

SCOTTISH HOSPITALS INQUIRY

**Bundle of documents for Oral hearings
commencing from 16 September 2025 in
relation to the Queen Elizabeth University
Hospital and the Royal Hospital for
Children, Glasgow**

Bundle 51 – Volume 1

**Sir Robert Francis Whistle-blowing Expert
Report and supporting documents**

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THE SCOTTISH HOSPITALS INQUIRY

EXPERT REPORT OF SIR ROBERT FRANCIS KC

Date of Submission: 14 July 2025

Authored by Sir Robert Francis KC

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1. INTRODUCTION

1.1. I am Sir Robert Francis KC. I have been instructed on behalf of the Chair of the Inquiry to prepare a report advising the Inquiry on various questions posed to me concerning the standards to be expected in the treatment of whistleblowers and the concerns they raise in the context of a newly built hospital or a hospital department in Scotland. I describe my instructions below. Where appropriate I have cited a source for text in footnotes and placed direct quotations in italics.

1.2. I have reminded myself of the duties of an expert witness. I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

1.3. **Terms of Reference**

The remit of the inquiry is to

consider the planning, design, construction, commissioning and, where appropriate, maintenance of both the Queen Elizabeth University Hospital Campus (QEUH), Glasgow and the Royal Hospital for Children and Young People and Department of Clinical Neurosciences (RHCYP/DCN), Edinburgh”

and to determine

how issues relating to adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care occurred; if these issues could have been prevented; the impacts of these issues on patients and their families; and whether the buildings provide a suitable environment for the delivery of safe, effective person-centred care.

I have been asked to assist in particular with the issues arising under the 4th Term of Reference:

To consider whether any individual or body deliberately concealed or failed to disclose evidence of wrongdoing or failures in performance or inadequacies of systems whether during the life of the projects or following handover, including evidence relating to the impact of such matters on patient care and patient outcomes; and whether disclosures of such evidence was encouraged, including through implementation of whistleblowing policies, within the organisations involved.

1.4. **My instructions**

I am asked to assist the Chair in reaching conclusions on whether:

disclosures of evidence relating to the impact of features of the water and ventilation systems of the hospital on patient care and patient outcomes was encouraged as a practical reality.

In particular answers are sought to the following three questions:

- i. How can an external observer or investigator tell if an NHS Board or Trust has a problem within its organisation related to the encouragement of reporting by staff of patient safety concerns?*
- ii. What principles should be followed by an NHS Board or Trust that wishes to create an effective system in which such concerns can be raised?*
- iii. From all of the work undertaken by you, what are the most effective changes that can be made by NHS Board or Trust to create an effective system in which such concerns can be raised?*

I note that none of these questions require me to suggest findings of fact with regard to what happened, or to comment on the propriety of what was or might have been done in response to concerns allegedly raised. The first two questions focus in effect on the standards that the leadership of a hospital or services relevant to this inquiry might have been expected, applying any practice which was commonly adopted at the relevant time. The third question again does not ask me to comment on what might be recommended in this particular inquiry but on what changes I would suggest in general are effective in responding to patient safety concerns.

I am asked to proceed on the basis that the facts, and inferences to be drawn from the evidence to the Inquiry are those set out in the scenario prepared by Counsel to the Inquiry for the purpose of instructing me, and as attached to this report as Appendix 1.

1.5. Experience and conflicts of interest

I set out a more detailed curriculum vitae of my career and experience in Appendix 2. In summary I have been a barrister at the Bar of England and Wales for 50 years and was in self-employed practice at what is now Serjeants' Inn Chambers from 1974 to 2020, when I retired from full-time practice and ceased to be registered with the Bar Standards Board. I continue to offer my expertise in medical and healthcare related issues on a consultancy basis and to give presentations and talks on such issues in this country and abroad to audiences in and outside the healthcare sector. For the vast majority of my life in full-time practice I specialised in medical law, including clinical negligence, patient decision-making, professional discipline, healthcare regulation and public inquiries. Of particular relevance to this Inquiry I chaired the Mid-Staffordshire NHS Foundation Trust Independent Inquiry and the Mid-Staffordshire NHS Foundation Trust Public Inquiry which examined systemic failings which contributed to widespread harm to patients and the Freedom to Speak Up Review. This work involved a detailed analysis of the management of safety and the raising of concerns by staff in hospital settings. I also appeared as counsel for a senior core participant at the Bristol Royal Infirmary Inquiry which addressed similar issues. I have also been a non-executive director of the Care Quality Commission, the regulator of

healthcare providers in England and Healthwatch England, which supports local Healthwatch the statutory patient and service users' champions.

Since starting to prepare this report I have been appointed interim Chair of the Infected Blood Compensation Authority.

I do not consider I have any conflict of interest in relation to these matters and what follows is my honest opinion, independently arrived on the basis of my experience. I have not consulted anyone in relation to the preparation of this report other than the legal team of the Inquiry for the purpose of receiving and clarifying my instructions and remit.

1.6. Approach

In order to answer the questions posed I shall first set out my understanding of the role played by whistleblowers in this matter, then consider the relevant guidance and other context before proceeding to the questions themselves. For ease of reference I also attach as appendices a list of persons referred to and their roles, and a glossary of terms and abbreviations.¹

¹ Appendices 3 and 4 respectively.

2. Background

2.1. *The concerns raised*

The scenario sets out understandings or assertions of fact, based on the voluminous evidence available to the Inquiry. I have set out in the form of a chronology a summary of what appear to me to be relevant events, indicating alleged incidents of whistleblowing in bold.² Without rehearsing the detail here, in summary some of the more significant issues raised in the scenario are as follows:

2.1.1. Attempt by Drs Peters and Inkster to raise concerns between July and November 2015³

It is alleged that both these infection control doctors raised general cultural concerns and specific issues relevant to patient safety. While various responses were given, it is suggested that the accuracy of their concerns about ventilation systems was not investigated or acknowledged. The strength of feeling was such that Dr Peters and Dr Inkster resigned from infection control doctor roles. A review by Dr Stewart was instituted which looked at cultural issues but not the specific infection issues. Their continued expressions of concern about such issues were not, it is suggested, addressed.

2.1.2. Dr Inkster's communication of her reluctance to approve a decision to return adult bone marrow transplant patients to ward 4B – November to December 2015:⁴

Dr Inkster was asked to sign off and approve the return of adult bone marrow transplant patients to ward 4B, in the first instance without apparently being supplied with any relevant information about the remedial work which had been undertaken. She wanted external review of this issue. She succeeded in arranging this through Health Protection Scotland, but against some resistance of NHS GGC managers.

2.1.3. Attempts by Dr Redding to raise issues of concern relevant to patient safety and culture from 2015 to 2017⁵

She expressed concerns to several senior managers about what she described as an atmosphere of intimidation and bullying, of not putting things in writing or recording concerns in minutes.

2.1.4. Formal whistleblowing process October 2017:⁶

² Appendix 5.

³ Scenario paragraphs 145 – 170.

⁴ Scenario paragraphs 172 – 180.

⁵ Scenario paragraphs 181 – 185.

⁶ Scenario paragraphs 186 - 210

Concerns were raised about infection control doctors being asked to approve formally the adequacy of infection control remedial works in respect of which they had insufficient expertise. Dr Peters supported these concerns⁷ and as a result the doctors sent an SBAR on 3 October 2017. This resulted in a meeting the following day attended by 11 senior managers, Dr Redding and Dr Peters. The content and tone of the meeting is in dispute, but following it a 27 point action plan was prepared. It does not appear this met with the approval of the whistleblowers. Dr Redding then escalated her concerns to stage 2 of the whistleblowing policy. The matter was handled by Dr de Caestecker, Director for Public Health. In her report⁸ she concluded that the doctors' concerns were "legitimate", but either had been or were being addressed. She also made scathing criticisms of the attitude of Dr Peters [which she had not been asked to respond to] which are significant enough to quote in full:⁹

I heard an unfortunate but consistent circumstance about the situation summarised below:

*Dr Peters is very knowledgeable about infection control invading ventilation. She finds it difficult to accept balance of risk (e.g. if theatres or wards need to close, patients may be put at greater risk)
She is no longer an infection control doctor having resigned from this role
She does not accept being part of team and listening to views of others
She does not accept that infection control is a nurse led service
She sends frequent requests for updates which are not directly relevant to her role
She has caused great anxiety to colleagues by her styles of communication particularly the persistent stream of emails to the IC team and to TI.*

Dr Peters has subsequently accepted that she had discussed with Dr Inkster her communication style and had changed it as a result.

The report's recommendations included a requirement to acknowledge explicitly to Dr Peters that she had raised legitimate and important infection control issues and was instrumental in getting them dealt with, but that the infection control team should be "supported" to deal with her multiple emails about issues with which she had no direct role.

2.1.5. Dr Inkster's removal as chair of the IMT and her resignation – August 2019

The scenario¹⁰ gives a detailed description of the evidence surrounding Dr Inkster's removal as chair of the IMT in August 2019. While the nature of the discussion appears to be disputed, there is common ground that

⁷ See Bunde 14 vol 1, Document 69, Page 696 et seq.

⁸ Bundle 27 vol 4, Document 6, Page 81

⁹ Ibid page 83.

¹⁰ Scenario §234-278.

the invitation¹¹ to the meeting did not notify attendees of an intention to discuss Dr Inkster's suitability as chair was, and that she was not invited to attend. The minute of the meeting¹² records complaints about behavioural issues and communication at meetings which were described as "*confrontational*", "*uncomfortable*", "*off the scale bad*", "*totally disrespectful*". It was suggested "*feelings of defensiveness and vulnerability*" were experienced during meetings, as well as "*toxicity*", "*lack of identification as a team*", "*feelings of blame being attributed*": "*some people felt unable to speak up at the IMT because of this culture.*" Without expressly saying so, the minute places responsibility for these defects on the chair, while recognising how difficult the role was. The meeting decided, according to the minute, that a new chair should be appointed.

In a letter of 2 September 2019¹³ Dr Inkster tendered her resignation from her roles as lead and sector ICD. In it she claimed that recently she had experienced:

A lack of response and I have felt unsupported and undervalued by members of my infection control team and management, Despite being chair my comments on Comms have been disregarded. .. I have been excluded from discussions and requests for environmental results for the review and a colleague has informed me of plans for a Great Ormond Street visits for which I am not included. Last week I was asked to demit chair of the IMT with four different reasons cited by the ICM, three of those in public and all of which were untrue. I was informed... that the feedback from IMT was dreadful and that everyone... in the room stated this....my professionalism has undoubtedly been called into question.

It appears that after her resignation Dr Inkster was required to consult the employer's occupational health department who advised that she should be sent on sick leave for stress, whereas her own doctor considered she was fit for work.

2.1.6. Stage 3 Whistleblow and subsequent investigations¹⁴

On 21 November 2019 Dr Redding invoked stage 3 of the organisation's whistleblowing policy, in part because of her concern at the accuracy of statements to the press to the effect that there had been no water testing in 2017. The stage 3 report¹⁵ accepted that the report to the press in this regard had been inaccurate, as there had been testing for particular types of bacteria and that this was "*extremely regrettable*". Concerns raised by Dr Redding about the number of air changes in rooms were rejected in the report on the basis that the infection control team had a

¹¹ Bundle 14 vol 2, Document 144, Page 568.

¹² Bundle 6, Document 22, Page 70.

¹³ Bundle 14 vol 2, Document 151, Page 579.

¹⁴ Scenario § 279.

¹⁵ Bundle 27 vol 4, Document 11, Page 116; report dated May 2020.

different professional view. Contrary to her concerns, the report also concluded that clear guidance had been given on the suitability of rooms for particular patients. A comment was made that¹⁶:

Dr Redding ... is not a practising Microbiologist within NHS GGC, and therefore cannot comment from experience on current communications and arrangement, of which she does not have first hand knowledge.

Likewise her concerns about the use of chilled beams were rejected on the basis of a different opinion based on guidance, as was a suggestion that the Board had presented false data in asserting that QEUH infection rates were reasonable and in line with other sites.

The report devotes considerable space to concerns about alleged bullying and also whether the earlier raising of concerns had been treated as stage 1 whistleblowing in accordance with the then policy. The conclusion, recognising that the concerns were important and praising Dr Redding for her courage in raising them, was that reports of bullying were “*hugely worrying*” and that it was essential that if discovered whether these concerns were shared by others, in part through a review to be conducted by Prof Bain.

2.2. Case as submitted by Counsel to the Inquiry

Counsel submits the evidence leads to a number of conclusions:¹⁷

- *There is no substantive evidence to support the view that Dr Peters and Dr Inkster were ever wrong when they identified flaws in the ventilation systems of the hospital, which they then drew to the attention of colleagues and NHS GGC.*
- *At every turn NHS GGC senior managers, including the Medical Director, sought to minimise or belittle the points they were making, whilst at the same time reacting to the flaws identified in a way that suggests that they recognised (eventually) that the flaws existed.*
- *Those senior managers used informal meetings, whistleblowing reports and eventually the power to remove Dr Inkster as IMT chair, in order to undermine points being made by Dr Redding, Dr Peters and Dr Inkster, and to protect the reputation of NHS GGC.*
- *There was some evidence that, from 2017, Dr Peters may have had a communication style in her emails that was aggravating to those in IPC and senior management who heard from her, but even if that is the case it must be acknowledged that this was after two or more years of having her concerns ignored or sidelined*

¹⁶ Ibid page 119.

¹⁷ Scenario §295-296.

- *Even if one was to decide that Dr Inkster's leadership of the Gram-Negative Bacteraemia IMT in August 2019 was sub-optimal ... by that point Dr Inkster was overworked, under supported, and undermined in her role as lead ICD and chair of the IMT, and that would have to be taken into account.*
- *Dr Armstrong's criticism of Dr Redding, Dr Peters and Dr Inkster that they put their interest ahead of patients is not supported by the other evidence. Had there been evidence of this, as NHS GGC's Responsible Officer, Dr Armstrong would have had to deal with the issue at the time by formal disciplinary response or GMC referral.*
Dr Redding, Dr Peters and Dr Inkster should be praised for their commitment to ensuring that the effect of the flaws in the water and ventilation systems of the QEUH/RHC on its patients were fully investigated.

Counsel to the Inquiry suggests that while many witnesses have described growing awareness of flaws in the water and ventilation systems and of concerns in the response to concerns, the principal protagonists for expressing those concerns were Drs Redding, Peters and Inkster. While only Drs Peter and Redding invoked formal whistleblowing processes, all three were subject to severe criticism for their views in a position paper presented on behalf of the GGC Board to the Inquiry published in December 2022.¹⁸ This contained a list of 15 "examples" of alleged misconduct and undermining of efforts to manage infection control. The allegations include "excessive and unnecessary demands", of managers, failure to respect the opinions of professional colleagues, a failure to apply principles of risk management, making false accusations on the accuracy of Board public statements, and providing inaccurate information to patients and families regarding infection and the hospital environment. It was suggested¹⁹ that the "challenges" faced by the Board, were "significantly exacerbated" by the whistleblowers:

whose various actions appeared to have been designed to undermine their colleagues, and the steps being taken collectively to ensure the safety and welfare of patients and, in consequence, undermined the crucial bond of trust between the hospital and its patients.

It is the submission of Counsel to the Inquiry that NHS GGC managers have sought to *minimise or belittle* the concerns raised by the whistleblowing doctors.

2.3. Comment

¹⁸ Scenario 140; Bundle 25, Document 62, Page 1262, but see page 1282 in particular.

¹⁹ Ibid page 1284.

It is not for me to analyse the merit of the conduct as described by Counsel or the contrary accusations made in NHS GGC's position paper, but I can make a number of observations:

- 2.3.1. The concerns raised were relevant to the safety of patients and the use of the relevant hospital premises for that purpose.
- 2.3.2. There would appear to have been at best a reluctance to accept these concerns or the right of the doctors to raise them.
- 2.3.3. It is not clear that all such concerns were investigated rigorously or at all.
- 2.3.4. The doctors were resented for raising these concerns or at least for persisting in doing so.
- 2.3.5. The fact that allegations of the type made in the position paper have been made at all suggests a complete breakdown of trust between the whistleblowers and their employers in relation to serious issues regarding patient safety.
- 2.3.6. These are typical of the sort of issues which in my experience not only arise but persist when an appropriately open and "safe" culture is not being consistently maintained. Certainly, even if there was justification for dismissing the concerns raised, the position paper of the NHS GGC cited above does not display a tone which is conducive to encouraging professionals with honestly held safety concerns to raise them, or, if they have already done so, to persist even where they genuinely believe these have not been addressed.

3. Policies

I have been referred to several whistleblowing policies adopted by NHS GGC and a review of their implementation:

2013	NHS GGC Whistleblowing policy. ²⁰
2018	NHS GGC Whistleblowing policy ²¹
29 March 2021	NHS GGC Paper presenting the whistleblowing policy ²²
29 March 2021	NHS Scotland – Whistleblowing policy – how to raise a whistleblowing concern ²³
March 2021	Whistleblowing Review for GGC by staff governance committee ²⁴

3.1. NHS GGC Whistleblowing Policy June 2013²⁵

This policy asserted that

Staff have a responsibility to protect patients from risk of harm posed by another colleague's conduct, performance or health by taking immediate steps to ensure their concerns are dealt with or raised for appropriate investigation. NHSGG&C promotes a culture in which staff can raise concerns openly and safely.... When the concern feels serious because it is about a patient safety issues.... Or serious risk that might affect patient, colleagues or the organisation itself, staff are encouraged to raise such issues in the first instance with their Line Manager.

§ 13.2.4. ... NHSGG&C wishes to promote an open culture that recognises the potential for staff to make a valuable contribution to the running of public services

§13.3.1 ...The Board wishes to create a working environment which encourages staff to contribute their views on all aspects of patient care and patient services.

The Policy sets out how concerns are to be handled once raised. In particular the line manager was to consider how the concern should be dealt with in the first instance, the options being informal review, internal inquiry, or formal investigation.²⁶ If at any time it *becomes evident* that formal disciplinary action may be a *possible outcome* the review, inquiry or investigation will be

²⁰ Bundle 27 Vol 4, Document 3, Page 45

²¹ Bundle 27 Vol 4, Document 4, Page 53.

²² Bundle 27 vol 4, Document 13, Page 131.

²³ Bundle 25, Document 68, Page 1417.

²⁴ Bundle 27 Vol 4, Document 14, Page 133.

²⁵ Bundle 27 Volume 4, Document 3, Page 45.

²⁶ Ibid paragraph 13.8.1

conducted in accordance with the disciplinary policy.²⁷ Where the matter has been escalated beyond the first two stages, the responsibility for handling passes to a non-executive member of the Board.²⁸

3.1.1. *Comment*

Understandably at this time, there was no provision for Freedom to Speak Up Guardians, champions or ambassadors, but it is nonetheless fair to observe that the policy would have facilitated a transfer of a safety concern to a disciplinary process, involving either the person raising the concern or any person about whom a concern was raised. My experience suggests that policies encouraging the raising of concerns, which should be a consensual and collaborative process, should be separated and distinguished from disciplinary processes.

3.2. **NHS GGC Whistleblowing Policy - 2018²⁹**

This policy committed NHS GGC to “*a healthy workplace culture built on openness and accountability. Integral to achieving this is to encourage staff to raise any serious concern they may have about patient safety... or serious risk as soon as possible.*”³⁰

3.2.1. *Comment*

The procedures set out appear to be very similar if not identical to those in the 2013 policy. Although this policy post-dates the publication of the Freedom to Speak Up Review [2015], there was still no provision for Freedom to Speak Up Guardians, ambassadors or champions, and the whistleblowing policies remained closely associated with the possibility of disciplinary action. I am not aware of how common it was in Scotland at this date for healthcare organisations to have appointed the equivalent of Freedom to Speak Up Guardians, but while the UK government and NHS England had agreed to this recommendation, take up by NHS Trusts and Foundation Trusts in England was slow.

Policies and processes for raising and addressing concerns raised by staff and offering means of resolving disputes are of course necessary and play an important part in indicating the leadership’s expectations. However they are not a sufficient measure on their own to ensure that all staff feel safe to raise serious or difficult concerns, or that such concerns are properly addressed when they are raised. It is quite possible to have a policy adopting all the principles I describe below in an organisation where management and/or staff still conduct themselves in a counterproductive manner.

²⁷ Ibid paragraph 13.8.6

²⁸ Ibid paragraph 13.9.1

²⁹ Bundle 27 Volume 4, Document 4, Page 53.

³⁰ Ibid page 53 para 13.1.1

3.3. **April 2021 NHS Scotland whistleblowing standards**³¹

The Independent National Whistleblowing Officer³² published Standards in April 2021. This required NHS services to have effective procedures for raising concerns which are:³³

- *open*
- *focused on improvement*
- *objective, impartial and fair*
- *accessible*
- *supportive to people who raise a concern and all people involved in the procedure*
- *simple and timely, and*
- *thorough, proportionate and consistent.*

3.3.1. *Comment*

The detail may require consideration in full but among the many relevant requirements of these standards it should be noted that support should be offered to all staff who are involved in a concern at all stages through the process and that procedures for raising concerns should be objective, based on evidence and driven by the facts and circumstances, not assumptions. The Officer has set out detailed guidance on the procedures to be followed in the NHS and the governance requirements. These include a whistleblowing ambassador – a role which appears similar to the Freedom to Speak Up Guardian I proposed for the NHS in England. While I anticipate that the events being scrutinised by the Inquiry predate the coming into existence of the INWO or indeed the SPSO, the principles adopted appear to align with those advocated in the reports to which I have referred.

3.4. **March 2021 NHS GGC whistleblowing review**³⁴

This review appears to have been commissioned by the staff governance committee to support the development of a new policy in response to the expected publication of the National Standards referred to above. It was a three year retrospective review of individual and management experience of whistleblowing to support the development of a new policy, taking account of

³¹ *The National Whistleblowing Standards – Whistleblowing Principles*
https://inwo.spsso.org.uk/sites/inwo/files/Standards/NationalWhistleblowingStandardsPart01_Principles.pdf

³² The Independent National Whistleblowing Officer was a post created in 2020 by *The Public Services Reform (The Scottish Public Services Ombudsman) (Healthcare Whistleblowing) Order 2020* SSI 2020/5 <https://www.legislation.gov.uk/ssi/2020/5/contents/made> which provided for this work to be undertaken by the Scottish Public Services Ombudsman, a role which was created by the Scottish Public Services Ombudsman Act 2002.

³³ Ibid page 2

³⁴ Bundle 27 Volume 4, Document 13, Page 131.

the new Standards. The review focussed on the handling of whistleblowing cases, not their outcomes.

3.4.1. Recommendations were made based on the findings of the review which included the following:

- a) Investigations into whistleblowing cases were conducted in a way that was viewed as a *broadly positive* experience by those interviewed.
- b) Some cases were incorrectly classified as not whistleblowing: 50% of the cases reviewed from the complaints department.³⁵
- c) The current whistleblowing experience had not been positive for many whistleblowers, managers and others involved: 60% of whistleblowers and 33% of managers reported a negative impact on their mental health. A quarter of whistleblowers interviewed would not whistleblow again Managers reported feeling *accused* of wrongdoing:³⁶

With Managers less directly involved and Senior Managers, feelings of stress appeared to relate to a strong sense of responsibility for something gone wrong in their workplace.

- d) The whistleblowing process was being used to investigate matters which were not whistleblowing within the meaning of the policy.
- e) There was limited understanding of the availability of a step 1 investigation.
- f) Recommendations from investigation reports were not rigorously performance managed thus losing learning.
- g) The review team developed an admittedly subjective opinion that managers did not believe that whistleblowing should be promoted in support of a learning culture, and regarded it as reflecting negatively on their department.

*In a small number of cases, this appeared to manifest itself in a less than positive attitude towards Whistleblowers.*³⁷

It was reported that managers perceived whistleblowing cases they received as *accusations*, a feeling not noticed by investigators..

- h) Managers felt they lacked *ownership* of the process.

³⁵ Bundle 27 Volume 4, Document 14, Page 138 §5.1.

³⁶ Ibid page 139-140 §5.3

³⁷ Ibid page 143 §5.7

- i) There was no documented process to highlight serious urgent issues to the appropriate manager for immediate action.

3.4.2. *Comment*

This report is expressed in carefully guarded language, and one of its authors is a highly respected expert in patient safety issues.³⁸ While again it is not for me to comment on whether these findings are justified on the evidence, the report is indicative of a culture in which the value of serious concerns being raised was not widely understood, and in which there was a risk of the fear of being blamed for something that had gone wrong was stronger than the motivation to reflect on what was reported and its implications for safety.

³⁸ I should declare that Professor Vincent was an adviser to the Mid-Staffordshire Public Inquiry which I chaired and is the author of a thoughtful book on patient safety: Vincent, *Patient Safety* 2nd edition 2011, BMJ Books.

4. What principles should be followed by an NHS Board or Trust that wishes to create an effective system in which such concerns can be raised?

I have chosen to address this question first, although it is second in Counsel's list, as it seems to me to logically precede the first question. I will first consider some of the sources which should be familiar to any leader in the NHS in England and Wales, and I see no reason why the same could not apply in Scotland. Indeed I was asked to give evidence to the Scottish Parliament's Health and Sports Committee on 13 June 2017 when I drew their attention to the lessons to be learned from the Mid Staffordshire Inquiries and the Freedom to Speak Up Review.³⁹ I am aware the protections and support available for whistleblowers are different in Scotland. However this is unlikely to affect the principles which an NHS Trust should follow. Therefore, it may be helpful to point the Inquiry to some of the many sources for such principles before turning directly to the question.

4.1. *The Principles of Public Life*

- 4.1.1. The seven principles of public life, often known as the Nolan principles after the chair of the Committee on Public Standards in Public Life which first promulgated them, have been adopted and promoted as obligations of public officials in the UK ever since they were first promulgated in 1995.⁴⁰ The principles are:

Selflessness – Holders of public office should act solely in terms of public interest.

Integrity – They must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence their work.

Objectivity – They must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability – They are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness – They should act and take decisions in an open and transparent manner: information should not be withheld from the public unless there are clear and lawful reasons for so doing.

³⁹ For a recording of that evidence see <https://www.scottishparliament.tv/meeting/health-and-sport-committee-june-13-2017>. I attach as appendix aa a copy of the written statement I offered to the Committee.

⁴⁰ *The Seven Principles of Public Life*, 31 May 1995 Committee on Standards in Public Life <https://www.gov.uk/government/publications/the-7-principles-of-public-life/the-7-principles-of-public-life--2> See also the *summary of the Nolan Committee's First Report on Standards in Public Life* https://assets.publishing.service.gov.uk/media/5a7da2ed40f0b635051d0604/1stInquiry_Summary.pdf

Integrity – They should be truthful.

Leadership – they should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

4.1.2. *Comment*

While universally accepted as obligations of leaders in public bodies these principles have not on their own proved sufficient to prevent serious organisational and cultural failures. When the Committee reviewed the application of their Principles in 2025 the Chair noted that:⁴¹

The common themes among organisations that have failed the public in recent years are clear for all to see.

Many of the reports of public inquiries and other independent reviews have revealed weaknesses in organisational culture, characterised by defensiveness and a reluctance to listen to and act on concerns raised by employees and members of the public. There was often a failure to identify and address emerging issues before they escalated and a failure to learn from previous mistakes or similar incidents and failures...

*... culture and leadership, at all levels, are central to ensuring that these processes are effective. And that building an organisation where it is second nature for people to speak up about concerns is an art and not a science. By this I mean that there is no blueprint to follow, but **when leaders are committed to advocating the benefits of an open culture and listen with curiosity when staff raise concerns, or suggestions for better ways of doing things, organisations can catch risks or make improvements and, as a result, are better able to deliver their purpose in the public interest.** It is not always easy to speak up – it requires moral courage to be the person who says, ‘I’m not sure this is going to plan,’ or, ‘is there a risk that if we do X, it will have these negative consequences?’ But in doing so, we honour the basic contract that we as holders of public office have with the public we serve.*

- 4.1.3. A number of the themes considered by the Committee on Standards in Public Life in this report are in my opinion particularly relevant to the present Inquiry. These include:

⁴¹ Chalmers, *Recognising and responding to early warning signs in public sector bodies – A review by the Committee on Standards in Public Life* March 2025 page iv [emphasis supplied] (to be added to a bundle).

- a. Data and risk – It was observed that⁴²

Everyone within a public sector body has a responsibility to identify and report risks. People working in public-facing roles often see the first signs that there may be an emerging problem in the delivery of public services. It is therefore crucial that frontline workers and their managers have processes in place that enable them to identify potential issues. Creating a culture where people feel safe to speak up is a core part of an organisation's ability to identify and act on risks...

... They require leaders to be curious about what the data is saying about their organisation and.... 'to poke into the dusty corners'

- b. Effective scrutiny by the board – it was observed that board culture was a crucial factor in effectiveness and will be heavily influenced by the relationships between and among the executive and non-executive directors.⁴³
- c. Learning from successes and failures - The committee pointed out the need to have systems in place enabling lessons to be learned from things that go wrong in order to avoid recurrence. Organisations should also⁴⁴

Take note of recurring themes when things go wrong elsewhere in public life and consider what their own organisation might learn from these crises.

- d. Leadership and culture – The committee set out succinctly three characteristics of good leadership:⁴⁵

- **Clarity.** Leaders must be clear that they welcome potential problems being brought to their attention early and that everyone in the organisation has a duty to deal with the public with openness and honesty
- **Consistency.** Leaders must be role models for the standards they expect of others, even when they are under pressure. When employees speak, leaders must listen.
- **Consequences.** Leaders must address behaviour that is inconsistent with a culture that values people raising concerns. In public life, the 'how' is as important as the 'what' in getting things done.

... Employees need to feel that leaders are genuinely interested in what they have to say, and leaders need to be visible and available. The way leaders respond when people raise concerns has a ripple effect though

⁴² Report page 3.

⁴³ Ibid page 4.

⁴⁴ Ibid page 5.

⁴⁵ Ibid page 6.

an organisation – for good or bad. Strong leadership requires leaders to be curious about their organisation and to welcome concerns and complaints as information that will enable them to make improvements.

- e. Various barriers to identifying and learning from problems in public sector bodies were identified. These included:
 - Institutional defensiveness and reputation management
 - “Groupthink”
 - Poor relationships
 - Failure to build a speak up culture
 - Failure of board scrutiny
- f. The report referred to various recent inquiries, and a table of potentially relevant quotations is appended as appendix 6. However, of particular application to the present inquiry is the *Vale of Leven Hospital Inquiry Report – 2014*.⁴⁶ The report of this inquiry was published in November 2014 following a disastrous outbreak of clostridium difficile in a Scottish Hospital. Not only did the Inquiry find serious deficiencies in medical and nursing care, but also deficient infection prevention and control practices. The report observed that

*The important principle of Board to ward and ward to Board means that there must be an effective line of reporting, accountability and assurance.*⁴⁷

It concluded that:

A lack of strong management as well as personal and system failures contributed to the development of a culture in the VOLH that had lost sight of what is of the very essence of a hospital – a caring and compassionate environment dedicated to the provision of the highest possible level of care.

Among other deficiencies found were:

- A lack of leadership curiosity: a failure of what the Inquiry called “one of the most fundamental aspects of management, namely to ask questions”⁴⁸.
- A reactive culture: a failure to seek proactively assurance that systems and personal were working effectively
- Acceptance of poor management behaviour: “accepted behaviour than puts patients at risk has no place in any Health Board’s philosophy”.⁴⁹

⁴⁶ *The Vale of Leven Hospital Inquiry Report* November 2014 SG/2014/211 (to be added to a bundle)

⁴⁷ Ibid executive summary page 6.

⁴⁸ Ibid executive summary page 14.

⁴⁹ Ibid executive summary page 16.

4.2. The report of the Committee on Standards in Public Life explicitly referred to other recent reports, but in fact the themes identified above have consistently been expressed in inquiries and reports dating back to the beginning of the century if not before. To offer but a few examples:

4.3. ***The Bristol Royal Infirmary Inquiry***⁵⁰

4.3.1. This inquiry related to the substandard care provided to paediatric cardiac patients. I consider that all leaders of NHS provider organisations in the UK should have been aware of the findings of this inquiry and the lessons for all such organisations it offered. While some of the recommendations were institutional and outside the immediate control of hospital leadership, many were cultural and therefore ones to which any senior leader should have had regard. While the failure prompting this inquiry concerned inadequate standards of surgery, I see no reason why the lessons offered were not equally applicable to other areas of safety for patients, including infection control and adequacy of building design and construction.

4.3.2. A particular focus of the Bristol Inquiry was the failure of the executive to give sufficient weight to concerns raised by a clinician and the treatment of that clinician. In relation to safety the report summary stated:⁵¹

There was too little recognition that the state of buildings and of equipment, and the training of the staff, could cause actual harm to the children. For the future, the NHS must root out unsafe practices. It must remove barriers to safe care. In particular, it must promote openness and the preparedness to acknowledge errors and to learn lessons. Healthcare professionals should have a duty of candour to patients. Clinical negligence litigation, as a barrier to openness, should be abolished. Safe care should be promoted and led by a non-executive member of every trust board.

4.3.3. Many seminal recommendations were made by Sir Ian Kennedy. These included a duty of candour. Recommendations 33, 34 proposed a duty of candour owed to patients who have been the subject of an adverse event. This recommendation was accepted by the Government, but no

⁵⁰ *Final Report - Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995* Cm 5207 July http://www.bristol-inquiry.org.uk/final_report/the_report.pdf . I should declare that I appeared at this Inquiry as leading counsel for the Trust's Chief Executive.

⁵¹ http://bristol-inquiry.org.uk/final_report/Summary.pdf paragraph 14

statutory provision was put in place until 2014, after I made a similar recommendation in the Mid Staffordshire Inquiry.⁵²

- 4.3.4. Sir Ian was highly critical of the treatment of staff who raised concerns and the leadership response to concerns about safety. He said:⁵³

In Bristol too few people had too much power. Unhappily, if the people have flaws, the organisation becomes vulnerable. An organisation offering a service must, of course, have dedicated staff. But that is not enough. It must also have in place within it systems that allow it to learn, develop and prosper, quite apart from any external mechanisms. A key feature of such systems is that all involved must feel able to be open about their work and the work of colleagues. This is a central message which emerges from Bristol.

- 4.3.5. He was also critical of a system of management which discouraged problems being reported to the central leadership:⁵⁴

Sadly, a system of separate and virtually independent clinical directorates, combined with a powerful message that problems were not to be brought to the centre for discussion and resolution, meant that there was power but no leadership. An environment was created in which problems, which we repeat are likely to arise in all institutions, were not adequately identified or addressed in Bristol.

- 4.3.6. He was clear that the problems he identified were not confined to a particular hospital and proposed a series of steps to bring about a culture in the NHS, one of openness, accountability, quality and safety, public service and teamwork.⁵⁵ He recognised that there was a tension in the health service between safety requirements and the pragmatism sometimes driven by resource constraints or other factors:⁵⁶

The challenge historically has been the extent to which the NHS will compromise the culture of safety in favour of the culture of pragmatism. Pragmatism, it might be thought, must give way to observing the appropriate safety standards. In fact, both of the apparent responses to the fact that standards cannot be met have implications for safety. The first response may be to cease activity until remedial action can be taken... This means, ... , that fewer patients will be treated, or patients will have to wait longer, or they will have to travel further for treatment Alternatively, the hospital can carry on offering the service, recognising

⁵² For the Mid Staffordshire Inquiry see below. The statutory duty of candour was introduced by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 <https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-20/regulation-20-in-full>

⁵³ Report Chapter 12 para 61.

⁵⁴ Ibid Chapter 15 para 19.

⁵⁵ Ibid Chapter 22.

⁵⁶ Ibid Chapter 22 paras 37-38.

that safety is being put at risk, but also recognising that those who are successfully treated without extra waiting and travel have gained in terms of safety.

Thus, where the culture of safety is compromised hospitals are in a 'lose/lose' situation. They put their patients at risk whichever course they adopt. The way forward depends, therefore, on an understanding by all of the nature of this problem, that it often cannot be solved quickly, and that the process of solution requires a series of co-ordinated steps. This is a process, not something to be achieved overnight. Questions of safety must be discussed in an open and transparent manner, so that all, particularly current and future patients, can make suitably informed decisions.

4.3.7. To address this real dilemma among many other recommendations Sir Ian proposed that steps be taken to make the NHS work place a transparent one in which staff felt it was safe to raise concerns. For example:

- Recommendation 107: *Every effort should be made to create in the NHS an open and non-punitive environment in which it is safe to report and admit sentinel events.*
- Recommendation 112: *All sentinel events should be subject to a form of structured analysis I the trust where they occur, which takes into account not only the conduct of. Individuals, but also the wider contributing factors within the organisation which may have given rise to the event.*
- Recommendation 113: *The reporting of sentinel events must be made as easy as possible.*
- Recommendation 121: *... an executive member of the board should have the responsibility for putting into operation the trust's strategy and policy on safety in clinical care. Further a non-executive director should be given specific responsibility got providing leadership to the strategy and policy aimed at securing safety in clinical care.*

4.4. Mid Staffordshire NHS Foundation Trust Inquiries⁵⁷

4.4.1. Before the Public Inquiry, which I chaired, there was a non-statutory inquiry, which I also chaired. This made 18 recommendations. The

⁵⁷ Reports: *Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009*, 24 February 2010 HC375-1 [Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009 HC 375-I](#) and *Independent Inquiry into care provided by Mid Staffordshire Foundation Trust Inquiry: Volume 2 HC 375-II*; *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* HC898-1 to HC 898-3 February 2013 "https://assets.publishing.service.gov.uk/media/5a7c9bec40f0b65b3de09fde/0898_i.pdf

Public Inquiry made 290 recommendations. The Government accepted most of them at least in principle.⁵⁸ While most recommendations were inevitably focussed on this particular Trust, recommendation 18 of the Independent Inquiry was that all NHS Trusts providing hospital services should review their own systems in the light of the report. Recommendation 1 of the Public Inquiry report was that all NHS organisations should review annually their implementation of its recommendations. I see no reason why Scottish leaders would not have considered the lessons from both these reports.

- 4.4.2. The first report focussed on the experiences of patients and staff at the hospital during the relevant period; a frankly shocking disregard of quality and safety was reported in many [but not all] parts of the hospital. This led to my first recommendation in the Independent Inquiry that:⁵⁹

The Trust must make its visible first priority the delivery of a high-class standard of care to all its patients by putting their needs first. It should not provide a service in areas where it cannot achieve such a standard.

- 4.4.3. It is fair to say that this was a stronger recommendation than that made by Sir Ian, and I accept that a degree of pragmatism has realistically to be accepted. However, Sir Ian was clear that acceptance of risks of harm was for patients to decide, on the basis of honest and transparent information.
- 4.4.4. I also felt that staff should be supported in raising concerns and protected from adverse consequences:

*Recommendation 8: The Board should give priority to ensuring that any member of staff who raises an honestly held concern about the standard or safety of the provision of services to patients is supported and protected from any adverse consequences, and should foster a culture of openness and insight.*⁶⁰

- 4.4.5. The Public Inquiry uncovered concerning stories of the way staff who raised concerns were treated.⁶¹ This resulted in a number of recommendations including:

⁵⁸ See *Hard Truths – The journey to Putting Patients First, The Government Response to the House of Commons Health Committee Third Report of Session 2013-14: After Francis: making a difference* Cm 8755 [Hard Truths: The Journey to Putting Patients First: Volume One](#).

⁵⁹ Independent Inquiry report, Page 26, 403.

⁶⁰ Ibid page 27, 410.

⁶¹ Public Inquiry report, Volume 1, Chapter 2 paragraphs 2.371-2.400. See also recommendations 23 and 274.

