Scottish Hospitals Inquiry

Witness Statement of Questions and Responses

Professor Craig White

Background

1. I am providing this witness statement to the Inquiry to provide an overview of the role I performed in respect of communications and engagement with families associated with the NHS Greater Glasgow and Clyde ("NHSGGC") paediatric haemato-oncology service regarding issues that had arisen and were continuing to arise at the Royal Hospital for Children/ Queen Elizabeth University Hospital (collectively referred to as "QEUH") in Glasgow.

2. In providing this statement, I want to thank all of the families who I engaged with for their time, for making contact with me and for helping me to appreciate and understand the additional distress they faced and experienced as a result of their concerns and experiences. I am very grateful to Professor John Cuddihy for his insights, support and collaboration in working with me and agreeing to link with wider families and for doing all this so while already dealing with the distress and challenges of caring for a child with a diagnosis of cancer.

3. I would also like to thank the staff of NHS Greater Glasgow and Clyde for responding to my many requests for information and meetings and for their responses to advice, challenges and suggestions for change and improvement.

Professional qualifications and experience

4. I graduated from the University of Glasgow as Bachelor of Science with First Class Honors in Psychology in 1992. I subsequently obtained the degree of Doctor of Clinical Psychology from the University of Manchester in 1995. I obtained the degree of Doctor of Philosophy in Psychological Medicine from the University of Glasgow in 2004. I obtained the degree of Master of Medical Law with Merit from the University of Glasgow in 2014. I obtained the Diploma of Legal Medicine, with Distinction, from the Faculty of Forensic and Legal Medicine in 2023.

5. I qualified as a clinical psychologist in 1995, and since the inception of the Health and Care Professions Council's statutory registration arrangements, I have had active statutory registration as a Practitioner Psychologist in clinical psychology and health psychology.

6. I am a Founding Fellow of the Academy of Cognitive Therapy, a Fellow of the British Psychological Society and Fellow of the Royal College of Physicians of Edinburgh. I am an Associate Member of the Faculty of Forensic and Legal Medicine of the Royal College of Physicians of London. I am a Member of the International Society for Traumatic Stress Studies.

7. Throughout my career, I have engaged in continuing professional development in support of my leadership development. I completed the Delivering the Future: Developing: Scotland's Future Strategic Clinical Leaders programme from 2006-7 and also the national Project Lift Talent Management and Leadership Development programme in 2019.

8. Following my qualification as a clinical psychologist, I worked in the NHS in Scotland in adult mental health services and in district general hospitals. In 1998 I was appointed Cancer Research Campaign Clinical Research Fellow in Psychosocial Oncology at the Department of Psychological Medicine of the University of Glasgow. I returned to work in the NHS in 2004 as Macmillan Consultant in Psychosocial Oncology and was subsequently appointed Deputy Director of Psychological Services for NHS Ayrshire and Arran. In 2006, I was appointed to a series of interim Associate Director roles across a range of corporate areas, including strategic planning and performance and health records services. I was the Clinical Lead for the Board's Management Clinical Network in Palliative and End of Life Care and Regional Clinical Lead of the West of Scotland Cancer Networks for Supportive and Psychological Care.

9. In 2009, I was appointed Assistant Director of Quality, Governance and Standards at NHS Ayrshire and Arran and had operational responsibility for a range of corporate departments, including complaints, adverse events investigation, litigation, risk management, information governance, research and development. I also held the responsibilities of Board Caldicott Guardian during this time. A Caldicott Guardian is a

senior staff member responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. All NHS organisations must have a Caldicott Guardian.

10. In 2013 I was nominated to provide a service to the Scottish Government through appointment to the role of Divisional Clinical Lead in the Healthcare Quality and Improvement Directorate of the Scottish Government, undertaking the roles of National Clinical Lead for Palliative and End of Life Care and to lead work to develop and consult on policy development regarding the introduction of a statutory Organisational Duty of Candour in Scotland. I led the team that supported the development of a Bill that then subsequently incorporated the Organisational Duty of Candour provisions into primary and secondary legislation. I also led work nationally to support the introduction of person-centred flexible visiting across NHS Scotland hospitals and the use of Care Opinion by NHS Boards.

11. In 2017, I was appointed by the Minister for Mental Health to undertake a review of the arrangements for investigating the deaths of patients in hospital for treatment of a mental disorder. I established and Chaired a Review Group. Our report was published and submitted to the Scottish Parliament in December 2018, in accordance with the requirements of Section 37 of the Mental Health (Scotland) Act 2015.

12. In 2018, I led the support and coordination required to conduct an independent review of NHS Lanarkshire's plans for the redevelopment of the Monklands Hospital. I worked with the independent Co-Chairs and the Independent Review Panel, which reported to the Scottish Government in June 2019.

13. In June 2020 I was appointed to the Scottish Government role of Deputy Director, Test and Protect Portfolio. This role included being Senior Responsible Owner for a Pathways programme that had been established within the overall set of programmes in support of the national response to the Covid-19 pandemic. The Pathways programme ensured that processes were designed as part of the overall Test and Protect Portfolio outlining the range and sequence of actions required to implement policies on testing, contract tracing, isolation and support. I was responsible for the management of a team of civil servants and external contractors working on this programme, and for the

establishment of the Test and Protect Design Authority that was responsible for the prioritisation and co-ordination of the activities required for the development of pathways and processes to deliver the Test and Protect programme across the NHS and a range of public service settings.

14. I co-chaired the Scottish Government and the Convention of Scottish Local Authorities ("COSLA") Community Engagement Guidance Working Group's activities to develop the 'Planning with People Community Engagement and Participation Guidance' to support the delivery of statutory duties for engagement and public involvement. This was published in March 2021.

15. Outside of my role and the service provided to the Scottish Government, I practice on a sessional basis as a Consultant Clinical Psychologist in the independent sector and work as a skilled witness in the legal system, mostly in the civil legal system, in respect of claims relating to historical abuse in childhood, personal injuries, equalities, asylum and immigration, and negligence cases. I am an Honorary Professor at the Institute for Health and Wellbeing, College of Medical, Veterinary and Life Sciences at the University of Glasgow.

16. I currently provide the Scottish Government with a service through my role as Associate Director, Healthcare Quality and Improvement in the Directorate of the Chief Operating Officer, NHSScotland, and the Scottish Government Health and Social Care Directorates.

Appointment

17. On 4 October 2019, the Cabinet Secretary for Health and Sport appointed me to lead and direct work required to ensure that the voices of the families affected by the infection outbreaks at NHSGGC were heard and that they would be provided with information as a matter of priority.

18. My appointment was initially in respect of issues and questions raised with the Cabinet Secretary by parents of children and young people who had been, or were being, treated in the QEUH that had been in touch with Scottish Ministers and Scottish

Government officials. I was advised that the Cabinet Secretary, along with the Chief Nursing Officer (Fiona McQueen), had met with some affected parents and family members on 28 September 2019 and 02 October 2019.

19. The families had told the Cabinet Secretary that they wanted more information from NHSGGC on infection control initiatives, work ongoing in areas of the QEUH and the outcome and timeline of safety measures put in place by the Board. Having heard their concerns related to the infection outbreaks at the QEUH raised with her, one of the steps the Cabinet Secretary took was to arrange for my appointment. The Cabinet Secretary had thought it important that the patients and families had a single point of contact.

20. I brought to this role experience over the course of my career in the NHS, university sector and Scottish Government, reflecting my clinical professional background, senior management and leadership roles (clinically and in policy development) and roles in the senior civil service.

21. My understanding is that I was appointed because of the range of experience I have outlined above, together with my particular experience in relation to Organisational Duty of Candour (which I explain and say more about below) and the overall level of trust and confidence I had built with senior colleagues and Ministers as to my approach to engagement and complex governance scenarios.

22. My remit in relation to this role is outlined in a 'Scope, Role and Remit' document prepared by the Scottish Government dated 8 October 2019 **(A33949846 - Email chain - J Downie, C White and others - Attaching "Scope, Role and Remit of Professor Craig White re Concerns Raised by Patients and Families… - 08 October 2019" - 04 to 08 October 2019 - Bundle 27, Volume 12, Page 7) (A33949849 - Scope, Role and Remit of Professor Craig White re Concerns Raised by Patients and Families within Paediatric Oncology/Haematology Service at Royal Hospital for Children/Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde - 08 October 2019 - Bundle 27, Volume 12, Page 12)**. That document narrates that, on 4 October 2019, the Cabinet Secretary for Health and Sport (Jeane Freeman) appointed me to *"lead and direct the work required to ensure that the voices of the families*

affected by the infection outbreaks at NHS Greater Glasgow and Clyde ("NHSGGC") are heard and that the information they have asked for and entitled to receive is provided as a matter of priority".

23. I was instructed to:

23.1. Review the concerns of patients and families who have experienced care within the paediatric oncology/haematology service at RHC/QEUH ("those affected"), ensuring that these are addressed urgently and advising on those that should be considered by the ongoing independent review and/or (the then prospective) Public Inquiry.

23.2. Consider the work of NHSGGC's Incident Management Team ("IMT") to date in addressing the areas of concern raised by those affected and staff involved. I was to be supported, as necessary, by subject matter experts within Health Protection Scotland and provide advice and make recommendations to the Chief Nursing Officer.

