please see **(A32812773 - Minutes BICC Meeting – 5 October 2020 - Para 98 - Bundle 13, page 468)** you said there was an Action Plan and a fortnightly meeting to look at the recommendations.

(a) Who attended the fortnightly meetings?

A. I was referring to the Gold Command Better Everyday meetings which were scheduled and Chaired by the CEO, with membership from Acute services COO, Director of Facilities and Estates, Director of South Sector, Interim Director of IPC, Infection Control Manager, Deputy Director of Nursing Acute and Other South Sector Clinical Leaders, Director of Communication and

Public Engagement. Progress against the 3 external reports, including the case note review were shared at these meetings that I attended.

(b) What actions were agreed on?

A. Please refer to Action Plan found at answer to Question (30).

(c) What action was taken?

A. Please refer to documents found at answer to Question (31)

(d) What, if anything, remains outstanding?

A. Please refer to answer to Question (32), in addition the focus of this work continued and became Business as Usual (BAU) following de-escalation from SG NHS Scotland Performance Management Framework.

40. Can you point us to documentation that confirms your position in respect of whether recommendations have been implemented.

A. All completed action templates and supporting evidence is stored on our dedicated SharePoint site: Oversight and Case Note Review - Action Plan. Oversight and Case Note Review - Action Plan - Documents - All Documents (sharepoint.com) **(A37370185 - ARGG - Master OB Action Plan - Bundle 27, Volume 14, Page 25)**, I also refer you to RFI 4.

41. What recommendations, if any, remain outstanding? If recommendations are outstanding, why?

A. I refer you to the SharePoint in my response above, as far as I am aware there are no actions outstanding.

<u>Infection Control in General</u>

42. What is your understanding of what Hospital Acquired Infection is? In your view, what is the distinction, if any, between Hospital Acquired Infection and Healthcare Associated Infection?

A. I refer you to the definition from ARHAI Point prevalence survey the onset of infection must have occurred within one of the following time frames; day 3 of current admission onwards (if day of admission is Day 1); present on

admission (or presenting on day 1 or 2) in patients discharged from hospital (acute or non-acute) in previous 2 days; surgical site infection present on admission (or presenting on day 1 or 2); Clostridium difficile infection (CDI) present on admission (or presenting on day 1 or 2) in patients discharged from hospital (acute or non-acute) in previous 28 days; device-associated infection (pneumonia, urinary tract infection (UTI), bloodstream infection (BSI)) following insertion of device (including day 1 or 2 of admission).

43. To what extent is infection, whether endogenous or arising from the environment (in or out of hospital), always a risk for certain sorts of patient? Is there a limit to what can be done to prevent this? Are there certain sorts of infection that can be expected to arise no matter the level of care taken in relation to IPC/hygiene?

A. As long as patient main defences against infection are compromised due to treatments e.g. chemotherapy antibiotics, steroids, operative procedures, or the use of invasive devices we will continue to have healthcare associated infections. However, we continue to focus unrelentingly on how we can prevent avoidable healthcare associated infections. However, I note that this is a specialist area and I am not a Infection Control Specialist.

Concerns about infection

44. Do you have any specific concerns about amounts, locations, clusters, or types of infection within the hospital from the time of its opening to date?

A. At the time of the hospitals opening I was not yet in post therefore cannot comment on infections within the hospital at this time. I instead refer you to the NHSGGC Positioning paper from April 2023 **(A43708013 - NHS GGC Positioning Paper on Infection, including Appendix 1 - Summary of Patient Safety Indicators by Sandra Devine - 05 April 2023 - Bundle 25, page 345)** and the ARHAI 2019 report **(See A49689613 - HPS Report - Review-of-nhsggc-paediatric-haematooncologydata - Bundle 27, Volume 10, page 350)**.

45. To what extent does the infection experience observed by you differ from what might have been expected by you before the hospital opened?

A. I only came into this unique role in 2020 so I am reliant on the reports commissioned by the Scottish Government specifically in relation to that context e.g. ARHAI 2019 Blood Stream infections **(See A49689613 - HPS Report - Review-of-nhsggc-paediatric-haematooncologydata - Bundle 27, Volume 10, page 350)**. I cannot speculate but would rely on reports from colleagues.

46. Do you have any concerns, or are you aware of any concerns, that patients either have been, or are at, increased risk of infection from exposure to pathogens via the water supply, drainage, or ventilation system?

A. I was not in post at the time therefore I refer you to the NHSGGC Position paper from April 2023. As stated in section C on taking up the role of interim director of IPC I undertook an independent review of how the IPC systems were working. While I am not an IPC specialist, I am a senior leader and directors in NHS Scotland who has been working at board and assurance level for years. As indicated in my answers to specific incidents within my time in the post I had oversight and close contact as the IPCT led and managed these incidents with their fellow clinicians. From the outset of my time working with NHSGGC and continuing today my colleagues at all levels are extremely aware that the environment could be a source. I believe that there is a heightened awareness, but this is in the context of a rigorous process whereby each and all hypotheses are tested to ensure appropriate actions are taken and that there is oversight in terms of reporting and actions taken for assurance. The performance of GGC as a system is demonstrated in the performance indicators in the HAIRT which shows an improving picture in recent times, and this is within the context of caring for some of the most vulnerable groups in healthcare.

During my time in post, which included the global pandemic, I have the opportunity to view many and varied reports from different sources and apart from the two cases documented from 2016 and 2019 I do not believe that the environment in QEUH/RHC poses an increased risk to patients. As I have

indicated throughout my statement this is a dynamic system and we continue to ensure that IPC is a key priority and that we continue to respond to any incidents or events and learn from these and create an ambitious agenda for IPC in NHSGGC.

Infection Control at QEUH/RHC

47. On taking up your role, how was infection within the QEUH/RHC:

(a) Monitored

A. Since 2012 an electronic patient management system (ICNet) has been used in NHSGGC. This system links information from hospital systems, e.g. Virology including Lighthouse labs, microbiology, theatres and TrakCare. This ensures that results are received in real time (every 15 minutes) by the teams who in turn can act upon this promptly. A full record of the patients' diagnosis and management is included in the system which facilitates documentation audit. The system allows IPCT SMT to view the records of any patient referred via this system in any hospital across the board. ICNet (IPC surveillance software) links directly with the NHSGGC Microbiology & Virology labs.

All patients with alert organisms or conditions (AO/AC) are referred to the Infection prevention and Control Teams directly from the laboratories. These AO/AC are generally microorganisms/infections which could potentially cause harm to others, e.g. Tuberculosis, meningitis or that have the potential to be a risk to the wider public health, e.g. multi-resistant organisms (MRSA). They are referred specifically, so that additional precautions can be implemented (Transmission Based Precautions).

Patients with AO/AC are visited by an infection prevention and control nurse, who explains the condition and the precautions necessary to prevent spread, e.g. the requirement for isolation. Ward staff are given care plans or check list with the precautions required to prevent spread and they are asked to review this daily.

Triggers are in place and again are an automated process defined by ICDs but are normally two cases of the same organism in the same place in a defined timescale. This ‘triggers’ an additional review.

Statistical Process Control Charts are also used for some types of infections and this demonstrates trends over time.

(b) Investigated

A. NHS Greater Glasgow and Clyde has an Incident Management Process Framework which describes in more detail how incidents and outbreaks are managed within hospitals in GGC. This framework is informed by the following documents:

Chapter 3 HPS National Infection Prevention and Control Manual http://www.nipcm.hps.scot.nhs.uk/chapter-3-healthcare-infection-incidents-outbreaks-and-data-exceedance/Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led Incident Management Teams. **(A42378956 – National National Infection Prevention and Control Manual - NIPCM - NHS NSS - Version last updated 4 October 2021 (contains references to a relaunch on 11 July 2022 and the copy being generated on 2 February 2023) Bundle 27, Volume 4, page 165)**

Scottish Health Protection Network. Scottish Guidance No12.1 (2020 edition **(A32812772 - Management of Public Health Incidents: Guidance on the Roles and Responsibilities of NHS Led IMTs SHPN – Scottish Guidance No 12.1 Interim update 2020 – Bundle 27, Volume 14, page 88)**

(c) Reacted to

A. Actions plans are included where appropriate in the papers for the IMT minutes. Actions taken are included in the Hot Debrief tool which is circulated to the IPC governance groups if the chair of the IMT has indicated that this is required. There may be occasions when this may not be done, e.g. during COVID when the actions and lessons were in the main the same over multiple IMT process.

(d) Reported, both internally and externally?

A. The Healthcare Associated Infection Reporting Template is a national reporting tool and is a Scottish Government (SG) template. Currently it goes as a full report to the AICC, PICSG, BICC, Board Clinical Governance Forum (BCGF) and the Clinical and Care Governance Committee (CCGC). A Summary of the Healthcare Associated Infection Reporting Template goes to the NHS GGC Board Meeting. The Healthcare Associated Infection Reporting Template includes a summary of any incidents which score red or amber using the Healthcare Infection Incident Assessment. There is a weekly report which is issued to the Board Executive Directors and the Service Directors. This is a contemporaneous report and includes information on current incidents or outbreaks (amber and red). All incidents/outbreak are reported to HPS via an online reporting template regardless of the HIIAT assessment.

48. What were your views on the effectiveness of the processes in place?

A. I reviewed NHS GGC processes as part of on boarding, moreover within 5 weeks we were in a global pandemic. I observed closely NHS GGC responding to the impact of Covid-19 across almost 500 wards therefore seeing the system respond at scale. Performance against the national infection targets were strong and improving across NHS GGC and sitting well against the performance of the other Health Boards across Scotland and this continues to improve. This performance, the response to incidents and the delivery progress against the objectives within the IPC annual plan was monitored through the Board Infection Control Committee (BICC) Care and Clinical Governance and onward to the NHS Board via the HAIRT.

49. Did you have any general concerns about the accuracy of reporting?

A. I did not have concerns about the accuracy of the reporting but do acknowledge that this is a large and complex board.

50. Did you have concerns about accuracy of reporting after allegations of inaccuracy were raised with you?

A. It is correct to say that the April HAIRT had reported two cases. This reflected a point in time as this was an ongoing process with IMT in place at the time. There was reporting to ARHAI onward to Scottish Government.

51. Please see **(A46157883 – Email chain from C Peters to J Copeland - LW Enterobacter aerogenes - 28 April 2020 to 02 June 2020 – Bundle 14, Volume 3, page 75).** Dr Peters contacted you on 5 May 2020 to highlight an inaccuracy in reporting an ongoing Enterobacter outbreak in the ITU to the Board as involving two patients when three patients had died and a fourth was very unwell.

A. It is correct to say that the April HAIRT reported two cases. This was an ongoing process with IMT in place and reporting to ARHAI onward to Scottish government. Queen Elizabeth University Hospital- Critical Care Unit (ITU COVID HUB). Two patients with Enterobacter aerogenes isolated from blood cultures in a two day period. HIIAT asses as amber on 17/04/20 then as green on the 20/04/2020.Two patients both Covid-19 positive were nursed in CCU in QEUH and had positive blood cultures with Enterobacter aerogenes within 48 hours of each other. One patient sadly passed away. Enterobacter was not listed as either a primary or contributory factor in this patient's death. Both isolates will be sent for typing when the national reference laboratory resumes service. This incident was assessed as green on 20/04 and closed however one of the actions was to monitor the unit for a further 14 days from the last case on the 12/4. On the 29/4 two new cases were reported to IPCT, the incident was assessed again and scored AMBER, ARHAI and Scottish Government were updated accordingly on the 30/4. There was an IMT on 7/5 where the incident was scored as GREEN and closed. In the May HAIRT there was an update on this incident as cases were occurring at the end of April into May after the first incident had been closed then re-opened (there had been no new cases for 14 days). The May update in the HAIRT as follows: Update – QEUH: ITU Enterobacter aerogenes – Four cases of HAI Enterobacter aerogenes were identified in ITU in QEUH. Two patients had the organism isolated from blood cultures the other two cases were from a line tip and/or a sputum, HIIAT identified. Two patients sadly passed away and Enterobacter did not contribute to this; the other two patients recovered.

Typing confirmed that all were the same type. An IMT met and actions were put in place. There have been no new cases since the 29th of April. **(A32812772 – HAIRT – FINAL – May 2020 – Bundle 27, Volume 14, page 214)**

This demonstrates that the local team were aware of the issues and already following due process, this was not prompted by these communications from Dr C.Peters but was already in place.

52. Please see **(A46157886 - Email from C Peters to A Wallace and others re IPC Sector Reports CONFIDENTIAL - 18 September 2020 - Bundle 14, Volume 3, page 277)**. Dr Peters wrote to you in confidence regarding concerns that the IPC Sector Report was not fully reflective of the current situation at QEUH/RHC.

A. This email was sent to me several months after the event along with the conclusions of the IMT process. Given the level of concerns from some colleagues I had ensured that ARHAI colleagues were in attendance and fully supported the process, which I had been briefed on. The sector report referred to was from 3rd of July 2020 when this process was ongoing. **(A50590012 – South Glasgow Paediatrics Sector Report – 03 July 2020 – Bundle 27, Volume 14, page 78).** The IMT was held on the 2nd of July so the sector report should be viewed in that context. **(A41890578 – 02.07.2020 – IMT Minutes Ward 6A – Bundle 1, page 431).** Again, given the level of interest and questions being raised I ensured that Dr Peters was invited to the IMT, but she was not able to attend.

The Sector report stated;
'IMT 02.07.20" HPS in attendance.
HIIORT sent to HPS.
Weak positive Cryptococcus result isolated from plasma.
CSF Cryptococcus antigen reported as negative (29/6).

Samples have been sent to Bristol Mycology reference lab for further testing.

The Family have been informed of result by clinical staff.

Clinical team will provide an update for the ward staff. Plant rooms will be inspected by microbiologist.

There is no change to current antifungal prophylaxis regime, IMT will reconvene when results from Bristol are available.