- Recommendation 2 which proposed a common set of shared core values and standards, including transparency, honesty, and candour.⁶²
- Recommendations 3 to 29⁶³ which expanded on the values required. These included:
 - *Staff put patients before themselves;*
 - *They will do everything in their power to protect patients from avoidable harm;*
 - *They will be honest and open with patients regardless of the consequences for themselves;*
 - *Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so;*
 - *They will apply the NHS values in all their work.*

4.4.6. The fundamental standards suggested were to be defined to make clear the minimum required to protect patients from avoidable harm, a breach of which should not be tolerated.⁶⁴

- Recommendation 12: *Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting”.*

4.4.7. I made a wide range of recommendations to create and promote openness, transparency and candour.⁶⁵ Some of the detail is specific to the structure of the NHS in England and Wales, but I would have expected the overarching objectives and principles to be as applicable in Scotland. I observed that:⁶⁶

Openness, transparency and candour... , has several elements. The term embraces the concept of being open and truthful about individual incidents in which things have gone wrong. It also involves offering a balanced picture of performance generally that is devoid of the “spin” of downgrading important matters of concern and exaggerating positive achievements. It requires insight into personal and organisational deficiencies and the welcoming of constructive criticism. Above all, it requires a determination to put right what has gone wrong, not only for any who have suffered as a result, but to protect future patients from a

⁶² Public Inquiry report volume 3, Chapter 20 *Culture*, Page 1399.

⁶³ Ibid Volume 3, Chapter 21, *Values and Standards*.

⁶⁴ Ibid page 1435 paragraph 21.107.

⁶⁵ Ibid Chapter 22 *Openness, transparency and candour*, recommendations 173 to 184.

⁶⁶ Ibid Page 1488, paragraph 22.152.

repetition of wrongdoing. It requires a willingness to learn and be challenged.

4.5. I was recently asked to advise the Thirlwall Inquiry on, among other matters, the extent to which public inquiry recommendations have been implemented.⁶⁷ To avoid repetition I now quote what I wrote about the implementation of these recommendations on openness, transparency and candour:⁶⁸

a. *As noted above recommendations for such a duty had been made by the Bristol Inquiry but not implemented. It was my view that the events at the Mid Staffordshire NHS Foundation Trust demonstrated beyond argument the need for such a duty. As indicated in the Schedule the Government reflected at least the theory of these recommendations by introducing a duty of candour into the Health and Social Care (Regulated Activities) Regulations.*⁶⁹

b. *The requirements of openness and honesty in all communications were included in the NHS Constitution:*

(i) *Patients were told they had a right to*

... an open and transparent relationship with the organisation providing your care. You must be told about any safety incident relating to your care which, in the opinion of a healthcare professional, has caused, or could still cause, significant harm or death. You must be given the facts, an apology, and any reasonable support you need.

(ii) *The NHS pledged to promote supportive and open culture that help staff do their job.*

(iii) *Staff were under a duty to be honest and truthful in applying for a job and in carrying it out, and to “aim” to be **open with patients, their families, carers or representatives, including if anything goes wrong; welcoming and listening to feedback and addressing concerns promptly and in a spirit of co-operation.***

and to

contribute to a climate where the truth can be heard, the reporting of, and learning from errors is encouraged and colleagues are supported when errors are made.

⁶⁷ Part 1 of my report to that inquiry can be found at <https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-evidence/INQ0101077.pdf> and part 2 at <https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-evidence/INQ0101079.pdf>

⁶⁸ Expert Report of Sir Robert Francis KC – Part 2 paragraph 8.23 footnotes omitted.

⁶⁹ Regulation 2.

- c. The CQC issues guidance on the statutory duty candour,⁷⁰ the compliance with which it regulates. It points out that the duty arises when an incident which has occurred during the provision of a regulated activity, is unintended or unexpected and has or might result in death, severe or moderate harm to the patient. Even if one of these criteria is not present there is an overarching duty to be open and transparent. The duty is triggered by an incident, not its outcome. CQC has also endorsed guidance for patients prepared and published by Action against Medical Accidents [AVMA].⁷¹
- d. Although I have been unable to find an analysis showing the total number of enforcement actions taken by CQC in relation to the duty of candour – and their list of prosecutions to date does not explicitly list any for a breach of this regulation. However, CQC is prepared to take action in some cases:
- (i) It was reported in February 2019 that for the first time it had issued a fixed penalty notice for a failure to apologise to the family of a baby boy within a reasonable period.⁷²
 - (ii) In October the same year it issued 13 such notices to a different trust for failing to apologise to patients within a reasonable time.⁷³
 - (iii) In July 2021 it reported issuing 2 more such notices against a different Trust for failing to provide the family of a person who died after complications in childbirth with an account of the incident or offer an apology.⁷⁴
- e. While the Government accepted the recommendations with regard to the organisational duty of candour in principle, it did not implement anything which gives the patient a remedy for a breach of that obligation affecting them individually.
- f. The Government declined to create offences in relation to individual healthcare professionals for providing misleading information to patients, obstructing others in the performance of their statutory duties of candour and openness, or making dishonest statements to commissioners or regulators, on the ground that such matters were sufficiently covered by the powers of professional regulators.

⁷⁰ GMC Regulation 20 – duty of candour updated 30 June 2022

<https://www.cqc.org.uk/sites/default/files/2022-12/20220722-duty-of-candour-pdf-version-FINAL-2.pdf> [downloaded 2 March 2024]

⁷¹ AVMA The Duty of Candour 26 June 2023 <https://www.avma.org.uk/wp-content/uploads/Duty-of-candour.pdf>

⁷² Sean Elson, Care Quality Commission issues first 'duty of candour' breach fine (13 February 2019) <https://www.pinsentmasons.com/out-law/news/care-quality-commission-issues-first-duty-of-candour-breach-fine>

⁷³ <https://www.cqc.org.uk/news/releases/trust-fined-failures-complying-duty-candour-regulation> [accessed 2 March 2024]

⁷⁴ <https://www.cqc.org.uk/news/releases/doncaster-bassetlaw-teaching-hospitals-nhs-foundation-trust-fined-failures-complying>

- g. However, the Government did make the provision of misleading prescribed information by a prescribed publicly funded healthcare provider, and if knowingly involved, their directors, an offence, subject to a defence of due diligence.⁷⁵ The information prescribed by regulation is currently specified data on clinical outcomes, complaints, waiting times and maternity services, which is required to be submitted by providers to the National Health and Social Care Information Centre,⁷⁶ and also information in published Quality Accounts. On conviction, in addition to a fine, or on conviction on indictment up to 2 years imprisonment, the court may make a remedial order requiring the provider to remedy the misleading conduct, any matter appearing to the court to have resulted from the conduct and any deficiency in the management of information in policies systems or practices of which the conduct appears to be an indication. The court may also order a publicity order requiring the provider to publicise the conviction, sentence and remedial order.⁷⁷
- h. Following the inquiry into the case of Elizabeth Dixon the Government again supported the concept of openness and transparency, as part of a just and learning culture as contributing to patient safety. Their response⁷⁸ pointed to the Patient Safety Strategy, the work of the CQC, and the promotion by NHS Resolution of that culture.
- i. There is mounting evidence that the duty of candour is not being complied with consistently, effectively or in some cases at all. The recent All-Party Parliamentary Group's report on birth trauma⁷⁹ after reviewing multiple distressing accounts of women's experience of maternity services concluded that:

It is clear that the statutory duty of candour, introduced in the wake of the Francis report, is not being applied effectively.

- j. On 6 December 2023 the Government announced⁸⁰ a review of the duty of candour in response to recent critical reports with a view to establishing the

⁷⁵ Care Act 2014 section 92; The False and Misleading Information (Specified Care Providers and Specified Information) Regulations 2015 SI 988 as amended [downloaded 3 March 2024] [The False or Misleading Information \(Specified Care Providers and Specified Information\) Regulations 2015](#)

⁷⁶ Now merged into NHS Digital, which in turn has been merged into NHS England with effect from 1 February 2023: <https://www.england.nhs.uk/2023/02/nhs-digital-and-nhs-england-complete-merger/>

⁷⁷ Care Act 2014 section 93

⁷⁸ DHSC, Policy Paper. Government response to the findings of the independent investigation into the death of Elizabeth Dixon, 11 May 2023, <https://www.gov.uk/government/publications/government-response-to-the-investigation-into-the-death-of-elizabeth-dixon/government-response-to-the-findings-of-the-independent-investigation-into-the-death-of-elizabeth-dixon> [downloaded 28 March 2024]; for the report see https://assets.publishing.service.gov.uk/media/5fbf9792e90e077edf1127f0/The_life_and_death_of_Elizabeth_Dixon_a_catalyst_for_change_accessible.pdf [downloaded 28 March 2024]

⁷⁹ Listen to Mums: Ending the Postcode Lottery on Perinatal Care, A report of The All-Party Parliamentary Group on Birth Trauma, 13 May 2024, <https://www.theo-clarke.org.uk/birth-trauma> [downloaded 14 May 2024]

⁸⁰ Department of Health & Social Care, Guidance: Duty of Candour review: terms of reference, 6 December 2023 <https://questions-statements.parliament.uk/written-statements/detail/2023-12->

extent to which the policy and its design are appropriate for the system, the extent to which the policy is honoured, monitored and enforced, and to what extent it has met its objectives.

- k. Allegations still emerge suggesting that “gagging” clauses and non-disclosure agreements are still inhibiting some from “speaking up”. I have commented elsewhere on the absence, to date, of regulation for health service managers.*
- l. In conclusion, the duties of openness, transparency and candour have been clear and applicable throughout the NHS since before 2015. The requirements of candour have been set out in well publicised regulations, guidance and other reports and statements. In spite of that, there have been a number of unfortunate incidents which suggest that these requirements have and are not consistently complied with.*

4.6. Freedom to Speak Up Review⁸¹

- 4.6.1. Following the Mid-Staffordshire Inquiries I was asked to review the treatment of whistleblowers and the concerns they raised in the NHS in England. I proposed the adoption of a set of principles, which I have set out in Appendix 7 below.⁸² Again, omitting points which are likely to be less relevant because of the Scottish context, I adopt and repeat what I said in my report to the Thirlwall Inquiry about this report. I stress that the review – and my report to the Thirlwall Inquiry - concerned the position of the NHS in England, although as already suggested I would have expected the principles to be substantially recognised and accepted in Scotland as well:⁸³

06/hcws100 ; <https://www.gov.uk/government/publications/duty-of-candour-review-terms-of-reference/duty-of-candour-review-terms-of-reference>

⁸¹ *The Report – Freedom to Speak Up Review* February 2015 <http://freedomtospeakup.org.uk/the-report/>

⁸² A full list of these Principles is set out in Appendix 7.

⁸³ Ibid Part 1, Page 100, paragraph 10.

4.6.1.1 *I was asked by the Secretary of State to conduct this review into the treatment of whistleblowers in the NHS largely because of the volume of complaints of which he was made aware from NHS staff or former staff who claimed to have been treated extremely unfairly having raised legitimate concerns about safety or propriety in the service. I was not asked to investigate these cases as such but to examine the culture and the systems by which staff raising concerns were dealt with. As the report shows I was extremely concerned by what I learned. I proposed that at local level employers needed to have policies, leadership and culture which welcomed and supported staff raising their concerns as part of normal business. Part of that support should be in the form of a new concept, a Freedom to Speak Up Guardian, employed by the organisation to be a support for staff with concerns they believed were not being properly addressed. The Guardian had to be a person who had the confidence of the Chief Executive, the Board, and the staff, and to be given authority to go anywhere necessary in the organisation to seek a solution to the problems raised. At national level I recommended the creation of a post which was eventually called the National Freedom to Speak Up Guardian for the NHS to provide support and advice for the local guardian network and to review organisations' compliance with good practice.*

4.6.1.2 *I am pleased to say that virtually all my recommendations and principles were accepted by the Government and steps taken to implement them. Unfortunately, while I continue to believe the principles I have identified are the right ones, they are clearly not sufficient to allow staff freedom to speak up without the right leadership, sufficient staff and appropriate resources being in place. While there are many examples to choose from, I will cite the appalling story told in one of the latest reports about the Edenfield Centre run by Greater Manchester Mental Health NHS Foundation Trust,⁸⁴ where the events reported on all occurred well after the principles of this report – and indeed those described in many of the other reports considered here – should have been in place.*

4.6.1.3 *Without commenting separately on all the principles I will highlight some of them.*

4.6.1.4 **Principles 1, 2: Culture of safety**

- (a) *... national level guidance was issued to boards and leaders. This was renewed in 2022.⁸⁵ CQC inspection of providers is likely to include a*

⁸⁴ Shanley, *Independent Review of Greater Manchester Mental Health NHS Foundation Trust – Final Report* January 2024 [NHS England Report Template 7 - no photo](#).

⁸⁵ National Guardian, *National guidelines on Freedom to Speak Up training in the health sector in England* August 2019 <https://www.cqc.org.uk/sites/default/files/20190812%20-%20National%20guidelines%20on%20Freedom%20to%20Speak%20Up%20training%20in%20the%20health%20sector%20in%20England.pdf> NHS, *Freedom to Speak Up policy for the NHS*, version 2 PAR 1245i June 2022 <https://www.england.nhs.uk/wp-content/uploads/2022/06/PAR1245i-NHS-freedom-to-speak-up-national-Policy-eBook.pdf> ; NHS/National Guardian, *Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services* PAR 1524ii June 2022

consideration of their freedom to speak up policies and implementation. Thus the “quality statements” against which it inspects leadership include:⁸⁶

People and staff are encouraged and supported to raise concerns, they feel confident that they will be treated with compassion and understanding, and won’t be blamed, or treated negatively if they do so.

Raising concerns helps to proactively identify and manage risks before safety events happen.

- (b) *Clearly the system does not work perfectly: CQC has recently had to review its own treatment of concerns raised with it by NHS staff, following an admitted deficiency in the way it dealt with issues raised with it.⁸⁷*
- (c) *Examination of the NHS Staff Survey⁸⁸ suggests that the desired culture is absent for too many employees. In the 2023 survey:*
 - (i) *71.02% of respondents agreed that their immediate manager “cared about their concerns”, leaving 28.98% who presumably did not agree.*
 - (ii) *9.07% had experienced discrimination at work from managers or colleagues.*
 - (iii) *62.31% feel safe to speak up about anything that concerns them – a slight improvement on the previous year.*
 - (iv) *50.07% were confident that their organisation would address their concern.*
 - (v) *71.28% would feel secure raising concerns about unsafe clinical practice.*
 - (vi) *50.07% were confident their organisation would address their concern, a slight improvement on the previous year.*

https://www.england.nhs.uk/wp-content/uploads/2022/04/B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf ; NHS/National Guardian, Freedom to Speak Up a reflection and planning tool, June 2022 https://www.england.nhs.uk/wp-content/uploads/2022/04/B1245_iii_Freedom-to-speak-up-a-reflection-and-planning-tool.docx [all downloaded 5 March 2024]

⁸⁶ CQC, *Single assessment framework – Key questions and quality statements* last updated 9 January 2024, <https://www.cqc.org.uk/guidance-regulation/providers/assessment> [downloaded 5 March 2024].

⁸⁷ Durairaj, *Listening, learning, responding to concerns*, 29 March, 20 September 2023 CQC <https://www.cqc.org.uk/publications/listening-learning-responding-concerns/listening-learning-responding-concerns-phase-2-report> [downloaded 5 March 2024].

⁸⁸ NHS Staff Survey 2023 national results [see above for online reference].

- (vii) 10.17% said they had experienced harassment, bullying or abuse from managers [18.09% from other colleagues; 25.78% from patients/service users] in the last 12 months.
- (viii) 51.86% of staff who had experienced harassment, bullying or abuse said they or a colleague had reported it.
- (ix) The 2022 survey reported that 0.8% had experienced at least one episode of violence from managers and 1.8% from colleagues in the previous 12 months. The 2023 report gave no figures for this owing to an issue with the data.
- (x) 57.11% believed that in their team disagreements were dealt with constructively.
- (xi) 33.19% had seen errors, near misses or incidents in the last month that could have hurt staff or patients; 59.45% said their organisation treated those involved fairly.

Many of these results showed a marginal improvement on the those reported in the previous survey, but when the negative implications are translated into the absolute numbers of the over 707,000 respondents who gave negative answers it is clear that there is a very high level of discontent among staff about their experiences at work.

- (d) In its recent report the Expert Advisory Panel of the Health and Social Care Select Committee⁸⁹ have indicated that they consider that the FTSU recommendations are in the course of being implemented by way of the progress in setting up the FTSU guardian network and in publishing guidance, including the recent patient safety incident framework. However, they noted “considerable variation” in the roll-out and operation of guardians, and that some trusts have yet to implement the safety framework. The Panel noted the difficulty in finding evidence of measuring and reporting patient safety incidents. There was concern that non-executive directors do not always have the skills to challenge patient safety reports. However, the CQC’s new assessment framework includes quality statements for learning culture and freedom to speak up which will be taken into account in the rating of providers.
- (e) Given these serious problems, to some of which I will return below, I consider that Principles 1 and 2 can fairly be said to be works in progress. It is disappointing that better progress has not been achieved in the 9 years since the Freedom to Speak Up Review. It is, though,

⁸⁹ Expert Advisory Panel, *Evaluation of the Government’s progress on meeting patient safety recommendations*, 22 March 2024, Health and Social Care Select Committee HC 362 <https://committees.parliament.uk/work/8056/expert-panel-evaluation-of-governments-progress-on-meeting-patient-safety-recommendations/publications/reports-responses/> [downloaded 23 March 2024]. I am a member of the Expert Advisory Panel but stood down from this inquiry and took no part in it.

encouraging to see that there is a demonstrable willingness among staff to raise problematic concerns is evidenced by the fact that Freedom to Speak Up Guardians recorded over 25,000 cases in 2022/23, a 25% increase on the previous year.⁹⁰

4.6.1.5 **Principle 3 – Culture free from bullying**

- (a) As indicated in Schedule, all parts of the NHS are expected to do all in their power to eradicate bullying, intimidation and harassment. I anticipate that all NHS Employers will have policies which prohibit such behaviour under threat of disciplinary action should it occur. Unfortunately it is clear from the survey figures quoted above that such conduct is far too prevalent. For example, in the course of my writing this report, CQC have published a report on a well-known Trust, previously rated as “Good” at which, following an inspection late last year, has been downgraded to “Inadequate” for leadership.⁹¹ Among other critical comments the report stated:

We met and spoke with a number of members of staff who came forward and recounted their experiences at the trust or recounted to them from fellow colleagues as they remained anxious to speak up. The majority of these were women in senior roles throughout the organisation. They talked of experiencing bullying, harassment (in its many forms), intimidation, disrespect, and misogyny. A number of these staff told us they had spoken up in the past but had felt unsupported by the process or the organisation. A number reported feeling let down by the speaking-up process when it was passed to others to resolve, and some talked of being embarrassed with colleagues; felt their confidentiality had been failed; and some talked of taking the tough decision to leave the organisation. Some staff reported that they would not speak up again due to their poor experience of previously doing this.

- (b) The steps referred to above include widespread injunctions against bullying. Nonetheless whatever measures are being taken to do not appear to be working throughout the system.
- (c) I must emphasise that bullying behaviour does not merely affect the quality of the victim’s experience of the workplace, it is a serious safety issue. Research suggests that bullying – or more broadly, incivility - has at least a temporary effect on the cognitive abilities not only of victims but those who witness such behaviour, and reduces their ability

⁹⁰ <https://nationalguardian.org.uk/learning-resources/speaking-up-data/> this web page also contains a spreadsheet for the current year to date.

⁹¹ CQC, *University Hospitals Birmingham NHS Foundation Trust Inspection Report* (8 March 2024) <https://api.cqc.org.uk/public/v1/reports/c837b38b-36e2-4ac5-98b3-2e3c68c68107?20240308010509> [downloaded 8 March 2024].

to attend to the task in hand.⁹² This is in addition to the obvious disincentive of those bullied to speak up about their concerns.

4.6.1.6 **Principle 4 – Visible Leadership**

I considered that good leaders need to role model behaviour which welcomes the raising of concerns and openly accepts responsibility for things that have gone wrong, as a means of demonstrating that it is safe to be open about such things. Unfortunately I consider that this may be challenging for leaders in whom the system's culture instils fear that failure to achieve expected standards or targets may result in their dismissal.

4.6.1.7 **Principle 5 - Valuing Staff**

This principle was intended to encourage employers to celebrate and recognise employees who had spoken up. Clearly this is difficult when a concern has been raised under conditions of anonymity, and I certainly found it difficult in the course of my review to acquire evidence of successful practice.

NHS Employers has guidance encouraging recognition of employees in appreciation of their efforts for the organisation.⁹³ NHS England has a staff recognition framework.⁹⁴ The National Guardian celebrates speaking up specifically and annually in a Speaking Up Month.⁹⁵ Therefore there is plenty of encouragement, but I agree that evidence of what local activity there is in this regard is sketchy.

4.6.1.8 **Principle 6 – Reflective Practice**

Reflective practice is encouraged for the professions it oversees by the Health and Care Professions Council.⁹⁶ Health Education England published a guide on “transformative reflection” in 2023,⁹⁷ likewise the General Medical Council in 2021 and the NMC in 2018.⁹⁸ Both GMC and NMC require evidence of reflection as part of the revalidation process. In a recent controversial case, the GMC was criticised for seeking disclosure of a registrants note prepared as part of their reflection. A policy has now been adopted that such notes will

⁹² For resources on this subject see <https://www.civilitysaveslives.com>

⁹³ NHS Employers, *Employee recognition: Employee recognition refers to the ways an organisation shows its appreciation for their employees* (31 October 2022) <https://www.nhsemployers.org/articles/employee-recognition>

⁹⁴ NHS England, *Staff recognition framework: A guide for senior leader and managers*, (October 2023) <https://www.england.nhs.uk/long-read/staff-recognition-framework/>

⁹⁵ National Guardian, *Speak Up Month 2022: Freedom to Speak Up for Everyone* <https://nationalguardian.org.uk/2022/10/05/speak-up-month-2022/>

⁹⁶ HCPC, *Reflective practice: Recognise, reflect, resolve: The benefits of reflecting on your practice* (March 2021) <https://www.hcpc-uk.org/standards/meeting-our-standards/reflective-practice/>

⁹⁷ NHS England, *Transformative Reflection* <https://www.hee.nhs.uk/our-work/enhancing-generalist-skills/enhance-learning-resources/handbook/cross-cutting-themes/transformative-reflection>

⁹⁸ GMC, *The reflective practitioner: Guidance for doctors and medical students* https://www.gmc-uk.org/-/media/documents/dc11703-pol-w-the-reflective-practioner-guidance-20210112_pdf-78479611.pdf .

not be called for in connection with fitness to practice proceedings, but a court can order such disclosure if relevant in court proceedings.⁹⁹

4.6.1.9 **Principle 8 – Investigations**

- (a) *The Schedule suggests that the requirement for proportionate, fair and blame-free investigations to establish facts has been implemented. It is certainly the case that the policies and guidance referred to advocates just that. NHS policy published in response to my review in April 2016 stated:¹⁰⁰*

Where you have been unable to resolve the matter quickly (usually within a few days) with your line manager, we will carry out a proportionate investigation – using someone suitably independent (usually from a different part of the organisation) and properly trained – and we will reach a conclusion within a reasonable timescale...

The investigation will be objective and evidence-based and will produce a report that focuses on identifying and rectifying any issues and learning lessons to prevent problems recurring.

- (b) *A recent collection of recommendations from National Guardian case reviews states:¹⁰¹*

Reasonable steps should be taken to respond to the issues raised by those who speak up in confidence. Matters should be investigated as fully as possible.

- (c) *I am unaware of any reported data on the number of such investigations undertaken by registered healthcare providers, and I am not convinced that this principle is applied to all concerns raised by staff.*

4.6.1.10 **Principle 9: Mediation and Dispute Resolution**

While this was recommended by review and is supported by the National Guardian's guidance I am unaware of the use of these methods being reported, although there have certainly been a number of apparently intractable disputes.

⁹⁹ GMC, *the reflective practitioner* 2021, https://www.gmc-uk.org/-/media/documents/dc11703-pol-w-the-reflective-practitioner-guidance-20210112_pdf-78479611.pdf

¹⁰⁰ NHSE/I, *Freedom to Speak Up: raising concerns (whistleblowing) policy for the NHS* April 2016 page 8 <https://www.england.nhs.uk/wp-content/uploads/2021/03/freedom-to-speak-up-raising-concerns-policy-for-the-nhs-april-19.pdf>

¹⁰¹ National Guardian, *Learning from case reviews*, December 2021 page 6 https://www.gmc-uk.org/-/media/documents/dc11703-pol-w-the-reflective-practitioner-guidance-20210112_pdf-78479611.pdf

4.6.1.11 **Principle 11: Support**

As the material quoted in the schedule suggests there is a widespread requirement for clarity in organisations about where those who wish to raise concerns can go, and I believe that all NHS organisations are likely to have such a policy. What is less easy to discern is the degree of uniformity in the range of personnel to whom a whistleblower may refer. It may be restricted in practice in some places by the identity of those appointed to such roles. For example, I have received anecdotal evidence of NHS Trusts where the FTSU Guardian has also been a non-executive Board member. I regard that as presenting a conflict of interest which is likely to deter some employees from using that channel of communication.

4.6.1.12 **Principle 12: Support to find alternative employment**

- (a) *In response to this recommendation pilot schemes were run in 2017, which offered support to 16 people who had left the service following raising concerns. One in three of them were successfully helped to retain or regain NHS employment. That was deemed a success, and in 2019 NHSE/I set up a Whistleblowers Support Scheme for staff who have suffered a detriment as a result of speaking up.¹⁰² The scheme offered, where appropriate, help with transition from one employer to another, shadowing, work experience and work placement in a health and social care organisation. Understandably it was emphasised that the scheme was unable to guarantee an offer of suitable employment. One of the eligibility criteria was that the applicant had applied for suitable employment but had been unsuccessful. However, a review of that scheme found that people:*

experienced challenges in moving forward in their professional and personal lives and required support with their health and well-being, career coaching and personal development.

¹⁰² <https://www.longtermplan.nhs.uk/nhs-whistle-blower-support-scheme-to-roll-out-across-the-country/> 8 October 2019 NHS, *A guide to the Whistleblowers' Support Scheme*, March 2021 <https://www.england.nhs.uk/wp-content/uploads/2021/03/whistleblowers-support-scheme-guide-update-march-2021.pdf> [downloaded 5 March 2024]

- (b) *In 2022 the Scheme was changed to offer largely psychological support.¹⁰³ The scheme was clearly limited in size: it offered 10 places although 38 more people had applied. It did not then offer same sort of support as in the previous year with regard to introduction to work placements etc. An evaluation adjudged the scheme to be a success in raising the psychological scores of participants. However understandably negative feedback was received from those not accepted into the scheme, in particular because most had been unaware there was a limit on numbers. It is clearly very important that any limitations of a support scheme are made clear in advance to applicants: as a cohort they are likely to be particularly sensitised to rejection by their past experiences.*
- (c) *At the time of writing this, the scheme is closed, but will reopen at some unspecified date to applications for a cohort in September 2024.¹⁰⁴*
- (d) *Therefore the scheme has moved away from its original intention of directly assisting employees who had suffered a detriment from raising concerns retain or regain NHS employment. It offers support to a very limited number of people, even though the numbers applying are in low double digits. This suggests there have been practical challenges in providing realistic practical help to those who have lost their job through victimisation to obtain alternative employment in the NHS. In my view there is a moral obligation on the part of the system to do whatever can be done to help them. I am not confident that is now in place.*

4.6.1.13 **Principle 12: Transparency**

- (a) *As stated in the Schedule all prescribed bodies are required to report annually on whistleblowing disclosures made to them. I am unaware whether any administrative or regulatory requirement has been imposed on NHS providers to make similar reports.*

¹⁰³ NHS England, *Speaking Up Support Scheme evaluation report 2023*, 11 January 2024, <https://www.england.nhs.uk/long-read/speaking-up-support-scheme-evaluation-report-2023/> [downloaded 26 March 2024]

¹⁰⁴ NHS England, *Speaking Up Support Scheme*, <https://www.england.nhs.uk/ourwork/freedom-to-speak-up/speaking-up-support-scheme/> [accessed 26 March 2024]

- (b) Settlements of claims for unfair or discriminatory dismissal have frequently been accompanied by confidentiality agreements, the terms of which have been interpreted as preventing the employee from raising public interest concerns about the employer. By law any provision in a contract between a worker and an employer which purports to preclude the worker from making a protected disclosure is void.¹⁰⁵ It has been made clear frequently and emphatically that agreements should not include such a term as explained in the Factsheet quoted in the Schedule. In 2018 the Solicitors Regulatory Authority issued a notice warning solicitors that they are professionally obliged not to take unfair advantage of another party when dealing with non-disclosure agreements and that the SRA was concerned to ensure that such agreements were not used to prevent reporting to regulators.
- (c) In 2019 the then Secretary of State for Health stated that making a settlement agreement infringing an individual's right to speak up was completely inappropriate.¹⁰⁶ In the same year NHS Employers issued guidance¹⁰⁷ on settlement agreements which reinforced the requirement that:

Nothing in a settlement agreement should prevent a worker from speaking up, either before or after the agreement has been signed. Workers can and should speak up about any matter that may prevent an organisation from delivering high quality safe care. This includes, but is not limited to, matters related to patient safety, bullying, and harassment, and cultural issues that may affect quality of care or the wellbeing of workers.

- (d) Unfortunately, the clarity of the law and of this guidance has not prevented allegations being made of clauses being inserted into settlement agreements purporting to restrict the right to speak up. Thus in the same year the Government conducted a consultation on reforming the law on confidentiality in relation to this issue among others, and then pledged¹⁰⁸ legislation to ensure these clauses are not used to prevent a disclosure to regulated health and care professionals, to clarify the limitations on such clauses, to improve the availability of independent legal advice to individuals signing such an

¹⁰⁵ Employment Rights Act 1996 section 43J [as inserted by the Public Interest Disclosure Act 1999 section 1]. [Employment Rights Act 1996](#)

¹⁰⁶ PA, *NHS non-disclosure agreements to end, vows Matt Hancock*, 27 April 2019 The Guardian <https://www.theguardian.com/society/2019/apr/22/nhs-end-non-disclosure-agreements-vows-matt-hancock>

¹⁰⁷ NHS Providers *The use of settlement agreements and confidentiality clauses* updated February 2019 https://www.nhsemployers.org/system/files/media/The-use-of-settlement-agreements-and-confidentiality-clauses_0.pdf [downloaded 5 March 2024]

¹⁰⁸ DBEIS, *Confidentiality Clauses, Response to the Government consultation on proposals to prevent misuse in situations of workplace harassment or discrimination*, July 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818324/confidentiality-clause-consultation-govt-response.pdf [downloaded] 5 March 2024

agreement and to provide guidance on drafting. No such legislation has been forthcoming to date.

4.6.1.14 **Principle 14 – accountability**

..., the Fit and Proper Person Test ... could be used as a form of accountability for suppression or discrimination against an NHS whistleblower. Evidence of this occurring is hard to obtain, but in one well publicised case a Chief Executive was suspended following adverse Tribunal findings but was still permitted to be employed as an acting chief executive elsewhere.¹⁰⁹ The Kark Review,¹¹⁰ ..., set out eloquently the deficiencies in the Test which apply particularly strongly to misconduct relating to whistleblowing.

4.6.1.15 **Principle 15 – regulatory action to protect whistleblowers**

I was concerned that systems regulators in receipt of protected disclosures, and professional regulators receiving complaints possibly designed to silence or ruin whistleblowers, needed to do more to protect them. While there is much guidance addressed to those subject to regulation about their conduct, there is less with regard to the regulators themselves. Recently the CQC has had cause to review how it receives and treats whistleblowing information. While the report¹¹¹ refers to the fact that some informants will fear reprisals, I do not detect in this report any clear proposals with regard to what CQC will do to protect or reassure such persons.

4.6.2. **Government review of whistleblowing protection**

The Government announced a review of the whistleblowing “framework” in 2023 with an expected conclusion by the end of that year.¹¹² The UK Government has very recently published a report by Dr Penny Dash which reviews the work and effectiveness of, among other bodies, the NHS National Freedom to Speak Up Guardian. In its response the Government has announced that the post of the NHS National Freedom to Speak Up Guardian

¹⁰⁹ Independent, *Health watchdog says lessons must be learned after NHS fraudster landed multiple top jobs* 19 December 2018 <https://www.independent.co.uk/news/health/nhs-fraud-scandal-health-trust-whistleblower-job-appointment-ombudsman-report-a8689091.html> [downloaded 5 March 2024]

¹¹⁰ Kark and Russell, *A Review of the Fit and Proper Person Test*, <https://assets.publishing.service.gov.uk/media/5c937b7e40f0b633f5bfd89c/kark-review-on-the-fit-and-proper-persons-test.pdf>

¹¹¹ Duraig *Listening, learning, responding to concerns* 29 March 2023 updated 20 September 2023 CQC <https://www.cqc.org.uk/publications/listening-learning-responding-concerns/5-reviewing-expectations-and-experiences-people-who-raise>

¹¹² Department for Business & Trade, *Policy paper: Review of the whistleblowing framework: terms of reference* (2022-2023) <https://www.gov.uk/government/publications/review-of-the-whistleblowing-framework/review-of-the-whistleblowing-framework-terms-of-reference> [downloaded 6 March 2024]

and the NGO's office are to be abolished, and that their functions will be continued by commissioners and "Patient Experience" Directors.¹¹³

4.7. **The Morecambe Bay Investigation**

In March 2015 Dr Bill Kirkup published his report on the scandal in maternity at the Morecambe Bay Hospital.¹¹⁴ The succinct description of what he found at this hospital could serve as a definition of the factors which together indicate an unhealthy and unsafe culture resulting in a service which is dysfunctional and unsafe:¹¹⁵

The origin of the problems we describe lay in the seriously dysfunctional nature of the maternity service... clinical competence was substandard, with deficient skills and knowledge, working relationships were extremely poor, particularly between different staff groups,... there were failures of risk assessment and care planning that resulted in inappropriate and unsafe care; and the response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.

4.8. **The East Kent Investigation**

- 4.8.1. Sadly, in spite of Dr Kirkup's excellent recommendations in his Morecambe Bay report, he was required to reflect on their effectiveness – and those of other inquiries – in 2022 in his report¹¹⁶ on a very similar scandal at East Kent Hospital. He warned the Secretary of State:

It is too late to pretend that this is just another one-off, isolated failure, a freak event that "will never happen again". Since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more.

¹¹³ See Dash, Review of patient safety across the health and care landscape, 7 July 2025 <https://www.gov.uk/government/publications/review-of-patient-safety-across-the-health-and-care-landscape> ; BBC News *hundreds of NHS Agencies to be scrapped* : 28 June 2025 Reed <https://www.bbc.co.uk/news/articles/c3w4xl8gyyqo>

¹¹⁴ Kirkup, *The Report of the Morecambe Bay investigation*, March 2015 https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf

¹¹⁵ Ibid executive summary para 4.

¹¹⁶ Kirkup, *Reading the Signals – Maternity and neonatal services in East Kent – the Report of the Independent Investigation*, October 2022 HC 681 https://assets.publishing.service.gov.uk/media/634fb083e90e0731a5423408/reading-the-signals-maternity-and-neonatal-services-in-east-kent-the-report-of-the-independent-investigation_print-ready.pdf

4.8.2. The investigation heard persuasive evidence of a host of cultural deficiencies including:¹¹⁷

- A lack of staff engagement;
- A conflicting culture between doctors and midwives;;
- Inconsistent teamworking;
- Tolerance of poor senior professional bullying behaviour and bullying generally
- Lack of diversity and discrimination;
- Shortage of staff;
- Lack of organisational development training;
- A leadership culture of denial and resistance to change;
- A culture of blame.

4.9. *National Freedom to Speak Up Guardian reports*

Unfortunately the problems in this area persist. The National Guardian publishes annual figures on the number of cases reported to local guardians. She remained concerned in 2022 at the number of staff speaking up who reported suffering a detriment for speaking up.¹¹⁸

4.10. *National Maternity investigation 2025*

If further evidence is required that the cultural issues identified in the reports cited above persisted, when I had nearly completed this report, the Secretary of State for Health and Social Care announced¹¹⁹ a national inquiry into England's maternity services following concerns that deficient care and culture in this area had persisted over the years since the Morecambe Bay scandal. In her statement supporting the announcement of this investigation the Chief Midwifery Officer said:

We know we have significant issues to address concerning safety and culture within maternity and neonatal services.

4.11. *General Medical Council guidance*

¹¹⁷ This list is largely taken from the report chapter 4.

¹¹⁸ *Culture is a patient safety issue. – A summary of speaking up to freedom to speak up guardians 1 April 2023 – 31 March 2024* <https://nationalguardian.org.uk/learning-resources/speaking-up-data/>

¹¹⁹ Press release: *National maternity investigation launched to drive improvements* 23 June 2025 <https://www.gov.uk/government/news/national-maternity-investigation-launched-to-drive-improvements>

- 4.11.1. In January 2012 the GMC published *Good Medical Practice*.¹²⁰ This required doctors to

Promote and encourage a culture that allows all staff to raise concerns openly and safely.

- 4.11.2. Doctors were also required to take *prompt action if you think that patient safety... is or may be seriously compromised*.

- 4.11.3. In the case of risks due to *inadequate premises, equipment or others resources, policies or systems*, the doctor must *first protect patients and put the matter right if that's possible*. After that, the doctor *must then raise your concerns in line with your workplace policy* and the GMC's guidance.

- 4.11.4. The current version¹²¹ repeats these requirements in the same or virtually the same language.¹²² Detailed guidance is given on what to do if not satisfied that action is being taken on a concern raised.¹²³

- 4.11.5. Where the term *must* is used in *Good Medical Practice* or associated the guidance, the GMC intended to refer to a legal or ethical duty which doctors are expected to meet unless they can show a justification not to do so.

4.12. Nursing and Midwifery Council Guidance

The NMC guidance is in similar terms to that of the GMC. It requires nurses to raise concerns

*immediately whenever you come across situations that put patients or public safety at risk.*¹²⁴

You must raise and if necessary escalate any concerns you may have about patient or public safety or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices.

... protect anyone you have management responsibility for from any harm, detriment victimisation or unwarranted treatment after a concern is raised.

¹²⁰ Bundle 25, Document 63, Page 1284. This version was first published on 25 March 2013, came into effect on 22 April 2013, and was updated on 29 April 2014 by the addition of a section on honesty.

¹²¹ GMC, *Raising and acting on concerns about patient safety*, 12 March 2012, Bundle 25, Document 67, Page 1401.

¹²² Ibid page 1404 para 2, page 1406 para 7, *Good Medical Practice* (2024) Bundle 25, Document 64, Page 1325, para 75.

¹²³ Ibid page 1407-1408 paras 11 – 18.

¹²⁴ NMC, *The Code - Professional standards of practice and behaviour for nurses, midwives and nursing associates* Bundle 25, Document 66, Page 1389 para 13 – Page 1391 para 16.

4.13. Comment

Professional guidance of this nature can often pose a dilemma for registered professionals. On the one hand they are obliged by their codes of conduct to raised and report concerns – and to persist in doing so if they are ignored – and risk disciplinary sanction and possible erasure if they fail to do so. On the other hand in an unhealthy workplace culture they may fear detriments to their career if they do fulfil these obligations. The moral hazard and stress caused by this conflict can inadvertently contribute to the barriers to a culture in which staff feel free to speak up. In my opinion it is important that in investigating possible breaches of professional obligations, regulators take into account the environment and the systems in which the registered professional has to work.

4.14. The Infrastructure and Projects Authority's principles

The Committee on Standards in Public Life's report cited above quoted the principles proposed by the Infrastructure Project Authority as the basis for government projects to be delivered successfully. They are:

Principle 1: Focus on outcomes

Principle 2: Plan realistically

Principle 3: Prioritise people and behaviour

Principle 4: Tell it like it is

Principle 5: Control scope

Principle 6: Manage complexity and risk

Principle 7: Be an intelligent client

Principle 8: Learn from experience

I suggest that they provide a framework within which the cultural tools considered in the other reports cited above could be fitted. I would only add the importance of openness, transparency and candour, without which it is all too easy for leaders, particularly at Board level to be misled or mislead themselves about the reality of their organisation.

4.15. Conclusion

Returning then to the question, I suggest that the principles set out in the Freedom to Speak Up Review providing a useful starting point. I have considered the National Whistleblowing Principles and suggested procedures

published by the Independent National Whistleblowing Officer,¹²⁵ and accept that they provide a positive foundation which an organisation could deploy to support a healthy culture. As I have pointed out above, however, it remains important to ensure through strong leadership that such principles and processes are used to support the raising of concerns rather than to be a disguise for discouraging this. For example a concern should be dealt with positively even if raised in the “wrong” way, and even if the person raising it is accused by some of having an ulterior motive.