23.3. Establish ongoing channels of communication, engagement and information provision with patients and families within the paediatric oncology/haematology service, their representatives and others as deemed appropriate.

23.4. Ensure that the issues raised by those affected are addressed by NHSGGC with a specific focus on infection control measures; the work underway in the haematology/oncology areas of the hospital; the intended outcome and timeline of the enhanced safety measures which NHSGGC had put in place; and other specific matters that had and may be raised by those affected.

24. In order to progress this work, I was mandated to:

24.1. Agree with the Chief Executive and Board of NHSGGC that I should be provided with all responses and supporting information requested in respect of ensuring that satisfactory responses are provided to the known existing questions, issues and requests for information from those affected.

24.2. Act as the Scottish Government's point of contact for affected individuals and work in partnership with NHSGGC's senior staff, providing direction, support and guidance on the actions required in support of my review of the issues, questions, concerns and needs of those affected.

24.3. Meet in person with any of those affected who wished me to do so.

24.4. Work with NHSGGC to ensure that the staff involved in considering and addressing the concerns of patients and families received the support that they identified as necessary.

24.5. Liaise with staff within NHSGGC who may be able to assist me in considering, understanding, supporting or advising on any aspect of the action required to review the work that has been undertaken by NHSGGC to date; that which needed to be undertaken at that point in time and may be required in the future to effectively address and respond to the issues raised by those affected.

24.6. Seek information in support of my exploration, consideration and examination of all actions, decision-making and any relevant supporting information as would be necessary to enable me to ensure that those affected receive responses that reflect best practice in the necessary communications, support and engagement in the current circumstances.

Ensure that my actions were at all times informed by best practice in the handling and management of the issues raised in respect of infection control, safety, clinical governance, effectiveness, improvement support and person-centredness of perspective, approach and response.

25. In discharging these responsibilities, I reported directly to the Cabinet Secretary for Health and Sport and was supported in my work by officials from the Directorate of the Chief Nursing Officer of the Scottish Government. In relation to staff within NHSGGC (referencing paragraph 24.5 above), my principal points of liaison were the Chief Executive, Executive Nurse Director, Director of Estates and Facilities, Head of Corporate Governance and Director of Communications, who were able to provide me with background information, documents and respond to requests for action to be taken.

I also liaised with other staff within NHSGGC when required on an issue-by-issue basis, for example the Lead Nurse for the Royal Hospital for Sick Children, the Deputy Medical Director for Acute Services, the General Manager, Women's and Children's Services and the Clinical Lead when individual family questions or concerns required this. I also attended meetings at which clinicians from the service were present.

26. I was instructed to make recommendations to the Chief Executive and Board of NHSGGC on any actions required to address the issues considered by the Cabinet Secretary for Health and Sport; including any actions required to improve the effectiveness of NHSGGC's responses to the incidents/outbreak (including those required in respect of the approaches required in the future by NHSGGC, HPS and Scottish Government). Although my scope, role and remit remained broadly similar to that outlined in this document, when NHSGGC was escalated in November 2019, my responsibilities then included making recommendations on actions through the established governance structures for the Oversight Board agreed in December 2019.

Communication with patients and their families

27. Following my appointment, I wrote to all patient/family representatives who had been in attendance at the meeting with the Cabinet Secretary **(A33949847 - Letter from Professor Craig White to Patient/Family Representatives following meeting with Jeane Freeman - 09 October 2019 - Bundle 27, Volume 12, Page 21) (A33949845 - S5W-25642 - To ask the Scottish Government what discussions it has had with families of paediatric cancer patients affected by the infection outbreaks at the Royal Hospital for Children and the Queen Elizabeth University Hospital, NHS Greater Glasgow & Clyde? - Bundle 27, Volume 12, Page 22) (A33949850 - Email chain - J Downie, A Corr, C White and others - Follow up work for Monday following GIQ and letters - Attaching "Prof White Letter - RHC Families - 091019, S5W-25642 GIQ and Prof White - Remit" - 04 to 09 October 2019 - Bundle 27, Volume 12, Page 15)**. I set out that, following the meeting with Jeane Freeman MSP, Cabinet Secretary for Health and Sport, I had been appointed by her to review the concerns that had been raised with her, to act as a dedicated point of contact and to work with NHS Greater Glasgow and Clyde to ensure that the representatives' wishes for responses to questions would be addressed promptly and also that the immediate practical issues raised would be dealt with swiftly.

28. I provided a copy of the Cabinet Secretary's response to a question posed in the Scottish Parliament **(A33949847 - Bundle 27, Volume 12, Page 21/A33949845 - Bundle 27, Volume 12, Page 22)**, along with a document outlining the scope and remit of my appointment and my contact details.

29. I explained that I had been meeting that week with the Chief Executive, Chair and relevant Directors within NHSGGC and would also be meeting with several other senior clinicians and managers over the coming week.

30. In my meetings with the Chief Executive, Chair, and relevant Directors within NHSGGC that week, I discussed with them the fact that patients' representatives had raised various concerns, issues, and questions with NHSGGC and the Scottish Government, to which they had indicated they had not received satisfactory responses. I provided advice to the Chief Executive of NHSGGC on what I saw as the required approach to address the ongoing concerns and dissatisfaction of a group of families whose children had recent or ongoing contact with the paediatric haemato-oncology service.

31. My approach was to ensure that I quickly established an awareness of the issues of most concern to the families that had previously met with the Cabinet Secretary, established contact with the families who were in contact with the services and with relevant senior staff at NHSGGC. I ensured that my contact details were available and that arrangements were put in place within Scottish Government for me to have dedicated support, including establishing a direct telephone line to officials who were supporting my work.

32. I prioritised ensuring regular communication with all families, aiming to provide timely responses to any communications received directly. I established communication channels and then provided updates regularly.

33. During October and November 2019, I recognised that I needed to have effective mechanisms in place for oversight of the totality of communications and engagement activities with affected families (with NHSGGC and with Scottish Government). I therefore asked NHS Greater Glasgow and Clyde to develop an electronic mechanism that could be accessed by me and authorised staff in NHS Greater Glasgow and Clyde

and the Scottish Government to capture, track and record the nature of communication and engagement activities relating to the concerns being expressed. I also emphasised the importance of the paediatric haemato-oncology service having mechanisms to have accurate and up to date contact information and preferences for all families in contact with in-patient, out-patient and daycare facilities within the service.

34. I had previous experience of establishing a similar electronic system to support my role as operational lead for the investigation of adverse event review processes when I worked in NHS Ayrshire and Arran and had the benefit of being able to be clear on what I required to be developed. This was useful in the commissioning and design of this system, which was possible through national work that had been undertaken to implement nationally consistent arrangements for secure access and use of Office365/ SharePoint software.

35. This system, when developed and implemented, provided me with an efficient and effective means of having oversight of activity in relation to all of the families in contact with NHSGGC or the Scottish Government. I was able to review details of contacts being made, actions being identified and review any supporting documentary evidence uploaded against actions and the contacts made with each family. I also made use of functionality within the system to set alerts to notify me when any changes were made or documents uploaded, as well as provide regular reports on communication and engagement activity. There were approximately 70 individual families where there was ongoing communication and engagement that I could then oversee and track through this system when it was established.

36. I based myself with NHSGGC's corporate offices at JB Russell House in Glasgow in order that I could establish relationships with the NHSGGC staff who were involved in responding to concerns, meet with them regularly and have direct access to the information I required to discharge my responsibilities, as reflected in the terms of my appointment by the Cabinet Secretary. In doing so, I had taken account of the Cabinet Secretary's response to a question in the Scottish Parliament that included a response to the concerns she had heard directly from affected families. She said "*All of this is information they are entitled to and should receive. Whilst this level of detail must come from the Board, families should not be expected to seek it piecemeal from a range of*

individuals. Nor would it be right that the responsibility for providing this should sit with the clinical teams. That is why I have appointed Professor Craig White, the Divisional Clinical Lead in the Healthcare Quality and Improvement Directorate at the Scottish Government, to review their concerns and act as their dedicated liaison person and single point of contact in respect to these issues".

37. NHSGGC provided me with an office and arranged for me to have access to the Board's email system and Intranet. This also meant that, because I was on site, I could be available at short notice to join meetings or speak personally to relevant Executive Directors and senior management when I needed to.

38. I continued to write to families in contact with the service (through the updated contact details developed for the service) and the group of families who had active ongoing contact through NHSGCC corporate departments, the Scottish Government, and me – to keep them updated on my work or respond to specific communications received.

39. I also met with Professor John Cuddihy on 23 October 2019 and subsequently agreed with him that we would work together given his established relationships with affected families and my awareness that a feeling of mistrust had developed following the experiences of some of the affected families.

40. I wrote again to affected families on 29 October 2019 **(A33903159 - Letter from Professor Craig White to [redacted] - 29 October 2019 – Bundle**

41. **27, Volume 12, Page 24)`** and attached a document **(A33943938 - NHSGGC Responses to Family Questions - Bundle 27, Volume 12, Page 26)** prepared by NHSGGC, which outlined NHSGGC's responses to the questions that had been raised by families the Cabinet Secretary had met previously. I had previously reviewed drafts of this document and provided my opinion on whether I thought that these were addressing the questions (based on my emergent understanding of the source of dissatisfaction and information needs of the families who I was beginning to engage with directly by that time). The Board had by then also agreed that they would nominate Jennifer Haynes, Board Complaints Manager, to be their single point of contact.