This was an accurate report of the position after the IMT had met with further investigation by the Reference laboratory required. On 7/7 the clinical expert from the reference lab was that “I do not think based on this evidence that full scale look for environmental sources is warranted at this stage. I cannot be definitive that these represent false positives although it is likely and they are less than proof of infection” **(A48304896 - Email re lab results - 13 July 2020 - Bundle 20, Document 98, page 2094)**. This was not evidence of inaccurate reporting. It was a summary based on the findings of the IMT. It would not be normal practice to list all microbiology reporting during incidents in what is a weekend handover document. With regard to the information to parents Dr Sastry’s was also included into the papers as was Dr Peters. Dr Sastry asked that his comments should be inserted into the minute even though he was not in attendance and this was done. ARHAI were sent the final conclusion of the IMT. The chair Professor Leonard approved the minute was a true reflection of the discussion held at the meeting. ARHAI colleagues were also included in this circulation and would have had oversight.

53. Please see **(A46157881 - Email chain from A Wallace to C Peters - IPC Sector Reports - 03 July 2020 to 06 July 2020 - Bundle 14, Volume 3, page 179)**, regarding an allegation that IMT minutes were inaccurate. Also at paragraphs 110 and 111.

A. Please see my response to the previous question (B).

54. What steps did you take to understand the issues of inaccuracy raised, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues? How effective was the action?

A. I understood that Dr Peters did not agree with the contents of the minutes and conclusions of the IMT, however, as previously stated I was determined to ensure I could have the benefit of all colleagues input. Therefore, I wanted to ensure that Dr Peters had the opportunity to attend the IMT but as previously shared she was unable to. I was not in attendance but can confirm that IMT process is a multidisciplinary independent process which is documented. These are all agreed by the team managing the incident. It would be inappropriate for me to try and influence this process however I can ensure that the correct representation is included and I was satisfied that this was the case.

55. What did you do to find out, and understand, the challenges being faced by the IPCT?

A. In my role as Interim Director of Infection Prevention and Control I spent time with and was in constant contact with the Infection Control Manger, given the part time basis of my role I used the 2-3 long days a week to be present in GGC and at other times I was in contact via Microsoft teams and telephone calls. I spent significant time understanding the details of the situation and confirming the approach. These conversations were often followed up in writing and through written briefs that the IPC team would furnish me with. I also refer you to the discovery process of the 5 stage OD plan **(See A49690612 - GGC Discovery Presentation - Bundle 27, Volume 10, page 235)** which captured the significant challenges faced to support all colleagues.

56. Did you discuss the challenges with staff and IPCT? What form did the discussions take?

A. See the answer to question (50) and in addition I also had regular meetings, and was involved in different workstreams e.g Silver Command, BICC and IMT'S.

57. What did you learn from the discussions?

A. I learned that it was a complex case that required intervention from the multi-disciplinary team and external experts.

58. What do you think had been learned from the infection and bacteraemia outbreaks?

A. That reporting was robust and there was learning for all of Scotland.

59. How was the learning, if any, put into practice? By whom?

A. An action plan was created by ARHAI and they are still developing systems regarding surveillance of Gram Neg Environmental organisms.

60. What measures were put in place?

A. Additional systems that are not in place anywhere else in Scotland are used in the PICU, NICU and Ward 2A. These were based on ARHAI data methods applied to 2A.

61. Did the measures achieve what it was hoped they would achieve?

A. The aim for the measures is always reduction.

The Water Supply in General

62. With reference to dates and locations within QEUH/RHC, please answer the following: What concerns do you have about the water supply since January 2015?

A. I was not in post in the period before 2020, however since my appointment to NHSGGC I was aware that there was a constant focus on understanding the historic and current water system in QEUH and RHC. Please refer to the NHSGGC position paper from the 5th of April 2023 **(A43708013 – NHS GGC Positioning Paper on Infection, including Appendix 1 - Summary of Patient Safety Indicators by Sandra Devine - 05 April 2023 - Bundle 25, page 345)**

(a) Were you aware of concerns, and did you have your own concerns? What were they?

A. I was aware of the concerns and because of this ensured that in the IPC decision making it was always a key point for consideration. However, the corollary was also a concern as the environment, including water often became contentious with a reliance on expert opinions.

(b) How did the concerns manifest and what promoted them: e.g. instructions not to drink water, closure of rooms, investigations, use of filters etc?

A. I was not in the post at the time when the concerns were initially raised however my understanding since I have come into post is that there were reasonable mitigations in place.

(c) What were the suggested causes?

A. I was not in post at the time, therefore please refer to the ARHAI water report. **(See A49689762 - Nov 2018 HPS GGC final water report for SG - Bundle 27, Volume 10, page 278)**

(d) Were you provided with results of tests on the water and drainage? In what capacity?

A. I was not in post at the time, but my understanding was that these results were in the remit of the Board Water Safety Group and Water Technical Group.

63. Impacts from concerns with the water supply:

(a) Do you consider there to have been a risk of infection from the water supply? If so, explain.

A. Water is not sterile so will always require controls; however, I was not in post at this time so cannot comment on these specific concerns. I refer you to the NHSGGC position paper from 5th April 2023. **(See A43708013 - NHS GGC Positioning Paper on Infection, including Appendix 1 - Summary of Patient Safety Indicators by Sandra Devine - 05 April 2023 - Bundle 25, page 345)**

(b) Were there other impacts: e.g. closure of facilities, transfers of patients, restrictions in ability to wash?

A. I was not in post at this time therefore I am unable to comment.

(c) Can you comment on the suggestion from some witnesses that there was greater use of source isolation at times?

A. I was not in post at this time therefore I am unable to comment.

(d) Was there any change in the approach to hygiene and cleaning: e.g. use of deep cleaning?

A. We are always reviewing new technologies we currently use HPV but this is not supported by ARHAI.

(e) Were rooms closed and/or was access to the ward restricted? Where? When?

A. I was not in post at the time therefore cannot comment on the measures put in place.

(f) Did patients require to be admitted or decanted to other wards; did this mean that treatment protocols and facilities would vary from what patients ought to have received?

A. I was not in post at the time therefore cannot comment on the measures put in place.

(g) What were the impacts on staff and on patients overall?

A. I was not in post at this time, however since coming into post and hearing patients, families and colleagues experiences I am aware that there were concerns raised by all.

64. Remedial measures:

(a) Are you aware of remedial measures being taken: e.g. room closure and cleaning; ward closure; investigative and remedial works? What were these and when were they taken?

A. I was not in post at this time therefore not aware of the remedial actions taken.

(b) What is your understanding of whether any issues with the water system (including drainage) have been resolved; are you satisfied with this or do you still have concerns?

A. I was not in post at this time, although since taking up post my understanding is that Chlorine Dioxide plan was in place and point of use filters although there is a process to remove these.

The Ventilation System

65. With reference to dates and locations within QEUH/RHC, please answer the following: What concerns do you have about the ventilation system since January 2015:

(a) Were you aware of concerns, and did you have your own concerns? What were they?

A. I was not in post until 2020, I do not have the expertise to answer questions re ventilation.

(b) How did the concerns manifest/what promoted them: e.g. closure of rooms, investigations, use of mobile HEPA filters etc?

A. I was not in post at this time therefore please refer to IMT Minutes regarding the Cryptococcus cases in 2019.

(c) What were the suggested causes?

A. Please refer to my above responses to question (A) and (B)

66. Were you aware of any particular features of the ventilation system as follows, in particular wards? If so, when and how did you become aware, and in which wards were the features?

(a) Presence of HEPA Filters

A. I was not in post at the time but I am now aware that additional mobile HEPA filters were deployed and that in wards 6A, 4c and 4b HEPA filters were installed in the en-suite shower rooms from IMT.

(b) Air Changes Per Hour (ACH)

A. I was not in post at this time but I understand that the ACH are 2.5 but should be 6.

(c) Air Pressure Differentials

A. I do not have the professional expertise to comment on vents.

(d) Air pressure monitoring systems

A. I do not have the professional expertise to comment on vents.

(e) Ward temperature issues

A. I was not aware of ward temperature issues.

(f) Room ceilings, particularly in isolation rooms

A. I was not in post at the time that this was an issue.

(g) Rooms seals for pressure retention

A. I was not in post at the time of this issue.

(h) PPVL issues with rooms

A. I was not in post at the time of this issue.

(i) Thermal wheels

A. I was not in post at the time of this issue.

(j) The use of chilled beams in general

A. I was not in post at the time of this issue.

(k) Chilled beams, usage in rooms designed for immunocompromised patients and leakage.

A. I was not in post at the time of this issue.

(l) Any other particular features.

A. I was not in post at time of this issue.

67. Was there ever a time when you could not find out the particular features of a room or ward in the hospital that you needed to understand as part of your duties?

A. No, if I had an issue I could reference Prof Tom Steele as an expert.

68. Impacts from concerns with the ventilation system:

(a) Do you consider there to have been a risk of infection from the ventilation system? If so, please explain.

A. I do not have the professional expertise to comment on ventilation, please refer to the experts.

(b) Were there other impacts caused by the ventilation system: e.g. closure of facilities, transfer of patients?

A. I was not in post at the time therefore, please refer to IMT mins for full details.

(c) Can you comment on the suggestion from some witnesses that there was greater use of source isolation at times?

A. No, isolation is used at the point of need/assessment.

(d) Was there any change in the approach to hygiene and cleaning: e.g. use of deep cleaning?

A. I was not in post at the time, but I am now aware from IMT mins that there was a Deep cleaning standard practice using HPV but there is limited evidence to support the use of this.

(e) Were rooms closed and/or was access to the ward restricted? Where? When?

A. I was not at post at the time, therefore I am unaware which wards were closed and when.

(f) Did patients require to be admitted or decanted to other wards; did this mean that treatment protocols and facilities would vary from what patients ought to have received?

A. I was not in post at the time, therefore unable to comment on this.

(g) What were the impacts on staff and on patients overall?

A. I was not in post at the time, however since taking up my role I have become aware that throughout this time there were many concerns raised by patients and staff.

69. Remedial measures:

(a) Are you aware of remedial measures being taken: e.g. room closure and cleaning; ward closure; investigative and remedial works? What were these and when were they taken into?

A. I was not in the post at the time when this occurred, therefore I had no involvement in remedial measures.

70. What is your understanding of whether any issues with the ventilation system have been resolved; are you satisfied with this or do you still have concerns?

A. I was involved in the risk assessment process in support and approval to re-open Ward 2AB in March 2022. This decision involved a range of internal and external colleagues including with full support from ARHAI and NHS Assure.

Healthcare Associated Infection Reporting Template (HAIRT)

71. Please explain your involvement with HAIRT in your role as Interim Operational Director for IPC e.g. completion, reporting.

A. As part of the work on taking up post working with the ICM we refreshed our approach to the HAIRT benchmarking with other NHS Boards approaches and responding to our current context. This report is developed by the IPCT with the ICM leading and drawing the information together for the report in preparation for its onward travel through key governance groups to the NHS Board every 2 months thus at every Board meeting.

Incident Management Team from 2020

72. Please describe the culture at IMTs on your taking up your role, and any developments from 2020.

A. I found the IMTs well attended by IPC and the appropriate multi-disciplinary clinical leaders from the area required, as well as by senior manager colleagues from the service that they were responsible for, communications team members and any other corporate functions required such as Occupational Health as an example. It was a respectful, challenging space to ensure the correct actions were taken whilst understanding the impacts of the incident on the safe flow of patients across the system. In addition, I always where appropriate included ARHAI colleagues to further provide challenge and participate in the IMT process.

73. What happened when there was a difference of opinion amongst the IMT? Was there a process in place? How effective was the process, if any?

A. I refer you to the Greater Glasgow and Clyde Outbreak and Incident Management Plan which includes the following section: “Should any member

of the IMT be unhappy with the way the team is functioning, they are encouraged to raise this with the group or with the IMT chair in private. If their concerns cannot be resolved satisfactorily they are free to raise them with their senior manager who in turn can raise it with the chief executive of their agency. That chief executive has the option of raising it with the chief executive of the NHS Board leading the investigation who will ultimately bring it to the attention of the chair via their DPH, involving the relevant counterparts of any other agency involved in the dispute. The lead officer for the NHS Board is responsible for resolving these issues, preferably within the framework of the multi-agency IMT. **(A42362014 - Greater Glasgow and Clyde Outbreak and Incident Management Plan - February 2020 - Bundle 27, Volume 9, page 103)**

74. Where there was a difference of opinion, did NHS GGC consider instructing e.g. external peer review or a round table discussion including experts? If not, why not?

A. My understanding is that this was considered prior to me taking up post, around the time of the change of chair in the long running IMT, by the water technical group which was in place and had external experts on it, it was decided it was not required. In my time in post and with the continued challenge from some microbiology colleagues internally and playing out externally often to a colleague within SG policy group I considered a further process of a space to foster such an approach. After careful consideration and the potential impacts on the IPCT that I was supporting and who were responding extremely well my assessment was that this would undermine many colleagues and my overarching approach was to continue to improve patient care and experience and support all colleagues where I could equally.

75. What is the process and what steps are taken to end an IMT?

A. There is a multi-disciplinary process red. Actions are agreed and in place and HIAT is deescalated.

76. How do you decide that an incident is over?

A. There is a multidisciplinary decision control in place, with no new patients.

77. How do you assess that there is no longer a significant risk to public health?

A. We are advised by IMT.

78. What circumstances would merit a public statement or statement to interested parties, when an incident is over?

A. Ongoing communications as part of an agenda of the IMT and public statement is considered at every meeting, I also refer to NHS GGC Stakeholder Communication & engagement strategy found at **(A49689996 - nhsggc_board_stakeholder-comms-engagementstrategy – Bundle 27, Volume 10, page 300)**.

79. What, if any, documentation is prepared as a result of the IMT process?

A. There is a HOT (rapid) debrief for shared learning which is included on the BICC agenda for completeness. There is also an option for a full outbreak report, which is included in the incident section of the HAIRT.

80. What, if any, report is prepared as a result of the IMT process?

A. Please see answer to Question 72.

81. Who would prepare the report?

A. The chair of IMT would prepare the report.

82. What process is used to summarise the conclusions, results and lessons learned of each IMT?

A. HOT debrief and this is included in the ARHAI template.

83. What, if any, de-brief meetings take place at the end of the IMT process?

A. Please see my response to question 77 above.

84. How soon after an incident is over should a de-brief meeting take place?

A. A de-briefing should take place as soon as possible after an incident is over, but service pressures must be considered.