¹²⁵ INWO, *Whistleblowing principles* (23 January 2024) <https://inwo.spsa.org.uk/whistleblowing-principles>

5. How can an external observer or investigator tell if an NHS Board or Trust has a problem within its organisation related to the encouragement of reporting by staff of patient safety concerns?

It would be possible to list a large number of cultural indicators but I suggest the health of an organisation's culture can be assessed by reference to a number of factors none of which would be sufficient on their own.

5.1. Policies and procedures

It will be apparent from the various reports cited above that the safety of patients, and staff depends on the existence of a culture in which both are encouraged to raise matters which concern them and in which the organisation at all levels listens to and acts on those concerns. As indicated above, in my opinion the existence of policies and procedures which support and encourage such attitudes is important, but by no means a guarantee that they – and their spirit – reflect the reality within the organisation. Therefore, a review which confines itself to an examination of the paper policies will be unlikely to offer a true reflection. Further, the findings of a review, or an inspection, in the form of an eyewitness examination of how staff implement the policies, may only provide a snapshot. Positive findings in one part of a hospital may not reflect what is happening elsewhere, or even what would be found in the same part on another day. This is because workplace culture is not a static affair, but rather a dynamic one responding to different events and circumstances and differing combinations of personnel. In the end a culture can only be judged by the behaviours over a period of the people working within it and not by formal compliance with policies, let alone the bureaucratic processes associated with them.

5.2. Leadership

All reports into major healthcare scandals identify the the importance of the role of leadership. In order for a healthy culture to survive and thrive, leaders need to promote and exemplify the desired behaviours in their own work and interactions with others. This requires leaders to

- Be seen to listen to and welcome staff concerns;
- Ensure that concerns are investigated thoroughly and authoritatively, focussing on the events rather than the personalities;
- Where concerns are found to be justified to take relevant remedial action;
- Where concerns are found not to be justified to identify the reasons for this;
- In both cases to communicate to the staff raising the concern the conclusion, any action taken, and any reasons for not finding the concern justified;
- Accept personal and corporate responsibility where appropriate;

- At all times prioritise the interests of patient safety over the organisation's reputation.

5.3. *Bullying*

Staff will be deterred from speaking up if they are surrounded by bullying behaviour, whether it be from more senior staff or peers. In both cases, people will be tempted to *keep their heads down*. Such an environment is also likely to lead to more staff sickness and turnover. As indicated above, all registered healthcare professionals are under a professional duty to raise safety concerns and persist in doing so, or be in jeopardy of regulatory sanction. The tensions arising from the conflict between this duty and the pressures of their workplace atmosphere will lead to a reduction in staff willingness to raise concerns or even stay in the employment, unless there is constant encouragement to speak up, and for that to be part of *business as usual*.

5.4. *How raising concerns is treated*

Those receiving concerns can be tempted to focus on the process for handling concerns rather than their substance and their relevance to safety. The emphasis should be on the need to share concerns rather than a preoccupation with the whistleblowing category into which they might fall. Just as safety should be everybody's business, so should the handling of concerns arising in areas for which they are responsible. It is more important to ensure a concern is investigated rather than to establish whether it has been reported in the correct channel.

5.5. *Supportive teamwork*

In a positive culture all members of team will be encouraged to contribute to a discussion, and will be listened to if they have a suggestion or question. Operation checklists will be reviewed in the presence of all involved, and all given a chance to agree or disagree.

5.6. *Recognition of successes*

Where a concern has resulted in a safety improvement, the individual raising it should be recognised and thanked. Where possible examples of this should be shared more widely to encourage others to behave in the same way.

5.7. *Staff morale and well-being*

Evidence of how staff are enabled to contribute to making improvements in the service and how they are supported in raising concerns, learning from both good practice and mistakes, and generally treated will be found in thorough staff surveys, but also in how the organisation approaches and addresses things which have gone wrong and "near misses". While low morale can obviously be caused by many factors not directly related to safety or quality of care, it should be possible to identify cultural issues through surveys, inspections, and case reviews.

6. From all of the work undertaken by you, what are the most effective changes that can be made by NHS Board or Trust to create an effective system in which such concerns can be raised?

Many of the various measures to improve and make more effective an organisation's system for raising concerns have now been widely adopted, at least in England. While it is true to observe there has not been a consistently better performance among those organisations which have done so, there is some association between their wholehearted and thorough adoption and better CQC ratings and other assessments. While what follows is by no means a comprehensive list, I suggest that a healthcare organisation which does not adopt at least these measures is unlikely to enjoy a health, open, transparent safe and learning culture.

6.1. *Clarity of leadership*

Leaders should ensure that not only the top of the organisation, but that every leader of a department, ward or other unit understands and adopts the FTSU principles. Leaders need to be seen by their staff to role model the principles, and that means, for example, readily accepting, if necessary in public, organisational, and where appropriate, personal responsibility when something has gone wrong. If staff see defensiveness, let alone denials they know to be untrue, they will be very reluctant to raise concerns.

6.2. A recent literature review and encyclopaedic analysis¹²⁶ on the reasons for the incidence of unprofessional workplace behaviours between colleagues – in itself a major ingredient in unhealthy and unsafe cultures in healthcare settings – highlighted leadership” as a key contributor to harmful work cultures in 6 ways:

- “*complicit and permissive leadership*”
- “*negative role-modelling and prior learned behaviour*”
- “*authoritarian leadership style*”
- “*lack of accountability by leadership*” or a “*culture of tolerance*”
- “*organisational deafness*” or when people speak up and are not heard
- “*cliques*”

I agree that avoidance of these defects on the part of leaders at all levels of an organisation is essential for the promotion of a healthy and safe culture.

6.3. *A corporate expectation of candour, openness and transparency*

¹²⁶ Aunger JA, Abrams R, Westbrook JI, Wright JM, Pearson M, Jones A, et al. *Why do acute healthcare staff behave unprofessionally towards each other and how can these behaviours be reduced? A realist review. Health Soc Care Deliv Res* 2024;12(25). <https://doi.org/10.3310/PAMV3758> August 2024 <https://www.journalslibrary.nihr.ac.uk/hsdr/PAMV3758#s1>

I will not rehearse what is said elsewhere on these topics, but these expectations must apply to all who work in or for the organisation. There should be no place for the quiet suggestion to colleagues that they should “*keep their head down*” if they express a concern, still less be criticised for doing so. Rather they should be supported to transmit their worries to an appropriate recipient and such action should be celebrated.

6.4. Staff surveys

The NHS Staff survey, which includes figures at NHS Trust level, continues to show worrying percentages of staff who do not feel safe enough to raise concerns and work in environments in which they do not feel they would be fairly treated if they reported a mistake, as demonstrated by the selection of figures I have taken from the most recent report:¹²⁷

¹²⁷ NHS Staff Survey 2024 – National Results Briefing, March 2025
<https://www.nhsstaffsurveys.com/results/national-results/>

Question	Positive %: 2024	2023	2022	2021
Immediate manager cares about their concerns	71.23	71.04	69.55	68.55
Immediate manager takes effective action to help with problems	68.11	67.84	65.73	64.73
Personally experienced discrimination at work from managers, team leaders or colleagues in the last 12 months	9.22	9.09	9.04	8.37
Their organisation respects individual differences such as different cultures, working styles backgrounds and idea	70.70	70.63	69.52	68.58
People they work with are understanding and kind to each other	70.53	71.24	71.10	70.57
Would feel secure raising concerns about unsafe clinical practice	71.53	71.45	72.05	75.13
Were confident that their organisation would address their [clinical safety] concern	56.83	56.87	56.76	59.51
Felt safe to speak up about anything that concerns theme in the organisation	61.82	62.34	61.53	62.07
Were confident that their organisation would address [this] concern	49.52	50.08	48.67	49.77
Have experienced at least one incident of harassment, bullying or abuse in the last 12 months from patients/members of the public...	25.08	25.34	27.89	27.84
.... From managers...	9.46	9.94	11.11	11.55
... from other colleagues	17.56	17.71	18.79	18.78
% of staff who had experienced such harassment, bullying or abuse and said they or a colleague had reported it	54.00	51.84	49.85	48.90
Their organisation treats staff who are involved in an error, near miss or incident fairly	59.71	59.51	58.21	

Question	Positive %: 2024	2023	2022	2021
When errors, near misses or incident are reported their organisation takes action to ensure that they do not happen again	68.21	68.22	67.42	

The proportion of responses which are negative suggests that an alarming number of NHS staff have had bad workplace experiences and do not feel safe to speak up about important issues. While this is clearly of concern, the Survey itself is a good model for how to measure the factors which make up a healthy culture,

6.5. ***Appointment of and support for FTSU guardians and champions***

The terminology is less important than the principle, namely all staff must have free access to a colleague who is empowered to support individuals who fear their concerns are not being heard or acted on, and who has the trust of staff and leadership alike. While it is important that Boards have a named director overseeing this area, it is not sufficient. There must be one or more guardians, not in the normal management hierarchy, who are accessible to all staff.

- 6.5.1. I continue to hold the opinion that FTSU Guardians are an essential part of a healthy culture. However, it is essential that all the requirements for this role are in place. If this is so, then they can provide an early warning that the culture in a particular workplace, unit, or ward is deteriorating. The effectiveness of the role will be enhanced by the appointment of FTSU champions or ambassadors – the precise name of the role is unimportant - to support the work of the Guardian in all parts of the organisation.
- 6.5.2. Currently, perhaps because of the decline in morale indicated by the survey [see above]. FTSU Guardians are reporting that they are handling an increasing number of cases: 32,000 across the NHS in England in 2023/4, a 27.6% increase on the previous year.. they are also reporting that 4% of their informants thought they had suffered a detriment for speaking up.¹²⁸
- 6.5.3. However, there is some evidence that in the NHS in England at least the now widespread adoption of FTSU guardians is associated with the more successful organisations. There is a positive correlation between the compliance with FTSU principles, as demonstrated through the NHS staff survey, and the ratings awarded by CQC to healthcare providers. Generally the national average for the National Guardian's FTSU Index slowly rose between 2016 and 2020, and on average

¹²⁸ *Making Speaking Up Business As Usual – Annual Report 2023-2024*, March 2025 CP 1265
[Making Speaking Up business as usual](#)

FTSU Guardians in providers which received the lower ratings from the CQC received more reports than those in providers which have been awarded higher ratings.¹²⁹ However the “score” derived from the survey results after that date shows a decline, and a marked disparity has been noted between the highest and lowest scoring organisations.¹³⁰ The latest results show a “plateauing” in staff confidence.¹³¹

6.5.4. There is little research as yet into the effectiveness of the FTSU Guardian role but a 2022 literature review and case study¹³² concluded that optimal implementation of the Guardian role had 5 components:

- (1) *Establishing early, collaborative and coherent strategy congruent to the values [which] fosters the implementation of.*
- (2) *Policies and robust yet supportive practices.*
- (3) *Informed by frequent and reflexive monitoring of FTSU implementation, which is*
- (4) *Underpinned by sufficient time and resource allocation that leads to.*
- (5) *A positive implementation climate which is congruent with FTSU values and best places to engender positive and sustainable FTSU culture and the well-being of a Guardian.*

6.5.5. The authors made a number of recommendations about the resourcing and support for this role and in particular considered that metrics such as the Speak Up index ratings should not be considered the only indicators of FTSU culture or considered in isolation from other sources of data.

6.6. ***Intolerance of bullying, abuse, discrimination and oppression***

Such behaviour cannot be tolerated at any level of the organisation and must be called out. It needs to be recognised as a safety issue, and treated as potentially a serious disciplinary matter. There should be no room in an organisation for those who persistently behave in an unacceptable manner. However, it is important that persistence in raising a genuinely held concern should not be misnamed bullying.

¹²⁹ *Freedom to Speak Up Index Report 2021*, National Freedom to Speak Up Guardian May 2021 pages 6, 7, 9 <https://nationalguardian.org.uk/wp-content/uploads/2021/05/FTSU-Index-Report-2021.pdf>. The National Guardian analyses the answers to the relevant questions in the Survey and produces a “score”.

¹³⁰ *Fear and Futility – what does the Staff Survey tell us about speaking up in the NHS?* – National FTSU Guardian June 2023 <https://nationalguardian.org.uk/wp-content/uploads/2023/06/Fear-and-Futility-NHS-Staff-Survey-1.pdf>

¹³¹ Bereket, *Speaking Up in healthcare: has progress plateaued – and what must be done?* 20 March 2025 National FTSU Guardian’s Office <https://nationalguardian.org.uk/2025/03/20/speaking-up-in-healthcare-has-progress-plateaued-and-what-must-be-done/>

¹³² Jones A, Maben J, Adams M, Mannion R, Banks C, Blake J, et al. *Implementation of ‘Freedom to Speak Up Guardians’ in NHS acute and mental health trusts in England: the FTSUG mixed-methods study*. Health Soc Care Deliv Res 2022;10(23). <https://doi.org/10.3310/GUWS9067> August 2022 https://www.ncbi.nlm.nih.gov/books/NBK583156/pdf/Bookshelf_NBK583156.pdf

6.7. **Investigation of concerns**

There is no point in staff raising concerns if they are not investigated and acted on. This requires the resource to enable this to happen. Generally, any serious concern relevant to safety requires an impartial, fair, and authoritative investigation by someone who is trained to do this. All too often investigations, if they happen at all, are conducted senior managers or leaders picked at random. Where the issue involves technical or clinical expertise an external investigator may be required. Ideally the mode of investigation, and even the identity of the investigator, should be agreed with the person raising the concern, and if the concern is about a particular individual, that person, too. It is important that the investigator and the methods of inquiry used have the confidence of the person raising the concern, the organisation and the staff more generally, who, whatever the attempts made at confidentiality are likely to be watching closely. The task of the investigation is to establish the facts relevant to the concern, not to establish blame, or to exculpate the organisation, but to ensure that any safety issue raised is dealt with. It is also important that the investigation is prompt, not only to protect patients and the organisation from the relevant risks but also to encourage the open culture required. Staff are most often discouraged from reporting concerns through lack of confidence that anything will be done about them.

6.8. **Peer review**

Much peer review happens in healthcare settings, for example Royal College reviews. It is sometimes a less apparently threatening way of approaching sensitive problems. It is important that it is a genuine effort at offering constructive and objective opinions as a “*critical friend*” and not designed as a device to confirm a decision already taken.

6.9. **Comprehensive data to inform action**

I have already referred to the NHS staff survey separately, but in order for boards and other leadership to ensure safety, data which gives a rounded picture of their organisation is required. Such data but be sufficiently granular to inform leaders of the health of each unit or department and not just the organisation as a whole. It is quite possible for an organisation to allow the development of “*silos*” of both good and poor practice, and it needs to know about both. There are a number of essential areas on which reliable information should be collected. What these are will be context specific, but are likely to include:

- staff experience, morale and attitudes of the type collected in the NHS survey,
- staff turnover and health,
- occurrence and reporting of adverse incidents, complaints, grievances, and speaking up
- performance in investigations, reporting, and disciplinary processes

6.10. **Learning**

It is important not only to collect data but to have appropriate reactions to the results. In relation to potential safety issues it is not sufficient to defer action on concerning results on the excuse that the data does not prove a serious problem exists. A gross example of such a failing may be seen in the response of some to information about infected blood that it did not prove conclusively that such blood could transmit infection to patients. The Inquiry report roundly condemned that approach to a risk of serious harm to patients.¹³³ In the Mid Staffordshire Inquiry I found that, faced with mortality figures showing the hospital was a statistical outlier, the Board prioritised a challenge to the technical validity of the statistics over commissioning a case note review in the outlier wards. It is also important to recall that statistics in health are made up of real patients and real conditions and that apparently small percentages can represent many thousands of people. It is for that reason that apparently low percentages, for example of reported experiences of bullying, are so important: they represent thousands of staff who have directly experienced oppressive behaviour, witnessed by thousands more. Discounting the significance of such figures can allow a fear of speaking up to spread. Likewise action must be seen to be taken in response to reported incidents, concerns raised, complaints and grievances.

6.11. Training

Raising concerns and receiving them appropriately is not easy, especially if they concern a colleague's competence or judgement. All staff should be exposed to training, preferably in a non-hierarchical setting, to equip them with the challenges that can arise. It is my personal view that such training should be experiential and in teams, rather than of the online, remote variety. It is also clear that investigators need to be trained as well.

¹³³ Infected Blood Inquiry, *The Report – what happened and why?* Volume 4, page 44 [footnotes omitted: “The line “no conclusive proof”, whilst technically correct, was indefensible. It did not spell out the real risk. It gave false reassurance. It lacked candour and, by not telling the whole truth, it was misleading. There was no good reason for the decision to adopt and maintain this line. It represented a deliberate choice by the DHSS to emphasise the absence of conclusive proof rather than the presence of a likely risk. Its motives for so doing are likely to have been a combination of reassuring people who might need a transfusion and encouraging people with bleeding disorders to continue to accept treatment with concentrates and because it might mitigate the fact that the DHSS was not taking more radical or proactive steps.”
https://www.infectedbloodinquiry.org.uk/sites/default/files/Volume_4.pdf

6.12. Accountability

- 6.12.1. Healthcare providers and those who work for them are accountable, in the sense of being responsible for many, sometimes conflicting obligations both collectively and individually. For example an NHS Trust may be held to be accountable for balancing its budget, and also delivering a high quality care to its patients. Accountability is about how they exercise those responsibilities. Here the focus is on the responsibility to promote a healthy and patient focussed safety culture.
- 6.12.2. The most basic form of accountability is the obligation on professionals and leaders to explain their decisions, actions and outcomes when required appropriately to do so, whether to patients, service users, their managers or leaders, or external stakeholders including the public. This necessarily includes being honest about the limits of either individual or collective knowledge. It is also important for all to recognise that their first responsibility is to patients [whether or not they are registered professionals bound to recognise that by a code of conduct], but there is an obligation to colleagues as well.
- 6.12.3. A second form of accountability is to learn from best practice, to reflect on what could be done better, and contribute towards ensuring that unwanted outcomes are avoided and not repeated. This needs to be a shared endeavour, with each person involved playing their part. Confrontation, accusations, and seeking out someone blame have no place in a healthy safety culture, as opposed to candour, and objective consideration of how and why an adverse event has happened, and how the risk of recurrence can be mitigated or avoided altogether.
- 6.12.4. The third form of accountability is to the obligation to do all that is reasonably practicable to remedy any harm done to a patient or service user.
- 6.12.5. The final accountability, which ideally is a last resort, is to be liable to some form of sanction or remedy for a failure to comply with expected standards of competence and conduct or for persistent breach of the values which drive a healthy and safe culture.
- 6.12.6. The acceptance of accountability in all these meanings must be shared by all in an organisation.

7. Conclusion

I have sought to give answers to the questions posed, largely relying on recommendations I and others who have chaired inquiries into incidents of serious harm occurring in healthcare settings. I am conscious that I have relied in part on my own previous recommendations but would point out that they merely echo what others have proposed and have in large part been accepted by the government of the day. Acceptance, however, has not always been followed by wholehearted or consistent implementation. As much can be seen from Part 1 of my report to the Thirlwall Inquiry¹³⁴ or the more extensive examination of implementation undertaken by that Inquiry's legal team.¹³⁵ The combination of the consensus to be seen in the recommendations made by multiple inquiries and investigations, and the evidence of non-implementation suggests the persistence of cultures which discourage or obstruct staff from raising safety concerns or acting to remedy them could be halted by a coordinated and committed approach perhaps absent in the past. I suggest that this requires an effective and independent system of accountability and monitoring in this area.

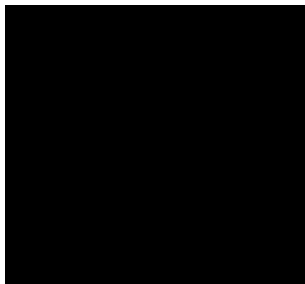
¹³⁴ Sir Robert Francis KC, Thirlwall Inquiry Expert Report Part 1, 30 May 2024 <https://thirlwall.public-inquiry.uk/evidence/inq0101077-expert-report-of-sir-robert-francis-kc-part-1/>

¹³⁵ *Review of Implementation of Recommendations from Previous Inquiries into Healthcare Issues prepared by the Thirlwall Inquiry Legal Team* 15 May 2024 <https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-documents/Table-of-Inquiries-Reviews-and-Recommendations-made-and-whether-they-were-implemented.pdf>

8. STATEMENT OF TRUTH

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true.

[SIGNED]



[signed electronically]

[DATE] 14 July 2025

SIR ROBERT FRANCIS KC
Serjeants' Inn Chambers
Fleet Street
London EC4Y 1AE

APPENDICES

APPENDIX 1 - Scenario for Sir Robert Francis

A. Introduction

1. The Inquiry Team would be obliged to receive a report from Sir Robert Francis that provides answers to the following three questions in order to assist the Chair in reaching conclusions in respect of TOR 4, particularly in respect of whether disclosures of evidence relating to the impact of features of the water and ventilation systems of the hospital on patient care and patients outcomes was encouraged as a practical reality.
 - i. How can an external observer or investigator tell if an NHS Board or Trust has a problem within its organisation related to the encouragement of reporting by staff of patient safety concerns?
 - ii. What principles should be followed by an NHS Board or Trust that wishes to create an effective system in which such concerns can be raised?
 - iii. From all of the work undertaken by you, what are the most effective changes that can be made by NHS Board or Trust to create an effective system in which such concerns can be raised?
2. The Chair has yet to reach a determination on the factual issues that underly and provide context to these questions. Whilst it might be theoretically possible to wait until he has done so before asking you to consider the questions set out above, that would prevent the conclusions of your report being put to senior management and board members of NHS GGC in our Glasgow IV – Part 3 hearing block in September/October 2025 and would, it's suspected, likely further delay the conclusion of the Inquiry.
3. To that end it is proposed that you proceed on the basis that the Chair accepts the factual situation and inferences set out in this scenario. The scenario attempts to summarise the events that took place between 2015 and 2024 as a number of clinicians within NHS GGC sought to raise concerns about infections they saw as linked to the water and ventilation

systems of the QEUH and also the operation of the IPC team within the NHS GGC in general and the QEUH in particular.

4. The scenario is necessarily a summary. Some less significant events are missed out and the amount of detail that is provided drops off the further events are from attempts made by Dr Inkster, Dr Peters and Dr Redding to draw attention to their concerns about the impact of the water and ventilation systems on patient safety and related concerns about the operation of the IPC team at the QEUH/RHC and within NHS GGC. If you believe you require an explanation of events only touched upon in this scenario, please ask.
5. The substance of the scenario is drawn from the closing submissions of Counsel to the Inquiry at all three hearings that have been held in respect of the QEUH/RHC along with narrative sections in the reports of the Inquiry's appointed experts. You should not need to read these, but you will be provided with access to the reports of the Inquiry's appointed experts as they can be found in Hearing Bundle 21.
6. References in footnotes are to Hearing Bundles and in light of the substantial work involved in creating a bespoke bundle for you to work from we ask you to find any document referenced in a footnote in those bundles which you can find in your Objective Space.

B. Context: The Queen Elizabeth University Hospital

7. The QEUH was completed and opened in the summer of 2015. It provides facilities for specialist health care for people of all ages and an array of conditions. It is a local hospital to much of south Glasgow, a regional specialist hospital for the west of Scotland, and a Scottish national hub for treatment and care of specific conditions including adult and paediatric bone marrow transplant.
8. The overarching aim of the Inquiry is to consider the planning, design, construction, commissioning and, where appropriate, maintenance of both the QEUH and RHC. The Inquiry is asked to determine how issues relating

to adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care occurred; if these issues could have been prevented; the impacts of these issues on patients and their families; and whether the buildings provide a suitable environment for the delivery of safe, effective person-centred care. This fully set out in the **Remit and Terms of Reference of the Inquiry**.¹³⁶

Procurement of the QEUH

9. Between 1998 and 2001, NHS Greater Glasgow undertook an Acute Services Review which was intended to develop a strategy to address challenges facing the delivery of acute services in Glasgow. Once approved by the Scottish Government in June 2002 this involved the development of the new South Glasgow Hospital Campus (later known as the QEUH) and was described in the Outline Business Case (“OBC”) as seeing both *“the single biggest phase of modernisation and rationalisation of [NHS GGC’s] adult clinical services”* but also incorporating *“the creation of a new Children’s Hospital for the Greater Glasgow and West of Scotland populations and the completion of the modernisation of Glasgow’s Maternity Services”*.
10. The plan was to build a 1109 bedded adult new build acute hospital with A&E services, acute specialist inpatient care, a small volume of medical day cases and outpatient clinics serving the local population and also a 240 bedded children’s hospital that would also provide A&E services and a comprehensive range of inpatient and day case specialist medical and surgical paediatric services on a local, regional and national basis. A proposed New Laboratory building would provide biochemistry haematology blood transfusion and mortuary services. The expected benefits of the project were many, ranging from the provision of high-quality services to *“Modern, fit for purpose facilities which meet the needs of patients, visitors and staff”*.

¹³⁶ [Scottish Hospitals Inquiry - Remit and Terms of Reference.pdf](#).

11. The hospital was initially to be procured by a public private partnership route, but after a review it was decided to use an NEC 3 Design and Build Contract for a more conventional capital funded procurement. After the OBC stage tenders were sought and in November 2009, after a five-week evaluation process, NHS GGC selected Brookfield as preferred bidder. On 18 December 2009, Brookfield and NHS GGC entered into a contract to build the hospital.
12. In December 2010, the Full Business Case (“FBC”) was approved by the Scottish Government. A reviewable design period then followed when designs were developed. NHS GGC and Brookfield then signed the Authorisation to Proceed to Stage 3 (construction) on 16 December 2010. On 28 March 2011 Brookfield started on site. NHS GGC took possession of the building on 26 January 2015. On 29 January 2015, the Stage 3 Sectional Completion Certificate was issued. It certified that sectional completion was achieved on 26 January 2015. This was four weeks earlier than the Scheduled Completion Date of 28 February 2015.

Patient Migration

13. Patient migration started on 27 April 2015 from the Western Infirmary, Victoria Infirmary, Mansion House Unit and Gartnavel General Hospital. On 1 May 2015, the Inpatient departments of the Southern General Hospital moved to the new campus. On 6 June 2015 the adult BMT transplant team moved into Ward 4B from the West of Scotland Cancer Centre (known as “the Beatson”). On 10 June 2015, the Royal Hospital for Sick Children at Yorkhill moved into the new RHC building at the QEUH. By 14 June 2015, the move by all units and hospitals to the new campus was complete.

The key wards

14. The main QEUH hospital building contains a lower three floor structure which extends across into the RHC and a tower block above. Each floor in the tower has four adult wards. The key wards that the Inquiry has considered are:

- Ward 1D – RHC - the Paediatric Intensive Care Unit (PICU).

- Ward 2A – RHC - Schiehallion Unit inpatients.
- Ward 2B – RHC - Schiehallion Unit day cases.
- Ward 4B – Tower – Adult Bone Marrow Transplant (BMT).
- Ward 4C – Tower – Adult Haemato-oncology & Renal.
- Wards 5C and 5D – Tower - Infectious Diseases.
- Ward 6A – Tower – until September 2018 a care of the elderly ward then the home of the Schiehallion Unit after decant from Ward 2A RHC.
- Seventh floor wards in the tower – wards for respiratory patients and (separately) Cystic Fibrosis patients.

The Schiehallion Unit

15. Whilst the remit of the Inquiry extends to the whole hospital, the focus has been on the experience of patients in the paediatric haemato-oncology and paediatric benign-haematology unit known as the “*Schiehallion Unit*”. The Schiehallion Unit was established in 1996 to deliver this highly specialised service. Under the leadership of Professor Gibson, the service developed from a small consultant base to a large multi-disciplinary team delivering a range of treatments and clinical trials in a holistic setting. The Schiehallion Unit is also the home of the national paediatric Haematopoietic Stem Cell Transplantation service (“*HSCT*”). For ease, the HSCT service is referred to as the Bone Marrow Transplant service (“*BMT*”) in Inquiry documents. Prior to moving in 2015 the Schiehallion Unit was at the Royal Hospital for Children at Yorkhill. From June 2015 to September 2018 the Schiehallion Unit was located in new purpose-built facilities in Wards 2A and 2B of the RHC. In September 2018 the Schiehallion Unit was decanted to Ward 6A in the adult hospital and HSCT patients were decanted to Ward 4B in the adult hospital which then hosted the adult BMT unit.

Later aspects of the procurement

16. On 31 August 2016, Brookfield changed its name to Multiplex Construction Europe Limited ("*Multiplex*"). On 26 January 2017, following the end of the two-year defects liability period, the Final Defects Certificate was issued by Capita Symonds on behalf of NHS GGC for "*Stage 3 Adult and Children's Hospital and Energy Centre*".
17. In January 2020 NHS GGC commenced court proceedings in the Court of Session, Edinburgh against Multiplex and other consultants and contractors. NHS GGC put a copy of the Summons initiating those proceedings on their website. NHS GGC seeks to recover a sum in excess of £71 million in respect of losses alleged to have been sustained as a consequence of defects in the construction of the QEUH. Multiple breaches of the Building Contract are alleged including those relating to the water system, and ventilation in standard isolation rooms, Adult Hospital Ward 4B and RHC Ward 2A. No claim is made in relation to the ventilation of the general wards.

Context: Key people

18. The key people in these events are:
 - Robert Calderwood, NHS GGC Chief Executive until 2017
 - Jane Grant, NHS GGC Chief Executive from 2017
 - Grant Archibald, NHS GGC Chief Operating Officer
 - Kevin Hill, Director of Women & Children's Services, NHS GGC
 - Jonathan Best, Director Regional Services, NHS GGC
 - Gary Jenkins, former Director of Regional Services, NHS GGC
 - Dr Jennifer Armstrong, NHS GGC Medical Director and Healthcare Acquired Infection (HAI) Lead until 2020. Retired October 2024
 - Dr Scott Davidson, Medical Director, NHS GGC since 2024. NHS

GGC Deputy Medical Director (Acute Services) from 2019 to 2024

- Dr David Stewart, NHS GGC Deputy Medical Director until February 2019
- Dr Chris Deighan, NHS GGC Deputy Medical Director (Corporate) in 2019
- Dr Alan Mathers, Chief of Medicine for Women and Children at the RHC/QEUEH
- Dr Linda de Caestecker: Director of Public Health and an Executive Member of the Board of NHS GGC until her retirement in March 2022
- Dr Emilia Crighton: Public Health Consultant and now Director of Public Health and an Executive Member of the Board of NHS GGC
- Professor Brenda Gibson, Lead Clinician of the Haematology and Oncology Service at the RHC, Programme Director for Haematopoietic Stem Cell Transplantation (SCT) and Departmental Lead for Systemic Administration of Chemotherapy (SACT)
- Dr Dermot Murphy, Consultant Paediatric Oncologist at the RHC
- Dr Redding, Consultant Microbiologist, former lead ICD, retired 2018.
- Professor Brian Jones: Consultant in Medical Microbiology. He was Head of Service for Microbiology in NHS GGC from 2013 to 2020.
- Professor Alistair Leanord: Chief of Medicine, Diagnostics in NHS GGC
- Tom Walsh, NHS GGC Infection Control Manager
- Sandra Devine (nee McNamee), Director of Infection Prevention and Control in NHS GGC

- Dr Cruickshank, Retired Microbiologist. From November 2015 to May 2016, Dr Cruickshank was the Interim Clinical Director for Infection Control Doctors at NHS GGC.
- Professor Williams, Consultant microbiologist in NHS GGC from 2002 to 2016 and NHS GGC Lead ICD until February 2016
- Dr Inkster, Consultant Microbiologist and also Regional Sector ICD until February 2019. Then NHS GGC Lead ICD until September 2019 with a gap in the second half of 2017 when she was on sick leave.
- James Redfern: Director of Women and Children's Services. Mr Redfern was previously General Manager for Paediatrics and Neonates.
- Jennifer Rodgers: Deputy Nurse Director for Corporate and Community Services in NHS GGC. Ms Rodgers was previously Chief Nurse for Paediatrics and Neonates.
- Melanie Hutton: General Manager for Paediatrics and Neonates. Ms Hutton was previously Clinical Service Manager and Lead Nurse
- Dr Peters, Consultant Microbiologist and also South Sector ICD and then QUEH ICD from late 2014 until 2017.
- Dr Alison Balfour: Consultant Microbiologist and Infection Control Doctor at the QEUH from 2015 until her retirement in 2022.
- Dr Kalliope Valyraki: Consultant Microbiologist. Dr Valyraki was an Infection Control Doctor at the QEUH from March 2017 to July 2021
- Pamela Joannidis: Retired Infection Control Nurse. From 2007 to 2013, Lead Infection Prevention and Control Nurse in the South Sector in NHS GGC. From January 2013 to March 2019, Nurse Consultant and was involved in setting up the Paediatric Infection Prevention and Control team at the RHC.

- Lynn Pritchard: From October 2015 to September 2022, Ms Pritchard was the Lead Infection Prevention and Control Nurse for the South Sector in NHS GGC. From September 2022, Ms Pritchard became a Nurse Consultant in Infection Prevention and Control
- Clare Mitchell: Lead Infection Prevention and Control Nurse from 2010 and October 2015. Senior Infection Prevention and Control Nurse from October 2015 to 2020.
- Dr Iain Kennedy: Since August 2014, a Consultant in Public Health Medicine, within the Public Health Protection Unit at Gartnavel Royal Hospital, Glasgow
- Ms Kathleen Harvey-Wood: Principal Clinical Scientist in microbiology at the QEUH up to her retirement in May 2023
- Professor Tom Steele: Director of Estates and Facilities 2018 to date. Prior to that Director of HPS
- David Loudon, Project Director for the new QEUH
- Alan Gallacher, General Manager (Estates) from August 2015
- Iain Powrie, Senior Estates Manager for the QEUH
- Annette Rankin, Nurse Consultant in Infection Prevention and Control for HPS and then ARHAI Scotland.
- Susan Dodd: Nurse Consultant at ARHAI Scotland. Between March 2017 and August 2019, Ms Dodd was the Lead Infection Prevention and Control Nurse at the RHC
- Jim Leiper: Mr Leiper had been Head of Estates at NHS Tayside, Director of Estates, Facilities, and Capital Services at NHS Fife, and Strategic Director of Facilities at Health Facilities Scotland
- Health Protection Scotland (HPS). HPS was responsible for the coordination of health protection in Scotland including protection

against the spread of infectious disease. Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) was part of HPS and is a clinical service providing national expertise for infection, prevention and control (IPC), antimicrobial resistance (AMR) and healthcare associated infection (HAI) for Scotland. It produces the National Infection Prevention Control Manual ("*NIPCM*") to which health boards are required to adhere when reporting infection outbreaks.

- Health Facilities Scotland (HFS) was formerly known as the NHS Scotland Property and Environment Forum. Its function was to provide operational guidance to NHS Scotland bodies, including health boards in relation to facilities, decontamination, equipment and other technical matters.

Infection Prevention and Control ('IPC') in NHS GGC

19. Following the Vale of Leven Public Inquiry the managerial function for IPC in NHS GGC was removed from the Laboratory Directorate and given to the Infection Control Manager ("*ICM*") and the lead Infection Control Nurse ("*ICN*"). The lead ICN would be a senior nurse consultant. The lead ICD reports to the ICM in management terms but has direct professional access to the Medical Director who is also Healthcare Acquired Infection (HAI) Lead. Those consultant microbiologists who work sessions as ICDs are managed in terms of IPC service management by the Lead ICD, and as consultant microbiologists by the microbiology Head of service for Microbiology. Consequently, consultant microbiologists and the ICDs report through two separate lines of management for different parts of their jobs.
20. The QEUH and RHC form part of the South Sector of NHS GGC. In 2015, the ICD for South Sector was Dr Peters. The adult haematology and BMT services that were planned to go into the QEUH were part of the Regional Sector. Its ICD in 2015 was Dr Inkster.
21. Dr Inkster explained that in her view, before the opening of the QEUH, NHS GGC IPCT were very good at mandatory reporting, mandatory

surveillance, adhering to the National Manual, workflow and presenting data, and SPC charts. She felt they were unfamiliar with how to approach new threats. If something was new and different and hadn't been described in guidance, the approach was that things might often be downplayed, that they might look for other reasons as to why infections were happening, that they weren't particularly open to new knowledge at the time from the literature or other sources.

22. The management of IPC was carried out through three committees. The IPC SMT, the AICC and BICC. The key minutes for these groups are in Hearing Bundle 13.¹³⁷
23. Dr. Inkster explained there is no out of hours ICD or ICN service in NHS GGC, and quite often on-call microbiologists who may have had no infection control sessions as ICDs end up responding to concerns from clinicians out of hours. Where there is an infection control concern following receipt of a sample, microbiologists would normally communicate that with the lead ICD of the Infection Control team or the sector ICD. Also, ICNs would generally be copied in. Dr. Inkster added that depending on the severity of the situation, the Infection Control Manager and the Associate Nurse Director for Infection Control may be copied in. Dr Inkster told the Inquiry that if a microbiologist was faced with an outbreak or incident then the issue would be escalated to senior management, or a Situation Background Assessment and Recommendation document (“*SBAR*”) would be created.
24. Given the terms of the **Stage 2 Whistleblow Report**,¹³⁸ the Inquiry Team put the proposition that IPC should be a nurse-led service to all IPC clinicians who gave evidence in Glasgow III. All agreed that it could not be ‘nurse-led’ in the sense that ICNs made all the decisions, but might be described as ‘nurse-led’ in the sense that a high proportion of tasks were

¹³⁷ A48890718 Hearing Commencing 19 August 2024 - Bundle 13 - Additional Minutes Bundle (AICC/BICC etc).

¹³⁸ Bundle 27, Volume 4, Document 6, Page 81.

carried out by ICNs.

C. Issues with the building that arose in the QEUH

25. The Inquiry has heard evidence about issues with the building that arose at the QEUH in 2015 either before services commenced at the hospital or soon after. These relate to: Ward 2A ventilation, Ward 4B ventilation and isolation rooms. A further issue around water testing, water quality and legionella risk arose later, but had its roots in events in 2015. A fifth issue around the designed air change rate in general wards came to light in May 2016.
26. On 25 June 2015 the South Sector ICD, Dr Peters, and the Regional Sector ICD covering adult BMT and Haemato-oncology & Renal, Dr Inkster, met Mr Powrie for Dr Inkster to become familiar with the broader QEUH site. This was because Dr. Inkster would be covering as ICD for the whole hospital during Dr Peters' programmed absence.. That day they learned that none of the PPVL isolation rooms had HEPA filtered air supply, there had been no IPC signoff of commissioning and validation data on ventilation for any part of the hospital, and there was no *"easy to read collection of relevant documents for the specialist ventilation areas including design spec, commissioning and validation data"*¹³⁹

Ward 2A Ventilation

27. The first issue that emerged in Ward 2A, by 3 June 2015 at the latest, was the lack of HEPA filters in the isolation rooms that were intended for children undergoing bone marrow transplant. Estates managers also had concerns about how the PPVL rooms had been designed with the main extract in the bedroom. This was not in accordance with guidance. It seems that no air sampling had been undertaken in the ward that was to house paediatric BMT patients before the patients arrived.
28. Ward 2A had no specialist ventilation arrangements aside from the BMT

¹³⁹ Bundle 14, Volume 1, Document 15 at Page 337.

isolation rooms and it later emerged in May 2016 that the air change rate in the rest of Ward 2A was at 3 ACH or less, which is half of the standard set in the relevant Scottish guidance; SHTM 03-01. BMT units must also adhere to the standards set by the Joint Accreditation Committee ISCT-Europe (“JACIE”) and be accredited by JACIE. All of Europe adheres to the JACIE standards; the USA operates a similar accreditation system. The standards set by JACIE are not overly prescriptive to enable compliance by low and middle-income countries. The standard set by JACIE is that transplant units should be designed to “*minimise microbial contamination*”. When the Schiehallion Unit moved to the RHC, clinicians, including Professor Gibson, were told that the HEPA filtration that had been installed in the BMT isolation rooms met the JACIE standards of protection against microbial infection. Clinicians who gave evidence in Glasgow II were consistent in their understanding that BMT patients should be cared for in rooms which provided specialist ventilation in at least two respects: (i) High Efficiency Particulate Air (HEPA) filtration; and (ii) positive pressure compared to the rest of the hospital.