42. I further explained that I had met with the Chair of the Independent Review that was established to look at the design, commissioning, handover and ongoing maintenance at QEUH, and how these contribute to effective infection control. I explained that I had confirmed with the Chair of the Review that I would ensure that questions, feedback and experiences from patients and their families that are within the remit of the Review would be passed to them in order that they could consider them as part of their work. I asked the representatives for any follow-up questions or requests for information and offered to provide further support or information.

43. I again wrote to all families who had previously met with the Cabinet Secretary, the Chair and Chief Executive of NHSGGC, or who had contacted me personally, on 15 November 2019 **(A49651390 - Email chain - Letter from Professor Craig White to families after media coverage - Forwarded to Cabinet Secretary for Health and Sport - 15 November 2019 - Bundle 27, Volume 12, Page 43)**. This was prompted by coverage in the media of the concerns of a parent whose child died in 2017. Within that correspondence, I referred to NHSGGC's recognition, through my initial engagement with them, that they needed to improve their approach to communication and engagement with affected families. I also referred to the Scottish Government's recognition of the distressing impact of the news coverage relating to unanswered questions of the family of a child who had previously died.

44. I wanted to give assurance that all necessary steps were being taken to ensure that communication channels were in place and remind the families that I continued to be available to support them in any way they would find helpful.

45. I wrote to the families with a summary update on 16 November 2019 **(A33903190 - Email chain - C White and J Cuddihy - Update on Discussions with NHS Greater Glasgow and Clyde to families - 16 to 19 November 2019 - Bundle 27, Volume 12, Page 86)** in relation to arrangements for determining water safety, as this continued to be a source of concern to some families who had contacted me and was reflected in discussion with Professor Cuddihy. I narrated that my understanding that NHSGGC's decision to switch back to filtered water was taken following a new kitchen facility being opened and the standard precautions in place across all hospitals that discourage drinking water from ward sinks dedicated for handwashing. I also listed several other

ongoing actions and monitoring processes that I had been advised of as having influenced NHSGGC's decision-making about the safety of water. I indicated that I was asking NHSGGC for further information, reflecting the expressed needs of the families who had contacted me about their ongoing concerns about this.

46. I wrote to the families again on 18 November 2019 with a further update **(A33903190 - Bundle 27, Volume 12, Page 86)**. This reported on a meeting I had held that morning with NHSGGC's Director of Estates and Facilities, at which I had asked for summaries to be prepared of the water sampling arrangements that were in place together with illustrative examples of the data and a summary of what the data had shown over time. I had been advised that this was being worked on that afternoon and that I had arranged to meet with the Director again the following morning to review what had been collated. I also confirmed I would clarify the position in respect of sharing the findings and recommendations from the Health Protection Scotland report on a review of paediatric haemato-oncology data.

47. This reflected the importance I placed on ongoing, proactive and timely communication. This seemed to me to be a crucial aspect of good communication against a backdrop of ongoing media reporting and given the similar processes and contributory factors to those that had previously contributed to the dissatisfaction, distress and ongoing concern of the families I had been communicating with.

48. I issued further communications in November 2019 to those who had been in direct contact with me regarding actions I had taken in response to concerns expressed about clarity of decision-making, the water safety monitoring arrangements, arrangements to respond to child-specific concerns about care and their care plan, use of medicines, and parental concerns and fears about access to the hospital building. **(A49650838 - Email chain from C White - Update on Discussions with NHS Greater Glasgow and Clyde to families - Forwarded to Cabinet Secretary for Health and Sport - Attaching "QEUH WATER TESTING_REDACTED 1" and "Dr.Crichton - Explanation re Water Sample Report - 191119" - 19 November 2019 - Bundle 27, Volume 12, Page 45); (A49650913 - Email chain from C White - Update on Discussions with NHS Greater Glasgow and Clyde to families - Forwarded to S Bustillo, J Grant and others - Attaching "QEUH WATER TESTING_REDACTED 1"**

and "Dr.Crichton - Explanation re Water Sample Report - 191119" – 19 November 2019 - Bundle 27, Volume 12, Page 56); **(A33944092 - Email from C White to L Allan - Attaching multiple documents - 25 November 2019 - Bundle 27, Volume 12, Page 58)**; **(A33903190 - Bundle 27, Volume 12, Page 86); (A33939227 - Email chain - C White and [redacted] - Update on Discussions with NHS Greater Glasgow and Clyde - Concerns following update - 19 to 20 November 2019 - Bundle 27, Volume 12, Page 90)**.

49. The Cabinet Secretary wrote to the families concerned on 28 November 2019 **(A34059477 - Email from C White to [redacted] - Attaching letter from Jeane Freeman to families - Update on Public Inquiry 28 November 2019 - 11 December 2019 - Bundle 27, Volume 12, Page 94)** with an update in relation to the Public Inquiry. She indicated that she intended to share terms of reference with affected patients and families for comment before the Inquiry's formal setting-up date and invited them to share any thoughts or concerns they had with me.

50. I wrote to families that had been in contact with me on 29 November 2019 **(A33977151 - Email from C White to families - Establishment of Oversight Board - Communication and Engagement Sub-Group - 29 November 2019 - Bundle 27, Volume 12, Page 96)** to inform them of the escalation; and to all families with links to the service on 3 December 2019 **(A33977250 - Letter from Professor Craig White to families - Escalation of NHS GGC to Stage 4 of NHS Board Performance Escalation Framework - 03 December 2019 - Bundle 27, Volume 12, Page 97)** in relation to the escalation of NHSGGC on 22 November 2019 to Stage 4 of the NHS Board Performance Escalation Framework for matters relating to infection control governance, communication, engagement and public confidence. I emphasised the ongoing commitment to the work I had been doing and confirmed that there would be a specific communication and engagement subgroup established as part of the Oversight Board structure. I advised that Professor Fiona McQueen, the then Chief Nursing Officer for Scotland, would be Chairing the Oversight Board, that I would be a member and would also be Chairing an Engagement and Communication Sub-Group.

51. I wanted to ensure that the work of the Oversight Board was informed by feedback from the patients and their families on their experiences and provided a link to a bespoke

survey to facilitate feedback. From a total of 208 survey visits, 20 responses were received, some of which provided examples of areas where improvements were required in the support, information and transparency of communications. Suggested areas for improvement included improved openness and transparency, a broader range of mechanisms to support personalised communications and more emphasis on discussion and dialogue. All requests for meetings, information or concerns raised were actioned. **(A49438292 - Email from E MacKay to C White and others - QEUH Case Note Review - Communications & Engagement meeting 09 March 2021 - Attaching Agenda and Action Log - 05 March 2021 - Bundle 27, Volume 12, Page 98).** The Communications and Engagement Sub-Group considered the survey responses in formulating its workplan and approach to work. **(A49650900 - PART 2 - Papers considered at NHS Greater Glasgow and Clyde Oversight Board Communication and Engagement Subgroup Meetings - Bundle 27, Volume 12, Page 223).**

52. Throughout this time, I was also regularly engaged in providing briefings to the Cabinet Secretary and senior Scottish Government colleagues and contributing to civil service advice and work relating to responses to decision-making, correspondence and responses to Parliamentary Questions.

53. When the Oversight Board was established, I continued to work on all of the areas previously highlighted, though now through the Oversight Board governance structures and processes that were established in December 2019.

Closed Facebook Group

54. NHSGGC established a closed Facebook group in September 2019 for patients and families associated with the Paediatric Haemato-oncology Oncology service. A letter from NHSGGC, dated 25 September 2019, to the families referred to the intention of establishing this Group as "to help keep you informed." **(A38097056 - Letter for parents in Ward 6A about the Closed Facebook page, from NHS Greater Glasgow and Clyde Health Board dated 25 September 2019 - Bundle 5, Page 443)**.

55. As I began to build a broader understanding of the approach that had and was being taken to reactive communications and engagement, I identified possible opportunities to

enhance and improve this route as a means of engagement with members, building on the previously stated aim of using this as a route to provide information.

56. I offered support and advice to NHSGGC colleagues about how to further explore and maximise the benefits of the closed Facebook group. It was agreed that I would be provided with access rights to the Group so that I could review the content of postings and responses. NHSGGC continued to be responsible for reviewing and responding to requests from families who wished to join this Group. I subsequently began to use the Group and identified this as a further useful means of disseminating relevant information and updates, as well as encouraging dialogue and engagement with Group members.

57. This group's membership increased from around 50 to over 160 and became a useful way of engaging with parents. Families expressed positive feedback on the utility of this mechanism for informing them about statements from the Scottish Government, the work of the Independent Review and the Independent Case Note Review, as well as engagement in dialogue about concerns about issues that mattered most to them, their children and their wider family. This Group was also used when concerns about the Covid-19 pandemic were emailed to me and posted there, including use to circulate a letter to parents from consultants in the service as the implications of the pandemic were becoming clearer.