85. How do you evaluate how effective the IMT has been for a specific incident?

A. There is no standard methodology to do this however the chair of the IMT especially if there is an indication that there are lessons to be learned across the board will complete a hot debrief document which is shared with the IPCT governance groups and members of the IMT. In addition to this the hot debriefs are now reviewed each year with a thematic analysis completed to identify and actions that require to be taken forward in a more formal process. This year two areas were identified as requiring further exploration; a) assessment on admission for symptoms which may indicate that infection is present b) methods to support the cleaning of near patient equipment. Both of these workstreams are being progressed by the IPC Quality Improvement Network.

86. Who are reports shared with? How is the report communicated within the NHS?

A. The reports follow the NHS Board Governance route: HAIRT to BICC, AICC, PICSS, CCGG, BCCF, NHS BOARD and HOT debriefs to AICC, BICC, PICSG

87. Who, within the organisation is responsible for endorsing the conclusions of the IMT report?

A. Please see answer to Question 79 which demonstrates the governance routes and meetings where the conclusions of the IMT are presented, therefore who endorsed the conclusions of the IMT.

88. What steps are taken by the NHS following the report prepared by the IMT?

A. The report is shared with the Governance Groups that are in place and all incidents are reported to ARHAI for sharing and learning nationally.

89. Who is responsible for preparing any action plan based on the IMT report?

A. The chair is responsible, but this is normally part of the IMT process.

IMT - Gram Negative Bacteraemia in Ward 6A - 16 April 2020

Please see **(A41890585 - 16.04.2020 - IMT minutes Gram Negative Blood Ward 6A - Bundle 1, page 428).**

90. What was your understanding of the issues faced by Ward 6A, which resulted in setting up the IMT?

A. My understanding is that there were two patients with gram bacteraemia within a 2-week period. Both with different organisms i.e. Klebsiella pneumoniae, Enterobacter cloacae. One was healthcare associated and the other was to be hospital acquired.

91. What was your role at the IMT?

A. The IMT as previously stated is an independent process, but I would have received updates at the time and then ensured that this was reported within established governance frameworks. This was HIAT amber so would have required to be included in the HAIRT. This was reported on the 9th of April to ARHAI and the report to ARHAI was updated on the 16th April after the IMT. May 2020 HAIRT report **(A32812772 - HAIRT - FINAL - May 2020 - Bundle 27, Volume 14, Page 193)** noted: Royal Hospital for Children: Ward 6A (QEUH) Paediatric haemato-oncology. Two cases of bacteraemia. HIIAT assessed as Amber 09/04/20 the GREEN on 16/04/20. Two gram negative bacteraemia were reported in a two week period. One was considered to be hospital acquired and the other healthcare associated. As per agreed triggers, an IMT was convened to review the cases. Two different organisms were identified neither of which are considered to be environmental organisms. A number of actions were put in place and the cases were reported as per chapter 3 of the National Infection Prevention and Control Manual to Health Protection Scotland and the Scottish Government. Both Patients were discharged home well and here have been no further cases.

92. When and how did you first learn of the issue of Gram-negative bacteraemia in Ward 6A?

A. I was made aware in a discussion with the ICM. Following this discussion the ICM reached out to SG colleague in the HAI policy unit and I was included by

cc, into an email to colleagues in SG from S Devine on 9 April **(A49966691 - Email from S Devine to A Wallace - Gram Negative Bacteraemia - Ward 6A - Attaching "April 09.04.20", "GNB Timeline Jan - Mar - Arpil2020 (2)", "HIIORT 09.04.20" and "updated-2020_04_09_SPC charts_GNBC_Paed haem-onc" - 09 April 2020 - Bundle 27, Volume 14, Page 4)**. This email included the following:

'Hi Lesley sorry I tried to give you a bell but will try again a while. We had a gram negative bacteraemia reported last night in 6A and this was the second in 2 weeks so triggers an IMT today. I have attached the HIIORT. Updated SPC, enhanced supervision report and time line. The minutes of the IMT will be available on Tuesday. Al was the chair. I'm happy to report to any questions re the situation or information I have sent to you. Both of the children are stable and not giving cause for concern. HIIORT sent to HPS and I have spoken to Susie."

93. What steps did you take to understand the event and what actions were taken?

A. I had multiple discussions with my ICM colleague in relation to this incident and in addition attached to the email above I received a copy of the HIIORT, with the timeline of cases and the results of the enhance supervision audit. The HIIORT included actions taken and proposed by IPCT. **(A40066691 – HIORT 09.04.20 - Bundle 27, Volume 14, Page 8)**

These actions included:

Actions Completed:
Enhanced supervision visit carried out 09.04.20,

Hand Hygiene audit carried out 09.04.20

Route cause analysis has been carried out for both cases,

Parents of both cases have been advised of GNB by clinical staff.

Actions Planned;

Line audit will be carried out by RHC nurse educator

Professor Leonard will check antibiograms for any patterns,

Typing will not be carried out due to suspension of typing by PHE due to COVID,

holding press statement will be prepared,

IMT planned for Thursday 16th April.

94. What were the hypotheses around the source of the issue?

A. The hypothesis was that this was a line related infection.

95. What did you understand was happening with the issue/event?

A. Actions planned as per Question 88.

96. What steps did you take or order to have taken and why?

A. Actions were consistent with what I would have expected.

97. Did these steps achieve what you hoped they would?

A. There were no further cases after the actions were completed.

98. Was this something you would expect to find in a new hospital?

A. There are always risk factors for bacteraemia in immunocompromised patients including the use of steroids and invasive devices. This could have occurred in any hospital and does in my experience. Klebsielle pneumoniae, Enterobacter Cloacae are considered to be organisms that colonise the gut. The use of filters on outlets and regular water testing were in place.

99. A patient's family had suggested the patient's infection was linked to water. At the IMT, it is noted that the family are to be informed that the infection is not water related, how did the IMT come to the conclusion that the infection was not water related?

A. The IMT considered this as NHS GGC had two years of environmental samples (including water and drains) which were reviewed. None had isolated K.pneumonaie one sample from the kitchen on 27/09/29 had been positive for Enterobacter Cloacae, which had been approx. 7 months previously. It was

shared that children did not have access to the kitchen and this child was still in nappies.

100. Knowing what you now know, are you comfortable you did all that could be done?

A. There is always learning but in that context I would say yes.

IMT - Serratia marcescens and Gram-negative bacteraemia in NICU from 2020

Please see
(A41890585 - 16.04.2020 - IMT minutes Serratia marcescens NICU - Bundle 1, page 428)
(A41890046 - 24.05.2021 - IMT minutes Serratia marcescens NICU - Bundle 1, page 474)
(A41890054 - 02.06.2021 - IMT Minutes Serratia marcescens NICU - Bundle 1, page 487)
(A41890053 - 10.06.2021 - IMT minutes Serratia marcescens and Gram Negative Blood RHC NICU - Bundle 1, page 501)

101. What was your understanding of the issues faced by NICU, which resulted in setting up the IMT?

A. The first IMT in relation to this incident was held on the 30th April 2021 discuss a cluster of Serratia marcescens colonisation and blood cultures in Neonatal unit, Maternity. There was also a general increase in gram-negative isolates from patients in this unit. Ultimately this IMT considered cases over a 6 week period with the first case identified 29.03.21 and last case 15.05.21. Total cases were confirmed 8 and 1 possible case. With the exception of 1 blood culture all were colonisation. The majority of isolates were part of a cluster confirmed on typing. From IMT 10/06/21. *3 isolates that are type 20, 3 isolates types are type 20 but have 2 band different compared to the first band 20, 1 isolate with a 3 band different, 1 unique, 1 not typed'

102. What was your role at the IMT?

A. I had oversight as the Interim Director of IPC. This was in relation to the NICU so I am aware of the vulnerability of this patient group.

103. When and how did you first learn of the issue of Serratia marcescens, and then Gram negative bacteraemia in NICU? and in 2022, it was suggested that the source of Serratia in 2022 cases was mothers' breast milk:

A. I cannot recall from memory the exact date that I was informed but I was in constant contact with the ICM and would have been verbally briefed prior too. I was at the first IMT but was briefed verbally at the time of the PAG on the 13th April 2021.

104. What steps did you take to understand these events and what actions were taken?

A. I attended the multidisciplinary IMT with colleagues from IPCT and several consultant neonatologists and colleagues from ARHAI in order to fully appreciate the challenges and complexity of this patient group to assure myself that the actions agreed were appropriate and being led by this team. Control measures put in place included:

Enhanced cleaning of the unit including terminal cleans of affected bays.

SICPS and hand hygiene audits.

HPV attempted but due to high acuity in the ward this was postponed and completed at a later date.

Ventilation check and vent cleaning carried out in conjunction with HPV process, all fell in with verification parameters.

POUF and regular drain cleaning were already in place.

Routine water sampling continued, but further water sampling including TVC and GNB was undertaken. (no evidence of Serratia in any water samples or environmental swabs taken around the sinks).

No out of spec samples from any water samples taken in the unit. Environmental sampling took place over the incident concentrating on frequently touched surfaces, equipment and areas surrounding the sinks.

105. What were the hypotheses around the source of the issue?

A. Serratia cluster suggested an un-identified source in the unit and possible patient to patient environment to patient transmission via staff hands or contaminated equipment.

106. What did you understand was happening with the issue/event?

A. Unit was very busy with high occupancy and acuity. Neonatologist reported that: “this is the largest Neonatal Unit in Scotland and work to a capacity of around 50 beds with approximately 35 intensive care and high dependency care with the remainder being made up of as special care beds. The unit provides additional specialist services for babies around the country including ECMO, cardiac services and cardiac surgery, all neonatal general surgery, ENT surgery and airway surgery. The mix of patients in the unit include patients that get a severity scoring equivalent of patients PICU rather than neonatal units around the country. The workload is extremely intense with a high focus on intensive care and high dependency care. It is multi-disciplinary and works across a lot of specialities across different sites. There has been a long term focus on infection prevention due to the extreme vulnerability of the babies as many are complex babies that are extremely premature and small”. They also reported that “they try to avoid infection in these babies and reduce the incidence of multi resistant organism colonisation and have a programme of regular screening of babies. This involves screening from HDU and ITU babies of endotracheal tube secretions or airway secretions and around wound swabs. This is the only unit in Scotland that does this extensive screening which can lead to an increased number of isolates from babies which triggers scrutiny of any environmental issues in the unit and staff precautions and procedures.” **(A41890048 - 30.04.21 - IMT Minutes Serratia marcescens NICU - Bundle 1, Document 97, page 445)**

107. What steps did you take or order to have taken and why?

A. Please see actions in my response to question 98.

108. Did these steps achieve what you hoped they would?

A. There were no new cases for 26 days so the IMT was stepped down after agreed controls were in place and were effective in preventing additional cases occurring.

109. Was this something you would expect to find in a new hospital?

A. This incident took place in the maternity building not in the new RHC.

110. Knowing what you now know, are you comfortable you did all that could be done?

A. Yes.

Cryptococcus – from 2020

Please see **(A47695221 - Email chain - Tom Steele, Jennifer Rodgers, Angela Wallace and other NHS GGC staff - IMT Ward 6A Draft Notes of Meeting 2 July 2020 - Cryptococcus - 08 July to 13 August 2020 - Bundle 19, page 1412)**

111. What can you tell us about Cryptococcus at QEUH/RHC in 2020? e.g. what was the issue, when did you become aware, what action was taken, was there communication between you and your colleagues, if not, what were the issues giving rise to that?

A. In June 2020, I was made aware of a child receiving care in RHC who through routine screening, due to a temperature had tested positive for Cryptococcus infection. From the various communications occurring in the system, my assessment was that there was a concern and anxiety in relation to a Cryptococcus infection present in the hospital. Establishing how the child was and the impact of this infection on this child, I recall was my first concern and the communication with the family, to ensure openness, clarity and that the parents questions were answered. Then my roles was to ensure that we responded to this swiftly and following the correct processes to fully

investigate this infection and in doing so seek to ensure that all relevant staff were involved.

112. What was your role in relation to the paediatric patient under the care of Dr Sastry, who tested positive for Cryptococcus in July? What issues were raised with you? What actions did you instruct, if any, as a result of the issues raised?

A. My role was to ensure that the IMT process was triggered and to ensure that we were supported by the colleagues from ARHAI in order that the process was transparent and effective, I also ensured that senior NHS GGC leaders were aware and that the Scottish Government colleagues were also fully aware that this was ongoing.

113. What was your role in the events surrounding Cryptococcus e.g. IMTs, communication with staff, patients, and/or media?

A. IMT communications are approved by the IMT. However I would have had oversight of this communication.

114. What were the hypotheses?

A. The IMT on the 2nd of July considered the following hypotheses: - environmental (Community or hospital) – Testing (false positive) – Activation of previous latent infection.**(A41890578 – 02.07.2020 – IMT minutes Ward 6A – Bundle 1, page 431)**

115. What was your view on the causes?

A. The IMT process is a multidisciplinary process which is documented, proposed hypotheses actions to be undertaken and eventual outcome are all included in these. These are all agreed by the team managing the incident. This is an independent process. I was not a member of the IMT so valued the assessment made by clinical colleagues. This view was supported by ARHAI who made no further comments on the conclusion of the process.

116. Can you explain why this case from summer 2020 was not referred to in the work of the Cryptococcus Incident Management Team Expert Advisory Sub-Group and particularly the report produced by Professor Hood in April 2022?

A. Dr Hood was part of the IMT. I can only assume that he agreed with the conclusion of the national reference lab in that this case was “less than proof of infection”.

Please see **(A46157881 - Email chain from A Wallace to C Peters - IPC Sector Reports - 03 July 2020 to 06 July 2020 - Bundle 14, Volume 3, page 179)**

117. A concern was raised that the IMT minutes may not have been accurate, what are your views on that?

A. Dr Peters was not in attendance at the IMT however she was invited to participate. The chair Professor Leonard approved the minute as a true reflection of the discussion held at the meeting after consultation with the wider IMT including colleagues from ARHAI and NES J Copeland.