29. Professor Gibson recalled being informed that Ward 2A as a whole was built to the standards required for a haemato-oncology unit, such that the rooms for treating BMT patients would have positive pressure and HEPA filtration. Prior to the migration of paediatric patients to the RHC she sought, and was given, assurance from the then Lead IPC doctor, Professor Williams, that it would be safe to begin transplant procedures on moving to the new ward.
30. However, when Professor Gibson visited Ward 2A shortly before the move, she also discovered that HEPA filters were not in fact installed in the BMT rooms on Ward 2A. Casings were present but the filters themselves were not. She was surprised that the omission of filters had not been detected during the commissioning process. She had been told the specification of the ward was to the required standard and trusted what she had been told. She expected Management, Estates and IPC to provide a safe environment in which to treat children; prior to this discovery she had no reason to doubt that that would be provided.

31. Pamela Joannidis, the nurse consultant who was setting up the IPC team within the RHC, understood in 2013 and 2014 that the Schiehallion unit was to have a lobby and be HEPA filtered. It would be a sealed ward with positive pressure to the rest of the hospital, on the understanding that replicated the existing Schiehallion unit at Yorkhill. In July 2015 on a walkaround, she noticed there was no airlock and asked Professor Williams why this was the case. In July 2015 she did not know what the specification was for the Schiehallion unit.
32. Dr Inkster recalled that the old Schiehallion ward at Yorkhill Hospital had eight isolation rooms which were HEPA filtered, but that the rest of the ward was not filtered. She did not know the air change rate for the old Schiehallion ward.
33. **On 5 June 2015 in an email to the Medical Director, Dr Armstrong,** concerns were raised by Professor Williams about the absence of HEPA filtration in Ward 2A and that this would be “*potentially unsafe*” as regards children presently cared for in facilities with HEPA filtration.¹⁴⁰. Professor Williams explained that Facilities Manager Mary Anne Kane found out that HEPA filters had not been fitted on 29 May 2015, before the paediatric BMT moved over on 1 June 2015.. While it was a possibility this might stop the RHC from opening, HEPA filters were sourced from Northern Ireland, fitted, and the unit opened.
34. To assist, perhaps, in placing some of the later events in context, particularly the attitude to those raising problems, an exchange is noted between Dr Peters and senior microbiologist Professor Leanord. In August 2015 Dr Peters suggested that more needed to be done about the building. In reply Professor Leanord said words along the lines of, ‘why put your head above the parapet’. That was taken by Dr Peters to mean that, ‘If you keep raising concerns, that could be a difficult road.’ Professor Leanord has not disputed Dr Peters’ recollection of this conversation. While this was

¹⁴⁰ Bundle 14, Volume 1, Document 8 at Page 200.

friendly advice, Dr Peters did not understand it. She explained, 'it's really a core foundational principle of any interaction with patients that you've got a responsibility to act in their best interests. And, a bit of discomfort for you or just not being terribly popular, that doesn't come into any equation that I know of for patients. So, you have to act in the patients' best interest.-- That is a foundational part of your job. If you're not doing that, you're not doing your job.' Professor Leanord subsequently described Dr Peters and Dr Inkster as two of the most experienced and well-versed colleagues.

35. In the absence of HEPA filters, transplants would not have been able to take place and had the issue not been resolved, migration to the RHC would have been delayed. **In an email dated 5 June 2015 to the then Clinical Service Manager**¹⁴¹, Professor Gibson noted the likelihood that a transplant planned for 20 June would have to be delayed as a result of the missing HEPA filters. Professor Gibson wrote:

It is inconceivable that a transplant unit was built without HEPA filtration. Truly shows the priorities all show and no substance.

36. Reference might also be made to the evidence of paediatric haematology consultant Dr Murphy at Glasgow II as regards the missing HEPA filters:

... the day before we were due to move into Ward 2A when the hospital was opening, there were no HEPA filters in place, and we had to fly them over from Ireland. It was only because Prof Gibson walked around with Alanna McVeigh, one of the Transplant Department's Administrators, on the day before that that was recognized. I mention this because I think it highlights the level of knowledge of the builders who were fitting out the hospital and the approach to detail that was being taken when it was built.

When my colleagues from the UK or from Europe come to me and say, "We're just refurbishing our ward, we're moving on to a new ward, we know you've got a new children's hospital, what were the lessons you learnt?", I say to them, "Well, one of the lessons I learnt was, make sure you've got HEPA filters in your HEPA filtration suites." They look at you as if you are joking. I would have had the same reaction, but that was the level of build quality.

¹⁴¹ Bundle 8, Document 25, Page 125.

37. On 6 July 2015, the Board Infection Control Committee (BICC) minutes record discussion: *“around HEPA filters and the need to ensure air pressures are correct as Dr Peters had reported there were some issues around slightly positive air pressures”*. One Microbiologist advised: *“there are issues with ventilation in QEUH in a couple of areas and one room in particular”*. Dr Peters noted that at this meeting, attended by Professor Williams and chaired by David Stewart, that Professor Williams stated there were no issues with the ventilation. Dr Peters also recalled intervening to outline her concerns, but later found out that the draft minutes did not fully reflect these. There appears to be a dispute about the accuracy of the minute of the AICC meeting of 6 July 2015, and some dispute about the nature and extent of the issues which were raised.¹⁴²
38. Further concerns about the safety of the BMT rooms emerged following migration. Professor Gibson recalled that although the first two transplants proceeded without incident, concerns about air quality on Ward 2A emerged around July 2015 and continued into August and September. Air sampling on Ward 2A indicated high particle counts in the ward corridor. On raising this with Professor Williams, Dr Ewins recalled being informed that some ‘noise’ in the air sampling results was to be expected; the corridor was not pressurised and the unit not sealed from the rest of the hospital.
39. Of more immediate concern was the discovery of raised particle counts in the BMT isolation rooms in Ward 2A themselves¹⁴³. Further investigation using smoke tests revealed that the BMT rooms were not properly sealed; air could enter the room through unsealed areas (for example, light fittings). Professor Gibson and Dr Inkster recall that at a point likely before 10 June 2015, Aspergillus was found in the air sampling in BMT rooms, but not in patients. Despite these air sampling results, Professor Gibson recalled some debate about whether the rooms were in fact safe. There was doubt about interpreting the air sampling results. Professor Gibson and Dr Ewins

¹⁴² Bundle 13, Document 32, Page 250 at Page 254.

¹⁴³ Bundle 14, Volume 1, Document 10, Page 269.

recalled that the Lead ICD was not satisfied that transplants could proceed safely.

40. These concerns arose at a time when the unit had an extremely vulnerable patient awaiting transplant. As transplant patients do not have the luxury of time, and there is a narrow window in which a transplant can proceed, clinicians were in the unenviable position of potentially having to balance the risks of treating and not treating a desperately sick child.
41. An exchange of emails between 6 August and 4 September 2015 captured the clinicians' growing sense of frustration around the unanswered questions regarding the safety of the BMT rooms, and the fact the unit had been allowed to move when the safety of the environment may not have been assured¹⁴⁴. **In her email dated 4 September 2015**, Professor Gibson escalated her concerns to the board's Medical Director, Dr Jennifer Armstrong¹⁴⁵. Professor Gibson explained that the concerns about the BMT rooms had been unresolved for two months. Deadlines for resolution had been breached. Families in the anxious position of knowing their child needed a transplant, were in an uncertain position. Clinicians had lost faith. She said:

We have no feeling that the appropriate sense of urgency is in place...the transplant programme has been severely compromised.

42. Professor Gibson recalled that Dr Armstrong attended a meeting three days after the email was sent. Dr Armstrong gave the instruction that transplants could move forward. Professor Gibson did not recall receiving an explanation for why the problem arose in the first place. The Minute of that meeting of 7 September 2015 records that those present were: Dr Armstrong, Dr Mathers, Mr Hunter, Mr Redfern, Mr Archibald (by telephone), Professor Gibson and Professor Williams.¹⁴⁶

¹⁴⁴ Bundle 8, pp.128-133. See Page132.

¹⁴⁵ Bundle 8, Document 31,Page133.

¹⁴⁶ Bundle 13, Document 118, Page 843.

43. Dr Ewins recalled remedial work being done to seal the BMT rooms. There came a point where air sampling showed that two of the BMT rooms had air sampling results of a tolerable level so that transplants could proceed.
44. It might again be useful to note the perception of one of the less involved participants, Dr Mathers, when discussing events in respect of Ward 2A in September 2015. He said: *“There was an appreciation that fungal infections were a risk to anyone whose immune system was severely compromised, and the risks and the benefits were debated at length in a constructive and collegiate manner.”*
45. Although there was clearly a period of frustration on the part of clinicians in 2015, Professor Gibson was satisfied at the time that the response to the known issues was adequate. The problems with filters were resolved quickly enough to allow migration as planned. ‘Snagging’ problems with the BMT cubicles were not entirely unexpected. Remedial works were carried out. More generally, Professor Gibson understood that plans were put in place in 2015 to begin a programme of upgrading the Ward 2A BMT rooms to a higher specification. Although frustrated that there were problems, there appeared to be a plan to address these.
46. At some point in late 2015, prompted by queries raised by Dr Peters, Ian Powrie enquired of the Project Team about ACH. It took several enquiries before he was given the M&E Clarification Log and ZVP Ventilation strategy. He had not been aware of these documents previously. The result of this investigation is covered in the section ‘Air Change Rates in General Wards’ below.
47. When Ward 2A was decanted to Ward 6A in September 2018, NHS GGC instructed Innovated Design Solutions to look at the ventilation systems of both Wards 2A and 2B, and in due course a statement was issued that the ‘opportunity’ was being taken to ‘upgrade’ the ventilation. Counsel to the Inquiry have submitted that NHS GGC knew at senior level that the ventilation system on Ward 2A did not meet the standard in SHTM 03-01 (not least because of the conclusion reached eighteen months earlier in

March 2017 in a report to the Acute Service Committee). The work that was to be done during the decant was not an upgrade, but a complete replacement that involved major building works to strip out the existing systems and replace them.

Ward 4B Ventilation

48. In respect of Ward 4B, adult BMT patients moved into the QEUH on 6 June 2015. However concerns had been raised about the PPVL isolation rooms in this ward by the Sector ICD, Dr Inkster, in February 2015. In the summer of 2015 Dr Inkster had also raised concerns about air sampling results, a lack of 10 ACH, a lack of HEPA filtration outside the isolation rooms, and lack of pressure monitors. Some work was done in the ward in July 2015, but in any event the haematology consultants raised concerns about safety, and on 8 July 2015 the adult BMT unit moved back to the Beatson. These events were reported to the BICC on 27 July 2015. Putting aside for Glasgow IV why Ward 4B was built as it was, it is completely clear that NHS GGC knew by the end of July 2015 that Ward 4B was not built to the standards their own haematology consultants expected. As Dr Armstrong put it, they did not get what they were expecting. It seems likely that at that point no-one in NHS GGC outside the Project Team really understood how far Ward 4B was away from compliance with SHTM 03-01. What appears to have stopped that being worked out was the lack of clarity about what the ventilation specification was, as built.
49. On 10 August 2015 a meeting took place chaired by Mr Archibald to discuss concerns regarding the adult BMT facility that had briefly been in QEUH Ward 4B. Finding out what the specification was, what the appropriate guidelines were, whether the facility had been properly commissioned, and what actions could be taken to improve the performance of the existing facility, were agreed.¹⁴⁷

¹⁴⁷ Bundle 13, Document 117, Page 842.

Isolation Rooms

50. At handover treating clinicians were expecting to find enhanced ventilation in three specific wards (Wards 2A, 4B and 4C) and in the isolation rooms in critical care. At that point there were 36 isolation rooms in the QEUH/RHC¹⁴⁸ of which 10 were in critical care (ITU and HDU). There were no isolation rooms in the infectious disease wards on the 5th floor.
51. A significant issue for the Inquiry is why these isolation rooms were initially constructed as Positive Pressure Ventilation Lobby Rooms (PPVL rooms). The Inquiry's Expert Mr Allan Bennett has described a PPVL room as:

A room with a positive pressure ventilated lobby (PPVL room) has air supplied into the anteroom which causes positive pressure that provides a barrier between the outside environment and the inside environment. Air from the supply flows both into the corridor and into the patient room. The air supply into the anteroom will be filtered to reduce any environmental contamination. This allows the patient to be supplied with clean filtered air which can be safely extracted away from the ward area.¹⁴⁹

52. Senior NHS GGC Manager Mr Leiper helpfully explained the problem with the PPVL rooms at the QEUH. The normal configuration was for the extract to be within the ensuite bathroom so that air flowed from the lobby through the patient space and out through the ensuite. In the QEUH the extract was in the patient room itself, which might not create the intended air flow. He had seen it demonstrated at a conference where the air had simply flowed straight across the ceiling and out the extract.
53. Dr Peters did a brief tour of the new building in late 2014 with Mairi Macleod of the Project Team and ICN Jackie Barmanroy. That was the first time she thought, 'I'm not sure this is right'. She was shown what was said to be a negative pressure room which she knew clearly wasn't - it was a PPVL room - but was told Professor Williams had signed it off. She

¹⁴⁸ PPP 14, Para 5.8; Bundle 26, Document 4 at Page 291.

¹⁴⁹ Bundle 21, Volume 1, Document 8, Page 622.

assumed Professor Williams was dealing with ventilation but had no direct information. In a further walk-round shortly after patient migration (when she was checking how prepared they were for possible serious infected cases) she found there were no negative pressure rooms anywhere in the hospital, nor were there any pressure gauges in PPVL rooms, which are standard for such rooms. There has been a considerable volume of evidence about Dr Peters and others trying to find out what the ventilation specifications were for these isolation rooms and Wards 2A, 4B and 4C. The extent to which the design had been signed off by IPC staff – including ICDs – during the design period for the hospital is a live issue for the remaining hearings.

54. There has also been a substantial volume of evidence about the isolation rooms in Wards 5C and 5D, as the Brownlee Infectious Disease Unit had moved to the QEUH from Gartnavel Hospital. Dr Peters spent a considerable amount of effort in the summer of 2015 trying to work out the specification for these spaces. Dr Inkster and Dr Peters both describe attending a meeting with representatives of Brookfield/Multiplex in June 2015, who were apparently surprised to learn there was an Infectious Disease unit at the QEUH. The extent to which an Infectious Disease Unit was part of the QEUH project brief is disputed and remains a live issue for the remaining hearings.
55. **On 6 May 2016, nine Infectious Disease consultants wrote to Dr Inkster** (who had then just been appointed as Lead ICD) raising concerns about the PPVL rooms in Ward 5C.¹⁵⁰ As consequence she wrote an **SBAR**.¹⁵¹ On 18 May 2016 she had a response from Anne Harkness and David Loudon which correctly identified that there were no negative pressure rooms available in the QEUH. It seems that there were no isolation rooms for the infectious disease unit when she left the QEUH. Infectious disease patients were placed in negative pressure rooms that had been set up in the Critical Care unit.

¹⁵⁰ Bundle 14, Volume 1, Document 4, Page 88.

¹⁵¹ Bundle 4, Document 10, Page 49.

Water Systems Issues

56. DMA Canyon carried out a pre-occupation L8 Risk Assessment in April 2015 which focused on the Legionella risk posed by the water system in the hospital. This was not done before NHS GGC issued a Stage 3 sectional completion certificate for the building and handover took place. Full details can be found in **the 2015 DMA Canyon L8 Risk Assessment**¹⁵². The Executive Summary should be read, but the key findings were that:

- In the basement plant rooms: a pipe bypassed the filtration plant, a main water tank had been isolated resulting in stagnant water, and single-entry expansion vessels were in use which gave rise to further places for water to rest and become stagnant. Debris was found in the cold-water storage tanks which was still there in 2017 and in 2018.
- Some of the calorifiers that heated the domestic hot water were offline, whilst others showed hot water temperatures in the mid-40s degrees centigrade (indicating insufficient heat from energy centre). This posed a risk that bacteria such as legionella and other microorganisms could grow within the system, as the hot water was below the 50 to 55 degrees minimum temperature required to inhibit such growth.
- In the cold side of the domestic system, temperatures were found to be more than five degrees over the 20 degrees maximum temperature required to inhibit bacteria such as legionella and other microorganisms. Temperatures peaked at 30 degrees (indicating heat gain in the system), with a risk that bacteria such as legionella could grow within the system.
- Significant communication issues existed between subcontractors, Brookfield and NHS GGC, where defects highlighted by NHS

¹⁵² Bundle 6, Document 29, Page 122.

GGC's Estates team were being acted upon without the Estates team being informed or allowed proper consideration of bacterial control. The Estates team were also unable to review/sign off that the actions taken had been carried out in a compliant manner minimising any potential bacterial control impacts.

- Out of specification microbiological samples at handover. The sample results were not provided to DMA Canyon and a responsive programme of flushing and local disinfection was already underway at the time. Stagnation in the cold water storage tanks and bypass pipework may have contributed to out of specification results.
- A sampling programme (testing for TVC, E. coli, coliforms and Legionella) was being conducted and that daily flushing and local disinfections were underway where positive results were found, but neither the sample results, nor the disinfection process was provided to DMA to review.
- Flushing of bib taps (like garden taps) should be included in the flushing regime to prevent stagnation in the long pipes within the Trades water system and possible proliferation of Legionella and other bacteria.
- EPDM hoses (noted in NHS guidance as not to be fitted except in specific circumstances due to the rubber lining cracking) should have been removed or replaced by WRAS approved hoses with linings other than EPDM or hard piped (with stainless steel).
- Low turnover/dead legs should have been removed wherever possible. These are pipes that are not regularly used, where the water can become stagnant. Where deadlegs were unable to be removed it was recommended that they be incorporated into a low use outlets flushing regime. Lines in the system that had low turnover should have been fitted with a double check valve to prevent potentially stagnant water contaminating the system.

- There was no Written Scheme, Water Safety Plan, formal management structure or communication protocols for the QEUH and there were significant communication issues between parties involved. There was an informal Written Scheme in place based on SHTM 04-01 and written guidance provided by DMA Canyon. A written scheme for controlling the risk from exposure of Legionella should have been properly implemented and managed. There were no personnel identified as having responsibility for Legionella control. A lack of defined communication between involved parties may have contributed to out of specification bacterial and Legionella results recorded by NHS GGC Estates.

57. The HFS Water Management Issues Technical Review of 2019 assessed the DMA Report as highlighting “*various risks associated with the water system at handover, with a significant number to be dealt with either immediately, as soon as reasonably practicable or within three months.*”¹⁵³ There has been evidence that the water system was filled around a year before handover and not maintained. This is a matter for the Glasgow IV-Part 1 hearing.
58. The 2015 DMA Canyon L8 Risk Assessment was hand delivered to Mr Powrie of NHS GGC Estates on 6 May 2015 and a meeting was held with NHS GGC Estates Managers on 28 May 2015¹⁵⁴, but it seems Mr Powrie did not read it, escalate it to more senior colleagues or advise IPC. The assessment did not reach senior NHS GGC staff until June 2018, when the then Director of HFS, Professor Steele took the 2015 and 2017 DMA Canyon L8 Risk Assessment reports to the Chief Executive of NHS GGC, Ms Grant. The reports had been provided to HPS in late Spring 2018 along with large volumes of other information to enable HPS to support NHS GGC in the management of the 2018 ‘Water Incident’.

¹⁵³ Bundle 7, Document 4, Page 111.

¹⁵⁴ Bundle 25, Document 37, Page 684.

59. ICDs (in particular Dr Inkster as lead ICD) were not told about the assessed risks posed by the water system. In early 2016 Dr Inkster and Dr Peters had been asking for water risk assessments for the hospital, and they were not being produced. They asked Ms Kane, Mr Walsh and Mr Powrie. Mr Powrie did not tell Dr Inkster about the 2015 DMA Canyon L8 Risk Assessment. Mr Walsh did not know about it before at least June 2018, but then he had not been attending the Board Water Safety Group despite being its co-chair. Dr Inkster reported the non-existence of water risk assessments to the IPC SMT on 25 February 2018¹⁵⁵.
60. The Inquiry's water expert Dr Walker has formed the opinion that the system was not compliant at the point of occupation, classifying it as high risk, with the risk of infection increasing over time as biofilm formed and the bacteria were able to multiply in the water system due to the poor temperature control. By 2018 when testing increased, there was evidence of widespread contamination and biofilm including on tap components and in drains.

Air Change Rates in General Wards

61. Mr Powrie has been investigating this issue since late 2015 and on 6 May 2016 he emailed Dr Inkster - copied to Mr Loudon, Anne Harkness and Mr Walsh. This was the first point that a member of the IPCT, and certainly Dr Inkster, became aware of the Ventilation Derogation from December 2009, which dropped the air change rate for most of the hospital from 6 Air Changes per Hour (ACH) to 3 ACH or less.¹⁵⁶ Dr Inkster recalled being very surprised, as she expected the rate to be 6 ACH. She did not feel there was sufficient justification for delivering less than 6 ACH, because no patient risk assessment had been undertaken for this derogation from SHTM 03-01. Mr Walsh as ICM is adamant that the infection control team had no involvement with the derogation from 6 ACH to 3 ACH, except a specific derogation relating to the Renal Dialysis Outpatient Unit. He was surprised

¹⁵⁵ Bundle 13, Document 70, Page 533 at Page 536.

¹⁵⁶ Bundle 20, Document 68, Page 1495.

that infection control were not told about the change from 6 ACH to 3 ACH until years after the derogation. How the Ventilation Derogation came about in 2009, a matter of days before contract close, is a key issue for Glasgow IV Part 1, but it remains remarkable that it appears to have been news to Dr Inkster and Dr Armstrong nearly a year after the hospital opened.

62. Professor Steele has given evidence that there are no other records that he could find once he got into post in late 2018 from which it can be worked out why this decision was made. This remains a key issue for Glasgow IV Parts 1 and 2.
63. Counsel to the Inquiry have submitted that it is a reasonable inference that, had an attempt been made to rigorously understand what had gone wrong in respect of specialist ventilation spaces, then the Ventilation Derogation might well have been discovered in 2015. It is also likely that if validation had been carried out the change would have been flagged to a wider organisation.

D. A Summary of emerging concerns about infections 2015 to 2019

64. This section is taken in part from the narrative within the report of the Inquiry's Experts in Infection Control, Dr Mumford and Ms Dempster. It aims to provide context for the specific events where the whistleblowers sought to raise concerns about the possibility of a link between the water and ventilation systems of the hospital and patient infections. Not only did Dr Mumford and Ms Dempster conclude that there was a link between the water system and the infections, but they noted that in all the PAG and IMT minutes¹⁵⁷ that were available to them, the hypotheses for the source of the environmental gram-negative infections have always included environmental sources. No other possible sources have been identified or hypothesised.

¹⁵⁷ Bundles Hearing Commencing 12 June 2023 - Bundle 1 - Incident Management Team Meeting Minutes (IMT Minutes) and Hearing Commencing 12 June 2023 - Bundle 2 - Problem Assessment Group Meeting Minutes (PAG Minutes).

Infections found in 2016 and 2017

65. In late 2015 or early 2016 Professor Williams resigned as lead ICD. The post was advertised with a closing date of 4 March 2016 and Dr Inkster was appointed. Just as with Professor Williams, Dr Inkster worked five sessions as lead ICD and five sessions as a Consultant Microbiologist.
66. The first unusual infection was recorded in February 2016, a case of *Cupriavidus pauculus* blood stream infection. It took some five months for this very rare infection to be investigated when the water supply to a sink in the aseptic pharmacy was tested and found to grow the same organism. Subsequent typing confirmed the two organisms matched and measures were taken to rectify the pharmacy sink and plumbing.
67. In August 2016 there were two cases of *Aspergillus*, one definite and one probable. Significant issues were found with the ventilation system including tears in the ducting. It was noted that the rooms on 2A did not have HEPA filtered air supply. Condensation was noted on the chilled beams. All of the actions and investigations for this incident were associated with environmental factors.
68. In 2016 there were a further nineteen cases with positive blood cultures due to a total of twenty-two environmental gram-negative organisms and/or candida, including one case of *Mycobacterium chelonae*. None of these were escalated to a PAG.
69. Forty-seven water samples were taken from ward 2A/2B during 2016, all were negative. NHS GGC records show that a total of 1885 samples were taken from QEUH and RHC during 2016. The Inquiry's Infection Control experts Dr Mumford and Ms Dempster are of the opinion that this is below the expected level of sampling and testing of a high-risk area such as the Schiehallion unit and consequently cannot be used to exclude contamination in the water system at this time.
70. From this point the number of unusual environmental gram-negative blood stream infections increased steadily. The Inquiry's Epidemiology expert Mr

Mookerjee is of the opinion that the point at which the rates of infection began to increase was the end of the second quarter of 2016. The Inquiry's Infection Control experts Dr Mumford and Ms Dempster are of the opinion that there was no overarching surveillance of environmental organisms despite the frequency with which they were occurring.

71. In October 2017 a further patient with *Aspergillus* was identified. This was not escalated to an IMT. However, an ongoing risk of airborne infection to neutropenic patients was recognised due to the lack of functioning protective isolation, a low number of air changes per hour and dust collecting on chilled beam units, with poor air quality on Ward 2A. At this time there were demolition projects ongoing on the QEUH site, increasing the risk of invasive fungal disease and as a result all neutropenic patients in the Schiehallion unit were given anti-fungal prophylaxis.
72. In November 2017 the Acute Infection Control Committee was informed that ward 2A was seeing a high number of outbreaks with central line associated blood stream infection (CLABSI). There were a further 24 cases of CLABSI with 27 environmental organisms from March to December 2017 including a case of *Cupriavidus pauculus* in September.
73. By way of context the Independent Review described the infections occurring during 2017 as "*an emerging picture of very unusual organisms causing blood stream infections*".¹⁵⁸ Professor Gibson describes a growing unease about the pattern of gram-negative infections on Ward 2A in 2017. There was, however, no advice from IPC or microbiology at that time which indicated a possible link to the environment.

The Water Incident in 2018

74. The year started with a *Cupriavidus* infection in January. After water testing in the aseptic pharmacy was negative, attention turned to Ward 2A. Water testing subsequently identified outlets in the ward which were positive for

¹⁵⁸ IR, para 8.37.18 at Page 288.

Cupriavidus. The working hypothesis of the IMT was that the water outlets were the source of Cupriavidus and attention turned to the water system as whole.

75. Other concerning environmental and enteric Gram-Negative infections were identified, and on **1 March 2018 Dr Inkster started the ‘Water Incident’ IMT by email, as a meeting could not be held due to severe weather.**¹⁵⁹

There was rapid engagement in the process by Estates Staff and a high level of interest and support from Dr Armstrong. A rapid decision was made to fit Point of Use Filters (‘POUFs’) to taps in the Schiehallion Unit and a Water Technical Group (‘WTG’) was established in conjunction. However, Dr Inkster is right to be troubled by the fact that those who knew of the two DMA Canyon L8 Risk Assessments and then attended the IMTs and the WTG did not think to mention to her the risks they knew were posed by the water system. It is difficult to know whether it would have made any difference if, between the Gap Analysis Meeting on 30 January 2018 and the first IMTs in March 2018, this had been brought to Dr Inkster’s attention. However it is probably a reasonable assumption that the belief that seems to have existed at the IMT debrief on 15 May 2018 - that the incident had been successfully resolved - might not have been so confident, and that the sense of events being out of control once infections returned in May 2018 might not have occurred if Dr Inkster and senior managers had been aware of it earlier.

76. As Dr Inkster explained in her evidence, the focus of the IMT then turned to the sink drains with black grime, probably caused by the fitting of POUFs and the reduction of pressure caused by them. The distress and anxiety caused to patients, families and staff by the realisation that the POUFs and other interventions had not stopped the incident was clearly terrible. It was then, in the summer of 2018, that the consequences of the failure to report or act on the 2015 DMA Canyon L8 Risk Assessment really started to bite, and the problems with the management of the IPCT prior to March 2016

¹⁵⁹ Bundle 14, Volume 2, Document 88 at Page 75.

can be shown to have had a real impact.

77. Dr Inkster was concerned that the Horne Optitherm Taps used in the hospital were the reservoir of infection due to their complexity and the presence of flow straighteners, which is a known risk for development of biofilm and risk of infection. It should be noted that as a consequence of a 5 June 2014 meeting with HPS and HFS, and in light of the *Pseudomonas* outbreaks in Northern Ireland and Australia in 2012, NHS GGC - and certainly Mr Gallagher and Mr Powrie - knew that the Horne Optitherm taps posed a water safety issue. The issue appears to have been reported as an AOCB to the Board Water Safety Group on 7 August 2014 and considered at further meetings, but it is now clear that nothing substantive or systematic was done to maintain these taps until 2021. No explanation has been given by senior NHS GGC staff for this significant and repeated oversight.

78. The Minutes of the 13 April 2018 and 20 April 2018 meetings of the WTG¹⁶⁰ confirm that those present clearly understood and accepted that at this point there was widespread contamination of the water system. The minute of the 13 April 2018 meeting records that:

It was noted that every floor had positive and negative readings whereby this would indicate widespread water infection.

79. Then the minute of the 20 April 2018 records that:

Every floor is showing some contamination with various species so we can assume there is a widespread contamination in the buildings. A review of commissioning data indicates there was TVC which were off the scale but now we need to determine the way forward and solution to the contamination.

80. There was then an acceptance in the meeting that there was a widespread water issue throughout the entire new building site, the new campus of both hospitals, the RHC and the QEUH. The actions taken were fitting POUFs as a temporary solution, silver hydrogen peroxide dosing, chlorine dioxide

¹⁶⁰ Bundle 10, Document 2, Page 9 and Bundle 10, Document 3, Page 14.

dosing, and decontamination of the flow straighteners in the Horne Optitherm taps.

81. Dr Inkster produced a **Full Incident Management Team Report covering the IMTs from 2 March 2018 to 13 April 2018** dated 5 June 2018¹⁶¹. That concluded: *"that the source of exposure is contaminated water supply"* throughout the QEUH and the RHC, and that contamination took place during installation, leading to development of a thick biofilm. Temperature control and maintenance were seen to have been factors. It was thought possible that infections were linked to the water as they were linked by *"time/place/person"*. However, testing was continuing in order to establish if a more definite link could be proven. NHS GGC now maintain that it cannot be proven and that there is therefore no link.
82. There is every indication that this report was widely circulated without attracting disagreement about that conclusion. Dr Armstrong did not remember if she saw it, but she must have. She explained that at the time they all believed there was a connection between the water and the infections and put in measures to deal with it. She was uncertain what the point of entry was. As she saw it, the question was whether the environment was more risky than other hospitals.
83. As a treating clinician in the Schiehallion Unit, Dr Murphy's evidence about the unusual pattern of infections was clear. When clinicians first recognised the unusual pattern of infections, they did not *"jump"* straight to the conclusion that there was some link to the built environment; it is not their practice, as evidence-based specialists, to jump to conclusions. His views, and those of his colleagues, were based on years of observing infection patterns in their patients and discussion with colleagues looking after similar patients. By March 2018, Dr Murphy understood there to be evidence of a contaminated water supply. He and his colleagues shared the concern of IPC that the infection pattern was linked to the built environment. By

¹⁶¹ Bundle 27, Volume 5, Document 19, Page 46.

September 2018, Dr Murphy found it difficult to escape the conclusion that there was a systematic problem with the built environment. Dr Murphy said that, following careful reflection, he came to the view that there was a contribution from the built environment to the infection pattern seen in the Schiehallion patient population. He was further of the view that some of the infections which were in his view linked to the environment caused patients to become very unwell, and in some cases resulted in the requirement for care in the PICU.

84. In response to the environmental risk to patients, all showers were taken out of use, with sterile water provided for drinking, and bottled water and wipes for washing. Staff were advised to use alcohol-based hand gel after hand washing. This caused considerable distress to patients and their families.
85. Further positive water results were seen on PICU and Ward 3C RHC. POUFs were fitted to outlets on Wards 2A, 2B, PICU and 3C
86. The incident did not end. Over the subsequent months, further cases of environmental Gram-Negative blood stream infections were seen; in total nine cases of *Stenotrophomonas maltophilia*, 3 *Pseudomonas aeruginosa*, 1 *Pantoea*, 1 *Cupriavidus pauculus*, 6 *Enterobacter cloacae*, 1 *Chryseomonas* and 1 *Acinetobacter*. Results of sampling the drains on Ward 2A had shown various gram-negative environmental organisms including *Enterobacter cloacae*, *Pseudomonas aeruginosa*, *Sphingomonas*, *Cupriavidus pauculus*, *Acinetobacter ursingii* and *Klebsiella oxytoca*. All of these organisms were seen in blood stream infections in Schiehallion unit patients in 2018 (except *Sphingomonas*, seen in 2017).
87. On 31 May 2018 HPS produced an initial report on the 'water contamination incident' at the QEUH/RHC (the HPS Initial Report).¹⁶² The HPS report records that HPS, HFS and NHS GGC had initiated a detailed investigation

¹⁶² Bundle 7, Document 1, Page 3.

into the contaminated water system within the hospitals, and that the results from ongoing water testing appeared to confirm that ‘regressional seeding of contamination’ continued to occur and supported ‘the theory that a whole system remedial approach is required.’ Water sampling had revealed not only the three organisms associated with the incident, but ‘numerous additional gram-negative bacilli and fungal species.’

88. Concern in the IMTs continued to focus on the link between the water contamination and infections in patients, with the organisms isolated from the water (*Cupriavidus* and *Sphingomonas*) added to the alert list for infection control across the campus.
89. On 29 August 2018, thick black and yellow grime was visible in the drains of Ward 2A RHC, following the cleaning regime which had been implemented only 4-6 weeks prior.¹⁶³ Drain swabs confirmed the presence of gram-negative bacteria, some of which were the same as organisms as isolated in-patient blood¹⁶⁴. Swabs taken from the drains revealed: coliforms; *Delta acidovarons*; *Chryseomonas indologenes*; *Cupriavidus*, *Pseudomonas aeruginosa*, and *Klebsiella oxytoca*.¹⁶⁵ Between 5 August and 5 September 2018, a further three instances of patient infection with gram-negative bacteria occurred in Ward 2A. All three cases were caused by gram-negative organisms which had been isolated from the drains. Two out of three of the cases matched swabs taken from the drains¹⁶⁶.
90. The IMT was reconvened on 5 September 2018¹⁶⁷. The IMT’s hypothesis was that contaminated drains were again the source of infections¹⁶⁸.
91. By the IMT of 13 September 2018 there appear to have been some 22 cases of gram-negative infections associated with the issues on Wards 2A/B. Dr Inkster said at the 13 September 2018 IMT that duty of candour

¹⁶³ Bundle 1, Document 35, Page 149.

¹⁶⁴ Bundle 1, Document 35, Page 149.

¹⁶⁵ Bundle 1, Document 35, Page 149.

¹⁶⁶ Bundle 1, Document 35, Page 149.

¹⁶⁷ Bundle 1, Document 35, Page 149.

¹⁶⁸ Bundle 1, Document 35, Page 149.

discussions were required with some of the families involved¹⁶⁹.

92. At an IMT meeting on Friday 14 September 2018, a two-phase contingency plan was discussed and the IMT recommended a decant.¹⁷⁰ On the afternoon of 14 September 2018, a meeting took place chaired by the Chief Executive, Ms Grant and attendees included Mr Walsh, Dr Inkster, Mr Hill, Ms Devine, Ms Kane and Mr Redfern. This executive group decided not to proceed with the decant at that time, but ordered various steps including examination of all drains in the RHC for black biofilm, a definition of works to be completed in Wards 2A/2B over a four week decant, the preparation of a risk assessment for a four week decant, and discussion about optimising access to BMT services for both adult and children's services during the decant.
93. The IMT met again on Monday 17 September 2018, where it was noted that the executive group had not approved the decant.¹⁷¹ The staff in Ward 2A were extremely anxious about the safety of patients and did not feel assured that patients were safe. A statement from Professor Gibson was read out at the start of the IMT:

I am in London today, but there will be Clinical representation at today's IMT. I understand that the IMT's recommendations from Friday were not approved at the meeting with Board members and that no decision was taken. I hope that I am expressing this correctly.

There has been another positive blood culture over the weekend which is extremely worrying. As doctors, we are often called on to give expert opinion/advice in Court. We would start off by stating our qualifications and why we might be considered experts in that field. At the IMT we should adhere to the same principle.

94. Clinicians were concerned about the decision, and a paper was sent to the Director for Women and Children requesting that the decant go ahead. Concern among nursing staff by this stage had reached the point that they had contacted their union for advice on continuing to treat patients in an

¹⁶⁹ Bundle 1, Document 37, Page 132.

¹⁷⁰ Bundle 1, Document 38, Page 164.

¹⁷¹ Bundle 1, Document 39, Page 171.

environment considered to be unsafe and this was reported in an IMT Minute¹⁷².

95. The IMT continued to try to understand and manage the outbreak. The minute records action points related to drain cleaning, requirement for further water samples and a reminder that patient wash bowls were single use only. The IMT remained of the view that a decant was necessary, as there remained issues that could not be addressed whilst the ward was occupied, and to find a permanent solution to the issues around the water and drains.
96. Mr Redfern prepared an **options paper for the decant**¹⁷³. Options under consideration were an alternative ward within the RHC, an adult ward in the QEUH, a mobile unit constructed on the QEUH campus, a ward in the Beatson, transfer/diversion of patients to an alternative paediatric service within Scotland, and a transfer/diversion to an alternative paediatric service out with Scotland. It was recalled by Ms Rankin that one of the preferred options was to have an on-site unit brought in (involving assembly of HEPA filtered portacabins) but the time to procure it was fairly significant.
97. Various criteria were applied to the decision making. A move to the Beatson was ruled out on the basis it would involve separating paediatric patients from other paediatric services within the RHC (PICU, theatres, hospital at night service). A move to another site was not deemed practical. A modular build was ruled out as a result of an estimated construction time of 12 weeks (at a time when it was thought the decant would be short term) and concerns about patient pathways.
98. A move to a ward within the RHC was discounted due to concerns about the safety of the environment within the RHC for vulnerable patients. Mr Redfern's evidence was that the QEUH and RHC shared a single water supply. The reason the environment in the RHC was thought unsafe was

¹⁷² Bundle 1, Pages 169 and 173.

¹⁷³ Bundle 6, Document 13, Page 38.

because of the risk of splashing from the sinks. The sinks in the QEUH were of a different type; it was therefore thought the QEUH would provide a safer environment¹⁷⁴.

99. It was agreed that the preferred option was to decant BMT patients to Ward 4B; the adult BMT service would free up a number of rooms. The remainder of Ward 2A and 2B patients would be moved to an adult ward in the QEUH.
100. On Tuesday 18 September 2018 an 8am meeting of senior managers and executive board members - called **the Water Review Meeting** - made the decision to decant the patients from Ward 2A.¹⁷⁵ The decision makers were Ms Grant - Chief Executive, Dr Armstrong - Medical Director, Mr Archibald - Chief Officer (Acute), Mr Best - Director Acute Services, Mr Leiper - Lead Project Manager, Mr Walsh – ICM, and Ms Kane - Interim Director of PPFM. The meeting *“agreed that due to the bio film being found in some sink areas within this ward and the patient demographic it would be appropriate to decant this patient group to another area in order to carry out investigatory works and get to the bottom of this problem”*.¹⁷⁶ Two points should be noted. Firstly, there was no person present with any expertise in IPC (Mr Walsh not being an ICD or ICN) and secondly these senior NHS GGC officials made their decision in part because of a recognition that biofilm was an issue.
101. By 19 September 2018, Ward 6A in the QEUH had been identified as the ward to which patients would move. Ward 6A was a general ward; its patients were moved to Gartnavel General Hospital¹⁷⁷. Ward 6A was not designed for haemato-oncology patients and did not benefit from any form of specialist ventilation.
102. The decant itself required considerable planning; it was a huge logistical operation. Preparatory works included: repairs being made, full deep cleans

¹⁷⁴ Bundle 6, Document 13, Page 38.

¹⁷⁵ Bundle 19, Document 35, Page 614.