Independent Review

58. On 22 January 2019, the Cabinet Secretary announced in Parliament an Independent Review into the design, build, commissioning and maintenance of the QEUH. On 5 March 2019 Dr Andrew Fraser and Dr Brian Montgomery were appointed to lead the Review. The remit of the Review was: "*To establish whether the design, build, commissioning and maintenance of the Queen Elizabeth University Hospital and Royal Hospital for Children has had an adverse impact on the risk of Healthcare Associated Infection and whether there is wider learning for NHSScotland*".

59. I had an introductory meeting with Dr Brian Montgomery, Co-Chair of the Independent Review, on 30 October 2019 and agreed that any issues raised with me in my role by the families and within the scope of their remit would be noted and passed to them. I provided this input to the Independent Review on 3 December 2019 **(A49651792 -**

Family questions to Independent Review - Bundle 27, Volume 12, Page 105). I also subsequently agreed with the Independent Review Co-Chairs that I would act as a point of contact for the families, issue an embargoed copy of the Independent Review report and facilitate follow-up communications on any questions arising following the publication of the Independent Review from individual families.

60. One of the main findings of the review, published in June 2020, was "Communication about QEUH and its problems since opening has been variable ranging from appropriate and effective in relation to clinical communication with patients and families, to inadequate and reactive in relation to external communication about serious problems with the building and possible links to infectious disease events".

Oversight Board and Communications and Engagement Sub-Group

61. The Scottish Government escalated NHSGGC to Stage 4 on the NHS Scotland Performance Framework on 22 November 2019. As I outlined earlier, this resulted in the establishment of an Oversight Board. I joined this Oversight Board, Chaired the Communications and Engagement Sub-Group ("CESG") and was also a member of the Infection Prevention and Control Sub-Group. The work of the Oversight Board and Infection Prevention and Control Sub-Group will be addressed in other witness statements, so here I focus on the work of the CESG.

62. The work of the CESG was set within the framework of the CESG's (and the wider Oversight Board's) Terms of Reference ("TOR") and governed by the Key Success Indicators agreed by the Oversight Board. These were that families and children and young people within the haemato-oncology service receive relevant information and are engaged in a manner that reflects the values of the NHS Scotland in full; and that families and children and young people within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHS Scotland in full.

63. The CESG TOR set out membership of the group (see page 18) **(A34187840 - QEUH Oversight Board - Communications and Engagement Subgroup - Terms of**

Reference - DRAFT - Bundle 27, Volume 12, Page 108). The outcomes for the group were listed as being to:

63.1. positively impact patients and their families in relation to how complex infection control issues and all related matters are identified, managed and communicated;

63.2. demonstrate a proactive approach to engagement, communications and the provision of information; and

63.3. identify what has worked well and where the provision of information, communication and engagement could have been and could be enhanced and improved to ensure that the outputs from the group are disseminated to key stakeholders and any wider learning points or recommendations are shared nationally.

64. In order to achieve these outcomes, the CESG was to retrospectively assess factors influencing the approach to communication and public engagement associated with the infection prevention and control issues and related matters at the QEUH/RHC. Having identified these issues, the CESG was then to work with NHSGGC to seek assurance that they had already been resolved or that action was being taken to resolve them; compare systems, processes and governance with national standards and make recommendations for improvement and good practice as well as lessons learned across NHS Scotland.

65. The CESG met on seven occasions between December 2019 and March 2020 **(A49434684 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 05 December 2019 - Bundle 27, Volume 12, Page 112); (A49434655 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 18 December 2019 - Bundle 27, Volume 12, Page 115); (A49435644 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 09 January 2020 – Bundle 27, Volume 12, Page 118); (A49435742 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 29 January 2020 - Bundle 27, Volume 12, Page 122); (A34187974 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 04 February 2020 - Bundle 27, Volume 12,**

Page 126); (A34187883 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 18 February 2020 - Bundle 27, Volume 12, Page 128); and (A34187906 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 03 March 2020 - Bundle 27, Volume 12, Page 131). An additional meeting was convened in July 2020 when parents expressed concerns about NHSGGC's response to the publication of the QEUH Independent Review and a media response following the BBC Disclosure programme **(A49435707 - NHS GGC and QEUH Oversight Board - Communication and Engagement Subgroup meeting - Minute - 01 July 2020 - Bundle 27, Volume 12, Page 136)**. I chaired all of these meetings. My approach was to create the conditions where the issues of concern to families could be explored and, through a balance of scrutiny, challenge and support, opportunities and actions for improvement could be identified.

66. The deliverables for the CESG were:

66.1. a prioritised description of communications and information to be provided to families, with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered);

66.2. development of a strategic Communications and Engagement Plan with a person-centred approach as key. This should link to and be informed by consideration of existing person-centred care and engagement work within the Board, to ensure continued strong links between families and NHS GGC. Specific enhancements and improvement proposals should also be clearly identified and should consider how the proposals from parent representatives on an approach that identifies and supports the delivery of personalised actions through the 'PACT' proposal can inform further work;

66.3. a description of findings following a review of materials, policies and procedures in respect of existing practices with regards to communications, engagement and decision-making arising from corporate and operational communications and engagement, linked to infection prevention and control and related issues. This was to include consideration of Organisational Duty of Candour, significant clinical incident reviews, supported access to medical records (including engagement, involvement and provision of information to families in relation to these processes, which are explained below).

66.4. A significant clinical incident review was the term used by NHSGGC for the process used to review events that may have contributed to or resulted in permanent harm with a view to conduct a detailed review of such events to establish the facts of what happened and determine any links between care delivery and outcome or the potential for learning to inform service improvement. This term was subsequently changed to Significant Adverse Event Review to ensure consistent terminology for these types of reviews across the NHS in Scotland. Supported access to medical records is the process by which NHSGGC responded to requests for copies of clinical records. The focus on incident reviews was referred to so that any observations relating to communication and engagement with people where there had been such a review could be considered and the other scenario was included as the family representative had advised that some families were not satisfied with the timeliness or support received throughout the process of seeking to obtain copies of medical records; and

66.5. a description of findings and recommendations to: (a) NHS GGC; (b) Health Protection Scotland; (c) NHS Scotland; and (d) Scottish Government on learning to support any required changes and improvements for communications and public engagement relating to the matters considered by the Subgroup.

67. The findings and recommendations from work of the CESG were set out in a paper developed by the Group **(A34187934 - NHS GCC and QEUH Oversight Board - Communications and Engagement Subgroup - Findings/Recommendations - August 2020 - Bundle 27, Volume 12, Page 343)** and then considered in developing the Interim Report of the Oversight Board published in December 2020 **(A49652167 - NHS GGC and QEUH Oversight Board - Interim Report - December 2020 - Bundle 27, Volume 12, Page 139)**. The COVID-19 pandemic impacted the Oversight Board and the CESG's ability to proceed with this work as originally planned. Further discussions and work of the CESG was considered through the Oversight Board, which published a final report in March 2021 **(A33448010 - The Queen Elizabeth University Hospital/NHS Greater Glasgow and Clyde Oversight Board Final report dated March 2021 - Bundle 6, Page 795)**.

68. The CESG considered a range of papers and material presented by NHSGGC to the Subgroup's meetings, including the presentations; discussions at the Subgroup meetings, both with NHSGGC colleagues and amongst the Subgroup members; and the experience of operating the new processes put in place in response to the infection issues, such as the 'closed' Facebook page for families and NHSGGC's communication with all those in contact with the service. The CESG also identified actions that required implementation by NHSGGC during the course of its work, such as the need to review the approach taken to co-ordinate communication with all families with some form of contact with the paediatric haemato-oncology services **(A49650900 - Bundle 27, Volume 12, Page 233)**.

69. The CESG benefitted from having two parent representatives on the Group, Professor John Cuddihy and [redacted] Professor Cuddihy also joined the Oversight Board. Professor Cuddihy established effective communication channels with a larger group of affected families and this became a very effective mechanism to disseminate copies of documents generated or being considered by the CESG and, more importantly, for these to then be considered with all of the various sources of information on matters of importance to families.

70. In January 2020 I asked the parent representatives for feedback on the impact of the various mechanisms that had been established to communicate with affected families **(A49650922 - Email chain - C White and J Cuddihy - Oversight Board Communication and Engagement - Feedback and Communication Links Established - 13 January 2020 - Bundle 27, Volume 12, Page 324)**. Professor Cuddihy advised me that parents had provided positive feedback on the arrangements put in place for Professor Cuddihy to provide an information sheet following his attendance at CESG meetings. In particular, this had been appreciated by parents who did not wish to communicate using other mechanisms. He advised that parents had commented that I had responded to matters raised by him and had posted an update on the Closed Facebook Group which had provided a confidence that the communication channel was operating effectively and that parents were being listened to. His feedback emphasised the importance of providing a range of mechanisms to support communication and engagement and confirmed that arrangements for providing

updates and requesting contributions to inform his role on the CESG were working effectively.

71. The Report set out findings and recommendations under two key issues that were highlighted in the escalation to Stage 4, and which were the focus of the work of the CESG:

71.1. communication issues, which related to how NHSGGC communicated and engaged with individual families and patients affected by the infection issues at the QEUH, as well as the wider public; and

71.2. Organisational Duty of Candour, which related to how NHSGGC carried out its legal obligations under the Organisational Duty of Candour in the context of the issues that gave rise to escalation.