118. By email on 6 July 2020 at 06:25, you said you would have the IMT minute reviewed. Was the minute reviewed?

A. Yes the minutes were reviewed.

(a) If so, by whom and by what process?

A. The minute was issued on 8/7 by Ann Lang (admin) to the members of the IMT.

(b) What was the finding?

A. Members of the IMT were given the opportunity to comment and minutes would have been updated accordingly.

(c) What happened as the result of the review?

A. The Final minute was issued on 10/07/2020 with an update from the National Reference laboratory and an update on the patient (discharged home).

(d) What action was taken?

A. The Minutes were issued and I had included Jenny Copeland in the minute process to ensure links to Dr. Peters.

(e) Were any changes made because of the review?

A. IMT is an independent process. I ensured that the minutes were circulated for comment and then the final version was also circulated.

Please see **(A46157885 - Email from C Peters to A Wallace re Cryptococcus CONFIDENTIAL - 02 September 2020 to 06 September 2020 - Bundle 14, Volume 3, page 270)** Dr Peters raised eight concerns regarding the Cryptococcus incident.

119. What steps did you take to understand the issues raised by Dr Peters, and what did you understand the issues to be?

A. My understanding of the issue was that she did not agree with the findings of the IMT despite the interpretation of the result by the national reference laboratory.

120. What action was taken, if any, was taken in relation to the issues?

A. I discussed the areas of concern raised by Dr Peters with IPCT, given the difference in opinion in addition to my own independent role and challenge. I ensured colleagues from ARHAI were present and contributed to the process to ensure all staff members were able to contribute equally.

Please see **(A46157888 - Email from C Peters to T Inkster re Cryptococcus - 01 October 2020 - Bundle 14, Volume 3, page 283)** where Dr Inkster raises eight questions regarding Cryptococcus:

121. What steps did you take to understand the issues raised by Dr Inkster, and what did you understand the issues to be? To which patients was Dr Inkster referring?

A. I believe this was in relation to the work to the Cryptococcal Advisory Group and the two patients being reviewed by this group.

(a) What steps did you take to resolve the differences of opinion which had arisen?

A. The Cryptococcal advisory group was ongoing and I was aware that experts from both PH England and ARHAI were on this group and reviewing the evidence.

(b) What action was taken, if any, was taken in relation to the issues?

A. I was aware that there was an established independent process and that a report would be forthcoming.

(c) How effective were the actions taken?

A. The conclusion of the report was that the most likely cause of infection was latency although I am aware that as the process was discussed and explored that if mitigation presented themselves, they were actioned immediately – please refer to the main report for details on these actions.

(d) Did you have any concerns regarding communication with patients, both before and after receiving the email? What were your concerns? What action did you take?

A. I had no concerns around the communication with the patients families.

(e) Did you have any involvement in communication with these patients or their families? If so, please give details.

A. I was responsible for working with colleagues to ensure the families of the two patients received the Dr John Hood report. I communicated via letter offering the chance to receive the report and any further support they may require in July 2022.

(f) How effective were the actions, if any, that were taken?

A. Please see my response to question (d) above.

122. Was the Cryptococcal Advisory Group Report made available to the IMT dealing with the Cryptococcus incident?

A. From memory I am not aware if this was made available. However, several members of this IMT were also members of the CAG including colleagues from ARHAI and the Chair of the Group. The full report was circulated to BICC on 30 October 2023.

123. Was there an incident debrief? If so, please provide details. If not, why not?

A. It was the responsibility of the Chair of the IMT to decide if a hot debrief would be prepared and then to author this. I think it should be noted that this was year 1 of COVID and the significant pressures the IPCT would have been under at that time. Please also note that the decision to complete a Hot Debrief is at the direction of the IMT Chair.

124. How satisfied were you with the management of the Cryptococcus incident in 2020 by NHS GCC?

A. I was in the role of interim director of infection prevention control at the time of this incident, there were, as previously mentioned, concerns from a microbiology colleague in relation to this incident. My responsibility was to ensure that the appropriate processes were triggered and in addition I tried to ensure that we had a wide representation including ARHAI to allow the IMT to fully consider the incident, with the aim of ensuring that NHS GGC and all teams responded appropriately.

(a) What else could have been done?

A. The conclusion supported by the national Reference Laboratory that this was likely to be a false positive and certainly less than proof of infection. They did not recommend any environmental monitoring (although I was aware this was ongoing as a part to the work of the CAG) so no further actions were necessary.

(b) How could matters have been handled differently?

A. From the outset and given this was the first time a cryptococcus infection presented since I came into post, I had hoped that perhaps all colleagues could work together in responding to this case and therefore care of this child. I listened to Dr Peters concerned and ensured that she was invited to the IMT but she declined to attend. The opportunity for all colleagues to hear and listen

to challenges and also having the opportunity to hear any comments and advice from ARHAI in this forum and the results from the Bristol Laboratory could have been extremely positive moving forward.

(c) What concerns, if any, did you have about how matters were dealt with?

A. I have no concerns with regard to how matters were dealt with, however challenges in relation to this incident to ensure that all views were consider whilst maintaining the independent IMT process including ARHAI participation required significant support to manage throughout this incident.

Dr John Hood's Report

Dr John Hood prepared a Report from the Cryptococcus Incident Management Team Expert Advisory Sub-Group, regarding the Cryptococcus infections at QEUH/RHC. Please see **(A39235063 - Report prepared by Cryptococcus IMT Expert Advisory Subgroup dated 5 April 2022 - Bundle 6, page 1115)**

125. Did you read Dr John Hood's report regarding Cryptococcus?

A. Yes.

126. If so, when did you read Dr John Hood's report?

A. I first received Dr John Hood's report by email on the 07/09/20 from the ICM. The report was still in draft form and not yet fully complete at this time.

127. What observations, if any, did you make after reading Dr John Hood's report?

A. I observed that each of the hypotheses were being fully explored.

128. What actions were taken following the Dr John Hood report?

A. I refer you to Dr John Hood's report where all the actions and mitigations are detailed.

129. Are you aware of whether NSS endorsed the findings of Dr John Hood's report?

A. My understanding is that they did not endorse the report in full despite members of ARHAI being present at over 20 meetings of the CAG.

Prevalence of Cryptococcus cases at QEUH/RHC

130. Why do you think there were Cryptococcus infections in non-HIV patients at QEUH/RHC between 2015 to date?

A. I am not an expert in this area, however my reflections on the report from the group would be that the report was evidence based and we may never know the definitive answer. I note the conclusion of the report that this was most probably a latent infection.

131. What are your views about the concerns surrounding the built environment and the Cryptococcus infections at QEUH/RHC?

A. In relation to Cryptococcus, from the information that I have seen, there does not seem to be a link with the built environment established. I note that there has been extensive testing of the hypothesis, including air sampling data, undertaken by the CAG. In my limited understanding I believe this supports the hypothesis that the building was not the source.

132. Is there anything you wish to add about your knowledge of, or involvement with, Cryptococcus cases at QEUH/RHC from 2015 to date, that could be of assistance to the Inquiry?

A. No.

IMT – Gram Negative Bacteraemia in Ward 6A – 5 August 2021

Please see **(A41890404 - 5.08.21 – IMT minutes Gram Negative Blood Ward 6A - Bundle 1, page 512)**

133. What was your role at the IMT?

A. My role was to ensure that the IMT process was triggered and to ensure that we were supported by colleagues from ARHAI in order that the process was transparent and that the Scottish Government colleagues were also fully aware that this was ongoing.

134. When and how did you first learn of the issue of Serratia marcescens and Gram negative bacteraemia in NICU?

A. I was on leave until 3 August. On 4 August I had a meeting with the acting ICM S Devine who would have briefed me then and the IMT was held on 5 August which I attended and I was also included into the ARHAI summary to SG on 6 August.

135. What steps did you take to understand the event and what actions were taken?

A. I attended the multi-disciplinary IMT with colleagues from IPCT and several consultant haemato-oncologists and colleagues from ARHAI in order to fully appreciate the challenges and complexity of this patient group and to assure myself that the actions agreed were appropriate and being led by this team.

136. What were the hypotheses around the source of the issue?

A. Most likely route is endogenous for GNB (x2 gut translocation, x1 via contamination of femoral line from soiled nappy) Contamination of line cannot be ruled out for Gram positive isolate.

137. What did you understand was happening with the issue/event?

A. There were 3 Gram Negative Bacteraemia (GNB) isolates in blood cultures within the haematology/oncology ward 6A, QEUH within the last 30 days. There were also surveillance measure in place: NHSGGC continue to monitor Gram Negative blood cultures associated with Ward 6A. The trigger is set at 2 GNB in a 30 day period. The IMT noted the following; Last Enterobacter cloacae blood culture in Ward 6a>1year, Last Klebsiella pneumoniae blood culture in Ward 6a 23.04.21, Last trigger for 2 GNB blood cultures in a 30 day period for Ward 6a was 20.11.20 (Serratia Marcescens & Klebsiella pneumoniae).

138. What steps did you take or order to have taken and why?

A. Action was taken as decided by the IMT. On this occasion the following actions were undertaken; Environmental sampling carried out in ward 6a 03.08.21 – no GNB isolated. Central Venous Catheter audit carried out 03.08.21-100% (13 out of 13 care plan fully completed) Additional peer Central Venous Catheter audit of line care practice will be carried out. These are carried out routinely. Validation of theatre ventilation (where lines were

inserted was confirmed. 4 weekly enhanced supervision is ongoing, RCA completed for every patient with a positive blood culture, Routine water testing ongoing every 4 weeks – no significant findings, point on use filters remain insitu on all outlets.

139. Did these steps achieve what you hoped they would?

A. IMT 19/08/21 reported no new cases since 29/07/21 HIIAT assessed as Green and the IMT was stood down.

140. Was this something you would expect to find in a new hospital?

A. Hypothesis which was accepted by the IMT including colleagues from ARHAI was that the most likely hypothesis was that these infections were endogenous and not associated with the building.

141. Knowing what you now know, are you comfortable you did all that could be done?

A. There will always be learning but I did all I could, so yes.

<u>Aspergillus– November 2021</u>

Please see **(A48794740 - Email from C Peters to A Wallace - Press Today - 18 November 2021 - Bundle 14, Volume 3, page 337).**

142. What can you tell us about Aspergillus at QEUH/RHC in November 2021? e.g. what was the issue, when did you become aware, what action was taken, was there communication between you and your colleagues, if not, what were the issues giving rise to that?

A. <u>Background</u>

Aspergillus has been included as an alert organism on ICNET since November 2016. There are currently lab sift rules for Aspergillus enabled on ICNET which will generate a patient case to open for Infection Prevention and Control Nurse (IPCN) review. The IPCN would ensure that the ward staff are aware of the result. They would discuss the result with the ICD. The ward would be visited and the result documented in the case notes. The IPCN

would liaise with the nurse in change to ensure there had been no recent water ingress. As all specimens are imported into ICNET directly from Telepath, this means that Microbiology, including Infection Control Doctors, are aware of Aspergillus results and can provide immediate advice to clinicians on the clinical management of their patients. Application of European Organisation for Research and Treatment of Cancer (EORTC) definitions are used to accurately define cases. This is normally a clinical decision made by the patient's consultant. What should also be noted is that the incubation period can range from days to months, there is difficulty to assign the standard hospital acquired definition to this organism. This was not a IPCT referral as there were no positive microbiology results for this patient.

143. What was your role in relation to patient, Andrew Slorance in 2020? What issues were raised with you? What actions did you instruct, if any, as a result of the issues raised?

A. I did not have a direct role in the events surrounding the care of Andrew Slorance. The board instructed a full review of his case, in response to the concerns raised by the family, there were also media queries and subsequent Parliamentary Questions. There was also an external review of his case by NHS Lothian.

144. What was your role in the events surrounding Andrew Slorance?

A. Please see my response to question above (137), I did not have a direct role in the events surrounding the care of Andrew Slorance.

145. What were the hypotheses?

A. As far as I am aware there was no hypothesis were generated as this was a single case without positive microbiology.

146. What was your view on the causes?

A. I would need to refer this question to clinical staff who were looking after this patient however I know that this individual was immunosuppressed.

147. Did any meeting take place with Mrs Slorance? If not, do you know why?

A. As far as I am aware, there was eventually no meeting between Mrs Slorance and the clinical team caring for Mr Slorance.

148. Why did you write to Mrs Slorance, referring her to the NHS GGC complaints service?

A. I wrote to Mrs Slorance on the 30th of August 2022, to offer Mrs Slorance the option of sharing the questions and concerns she had in relation to the care and treatment of her husband, Andrew. By using the NHS Scotland Complaints Handling Procedure (CHP) this would, in the absence of an agreed way forward, allow the organisation and those caring for Mr Slorance the ability to respond to the concerns. This had the intention of providing the answers to the questions Mrs Slorance sought. The NHS CHP is designed to ensure that the organisation responds appropriately, it also allows the ability to support patients, or in this case their families. It requires us to be fair to patients and their loved ones but also fair to our staff. Moreover, the procedure ensures that if patients or their families are not content with our processes or responses the Scottish public ombudsman (SPSO) will externally review these cases. It was in the hope that we may respond to Mrs Slorance concerns that I suggested this approach. I am the executive lead for the CHP in NHS GGC as part of my Board Nurse Director Role.

Prophylactic medication

149. To what extent, if at all, were/are patients in QEUH/RHC prescribed prophylactic medication additionally, as a result of concerns about increased HAIs, the water system (including drainage) and/or the ventilation system?

A. My understanding is that at different points in time Dr Teresa Inkster the Lead ICD recommended the use of prophylactic medication, but I was not in post at the time suggested in the question and please see my response below to Question (a)-(g).

Please identify and describe the medications in question, and is it the case that, in contrast to the general position across UK and Scotland, the following were/are prescribed in QEUH/RHC as a matter of course: Ciprofloxacin, Posaconazole, Ambisome, Caspofungin, Septrin?

A. This question should be referred to the patient's clinicians and colleagues in microbiology IPCT.

(a) What was the reason for the prescription of these medicines?