¹⁷⁶ Bundle 19, Document 35, Page 614.

¹⁷⁷ Bundle 1, Document 41, Page 182.

(including of the drains and vents), POUFs being fitted to taps and showers, and fitting of portable HEPA filters. The move took place on 26 September 2018. Wards 2A/2B were closed. BMT patients were transferred to Ward 4B in the QEUH (the adult BMT unit). All other patients were moved to Ward 6A QEUH.

103. The Lead ICN for the RHC, Susan Dodd, explained that she felt Ward 6A was a safe place to decant the Ward 2A children as it was the best option, but she was nervous it was not absolutely safe due to water and drain issues. Dr Inkster was comfortable with the move from Ward 2A to Ward 6A in the circumstances, even though it had no HEPA filters and positive pressure. However, there were mitigating factors since Ward 6A did not have the trough sinks and did not appear to have the same problems with drains at that time.
104. None of the Glasgow 2 clinician witnesses suggested that Ward 6A was anything other than a sub-optimal solution for housing Schiehallion Unit patients. Rather, it was intended as a short-term solution to an urgent problem. As Professor Gibson indicated, the challenges presented by Ward 6A were considerable. Inpatient and day care services were combined on a single ward. Available space was compromised. Rooms had to be used flexibly. Young patients had to share lifts with adult patients (until a dedicated lift was allocated).
105. The understanding of risk from the water system held by IPC in late spring or early summer of 2018, can be seen from the full Incident Management Team Report covering the IMTs from 2 March 2018 to 13 April 2018¹⁷⁸. Taken with the conclusion of Dr Kennedy's October 2018 epidemiology paper, that there had been an increase in the gram-negatives that formed the case definition of the water incident IMT in 2017 and 2018, and the position set out in the **SBAR which was used to brief the Chair of NHS GGC, Mr Brown, on or about 13 November 2018**¹⁷⁹, Counsel to the

¹⁷⁸ Bundle 8, Document 6, Page 53.

¹⁷⁹ Bundle 4, Document 32, Page 133.

Inquiry has submitted that it has to be the case that, at the end of 2018, NHS GGC clearly considered that the decant was carried out in response to the risk of infection from the water supply and that 23 cases had been linked to the water supply.

Events following the decant of the Schiehallion Unit

106. In the autumn a Chlorine dioxide dosing system was implemented across the hospital to manage the contamination levels alongside point of use filters, temperature control and ultrafiltration. Following the implementation of Chlorine dioxide dosing, two further cases of *Mycobacterium chelonae* infection were identified - one in summer 2018 and the second in 2019. *Mycobacterium chelonae* is recognised as resistant to chlorine dioxide. One of these cases was matched to an isolate from the water supply. This is the second case of infection with a confirmed link to the water system.
107. The existence of a link between infections and the water system appeared to have been accepted when the patients from Wards 2A and 2B were moved to Ward 6A and 4B(BMT) in QEUH so that Wards 2A and 2B could be refurbished. This major refurbishment work was extended to include the ventilation system and patients returned to wards 2A and 2B in March 2022. Following the return to the wards, the infection rate with environmental gram- negative organisms has dropped to the level seen in 2015.
108. In summary, Counsel to the Inquiry have submitted that the water and waste-water systems were demonstrated to be contaminated throughout and a wide range of environmental bacteria were isolated from water samples. The ventilation system was not adequate with low numbers of air changes per hour, lack of pressure gradients, lack of HEPA filtration, mixing of extract and intake air via thermal wheels, and a chilled beam system which caused condensation, dripping and accumulation of dust. The inadequacies of these two systems presented an avoidable risk of environmental infection.

November/December 2018 – Cryptococcus

109. In December 2018 two cases of *Cryptococcus neoformans* blood stream

infection were identified in haematology patients. Specifically, an adult patient on Ward 4C and a paediatric patient who had been moved at the time of the decant to Ward 6A (QEUH) and later to PICU. Both patients had been unable to take anti-cryptococcal prophylaxis due to the nature of their conditions, neither were accommodated in rooms with HEPA filters and both died.

110. The initial hypothesis of how these infections occurred was that they could be related to a pigeon infestation in a plant room and that aerosols from pigeon guano could have entered the ventilation system during routine maintenance. This was extensively investigated and a considerable tension arose between Dr Inkster and Dr Peters on one side and Professor Steele as new Director of Estates on the other. Other species of *Cryptococcus* were found by air testing and culturing pigeon guano, including air testing on Wards 6A and 4C. No *Cryptococcus neoformans* was isolated albeit *Cryptococcus* is hard to culture from air samples. In addition, very high particle counts were found on Ward 6A. Concern was high that an airborne source was involved, and mobile HEPA filtration units were deployed in wards caring for particularly vulnerable patients including Ward 6A. Such was the concern about the air quality, that patients on Ward 6A (and 4C) were given antifungal prophylaxis.
111. An expert sub group of the IMT was created and a report was produced in May 2022¹⁸⁰, but it should be noted that the three NSS representatives on the group (drawn from HPS/ARHAI and HFS) were not happy with the final report and did not support its conclusions - so that it is, in effect, a report of its Chair, Professor Hood. Amongst other things, NSS did not approve of some of the methodology and conclusions, and thought it was biased towards a particular result exonerating the hospital environment. The Inquiry's Ventilation Expert Mr Bennett agreed with these criticisms, albeit that NHS GGC have submitted that he is not qualified to reach those conclusions. Counsel to the Inquiry have submitted that the NSS criticisms

¹⁸⁰ Bundle 6, Document 39, Page 1115.

are persuasive, reject the argument for NHS GGC that most hypotheses can be ruled out, reject also any view that the answer is reactivation, but conclude that the precise source may never be established. It does seem clear that whilst causation cannot be proven, the failure to place these patients in a room with HEPA filtration would expose them to any *Cryptococcus* spores that were sucked into the ventilation system.

Gram-Negative Infections in 2019

112. Due to the extended nature of work to Ward 2A/2B, the Schiehallion cohort remained on ward 6A (with BMT patients on 4B). After a short term decant from Ward 6A to the Clinical Decision Unit (a small ward within the RHC) whilst repairs were carried out in Ward 6A, Gram-Negative infections began to be found in Ward 6A again.
113. From June to September, twelve cases of environmental gram-negative blood stream infection were seen (three *Stenotrophomonas maltophilia*, one *Pantoea septica*, three *Enterobacter cloacae*, one *Chryseomonas*, one *Elizabethkingia*, one *Serratia marcescens* and two cases of *Pseudomonas putida*). A third case of *Mycobacterium chelonae* was identified and the previous case from 2018 investigated further.
114. Water sampling from Ward 6A had low levels of gram-negative organisms but *Mycobacterium chelonae* had been isolated from a number of outlets. The samples were taken with point of use filters removed. It was hypothesised that as point of use filters were in place on the ward, the *Mycobacterium chelonae* patient had been exposed to unfiltered water elsewhere on site.
115. The hypotheses for the gram-negative infections were initially related to splashing disturbing the drain biofilm and contaminating hands of staff or patients, or creating an aerosolization which could contaminate the patient's skin and/or line, however in later IMTs this changed to chilled beams dripping or leaking condensation or access to unfiltered water outside the ward. It should be noted that the use of chilled beams in the ventilation system of wards was an innovation in the QEUH and controversial, as

condensation or leaks had been an issue known to ward staff, IPC staff and microbiologists since 2016. However, the question of whether the chilled beams could be a source of infection risk became a point of contention between Dr Inkster and Dr Peters on one side and Professor Steele on the other.

116. Air samples taken on 15 July 2019 found counts of aspergillus in the patient's en-suite bathrooms. There was also a patient on the ward being investigated for possible fungal infection.
117. In early August 2019 the risk to patients was thought to be high enough to send new patients to the Edinburgh children's hospital rather than admit then to Ward 6A. Sandra Devine (then ICM) explained in her statement that she considered that the senior members of the board were well aware and were closely monitoring the situation, as it was an extremely serious situation,
118. As of 8 August 2019, the number of what were thought to be unusual gram-negative infections had increased again, bringing the total to 10. (Stenotrophomonas, Enterobacter, Pseudomonas, Rhodococcus and a fungal infection are mentioned in the unredacted minutes).¹⁸¹ Exposure to water leaking or dripping from chilled beams or exposure to unfiltered water were the hypotheses¹⁸².
119. There is some evidence of a widespread incident with condensation on chilled beams on or about 22 July 2019, potentially related to very high temperatures. Wards had to close rooms.¹⁸³ Dr Peters notes reports of leaking chilled beams on 3 June 2019 in 6 rooms. Some of the beams were visibly dirty, with one room having a raised fungal count.
120. It was around this time that a patient's family reported a leak from a chilled beam. The child's sock was wet, and the mother noticed this had been

¹⁸¹ Bundle 1, Page334.

¹⁸² Bundle 1, Page341.

¹⁸³ Bundle 12, Document 153 Page 1260.

caused by a drip from the ceiling. Dr Inkster asked Dr Peters to investigate, and she took photographs showing a drip from a pipe. From the condensation on the pipe and floor below they grew an unusual organism called *Pseudomonas oleovorans*, which tends to be found in cooling agents and lubricants. Dr Inkster considered this fairly conclusive that it was leaking cold pipework and not, as Professor Steele then insisted, leaks from the hot circuit. In respect of infection link, Dr Inkster conceded there was no evidence of bacteria being found in the chilled water circuit and in samples from patients, but pointed out if one organism is found then the environment might be conducive to other organisms.

121. Ms Rankin of HPS/ARHAI was of the view that in 2019 chilled beams were the most likely hypothesis for the water infections given there were reports of them leaking onto a patient's bed and there had been positive microbiology.
122. Professor Steele investigated Dr Peters' suggestion that Chlorine Dioxide could be added to the chilled beam water. Professor Steele also noted that NHS GGC had a maintenance contract on the closed system to sample the system and add biocide, which started in short order after.
123. The 14 August 2019 IMT¹⁸⁴ was a difficult meeting and it and its consequences are discussed in the section below 'Removal of Dr Inkster as Chair of the IMT and her resignation'. By the subsequent meeting on 23 August 2019 Dr Inkster had been removed as IMT Chair and replaced by Dr Crighton.
124. The IMT of 23 August 2019¹⁸⁵ confirmed that the primary hypothesis was that the increase in Gram-Negative bacteraemia was the chilled beams either leaking or dripping condensation onto patients and their surroundings. Dr Kennedy is recorded as talking about his epidemiology report noting that patterns were similar to the old Yorkhill hospital, and these

¹⁸⁴ Bundle 1, Document 77, Page 343.

¹⁸⁵ Bundle 1, Document 78 at Page 350.

infections had been seen there before. Dr Inkster was not re-assured as Yorkhill was a very old building with poor water quality. The minute of the IMT meeting also records agreement that a peer review in relation to Ward 6A ought to be carried out by someone external to NHS GGC who worked in a similar ward¹⁸⁶.

125. All consultant microbiologists at QEUH (including Dr Peters and Dr Inkster) produced an **SBAR on 25 August 2019**¹⁸⁷. It was sent to Dr Crichton by Dr Peters on 27 September 2019.

Events after the resignation of Dr Inkster

126. Schiehallion Unit clinicians recalled that the change in the Chair of the IMT on 23 August 2019 signalled a change in the IMT's methodological approach. The consistent impression of the clinical witnesses was that the emphasis of the IMT's investigation switched. Prior to the change in Chair, the IMT had sought an explanation for the unusual pattern of infections. After the change in Chair, clinicians felt the emphasis was on disproving the validity of the underlying suspicion about infection; that an unusual pattern had to be positively proved before it could be investigated.
127. On 30 August 2019, Professor Gibson and her clinician colleagues wrote to the Chief Executive, Jane Grant and board Medical Director, Jennifer Armstrong¹⁸⁸. They expressed their concerns about infection and environmental issues affecting immunocompromised patients for the preceding 18 months and the ongoing uncertainty about the safety of the environment. Clinicians sought a review from a recognised expert in paediatric infection control from out with Scotland. As the letter makes clear, the concern of clinicians had reached the stage that they had contacted their medical defence unions. Based on advice provided by their defence unions, clinicians emphasised to the board their understanding of the respective responsibilities for provision of medical treatment and for

¹⁸⁶ Bundle 1, Page348 and Page353.

¹⁸⁷ Bundle 4, Documents 41 and 42 from Page 165.

¹⁸⁸ Bundle 6, Page1416.

provision of a safe environment: clinicians had responsibility for treatment; NHS GGC led by the Chief Executive had responsibility for provision of a safe environment in which to provide treatment; IPC had responsibility for advising on the safety of the environment; the IMT had responsibility for acting on the advice given by IPC¹⁸⁹.

128. This letter is understood to have been followed by meetings with Jonathan Best, the Chief Operating Officer and Dr Scott Davidson, Deputy Medical Director on 2 September 2019. In a written response to the clinicians dated 4 September 2019, Jane Grant and Jennifer Armstrong indicated that as a result of that meeting, efforts were underway to source an “*appropriate colleague to provide the external advice agreed at the IMT and suggested within your letter...*”¹⁹⁰ and that a meeting would be arranged with clinicians in the near future. It is understood that clinicians met with Dr Jennifer Armstrong on 9 September 2019. No independent external review took place.
129. At the IMT on 6 September 2019¹⁹¹, Professor Steele maintained that he did not believe there was a leak from the chilled water circuit, that if there was a leak it would have come from the hot water which would evaporate. Counsel to the Inquiry has submitted that, given Dr Peter’s earlier evidence that photographs of leaks existed and that subsequently the chilled water system failed and is subject to litigation between NHS GGC and its suppliers, it does seem the case that at this point the chilled water system that served the chilled beams was leaking into patient care areas.
130. At an IMT meeting on 13 September 2019, Professors Jones and Leanord are recorded as having said that Ward 6A was “*microbiologically safe*”¹⁹². On 10 October 2019 an SBAR¹⁹³ was produced to support the recommendation to/of the IMT of 13 September 2019 to re-open the ward

¹⁸⁹ Bundle 6, Page 1417.

¹⁹⁰ Bundle 8, Page 85.

¹⁹¹ Bundle 1, Document 79, Page 354.

¹⁹² Bundle 1, Page 360 at Page 362.

¹⁹³ Bundle 4, Document 46, Page 193.

for new admissions.

131. Three further cases of environmental gram-negative blood stream infection were identified in the next 18 days. The chilled beam hypothesis was discounted. However, no other hypothesis was put forward and the source of the infections was not confirmed.
132. At the IMT on 11 October 2019¹⁹⁴ Ms Joannidis presented a ‘root cause analysis’¹⁹⁵ of a number of the cases then faced by the IMT. There is some doubt as to whether this was truly a ‘root cause analysis’ and in any event the text of it was not produced by NHS GGC until after the close of evidence in Glasgow III.
133. **In October 2019, Dr Inkster and Dr Peters produced an SBAR looking at the 6A incident, data and epidemiology**¹⁹⁶. This document argued that the proportion of environmental gram-negative organisms in blood cultures had increased since April 2016 and this was particularly noticeable from July to September 2019. It also confirmed that Ciprofloxacin prophylaxis had been implemented in August 2019 for the Schiehallion unit patients. Of note is a graph showing a sustained increase in Enterobacter blood stream infections.
134. The conclusion of Professor Leanord and Professor Jones that the ward was microbiologically safe had been resisted by representatives of HPS/ARHAI who attended the IMTs. In **November 2019 a SBAR**¹⁹⁷ was written to support the reopening of ward 6A to new referrals, which stated: “currently there remains no direct working hypothesis linking the series of infections which prompted the Incident to Ward 6a environment”. The document seeks to suggest that there is no connection to previous incidents involving environmental organisms. With the approval of the Chief Nursing

¹⁹⁴ Bundle 1, Document 84, Page 382 –discussed at Item 4, Page 383.

¹⁹⁵ Pamela Joannidis, Statement, Question 20, Witness Bundle - Week Commencing 26 August 2024 - Volume 2, Page 450.

¹⁹⁶ Bundle 4, Document 41, Page 165.

¹⁹⁷ Bundle 4, Document 48, Page 202.

Officer (and therefore the Scottish Ministers)¹⁹⁸ the ward was re-opened to new admission following the IMT of 11 November 2019¹⁹⁹.

135. On 12 November 2019, a letter from Kevin Hill to parents was published on the Schiehallion parents Closed Facebook Group²⁰⁰. This indicated that environmental test results from Ward 6A were “satisfactory” and that the water supply was “safe and effective”.
136. The IMT on 14 November 2019 noted²⁰¹ that a final report from HPS was now available, which concluded there was no evidence from available data to support continuation of the restrictions. Dr Murphy continued to express his concerns that an explanation for the infections had not been found. On the same date, Mr Redfern prepared an SBAR recommending that restrictions be lifted²⁰². The IMT of 14 November 2019 was the last one that Dr Crichton chaired as this was the end of the incident itself.
137. Ms Imrie (Clinical Lead for HPS/ARHAI) could not recall any clusters of cases after the ward was re-opened and described a complex situation where unusual infections kept popping up in ward 6A patients even though the water system was being dosed with chlorine dioxide and POUFs were fitted.
138. The Schiehallion Unit moved back to the refurbished Wards 2A and 2B in March 2022. Dr Peters remains in post as a consultant microbiologist at QEUH and remains profoundly concerned that environmentally related infections continued in the Schiehallion Unit cohorts and other immunocompromised patient groups at the QEUH in 2020, 2021 and 2022 and that patient safety issues persist.

¹⁹⁸ Bundle 1, Page 392 at Page 393.

¹⁹⁹ Bundle 1, Document 87, Page 397.

²⁰⁰ Contained at Appendix 2 of Mark Bisset’s witness statement at p.55A.

²⁰¹ Bundle 1, Page 402 at Page 403.

²⁰² Bundle 4, Document 48, Page 202 at Page 204.

E. The Whistle-blowers

139. The inquiry has heard from many witnesses who were closely involved in the response to (a) the growing awareness of flaws in the water and ventilation systems of the QEUH/RHC and (b) the IPC response to potential HAIs or HCAs in the hospital including PAGs and IMTs, but the ‘whistle-blowing’ actions of three consultant microbiologists has been key to that evidence.
140. Dr Redding, Dr Peters and Dr Inkster are the three consultant microbiologists who have become known as the ‘whistle-blowers’. It should be noted that Dr Inkster was never formally a ‘whistle-blower’, in the sense that she did not make use of the NHS GGC formal Whistleblowing policies and was not involved with the formal Whistleblowing processes commenced by Dr Redding and Dr Peters in September 2017. However, all three have been the subject of criticism by NHS GGC for the manner in which they have raised concerns about the water and ventilation systems of the QEUH, and the operation of the IPC team within NHS GGC in general and the QEUH in particular. The NHS GGC critique of these three doctors can be found in its **December 2022 positioning paper**²⁰³ and amounts to an assertion that they should not be believed because they are ‘aggrieved’.

Dr Christine Peters

141. Dr Peters joined the NHS GGC IPC team in August 2014. She was appointed Consultant Microbiologist South Sector ICD alongside Dr Pauline Wright (who resigned that role in the summer of 2015). This was planned to cover the new QEUH/RHC. It seems that there was no job description for the ICD role and that soon after she joined, she was told by the then lead ICD Professor Williams not to put things in writing. She identified a particular conversation by telephone and has maintained her position, notwithstanding that Professor Williams has denied it. When she asked colleagues about this matter at the time, their response was, ‘that’s just

²⁰³ See Bundle 25, Document 62, Page 1282.

Craig'. Dr Peters has also spoken of attending an early IMT SMT meeting and being told by a colleague that she should not ask questions. Both developments shocked her. The situation seemed unhelpful, with colleagues being fearful. Dr Peters also objected to ICD meetings not being minuted. She has denied any suggestion that she did not seek or consider the views of others. Professor Brian Jones has also acknowledged that Professor Williams was not a team player. In his view, the multiple roles and responsibilities that Professor Williams had undertaken was in fact a risk to the organisation due to the lack of oversight.

Dr Teresa Inkster

142. Dr Inkster is currently a consultant microbiologist and infection control doctor with ARHAI Scotland, which is part of NSS Scotland. She became a microbiologist and Infection Control Doctor ("ICD") with NHS GGC in 2009. She became Regional Sector ICD in 2015. She was appointed Lead Infection Control Doctor for NHS GGC in April 2016. Dr Inkster went on sick leave in June 2017 and returned in January 2018. She resigned as Lead ICD on 2 September 2019. She left NHS GGC in September 2023. During her time at the QEUIH, Dr Inkster resigned or attempted to resign from ICD sessions on three occasions: in July 2015, on her return from sick leave in January 2018 and in September 2019. The circumstances of each resignation are relevant to the Remit and Terms of Reference of the Inquiry.

Dr Penelope Redding

143. Dr Redding was a consultant microbiologist from 1984 until her retirement in 2018. She was one of the first ICDs in Glasgow. Professor Williams took on her role as Lead ICD in 2008. The Inquiry heard evidence that Dr Redding was a clinical director for all the laboratories of Greater Glasgow and Clyde from 2008 to March 2011. By the time she retired in March 2018 she was one of the longest serving consultant microbiologists in NHS GGC. Although the leading 'Whistleblower' in the sense that she was the only doctor who formally raised her concerns to Stages 2 or 3 of the NHS GGC Whistleblowing policy, Dr Redding did not have a great operational connection to the growing concerns about potential links between infections

in the Schiehallion Unit and the hospital environment between 2015 and her retirement. Her role is best described as a conduit for concerns raised with her by others.

144. This section of the Scenario considers five different key events that might broadly be seen as ‘whistleblowing’ in the sense that they involve an attempt by one or more of these doctors to raise concerns about the impact of features of the water and ventilation systems on patient safety. Each key event is preceded by a short summary.

First major attempt by Dr Peters and Dr Inkster to raise issues – July 2015

145. *This involves Dr Peters and Dr Inkster raising concerns in 2015, both about the culture or operation of the IPC team and specific concerns about the ventilation and water systems of the new hospital, in letters in which they sought to resign their ICD sessions. The culture or operation issues were addressed in a report by Deputy Medical Director Dr Stewart, the short-term appointment of Dr Cruickshank as Clinical Director for Infection Control Doctors and in due course by the March 2016 appointment of Dr Inkster as Lead ICD, but the accuracy of specific concerns about the ventilation systems of the new hospital raised by Dr Peters and Dr Inkster were not acknowledged to them or investigated in the sense of any attempt being made to find out how they had come about.*
146. Between 19 June and 7 July 2015, Dr Inkster and Dr Peters stood in for Professor Williams to cover ventilation issues in the QEUH/RHC whilst he was on leave. What they discovered is recorded in a document by Dr Inkster.²⁰⁴
147. Thereafter, on 8 July 2015, Dr Peters resigned from her South Sector ICD sessions²⁰⁵ and Dr Inkster resigned from her Regional Sector ICD sessions on the following day.²⁰⁶ Dr Peters and Dr Inkster then met with Professor

²⁰⁴ Bundle 14, Volume 1, Pages 416 to 419.

²⁰⁵ Bundle 14, Volume 1, Document 26, Page 414.

²⁰⁶ Bundle 14, Volume 1, Document 27, Page 416-420.

Jones, Head of Service for Microbiology, and Dr Cruickshank, the Clinical Director for Laboratories. Dr Wright also wanted to give up her sessions and was permitted to do so. Neither Dr Inkster nor Dr Peters were permitted to resign their sessions and continued as ICDs.

148. Both letters of resignation identified clear deficiencies in the ventilation systems of both the adult and paediatric BMT and in respect of water quality and testing results (with specific reference to Legionella). These formed a significant part of their reasons for resignation. Dr Peter's explained in evidence that:

"The real big deal breaker for me was that there didn't seem to be the correct levers to try and do your job and at least find a way through the problems in a way that was controlled, good governance, collaborative, good practice. Just normal, functional working."

149. A key reason for Dr Inkster's resignation was a lack of clarity on the ICD role. She also felt she did not have the ability to request and receive information. Her resignation email explained she had "major concerns regarding the specialised ventilated areas within QEUH and RHC and the impact on patient safety".²⁰⁷
150. There was a meeting on 7 July 2015 with Dr Inkster, Dr Peters, Dr Cruickshank and Isobel Neil. They told Dr Cruickshank what their concerns were and put their concerns in writing. Dr Cruickshank did not see what they had written until she was later made Interim Director for ICDs. Her impression from the meeting was that their concerns were primarily to do with ventilation and patient safety, as procedures they thought should have been followed were not being followed, with the systems in place potentially compromising safety.
151. Dr Armstrong learned that Dr Peters and Dr Inkster wanted to demit their ICD roles around 9 July 2015 when she got a call from Mr Walsh about the resignations. She had an e-mail between herself and the CEO, Mr

²⁰⁷ Bundle 14, Volume 1, Document 27, Page 420.

Calderwood where she made him aware that three ICDs wanted to demit their sessions. Dr Armstrong maintained that she asked Dr Stewart to investigate the reasons they wished to demit.

152. Dr Stewart initiated a review on Dr Armstrong's instructions after Dr Cruickshank and Professor Jones raised the concerns with him, but his review did not investigate the patient safety aspects of the concerns raised. Dr Stewart understood it was made clear to the participants in related interviews for the report that it was about cultural issues. Dr Stewart can now remember little about his review '**Summary of Infection Control Issues**²⁰⁸' but the final paragraph on the first page curiously describes "a lack of appreciation by some ICDs of the need to risk assess decisions from an organisational political perspective".
153. Dr Stewart gave evidence that he was surprised he used the word 'political' and he could not explain why it was there. He clarified that reputational damage was not in his thinking at all when he wrote the report. He suggested that the word 'political' may have been inserted by another colleague, although acknowledged that he was responsible for the report. In Dr Stewart's view, the reference in his report to some ICDs needing to risk-assess from an organisational perspective, was that healthcare is a series of interconnected moving parts and a decision cannot be made in isolation. He gave an example of how shutting a ward might have an effect on A&E waiting times, with ambulances outside the hospital and patients being nursed in corridors. In his opinion, the bigger picture must be looked at rather than taking a "purist" infection control view and shutting a ward and stopping further admissions until the situation was dealt with. This involved looking at ways to mitigate the risk. He used the analogy of a cog being taken out and trying to keep a machine running.
154. In Dr Inkster's view, read short, this final paragraph on the first page of Dr

²⁰⁸ Bundle 14, Volume 1, Document 41, Page 464.

Stewart's report meant organisational reputation was the priority.

155. The terms of that paragraph ("On the one hand there are reports from ICDs of having their professional authority undermined by the over-turning of their decisions by the IC management Team") rather confirms the evidence of Dr Inkster that she and Dr Peters had informed Dr Stewart that their professional authority was being undermined by the IPC management team overturning her decisions. Dr. Inkster further acknowledged that Dr Stewart's next comments about ICDs not taking decisions when given authority to do so was directed at her.
156. Dr Cruickshank was then appointed Interim Clinical Director for Infection Control Doctors by Dr Armstrong. She was appointed for six months to improve the relationships in the IPC team. Dr Cruickshank explained that she principally dealt with the lack of clarity of the roles and responsibilities of ICDs. She was trying to get the system to work better. Her main concern was that the management structure and working relationships between infection control and microbiology were not working properly.
157. When asked about why Dr Stewart's report was limited to organisational and communications issues, Dr Armstrong explained that she thought there were two separate processes. She thought there was a process about demitting their sessions because of dignity at work issues, and the separate issue of patient safety came to her attention in November 2015, in an e-mail from Dr Cruikshank. Dr Armstrong then got involved in getting Dr Cruikshank into the clinical director role.
158. When referred to Dr Stewart's report,²⁰⁹ Dr Armstrong was asked about paragraph 6 of the report agreed with Dr Stewart around the notion of conflicting views and opinions and the decision-making process. She agreed that there needed to be greater clarity.
159. It was put to Dr Armstrong that there were then two statements of things

²⁰⁹ See Bundle 14, Volume 1, Document 41, Page 464.

raised with Dr Stewart. Regarding whether the ICDs felt undermined by the management team, Dr Armstrong explained that Dr Stewart interviewed several people. He did that with a HR person. Therefore, when he was writing his report, she took that as part of his findings.

160. It was put to Dr Armstrong that Dr Stewart also reported that ICDs were not taking decisions when they had the authority to do so. Dr Armstrong thought that one of the things Dr Stewart had suggested was bringing the parties together for a meeting. She would have known about the two issues and would have wanted to explore that more to try and understand what that meant.
161. Regarding the final sentence of paragraph 6 of Dr Stewart's report, Dr Armstrong explained that it was not about politics. She thought that infection control was one part of the decision-making process. The report was about how infection control was managed, not the reputation of the board. Dr Armstrong did not see that a possible perspective that the final sentence of the report referred to the reputation of the board.
162. Dr Stewart's report was not made available to Dr Inkster or Dr Peters at the time, but a **letter was sent to a range of microbiologists and members of the IPCT on 30 October 2015.**²¹⁰ Dr Inkster thought that the letter labelled her and Dr Peters as being difficult and risk averse. In essence, there were personality issues and little if any genuine concern for the patient safety issues that both her and Dr Peters had raised.
163. Over the next two months there was an **exchange of correspondence**²¹¹ between Dr Inkster, Dr Peters and Dr Stewart where the microbiologists raised their concerns about patient safety and Dr Stewart offered the reassurance he had received from Dr Armstrong. Dr Inkster explained that she kept going back to Dr Stewart because she could see no evidence that anything had changed, and she was informed that the BMT would be

²¹⁰ Bundle 14, Volume 1, Document 45, Page 472.

²¹¹ Bundle 14, Volume 1, Documents 46,47 and 48, Pages 474, 476, and 478.

moving back to the QEUEH from the Beatson.

164. Dr Peters replied to Dr. Stewart's letter of 30 October 2015 by email, enquiring if he would provide an individualised response to other concerns, particularly patient safety issues. On 2 November 2015, Dr Stewart acknowledged in evidence that he responded to Dr Peters that the issues to be addressed were communication and behaviours, clarity of roles and transparency of decision-making. He went on to say in the email that he understood that significant progress had been made with the building issues and explained in evidence that this knowledge of significant progress had come from Dr Armstrong. He recounted that Dr Armstrong had told him the concerns were known. The Infection Control team were aware of all the issues and that they were dealing with them. Moreover, he recalled that Dr Armstrong told him that progress was being made.
165. Dr Peters concerns were not allayed by attendance at an Organisational Development Day, where comment was made by the chair, Dr Stewart, about 'some ICD's lack of political awareness'. As she put it, you would not reject a return to the Beatson out of embarrassment. Dr Cruickshank was appointed into a new additional role as the clinical director for infection control doctors, it seems to address cultural issues between Professor Williams and the ICDs who were supposed to report to him. This change did not address the substantive concerns that Dr Peters and Dr Inkster had raised in July 2015.
166. Dr Peters also picked up more issues with incorrectly designed PPVL rooms. An incident on 30th August 2015 led to infectious patients having to be sent to Monklands²¹². Dr Peters wondered - if the emphasis had been on these critical rooms, what else might be wrong? She continued to raise her concerns. She had one reply from Dr Stewart who asked if everything was now OK. She felt that was disingenuous. It was, she thought, a technique to

²¹² A hospital outside Glasgow in the Lanarkshire Health Board area to which highly infectious patients were transferred for care.

try to get her into a position to please those higher up.

167. Professor Williams, as lead ICD, was asked why three ICDs all wanted to resign. He claimed to have no idea. He also maintained that he left NHS GGC of his own accord.
168. A letter prepared by Dr Inkster and Dr Peters dated 9 November 2015 and sent to Dr Stewart raised a significant list of concerns including: (i) a lack of involvement on the part of the ICT in relation to the design of the hospital; (ii) in relation to the adult BMT unit, the absence of environmental monitoring prior to patients moving in and the non-availability of information regarding specification and validation reports; (iii) a concern that despite monitoring of the air in the children's BMT unit disclosing evidence of fungal spores and there being holes in the ceilings of rooms, children were moved in and transplants proceeded. The two clinicians said they did not consider that their concerns were being addressed.
169. Dr Stewart explained that on receipt of the letter of 9 November 2015, he escalated that to Dr Armstrong and the general response was that these were known issues, and the relevant team were dealing with them. He observed that he was very much a go-between in the middle of the issues raised and Dr Armstrong. He accepted that he was merely a provider of information – rather than an actor.
170. The suggestion that Dr Stewart's email to Dr Inkster and Dr Peters on 22 December 2015 was disingenuous was refuted by Dr Stewart. He argued that he would never knowingly do anything dishonest, and he understood that he would have received information from Dr Armstrong before writing the email. He argued that he was an advocate for Dr Peters and Dr Inkster but conceded that he was not able to hold Dr Armstrong to account. He refuted a suggestion that he could have done more to highlight the hospital build issues that had been brought to his attention than just send his email on 22 December 2015 to Dr Inkster and Dr Peters. He was up to his eyes in managing other aspects of the service and he did what he could.
171. It seems that Dr Armstrong is denying that Dr Stewart told her about the

patient safety issues in July 2015, that she had not seen the letters of resignation from Dr Peters and Dr Inkster until recently, and that she only asked Dr Stewart to carry out a dignity at work investigation that became his ‘*Summary of Infection Control Issues*’.²¹³ It is difficult to reconcile Dr Armstrong’s evidence on this issue with that of Dr Stewart and Dr Cruickshank. Dr Stewart was particularly clear that the reason he felt able to go back to Dr Peters and Dr Inkster with reassurance that their concerns had been addressed was because he was being told that by Dr Armstrong. She knew what was going on with the ventilation in Ward 2A and Ward 4B. He did not. It is submitted that Dr Armstrong’s evidence in this area is simply not reliable.

Dr Inkster and the first attempt to return adult BMT to Ward 4B

172. *This involves Dr Inkster being asked to sign off work done to enable the return of the adult BMT service from the Beatson to Ward 4B less than six months after their departures. She was concerned about the lack of information she was given and the work done. She brought in HPS and her advice was accepted, but with some pushback from NHS GGC Managers.*
173. After adult BMT patients had returned to the Beatson on 8 July 2015, minutes from the Board Infection Control Committee (“BICC”) meeting on 30 November 2015 record that adult BMT patients were due to transfer to the QEUH on 19 December 2015, and Professor Williams advised that there was no national standard for testing BMT rooms²¹⁴. The BICC was normally chaired by Dr Armstrong.
174. On 29 November 2015 Dr Inkster was asked by Professor Williams to sign off Ward 4B to allow the return of the adult BMT patients from the Beatson back to the QEUH.²¹⁵ Dr Inkster asked for material relating to the original specification, the validation, and the air sampling, but nothing was forthcoming. At the time of the initial meeting, they had the keys to the ward

²¹³ Bundle 14, Volume 1, Document 41, Page 464.

²¹⁴ Bundle 13, Document 35, Page 268 at page 271.

²¹⁵ Bundle 14, Volume 1, Document 53, Page 495.

and were moving in three weeks. Dr Inkster took the view that, because she had none of this information and nobody at that point could tell her what had actually been done, she was not comfortable signing off the ward..²¹⁶

175. The work that had been done to the mechanical ventilation system in Ward 4B in December 2015 included installing metal frame plasterboard ceilings in place of suspended ceilings to reduce air permeability, applying sealant to various areas and replacing sealed lighting units. The measures were designed to improve the pressure differential between the rooms and the corridors on the ward. HEPA filtration was also installed.
176. Dr Inkster sought assistance from HPS and a SBAR was received from HPS on 4 December 2015.²¹⁷ There was resistance to involving HPS from the ICM (Mr Walsh) and Lead ICD (Prof Williams), who referred to previous input from Health Facility Scotland. Dr Inkster accepted that at this point, a lot of people including her were “flailing around in the dark and slightly unaware of what’s happened and going on”. Dr Mathers described her concerns as clearly articulated.
177. On **14 December 2015 the “BMT Unit Transfer to QEUH Meeting”** took place and the decision was made to postpone the move of the BMT unit back to the QEUH.²¹⁸ The reason given in the minutes was “to enable feasibility study into HPS requirements to be undertaken” and those recommendations are noted at the foot of the minute.
178. On 25 January 2016, the BICC meeting minutes rather optimistically record Professor Williams reporting that discussions about the specifications for the adult BMT Unit were ongoing, but ‘all ventilation issues’ were now complete. The key issue was said to be the HEPA filtration of corridors, and the compliance of what was in place with the ‘guidance’.²¹⁹

²¹⁶ Bundle 14, Volume 1, Document 53, Page 497.

²¹⁷ Bundle 3, Document 4, Page 36 and Bundle 14, Volume 1, Document 53, Page 496.

²¹⁸ Bundle 13, Document 122, Page 850.

²¹⁹ Bundle 13, Document 36, Page 278.

179. On 23 March 2016 Mr Loudon issued a Project Managers Instruction (PMI 471²²⁰) to Multiplex to carry out further work on the ventilation systems in Ward 4B. The PMI required Multiplex to achieve 6 air changes per hour; room pressures of +2.5 to +8 pascals; the corridor to be HEPA filtered, and the entrance to the ward to be air locked using double door at the front entrance. It should be noted that these specifications differ from the December 2015 HPS SBAR and in any event the work was not then done at this point.
180. The process of working out what to do with Ward 4B began in January 2016 with an email from Mr Archibald to a large team including Dr Inkster, Mr Moir, Mr Powrie, Dr Jones, Professor Williams, Mr Walsh and Ms Rankin.²²¹ The process is discussed in some detail in Dr Inkster's statement.²²² Dr Inkster provided three options.²²³ It appears that the then Chief Executive Mr Calderwood was to be briefed in March 2016²²⁴. The process of developing options did not conclude in 2016.

Informal attempts by Dr Redding to raise issues

181. This event involved Dr Redding trying to raise issues around patient safety and the culture in the IPC team with senior NHS GGC staff in 2015 to 2017. She received little response and eventually joined in a formal whistleblow.
182. Dr Redding's involvement in 2015 to 2017 was to report concerns brought to her by others with Dr Stewart, Grant Archibald, Mr Calderwood and Ms Grant. That she was raising such issues must be taken to corroborate that such issues were live within the IPC team at the time. A good example is an email of 16 September 2015 to Mr Archibald and David Stewart²²⁵ following a meeting a few days before which she discussed in evidence. Dr Redding

²²⁰ Bundle 23, Document 19, Page 213 and Bundle 14, Volume 1, Document 53, Page 504.

²²¹ Bundle 14, Volume 1, Document 53, Page 492.

²²² Hearing commencing 19 August 2024 - Witness Bundle, Volume 7, Paras 243 to 246 at Pages 86-87.

²²³ Bundle 14, Volume 1, Document 53, at Page 493.

²²⁴ Bundle 14, Volume 1, Document 53, at Page 494.

²²⁵ Bundle 14, Volume 1, Document 40, Page 463.

was full of praise for Dr Peters, and explained how lucky NHS GGC was to have Dr Peters in a meeting with Dr Stewart and Mr Archibald.

183. The essence of the concern that Dr Redding expressed about the culture of the IPC team in NHS GGC was that there was an atmosphere of intimidation and bullying, a practice of not putting things in writing or emails and not recording things in minutes. She maintained that there was a culture of bullying from the top of the organisation all the way down. She explained how many colleagues could speak to the bullying but were afraid to speak up and approached her for support due to her management experience. Her core advice was always to put in writing that a concern had been raised.
184. Dr Redding provides confirmation (if confirmation was needed) that Dr Inkster and Dr Peters were not acting unreasonably or in isolation in raising issues about the way IPC in the QEUH/RHC was being managed in 2015 (particularly when they resigned their IPC sessions). Whilst Dr Stewart's report²²⁶ and Dr Cruickshank's appointment as Interim Clinical Director for Infection Control Doctors, November 2015 to May 2016, confirm that something had to change as a result of their concerns, it assists to know, from Dr Redding, that all was not as it should be within the IPC team in the new QEUH/RCH in 2015 and into 2016.
185. In 2017, Dr Redding raised issues of concern with Jennifer Armstrong, Tom Walsh and Sandra Devine in **a series of emails**.²²⁷ These became a Stage 1 Whistleblow with Dr Armstrong in September 2017. Dr Redding explained that she followed the 2013 version of the NHS GGC Whistleblowing policy.²²⁸ The detail of the **SBAR of 3 October 2017**²²⁹ and **the meeting that followed on 4 October 2017**²³⁰ are discussed in the next section of

²²⁶ Bundle 14, Volume 1, Document 40, Page 464.