72. The Report highlighted, within its findings, possible areas of assurance ('what had worked well') and areas for improvement ('what needed to improve'). The Report also highlighted, within its recommendations, where national learning for NHS Scotland as a whole could be relevant.

73. The findings and recommendations considered NHSGGC's strategic intentions for person-centred care, as set out in its 2019-23 Healthcare Quality Strategy. The CESG also took account of the context, including that there was little precedent for the challenges – not least in understanding the scale and nature of the infection issues – arising from a large, newly-built hospital complex such as the QEUH; and the challenges and opportunities that arose as a result of the size and expanse of NHSGGC.

74. The CESG recognised that relationships with key groups and communities were vital to its work.

75. Under the heading of Communications, the key findings of the CESG as to what had worked well included:

75.1. Good communication at point of care;

75.2. Establishing new mechanisms for communication (e.g. establishment of the closed Facebook page and database to capture communication preferences of each family (with the caveat that these would have had greater impact if established earlier);

75.3. Senior engagement on communication issues (again with the caveat that these would have had greater impact if established earlier);

75.4. Management focus on service provision/business continuity was maintained, despite the 'crisis management' approach that appeared to continue for some time in the face of the continuing infection issues in the QEUH; and

75.5. Staff impact and wellbeing was considered, although a more targeted approach could have been adopted in relation to staff, patients and families.

76. Under the heading of Communications, the key findings of the CESG as to what needed to be improved included:

76.1. Several families reported a consistent lack of transparency in the communications by NHSGGC, creating an impression that there was 'something to hide' in terms of what might lie behind the infection incidents - while a minority may have voiced their views, that did not make addressing their concerns any less essential, nor could it be read that their views were not shared by the larger, more 'silent' group of families;

76.2. Frustration by families at NHSGGC's 'reluctance' to address questions about the infection incidents and their background was heightened by NHSGGC's difficulties in discussing some issues because of its pending legal case against Multiplex - continuing silence on issues would not address fundamental concerns on communications and engagement that gave rise to escalation to Stage 4;

76.3. Families did not always feel that communications with them was the priority for NHSGGC, as opposed to communication with other groups or the wider public – this might reflect the complex challenges faced by NHSGGC but led to an ingrained lack of faith in NHSGGC's ability to prioritise their needs among some families;

76.4. NHSGGC did not always demonstrate a clear, person-centred tone in addressing such sensitive issues among families - the willingness to recognise the nature of concerns, apologies for their impact and take decisive action in the face of unknown issues (such as the decision to de-cant Wards 2A and 2B) would have strengthened some of the communications effort and reduce the mistrust that appeared to build;

76.5. Not all the communications were as effective as more direct ward communications, particularly for patients and families not currently engaged with the service;

76.6. Timeliness of some communication, which could often be more 'reactive' than 'proactive';

76.7. NHSGGC 'Management' was perceived by some families as using frontline staff to communicate 'difficult' messages relating to NHSGGC corporate responsibilities, with senior management in NHSGGC not being sufficiently and consistently visible in speaking/communicating with them at an early stage;

76.8. The consistency of information and messaging was variable and key messages, especially when delivered directly on wards, could have sometimes benefited from a more joined-up approach of infection prevention and control ("IPC") and facilities/environment personnel;

76.9. Further work was identified to find better ways of supporting co-ordination and communication of the ways in which families could raise and have their questions (about point of care or wider organisational issues) responded to and for those responses to be more rapid, noting the backdrop of social media acting as an accelerator and 'echo-chamber', the press and political demand for clear answers and causation and uncertainty as NHSGGC was trying to understand the source of a complex, and at times, resolutely unsolvable set of issues; and

76.10. The role and coordination of messaging by external bodies, particularly NHS Health Protection Scotland (HPS) and the Scottish Government, was not always clear during the period, and did not provide a consistent source of support or advice to NHSGGC in addressing the communication challenges that they faced. This reflected NHSGGC's

feedback that greater external coordinated support and advice would have been helpful, though they did not believe that this was readily accessible.

77. Under the heading of Communications, the key recommendations of the CESG included:

77.1. The Health Board should learn from the challenges of communicating against a background of uncertainty and where a critical situation is slowly evolving by pursuing more active and open transparency by undertaking a review of how it engages with families in line with the principles of its communication strategies. That review should include close involvement of the families that were affected by the infection incidents;

77.2. The Health Board should embed the value of early, visible and decisive senior leadership in its communications and engagement efforts and, in so doing, more clearly demonstrate and communicate a leadership narrative that reflects this strategic intent. That should be manifested in consistent communications by senior leaders in the Health Board with families in such circumstances;

77.3. To ensure that a person-centred approach is embedded in all of its official communications – corporate to point of care – and that patients and families are responded to in a timely manner, the Health Board should ensure that the Executive leads for communications and for person-centred care jointly, regularly and systematically review the quality of their communications with family representatives, and report on this to Executive Team of the Health Board;

77.4. The Health Board should make sure that there is a systematic collaborative and consultative approach in place for taking forward communications and engagement with families and patients. Co-production should be pursued in learning from the experience of this challenge. Impact assessments should be considered more actively and used sensitively. The priority should be on reliable and consistent delivery of this in a way that empowers clinical leaders and directors across professions. The review of communications noted previously could provide recommendations that would enable this to be embedded in the Health Board's operations going forward;

77.5. The Health Board should ensure that the principles of direct, person-centred and compassionate communications on the ward with patients and families be applied in a way which ensures consistency of experience across all patients and families. While this was reflected in the experience of some patients and families, it was not widely experienced by all of them, particularly those with ongoing questions and concerns about infection prevention and control;

77.6. Finding the right ways of communicating to patients and families who are 'outside' of the hospital is a key challenge that Health Boards must address when faced with these circumstances. The experience of NHS GGC should inform national learning on how this can be improved across NHS Scotland in future;

77.7. The Health Board should systematically elicit and reliably act on people's personal preferences, needs and wishes, particularly in circumstances where longer-term communication with patients and families is taking place. An action plan setting out how the learning from the communication challenges of Healthcare Associated Infections in the paediatric haemato-oncology service within NHS GGC will inform that approach going forward should be presented to the Scottish Government by the Health Board. This should also support national learning;

77.8. The Health Board should learn from other Health Boards that have developed good practice in addressing the demand for speedier communications in a quickly developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning;

77.9. The Health Board should review and take appropriate action to ensure that there is an environment where staff are open about what is happening and can discuss patient safety events promptly, fully and compassionately;

77.10. The recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy for the Health Board, and indeed, the wider strategic culture and approach of the Health Board, with a view to forming the basis for wider national learning; and

77.11. The Scottish Government, with Health Improvement Scotland and Health Protection Scotland, should review the external support for communications to Boards facing similar intensive media events.

78. The Organisational Duty of Candour was also considered by the CESG. The Organisational Duty of Candour is a legal duty, applicable to all organisations that provide health services, care services or social work services in Scotland. It sets out how organisations should tell those affected that an unintended or unexpected incident appears to have resulted in or could result in harm or death. The procedure to be followed is set out within The Duty of Candour Procedure (Scotland) Regulations 2018 (which were made in exercise of the powers conferred upon the Scottish Ministers by section 22(1) and (2) of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016, which came into force on 1 April 2018).

79. The organisation concerned is required to notify, apologise to and meaningfully involve those affected in a review of what happened. When the review is complete, the organisation should agree any actions required to improve the quality of care, informed by the principles of learning and continuous improvement. They should tell the person who appears to have been harmed (or those acting on their behalf) what those actions are and when they will happen. It recognises that when unexpected or unintended incidents occur during the provision of treatment or care, openness and transparency are fundamental. This is intended to promote a culture of learning and continuous improvement and places people at the heart of health and social care provision.

80. The CESG found that the Organisational Duty of Candour had been actively considered by NHSGGC during the relevant period, although it was not formally activated for any of the incidents of concern within the paediatric haemato-oncology service. There was evidence of clinicians involved with Incident Management Teams ("IMT") of taking actions to reflect their recognition of their Professional Duty of Candour in respect of the incidents and outbreaks being considered, including the need to develop clarity on any Organisational Duty of Candour actions required to respond to incidents considered as part of the IMT process.

81. An IMT is a multi-disciplinary, multi-agency group with responsibility for investigating and managing a ‘public health incident’ or possible healthcare associated infections. The terms ‘incident’ and IMT are used as generic terms to cover both public health incidents and outbreaks.

82. My understanding of relevant guidance is that an IMT relating to potential healthcare associated infection is established:

82.1. if there are two or more people experiencing a similar illness which is temporally and spatially linked (time and place);

82.2. if there is a single case of a rare disease or a serious illness with major public health implications (e.g. botulism, viral haemorrhagic fever, extensively drug-resistant tuberculosis (XDR-TB), polio, diphtheria, rabies;

82.3. if there is a higher than expected rate of an infection which is over and above the usual background rate for the time and place where the outbreak occurred; or

82.4. if there is a high likelihood of exposure of a population to a hazard (e.g. a chemical, food, water or infectious agent) at levels sufficient to cause illness.

83. In response to a suspected incident/ outbreak, it is the responsibility of the NHS Board (specifically the infection control doctor (“ICD”)/consultant microbiologist and/ or consultant in public health medicine (“CPHM”)) to establish if an IMT is required.