A. Please see my response to question (a).

(b) Was the prescription of any of these linked to concerns about the environment and if so what concerns?

A. Please see my response to question (a).

(c) Which group of clinicians were responsible in an individual case for the prescription of this medication to patients: i.e. would it be treating haematologists/oncologists or somebody else?

A. Please see my response to question (a).

(d) Are you aware of any general decision being taken regarding whether this additional/different medication ought to be made available to patients; if so which bodies/individuals were involved in that?

A. Please see my response to question (a).

(e) In what way, if at all, did the way in which these treatments were used differ from the standard use of prophylactic medications (i.e. duration of use; dosage etc)

A Please see my response to question (a)

(f) What risks did patients face if they did not receive this medication?

A Please see my response to question (a)

Describe the approach to communication (a) within GGC and the hospital and (b) with patients in respect of the prescribed prophylactic medication discussed above:

(a) Were staff given any guidance or was there any discussion about their use?

A This would be the responsibility of the clinicians who would have prescribed this medication.

(b) Were staff given any guidance or was there discussion about how this matter was to be communicated with patients?

A The normal process is described as above.

(c) What approach was taken to discussing with patients?

A I would need to refer this question to clinical staff caring for these patients and their families.

(d) Are you aware of any withholding of information about the prescription of prophylactic medication or any suggestion or instruction that matters to do with the use of prophylactic medication ought not to be shared with patients?

A No

Ward 4c

150. To what extent are you aware that the ventilation system of Ward 4C does not meet the Scottish Health Technical Memorandum (SHTM 03-01) Ventilation for Healthcare Premises?

A I understand from colleagues that the air change rate in all of the general wards in QEUH is 2.5 rather than the 6 recommended in the SHTM guidance.

(a) When did you first become aware of this?

A I was not in post at this time, and I am unable to recall exactly when I became aware of this.

(b) What changes, if any, are you aware of the hospital management/NHS GGC making to the ward by bringing in additional equipment, when that took place and what equipment was brought in?

A I was not in post at this time

(c) What changes, if any, are you aware of the clinicians running the ward taking to mitigate any risk that would arise from noncompliance with SHTM 03-01?

A I was not in post at this time

(d) Do you consider that the fact that ventilation system of Ward 4C does not comply with SHTM 03-01 gives rise to any increased risk of infections in patients and why have reached that conclusion?

A I do not have the expertise to answer this question

(e) Are you aware of whether any risk assessment (including HAI Scribe) has been carried out by NHS GGC at any time about whether the ventilation system of Ward 4C – to the extent it is not in compliance with SHTM 03-01 – presents and acceptable or unavoidable risk to patients?

A I was not in post at this time

(f) Are you aware of any attempt by the Health and Safety Executive to take enforcement action against NHS GGC in respect of the ventilation system of Ward 4C, what was the basis of that action, what was the response made by NHS GGC and what was the result of any such action by HSE?

A I was not in post at this time.

Communication

Issue and Resolution Log

Please see **(A42252321 - Email from Jenny Copeland to Christine Peters, Teresa Inkster and Angela Wallace re Confidential: Draft docs from today's meeting - 03 March 2020 - 3 March 2020 - Bundle 14, Volume 3, page 63)**

151. Please tell us about the log e.g. what it is or was; what it contains; the intention behind it; who completes it; actions identified as a result; who instructs actions and who carries out actions; effectiveness of the log.

A. The issue and resolution log was my suggestion from the ongoing meetings I had with colleagues who had concerns, Dr Christine Peters and Dr Teresa Inkster. The intention was to capture the issues that colleagues felt were key to their historical concerns. On starting my role, I wanted to ensure that all my colleagues in GGC had the opportunity to share their perspective. On listening to their experience, I felt that colleagues were rooted in the issues from the past few years, I also felt that colleagues were quite disconnected from the organisation and the organisation was and had been moving forward, I was hopeful that some of the issues had progressed, but colleagues were not perhaps up to date with the situation. I further assessed that this approach

would be key to creating new ways of communication and working. Despite considerable effort to answer questions that colleagues sought I do not think that this was effective but important that this was completed as part of the work to build relationships. Please see final issues and resolution log at **(A49689383 - Appendix 9 - 15.1.21 Issue log review meeting Summary of actions.docx - Bundle 27, Volume 10, page 333)**.

152. Is the log still in place? If not, why not?

A. The log is no longer in place; it was completed with written updates by IPC and Estates and Facilities colleagues. The final version of the log was fed back to Dr Christine Peters and Dr Teresa Inkster supported by OD consultant Jenny Copeland, attended by myself and Professor Tom Steele via Microsoft teams meeting on the 15th of January 2021.

153. How effective is/was the log?

A. I think it was important to try and provide as much information to these colleagues as possible. It may have had some value, as many of the issues had been progressed and moved on during this time. However, colleagues continued to share that they were discontented with the past and the present, despite the updates and ongoing wider Organisational Development (OD) work in progress.

Communication between Infection Control and Estates and Facilities
Please see **(A32812576 - Minutes BICC meeting - 15 December 2020 para 110 - Bundle 13, page 477)**

154. You informed BICC that you met with Mary Anne Kane to discuss how to show the connection with Infection Control and Estates and Facilities. You suggested having a report to highlight the key issues, and to have a dedication section on BICC on how Infection Control and Estates and Facilities are working together and to have examples of this.

A. My assessment from taking up my role that the relationships and communication between IPC and estates were effective and positive. In this section I am indicating that on taking over as the chair of BICC in my interim

DIPD role, I wanted to ensure we have a dedicated section on the agenda for estates and facilities.

155. What was your role at the BICC?

A. On taking up my Interim role, I took over as the chair of Board Infection Control Committee.

156. What did you want to show the connection between the teams to be?

A. Strong membership from IPCT, estates and facilities, public health, H+S, occupational health, pharmacy, clinical and managerial colleagues are vital to BICC and working together to ensure IPC system is effective. NHS GGC had also patient public partner representation and this remains in place. This ethos and approach, I further developed in my approach via gold and silver command work, working with estates and facilities director Professor Tom Steele and his team under the banner of safe, clean clinical environments. **(See A49689717 - QUEH IPCG Sub Group.pptx Draft Presentation.pptx Version 9 - Bundle 27, Volume 10, page 205)**.

157. Why is communication between these teams important? e.g. communication of Estates issues within the hospital environment, of infection, and of bacteraemia.

A. Communication, close working relationships and systems/processes and adherence to standards are vital between IPCT and estates and facilities in the effort to prevent and control infection to patients in hospital and clinical settings. The importance of a clean, safe environment for all aspects of healthcare is paramount hence the key relationships required formally and informally. Estates involve IPCT in any build project to ensure IPC is fully embedded into the design and also that any finishes and materials used enable access for maintenance and cleaning. This process has been further strengthened by the requirements of NHS Assure. The cleaning regimes and maintenance of the facilities, will assist in preventing HCAI. The communication between IPC and Estates and Facilities is both proactive and reactive and both of these are paramount to provide safe provision of healthcare facilities.

158. What did you consider were the key issues?

A. On taking up the post, my observations were that there were good relationships between IPCT and Estates and Facilities. This was at strategic and operational levels. I did however understand that the recent history of the build of the QEUH and RHC, the ongoing focus of rectification, the constant external scrutiny including the media attention placed constant focus on these teams. The impact of this I could see added significant additional pressure to their teams. However, I experienced support and responsiveness from the IPC and estates teams at all times and continued to do so across all NHS GGC sites.

159. What were your views on communication between Infection Control and Estates and Facilities?

A. Please see above. I can confirm the communication between IPC and Estates and Facilities to be effective. This was tested and observed to be effective by external scrutiny across visits by NHS HIS.

160. How did the teams communicate?

A. The teams communicated formally and informally.

161. Was a report prepared, as you suggested? If so, what is the report's title? Where, when and to whom was it presented?

A. I suggested the report was developed by Estates and facilities, giving a dedicated a space on the agenda at the Board Infection Control Committee (BICC). The report provided assurance in relation to IPC with any escalations regarding either to be raised at any time and at BICC if required. (See BICC minutes – (**A32812773 - Minutes - BICC Meeting - 05 October 2020 - Bundle 13, page 468**).

162. If a report was not prepared, why not?

A. The report is scheduled on BICC on every agenda.

163. Was a dedication section set up on BICC on how the teams were working together? If not, why not?

A. The rationale of the reports on the BICC was to ensure that BICC had clear focus on cleanliness and the clinical environments. It was not about the relationships between IPC and Estates and Facilities.

164. Could communication between the teams be improved?

A. Communication and ways of working will always require to be in focus and developed but I did not at the time or currently see required improvements.

165. If so, what steps were taken to improve communication?

A. Please see above my response to question (158) above.

166. How effective were the steps?

A. Please see my response to question (158) above.

167. Can you give any examples of the teams working together?

A. The teams regularly meet and work together on committees including: The infection control and the built environment, board water safety group, board ventilation safety group, Board infection control committee and Acute Infection Control Committee. There is also ongoing partnership working in terms of the requirements of the HAISCRIBE.

168. How would you describe communication between the teams now, or at the time your role ceased?

A. In my view, communications between the teams were positive, the constant scrutiny and focus on the QEUH and RHC, was and continues to be a source of additional strain for colleagues. However, I observed and experienced that this experience enhanced the working relationships and effectiveness of their approach, work and communication.

Communication between Infection Control and Microbiology

169. What were your views on communication between Infection Control and Microbiology?

A. Communication between IPC and Microbiology across the north and Clyde sectors were positive, productive and cohesive, working towards quality of care and experience of patients and working well with a range of clinicians and managers in these sectors. Communication between IPC and Microbiology in the south had deteriorated significantly between a small number of microbiologist and IPC team members over time due to the previous and ongoing concerns of some microbiology colleagues in relation to the built environment in the QEUH and RHC. These concerns focused on infection were related to the environment and how a range of GGC colleagues including the IPC team were able to respond and manage services related to QEUH and RHC.

170. How did the teams communicate?

A. The IPC and Microbiology colleagues are required to communicate in a range of ways both informal and formal. Focused around the care of individual patient management plans, working together to provide expert advice in a range of settings and including the management of IP&C in and out of hours via on call systems. There are a range of management meetings within the diagnostics directorate at sector level including the service leads where Microbiology service leads and IPC colleagues collaborated.]

171. Could communication be improved?

A. During my time in GGC building on and developing ways of working including communication has been an ongoing focus, although the relationships with some colleagues as stated in my answer to Question 161 remains challenging and is a continued source of tension and concern. This challenge from a small number of microbiology colleagues can cause significant system disruption, increased and additional anxiety for IPC as the narrative is that there concerns are not being explored and responded to appropriately. An example

of this can be found at **(A49690229 - Appendix 10 - Email Chain Re Duty of Candour - Bundle 27, Volume 10, page 335)**.

172. If so, what steps were taken to improve communication?

A. On taking up this post and in determination to ensure all GGC colleagues had an approach to develop or reinstate new ways of working. This re-set approach [Clean Slate] was adopted as I met with GGC colleagues including IPC and Microbiology who were central to the OD plan commissioned by the CEO, and key to developing a new brand or tangible change in how we were perceived internally and externally.

173. How effective were the steps?

A. The approach had some successes, please see 5 stage OD plan and gold/silver command work plan **(A49690612 - GGC Discovery Presentation – Bundle 27, Volume 10, page 235)** but the relationships between small number of Microbiology and IPC, including communication remains challenging as described in 163.

174. Were Buzz meetings part of steps to improve communication between the teams?

A. Yes I developed the 'Buzz Meetings" as a key step to supporting or rebuilding communication and ways of working between IPC and Microbiology and the wider clinical IPC community across the system and support of the in the south sector in particular.

(a) Please describe a Buzz meeting e.g. intention behind the meetings, who is present, culture in the meeting, minute taking or recording of discussions, agreeing actions, outcomes, implementation of actions.

A. Key to the Organisational Development work was to support ways of working and re-establishing communication. I also wanted to ensure I had a space and way of hearing all contributions to the work of IPC across NHSGGC. Thus, the silver command work "infection Control is everyone's business" was designed to connect all colleagues across NHSGGC using role clarity and local approaches to improvement and IPC focus. This aspect of the wider approach

was for the key specialities therefore a weekly multi-professional meeting i.e. 'Tuesday Buzz' was developed. The aim was to facilitate cross profession collaboration and build real time ways of colleagues working together. Membership included members of the PICT, Senior Managers within Microbiology and Diagnostics, Clinical Director for Laboratory Medicine, Head of Service (Microbiology) Virology and Microbiology colleagues. This 'buzz' continues currently and is a space where we can share intelligence and mutually assist and support each other. This meeting is not recorded by a minute although it is recorded on teams.

(b) How effective were Buzz meetings?

A. The Buzz meetings were an important step to bring a wide specialty perspective across the clinical IPC area. It was important to create a space that was looking at IPC across the system, and bring colleagues together in new ways and in relationships that had suffered significant loss of trust and respect. Covid-19 happened quickly and the ability for this group to consider, and where required influence the organisation was key. I think it had some positive outcomes however at times the concerns and perspectives from some colleagues continued to dominate the space.

(c) Do Buzz meetings continue at QEUH today, or at the time your role ceased?

A. Buzz meetings continued until I left my role, it was reviewed and evaluated by the colleagues attending and evolved from this work and continues today now called the 2 Microbiology, Infection Control, Virology Teams. NB this was and is a whole system meeting, not confined to QEUH/RHC.

175. How would you describe communication between the teams now, or at the time your role ceased?

A. The communication between IPC and a small number of microbiologists remains challenging and concerning despite continued effort as colleagues provide IPC Service to the organisation whilst often experiencing significant challenges to decision making and criticisms to IPC approaches in respect to the RHC and QEUH.

Communication and infection

176. Please explain your understanding of communication from management to clinical staff regarding infection risk where there had been, or was, a concern about links to the hospital environment.

A. I have not witnessed this scenario described in the question that I can recall.

177. As regards such concerns, please explain your understanding of:

(a) All instruction from management to clinical staff regarding what and how to communicate with patients.