²²⁷ Bundle 14, Volume 1, Document 73, pages 722-727.

²²⁸ Bundle 27, Volume 4, Document 3, Page 45.

²²⁹ Bundle 4, Document 19, Page 104.

²³⁰ Bundle 14, Volume 1, Document 83.1, Page 753.

this scenario.

The Stage 1 Whistleblow and SBAR of 3 October 2017

186. In the months prior to the Stage 1 Whistleblow and SBAR of 3 October 2017, there is evidence of some microbiologists with ICD sessions being unhappy to approve building work which impacted on ventilation. In Scotland this is done through the HAI-Scribe system. For each piece of work an ICN will complete a form (known as an HAI-Scribe) and an ICD will sign off that the work meets the necessary standards.
187. In August 2017 a microbiologist with ICD sessions was asked to sign a HAI Scribe relating to the replacement of the ceilings in 24 ensuite shower rooms in Ward 4B.²³¹ There is no reason to think that the work that had been done brought Ward 4B to the standard required by NHS NSS in their December 2015 SBAR²³² and it is remarkable that this HAI-Scribe predates the later SBAR from NHS NSS of October 2017 which still raises issues.²³³ It is accepted that this particular ICD was unwilling to sign the HAI Scribe giving the reason that he did not have sufficient knowledge of the project or expertise to do so. In her evidence the ICN who prepared the HAI-Scribe, Ms Pritchard, took the view that one could complete a HAI-Scribe without knowing the background, but appeared to accept that you needed to know the background for a more complicated one. The individual unwilling to sign the HAI-Scribe was someone for whom Dr Peters was a line manager. She raised the issue with Professor Jones and Dr Armstrong,²³⁴ but rejected the idea she was 'sticking her nose in'
188. Dr Peters also described how a similar issue arose when she was asked to help another ICD colleague, Dr Valyraki, over a HAI Scribe for works on 4B. Dr Valyraki had no experience of these. Dr Peters explained the situation. She believed Dr Valyraki was being pressured to sign off works, this time to

²³¹ Bundle 20, Document 1, Page 13.

²³² Bundle 3, Document 4, Page 36.

²³³ Bundle 3, Document 7, Page 57.

²³⁴ Bundle 14, Volume 1, Document 69, Page 696.

ward 4B. Dr Valyraki was upset and came to see Dr Peters on 28 November 2017. Dr Peters became involved as her line manager, went to the ward with her, and found dusty conditions, although there were still vulnerable patients in the vicinity. Doctor Valyraki had a coughing fit. Dr Valyraki did not address this incident in her statement. Dr Peters felt it was important to have a proper understanding of what works were being done, how it related to the bigger project and so on. She organised a meeting but found it difficult because it was hinted that she was causing works to be delayed and, after all 'it was only a bit of dust'. She agreed that the delay was unfortunate but, in her view, you did not weigh up one risk against the other. 'What you say is you do the SCRIBE properly and that will actually ensure that you get there faster.' According to Dr Peters, Sandra Devine said the work had been carried out with full discussions with HPS and HFS, and Dr Peters was asked not to contact them. However, it transpired that HPS were not aware the works.

189. Dr Armstrong confirmed that Dr Peters stopped the works going ahead. Dr Inkster was off sick at the time. Professor Jones stepped in to sign off the HAI SCRIBE so the work could take place. Dr Armstrong was asked if there was not a similarity between these events and those in late 2015 when Dr Inkster was asked to sign something off. Dr Armstrong's understanding of 2015 was that the work was carried out by the contractor and Professor Williams. Dr Inkster came into her role and looked at the work and thought it was not going to pass muster. Dr Armstrong did not recognise that there was an issue with the management structure of the IPC team.
190. In respect of these events around Ward 4B in 2017 the Inquiry does not have evidence of the microbiologist who was initially asked to sign off the work in August 2017 and Dr Valyraki has been unable to provide evidence about the other event about which Dr Peters spoke. However, it is notable that it has not been disputed that this unnamed microbiologist with ICD sessions was asked to approve this work in August 2017 and had these concerns. There is also a real similarity between these events and the occasion when Dr Inkster was asked to sign a HAI-Scribe for work in Ward

4B in December 2015.²³⁵ It is more likely than not that on at least two occasions, ICDs without the necessary knowledge and/or experience were asked to sign off work to Ward 4B to enable the return of the adult BMT service to the QEUH.

191. Following the emails from Dr Redding to Dr Armstrong in September 2017, and at the request of Dr Armstrong on 3 October 2017, **an SBAR was prepared by three consultant microbiologists**²³⁶. The SBAR raised concerns about the risk to patients arising from infection control issues linked to the facilities in the QEUH and RHC, as well as the structure of the IPCT service within NHS GGC. Dr Peters and Dr Redding both explained that they had raised these issues with Dr Armstrong because they did not consider that they were being listened to when they had raised matters with Tom Walsh, Sandra McNamee, Jane Grant, Grant Archibald, Dr Stewart, Dr Armstrong and Aileen McLellan.
192. The issues were raised in the SBAR under three main headings: Patient Placement, Cleaning, and Estates. Within those categories there were concerns about: the adequacy of the ventilation provision for certain patient groups (including immunocompromised patients), cleaning, water quality and testing, and the resourcing and structure of the IPC service. In particular six issues stand out. These were:
1. That the standard rooms in the hospital should have had 6 ACH and only had 3 ACH, in breach of the SHTM 03-01 standard
 2. Positive Pressure Ventilated Lobby (PPVL) rooms were not suitable for patients with airborne infections and such patients should not be housed in the new hospital.
 3. There were insufficient rooms for the isolation of immunocompromised/BMT patients in the RHC.

²³⁵ Described in some detail in the narrative above.

²³⁶ Bundle 4, Document 20, Page.104.

4. There was no cleaning and maintenance policy for TMV taps.
 5. There were issues around the lack of water testing and the ICD role in requesting and receiving the results in a timely manner in exceptional circumstances.
 6. Where a water source of infection needed to be investigated.
 7. There was a lack of experience of the Infection Control Team in the absence of Dr Inkster, who was then on sick leave.
193. The SBAR also identified the dates on which each concern was raised and escalated. Many of the concerns were first raised in 2015, including those about air quality on Ward 2A, which was said to represent a continuing risk.
194. Dr Armstrong accepted that at Stage 1 Whistle Blow the Whistleblowers were acting on the duties they hold under good medical practice, to advise people of problems that they think they can see. Dr Armstrong didn't mind them writing to her. She considered that there were other ways it could have been dealt with before it reached her. She wanted to see it in writing to systematically address the issues.
195. It was put to her that many of the things might have been raised because they were microbiologists who were not in the management structure. Dr Armstrong thought that was a good point.
196. A meeting to discuss the SBAR of 3 October 2017 took place on 4 October 2017. **The Inquiry has the minute of the meeting.**²³⁷
197. Dr Redding and Dr Peters cover what took place at the meeting in great detail in their statements and in evidence. Dr Peters said the meeting started badly when she introduced herself as Clinical Lead for Microbiology at the QEUH and Dr Armstrong responded that she was 'head of nothing'. Dr Armstrong has denied saying that. Dr Armstrong explained she wanted

²³⁷ Bundle 14, Volume 1, Page 753.

to walk out of the room, having understood all of the issues and documented them. She had no concern about anyone's behaviour at the end of the meeting. A range of concerns were discussed. It was put to Dr Armstrong that Dr Redding described the meeting on 4 October 2017 as difficult and that she was intimidated by the number of people in attendance. Dr Armstrong explained that coming into a meeting like that could be intimidating, but that the meeting on 4 October 2017 was not conducted in an intimidating fashion. She walked out with Dr Redding at the end and said that they had a pretty decent exchange. What she wanted to do was to get the directors to take it seriously.

198. Of note, perhaps, was a discussion over PPVL rooms. The ID consultants were still not happy and by October 2017 patients were still being sent to other hospitals. One of the meeting attendees was David Loudon. According to Dr Peters he was angry, asserting that 'the rooms had been built to standard'. In response to questions from the Chair, Dr Peters confirmed that there were isolation rooms in a number of locations which were supposed to be in accord with HPN Supplement 1.
199. Dr Peters thought it was odd to be told at the meeting that only now were HPS being consulted about the specification (HPS maintaining that they had not been involved in any original decisions). Anne Harkness seemed to suggest building a new ID unit if the rooms could not be modified. There also continued to be a debate about air sampling standards. In Dr Peters' view it was no answer to say that there were no national standards. They were not getting answers. A point about ACH and chilled beams was met by David Loudon saying Dumfries had them. Rates of infection complaints were answered by Sandra Devine referring to a Point Prevalence Survey (which Dr Peters thought irrelevant). David Loudon thought they had no business asking about water sampling. In retrospect it was odd not to hear about the DMA Canyon Report.
200. There was discussion about line infection rates in 2A. Sandra Devine noted there was no benchmark in this area. Dr Peters replied that they needed to establish the actual rate however Ms Devine said there were insufficient

resources for this. It is likely Ms Devine said at the meeting that, during a point prevalence survey, the QEUH was found to have levels of infection under the national average, that all Alert Organisms were monitored by the IPCT, and that there were no indications that this site had a higher-than-average infection rate. Dr Redding pointed out that this would not pick up unusual organisms or the outbreaks that the authors of the SBAR were concerned about. The same analysis from Ms Devine is set out in her appendix to the April 2023 NHS GGC Positioning Paper²³⁸. The relevance of a PPS can be doubted. NHS GGC still maintain that the rate of infections at that time was not unusual.

201. After the meeting of 4 October 2017, Dr Redding reported raising concerns about the accuracy of the minutes and that she and Dr Peters asked for amendments which were not made. A number of statements recorded in the Minute²³⁹ are worth drawing attention to as they relate directly to major issues of interest to the Inquiry:

1. **Air change rates in standard rooms:** “Dr Redding asked if the air changes can be changed from 3 to 6 in some rooms but not in all areas and David Loudon advised this was not realistically possible.”
2. **Positive Pressure Ventilated Lobby rooms:** Mr Loudon explained that the Positive PPVL rooms were “signed off by the board and clinical teams; he also confirmed that remedial work had been carried out due to issues raised at the snagging stage of the build.” Ms Devine explained that “the inclusion of the Infectious Diseases service was a late amendment to the QEUH project and therefore not commissioned as an ID unit at the outset”. Ms Harkness appears to be recorded as saying that, in response to the 3 October 2017 SBAR, “she met with Directors and ID Physicians, and they agreed a pathway for these patients to be transferred to other sites. She also commented that, based on the external advice, unless the existing rooms can be

²³⁸ Bundle 25, Document 10 from Page 364.

²³⁹ Bundle 14, Volume 1, Document 83.1, Page 753.

modified in some way the only alternative was to build a new Infectious Disease Unit, which would require a significant resource”.

3. Rooms for the isolation of immunocompromised/BMT patients in

the RHC: HEPA filters were installed in two of the rooms in adult ITU but there had been no request to add these to isolation rooms throughout the adult or children’s hospital. “The group debated the definition and severity of immuno-compromised patients.”

4. Water testing: The minute records that it was accepted that the reason testing results were not received by a certain microbiologist was possibly due to “recent changes in staff in both estates and IPC”. This appears to amount to acceptance that there had been a problem with ICDs getting water testing results.

5. TMV Taps: “David Loudon stated that we are not required to test all taps but a sample and that this was in accordance with guidance.” It is notable that more than two years after the QEUH opened, and more than three years after the 5 June 2014 meeting about the Horne Optitherm Taps,²⁴⁰ the minutes for this meeting on 4 October 2017 record “In relation to TMVs Ian Powrie advised that these are maintained in all high-risk areas, and they are working towards carrying this out in all areas. He said the end piece of the taps cannot be removed and an SBAR is in place for this. Estates are finalising the installation of a heat sanitation system and once complete this will be sent to the Board Water Safety Committee for approval.”.

6. Infection Control Structure: The minute records Dr Armstrong proposing that consideration is given to having a further separate meeting to discuss this.

202. Those attending the meeting (including Dr Armstrong, Mr Loudon, Mr Best, Ms Devine, Mr Powrie and Ms Harkness) all appear to accept that the

²⁴⁰ Bundle 15, Document 9, Page 692 at Page 712.

problems identified in the SBAR of 3 October 2017 did exist, and it does seem as if the SBAR prompted action beyond what had already been started.

203. In a meeting of the BICC on 9 October 2017, the minutes record the receipt of emails concerning “*the ventilation and negative pressure rooms in QEUH and RHC*” and a meeting held by the Medical Director (MD) a week previously to progress matters on those issues. This would seem to be a reference to the Stage 1 whistle blowing/SBAR of 3 and 4 October 2017.²⁴¹
204. By November 2017, 4 of the PPVL rooms in Ward 2A had been converted to positive pressure rooms. At a meeting of the AICC on 6 November 2017, the minutes record that significant expenditure would be required to convert the rest of the rooms to positive pressure rooms.²⁴²
205. The Glasgow II hearing heard evidence about the awareness of clinicians and managers of the first of the aforementioned SBARs and the concerns raised within it. Professor Gibson indicated that she was not aware of the existence of the SBAR prior to her preparation for giving evidence to the Inquiry. She was aware that microbiologists and IPC had concerns and that those concerns had been escalated in the hope of action on the part of senior management. Ms Rodgers, who was the Chief Nurse at that time, was also unaware of the existence of the 3 October SBAR in 2017 although she too was aware of some of the issues identified, for example, the high rates of line related infections on Ward 2A and some concerns about patient placement.

The 27 Point Action Plan

206. After the meeting of 4 October 2017²⁴³ a **27-point action plan** was produced and reported to the Board Clinical & Care Governance Committee

²⁴¹ Bundle 13, Document 46, Page 337.

²⁴² Bundle 13, Document 13, Page 100.

²⁴³ Bundle 14, Volume 1, Document 83.1, Page 753.

on 5 December 2017²⁴⁴, and noted by the Board on 20 February 2018.²⁴⁵

Dr Armstrong thought that a lot of the actions in the 27-point action plan were already being carried out. Dr Armstrong was of the view that there would not have been many of the items in the SBAR that were not being acted on before the SBAR. Ms Devine said that while there had been things on the 27 Point Action Plan which were already in train, there were certainly things which needed to be addressed. Around this time, NHS GGC was looking to recruit external advice in relation to its ventilation systems. It was put to Dr Armstrong that many of the things were being raised because they were microbiologists not involved in the management structure. Dr Armstrong thought that was a good point.

207. It was put to Dr Armstrong that Dr Redding said that she may have been reassured if someone had sat down with them and told them what was being done about the action plan in the months after. If she had the information, she may not have needed to do the stage 2 whistle blow. Dr Armstrong said she could have got the action plan to them sooner. However, she said there was a series of e-mails between late October 2017 to February 2018 providing updates. There was one in November. There was another in January 2018 where Ian Powrie provided a lot of information on the ventilation within the QEUH. There was one when Dr Inkster came back in February on the patient placement policy. There was a lot of e-mail traffic. However, they could have done better at producing a decent report. When Dr Inkster came back, she shared the Action Plan with Dr Redding and Dr Peters on 13 March 2018.

208. Dr Redding was asked about the Action Plan. She explained that the plan to address the issues raised by the Whistleblowers was never able to be fully signed off by them because it contained errors. She and Dr Peters provided comments, but what was reported to the Clinical & Care Governance Committee on 5 December 2017 was unchanged. Dr Peters regarded the

²⁴⁴ Bundle 20, Document 48, Page 792 and Bundle 27, Volume 4, Document 7, Page 90.

²⁴⁵ Bundle 20, Document 48, Page 792.

Action Plan as wholly inadequate.

209. Dr Inkster was on sick leave when the 27 Point Action Plan was produced. She understood that Dr Armstrong was responsible for implementing the action plan. She also was concerned about the action plan missing items such as Aspergillus concerns in RHC. In March 2018 she commented on the version attached to the papers for the Clinical & Care Governance Committee on 5 December 2017²⁴⁶ and explained that her version went to the AICC, but that later it reverted back to the previous version at the Board Clinical & Care Governance Committee on 5 March 2019²⁴⁷ when issuing an update, and she was told that for governance reasons they had to stick to the original one even though it wasn't accurate.²⁴⁸
210. In March 2018 Dr Redding and Dr Peters drafted a response to the action plan; however, they did not submit it but instead moved on to Step 2 of the Whistleblow. Further comments were provided direct to Dr Armstrong on 30 August 2019.²⁴⁹

Stage 2 Whistleblow – February 2018

211. In October/November 2017 as the Action Plan arising from the meeting of 4 October 2017 had yet to be sent to her, Dr Redding warned Jane Grant, Dr Armstrong and Dr Stewart that she was considering a move to Stage 2 of the Whistleblowing policy. Once she had been sent the 27 Point Action Plan she took the issue to Dr de Caestecker by email on 8 February 2018 as Stage 2 Whistleblow.²⁵⁰ She explained this did not raise any new issues but focused on the failure to address the existing concerns around patient safety.
212. By way of context it is necessary to understand the events around the return of Dr Inkster from sick leave in January 2018. In her absence

²⁴⁶ Bundle 20, Document 48, Page 792.

²⁴⁷ Bundle 27, Volume 7, Document 42, Page 484.

²⁴⁸ Bundle 27, Volume 7, Document 53 at Page 562.

²⁴⁹ Bundle 14, Volume 2, Document 150, Page 578.

²⁵⁰ Bundle 14, Volume 2, Document 87, at Page 72.

significant changes to the status of the lead ICD within the reporting system for IPC had been developed. These would have involved her reporting as lead ICD to the Clinical Lead for Laboratories and no longer having a direct clinical reporting route to the Medical Director. Upon learning of them and consulting the BMA, she offered her resignation as Lead ICD. Dr Inkster is of the view that at that time it was evident that there was no medical leadership in IPC and that gave her concerns.

213. Ms Devine saw these proposed changes as amounting to the proposition that the Lead ICD should be managed by the microbiology management team. Dr Inkster was persuaded by Dr Armstrong to remain in post and the plans were withdrawn. Dr Armstrong explained in her evidence that she wanted Dr Inkster to come back to work. She said that Dr Inkster made a lot of very good points and was very, very good at her work. The team were upset because they felt that they had been working very hard, and Dr Inkster was upset. Dr Armstrong could understand that.
214. Dr Inkster also discovered that whilst she was away Sandra Devine had decided that her triggers for a PAG were too sensitive, resulting in unnecessary PAGs taking place. In Dr Inkster's view, there were issues with the building and the triggers needed to pick those things up. An ICD reported concerns they had with asking for, but not receiving, water testing results.
215. According to Christine Peters, it was around this time that it was agreed that Drs Valyraki, Inkster and Balfour would be ICDs for the south, and the rest of the microbiology team at the QEUH would no longer have ICD sessions.
216. This proposed restructuring and proffered resignation of the Lead ICD a matter of months before what would turn out to be the Water Incident in Ward 2A seems important. In essence, it seems significant that leadership figures realised that things needed to change in the IPCT, but that the solution was to interpose a further stage in management between the lead ICD and the HAI Executive lead, the Medical Director and the executive board members. When seen in the context of events in 2019, it does not

seem unreasonable to conclude that at the end of 2018, NHS GGC was more interested in structures and control of its ICDs than in enabling their voices to be heard. What would have happened if the Water Incident in Ward 2A in 2018 had occurred in a system where the management line for the lead ICD was further separated from the IPCT?

217. Dr Redding took her concerns to Dr de Caestecker by email on **8 February 2018 as a Stage 2 Whistleblow**.²⁵¹ This did not raise any new issues but focused on the failure to address the existing concerns around patient safety. In her email to Dr de Caestecker, Dr Redding summarised her concerns as:

“1. The standard rooms at the QE and RHC should have 6 air changes per hour (ACH/hr). No room meets this standard. There are only 3 ACH/hr. This is clearly a breach of the standard.

2. PPVL rooms are not suitable for the isolation of patients with air borne infections and they cannot be housed in this new hospital.

3. There are not sufficient rooms for the isolation of immunocompromised / BMT patients at RHC.

4. I am unclear where GG+C is with the management of immunocompromised adult patients at the moment.

5. Are the issues around ventilation on the GG+C Risk Register?”

218. The email explained that her “aims in following this Whistleblowing process include: 1. Ensuring patient safety and patient confidence is maintained; 2. Ensuring the issues are addressed; 3. That lessons are learnt so similar mistakes in the future can be avoided.”

219. Dr de Caestecker met with Dr Redding and Dr Peters. Dr Peters did not formally make a Stage 2 Whistleblow but accompanied Dr Redding to the meeting as the latter retired on the day of their meeting in March 2018. Dr de Caestecker then treated Dr Peters as a Whistleblower.

220. **Dr de Caestecker wrote to Dr Redding and Dr Peters in response to**

²⁵¹ Bundle 14, Volume 2, Document 87, Page 72

the Stage 2 Whistleblow on 4 May 2018²⁵². Dr Redding was concerned that the letter only mentioned the five points in her email, but that these were not all the issues she discussed with Dr de Caestecker and so wrote back.²⁵³ Dr de Caestecker responded on 21 September 2018.²⁵⁴ Dr Peters' response was by email on 15 May 2018²⁵⁵ and was positive and from her point of view drew matters to a close. Presumably, Dr Peters would have taken a rather different approach if she had seen the criticisms of her in **Dr de Caestecker's Stage 2 Whistleblow Report**²⁵⁶, but it is not NHS GGC policy to share such reports with Whistleblowers.

221. When they eventually saw the report, Dr Redding was scathing. Dr Peters was very critical as well and in respect of the criticisms directed at her personally she noted that the report criticised her for sending too many emails but (subject to a discussion with Dr Inkster on the topic which they resolved between them), she felt all of her communications were necessary. She also disagreed with conclusions that the issues raised in the Whistleblow had "already been dealt with in the main with action plans for the rest".
222. Dr de Caestecker was the NHS GGC Director who investigated the Whistleblow and wrote the report. She described the process in some detail in her statement. Dr de Caestecker reviewed SHTM 04-01, the minutes of the earlier meeting of 4 October 2017,²⁵⁷ the 27 Point Action Plan²⁵⁸, the Clinical and Care governance committee paper about these concerns²⁵⁹, emails and letters on the organisation of infection control, and risk registers. She also interviewed a small number of people: Dr Kennedy, Dr Jones, Mr Walsh, Ms Devine, Dr Green, Dr Inkster and Ms Kane.²⁶⁰ She summarised

²⁵² Bundle 14, Volume 2, Document 97, Page 223.

²⁵³ Bundle 14, Volume 2, Document 96, Page 218 and 219.

²⁵⁴ Bundle 14, Volume 2, Document 95, Page 220.

²⁵⁵ Bundle 14, Volume 2, Document 97, Page 222.

²⁵⁶ Bundle 27, Volume 4, Document 6, Page 81.

²⁵⁷ Bundle 14, Volume 1, Document 83.1, Page 753.

²⁵⁸ Although in oral evidence she maintained that she did not receive the 27 Point Action Plan until later during Dr Redding's Stage 3 Whistleblow.

²⁵⁹ Bundle 20, Document 48, Page 792 and Bundle 27, Volume 4, Document 7, Page 90.

²⁶⁰ Bundle 27, Volume 4, Document 6, Page 81.

her conclusions in her statement as:

"I concluded that the Whistleblowing concerns about ventilation and patient safety were valid but that they were already known and there was an action plan in place. There is now agreed policy that any changes from building regulations or original specifications must be signed off by infection control. The investigation had highlighted that the IPCT found Dr Peter's frequent communication difficult to manage given she was not an infection control doctor at the time and had no role in the day-to-day management of IPC."

223. There were four aspects of Dr de Caestecker's report which were explored in some detail:

- The scope of her report and why she did not investigate why 6 ACH were not achieved across the hospital,
- The section at the top of the third page that dealt with the issue of Air Change Rate,
- Why she included material about how (to quote her statement) "the IPCT found Dr Peter's frequent communication difficult to manage given she was not an infection control doctor at the time and had no role in the day-to-day management of IPC", and
- The statement in the report and also in the letter that there were no increased levels of infection, and the recent prevalence survey showed that RHC had lower rates than the Edinburgh Children's Hospital.

224. It was put to Dr de Caestecker that she should have followed up the third aim of Dr Redding which was to ensure that lessons were learned²⁶¹, and considered whether lessons had been learned about the hospital being built below standard and with a ventilation system that is not compliant with SHTM-03-01. She accepted that she did not do that and maintained that it was her job to look at whether the concerns raised were taken seriously and acted on. It was put to Dr de Caestecker that it might have been of value to investigate and answer the question, which might have prompted

²⁶¹ Bundle 14, Volume 2, Document 87 at page 74.

earlier action. She could see that, but didn't feel she could investigate that via the Whistleblowing. She did not consider it her role.

225. The top of the third page of the report²⁶² contained specific text about the issue of what the impact was of the fact that most of the hospital had three air changes per hour rather than the six required by SHTM 03-01 (2009 Draft). Dr Peters was unaware of any discussion with the infection control team. She was not aware of any risk assessment coming to that conclusion. Following evidence from Dr de Caestecker, an email from Dr Kennedy of 10 July 2018 which was copied to Dr Inkster including text approved by Dr Inkster was produced by NHS GGC.²⁶³ The agreed text in that email summarises the position on Air Changes as follows:

- Each air change reduces contamination the room by approx. 63%.
- 3 air changes dilutes airborne contamination to 5% of level at start of time period.
- 5 air changes dilutes airborne contamination to 0.67% of level at start of time period.
- Rule of thumb (CDC guidance, personal communication with PHE) is to aim for <1%.
- Scottish hospital building note recommends 6 air changes per hour.
- QEUH general single room accommodation achieves 3 air changes per hour.
- This was deemed adequate as rooms meant to be at slight negative pressure to corridor.
- Investigations in 2016 revealed the negative pressure was not as

²⁶² Bundle 27, Volume 4, Document 6 at Page 83.

²⁶³ Bundle 27, Volume 14, Document 6, Page 37.

spec.

- Additional risk to patients in standard accommodation negligible for most pathogens (3 ACH still brings contamination down to 5%, single accommodation, closed doors etc).
- Higher risk pathogens (MERS/MDR-TB) – alternative pathways now in place – no transmission of these pathogens noted in QEUH/RHC.
- Other risk would be Aerosol Generating Procedures – advice to keep FFP3 mask on whilst in room, and for period of time after end of procedure. 1 hour normally but extended to 2 hours in QEUH/RHC on basis of recent SBAR.

226. We did not have the opportunity to ask Dr Inkster or Dr Kennedy whether these words are exactly what Dr Inkster sent to Dr Kennedy as the email was produced after they gave evidence, but in contrast with the first paragraph on page three of the Stage 2 Whistleblowing, they do appear to be consistent with Dr Inkster's evidence on this issue and her SBAR of June 2016²⁶⁴.

227. Dr de Caestecker looked to see if there had been a risk assessment carried out about the reduced air change rate and could not find one. Dr de Caestecker did not think the absence of actions on the risk assessment of air changes was an example of an organisation not wanting to face up to a decision they have made. She noted that there had been a huge amount of work into improving the environment in parts of the hospital. Though, she noted that there had been no work done to the ventilation outside of Wards 2A, 4B and other isolation rooms.

228. Dr de Caestecker was challenged about why her report sets out a list of potential failings and issues around Dr Peters. She insisted that these issues came out in the interviews she conducted and felt that she had to

²⁶⁴ Bundle 4, Document 11, Page 52.

report it to put some help and support in place. She confirmed that she did not provide any indication to Dr Peters about the complaints or provide her with the report. She wanted Dr Rachel Green to speak to Dr Peters about it in a more supportive way, but did not know whether this was done. She noted that both Dr Redding and Dr Peters had working relations with the IPC team and insisted that they raised the issue of behaviour first.

229. The letter to Dr Redding and Dr Peters of 4 May 2018 states on the second page²⁶⁵ and the Stage 2 Whistleblowing report states on the fifth paragraph of the third page²⁶⁶ that “there were no increased levels of infection, and the recent prevalence survey showed that RHC had lower rates than the Edinburgh Children's Hospital.” It was put to Dr de Caestecker that this might not have been relevant and she accepted that what is written was about the national and routinely produced data about E. coli, Staphylococcus aureus, C. difficile that was available, and what was given to her by Tom Walsh and Sandra Devine. Given that the letter and report were written at the time of the Water Incident in Ward 2A, and around the time of the Water Incident IMT Full Incident Report of 5 June 2018²⁶⁷, it is difficult not to reach the conclusion that this response is, at best, misleading.

230. Dr Redding was asked about the part of the Stage 2 report that referred to Dr Peters. She challenged the substance of the complaint in her statement by pointing out that that “all Microbiologists need to know about issues that impact on our ability to do our job, both during the day and out of hours. If we are not aware of the status of ongoing issues or concerns, then we cannot ensure that the IPCT are kept fully informed.” She also stood up for Dr Peters and was clear that:

“I've known Dr Peters for many years and she's a very, very dedicated, hardworking microbiologist and she puts a lot of effort into ensuring that a team works well together to deliver a service, whether that be a microbiology

²⁶⁵ Bundle 14, Volume 2, Document 97, at Page 224.

²⁶⁶ Bundle 27, Volume 4, Document 6, at page 83.

²⁶⁷ Bundle 27, Volume 5, Document 19, Page 46.

service in the laboratory or a clinical microbiology service which interfaces with clinicians, and there are many people who would speak up for her ability in both those things.”

231. Dr Peters rejected these criticisms in general, but did accept that there had been a period when Dr Inkster, mainly through the IMT process, felt that she was asking too much of communication. Dr Peters explained that they discussed it, she took on board her comments and changed the way she communicated.
232. It was put to Dr de Caestecker that up until summer 2018, there had been a significant issue raised by Dr Peters about the infection risk in the new hospital linked to the environment which turned out to be right. She stated that she did not think that people were trying to deflect from the concerns raised by Dr Peters by drawing out a list of flaws in her behaviour. Dr de Caestecker stated that she was not aware of Dr Peters not receiving replies to e-mails that she sent about her concerns.
233. As part of her investigations, Dr de Caestecker did not find a stage 4 HAI SCRIBE carried out for the new building, as required by SHFN 03, part B of 2014.

Removal of Dr Inkster as Chair of the IMT and her resignation

234. *These events have their roots in the spring of 2019 when tension between Dr Inkster and Professor Steele prompted a meeting between them chaired by Dr de Caestecker. The issue appears to have been a December 2018 remark by Professor Steele who had (he explained in evidence) told Dr Inkster, in a ‘jocular’ manner not to put a document about her concerns around ventilation in Ward 4C in an email for fear it would leak. She took him seriously and told an HIS Inspector which appears to have seriously impacted her relationship with him and Dr Armstrong. It was, it seems, the IMT on 14 August 2019 that was the final trigger for action to be taken and at a meeting on 20 August 2019, at which she was not invited, Dr Inkster was removed as Chair of the IMT then running in respect of gram-negative infections in Ward 6A. She resigned as Lead ICD soon after and reverted to being a Consultant Microbiologist and eventually transferred to work at*

HPS/ARHAI as a Consultant Microbiologist and ICD.

235. Dr Inkster was asked about the attendance of executive board members at IMTs. By the time the GNB IMT of June 2019 had started she had noted a greater representation from senior management. At the time of the start of the GNB IMT in June 2019, she explained that as IMT chair she had some control of who attended the IMT, but that became very difficult when it was individuals who were part of the executive and it would have been very difficult for her to ask them to leave the room.
236. The 14 August 2019 IMT²⁶⁸ was a difficult meeting attended by a number of witnesses who were able to speak about the meeting including Dr Inkster (Chair), Sandra Devine, Annette Rankin, Dr Sastry, Dr Peters, Jamie Redfern, Jennifer Rodgers, Professor Steele, Dr Deighan, and Kathleen Harvey Wood. Counsel to the Inquiry have submitted that the Inquiry should proceed on the basis that:
- Dr Inkster explained that she had asked Dr Peters and Kathleen Harvey-Wood to come to the IMT, as she felt that her views were being challenged by Professor Steele, and she wanted microbiology support.
 - Prior to this meeting the Deputy Medical Director agreed to a discussion with the Medical Director to identify any possible area that could house the patients in Ward 6A: it was noted however that the IMT could make recommendations regarding decant, but the final decision would be endorsed by the chief executive.
 - The meeting did not start well because Professor Steele said that Jane Grant wanted minutes corrected to show that the decant decision from Ward 2A to ward 6A was Dr Inkster's, not hers.
 - Professor Steele seemed to challenge what was said about leaking

²⁶⁸ Bundle 1, Document 77, Page 343.

chilled beams, but Dr Peters' response was that she had the photographs.

- At this meeting it was reported that a new microorganism had been found, which was only ever found in the space station. Professor Steele seems to have difficulty in accepting this. He felt that “when we went into meetings, there would be other – seemed to me to be always another very rare thing we had found”
- Data of the number of comparable infections at Great Ormond Steet Hospital in London (GOSH) was discussed and when Professor Steele asked about this Dr Peters leaned across to Professor Steele and said there had been ‘0’ infections in GOSH.
- Dr Inkster, Dr Peters and Ms Harvey Wood were of the view that the organisms were environmental in nature. Dr Kennedy said that the organisms were normal and there was no increase in microbiology issues or bacteraemia.
- Dr Deighan maintained that he was just asking questions of Dr Inkster about whether there had been an increase in the number of bacteraemia's and sought to minimise any sense of confrontation, but he did accept that his question was built on his reading of a paper by Dr Kennedy, that was attached to the minute of the previous meeting, which he had not attended.
- Ms Rodgers explained in her statement from Glasgow II that there “were some difficult conversations and challenge around views” and that “people were undertaking mitigations but simultaneously struggling to understand the problem”. She appears (without naming her) to think that Dr Peters “had a more confrontational approach” and that two unnamed senior charge nurses from Wards 2A and 2B had told her they had found the meeting difficult and unhelpful.

237. Although not at this IMT, Ms Dodd, who had left for HPS ARHAI on 25 June 2019, explained in her statement that:

103. *There was also a lot of tension and at times frustration conveyed at IMTs by some senior management staff in particular. I recall Kevin Hill and Tom Steele being very frustrated at points throughout the incidents. Frustrations appeared to be directed at Dr Inkster. Dr Inkster often had to ask for reports or results on multiple occasions which were necessary to allow the IMT to fully explore the hypotheses. However, these were not always made available.*

104. *The content of previous minutes would be debated for a long time and IMTs often extended well beyond the allotted one-hour meeting time. I recall there being a change in practice at one point in NHS GGC regarding minute taking. These were to be changed to action notes instead. Often the action notes did not capture all the necessary detail, or some members would not be content with the context of the notes. The notes would then be updated following discussion, but I don't think there was a clear system for circulating final notes for each IMT. I didn't look forward to attending IMTs because I felt that it wasn't a supportive environment. It was also evident that supplementary discussions were taking place outside of IMTs and over time I no longer felt fully informed before or after an IMT. There were pre meetings before many of the IMTs attended by the SMT. I wasn't clear on the governance or decision-making taking place outside of IMTs. In terms of anything I was reporting at the lead IPCN meeting each week and at the AICC, I am not clear on what happened to those reports or what action was being taken.*

238. Ms Dodd's evidence is not consistent with the understanding later presented at the meeting of 20 August 2019 about the nature of the problem with the IMTs, but is consistent with Dr Inkster's evidence about IMTs that summer and Dr Peters and Ms Harvey-Wood's evidence about the IMT of 14 August 2019.
239. Professor Steele has explained that the IMTs were increasingly difficult in terms of determining where the environmental source was emanating from. Given all the work they had done to the water in terms of chlorine, drains, chilled beams, and point of use filters, the next thing Professor Steele asked the estates team to do was to look above the ceilings. He stated that people were frustrated that they couldn't find an answer despite the work done. Professor Steele considered that they had mitigated and improved where they could.
240. On Friday 16 August 2019, Ms Imrie at HPS was contacted by Dr Peters raising her concerns about the hospital. The concerns were then shared on an anonymous basis with the Whistleblowing executive within NSS and the Scottish Government. The main points raised were that Dr Inkster was

unable to do her job in protecting patients from infections due to the culture and organisational failings, citing lack of support from management, that critical information had been denied to her; or that false accounts were given by high level managers and that microbiology/clinical judgement regarding the fact that there was a real issue with unusual environmental pathogens in Haematology paediatric patients was being continuously questioned.²⁶⁹ Laura Imrie emailed Jason Birch of NHS GGC.²⁷⁰ This Whistleblow was later investigated by Dr de Caestecker along with a colleague from NHS Fife. They reported in December 2019²⁷¹. The report was about how the IMT was operating and the support for the chair.

241. After the IMT some IMT members (including Professor Steele, Kevin Hill, and Sandra Devine) raised concerns about the IMT with Dr Armstrong who was moved to act and spoke to Dr de Caestecker. They noted that the guidelines said that if the IMT is not working well then, the Director of Public Health can intervene. She agreed to chair the meeting on the 20th of August at the request of Dr Armstrong.
242. Dr de Caestecker sent an **invitation email on Friday 16 August inviting a range of senior NHS GGC staff to a meeting of 20th August 2019**.²⁷² From its **minute**²⁷³ the meeting appears to have decided to remove Dr Inkster as chair of the IMT. Dr de Caestecker accepted that the meeting was to discuss the working of the IMT, that Dr Armstrong drafted the invitation, and accepted the invitation might have been deliberately vague to not presuppose the outcome. She did not know why Professor Gibson was not invited. They did not consider inviting clinicians. It was Dr de Caestecker's position that the meeting was not asking if Dr Inkster was a good or bad chair, but rather about making the IMT work well. Somewhat remarkably, Dr de Caestecker also argued in evidence that it was not Dr

²⁶⁹ Bundle 27, Volume 5, Document 7, Page 24.

²⁷⁰ Bundle 27, Volume 5, Documents 7, Page 24.

²⁷¹ Bundle 27, Volume 7, Document 49, Page 536.

²⁷² Bundle 14, Volume 2, Document 144, Page 568.

²⁷³ Bundle 6, Document 22, Page 70.

Inkster's behaviour at the IMT of 14 August 2019 that was at issue, but Dr Peters'.

243. It seems Dr Inkster spoke to Sandra Devine on Monday 19 August 2019, who told her she would need to give up the chair of the IMT, as the meeting was terrible and there was no team working and that Dr Scott Davidson would be taking up the chair. Dr Inkster did not attend the meeting on 20th August 2019 as she was unwell, but the meeting went ahead in her absence. The Minute should be read as the best record of what was said.
244. In evidence Dr de Caestecker agreed that there was nothing in the minutes to describe a substantive reason to change the chair. There was a lot of discussion about the behaviour and management of the chair. She confirmed that there was nothing saying the IMT chair was going down the wrong evidential route. Somewhat strangely, Dr de Caestecker would not accept that the meeting only obtained a partial perspective that looked at one side of the argument. Her response to that was that what she wanted to do was to ensure that a crucial IMT was working well, and the feedback that she had received was that it was not.
245. Dr Deighan claimed not to remember receiving the email inviting him to the meeting of 20 August 2019 but accepted that he would have read it as an invitation to a meeting to discuss a number of issues regarding the haemato-oncology unit at the hospital and accepted that the subject of the meeting was not indicated from the invitation. He could not remember specifics of the meeting but accepted that the chair of the IMT was not being consulted. Had the meeting been about something he was doing and he had not been present he would not have been very happy. When it was put to him that it was not proper for a group of doctors and nurses to hold a meeting to discuss the then-lead ICD's conduct of her meetings without giving her notice and in her absence, he initially suggested that this would be better directed at the chair of the meeting. When pressed about his own responsibility he responded that he did not recall the email and did not recall the context in which the meeting was called. Dr Deighan was not aware of whether anyone in this meeting had taken the soundings of the

members of the IMT who weren't present at the 20 August 2019 meeting.