84. The IMT has responsibility for investigating and managing the incident. The IMT provides a framework, response and resources to enable the NHS board and (where relevant) other statutory agencies to fulfil their remits which I understand are:

84.1. To reduce to a minimum the number of cases of illness by promptly recognising the incident, defining how cases have been exposed to the implicated hazard, identifying and controlling the source of that exposure, and preventing secondary exposure;

84.2. To minimise mortality and illness by ensuring optimum health care for those affected;

84.3. To inform the patients, actually or potentially exposed groups, staff, clinical and management colleagues, public, their representatives and the media of the health risks associated with the incident and how to minimise these risks; and

84.4. To collect information which will be of use in better understanding the nature and origin of the incident and on how best to prevent and manage future incidents.

85. The CESG also found that NHSGGC's policy in support of Organisational Duty of Candour legislation did not fully reflect the legislation and guidance, primarily in respect of the reliance placed upon harm being viewed to be avoidable and/or related to acts of omission/commission of the organisation. While it was recognised that the implementation of the Organisational Duty of Candour in these circumstances had particular challenges, the legislation does not require a view on causation to be determined in deciding whether to activate the Organisational Duty of Candour procedure and includes provision for unexpected events that have resulted or could result in outcomes included in legislation (including increases in treatment and psychological harm) to activate the Organisational Duty of Candour procedure.

86. The CESG made two key recommendations in relation to Organisational Duty of Candour:

86.1. given that Organisational Duty of Candour was considered, but not formally activated, in these circumstances, NHSGGC should review its approach to ensure that it was not simply focused on patient safety incidents, circumstances where causality was clear and where events could result in death or harm; and

86.2. the national challenges around the application of the Organisational Duty of Candour highlighted by these events should be explicitly considered and acted upon by the Scottish Government and NHS Scotland.

87. The Scottish Government did not agree with the conclusions of the Independent Review as regards Organisational Duty of Candour; or NHSGGC's interpretation of the Organisational Duty of Candour as reflected in its decision-making with respect to the activation of the Organisational Duty of Candour procedure relative to affected families.

This was reflected in the Scottish Government's response to a copy of the Independent Review report provided to Scottish Government for factual accuracy feedback prior to publication **(A49651803 - SBAR - QUEH Independent Review - Request for Further Background on Reference to Organisational Duty of Candour - 07 June 2020 - Bundle 27, Volume 12, Page 328)**. This feedback did not lead to any change in these conclusions upon publication.

88. NHSGGC provided detailed comments on content relating to Organisational Duty of Candour as part of a process to seek feedback on a draft report of the Oversight Board. These were reviewed in detail **(A49651778 - NHSGGC Oversight Board Final Report – Comments Received from NHSGGC on Content relating to Organisational Duty of Candour - 04 March 2021 - Bundle 27, Volume 12, Page 333)** and considered by officials who were coordinating the production of the Oversight Board's report. Some of these issues have already been considered by the Inquiry in respect of decision-making and associated communication decisions by NHSGGC.

89. My prior experience as a Health Board Caldicott Guardian and lead role in the policy, legislative and implementation support processes on Organisational Duty of Candour were relevant to the advice I was providing to the Scottish Ministers. For example, in October 2020 I provided direction to Scottish Government officials (such as Phil Raines, who was Unit Head of Scottish Government QEUH Business Support Unit) who received communications articulating concerns from Professor Cuddihy on the implementation of obligations relating to the Organisational Duty of Candour **(A49651169 - Email chain - J Cuddihy, P Raines and C White - J Cuddihy correspondence on Mycobacterium Chelonae cases and organisational duty of candour - 20 to 29 October 2020 - Bundle 27, Volume 12, Page 338)**. This focused on emphasising the importance of the way in which the balancing exercise (for both professional and Organisational Duties of Candour) required in respect of competing interests relating to confidentiality and candour could have been approached differently.

90. The CESG Report was completed in July 2020 **(A34187934 - Bundle 27, Volume 12, Page 343)** and then presented to the Oversight Board in accordance with the agreed governance structures in place for the Oversight Board.

91. The work of the CESG significantly influenced the approach taken to consider and coordinate responses to questions and concerns raised by Professor Cuddihy regarding the publication of the Independent Review, Professor Mike Stevens' appointment, and parents' concerns about the impact of the BBC Disclosure documentary, all in July 2020 and thereafter.

92. During the time that I worked as Communications and Engagement Lead on the Oversight Board and the Independent Case Note Review, I also followed up on individual concerns raised with me by parents in individual meetings with them. The concerns were mostly related to questions arising for parents in the context of the ongoing care of their children or feedback they wished to provide on suggested improvements in care experiences. During the pandemic concerns and questions about hospital access and shielding list questions were responded to.

Implementation of recommendations from the CESG Report

93. An Advice, Assurance and Review Group ("AARG") was set up by the Scottish Government to provide advice, assurance and review of all reports, recommendations and closed actions, based on NHSGGC's overarching action plan in response to the Oversight Board's recommendations. The AARG was chaired by the Chief Nursing Officer (at that time Amanda Croft) and its membership comprised various Scottish Government officials, me included, together with various representatives from NHSGGC and a representative from NHS Forth Valley.

94. The terms of reference for the AARG included the following:

- Undertake an initial formal review of progress in first meeting of the AARG;
- Implement the recommendations within the action plans and the reports relating to improvement;
- NHSGGC to establish an ongoing and regular monitoring process of the plan within the Board and update the AARG accordingly
- Provide advice regarding weekly progress meetings between SG Lead and NHSGGC, including on further interventions, if appropriate;
- Consider and provide advice to CNO in her discussions/liaison with SG colleagues;

- Undertake a timely formal review and produce a briefing with recommendations for the CNO to take to the Chief Executive of NHS Scotland/ Director General of Health and Social Care regarding the level of escalation and any recommendations in relation to this; and
- Progress that review with CNO and the Chief Executive of NHS Scotland/ Director General of Health and Social Care to inform a meeting with the Cabinet Secretary.

95. The outputs of the AARG were to be that the AARG Chair would formally report on progress to the Cabinet Secretary in September 2021; and additional reporting to the NHSGGC Board would occur, with briefing to the Chief Executive of NHS Scotland/Director General of Health and Social Care accordingly **(A49650690 - QEUH/RHC Advice, Assurance and Review Group (AARG) - Terms of Reference - June 2021 - Bundle 27, Volume 12, Page 363)**.

96. I attended two meetings of the AARG, on 7 June and 19 August 2021. At the meeting on 7 June 2021, it was agreed that my formal role as lead for communication and engagement would end, though I would be available to any colleague in NHSGGC who might wish to contact me **(see Minutes at A44777856 - QEUH/RHC Advice, Assurance and Review Group (AARG) - Minute - 07 June 2021 - Bundle 27, Volume 12, Page 368)**. The 19 August 2021 meeting noted that NHSGGC had conducted an internal audit of the Organisational Duty of Candour policy and procedures and that their policy had been changed "*to make it more consistent with the legislation in terms of unexpected and unexpected incidents*". A copy of their revised policy was tabled for review at this meeting **(A49650938 - NHS GGC - Policy & Procedure - Duty of Candour - Compliance - OB - Final 14 - 29 July 2021 - Bundle 27, Volume 12, Page 371)**. This meeting agreed that NHSGGC's action plans would be subject to an ongoing process of audit by them to ensure maintenance and sustainability of actions **(see Minutes at A49650695 - QEUH/RHC Advice, Assurance and Review Group (AARG) - Minute - 19 August 2021 - Bundle 27, Volume 12, Page 390)**.

97. My understanding is that a paper was considered by the Scottish Government Health and Social Care Management Board in September 2021, which recommended de-escalation of NHSGGC from Stage 4 to Stage 2 **(A49438165 - NHS GGC escalation**

review based on the outcome of the QEUH / RHC Advice, Assurance & Review Group (AARG) - 15 September 2021 - Bundle 27, Volume 12, Page 396). The minutes of this meeting note that the Director General took the advice of HSCMB and was supportive of de-escalating NHSGGC to Stage 2, acknowledging the work done and the action taken. It was also noted that, as part of the ongoing assurance arrangements, NHSGGC would provide a monthly exception report in respect of the action plan. Additionally, the Chief Nursing Officer and Chief Operating Officer would meet quarterly with the Chief Executive and members of the senior team of NHSGGC and that these assurance arrangements would be kept under review **(A49437501 - Health and Social Care Management Board - Minute - 15 September 2021 - Bundle 27, Volume 12, Page 409)**.

98. I was not involved directly in the work of the AARG after the meeting in August 2021. My understanding is that there was a further meeting of the AARG on 17 December 2021.

99. On 24 November 2021 I was copied into an email that referred to the actions taken by NHSGGC in respect of the Oversight Board's recommendations relating to Organisational Duty of Candour. I had concerns about the content of the email referring to NHSGGC's response to the Oversight Board's recommendations on Organisational Duty of Candour, particularly the use of the words "perceived insufficiency" and "impressive evidence". I replied to the Associate Chief Nursing Officer, Irene Barkby, referencing discussion at the August 2021 AARG where my recollection was that NHSGGC's Executive Medical Director, Jennifer Armstrong, confirmed that their review of the Organisational duty of candour work had been an exercise that had neither involved engagement with any staff or patients and families, nor looked at outcomes. I referred to my understanding that NHSGGC's internal audit had been based on a review of documentation, which may have included the Board's revised Organisational Duty of Candour policy. I also highlighted that I had not received a draft Minute of the August 2021 meeting **(A49434796 - Email Chain - J Birch, I Barkby, C White and others - Submission on aspergillus in the QEUH CWard response - 24 to 25 November 2021 - Bundle 27, Volume 12, Page 417)**.