A. I have no example of where management colleagues issued instructions to clinical staff regarding communication with patients.

(b) All communication from management to patients

A. I was involved in my interim role, as GGC colleagues, through the oversight arrangements, were required to share intended communication with SG; some of these communications were with patients and families.

(c) All communication from management to the media

I was involved in my interim role, as GGC colleagues, through the oversight arrangements, were required to share intended communication with SG; some of these communications were in response to the media.

(d) The pre-broadcast advice to staff regarding the BBC Disclosure programme in 2020

A. I cannot recall pre -broadcast advice to staff regarding the BBC Disclosure programme in 2020.

(e) All communication between management and external bodies such as SG, HPS and HFS.

A. I have no examples of these concerns and I did not experience such concerns and in my role positively developed these communication routes with the support of the IPCT and the senior leadership team including the CEO.

Communication and Duty of Candour

178. Please explain the key aspects of the duty to communicate effectively with patients generally.

A. The duty of candour (DOC) means that every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes harm or has the potential to cause harm or distress. The key aspects are: to tell the patient (or where appropriate the patients family, carer or advocate) when something has gone wrong. Apologise to the patient (where appropriate family, carer) Offer an appropriate remedy or support to, if possible, put matters right. Explain fully to the patient and/or family the short and long term effects of what has happened. It is important to distinguish our responsibilities with regards to open communication with is underpinned by the IPC HAI Communications Strategy and the duty to communicate when something has gone wrong.

179. Please explain how the duty to communicate should be approached when it comes to telling patients about an infection; about the possible causes of the infection; about the impact upon health; and upon future treatment.

A. The duty to communicate when it comes to telling the patients about an infection; about the possible causes of an infection; about the impact upon health; and upon future treatment, as described above in question 170, the clinical team members follow the procedure steps above covering the key aspects.

180. Please explain how the duty to communicate should be approached where something has gone wrong during care or treatment.

A. The duty to communicate should be approached with openness and honesty with an apology, plans to rectify (if possible) and ensuring that the patient and/or family understand the information given and their questions are answered and documented.

181. What processes and/or guidance were in place in relation to communication with patients when you took up your role at QEUH/RHC?

A. NHSGGC had implemented the Duty of Candour procedure across the board on taking up my role as required in NHS Scotland.

182. What were your views on the processes and/or guidance, and how effective did you think they were?

A. The Duty of Candour processes were in place and with the work in my role and with the IPC team, I was aware that the procedure was being used. I did not review the effectiveness but was aware if the DOC had been completed by the local team during day-to-day work of IPC.

183. Are you aware of the duty of candour and how would you explain that?

A. Following the statutory duty of candour provisions and the Health and Care (Scotland) Act 2016, the duty of candour regulations became active on the 1st of April 2018 and set out the procedure that the organisations providing health services, care and social work services in Scotland are required by law to follow when there has been unintended or unexpected incidents that result in death or harm (or additional treatment is required to prevent injury that would result in death or harm.

184. Did you have any concerns about staff being asked to withhold information from patients and/or families by senior management? If so, please explain your concerns, any action taken, and the effectiveness of any action.

A. I had no concerns about staff being asked to withhold information from patients and/or families by senior management.

183. The Inquiry is advised that Dr Teresa Inkster did some work around the duty of candour during the time you were in post.

(a) What was proposed by Dr Inkster?

A. Dr Inkster shared with me work she had undertaken on Duty of Candour. I recall that she shared her initial work by email and that this work was before I took up post.

(b) What action was taken, if any, to implement the proposals and how effective was the action?

A. I am not aware of any action taken or if this work was shared with GGC colleagues.

(c) What are your views on the effectiveness of the measures in place now, or at the time your role ceased?

A. Please see my response to question (b).

Whistleblowing at QEUH/RHC

184. Please explain your understanding of the workplace environment and culture at QEUH/RHC on taking up your role.

A. I was made aware by the CNO Fiona McQueen and the CEO Jane Grant that some GGC colleagues had raised concerns as explained in question 9. As I took up post and began to meet and listen to internal GGC colleagues and external colleagues I became quickly aware of the positive workplace environment between a range of colleagues IPC, clinical staff and Management and leadership colleagues. I looked at workplace situations across NHS GGC in relation to Microbiology and IPC and across many areas, I saw examples of excellent care, teamwork and communication and positive relationships, these were often the same colleagues, and the only challenging culture was in QEUH and RHC and could be attributed to the areas where colleagues had raised concerns.

185. Did you have concerns about working relationships and the style of management? What were your concerns, if any?

A. On taking up my role, I remained as the HAI exec lead in NHS FV and within only a few weeks the Covid-19 pandemic began and all NHS Scotland systems moved into the gold command structures to face these unprecedented times. I assessed the style and tone of leadership and relationships akin to any other system including my home board, NHS FV. The behaviours of colleagues who have raised concerns, Dr Peters and Dr Inkster, were however something I had not experienced before despite almost 40 years continuous NHS experience. The overarching desire of all colleagues appeared to be in the service of patient care and provision of quality services. However, as I began to lead in my role,

I began to create new conditions in which colleagues could move forward or reset and the largest part of this was the impact and consequences of the behaviours. The scale of trauma or moral injury I witnessed was significant. The OD plans, including individual coaching appointments and OD support in the Buzz meetings, did not have the impact I had hoped for and Dr Peters continued to challenge IPC decisions regarding the management of infection incidents in QE and RHC. This hampered new ways of working that were tentatively building. Unfortunately the pattern prevails today.

186. What steps did you take to understand whistleblowing and whistleblowing policy at QEUH/RHC?

I was aware of the NHS Scotland new Whistleblowing processes, as the executive lead in my own board in NHS FV. Across NHS Scotland we had shared our developing policies and I was aware of NHS GGC's in this context on taking up post.

187. What was your understanding of whistleblowing and whistleblowing policy at QEUH/RHC?

A. Please refer to Question 178 there was one Whistleblowing policy for NHSGGC I was aware from Microbiology colleagues that there was a whistleblow from some of their fellow Microbiology Colleagues. This was shared as part of my introduction meetings with them, and Prof Marion Bain had shared with me. I was not aware of the details of the whistle blow in relation to QEUH and RHC.

188. How did you see your role in relation to Microbiology and the Infection Control Team? Were you part of the ICT, or did you become part of that team over time? What was explained to the teams about your role, who appointed you, and who did you report to?

A. Although I did not have microbiology in my role remit, from the outset I included microbiology in the OD work and made connections with the senior leaders in the organisation who led and managed microbiology across NHS GGC including the QEUH and RHC. My role was shared across the organisation on appointment, I immediately made connection with the Infection Control Manager (ICM) and the Interim Lead Infection Control Doctor (LICD) I became

part of the CEO's Strategic Executive Group (SEG) and directed the work of ICT with the ICM in the leadership role of the ICT.

189. Did you have any specific remit in relation to whistleblowing and/or whistleblowing policy at QEUH/RHC?

A. I did not have any role in relation to Whistleblowing or Whistleblowing policy in QEUH /RHC.

190. If so, what was your remit and how did you action that? e.g. what changes were introduced? How were staff made aware of changes? Was there written guidance?

A. Not applicable.

191. Did the changes, if any, improve the whistleblowing policy. Do you think the changes would make staff more inclined to disclose concerns, wrongdoing, failures, or inadequacies?

A. Not applicable.

192. How effective were the changes, if any?

A. Not applicable.

193. Please discuss your involvement with Dr Redding, and with her whistleblow e.g. what was your involvement, what interactions took place, what action was agreed on, what action was taken and/or implemented, how effective was the action, what was the outcome of the whistleblow and when did your involvement cease? Please also see paragraph 190 below re review of culture within Infection Control and Microbiology teams.

A. I had no involvement in Dr Redding's whistleblow.

194. Please discuss your involvement with Dr Peters, and with her whistle blow e.g. what was your involvement, what interactions took place, what action was agreed on, what action was taken and/or implemented, how effective was the

action, what was the outcome of the whistleblow and when did your involvement cease?

A. I had no involvement in Dr C.Peters Whistleblow.

195. Please see **(A46157878 – Email from C Peters to A Wallace and others re Current Issues – 19 May 2020 – Bundle 14, Volume 3, page 132)** Dr Peters referred to several issues in this email. What steps did you take to understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. In order to answer this question, I have had to review infection prevention control data at this time. My findings are as follows:

B. 19 May 2020 NICU S. capitis PAG held 13 may with regard to 2 cases of S. capitis. **(A50589881 – PAG Minutes – Staph Capitis -13 May 2020 – Bundle 27, Volume 14, page 86)** Both were considered HAI. A timeline shows that there are no bed space connections between the 2 cases, nevertheless a PAG was held. Last SICPs audit 22.04.20 - 98%. Ward had enhanced twice daily cleaning in place. Update 05/06/20: Antibiograms are different for the two cases. Stenotrophomonas Single transmission event would not meet the definitions proposed by Dr Inkster in 2017 in terms of triggering an escalation. Decontamination Room Considered in the actions in relation to the action plan developed in 2017 in response to clinical concerns by Dr Peters and other. Reported to governance committees throughout NHSGGC. This action was reported as not technically feasible. ITU Enterobacter Please refer to paragraph 37 Surveillance was in place as per the NIPCM during this entire period. Enterobacter was reported to ARHAI as stated and included in the HAIRT twice. MRSA PAG held on 24 April 2020 re two cases of MRSA in critical care. **(A50589872 – PAG Minutes – MRSA – 24 April 2020 – Bundle 27, Volume 14, page 84)** On review 2 patients had MRSA isolated from respiratory tract samples. Both patients had been nursed in Critical Care Unit 4 and crossed over for a period of 25 days. HIIAT green and reported to ARHAI. Pseudomonas - Single case of pseudomonas would have been considered as a single referral without escalation. An ARHAI water safety check list would have been completed and this areas is routinely tested for pseudomonas as it is considered augmented care. PICU Ventilation –

please refer to PICU action plan. **(A49689717 - QUEH IPCG Sub Group.pptx Draft Presentation.pptx Version 9 – Bundle 27, Volume 10, page 205)**.

This data demonstrates the actions taken by the IPC team following due processes and outcomes of the issues raised by Dr Peters. As DIPC, I would have had oversight of these processes and sought assurance that all actions had been taken and reported appropriately.

196. Please see **(A46157894 – Email from C Peters to A Wallace re Meeting – 16 November 2021 – Bundle 14, Volume 3, page 329)** Dr Peters raised issues with you concerning Wards 6A, 4B, and NICU, as well as the culture at meetings. What steps did you take to understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. In November 2021, a Hot debrief was completed for this incident. It was also reported to ARHAI. At the meeting on Sunday night my understanding is that [redacted] asked members of the IMT if this required a HIIAT. The advice given in that this was not in fact an infection incident then the HIIAT in this context was not appropriate. All members of the group agreed with this at the meeting on the Sunday which included a ICD. The concerns of Dr Gibson regarding the HIIAT assessment were noted. S Devine emailed Dr Gibson with the following statement **(A50590093 – Email from Sandra Devine to Brenda Gibson and others re leaks on Level – major incident meeting required – 05 November 2021 - Bundle 27, Volume 14, page 79)** - "We have ensured that both Scottish Government and ARHAI have been informed of this incident and we will continue to monitor any patients who have been in any way impacted. Email is not a perfect way to undertake a HIIAT assessment so please accept my apologies for this, however, the majority of those who responded have agreed with the assessment." 4BAir sampling protocol was agreed and had been in place apart from a brief spell during COVID when it was felt that the risk of having additional personnel in the unit was higher than not sampling the unit. This data demonstrates the actions taken by the IPC team following due processes and outcomes of the issues raised by Dr Peters. As DIPC I would have had sight of the processes in place and in working closely

with the ICM I would have asked for assurance that all actions had been taken and reported appropriately.

197. On 9 October 2020, Dr Peters received an SBAR from you concerning aspergillus in PICU. The SBAR concluded that mould from the leak area could not have caused the patient's infection. Peters disagreed and responded with a list of actions she would expect to be taken given that there was a leak and a known case of aspergillus in a high risk unit. What steps did you take to understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. In order to answer this question. I have had to review the Infection Control archive data for this time. My finding are as follows:

Air sampling protocol was agreed and had been in place apart from a brief spell during COVID when it was felt that the risk of having additional personnel in the unit was higher than not sampling the unit.

ICD (Dr Bal) monitors trends over time and gives advice on actions in this unit if required. He is in communication with the ward staff and they are clear on the actions to be taken and any implications for patient placement. If water leaks occur the Water Damage to Healthcare Environment SOP is in place and implemented. Reported to service and included in monthly clinical review group report in November and December. Full review by IPCT colleagues and Estates team, no evidence mould in the ceiling space on review. Rainwater breeched flat roof membrane. Two simulated rainwater test carried out post repair with no evidence of issues. The updates on this particular issue was contained in the weekly handover report on the 12/11/21.Increase in gram negatives there were two cases reviewed in November. One was a baby who had a blood culture positive for pseudomonas; case note review undertaken and water checklist completed. Single case of Shewanella putrefaciens was reviewed by neonatologists and IPCT as this was an unusual organism. No further cases. This was not in a blood culture but a nasopharyngeal aspiration so possible colonisation.

This evidence demonstrates the actions taken to resolve the issues raised by Dr Peters and the outcomes of this. This data demonstrates the actions taken by the IPC team following due processes and outcomes of the issues raised by

Dr Peters. As DIPC I would have had sight of the processes in place and in working closely with the ICM I would have asked for assurance that all actions had been taken and reported appropriately.

198. Please discuss your involvement with Dr Inkster, and with her whistle blow e.g. what was your involvement, what interactions took place, what action was agreed on, what action was taken and/or implemented, how effective was the action, what was the outcome of the whistleblow, what did you understand to be the reasons for Dr Inkster's resignation, and when did your involvement cease?