246. Dr Mathers was asked about the invite he received to the meeting of 20th August 2019. He agreed that it said nothing about the handling of IMTs or the chairing of IMTs. He accepted that if something similar had happened to him in his absence he would not be very happy about it. Asked about the nature of IMT discussions, he repeated his view that there were robust challenges but in general terms, things were conducted in a reasonable way.
247. A similar response was extracted from Sandra Devine, 'if it had been her, she would have been off complaining immediately'. She claimed to have treated the meeting at which a decision was made to remove Dr Inkster as IMT chair as a positive for Dr Inkster. Asked if she had not thought it inappropriate to do this when Dr Inkster was not there, she accepted that on reflection perhaps she should have raised that (and blamed her inexperience). She regretted how it all played out. More difficult to understand is one of her subsequent emails. NSS had recorded the removal of the IMT chair by NHS GGC. Sandra Devine then challenged that. She suggested the chair had agreed to be replaced. That was plainly not correct. In Sandra Devine's own words, 'I overstated her position, and I regret it.' Even that statement is not correct. It is not clear why it was done. When Dr Inkster emailed seeking a written explanation, Sandra Devine did not reply.
248. Professor Steele confirmed that he knew what the meeting on 20 August 2019 was to be about. He confirmed that Dr Inkster was not present, and that the reason for the meeting was to discuss the IMT and relationships. Professor Steele confirmed at the meeting they decided to replace the chair. He confirmed that he would have felt aggrieved if he had been removed as chair without being at the meeting. He further stated that the meeting of 14 August would have made him think of a lack of control in the meeting. Professor Steele considered that a lot of thinking had gone into the impact that meeting had on colleagues. He noted that perhaps the process could have been done more collaboratively with Dr Inkster.

249. In her statement, Ms Rodgers described the meeting of 20 August 2019 as “an open discussion” with “people speaking openly” but was not asked about the meeting in Glasgow II. Given Dr Inkster’s absence from the meeting of 20th August there is an argument that the Inquiry should have recalled Ms Rodgers in Glasgow III, but perhaps the practical approach is simply to assume that, in the absence of the subject of their discussions, those present on 20 August felt able to discuss what measures to take. Dr Kennedy accepted that while Dr Inkster did not know the agenda for the meeting, he knew about the 20 August 2019 meeting, having had earlier discussions with Dr de Caestecker that it concerned IMT performance. He conceded that it would have been appropriate to provide more information in the invite email sent on 16 August 2019.
250. Dr Armstrong wrote the e-mail of 16 August 2019 inviting recipients to the meeting of 20 August 2019. She wanted to say that the children’s ward was closed, and they had a debate around the cause. There was extreme stress for staff and patients. When that was going on, she had to step in as medical director. She had to put things back on track. There was a high clinical risk. There was a lack of understanding about what the hypothesis was. She had tried to write the invitation carefully and that it should have mentioned the IMT or the chair. She said she was trying to write an e-mail that didn’t pre-judge anything. She was not setting out that the meeting was to come and discuss the IMT chair, but about the functioning of the IMT.
251. When asked what steps she had taken to consult the clinicians treating the patients, Dr Armstrong explained that they were under extreme stress. They were delivering care to children. The Board needed to make sure the IMT was working. She accepted that she did not even contact any of the clinicians to check in with them, but felt that the Board needed to step in on the question of the balance of risk around the decision to send new patients to Edinburgh.
252. It was put to Dr Armstrong that some people at the meeting met the definition of an executive to make a decision. If Dr Kennedy was there, why not others. Dr Armstrong was asked if she would accept that the process

was carried out in such a way as to create an enhanced sense of suspicion in Dr Inkster by the end of the process. Dr Armstrong regretted that Dr Inkster was hurt. She was invited to the meeting. Dr Armstrong wanted it to be a meeting where they could come to a decision with Dr Inkster. It could have been handled a lot better. It was their responsibility as a board to put the IMT back on track. They did achieve that. The children went back to Ward 6A, and they have low infection rates.

253. It was put to Dr Armstrong that the opening background doesn't mention that the balance of risk was calling for action. Dr Armstrong was asked why it was that after the meeting, the minute doesn't discuss that they needed to act because of the risk, but rather that they needed to act because of behaviour. Dr Armstrong explained that the meeting was called because people said they had concerns about the meeting on 14 August. She had concerns about what happened. The reason they were acting was because of the concerns, but also because they were concerned about where the IMT was going. It was not making progress.
254. It was put to Dr Armstrong that there was an alternative perspective that there were people who didn't like the IMT. They were executive staff who were challenging microbiologists. They came to her and said they wanted to change the chair. Dr Armstrong took issue with that. When an IMT became bigger and the consequences were significant, every health board would be looking at sending senior clinical people in there. Where she thought they did go wrong was that it needed to be clearer why they were there. They should have been testing the evidence. Dr Inkster said she would have decanted the children. People had to test the evidence of that decision. It was a balance of risk.
255. It was put to Dr Armstrong that although there was a perception this IMT had come off the rails, she accepted that the other ones hadn't. They worked fine. Dr Armstrong was asked what the difference was between the water incident, or decant, or Cryptococcus, and this one given that they had the same chair and the same number of people. Dr Armstrong explained that, at the time, going through 2018, she wondered if there was enough

questioning at the IMTs. She thought the decant did need to happen. They needed to build a new unit for those children. The unit had not been built right. They had done a lot of modification to it, but to restore confidence, it was the right thing to do.

256. Regarding the interventions in 2018, Dr Armstrong said fitting filters was not the wrong thing to do. She said that actions needed to be taken. If one looked at the minutes in June 2019, she thought some actions in retrospect were not the right ones. For example, the drains. In 8 June 2018, there were 9 *Stenotrophomonas* cases. Dr Inkster suggested there was not a link to the water. Dr Inkster noted that Meropenem prescribing was up in the first quarter of the year. That then disappeared when you get to 13 June, and suddenly they became water cases. Dr Armstrong accepted she was not an expert in any of this. When one looks back you begin to see that, because she was reporting it publicly in the HAIRT. If one looked at the drain issue, they all thought there was aerosolization. They were all anxious about the building. Dr Armstrong said that what needs to come together in the IMT is the expertise of everyone around the table. If you have one voice dominating, good things do not happen. Her view was that when you get Dr Crighton and her experience with chairing, you can allow other voices to come through.
257. It was put to Dr Armstrong that Professor Steele got quite cross that Dr Peters gestured zero with her hands when explaining that there were no gram-negative cases at GOSH. Dr Armstrong was asked if there was not a connection between Dr Stewart's report in 2015 and these events in 2019. Dr Armstrong said no. What needed to come together in the IMT is the expertise of everyone around the table.
258. Dr Armstrong was asked if she subscribed to the view that it had become about proving themselves right and not focusing on the children. Dr Armstrong thought it became more about the debate. She had worked with Dr Inkster for a long period. Dr Inkster did a lot of good. Dr Armstrong thought it became more about the environmental focus than the patients. She thought people were focused on the patient but became over identified

with certain hypotheses rather than looking in a much broader way.

259. Dr Armstrong was referred to her witness statement where she said that there was a view set out in external review more about proving themselves right than the children. Dr Armstrong was asked if she was saying that Dr Inkster's behaviour became more about proving herself right than the children, and if so, why. Dr Armstrong explained that she thought her view was that she became identified with the hypothesis of the environment. It drove the IMT away from other areas it should explore. It led to a loss of perspective. She wanted the evidence looked at because if it's normal background, you start to take more abnormal reactions that have a greater impact on children. She could not give a yes or no answer. The focus became about the environment and led to a lack of focus on the children. The actions taken led to a lack of focus on the children.
260. Dr Armstrong was asked if Dr Armstrong's duty as a doctor was to act in the best interests of patients. Dr Armstrong stated that her position was that the IMT focus degenerated. It was not looking at the broad issues. It became skewed to the environment.
261. Dr Armstrong was asked if the focus of Dr Inkster was the best interests of her patients. Dr Armstrong stated that she thought she believed that. She did not think Dr Inkster's actions led to that. She would not go as far as to say she was not focused on the patients. It seems only fair to note that as discussed in Chapter 3 and Chapter 6 of the submission of counsel to the inquiry is that this criticism is not objectively justified, partly because there was considerable evidence that Dr Inkster was right to be concerned about infection rates in the summer of 2019 and the potential that chilled beams and residual risk from the water supply posed a risk to patients, but also because Dr Armstrong did not attend any of these IMTs herself, no IPC trained clinician or treating clinician was willing to back up her criticism, and most profoundly of all Dr Armstrong and Dr de Caestecker were clear that no thought was given to getting the insight of Professor Gibson, who might be well placed to assess the critique made by those people to whom Dr Armstrong did speak.

262. Regarding Dr Peters, Dr Armstrong was asked to what extent that she considered that the focus of Dr Peters was not the best interests of her patients. Dr Armstrong explained that at one IMT, the 14 August 2019 IMT, the focus was on their hypothesis and on the environmental issue and not on the wider focus on children. The focus was on the argument. Dr Armstrong said you would need to ask Dr Peters if her primary focus was the interest of patients. The focus was on what she had been brought there to do. The IMT became dysfunctional. That was the way it appeared to Dr Armstrong. She was relying on years of experience in the NHS and in her job. She knew what was coming out of the IMT. The chair did not report that IMT to her. Professor Gibson did not report it to her. Dr Armstrong had a view that has solidified over time. Her sources were the reports that came through the meeting on 20 August 2019. She thought the IMT was going the wrong way. She was not sure she could say it was not focused on the children. It was focused on the arguments.
263. It was put to Dr Armstrong that the Inquiry heard evidence that Sandra Devine communicated with NSS about the principle of whether a public health doctor could chair. She was asked why she did not brief HPS and ARHAI in advance. Dr Armstrong explained that it was the NHS GGC director of nursing, Mags Maguire, who texted Jacqui Riley to say they wanted to change the chair. Dr Armstrong accepted that the way it was handled was poor. She had told NSS about the meeting because she spoke to their medical director. She probably did not go into detail about the meeting. They should have done it better. NSS were not told they were going to replace the chair.
264. Dr Armstrong conceded that it was not being done in the most effective way possible. However, she was keen for the IMT going ahead. Sandra Devine had been trying to get in contact with Dr Inkster but was told not to contact her. It was handled badly. Moving the meeting to the Monday would have lost four or five days. They had a clinical risk.
265. Dr Armstrong was referred to an e-mail from Dr Crighton on 23 August 2019. Dr Armstrong was asked if she had been in contact with Dr Crighton

before this e-mail. She said she had not. Dr Armstrong wanted Dr Crighton to be fresh. She did not brief her in advance of taking over the Chair of the IMT on 23 August 2019. There was not time for that anyway. Dr Armstrong did not want to pre-empt anything.

266. Dr Inkster was adamant that no one contacted her between the meeting of Tuesday 20 August and the IMT of Friday 23 August to tell her what was going on. She recalled receiving the minutes of the 20 August meeting before the IMT of 23 August. She was very upset when she read them as she didn't recognise the reference to behaviour directed to her. Nobody had given her any feedback about her behaviour at IMTs. Dr Inkster felt that she did not really get sufficient feedback for her removal as chair of the IMT. She didn't feel there had been adequate discussion. She considered an appropriate approach would have been to discuss appointing a deputy chair with her. She did not consider the process of removing her as chair to have been fair because senior staff were discussing her behaviour with others.
267. There was confusing evidence about whether, after the meeting of 20 August 2019, Dr de Caestecker and Ms Devine knew whether Dr Inkster was back at work and would attend the IMT. No other ICD would take on the chair. Slightly surreally it emerged in evidence that Dr de Caestecker had offered the chair of the IMT to Dr Crighton and Dr Kennedy as a choice between attending another meeting and chairing the IMT. Her e-mail to Dr Kennedy and to Dr Crighton on 22 August 2019²⁷⁴ said nothing in the e-mail about Dr Inkster being off sick or about the IMT needing a new, permanent chair. Somewhat surprisingly, Dr Crighton received no briefing before the meeting of 23 August 2019, but somehow she learned that Dr Inkster was on sick leave. It was Dr Armstrong's evidence that she did not brief Dr Crighton in advance.
268. Immediately before the IMT on 23rd August 2019 some members of the IMT had to wait outside whilst a "pre meet" was being held by "senior members

²⁷⁴ Bundle 27, Volume 13, Document 8, Page 52.

of NHS GGC". No treating clinicians were at the pre-meeting and Ms Rankin from HPS/ARHAI was also waiting outside the room with Dr Inkster. Dr Kennedy, Sandra Devine, Professor Steele, Dr Deighan and Dr Crichton were in this pre-meeting. The purpose of the pre-meeting was to get Dr Crichton up to speed on the IMT. Waiting outside along with Dr Sastry, Professor Gibson, Dr Inkster, Ms Somerville, Mr Purdon, Mr Mallon, Dr Murphy, and Dr Ronghe.

269. The meeting opened considerably later than planned and was chaired by Dr Crichton who started with introductions. She had never met Dr Inkster before and maintains she did not know her to recognise her and had not been briefed on the reasons she was taking over.
270. The meeting did not start well. As introductions were underway some people at the meeting were confused because they did not know what was going on with the replacement of Dr Inkster by Dr Crichton. Dr Inkster told the IMT she had been told that the previous meeting had been dreadful, and everyone felt it was dreadful because of her own behaviour and the lack of team working. Nobody responded. Subsequently, Ms Rankin and Brenda Gibson told her that she had not been a terrible chair, and she had chaired the meetings well.
271. As the minute notes, an explanation was given by Ms Devine, but Dr Inkster has a slightly different take on what took place. Professor Gibson was unaware of the change in Chair before the meeting and asked the reason. Professor Gibson said, "Can I ask why there's a change in chair?" and Sandra Devine responded that she had a conversation with Dr Inkster and given complexities the chair was going to be changed. Ms Rankin recalled then interjecting and stated: "As long as due process is followed, and this is recorded in the minutes from a governance perspective." She commented further that she received a response that "We have discussed this with Professor Reilly". She recalled thinking it must have been extremely uncomfortable for Dr Inkster to sit through the IMT meeting. Ms Rankin recalled in evidence that during the IMT meeting, no explanation was given as to why there was a change of chair.

272. An unusual aspect of this meeting is that Ms Rankin's evidence was that the change of chair had been discussed and agreed with Professor Reilly, of HPS. Her evidence was that on checking with Professor Reilly after the meeting, the question asked by NHS GGC Director of Nursing on 20th August 2019 was about whether it was acceptable for a CPHM to chair an IMT if it wasn't an ICD and not about the specifics of this IMT.
273. Email exchanges between Ms Devine and Dr Inkster following the IMT of 23 August 2019 concerning the replacement of Dr Inkster as chair were unusual. Ms Rankin was of view that ARHAI should have been contacted by NHS GGC if they were thinking of replacing Dr Inkster, as the Scottish Government would have wanted to know of such a significant change, but this did not happen. NSS had recorded the removal of the IMT chair by NHS GGC. Sandra Devine then challenged that. She suggested the chair had agreed to be replaced. That was plainly not correct.
274. Dr Inkster was of the view that she was replaced as IMT chair because organisational reputation took priority over patient safety. In her view, the IMT was leading towards potentially another decant, and she thought that would be unpalatable to the organisation. They didn't want her involved anymore. She considered the shift to organisational reputation to have taken when the Cryptococcus incident occurred in January 2019.
275. Dr Crighton accepted that the meeting of 23 August 2019 could have been handled better, and in an ideal world she would have had a discussion with Dr Inkster to have a clear handover before the meeting. Dr Crighton never sought a handover from Dr Inkster.
276. **On 2 September 2019, Dr Inkster resigned as lead ICD. She emailed a letter to Dr Armstrong which contained detailed reasons²⁷⁵ and received a response²⁷⁶.** Dr Inkster summarised those reasons as: the IMTs being really difficult, that she felt undermined and challenged by colleagues,

²⁷⁵ Bundle 14, Volume 2, Document 151, Page 579.

²⁷⁶ Bundle 14, Volume 2, Document 152, Page 581

that her views were disrespected (having to try and send published papers to back up her arguments), that every day was a battle to be heard, that she was not being listened to (particularly around the epidemiology), duty of candour concerns with regard to patients and communications to families, her health, and issues around being paid. In addition, there were other items of concern such as payroll, sick leave and reporting structures. Asked in evidence if there was an underlying theme between this resignation and the withdrawn one in January 2018, Dr Inkster identified the culture in NHS GGC.

277. In a potentially remarkable codicil to her resignation, Dr Inkster reported that she was sent to see Occupational Health after her resignation and that the NHS GGC Occupational Health employee wanted to sign her off on sick leave for stress. She checked with her own doctor, was pronounced fit to work and continued to work.
278. Following evidence from Dr Inkster, Dr Armstrong described a meeting at the Golden Jubilee in July 2019. The Chief Nursing Officer had written to the ICMs, and HAI executive leads, and invited them to a meeting. Dr Inkster was not at the meeting and only found about the rest of the senior IPC staff attending the meeting because she was at the Golden Jubilee for a personal reason. Dr Armstrong was asked why she did not tell Dr Inkster about the meeting. Dr Armstrong explained that it wasn't about Glasgow, but about learning from the different boards. Dr Armstrong did not know Dr Inkster had found out or was upset about it. It was pointed out at end of the meeting that they should do another with ICDs. Counsel to the Inquiry have submitted that it is difficult not to see this meeting, and the failure to even tell the then Lead ICD of NHS GGC who was in the middle of what was the largest and most complex IMT in Scotland at the time, as evidence of a loss of trust or support from Dr Armstrong and other senior managers in Dr Inkster at that time.

Stage 3 Whistleblow and subsequent investigations

279. In 2019 Dr Redding prepared a paper for the Independent Review, she wrote to the Scottish Parliament Health and Sports Committee, approached

Anas Sawar MSP and met Jeane Freeman MSP, the Cabinet Secretary for Health Secretary at the time. Both meetings were with Dr Peters. On 21 November 2019, she raised **the Stage 3 Whistleblow**.²⁷⁷ She was in part prompted by a November 2019 press release from NHS GGC that stated that because no tests were done at the time, it was not possible to conclude that infections were connected to the water supply, and which criticised the “extremely disappointing” actions of a whistle-blower who had suggested that that there was a link with the water. As part of the Stage 3 Whistleblow, she met NHS GGC Board members William Edwards and Ian Ritchie on 4 December 2019 and an issue arose about whether the Board would recognise the emails of September 2017 and the SBAR of 3 October 2017 as a Stage 1 Whistleblow. On 29 January 2020 she had a scheduled meeting about the Stage 3 Whistleblow with Jennifer Haynes, Ian Ritchie, William Edwards, Dr Scott Davidson (Deputy Medical Director, Acute Services) and Tom Steele, Director of Estates and Facilities. When she received the final report²⁷⁸ Dr Redding was concerned that there were a lot of inaccuracies in what had been written and ultimately wrote to the Chair of the Board, Professor John Brown, to alert him to her concerns. Despite repeated requests by Dr Redding no changes were made.

280. Once the Independent Review had started work, Dr Redding formed the view that there had been an attempt by NHS GGC to cover up the Stage 1 Whistleblow. This led her to raise another stage 3 Whistleblow highlighting this concern.
281. Dr Redding clearly has many concerns about how her Stage 3 Whistleblow was investigated and how NHS GGC have reported her Whistleblow to the Independent Review. In our submission the primary importance of the evidence of Dr Redding arises from her Stage 1 and Stage 2 Whistleblows. Had she not acted in September 2017, the 27 point Action Plan would likely never have been created, and whilst the Stage 2 report entirely failed to

²⁷⁷ Bundle 27, Volume 4, Document 12, Page 126.

²⁷⁸ Bundle 27, Volume 4, Document 11, Page 116.

engage with the reasons why the QEUH/RHC was built with ventilation that did not comply with SHTM 03-01 (2009 Draft) - as it should have done - the way that Dr de Caestecker and senior NHS GGC staff responded to the good faith of Dr Redding and her colleagues is clearly something that this Inquiry should pay close attention to in addressing a number of Terms of Reference, including 1, 4 and 7.

F. NHS GGC Criticism of Dr Redding, Dr Peters and Dr Inkster

282. Counsel for NHS GGC produced a positioning paper for the Inquiry in December 2022²⁷⁹. There are aspects of the critique of Dr Redding, Dr Peters and Dr Inkster that require additional information.

RSV Virus Facemask Incident

283. Dr de Caestecker's report into Dr Redding's Stage 2 Whistleblow in May 2018,²⁸⁰ and Ms Grant's letter to Professor Stevens in response to the draft CNR Overview Report on 1 March 2018 (albeit Ms Grant appears to have the wrong year)²⁸¹ raise an allegation that:

Several members of the IPCT senior nursing team met with the Royal College of Nursing with concerns about the behaviour of one microbiologist in QEUH. The RCN thereafter met with the GGC Board Nurse Director and Medical Director to advise of their intention of raising a grievance through the appropriate policy. Following discussion, it was agreed to seek to resolve the position through early resolution resulting in alternative contact arrangements between the microbiologist and the ICNs.

284. This is widely acknowledged to be a reference to Dr Peters and an interaction with Infection Control Nurses that took place in December 2015. It is set out in an email exchange²⁸². On 15 December 2015, Dr Peters advised an ICN in the QEUH to advise staff in ITU to wear surgical masks and/or FFP3 masks due to a risk from a particular virus. Within 30 minutes, Ms McNamee (now Ms Devine) had challenged the advice on the basis that it might amount to a change of policy that required management

²⁷⁹ Bundle 25, Document 62, at Page 1282.

²⁸⁰ Bundle 27, Volume 4, Document 6, Page 81.

²⁸¹ Bundle 25, Document 3, Page 151 at Page 153.

²⁸² Bundle 27, Volume 11, Document 11, Page 70.

consideration, and a debate escalated between those in the email thread and offline in the IPC team. Whatever the merits of the advice (it is notable that after an intervention from Dr Inkster for whom she had 'the greatest respect', Ms McNamee agreed that masks should be worn) this event appears to have acquired totemic status in some circles. Senior Nurse Consultant in IPC Ms Urquhart described it as a source of tension between her and Dr Peters. Ms Devine clearly thought it was a significant issue to the extent that four ICNs sought advice from the Royal College of Nursing. Nevertheless, Ms Devine accepted the request had been made in the interests of patients, that Dr Peters was a very good ICD, and that not following the request could at least have been perceived as nurse resistance (Ms Devine was asked specifically if, 'when Dr Peters asked for something to be done or suggested something should be done, she would be doing that because she felt that was appropriate for the patients?' Her answer was 'Absolutely'.)

285. It is not for the Inquiry to determine whether the ICNs in the face-mask incident were not entitled to react as they did (albeit it is difficult to understand what could be problematic in a pair of microbiologists giving advice on use of personal protective equipment when dealing with an unusual virus). It is, however, remarkable that these events have subsequently been taken entirely out of proportion and repeated years after the event, in what can only realistically be seen as a disproportionate and repeated attack on Dr Peters. Given the nature of what actually took place, it is difficult to avoid the conclusion that this incident has, since 2018, not been raised in good faith as a concern about professional practice, but as a means to imply professional failure on the part of Dr Peters.

The Medical Director on the NHS GGC criticism of the whistleblowers

286. Regarding the conduct of the Whistleblowers, Dr Armstrong was referred to **the positioning paper for NHS GGC**²⁸³. Paragraph 69 refers to the

²⁸³ Bundle 25, Document 62, Page 1282.

conduct of Whistleblowers undermining infection control. Dr Armstrong agreed with that analysis.

287. It was put to Dr Armstrong that this was understood to describe behaviour from 2015 to 2019. She was asked what steps she took to address these serious issues with those doctors. Dr Armstrong explained that the 2015 review mentioned it. She regretted that they did not have a meeting. It should have been shared at that point, in a delicate way. Dr Green worked with Dr Peters in 2017/2018. Regarding Dr Inkster, Dr Armstrong had hoped that trying to get more support and mentoring for her from January to March 2019 might have helped. She was not sure if it did.
288. Dr Armstrong was asked if at paragraph (j) she was saying that Dr Peters or Dr Inkster provided inaccurate information to patients and families. Dr Armstrong thought there was evidence given by the board on specific cases. It could have been in relation to the Serratia case in 2018.
289. It was put to Dr Armstrong that certain IMT minutes contradicted entirely what was in the positioning paper. She was not aware of that. She accepted that she was the responsible officer for the health board. She does revalidation and appraisals for doctors. There were behavioural patterns over a number of years that are difficult to address.
290. It was put to Dr Armstrong that nobody had addressed this with Dr Inkster. Dr Armstrong thought that without a formal process it was difficult. She was not sure there was enough for disciplinaries. She wondered what they could have done different and if they could have done more.
291. It was put to Dr Armstrong that she agreed that the doctors had undermined infection control, but that there was not something to take up with disciplinary or to report to the GMC. Dr Armstrong thought there was some evidence of undermining the infection control team. That was addressed at the time by Dr Green. Dr Armstrong considered that when you see behaviours re-occurring, it becomes difficult. She did not have personal experience of all the instances.

292. Regarding paragraph (m), there was reference to making false allegations about colleagues. It was put to Dr Armstrong that the presumption was this was about Professor Steele and the joke. Dr Armstrong said it was not. There was a case in 2016 where one of the individuals made false allegations against three colleagues. An investigation was conducted, and it was disproved.
293. It was put to Dr Armstrong that the positioning paper came out a year and a half ago. It might be used to suggest that the Inquiry should not listen to the views expressed by these doctors. She was asked when Dr Peters and Dr Inkster were first wrong about the flaws in the built environment. Dr Armstrong thought they should be listened to. She thought there were significant issues with the QEUH. She thought Dr Inkster and Dr Peters did pick those up. There was a balance. It was not all good or all bad. The Inquiry should listen to Dr Inkster and Dr Peters.
294. Dr Armstrong was asked if the positioning paper sought to undermine the messenger rather than focusing on the message. Dr Armstrong rejected that. There were behaviours which had been quite damaging to people within NHS GGC. They had to raise some of those issues because the danger is that, if issues are not raised, one becomes too anxious to raise some issues. What the Inquiry heard from Sandra Devine was that some behaviours continue and are detrimental.

G. Approach taken by Counsel to the Inquiry

295. Counsel to the Inquiry has submitted that there is no substantive evidence to support the view that Dr Peters and Dr Inkster were ever wrong when they identified flaws in the ventilation systems of the hospital, which they then drew to the attention of colleagues and NHS GGC. These attempts began in the summer of 2015 and continued well into 2019. At every turn NHS GGC senior managers, including the Medical Director, sought to minimise or belittle the points they were making, whilst at the same time reacting to the flaws identified in a way that suggests that they recognised (eventually) that the flaws existed. Those senior managers used informal meetings, Whistleblowing reports and eventually the power to remove Dr

Inkster as IMT chair, in order to undermine points being made by Dr Redding, Dr Peters and Dr Inkster, and to protect the reputation of NHS GGC.

296. There was some evidence that, from 2017, Dr Peters may have had a communication style in her emails that was aggravating to those in IPC and senior management who heard from her, but even if that is the case it must be acknowledged that this was after two or more years of having her concerns ignored or sidelined. Similarly, even if one was to decide that Dr Inkster's leadership of the Gram-Negative Bacteraemia IMT in August 2019 was sub-optimal (which we do not consider to be supported by the evidence) by that point Dr Inkster was overworked, under supported, and undermined in her role as lead ICD and chair of the IMT, and that would have to be taken into account.
297. Dr Armstrong's criticism of Dr Redding, Dr Peters and Dr Inkster that they put their interest ahead of patients is not supported by the other evidence. Had there been evidence of this, as NHS GGC's Responsible Officer, Dr Armstrong would have had to deal with the issue at the time by formal disciplinary response or GMC referral. The fact that no such steps have been taken since 2019 supports the view, derived from a contextual understanding of what these three doctors actually did, that there is no merit to this criticism.
298. In our submission Dr Redding, Dr Peters and Dr Inkster should be praised for their commitment to ensuring that the effect of the flaws in the water and ventilation systems of the QEUH/RHC on its patients were fully investigated.

H. March 2025 HIS "NHS GGC Emergency Department Review"

299. In March 2025 Healthcare Improvement Scotland published this review into relationships over several years both between teams in the emergency department in the Queen Elizabeth University Hospital, and between staff in the department and senior leadership/management. We consider that it may assist you in addressing these issues. Within the report paragraphs

18-30 of the Executive Summary and Chapter 7 which covers Leadership and Culture would appear to be relevant (pages 139-167). Clearly the factual matrix of the issues with the operation of the Accident and Emergency departments of three hospitals within NHS GGC are not relevant to the Remit and Terms of Reference to the Inquiry, but the issues around leadership and culture identified by HIS do appear to be material you should be aware of.

APPENDIX 2 - CV

Overview

Barrister

Having been called to the Bar in 1973, I have been a member of what is now Serjeants' Inn Chambers as a self-employed barrister from 1974. I formally retired from registered self-employed practice on 31 March 2020 and am now an associate member of chambers. I was appointed Queen's Counsel in 1992, a Recorder of the Crown Court in 2000, and authorised to sit as a Deputy High Court Judge in the Queen's Bench Division since 2009. I retired from these judicial appointments on reaching the age of 70 in April 2020.

Medico-legal regulation, ethics, culture and patient safety

Throughout my career I have specialised in medical law, focusing in particular on

- clinical negligence
- healthcare professional discipline and regulation
- medical decision-making and consent: ethical issues involving adults and children lacking decision-making capacity.

I have experience of the various investigative and dispute resolution processes that occur in the healthcare sector, including

- court based litigation
- mediation
- complaints handling
- inquests
- internal and external non statutory inquiries
- public inquiries.

Inquiries and investigations

I chaired the Independent Inquiry into the Care Provided by Mid-Staffordshire NHS Foundation Trust 2005-March 2009 (report 2010), the Mid-Staffordshire NHS Foundation Trust Public Inquiry (report 2013), and the Freedom to Speak Up Review (report 2015).

These reports identified systemic deficiencies not only in the Trust but more generally in the NHS in relation to organisational culture, governance, leadership, candour and transparency. In particular they identified the vital importance of putting the patient/service user first in all policy decisions, of listening to their concerns – and those of staff - and acting on them, and of treating both them and staff with

respect. Many changes in practice, regulation, leadership development, culture and law have occurred as a result.

More recently I was commissioned by the Cabinet Office to propose a framework for compensating the victims of infected blood [report 2022: *Compensation and Redress for the Victims of infected Blood – Recommendations for a Framework*]. My recommendations resulted in an immediate interim payment of £100,000 to directly infected persons and certain other classes of affected victims and were generally accepted and developed by the Infected Blood Inquiry in two interim reports. In May 2024 I was appointed interim Char of the newly formed Infected Blood Compensation Authority

Charities

In the charity sector I have been a trustee of the Point of Care Foundation, a charity which promotes methods of enabling healthcare staff to care better for patients, and in particular the use of Schwartz Rounds as a means of allowing staff to reflect collectively on shared issues. I have also been a trustee of Prostate Cancer Research, a charity which focuses on raising and granting funds for research into treatments for this all too prevalent disease and places much emphasis on involving patients in the selection of projects to support. I retired from both these positions in 2022.

I am President of the Patients Association.

I am a patron of the Association of Continence Professionals

Honours

I have been awarded Honorary Fellowships of the Royal College of Anaesthetists, the Royal College of Pathologists, and the Royal College of Surgeons (England), and the Faculty of Forensic Medicine of the Royal College of Physicians. I have also received an honorary Doctorate of Medicine from St George's Medical School and of Law from the University of Exeter.

I was awarded a knighthood in 2014 for services to healthcare and patients.

CAREER SUMMARY

1963 - 1968 Uppingham School

1968 - 1971 Exeter University LL.B

1971 - 1972 President, Exeter University Guild of Students

1973 Called to Bar

1974 Joined Carpmael Building chambers [now Serjeants' Inn chambers] first as pupil and then as tenant.

1992 Queen's Counsel

1996 - 2000 Assistant Recorder

1999 - Consultant Editor Lloyd's Law Reports: Medical (now the Medical Law Reports)

2000 - 2020 Recorder

2000 - 2009 Joint Head of Chambers, 3 Serjeants' Inn [now Serjeants' Inn Chambers]

2002 - Governing Bencher, Honourable Society of the Inner Temple

2003 - 2005 Chairman, Professional Negligence Bar Association

2004 - 2009 Chairman, Inner Temple Qualifying Sessions Sub-Committee

2007 Member, Lord Neuberger's Entry to the Bar Working Party

2008 - 2009 Vice-Chairman, Training for the Bar Committee, Bar Council

2009 - 2020 Authorised to sit as a Deputy High Court Judge (Queen's Bench Division)

2009 - 2013 Chairman, Inner Temple Education and Training Committee, and Executive Committee member

2009 - 2010 Chairman, Mid-Staffordshire NHS Foundation Trust Independent Inquiry

2010 - 2013 Chairman, Mid-Staffordshire NHS Foundation Trust Public Inquiry

2014 - 2020 Authorised to sit as a Deputy High Court Judge [Administrative Court]

2014 Knighted [for services to healthcare and patients]

2014 Hon President, Patients Association

2014 Honorary Fellowship, UCL Partners NHS Staff College

2014 Honorary Fellowship, Royal College of Anaesthetists

2014 - Patron, Florence Nightingale Foundation

- 2014 - 2022 Trustee, Point of Care Foundation
- 2014 - 2022 Trustee, Prostate Cancer Research
- 2014 - 2022 Commissioner and Non-Executive Director, Care Quality Commission
- 2014 - 2018 Non-executive member CQC Audit and Governance Committee
- 2014 - 2015 Chairman, Freedom to Speak Up Review [Department of Health]
- 2015 - 2017 Member, Editorial Board, *Clinical Risk*
- 2015 Honorary Doctorate of Medicine, St George's Medical School
- 2015 Honorary Fellowship, Royal College of Pathologists
- 2015 - Affiliate, Institute of Global Health Innovation, Imperial College, London
- 2016 - Affiliate, Doubleday Centre for Patient Experience, University of Manchester
- 2016 Honorary Doctorate of Law, University of Exeter
- 2016 Honorary Fellowship, Royal College of Surgeons [England]
- 2018 - 2022 Chair, Healthwatch England
- 2020 - 2021 Reader-elect, the Honourable Society of the Inner Temple
- 2020 - Member, Expert Advisory Panel of the House of Commons Health and Social Care Select Committee [appointment renewed 2024]
- Member, Patient Safety Watch Advisory Board
- 2022 Retired from practice as a registered self-employed barrister: practicing certificate ceases to have effect. Now an associate member of Serjeants Inn Chambers [31 March 2022]
- 2022 Reader of the Honourable Society of the Inner Temple
- 2021 – 2022 Study for a framework of compensation for the victims of infected blood [report March 2022]
- 2023 Treasurer of the Honourable Society of the Inner Temple
- 2023- Patron Association of Continence Professionals
- 2024- Interim Chair of the Infected Blood Compensation Authority

LEGAL PRACTICE PROFILE

Robert Francis for many years specialised in medical law in all its aspects:

Inquiries

He has acted as chairman of three inquiries into the care and treatment of mental health service users who have committed homicide. He has appeared as counsel for interested parties at a number of public inquiries, including the Bristol Royal Infirmary Inquiry, the Royal Liverpool Children's Inquiry, the Neale inquiry, and the Undercover Policing Inquiry. He chaired the two Mid Staffordshire NHS Foundation Trust inquiries [reports 2010 and 2013 respectively], and the Freedom to Speak Up Review into the treatment of NHS staff who raise concerns.

Clinical negligence

He has undertaken clinical negligence actions on behalf of claimants (publicly or privately funded or on conditional fee arrangements) and defendants, including NHS bodies, private healthcare providers, all the medical defence organisations, and insurers. He was frequently instructed both at first instance and on appeal in high value claims and those involving complex medical and legal issues.

Medical ethics

He was instructed in cases involving difficult or controversial ethical dilemmas and problems in relation to treatment decisions for patients unable to make their own decisions, withdrawal or withholding of life prolonging care, socially controversial treatment such as sterilisation of mental patients, treatment of patients refusing consent to treatment etc. He has appeared in many of the leading cases in this field in the Court of Appeal and House of Lords.

Professional discipline and regulation

He appeared on behalf of practitioners before professional conduct committees of regulatory bodies such as the General Medical Council, the General Dental Council and on appeals from them to the Judicial Committee of the Privy Council or the High Court. He has sat as a legal assessor to professional disciplinary committees of the General Optical Council and the Chartered Society of Physiotherapists. He has sat as legal adviser to the Licensing Committee of the Human Fertilisation and Embryology Authority [2007].

Medical employment issues

He received instructions for professional staff and for employers in internal disciplinary procedures, and associated court proceedings and appeals. He has also acted as chairman of NHS internal disciplinary inquiries.

Public law

He has undertaken applications for judicial review in relation to all areas of his practice.

Criminal cases

He has been instructed in criminal cases, particularly those involving medically or professionally related issues.

INVOLVEMENT IN INQUIRIES AS CHAIR, COUNSEL OR WITNESS

Infected Blood Inquiry – evidence on work of IBCA – May 2025

Infected Blood Compensation Study, Chair [2021, report March 2022] – evidence to the Infected Blood Inquiry [July 2022]

Independent Inquiry into Child Sex Abuse, Witness [11 December 2020 – expert evidence on leadership and culture, jointly with Sir David Behan]

Expert Advisory Panel, House of Commons Select Committee on Health and Social Care, Member [December 2020-]

Independent Expert Panel on Prevention of and Response to Harassment, including Sexual Harassment, Bullying and Abuse of Power at UNAIDS Secretariat, Member [Report December 2018]

Undercover Policing Inquiry [leading counsel for the National Police Chiefs Council, July 2016 - 2019]

Freedom to Speak Up Review Chair [report February March 2015]

Mid-Staffordshire NHS Foundation Trust Public Inquiry Chair [report February 2013]

Independent Inquiry into care provided by Mid-Staffordshire NHS Foundation Trust January 2005-March 2009 Chair [report February 2010]

Independent Inquiry into the Care and Treatment of GB [chairman; report September 2009]

Independent Inquiry into the care and treatment of Peter Bryan and Richard Loudwell at Broadmoor Hospital, Chair [report September 2009]

Independent Inquiry into the Care and Treatment of Michael Stone, Chair [report September 2006]

Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale [counsel for interested party; report September 2004]

Bristol Royal Infirmary Inquiry [counsel for interested party; report July 2001]

Royal Liverpool Children's Inquiry [counsel for interested party; report January 2001]

EVIDENCE TO PARLIAMENTARY SELECT COMMITTEES

9 Sep 2021	House of Commons Health and Care Bill Committee – evidence session
2 Mar 2021	House of Commons Health and Social Care Committee – [<i>White Paper on Health and Social Care</i>]
16 Jun 2020	House of Commons Health and Social Care Committee [<i>Inquiry into delivering core services during the pandemic and beyond</i>]
1 May 2019 <i>Legislative</i>	House of Commons Health and Social Care Committee [<i>NHS proposals</i>]
16 Oct 2018	House of Commons Health and Social Care Committee [<i>gross negligence manslaughter in medical treatment</i>]
6 Jun 2018 session]	Joint Committee on draft Health Safety Investigation Bill [private session]
13 Jun 2017 <i>speak up</i>]	Scottish Parliament Health and Sport Committee [<i>freedom to speak up</i>]
11 Feb 2014	House of Commons Health Select Committee [<i>Mid-Staffordshire NHS Foundation Trust Public Inquiry report implementation</i>]
30 Oct 2013	House of Lords Select Committee on the Inquiries Act
12 Feb 2013	House of Commons Health Select Committee [<i>Mid-Staffordshire NHS Foundation Trust Public Inquiry report</i>]

Council of Europe

31 May 2013	Presentation to stakeholder meeting on protecting whistleblowers for the European Committee on Legal Cooperation [Strasbourg]

APPENDIX 3 - List of persons and organisations referred to

NAME	Position	Comments
Archibald, Grant	NHS GGC COO	
Armstrong, Dr Jennifer	NHS GGC Medical Director and Healthcare Acquired Infection Lead until 2020, retired 2024	
Balfour, Dr Alison	QEUH Consultant Microbiologist and Infection Control Doctor 2015 – 2022 [retired]	
Best, Jonathan	NHS GGC Director of Regional Services.	
Brookfield	Hospital building contractor, later changes name to Multiplex Construction Europe Limited	
Calderwood, Robert	NHS GGC CEO until 2017	
de Caestecker, Dr Linda	NHS GGC Director of Public Health, Executive Board Member until Mar 2022	
Crichton, Dr Emilia	Public Health Consultant, later Director of Public	

	Health, NHS GGC Executive Board member	
Cruickshank, Dr	NHS GGC Interim Clinical Director for Infection Prevention and Control Nov 2015 – May 2016, retired microbiologist.	
Deighan, Dr Chris	NHS GGC Deputy Medical Director (Corporate) from Feb 2019	
Devine, Sandra	NHS GGC Director of Infection Prevention and Control	
Crichton, Dr Emilia	NHS GGC Public Health Consultant, Director of Public Health, Executive Members of Board	
Davidson, Dr Scott	NHS GGC Deputy Medical Director (Acute Services) 2019 – 2024; Medical Director since 2024	
Deighan, Dr Chris	NHS GGC Deputy Medical director (Corporate) 2019	
Dodd, Susan	ARHAI Scotland Nurse Consultant; Lead Infection Prevention and /control Nurse, RHC Mar 2017 – Aug 2019	

Gallacher, Alan	General Manager (Estates) from Aug 2015	
Gibson, Prof Brenda	RHC Lead Clinician for Haematology and Oncology Service, Programme Director for HSTC, Departmental Lead for systemic Administration of Chemotherapy	
Grant, Jane	NHS GGC CEO from 2017	
Hill, Kevin	NHS GGC Director of Women and Children's Services	
Hutton, Melanie	Clinical Service manager and Lead nurse, then general Manager Paediatric and Neonates.	
Inkster, Dr Teresa	Consultant Microbiologist, Regional Sector ICD to Feb 2019. NHS GGC Lead ICD from Feb 2019 – Sep 2019 [on sick lead in 2 nd half 2017]	These dates cannot be corrected
Jenkins, Gary	NHS GGC Director Regional Services	
Joannidis, Pamela	NHS GGC, South Sector Lead Infection Prevention and control Nurse,	Jan 2013 – Mar 2019 involved in setting up Paediatric Infection Prevention and Control Team

Jones, Prof Brian	NHS GGC head of Service for Microbiology, Consultant in Medical Microbiology	
Kennedy, Dr Iain	Consultant in Public Health Medicine, Public health Protection /unit, Gartnavel Royal Hospital, Glasgow from August 2014	
Leiper, Jim	NHS Tayside Head FO estates; NHS Fife Directors of Estates, Facilities, Health Facilities Scotland Director of Facilities.	
Leonord, Prof Alistair	NHS GGC, Chief of Medicine, Diagnostics	?Leonard?
Loudon, David	QEUH Project Director	
Mathers, Dr Alan	RHC/QUEH Chief of Medicine for Women and Children	
McNamee		See Devine, Sandra above
Mitchell, Clare	Lead Infection Prevention and Control Nurse 2010-Oct 2015; Senior Infection Prevention and Control Nurse from Oct 2015 – 2020.	
Multiplex	Multiplex Construction Europe Limited, previously Brookfield.	