100. I proposed the following wording would be a more accurate reflection of my recollections of the discussion in respect of NHSGGC's response to the Organisational Duty of Candour recommendation of the Oversight Board:

*"*In terms of their work on Organisational duty of candour, the Board commissioned a review by their internal auditors, Azets. This was a desktop review which considered changes in the Board's Organisational duty of candour policy made following recommendations by the Oversight Board. The AARG encouraged the Board to ensure that their ongoing assurance work on these changes considered the effectiveness of implementation and took account of the impact on staff, patients and families. Officials have continued to engage with the Board's Director of Clinical Governance on Oversight Board recommendations on the application of the Organisational duty of candour procedure to instances of hospital acquired infections."

101. I have had no further personal involvement since this time in respect of the extent to which the recommendations of the Oversight Board relating to communication and engagement have been effectively or sustainably implemented.

102. I understand that Louise Slorance has provided the Inquiry with feedback that communications and engagement have not improved in NHSGGC. The only personal involvement I had in respect of Mrs Slorance's communications with Scottish Government was in November 2021 when, in response to concerns she had expressed to Scottish Government, I emailed an official in the Chief Nursing Officer's Directorate to emphasise the importance of Mrs Slorance having a dedicated point of contact at NHSGGC for ongoing support and communication. I referred to this being relevant to the improvements that the CESG encouraged NHSGGC to prioritise as part of their actions to deliver on the changes recommended by the Oversight Board **(A49433379 - Email Chain - J Birch, A McMahon, C White and others - Submission on aspergillus in the QEUH CWard response - Response from Louise Slorance - 24 to 29 November 2021 - Bundle 27, Volume 12, Page 428)**. I also provided advice on the Organisational Duty of Candour and stated the obligations, as I understood them, of NHSGGC in respect of accountability for transparent, person-centred and supportive communication and engagement informed by reviews, questions and concerns expressed by Mrs Slorance, accountabilities that relate to the Board's statutory duty of

quality and how the various responsibilities of the accountable officer in respect of clinical and care governance apply **(A49434277 - Email Chain involving C White, C Campariol-Scott and others - Submission on aspergillus in the QEUH - 24 November 2021 to 30 November 2021 - Bundle 27, Volume 1, Page 540)**.

103. In relation to the national challenges around the application of the Organisational Duty of Candour highlighted in the Report, I ensured that, when I returned to work in the Directorate of Healthcare Quality and Improvement, I worked with colleagues to review the implementation of the legislation since it came into force in April 2018. I completed a review and recommendations to the relevant Scottish Government policy teams on 9 December 2022 **(A49650907 - SBAR - Organisational Duty of Candour Annual Reports Review - 09 December 2022 - Bundle 27, Volume 12, Page 442)**. The Scottish Government has subsequently conducted a review of the updates to be made to the non-statutory guidance supporting the Organisational Duty of Candour legislation and at the time of writing this is planned for publication later in 2024.

Independent Case Note Review

104. On 28 January 2020, the Cabinet Secretary announced in Parliament the plans for a Case Note Review ("CNR"). The CNR, to be undertaken by a panel of independent experts led by Professor Mike Stevens, commenced on 24 February 2020. I was the Scottish Government's Communications and Engagement Lead for the CNR and chaired a communications group relative to the CNR. This group met on 30 October 2020, 17 December 2020, 21 January 2021 and 06 April 2021. Professor Stevens, Professor Cuddihy and supporting officials from the Directorate of the Chief Nursing Officer's Directorate were members.

105. My responsibilities included the implementation of any actions assigned to me by the CESG relating to communications and engagement activities, final approval of all communications relating to the process of case note review and providing communication support and advice to Professor Stevens and his colleagues. This included ensuring that proposed written communications about the CNR reflected the issues and learning identified through the prior communications and engagement work and that the improved mechanisms now in place to communication and engage with

affected families were utilised. These arrangements were reflected in a Communications Plan that was approved in August 2020 **(A49624113 - QEUH - Case note review - Communications Plan - v0.7 - Final - 26 August 2020 - Bundle 27, Volume 12, Page 447)**. NHS National Services Scotland provided a project management support for this Group and coordinated this workstream with all of the other work required to implement the CNR.

106. Of the 86 patients initially identified as eligible for inclusion in the CNR, NHSGGC received communication from one family requesting that their child be excluded and so the CNR undertook no consideration of the clinical circumstances of this case. I passed on a further nine written communications to the review for consideration. One raised specific concern relating to nursing care, which was considered by the CNR to be out of scope; another requested a copy of their child's medical notes from NHSGGC and a copy of any reports about their child, which was again considered by the CNR to be out of scope; and the remaining seven included specific concerns relating to their child's infection.

107. The main themes addressed by these 7 communications were summarised by the CNR as follows:

107.1. lack of clear communication about the nature of the infection(s);

107.2. questions raised about medication prescribed for and/or to prevent infection(s);

107.3. describing the impact the infection had had on their child/themselves, including delay in treatment;

107.4. concern about the length of time before the central venous line was removed; and

107.5. concern about the timing and interpretation of microbiological typing results from the reference laboratory.

108. I was involved in discussions in relation to what should happen prior to and following publication of the CNR report. I provided advice on the content of communication

reflected by my prior engagement with families. This was a very important stage in the CNR process. Discussions as to the process to be followed, included Professor Stevens and his team, NHSGGC, Professor Cuddihy and myself. It was agreed that the CNR would prepare individual written reports for each of the infection episodes included within the CNR for every patient. These would summarise the CNR findings in line with the framework to which the CNR worked during the CNR process (section 3.6).

109. I also ensured that any issues escalated to me on areas relating to the remit of the Oversight Board were communicated to the Chief Nursing Officer. For example, in February 2021, when I was formally advised that following review of evidence shared with them the CNR panel believed not all relevant data had been shared by NHSGGC relating to the Review. I advised the Chief Nursing Officer of this and her officials agreed to take further action to investigate the CNR panel's concerns.

110. The CNR viewed these as private reports from the Panel to the patient and family concerned. The CNR Team took responsibility for distributing the reports having first worked with NHSGGC to ascertain up to date contact details and communication preferences for the patients and families concerned and to confirm the most up to date medical status of all relevant patients.

111. It was agreed within the discussion group that families would receive written information about the process approximately 4 weeks before the reports were distributed. This would explain the timescale and offer the opportunity for patients and families to meet with members of the Panel after receiving their report, if they wished to do so. They would also receive information about the support available to them should they find the details of the report distressing or if it raised other concerns about their treatment experience and its consequences. The CNR also ensured that those families who had been bereaved by the death of their child would be able to access appropriate support.

112. Whilst those within the discussion group believed that the individual report should be 'owned' by the patient/family, the CNR Communication and Engagement Group believed it would be appropriate, subject to the consent of the patient/family, that a copy of the report should be made available to the clinical team who was, or at that time may

still have been, responsible for the care of each patient. The opportunity to share the report with the relevant clinical team was set out in the advance letter to the families.

113. When the CNR Team sent families their reports, they also sent an information sheet and consent form requesting consent to share the report with the relevant clinical team. Families were then able to contact the CNR Team to make an appointment for a meeting with the Panel had they wished to do so.

114. To further facilitate direct contact with the CNR Team, a specific operating procedure was established and an electronic mailbox was set up and was operational prior to the distribution of individual patient reports. It remained available until the process was complete. A contact telephone number was also provided for families to use if they preferred.

115. During this time the closed Facebook group continued to be used to reach parents with updates on all of the work, including the CNR process. I was also able to review membership of the closed Facebook group and ensure that any families not registered on this group received relevant communications through alternative routes.

116. My understanding is that a written summary of the meeting held with a family was not prepared but families were able to bring an additional person with them to the meeting to act as a supporter who could, if wished, also keep notes for the family during the discussion. Any agreed action points that emerged from the discussion were documented and shared in writing with the family after the meeting. This included an indication of how and by when it was hoped these could be addressed.

117. It was agreed that the CNR would treat the proceedings of the meetings as confidential and would not share the content of the discussion with any other person or organisation unless specifically requested and agreed by the family.

118. It was also agreed that once all meetings had been held with families who requested these, this would complete the work of the CNR team; and the Oversight Board and NHSGGC would be notified. The CNR was completed in January 2021 and the CNR Overall Report was published in March 2021. The staff from NHS National Services

Scotland, who provided a project management and co-ordination function to Professor Stevens and his team, also provided support that included the storage and retention of relevant records relating to family engagement and communication.

Reflections

119. In my view, the Cabinet Secretary's establishment of a single point of contact for advice and coordination with external agencies was beneficial for several patients and their families, the Scottish Government, and NHSGGC.