A. I had no involvement in Dr T Inksters Whistle blow.

199. Please see **(A38378979 – Email from T Inkster to A Wallace re post-mortem cases for advice and cryptococcus – 30 April 2020 to 05 January 2022– Bundle 14, Volume 3, page 91)** – Dr Inkster referred to Serratia bacteraemia in a child which she thought should be investigated as HAI but was not. What steps did you take to understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. This e mail although sent in April 2020 is in reference to a child admitted to PICU in November 2019. IMT was held on 27 November 2019 where this child's case was discussed with the multidisciplinary team including paediatric intensivists. A summary of case and actions taken as a result of the meeting is found in **(A41890244 – IMT Minutes Gram Negative Ward 1A PICU – Bundle 1, Document 90, page 412)** HIIAT Assessed as AMBER and reported to ARHAI **(A41890244 – IMT Minutes Gram Negative Ward 1A PICU – Bundle 1, Document 90, page 415)**

This summary created from data found in the Infection Prevention Control Archives at this time, demonstrates the actions taken by the team to resolve the issues raised by Dr.Inkster.

200. Please see **(A38378979 – Email from T Inkster to A Wallace re post-mortem cases for advice and cryptococcus – 30 April 2020 to 05 January 2022 – Bundle 14, Volume 3, page 91) –** Dr Inkster expressed concern about management of a patient with Aspergillus. What steps did you take to

understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. Patient with aspergillus [redacted].

E mail alerting me to this was on the 1 September 2020. This would have been referred to IPCT on 30 August 2020. I discussed this with acting ICM and a summary of the case including extracts from e mails from Paediatric Intensivists Dr Spenceley dated 4 September 2020 is found in **(A50590311 – Case Summary – Patient with Aspergillus – 01 September 2020 – Bundle 27 Volume 14 page 81).**

I also, as noted in the email, requested a review of ventilation.

Actions

Case reviewed by IPCT and PICU consultant.

Air sampling carried out 4/9 I bed bay and theatre. No aspergillus identified in air samples.

Deep clean of area.

Single case of colonisation so reporting to ARHAI is not required.

This data demonstrates the actions taken by the infection prevention control team to resolve the issues and outcomes of this process.

201. Please see **(A38378979 – Email from T Inkster to A Wallace re post-mortem cases for advice and cryptococcus – 30 April 2020 to 05 January 2022 – Bundle 14, Volume 3, page 91)** Dr Inkster expressed concern about gentamicin resistant MSSA and difference of opinion between microbiologists. What steps did you take to understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. In order to answer this question I have had to review infection prevention control data archives from this time. My findings are as follows:

Gent Resistant MSSA – September 2020. **(A41890030 – PAG Minutes – NICU - Gentamycin Resistant MSSA – 25 September 2020 - Bundle 27, Volume 14, page 21)**

NB IPCT put controls in immediately and do no wait until the PAG to initiate these (please see below extract from PAG doc). They are often noted in PAG as update on actions then further actions. Please note the PAG was held

before Dr Inkster's e mail to me on the 30/9. Although referencing 2019 these cases would have occurred many months after. There is no surveillance system that reviews cases over this extended time period.
Initially two cases of colonisation on 31/7 and 3/8. This would not meet the threshold for initiating a PAG. Next cases were 31/8 and on this occasion one was a blood culture so this did trigger the PAG. Date of reporting all samples would be at least 48 hours after the sample was taken. PAG 25/09/2020 **(A41890030 – PAG Minutes – NICU – Gentamycin Resistant MSSA – 25 September 2020)**
For context please be aware that IPCT were also managing first waves of COVID during this time.
It was agreed at the PAG that if there was a further colonisation or bacteraemia with a Gentamicin resistant MSSA within a 2 week period, an IMT would be held.
This evidence demonstrates the actions taken to resolve the issues raised by Dr Peters and the outcomes of this.

202. Please see **(A47135247 - Email chain from Teresa Inkster to Christine Peter and Angela Wallace - Re: Gent R Staph aureus - 02 October 2020 to 20 October 2020 - Bundle 14, Volume 3, page 287)** Dr Inkster raised concerns regarding cases of MSSA in patients in NICU. What steps did you take to understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. In order to answer this question I had to review Infection Prevention Control Data archives from this time, my findings are as follows. Please see:
IMT held in relation to above on 5 October 2020. New case 28 September 2021 **(A41890031 - IMT Minutes – Gent Resistant MSSA - 05 October 2020 - Bundle 27, Volume 14, Page 15)**.
This evidence demonstrates the actions taken by the ICP team to resolve the concerns raised by Dr. Inkster and the outcomes of these actions.

203. Please see **(A42253437 – Email chain from T Inkster to A Wallace - Re: Re ESBL NICU - 11 May 2021 to 18 May 2021 – Bundle 14, Volume 3, page 303)** Dr Inkster raised concerns about the range of environmental organisms in

NICU. What steps did you take to understand the issues, and what did you understand the issues to be? What action was taken, if any, was taken in relation to the issues?

A. In order to answer this question I have had to review Infection Prevention Control Data archives from this time and my findings are as follows:

NICU 2021- Please note NICU is in the retained estate and not in RHC.
I was assured that the triggers remained in place and acted upon. SOP re environmental organism was in place at the time and these continues to be used for identifying clusters of different organisms although on reflection and after reading reports commissioned by GGC this may not be based on sound evidence. I also would like to note that to this date there continues to be no national guidance in respect to surveillance of these types of organisms despite the initial incident having occurred over six years ago.

It found that it was difficult to agree to the suggestion that a microbiologist from the South join the IMT as the IPCT indicated to me that they did not feel that they were in a psychologically safe place.

IPCT Carried out the following processes in relation to NICU Jan- May 2021
PAG held 23/04/21 re:3 *Enterobacter cloacae* colonisations in a 2 week period. HIIAT – Green, reported to ARHAI**.(A41890149 – PAG Minute dated 23 April 2021 - Enterobacter cloacae – NICU – Bundle 2, Document 78, page 192)**
PAG 22/01/2021 Gentamicin Resistant MSSA. Single isolate. **(A42001477 – PAG Minutes – NICU -Gentamycin Resistant MSSA – 22 January 2021 – Bundle 27, Volume 14, page 13)**
PAG 12/05/2021 Single HAI *Klebsiella oxytoca* bacteraemia. HIIAT AMBER reported to ARHAI**.(A41890097 – PAG Minute dated 12 May 2021 – HAI bacteraemia Klebsiella Oxytoca – NICU – Bundle 2, Document 79, page 196)**
PAG 15/01/2021 1 baby in NICU has isolated *Klebsiella oxytoca* from a blood culture (HAI NICU). HIIAT Green reported to ARHAI. **(A41890162 – PAG**

Minute dated 15 January 2021 – Gram Negative Klebsiella Oxytoca – NICU – Bundle 2, Document 75, page 186)

PAG then IMT commenced 30 April 2021 cluster of *Serratia marcescens* colonisation and GNBs. HIIAT Amber both myself and ARHAI colleagues in attendance. **(A41890048 – 30.04.2021 – IMT minutes Serratia marcescens NICU – Bundle 1, Document 97, page 445)**

Review of cases NICU E.coli Gentamicin Resistant on 10/05/21 LICD conclusion was **(A50590644 – Email chain re NICU E Coli Gentamicin Resistance (Redacted) – 07 May to 10 May 2021)** "I will have to say that GM resistance monitoring is more useful for microbiology surveillance of resistance patterns to inform appropriate AB management but not for IC purposes, unless you know the reason why would we be concerned about GM resistance in NICU? I will reply to South microbiology concerns once I get all info".

This evidence demonstrates the actions taken by the ICP team to resolve the concerns raised by Dr.Inkster and the outcomes of these actions.

204. What are your views on whistleblowing, and the whistleblowing culture at QEUH/RHC both before your appointment as IDIPC and on taking up your role?

A. Please see answer 180.

<u>Culture within Infection Control and Microbiology teams</u>

205. How would you define 'a supportive safe space' in relation to practice and where would you expect to encounter such a space?

A. I would describe a supportive safe space as the culture as a team working together to be able to focus on providing safe, effective and compassionate care for patients, families and their significant others. That being part of an organisation that we are clear that our roles, objectives and that our peers and other colleagues are kind, respectful and challenge us to improve every day and listen to us if we are unsure on their concerns or worries.

206. A review was carried out concerning the culture within Infection Control and Microbiology teams, and presented to Dr Penelope Redding by you:

(a) When was the review carried out and by whom?

A. This "review" was the discovery phase of the OD plan developed from the commission from CEO Jane Grant. The OD plan and "review" as part of that was led by myself and supported by two professional OD colleagues, one external, Mrs Jenny Copeland and one internal colleague with a background in psychology Dr Terri Hunter.

(b) When did you present the findings to Dr Redding?

A. I included colleagues across GGC including colleagues who had recently left the organisation; Dr Redding recently retired, and I wanted to include her. I presented the feedback to Dr. Redding by telephone call on Monday the 10th of May 2021.

(c) How was the review carried out? e.g. interviews, meetings, in confidence, open discussions?

A. The review had a range of approaches 1:1 interview, team meetings all were, as agreed, in confidence, and this was maintained. Open discussions were not used.

(d) What were the findings?

A. Refer to **(A49690612 - GGC Discovery Presentation – Bundle 27, Volume 10, page 235)** OD 5 stage plan feedback slides.

(e) What concerns were raised? e.g. about processes?

A. It is fair to say that the whole OD process was extremely difficult at times. This was due to the level of concerns, the differing views which remained and the depth of trauma I witnessed and experienced from the staff who were and had been involved in either microbiology or IPC. On the 11th of May 2021, P. Redding followed up from our call by email with concerns that the majority of responses to the OD discovery survey were received from the Infection Prevention Control Team and therefore may not truly represent the current

feelings from the Microbiology team. She also shared that some members of the Microbiology team felt it was too stressful to speak out and share their true opinions and worried how this may impact on patient safety. Terri Hunter and I reassured Penelope that further work had taken place to support both teams since the time of the survey findings, and that the opportunity to take part in this work was equally available to both teams. (**See A49690639 - Email Chain - Angela _ Penelope _ Terri – Bundle 27, Volume 10, page 346**).

(f) What actions were agreed on? What actions were implemented?

A. The actions from this work can be found at **(A49690612 - GGC Discovery Presentation – Bundle 27, Volume 10, page 235)** and formed part of the action plan within the silver command IPC section and monitored by the gold command chaired by the CEO.

(g) How effective were the actions?

A. Please see answer to Question (f).

(h) How would you describe the culture within the teams now, or at the time you ceased secondment?

A. There remains considerable tension between a small number of microbiology colleagues who continue to have concerns and direct these concerns to the IPC often in ways that are unacceptable and lacking in respect. The IPCT have continued their transformation work described early in the approach when I came into post, with a permanent Director of Infection Prevention and Control (DIPC) in place driving the development of the team and building effective internal and external relationships.

Reflections

207. What are your reflections from your time as IDICIP at QEUH/RHC?

A. When I joined NHSGGC, in my role as Interim Director of Infection Prevention and Control, I encountered a situation and context at a level of complexity that I have never experienced in over 40 years of service; indeed, I believe this situation is unlikely to be seen again in NHS Scotland.

In my immediate assessment and, through the discovery phase of my role, I could see that the safety and care of patients and their loved ones was at the core of this unique and complex situation.

However, the approach and impact of the external environment on a system that was focused on acting in response to concerns, and often extremely deep-seated views, added considerable adverse pressure which did not serve the process well. I could not understand some of the motivations I witnessed which seemed to be at odds with seeking the truth and being accountable to the public we served.

This may have hampered the ability to share the emerging information, which could give the family the answers they sought and be part of that process.
Furthermore, I frequently witnessed the external environment, including the Oversight arrangements and in particular the multiple stories in the media and from politicians which claimed to be in support of patients and families, add additional trauma and in some instances potentially, prolong their grief.
Although I could have chosen not to step up and taken on the responsibilities of Directing Infection Prevention and Control, I did so in the hope of supporting everyone involved. My approach was to be lead and seek to engage and build internal and external relationships to move forward.

The ability to ensure the IPC Team had the safety to practice and the support in which to provide the care we were required to deliver across NHS GGC was at the centre of my approach. Despite this focus, I continued to witness and try to manage relentless challenge, as well as a pattern of behaviours, including mistrust that drove a system at times to expend energy and often over-working when efforts should, and must, be focussed on caring for the people we serve today.

As a result, it was one of the most professionally difficult and challenging times that I have experienced. There is no doubt about the detrimental impact this has had on me professionally and personally including my family.

Despite the situation described in my reflections, being asked by SG colleagues to take on this leadership role in GGC and the way the IPC Team and the wider organisation responded to creating a way forward was incredibly rewarding. Furthermore, the support from the CEO and her team and the way they responded to someone who was essentially a colleague out with their system and structures at the most difficult times for NHS GGC was key in my decision to return to NHSGGC as the Executive Nurse Director.

I have provided my reflections and information based on my recollection of my time in NHSGGC and referred to the documents provided by the Scottish Hospitals Inquiry and on reviewing documents some of which were before my time in role in NHS GGC. In my interim role and now my substantive role I have seen and been part of the Board's continued focus on finding the answers to the questions of patients and their families and the wealth of external reports commissioned and prepared for consideration of the SHI.

208. Is there anything further that you would like to add, which might be of assistance to the Inquiry?

A. From the time I have been in the Interim Director of Infection Prevention and Control role and my current post as Executive Nurse Director in NHS GGC there has been a continuous approach to learning from the events and searching for the reasons of concerns arising from the QEUH and RHC. As part of the submissions in support of the remit of the Public Inquiry it is incumbent on me to point to the information contained within the multiple reports developed which I believe will be of assistance to the inquiry and to the families who seek answers to their questions.

Declaration

209. I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

210. The witness was provided the following Scottish Hospital Inquiry documents for reference when they completed their questionnaire statement.