120. I have considered the scope, role, and remit of what I was asked to do and believe that I contributed to effectively ensuring that the 'voice', perspective, and experience of affected families were heard, more meaningfully engaged with and proactively considered through the various processes, organisations and structures involved. I met with all of the families who requested individual meetings with me and, at all times, sought to advocate their perspectives and experiences in the various meetings and processes I have described in this statement.

121. I believe that improvements were made in establishing channels of communication to better reflect the Scottish Government's policy commitments to person-centredness and candour and that this was effective in supporting a range of developments that created the conditions for more open and supportive dialogue with affected families. I think overall, more people developed a greater appreciation of the importance of ensuring people's views are given greater prominence and that Organisational responses are more explicitly developed with a relational and restorative focus (see below). Mrs Slorance's statement to the Inquiry reflects similar issues to those I encountered when I commenced my role. This suggests that there may have been insufficient proactive action taken to prevent, minimise or address the compounded harm that can occur if that isn't the approach taken. This raises questions about the extent to which the recommended improvements in the approach to communication and engagement have been reflected in the experiences of people expressing concerns and questions of a similar nature to those expressed by those involved in the processes outlined in this statement.

122. I gained insights into the potential for compounded distress and a deep sense of mistrust to develop when families experience fear, shock and anger and when their experience was that their views appeared not to be fully appreciated or understood. I recognised the challenges of ensuring that Organisational viewpoints did not overshadow individual family experiences, particularly if these were at odds with this and the potential for personal engagement to create the conditions to rebuild trust and confidence.

123. Although I believe NHSGGC colleagues sometimes found my challenges and scrutiny tough, I believe I developed productive working relationships with all colleagues and they understood why, give my role and remit on behalf of affected families, such challenges and approaches were an essential part of my remit.

124. I believe that because of the work undertaken on communications and engagement, NHSGGC colleagues felt more able to recognise and take actions to reflect insights into the improvements identified as necessary. I gained a good understanding of the particular complexities and challenges of Executive Directors and their accountabilities in an NHS Board with the size and scope of NHSGGC. I also appreciated the importance of ensuring that Executives are supported to develop the skills and confidence to proactively engaging in a more explicitly supportive and open dialogue. The work also reaffirmed experiences throughout my career of the power of ensuring that people directly impacted by adverse events, following deaths of relatives or when they are dissatisfied in any way with the quality or experience of care must have the opportunity to feel personally and meaningfully involved and engaged with staff and through that feel involved with the process of reviews that should form part of the relevant governance and improvement processes established in furtherance of NHS Board's duty of quality per the National Health Service (Scotland) Act 1978 section 12H.

125. Communication and engagement following adverse events must be more prominently influenced by work on who has been hurt and what their needs are. In particular a restorative inquiry framework and its focus on a relational process where all those affected come together in a safe and supportive environment with the help of skilled facilitators, to speak openly about what happened, to understand the human impact and

clarify responsibility for the requisite actions for healing and learning. This requires consideration of:

- Who has been hurt and what are their needs?
- Who is responsible for meeting these needs and what are their obligations?
- How can harms and relationships be repaired?
- How can we prevent it from happening again?

Declaration

I believe that the facts stated in this witness statement are true to the best of my knowledge, information and belief. I understand that this statement may form part of the evidence before the Inquiry and be published on the Inquiry's website.

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

Appendix A

A38097056 - Letter for parents in Ward 6A about the Closed Facebook page, from NHS Greater Glasgow and Clyde Health Board dated 25 September 2019

A33448010 - The Queen Elizabeth University Hospital/NHS Greater Glasgow and Clyde Oversight Board Final report dated March 2021

A49434277 - Email Chain involving C White, C Campariol-Scott and others - Submission on aspergillus in the QEUH - 24 November 2021 to 30 November 2021

Appendix B

A33949845 - S5W-25642 - To ask the Scottish Government what discussions it has had with families of paediatric cancer patients affected by the infection outbreaks at the Royal Hospital for Children and the Queen Elizabeth University Hospital, NHS Greater Glasgow & Clyde?

A33949846 - Email chain - J Downie, C White and others - Attaching "Scope, Role and Remit of Professor Craig White re Concerns Raised by Patients and Families… - 08 October 2019" - 04 to 08 October 2019

A33949847 - Letter from Professor Craig White to Patient/Family Representatives following meeting with Jeane Freeman - 09 October 2019

A33949849 - Scope, Role and Remit of Professor Craig White re Concerns Raised by Patients and Families within Paediatric Oncology/Haematology Service at Royal Hospital for

Children/Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde - 08 October 2019

A33949850 - Email chain - J Downie, A Corr, C White and others - Follow up work for Monday following GIQ and letters - Attaching "Prof White Letter - RHC Families - 091019","S5W-25642 GIQ" and "Prof White - Remit" - 04 to 09 October 2019

A33903159 - Letter from Professor Craig White to [redacted] - 29 October 2019

A33943938 - NHSGGC Responses to Family Questions

A49651390 - Email chain - Letter from Professor Craig White to families after media coverage - Forwarded to Cabinet Secretary for Health and Sport - 15 November 2019

A33903190 - Email chain - C White and J Cuddihy - Update on Discussions with NHS Greater Glasgow and Clyde to families - 16 to 19 November 2019

A49650838 - Email chain from C White - Update on Discussions with NHS Greater Glasgow and Clyde to families - Forwarded to Cabinet Secretary for Health and Sport - Attaching "QEUH WATER TESTING_REDACTED 1" and "Dr.Crichton - Explanation re Water Sample Report - 191119" - 19 November 2019

A49650913 - Email chain from C White - Update on Discussions with NHS Greater Glasgow and Clyde to families - Forwarded to S Bustillo, J Grant and others - Attaching "QEUH WATER TESTING_REDACTED 1" and "Dr.Crichton - Explanation re Water Sample Report - 191119" - 19 November 2019

A33944092 - Email from C White to L Allan - Attaching multiple documents - 25 November 2019

A33939227 - Email chain - C White and [redacted] - Update on Discussions with NHS Greater Glasgow and Clyde - Concerns following update - 19 to 20 November 2019

A34059477 - Email from C White to [redacted] - Attaching letter from Jeane Freeman to families - Update on Public Inquiry 28 November 2019 - 11 December 2019

A33977151 - Email from C White to families - Establishment of Oversight Board - Communication and Engagement Sub-Group - 29 November 2019

A33977250 - Letter from Professor Craig White to families - Escalation of NHS GGC to Stage 4 of NHS Board Performance Escalation Framework - 03 December 2019

A49438292 - Email from E MacKay to C White and others - QEUH Case Note Review - Communications & Engagement meeting 09 March 2021 - Attaching Agenda and Action Log - 05 March 2021

A49650900 - PART 2 - Papers considered at NHS Greater Glasgow and Clyde Oversight Board Communication and Engagement Subgroup Meetings

A49651792 - Family questions to Independent Review

A34187840 - QEUH Oversight Board - Communications and Engagement Subgroup - Terms of Reference - DRAFT

A49434684 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 05 December 2019

A49434655 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 18 December 2019

A49435644 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 09 January 2020

A49435742 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 29 January 2020

A34187974 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 04 February 2020

A34187883 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 18 February 2020

A34187906 - NHS GGC and QEUH Oversight Board - Communication and Engagement Sub Group - Minute - 03 March 2020

A49435707 - NHS GGC and QEUH Oversight Board - Communication and Engagement Subgroup meeting - Minute - 01 July 2020

A34187934 - NHS GCC and QEUH Oversight Board - Communications and Engagement Subgroup - Findings/Recommendations - August 2020

A49652167 - NHS GGC and QEUH Oversight Board - Interim Report - December 2020

A49650922 - Email chain - C White and J Cuddihy - Oversight Board Communication and Engagement - Feedback and Communication Links Established - 13 January 2020

A49651803 - SBAR - QUEH Independent Review - Request for Further Background on Reference to Organisational Duty of Candour - 07 June 2020

A49651169 - Email chain - J Cuddihy, P Raines and C White - J Cuddihy correspondence on Mycobacterium Chelonae cases and organisational duty of candour - 20 to 29 October 2020

A49650690 - QEUH/RHC Advice, Assurance and Review Group (AARG) - Terms of Reference - June 2021

A44777856 - QEUH/RHC Advice, Assurance and Review Group (AARG) - Minute - 07 June 2021

A49650938 - NHS GGC - Policy & Procedure - Duty of Candour - Compliance - OB - Final 14 - 29 July 2021

A49650695 - QEUH/RHC Advice, Assurance and Review Group (AARG) - Minute - 19 August 2021

A49438165 - NHS GGC escalation review based on the outcome of the QEUH / RHC Advice, Assurance & Review Group (AARG) - 15 September 2021

A49437501 - Health and Social Care Management Board - Minute - 15 September 2021

A49434796 - Email Chain - J Birch, I Barkby, C White and others - Submission on aspergillus in the QEUH CWard response - 24 to 25 November 2021

A49433379 - Email Chain - J Birch, A McMahon, C White and others - Submission on aspergillus in the QEUH CWard response - Response from Louise Slorance - 24 to 29 November 2021

A49650907 - SBAR - Organisational Duty of Candour Annual Reports Review - 09 December 2022

A49624113 - QEUH - Case note review - Communications Plan - v0.7 - Final - 26 August 2020