Appendix A

A42909010 - Bundle of documents for the Oral hearing commencing 12 June 2023 - Bundle 1 - Incident Management Team Meeting Minutes (IMT Minutes)
A43144409 - Bundle of documents for the Oral hearing commencing 12 June 2023 – Bundle 2 – Problem Assessment Group Meeting Minutes (PAG Minutes)
A43293438 – Hearing Commencing 12 June 2023 – Bundle 6 – Miscellaneous documents
A32812773 – Hearing Commencing 19 August 2024 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc)
A49384241 - Hearing Commencing 19 August 2024 - Bundle 14 - Further Communications - Volume 1
A49529391 – Hearing Commencing 19 August 2024 - Bundle 14 - Further Communications - Volume 3
A48408984 - Hearing Commencing 19 August 2024 - Bundle 19 - Documents referred to in the Quantitative and Qualitative Infection Link expert reports of Sid Mookerjee, Sara Mumford and Linda Dempster
A50066716 - Hearing Commencing 19 August 2024 – Bundle 20 – Documents referred to in the Expert Reports by Andrew Poplett and Allan Bennett
A49553951 - Hearing Commencing 19 August 2024 - Bundle 25 - Case Note Review Expert Panel, Additional Reports, and DMA Canyon

211. The witness provided the following documents to the Scottish Hospital Inquiry for reference when they completed their questionnaire statement.

Appendix B

A50258433 - Hearing Commencing 19 August 2024 - Bundle 27 - Miscellaneous Documents - Volume 10
A50597123 - Hearing Commencing 19 August 2024 - Bundle 27 - Miscellaneous Documents - Volume 14

Appendix C

Angela Wallace CV (A49689031)

PROFESSOR ANGELA WALLACE RGN MBA FRCN

Honorary Professor : Faculty of Health, Sciences & Sport : Stirling University
Member of Scotland's Executive Nurse Directors
Fellow of the Royal College of Nursing

EXECUTIVE NURSE DIRECTOR & SENIOR NHS LEADER

Profile

An accomplished, person centred and dynamic senior Executive Director with a proven track record of success. This substantial track record stretches over a 35 years career history which is recognised with increasing levels of professional and strategic responsibility working within Health Boards and across the NHS in Scotland.

With a unique blend of skills and attributes is dedicated to improving care and services for people. That improvement focus is underpinned by workforce performance improvement and leading and sustaining change through leadership. As a motivational and inspirational leader who thrives in highly pressurised, complex and ever changing environments.

Renowned as a 'can do' credible leader and operating as an astute, insightful, strategic thinker and creative solution finder. With the ability to flexibly combine people development, continuous improvement and leadership expertise skills to design, develop, implement and sustain short and long term strategies that improve care, experience, safety and assurance for patients and the public.

Drawing upon significant experience and sustained development within the NHS to deliver transformational change with diverse groups and stakeholders locally and across NHS Scotland. Possessing excellent interpersonal communication and influencing skills plus the ability to develop and maintain positive relationships with new and existing partners.

With substantial leadership competencies which are evidenced through commitment to leading and driving key agendas to achieve significant successes in the pursuit of world class health and social care for those who need our services.

Qualifications

- 1995 to 1998 Masters in Business Administration, Glasgow Caledonian University
- 1989 to 1991 Diploma in Professional Studies, National Board for Scotland

- 1983 to 1986 Registered General Nurse Training, United Kingdom Central Council
- 2008 to present Appointed Honorary Professor, University of Stirling, Faculty of Health Sciences and Sport
- July 2016 Awarded Fellowship of the Royal College of Nursing, United Kingdom

Development

- Coaching Programme – Certified Coaching Course 2021 “Personal Mastery in Coaching and Mentoring”
- Bespoke Leadership Development Programme (NES Funded) Focus on Leading and Challenging in Integrated Spaces
- Executive Patient Safety Officer Programme Institute for Healthcare Improvement (IHI) Harvard, Boston – USA
- Executive Nurse Director Board Development Burdett Trust with Kings Fund
- Executive Leadership Development - Including 360 degree feedback NHSScotland Leadership Qualities Feedback Tool
- Exceed – National Leadership Programme NHSiS & Office for Public Management
- Media Training

Elected

- Chair of Scotland’s Executive Nurse Directors (SEND) 2015 - 2017

Core Competencies

- Setting vision & strategy
- Managing change
- Taking risks & innovating
- Tactical & solution finder
- Building and maintaining relationships
- Developing others
- Valuing diversity
- Continuous improvement

Transferable Skills

- The ability to hit the ground running, working in a way that is confident and open to advice.
- Credible and expert leader who strives to build effective relationships
- Proven track record of delivery across a wide range of corporate priorities
- Adept at managing today whilst planning for the future
- The ability to lead and influence and remain effective in turbulent times

Career History Summary

2022 to Present Executive Director of Nursing, Midwifery & Allied Health Professionals and
Health Care Scientist
2004 to 2022 Executive Director of Nursing, Midwifery & Allied Health Professionals, NHS
Forth Valley - **Promotion**
(2020 to 2022) Interim Director of Infection Control and HAI Executive Lead – NHS GGC
2003 to 2004 Director of Nursing, Forth Valley Acute Operating Division - **Promotion**
2002 to 2003 Interim Director of Nursing, Forth Valley Acute Operating Division -**Promotion**
2001 to 2002 Deputy Director of Nursing, Fife Acute Hospitals NHS Trust- **Promotion**
2001 to 2002 Acting Director of Nursing, Quality, Therapies & Rehabilitation Fife Acute Hospitals NHS Trust **- Professional Development/Promotion**
1999 to 2001 Directorate Nurse Manager – Medicine, Rehabilitation & Care of the Elderly Fife Acute Hospitals NHS Trust - **Promotion**
1996 to 1999 Nursing & Quality Adviser – Senior Nurse Quality & Audit South Glasgow University Hospitals Trust -**Promotion**
1991 to 1996 Charge Nurse – Intensive Care & Coronary Care Units Victoria Infirmary, Glasgow - **Promotion**
1983 to 1991 Nurse Training & Staff Nurse Post - Victoria Infirmary, Glasgow - **Promotion**

Career Profile and Achievements

2022 to Present - Executive Director of Nursing, Midwifery & Allied Health Professionals and
Health Care Scientist

Key Responsibilities

The executive nurse director for NHS greater Glasgow and Clyde responsible for leading Nursing, Midwifery, Allied Health Professions and health care scientists in one of the largest healthcare systems in Europe. Providing strategic direction for over 18,000 nursing and midwifery staff, caring for a population of over 1.3million people, in a system with an annual budget of 4.4 billion. Executive lead for patient safety and person centred care, quality strategy public protection and lead for Health and Safe Care staffing act and Infection Prevention control.

Contributes to and delivers effectively across the full range of corporate governance for NHS GGC. Directs and manages on this diverse range of organisational priorities through small group of direct reports, Deputy Nurse Directors, Director of Midwifery and Allied Health profession, Heads of Nursing and Midwifery and Health

Care Science Strategic Lead with responsibility of total nursing budget in the range of £1 billion.

Key Achievements

- Created and implemented the first Public Protection Strategy for GGC – Safe guarding it matters to us. This was approved by the board in February 2024.
- Developed a unique approach to engage with Nurses and Midwives across NHS GGC to develop the first NHS GGGC Nursing and Midwifery Strategy. - Nursing and Midwifery in GGC 'Leading the Way'.
- Designed NHSGGC new Quality Strategy 'Quality everyone, everywhere' with significant co-production approach. Approved by the board June 2024.
- Director of Infection Prevention Control role is now fully established within NHSGGC reporting to the Executive Nursing Director and first IPC annual reports showcasing IPC developments for 22/23 developed.

2004 to 2022 - Executive Nurse Director, NHS Forth Valley

Key Responsibilities

The Executive Nurse Director for NHS Forth Valley who is responsible for leading the Nursing and Midwifery and Allied Health Professions and holds the accountability for the safe and effective practice of these professions. The principle nurse, a member of the NHS Board, providing professional advice and leadership on all matters relating to the professions. The Executive lead for Infection Control, Person Centre Care, Equality & Diversity, Whistleblowing, Mental Health, Learning Disabilities and Prisons, Children, Families and Child Protection, Safe Staffing and Health & Social Care system lead for assurance and oversight of care homes.

Appointed by NHS GGC and Scottish Government as Interim Director of Infection Control and HAI Executive Lead.
Provision of leadership, review and systematic support across NHS GGC in relation to Infection, Prevention and Control and a key role in directing and delivering infection control improvement agenda across NHS GGC and ensuring this learning influences national requirements as part of the Scottish government oversight arrangements.

Leads the delivery of a range of NHS Scotland policy initiatives including co-chair national model framework of health and care for care homes, transforming nursing care home roles. Membership of the Scottish Government Oversight Board in respect to Infection Control for NHS GGC and membership Advice Assurance Review Group (AARG) for the Scottish Government in support of Infection Control in NHS GGC. Appointed chair of Female Pathways (Forensic Mental Health) Delivered policy programmes of work including; the review of the Senior Charge Nurse and Leading Better Care, national review of learning disability nursing.

Key Achievements

- Created, developed and implemented a nursing and midwifery care assurance system that drives performance improvement in fundamental aspects of nursing care and is designed to detect changes that may prevent sub optimal care. Evidenced by the first HEI report with no recommendations or requirements and Cabinet Secretary positive press release from Older People in Acute Hospitals visit to Forth Valley Royal Hospital.

- Systematic development and implementation of progressive and ambitious nursing strategy to achieve a safe and effective nursing and midwifery service. Including consistent and dynamic use of workforce tools and the achievement of the first non case holding Senior Charge Nurse in Scotland.

- Dedicated and sustained focus on the implementation and delivery of the Scottish Patient Safety Programme (SPSP) since its inception on traction to achieve 20% reduction in Hospital Standard Mortality Rates (HSMR) and achieved and exceeded 30% reduction in adverse events significant success across all workstreams.

- Sustained focus on improving care and services by listening to patients. First to implement Patient Experience. Developed first Patient Experience Strategy in NHS Scotland. Instigated and maintained patient and public participation structures focused on improving care and achieving greatest levels of public engagement in the build of Forth Valley Royal Hospital and continues this today.

2003 to 2004 Director of Nursing, Forth Valley Acute Operating Division

Key Responsibilities

The leadership and accountability for the nursing and midwifery service across the Acute Trust then Acute Operating Division. The Lead Executive for Clinical Governance, including HAI and patient focus and quality of care.

Key Achievements

- Created and implemented a strategic and operational framework for the nursing and midwifery service to ensure synergy and integration with the corporate endeavour. This included success on the delivery of agreed objectives, changes in practice and positive effect on culture.
- Key role in the development and implementation of the Trust's Clinical Governance objectives and subsequent achievements in structure, clinical practice and patient care.
- Achieved improvement in the Trust's complaints performance in respect to both 20-day target and organisational approach and culture. Engaged the clinical units and their staff in a supportive way.

2002 to 2003 Interim Director of Nursing, Forth Valley Acute Operating Division

Key Responsibilities

For fourteen months in an interim post, contributed significantly to the development and delivery of the organisation's objectives. Commenced on a systematic approach to develop the nursing & midwifery service. A key member of the Executive and Trust Management Team delivering on an ambitious and exciting change programme which forms the cornerstone of the corporate objectives and Forth Valley Healthcare Strategy.

In addition, lead responsibility for the organisation's Clinical Governance arrangements including Patient Focus and Public Involvement.

Key Achievements

- Significant influence on the PFPI agenda across Forth Valley. Refreshed and refocused the strategic framework and objectives. Developed the first patient panel, integrated PFPI into organisation's top priorities, and achieved dedicated resource to ensure capacity to deliver.
- Modernisation and development of the Department of Nursing including the development of a practice development unit to support front line staff in conjunction with the Unit Management Team

2000 to 2002 Depute Director of Nursing including Acting Director of Nursing, Quality, Therapies & Rehabilitation - Fife Acute Hospitals NHS Trust

Deputised and supported the Director of Nursing across the full range of her responsibilities. Provided professional leadership through support and advice that enabled nursing and midwifery to deliver safe, high-quality patient-centred services. Additionally delivered on a diverse portfolio of corporate functions including nursing and midwifery practice and professional development, infection control, management of outpatient service, bed and bank service, patient involvement and quality agenda.

Key Responsibilities

Contributed as a member of the Executive Team and led, on behalf of the Chief Executive, a range of responsibilities including Clinical Governance, patient involvement initiatives and Trust complaints management. Participated in decision-making which enabled corporate decisions to be made on sound clinical information ensuring all resources allocated to the Trust were directed to meeting agreed targets.

Key Achievements

- Led the organisation through the Health Quality Service Accreditation preparation and review visit. Achieved partial accreditation with only 27 of the 4,000 criteria requiring further development.
- Recommended and secured the Trust's commitment to undertake Picker Europe patient feedback initiative. To build a baseline information for the Trust to develop this agenda further. Advised the Chief Executive on a clinical basis in the management of significant critical incidents.
- Role involved communication with patients, relatives, Scottish Executive, Health Board, Local Health Council and the media to ensure an open and transparent approach.

1999 to 2000 Directorate Nurse Manager – Medicine & Care of the Elderly-

Fife Acute Hospitals NHS Trust

Key Responsibilities

A new post which combined nurse management and professional leadership to 595 wte nursing staff. The scope of the post was across 34 wards over four sites and a budget of £13.3m. This required a significant degree of personal and professional credibility to re-establish this role in a flat structure but with a professional aim of being a part of a network and not recreate a nursing hierarchy.

Key Achievements

- Identified organisational structures and systems, which supported the efficient delivery of healthcare by the reduction in the usage of temporary nursing staff. This eradicated the Directorate's overspend of £250,000 in this area with proven improvement in the quality of patient care delivery.
- Led reorganisation of services within medicine to meet Directorate corporate objectives. This involved both investment and disinvestments of services through partnership working.
- Launched a programme of initiatives aimed at improving patient care through the development of the charge nurse role. This resulted in an inspired group that then led individual improvement initiatives in their ward. This style of leadership was recognised by the Scottish Health Advisory Team visit.

1996 to 1999 Nursing & Quality Adviser – Senior Nurse Quality & Audit South

Glasgow University Hospitals Trust

A senior nurse and direct support role to the Director of Nursing and Quality, with a focus on the development of the professional agenda

1991-1999 **Senior Charge Nurse Intensive Care and Coronary Care Unit -**

NHS Greater Glasgow and Clyde - Victoria Infirmary, Glasgow

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