Murphy, Dr Dermot	RHC Consultant Paediatric Oncologist	
NHS GGC		
Peters, Dr Christine	Consultant microbiologist, South Sector ICD, then QEUH ICD 2014 - 2017	
Powrie, Iain	QEUH senior Estates Manager	
Pritchard, Lynn	NHS GGC South Sector Lead Infection and Control Nurse Oct 2015 – Sept 2022. From Sep 2022 Nurse Consultant in Infection Prevention and Control	
QEUH	Queen Elizabeth University Hospital, Glasgow	
Rankin, Annette	HPS Nurse Consultant in Infection Prevention and Control, then for ARHA Scotland	
Redding, Dr Penelope	Consultant Microbiologist, former lead of ICD, retired 2018	
Redfern, James	General Manager Paediatrics and neonates, then Director of Women's and Children's Services	
Rodgers, Jennifer	NHS GGC, Chief Nurse for Paediatrics and Neonates, then Deputy	

	Nurse Director, Corporate and Community Services,	
Schiehallion unit	Established in 1996 under leadership of Professor Gibson as Royal Hospital for Children, Yorkhill. Became base of the national paediatric Haematopoietic Stem Cell Transplantation Service [HSCT]. Moved in 2015 to RHC Wards 2A, 2B. Moved again in September 2018 to Ward 6A with HSCT patients moved to Ward 4B [which also hosted BMT unit]	
Steele, Prof Tom	Director HPS to 2018; Director Estates and Facilities, 2018 to date.	
Stewart, Dr David	NHS GGC Deputy Medical Director until Feb 2019	
Valyraki, Dr Kalliope	QEUH Infection Control Doctor, Mar 2017-Jul 2021, consultant microbiologist	
Walsh, Tom	NHS GGC Infection Control Manager	
Williams, Professor	NHS GGC consultant microbiologist 2002-2016; NHS GGC Lead ICD to Feb 2016	

APPENDIX 4 - Glossary

TERM	MEANING
BICC	Board Infection Control Committee
DCN	Department of Clinical Neuroscience
HAI	Healthcare Acquired Infection
HFS	Health Facilities Scotland, formerly NHS Scotland Property and Environment Forum
HPS	Health Protection Scotland
IPC	Infection Prevention and Control
NHS GGC	NHS Greater Glasgow and Clyde
PPVL	Positive Pressure Ventilation Lobby Rooms
QUEH	Queen Elizabeth University Hospital
RHC, or RHCYP	Royal Hospital for Children and Young People
SBAR	Situation Background Assessment and Recommendation document

APPENDIX 5 - CHRONOLOGY

The scenario relates to events that took place in connection with the construction of Queen Elizabeth University Hospital [QEUH] and involves an examination of the role played by senior management, board members and clinicians there and within the jurisdiction of NHS Greater Glasgow and Clyde *[and of NHS Lothian]*.

DATE	EVENT	Ref	COMMENT
1996	Schiehallion Unit established		
1998-2001	Planning of new hospital services	Scen §9-10	
15 Nov 2009	NHS GGC selects Brookfield as preferred contract bidder	Scen 11	
19 Dec 2009	NHS GGC and Brookfield enter contract to build hospital	Scen 11	
18 Dec 2010	Authorisation to proceed to construction (Stage 3)	Scen 12	
29 Jan 2015	Stage 3 sectional completion certificate signed. QEUH completed and opens	Scen §7, §12	
Feb 2015	Dr Inkster raises concerns about		

	PPVL isolation rooms in ward 4B		
27 April 2015	Patient migration to QEUH starts from Western Infirmary, Mansion House Unit, Gartnavel General Hospital	Scen 13	
1 May 2015	Inpatient departments moved to new site from Southern General Hospital		
6 June 2015	Adult BMT team moved to Ward 4B from West of Scotland Cancer Centre (the Beatson)		
June 2015	Schiehallion Unit moved from Royal Hospital for Children, Yorkhill to Wards 2A and 2B at RHC.		
10 Jun 2015	Royal Hospital for Sick Children, Yorkhill, moved to RHC		
14 Jun 2015	Move of all units to new campus complete		
June 2015	Dr Peters and Dr Inkster attend meeting with construction who were “surprised”		

	to learn there was an infectious disease unit in the hospital		
19 Jun 2015 – 7 Jul 2015	Drs Inkster and Peters stand in for Prof Williams to cover ventilation issues	Scen §146	
?	Report by Dr Inkster to Health and Sport Committee	Scen 146 Bundle 14 vol 2 page 411-418	Page 413: <i>“Any derogation from SHRM/SHBN standards has the potential to increase the risk of infection acquisition... Any breakdown in the design, commissioning or validation process poses a risk that the environment does not meet standards and therefore increases the risk of airborne infections.”</i> Page 414: In her view the systems current for monitoring in Scotland were not adequate. Page 416-417: <i>“in my experience there are barriers to the reporting of environmental issues that need to be addressed. Lack of clarity regarding the most appropriate reporting route... , fears regarding publicity, financial implications of remediation, highly politicised context, and staff uncertainty that these issues pose real patient safety risks.”</i> She identifies 8 [systemic] areas requiring improvement based on her observations

			[NB: Scenario §146 suggests this document contains a report of what Dr Peters and Inkster found between June and July 2015: I am unsure this is correct. The text above was the closest I could find.]
Summer 2015	Dr Inkster and Dr Peters raise concerns re air sampling results, lack of ACH, HEPA filtration, and pressure monitors on ward 4B	Scen §145	
7 July 2015	Drs Inkster, Peters Cruickshank and Ms Neil put concerns in writing and at meeting with Dr Cruickshank	Scen 149; Bundle 14 vol 14 age 420	
8- 9 July 2015	Dr Peters and Dr Inkster resign from South Sector and Regional Sector ICD roles.. Note summarises their findings	Scen 147 Bundle 14 vol 1 page 416 – 420	Page 419: <i>“Following the AICC on Monday 6 July I was asked by infection control colleagues to comment and agree to a document summarising the situation with the adult BMT. I believed that this document did not reflect the facts as I understood them and therefore did not feel able to sign the document. My comments back were not well received, I was unclear where this document was being sent... I the(n) felt I had to resign as infection control doctor that afternoon...</i>

			<i>The reasons for my resignation stem largely from my experience within the past two weeks. I have major concerns regarding the specialised ventilated areas within QEUH and RHSC and the impact on patient safety. Dr Peters and I have put in numerous requests to various individuals.... For information.... Without this information being available it has made it impossible for me to perform risk assessments. I believe the limited information I had available demonstrates deficiencies in the current ventilation systems....</i> <i>Despite my requests for clarity I do not have a full understanding of the role of the ICD within the infection control team... I have a duty of care to provide the best possible service to patients At present I have concerns about patient safety and feel there has to be a clear understanding of all the issues that require to be resolved in relation to the new hospital."</i>
?	"Informal" review of infection control issues By Dr Stewart [Deputy Medical Director] and Head of HR at request of Dr Armstrong [Med Director/HAI lead]	Scen §151; Bundle 14 vol 1 page 464	Comment: the report appears to focus on process, relationships, behaviours and clarity of roles and responsibilities, and accountability: <i>"While it is clear that concerns for patient safety is the primary motivator for ICDs when arriving at decisions, there appears on occasion to be a lack of</i>

			<i>appreciation by some ICDs of the need to risk assess decisions from an organisational/political perspective.”</i> Dr Inkster suggests that this passage indicates that reputation was the priority for the organisation.
?	Dr Cruickshank appointed interim clinical director for infection control doctors for 6 months	Scen §156	Appointed to improve relationships in the IPC team. Dr Cruickshank stated that she thought patient safety being dealt with as a separate issue... [Scen §157]
4 Sep 2015	Prof Gibson emails concerns re safety of environment in BMT rooms to Medical Director, Dr Armstrong	Scen §41	
30 Oct 2015	Dr Steward emails all microbiologists including Inkster and Peters with conclusions of review	Bundle 14 vol1 page 472	Suggests areas of improvement including clarity of roles, responsibilities and reporting structures, effectiveness of team working [to be reviewed at facilitated workshop] and development of an action plan...
30 Oct 2015	Dr Inkster acknowledges letter and asks Dr Stewart “<i>how will the patient safety concerns be addressed</i>” Dr Stewart replies that her main worry had	Scen §163; Bundle 14 vol 1 page 474	

	been around estates and whether they were fit for purpose and how this was validated. <i>“I understand that significant progress has been made with respect to this and that there is now more confidence in these facilities, albeit work continues. If despite this you believe that there are ongoing safety issues, I would be grateful if you could elaborate on what these are.”</i>		
30 Oct 2015	Dr Peters asks Dr Stewart to clarify whether she is to expect an individualised response to the concerns she had raised in her resignation letter and her interview with Dr Stewart, <i>“particularly in relation to ongoing patient safety issues.”</i> Dr Stewart replies [2/11]: <i>“... you main worry was around the</i>	Bundle 14 vol1 page 476-477	

	<i>functioning of the isolation facilities, whether they were fit for purpose and how this was validated. I understand that significant progress has been made, with respect to this and that, although work continues, there is now more confidence in these facilities I am therefore concerned that you believe there are ongoing safety issues and would be grateful if you could elaborate on what these are.”</i> Dr Peters states she and Dr Inkster working on a document on past and current safety issues in collaboration with other colleagues.		
9 Nov 2015	Drs Peters and Inkster write letter outlining their safety concerns to Dr Stewart	Bundle 14 vol 1 page 478-481	<i>“Whilst we acknowledge there are issues within the infection control team with respect to functioning, governance, behaviour and cultures the focus of our concerns was and remains patient safety. It is unclear to us how the OD event later</i>

			<i>this month will adequately address these concerns.”</i>
23 Nov 2015	Dr Peters writes to Dr Cruikshank noting she had not been asked to comment on a public statement issued about infection issues and actions taken, and stating she remained concerned about air quality issues	Bundle 14 vol 1 page 482-483	<i>“I did not agree with this statement as I knew there had been issues with air quality in Schiehallion... I was, and remain concerned regarding air quality in the children’s isolation facilities, and although this is not in my current remit, I would be strongly of eh opinion that these needs to be further examined.</i>
22 Dec 2015	Dr Stewart emails Drs Peters, Inkster	Bundle 14 vol 1 page 490-491	<i>I am conscious that we have not yet replied formally to your letter in which you documented your outstanding concerns regarding infection control issues on QEUH campus. I was mindful that events were moving on at some pace and that many of the issues you had raised were being actively looked at. Pertinent to this of course may be the recent involvement of HFS and HPS. Given the work that has been undertaken or is planned, could you please confirm if your concerns have been addressed or what, if anything remains on outstanding issues?</i>
29 Dec 2015	Dr Peters replies to email of 22 December stating her concerns remain and further issues have arisen		<i>The key here is that we are now picking up problems with regard to the building and continue to have question marks over the suitability of the accommodation with regard to specialist areas... This is a highly complex area and input from external</i>

			<i>experts is critical to ensuring the best possible solutions are now put in place. It would be helpful to know how this is being addressed by the Board and precisely what is our remit is in taking this forward.</i>
2016	<i>19 cases of positive blood cultures from 22 gram negative organisms</i>		None of cases escalated to a PAG. Negative water sample taken during year insufficient to exclude contamination.
Feb 2016	<i>Case of Cupriavidus pauculus infection recorded</i>	Scen § 66	5 months taken to investigate
6 May 2016	9 infectious disease consultants write to Dr Inkster with concerns re PVL rooms in ward 5C. Dr Inkster writes an SBAR	Scen §55 Bundle 4 page 49	
Aug 2016	<i>Two cases of Aspergillus and issue found in ventilation system, noted rooms in ward 2A did not have HEPA filtered air supply</i>	Scen §67	All investigations associated with environmental factors
26 Jan 2017	Final defects certificate issued on behalf of NHS	Scen §16	

	GGC for stage 3 Adult and Children's Hospital and Energy Centre		
23 Aug 2017	Dr Peters raises concerns about the signing off of HAI Scribe approval of work to ward 4B: No clarity of CD responsibilities; Basic flaws in planned risk mitigation Board commissioning fails to consider a number of safety critical factors	Bundle 14 vol 1 page 698	<i>"A direct result of this dubiety is the situation we no find ourselves in with regard to 4B works [X] was expected to sign off a complex piece of work..."</i> <i>"My direct experience... in supporting [x] as his line manager and conversations and lack of information from the ICT, as well as my history within the organisation of having raised safety concerns related to infection control, mean that I feel it is my GMC duty to raise my concerns with you as Medical Dire and lead for HAI within GGC."</i>
1 Sep 2017	QEUH ICDs send joint email to IC SMT re concerns re safety		
21 Sep 2017	Dr Peters emails Dr Armstrong: her concerns re clarity of responsibility remain	Bundle 14 Vol 1 page 696	<i>"Had I not intervened despite not being an ICD, the work would have gone ahead that would have put patients at risk by effectively turning off their ventilation. The real issue here is poor process and lack of timely and relevant communication with the IC team. I do not have confidence this root cause has been dealt with."</i>

			<i>It is a stark fact that in the space of 2 years there have been no less than 5 ICDs, all Consultant Microbiologists at QEUE who have resigned/attempted to resign from their positions and have each cited internal issues within the IC team... including culture that lacks transparency and accountability and that they have felt professionally undermined and compromised”.</i>
<i>Oct 2017</i>	<i>Further patient with Aspergillus identified. Risk of airborne infection recognised due to lack of functioning protective isolation, lower number of air changes, dust on chilled air beam units, poor quality air.</i>	Scen §71	Not escalated to an IMT
3 Oct 2017	SBAR raised by Peters, Redding and [REDACTED]: concerns re appropriate placement of patients, cleaning, and estates in 2015; which had still not been resolved in 2017 and infections control management structure	Scen §191-193; Bundle 4 page 104	

4 Oct 2017	Meeting re SBAR chaired by Dr Armstrong and attended by other managers, Drs Peters and Redding	Scen §196-200 Bundle 14 vol 1 page 753	11 senior managers in attendance. Content and tone of meeting is disputed. The meeting resulted in a 27 point action plan . This did not satisfy the whistleblowers
Nov 2017	<i>Report to AICC that ward 2A seeing high number of outbreaks with central line associated blood stream infection: 24 cases of CLABSI with 27 environmental organisms March – Dec 2017</i>	Scen §72	
Jan 2018	<i>Case of cupriavidus infection; outlets in ward 2A positive for cupriavidus</i>	Scen §74	
8 Feb 2018	Dr Redding raised stage 2 whistleblowing complaint	Scen §211-217 Bundle 14 vol 2 page 72	Dr Redding received action plan but repeated the concerns expressed at the 3 October meeting and complained she had not been reassured of progress since then
1 March	Dr Inkster started water incident IMT by email	Scen §75 Bundle 14 vol 2 page 75	Rapid engagement by staff and support from Dr Armstrong; point of use filters fitted to taps and water technical group established

13/20 April 2018	Water Technical Group minutes widespread contamination in water supply ["every floor"]	Scen §78-80	
May 2018	Stage 2 whistleblowing report by L de Caestecker, DPH on concerns raised by Drs Redding supported by Peters.	Bundle 27 vol 4 doc 6 p 81	Dr Redding concerned that the report only dealt with the 5 points of concern raised in the complaint and not other which were matters discussed at the meeting. <i>"[Dr Redding and Peters] stated they felt isolated, with tarnished reputations die to raising the issues. Dr Redding felt there had been a lack of involvement of infection control doctors in the design and building of the QEUH... Both [doctor] felt that the roles in infection Control were not clear, and that infection control should be a doctor led service, and there was poor infection control teamwork and communication."</i> Findings <i>I am reassured... that the concerns raised by [the doctors] are being addressed. The RHGC changes are now complete and the QEUH adaptations and new rooms are on schedule to be in place by end of October 2018.... Despite the legitimate concerns about patient safety raised by [the doctors]</i>

			<i>there were no increased levels of infection and the recent national prevalence survey showed that RHC had lower rates....</i> Report reflects as “<i>an unfortunate but consistent circumstance</i>” managerial criticisms of Dr Peters’ conduct.
5 Jun 2018	Dr Inkster produces full incident management team report covering IMT from 2 March to 13 April 2018 stating source of exposure is contaminated water supply throughout QEUH and RHC from installation leading to think biofilm 8 recommendations	Scen §81-86 Bundle 27 vol 5 page46-55	Report states incident recognised promptly and immediate actions put in place – excellent team working But [Scen §86] incident did not end. 22 cases of various infections reported over subsequent months and clear to many that there was systemic building related issue.
29 Aug 2018	<i>Thick black and yellow grime visible in ward2A drains following cleaning regime implemented 4-6 weeks prior. Multiple organisms found in drains</i>	Scen §89	
5 Sep 2018	<i>3 patient infections since 5 August with organisms isolated from drains</i>	Scen §89	

13 Sep 2018	<i>Up to this date 22 cases of gram neg infections associated with wards 2A/B</i> Dr Inkster stated duty of candour conversations required with some families	Scen §91	
14 Sep 2018	IMT recommended 2 decant of ward; executive group decided not to proceed with decant but ordered exam of drains and definition of works to be carried out during 4 week decant	Scen §93	
17-18 Sep 2018	IMT noted exec had not approved decant. Prof Gibson suggests advice should only be taken from relevant experts in ventilation and drainage. Options paper on decant prepared on 17.9. Eventual decision to	Scen §93-100 Bundle 6 page 38-42	Prof Gibson: <i>“Can you please assure me that any advice taken or given on how to proceed with this worrying situation involves individuals who would be considered expert in the field of ventilation and drainage. We should only be following expert advice.”</i> Nurses contact union for advice re treating patients in unsafe environment

	decant taken on 18/9		
26 Sep 2018	Schiehallion Unit/ward 2A moved to Ward 6A in adult hospital [QEUH]; HSCT patients moved to Ward 4B in adult hospital	Scen §102-104	Decant required considerable planning; ward 6A not regarded as anything other than short term solution
June 2019	Dr Peters notes reports of leaking chilled beams in 6 rooms. Unusual Pseudomonas oleovorans detected in condensate.	Scen 118-120	
August 2019	New patients sent to ECH rather than ward 67A due to fear of infection	Scen 117	
20 August 2019	Dr Inkster removed as chair of IMT as result of decision taken at a meeting on this date, to which she was not invited, and in response to a notice of meeting which did not mention this as a subject	Scen §123-124; 234-	
25 Aug 2019	All QEUH microbiologists including Drs Peters and Inkster write SBAR; sent to Dr Crichton by	Scen 125; Bundle 4 page 165	Expressed concerns re air changes, use of chilled beam technology, HEPA filtration, Weak joins promoting aspergillus, no toilet seat in place risking toilet plume,

	Dr Peters on 29 Sep 2019 demanding an external review		unfiltered water, lack of solid ceilings, no double door, pay area in corridor, non-compliant kitchen sinks “ward 6A should be considered to have significant unacceptable levels of infection risk
13 Sep 2019	Prof Jones and Leanord say ward 6A microbiologically safe	Scen 129	
30 Aug 2019	Prof Gibson and colleagues write to CEO, Jane Grant, and board MD Jennifer Armstrong expressing concerns re infections	Scen 127 Bundle 6 page 1416	“We, the clinicians of the Haematology/Oncology Unit wish to express our concerns about the infection and environmental issues .A recurring theme of recent IMTs has been questioning of the magnitude and clinical significance of recently documented infections. Control measures ... have reduced the number of positive blood cultures but those that remain are rare... highlighting concerns about the safety of the hospital...” requested external review which did not take place
7 Oct 2019	SBAR by Drs Inkster and Peters re differing interpretations of data	Scen §133; Bundle 4 page 180	
10 Oct 2019	SBAR supporting recommendation of IMT of 13 Sep to	Scen 130	Not clear from document who wrote this

	reopen ward to new admissions	Bundle 4 page 193	
November 2019	SBAR recommending reopening ward 6A to new referrals:	Scen §134	“no working hypothesis linking the series of infections... to ward 6A environment” [Note that footnote reference does not appear to be correct]
11 Nov 2019	Ward 6A reopened to new admissions with approval of CNO [and ministers]	Scen §134	
13 Nov 2019	SBAR to Chair	Scen §108 Bundle 4 page 133	Reports to date 23 cases linked to water supply since February 2018 in wards 2A/B

THE QEUEH was opened in 2015 with a number of different functions: a district hospital for south Glasgow, a regional specialist hospital for the West of Scotland, and a Scottish national hub for the treatment and care of specific conditions, including adult and paediatric bone marrow transplant. The plans, developed between 1998 and 2001 were for a 1109 bed acute hospital A&E, acute specialist inpatient services, with a small volume of medical day cases and outpatient clinics for the locality and a 240 bed children’s hospital, also with an A&E department, and a comprehensive range of inpatient and day case specialist services. There would also be a new laboratory building for biochemistry, haematology, blood transfusion and mortuary services.

Leadership and managerial structure and responsibility for infection control at NHS GGC

The NHS GGC Infection Control Manager and Lead infection Control Nurse, a nurse consultant, were responsible for the management of infection prevention and control. The Lead Infection Control Doctor (ICD) reported to the ICM but also had direct access to the Medical Director who was also HAI Lead. The Lead ICD managed the service provided consultant microbiologists who undertook sessional work. These consultants were led in professional terms by the Microbiology Head of Service for microbiology.

QEUH and RHC were both part of the NHS GGC's South Sector for which in 2015 **Dr Peters** was the Infection Control Doctor. The adult haematology and bone marrow transplant services were part of the Regional sector whose ICD in 2015 was **Dr Inkster**.

There were three committees managing infection prevention and control: the Senior Management Team for infection control and prevention, the Acquired Infection Control Committee and the Board Infection Control Committee.

Reporting of infection control concerns

Dr Inkster gave evidence that while reporting and surveillance were generally good, new and different threats could be downplayed and explanations justifying not treating them as infections were preferred.

There was no out of hours infection control doctor or nurse service at NHS GGC. This led to consultant microbiologists who did not undertake infection control work responding to concerns raised by clinicians out of hours.

Normally an infection control concern about a sample would be reported to the lead ICD of the IC team or the sector ICD, often with a copy to the IC nurse. If considered serious the IC Manager and Associate Nurse Director for IC might be copied in. Outbreaks would be escalated to senior management or an SBAR would be created.

APPENDIX 6 - FINDINGS OF OTHER INQUIRIES QUOTED BY CSPL

The following is taken verbatim from selected quotations in the recent report of the Committee on Standards in Public Life of the findings of various inquiries, which seem particularly relevant to the issues raised in the current inquiry in relation to concerns expressed by staff. I have reordered the quotations and offered my own emphasis to particular parts of the quotes.²⁸⁴

INQUIRY	REPORT DATE	THEME	QUOTATION	Reference
<i>Windrush Lessons Learned Review</i>	2020	Failure to learn from past mistakes	<i>“A defensiveness borne of dealing with issues in the past, coupled with an inadequate</i> <i>comprehension of the potential scale and complexity of the problem, led to a lack of curiosity or willingness to learn or reflect.”</i>	Report page 88
<i>Ockenden Review</i>	2022	Failure to learn from past mistakes	<i>“In our interactions with families, we have seen clearly that the Shrewsbury and Telford</i>	Report pages 149, 40

²⁸⁴ *Recognising and responding to early warning signs in public sector bodies - A review by the Committee on Standards in Public Life – March 2025 pages 85 - 92*

			<i>Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time.”</i> <i>“The review team ... found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm.</i>	
<i>Infected Blood Inquiry</i>	2024	Failure to learn from past mistakes	<i>“When it became apparent in the mid 1980s how many people had suffered serious illness as a result of their treatment with blood or blood products by the NHS, there was little apparent effort to establish precisely why that was, and to learn the lessons for the future.”</i>	Report vol 1 page 219

<i>Grenfell Tower Inquiry</i>	2024	Failure to learn from past mistakes	<i>Both the department and BRE [Building Research Establishment] were warned on</i> <i>a number of occasions about the problems that could be caused by the use of combustible materials in the external walls of tall buildings with specific reference to</i> <i>cladding fires that had occurred abroad. Those warnings appear to have generated at</i> <i>best some informal conversations between BRE and the department, but more could</i> <i>and should have been done.”</i> <i>“Although we recognise that the Lakanal House fire had particular features that were not directly relevant to what occurred later at Grenfell Tower, there were lessons that could</i>	Report pages 129, 143

			<i>and should have been learnt from it which might have improved the robustness and</i> <i>clarity of the regulatory regime before the Grenfell refurbishment took place.”</i>	
<i>Windrush Lessons Learned Review</i>	2020	Failure to identify emerging themes that might have alerted the organisation to a developing risk	<i>“When we were looking for information about specific issues, we found it impossible</i> <i>to access all the complaints, correspondence, press queries, Freedom of Information</i> <i>requests and Parliamentary questions which came into the department before Windrush</i> <i>became a departmental label. This information is held on disparate IT systems, and in no</i> <i>standardised format. The systems monitor response times and service standards rather than the</i>	Report page 88

			<i>emerging themes that might help the department more broadly as to the full extent of a risk once it's identified."</i>	
<i>Ockenden Review</i>	2024	Failure to identify emerging themes that might have alerted the organisation to a developing risk	<i>In summary, this was a Trust which had a number of problems, but the perception was</i> <i>that until 2017 the maternity service was not a major risk...</i> The review team believes <i>that the Trust Board and the CCGs [Clinical Commissioning Groups] were 'reassured'</i> <i>rather than 'assured' with regards to governance and safety within the maternity service.</i> <i>Although independent and external reports consistently indicated that the maternity</i> <i>service should improve its governance and investigatory</i>	Report page 13

			<i>procedures, this message was</i> <i>lost in a wider healthcare system which was struggling with other significant concerns.”</i>	
<i>Infected Blood Inquiry</i>	2024	Failure to identify emerging themes that might have alerted the organisation to a developing risk	<i>It was not until May 1983 that there was within the DHSS [Department of Health and Social Security] any real focus on how best to respond to the risks of AIDS from blood or</i> <i>blood products and that was as a response to press reporting.”</i>	Report vol 1 page 21
<i>Grenfell Tower inquiry</i>	2024	Failure to identify emerging themes that might have alerted the organisation to a developing risk	<i>There was no analysis of the lessons to be learnt from significant single incidents, from the identification of patterns across different reporting periods, or from significant fires</i> <i>overseas. The work was being carried out at such a high level</i>	Report vol 1 page 130

			<i>of generality that it would</i> <i>have been difficult for BRE [Building Research Establishment] to identify any patterns</i> <i>indicating that changes to the statutory guidance were necessary to ensure that it</i> <i>remained relevant to the risks posed by the built environment.</i>	

APPENDIX 7 - List of Principles from the report of the Freedom to Speak Up Review

I quote below the Principles and Actions recommended in this report which appear to me most relevant to the issues before this Inquiry:

1. All organisations which provide NHS healthcare⁵ and regulators should implement the Principles and Actions set out in this report in line with the good practice described in this report.
2. The Secretary of State for Health should review at least annually the progress made in the implementation of these Principles and Actions and the performance of the NHS in handling concerns and the treatment of those who raise them, and report to Parliament.
 - a. Action 2.1: Every NHS organisation should have an integrated policy and a common procedure for employees formally to report incidents and raise concerns....
 - b. Action 2.2: NHS England, NHS TDA and Monitor should produce a standard integrated policy...
3. Culture free from bullying: Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
 - a. Action 3.1: Bullying of staff should consistently be considered, and be shown to be, unacceptable. All NHS organisations should be proactive in detecting and changing behaviours which amount, collectively or individually, to bullying or any form of deterrence against reporting incidents and raising concerns; and should have regard to the descriptions of good practice in this report.
 - b. Action 3.2: Regulators should consider evidence on the prevalence of bullying in an organisation as a factor in determining whether it is well-led.
 - c. Action 3.3: Any evidence that bullying has been condoned or covered up should be taken into consideration when assessing whether someone is a fit and proper person to hold a post at director level in an NHS organisation.
4. Culture of visible leadership: All employers of NHS staff should demonstrate, through visible leadership at all levels in the organisation, that they welcome and encourage the raising of concerns by staff.
 - a. Action 4.1: Employers should ensure and be able to demonstrate that staff have open access to senior leaders in order to raise concerns. Informally and formally.
5. Culture of valuing staff: Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from the improvements made in response to the issues identified.
 - a. Action 5.1: Boards should consider and implement ways in which the raising of concerns can be publicly celebrated.
6. Culture of reflective practice: There should be opportunities for all staff to engage in regular reflection of concerns in their work.
- ...
7. Raising and reporting concerns: All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.
 - a. Action 7.1: Staff should be encouraged to raise concerns informally and work together with colleagues to find solutions.

- b. Action 7.2: All NHS organisations should have a clear process for recording all formal reports of incidents and concerns, and for sharing that record with the person who reported the matter, in line with the good practice in this report.
8. Investigations: When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigations to establish the facts.
 - a. Action 8.1: All NHS organisations should devise and implement systems which enable such investigations to be undertaken, where appropriate by external investigators, and have regard to the good practice suggested in this report.
9. Mediation and dispute resolution: Consideration should be given at an early stage to the use of expert interventions to resolve conflicts, rebuild trust or support staff who have raised concerns.
 - a. Action 9.1: All NHS organisations should have access to resources to deploy alternative dispute resolution techniques, including mediation and reconciliation to
 - i. Address unresolved disputes between staff and between staff and management as a result of or associated with a report raising a concern
 - ii. Repair trust and build constructive relationships.
10. Training: Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
- ...
11. Support: All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.
 - a. Action 11.1 [all organisations should have a Freedom to Speak Up Guardian, a nominated non-executive director, an executive director, a manager in each department and an external independent organisation to receive reports of concerns]
 - b. Action 11.2: [all organisation should have access to counselling and other means of addressing stress and reduction of the risk of illness after staff have raised a concern]
12. Support to find alternative employment in the NHS: Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support
- ...
13. Transparency: All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements
14. Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:
 - Poor practice....
 - The victimisation of workers for making public interest disclosures
 - Raising false concerns in bad faith or for personal benefit
 - Acting with disrespect or other unreasonable behaviour when raising or responding to concerns
 - Inappropriate use of confidentiality clauses

- a. Action 14.1: Employers should ensure that staff who are responsible for, participate in, or permit such conduct are liable to appropriate and proportionate disciplinary processes.
 - b. Action 14.2: Trust Boards, CQC, Monitor and the NHS TDA should have regard to any evidence of responsibility for, participation in or permitting such conduct in any assessment of whether a person is a fit and proper person...
 - c. Action 14.3: All [regulatory and oversight] organisations ... should have regard to any evidence of poor conduct in relation to staff who have raised concerns when deciding whether it is appropriate to employ any person to a senior management or leadership position and whether the organisation is well-led.
15. External Review [establishment of a National Freedom to Speak Up Guardian]
- 16....
- 17....
- 18....
- 19....
20. Legal protection should be enhanced...

APPENDIX 8 - WRITTEN STATEMENT TO THE HEALTH AND SPORTS COMMITTEE 13 JUNE 2017

STATEMENT OF SIR ROBERT FRANCIS QC FOR THE HEALTH AND SPORT COMMITTEE OF THE SCOTTISH PARLIAMENT AT THEIR HEARING ON 13 JUNE 2017

I, SIR ROBERT ANTHONY FRANCIS, say as follows:

Personal

1. I am grateful for the invitation by the Committee to attend their hearing and offer this statement as an introduction to my perspective on whistleblowing, or as I prefer to call it, freedom to speak up, in the National Health Service. I make this statement in a personal capacity and nothing in it should be understood to be endorsed by or made on behalf of any organisation with which I am involved, including those to which I expressly refer below.
2. By way of background, I am a barrister in self-employed practice at the Bar of England and Wales. I was called to the Bar in 1973 and took silk in 1992. I have been a Recorder since 2000 and am authorised to sit as a Deputy High Court Judge. I am a governing Bencher of the Honourable Society of the Inner Temple. Between 2003 and 2005 I was chairman of the Professional Negligence Bar Association. For many years I have specialised in medical law, in particular clinical negligence, in which I regularly act for claimants and defendants, professional regulation, in which I have generally assisted registered practitioners, medical ethical decision-making on behalf of those lacking capacity to make their own decisions. I am not a specialist in employment law in general or public interest disclosure in particular but have a general knowledge of the area developed through the work I will describe below.
3. I have appeared professionally for core participants at a number of important public inquiries in England, including the Bristol Royal Infirmary Inquiry [report 2001], the Royal Liverpool Children's Inquiry [report 2001], and the Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale [report 2004]. I have chaired three independent inquiries into the care and treatment of persons who have been convicted of homicide while under the care and treatment of mental health services.
4. Of more central relevance to the Committee's considerations I was appointed by the Rt Hon Andy Burnham, then Secretary of State for Health to chair the Independent Inquiry into the care provided by Mid-Staffordshire NHS Foundation Trust [report February 2010],²⁸⁵ and the Rt Hon Andrew Lansley,

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http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf

his successor, to chair the subsequent Mid-Staffordshire NHS Foundation Trust Public Inquiry [report February 2013]²⁸⁶ and lastly by the Rt Hon Jeremy Hunt, the current Secretary of State to lead the Freedom to Speak Up Review [report March 2015]²⁸⁷.

5. Following on from this work I am now a non-executive director of the Care Quality Commission. I also have the honour of being the President of the Patients Association, Patron of the Florence Nightingale Foundation, and a trustee of the Point of Care Foundation, a charity dedicated to enhancing the capability of healthcare staff to provide high quality care to patients through support such as Schwartz Rounds,²⁸⁸ a Heads Of Patient Experience [HOPE] network and support for experienced based co-design.²⁸⁹ I am an honorary Fellow of the Royal College of Surgeons (England), the Royal College of Anaesthetists and the Royal College of Pathologists.

Perspective derived from the Mid Staffordshire inquiries

6. The story of the appalling experiences suffered by too many patients at Stafford Hospital shocked all who read about it, and the experience of meeting patients and their families as they shared their stories with me has motivated my continued involvement in the healthcare sector ever since. I have often been asked how such a departure from acceptable standards had gone undetected for so long. The answer is that in fact many people were aware of parts of the picture, but in adequate action was taken to address the concerns that many of them raised.²⁹⁰ There was evidence that over a number of years staff had repeatedly reported incidents which they attributed to inadequacies in staffing.²⁹¹ Not only was an impression that feedback – and therefore encouragement to raise concerns – was rare, there was also highly worrying evidence of a culture of fear promoted by some staff resulting in some of those who raised concerns being victimised. The most striking example came from the evidence of Helene Donnelly who reported being pressurised by senior colleagues to falsify discharge times in A&E records in order to given an appearance of compliance with target waiting times. Her evidence of the impact of this on her is worth recalling. She told me the following:

²⁸⁶

<http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report>

²⁸⁷ http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

²⁸⁸ Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. They are increasingly used by NHS providers to assist in the support of the well-being of their staff.

²⁸⁹ Experience-based co-design (EBCD) is an approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together in partnership. The approach is different to other service improvement techniques.

²⁹⁰ For a full chronological account of the warning signs I found, please see chapter 1 of the Public Inquiry report [Volume 1, pp47 et seq].

²⁹¹ See Chapter 2 paras 2.324-332 of the Public Inquiry report [Volume 1, pp222-225].

The culture in the department gradually declined to the point where all of the staff were scared of the Sisters and afraid to speak out against the poor standard of care the patients were receiving in case they incurred the wrath of the Sisters. Nurses were expected to break the rules as a matter of course in order to meet target, a prime example of this being the maximum four-hour wait time target for patients in A&E. Rather than “breach” the target, the length of waiting time would regularly be falsified on notes and computer records. I was guilty of going along with this if the wait time was only being breached by 5 ... or 10 minutes and the patient had been treated ... [but] when wait times were being breached by 20–30 minutes or more and the patient had still not been seen, I was not prepared to go along with what was expected. I was concerned about the terrible effect that our actions were having on patient care. I did raise this with Sisters [X] and [Y], however their response was extremely aggressive basically telling me that they were in charge and accusing me and anyone else who agreed with me of not being team players.²⁹²

The fear factor kept me from speaking out, plus the thought that no one wanted to know anyway, due to the lack of response to the Incident Report forms I had logged. I felt that external bodies would have told me that it was necessary to exhaust all internal mechanisms first before they would fully consider my complaints.²⁹³

When she did report her concerns she was abused and threatened:

... [T]he first sister ... made it very clear that she was very displeased with me and the fact that I’d spoken out ... [T]hreats were made, both directly and indirectly, friends of hers and the other sisters would make threats to me. People were very often coming up to me in – trying I think in a helpful way to tell me to, I quote “watch my back”, ... and people were saying, “Oh, you shouldn’t have done this, you shouldn’t have spoken out.” And then physical threats were made in terms of people saying that I needed to – again, watch myself while I was walking to my car at the end of a shift. People saying that they know where I live, and basically threats to sort of my physical safety were made, to the point where I had to at the end of a shift ... at night would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.²⁹⁴

7. I made recommendations all of which were intended to assist in changing the negative culture which persisted in too many places in the NHS through a combination of emphasis on putting the patient at the centre of healthcare, regulation, leadership development, support for staff and, above all, increased

²⁹² Chapter 1 para 1.197 of the Public Inquiry report [Volume 1, Page 108].

²⁹³ Chapter 2 para 2.374 of the Public Inquiry report [Volume 1, Page 235].

²⁹⁴ Chapter 22 para 22.18 of the Public Inquiry report [Volume 3, Page 1504].

openness, transparency and candour about matters of concern. Among the recommendations I made were those designed to bring about:

- An obligation on staff to report safety concerns and to give including action taken or reasons for not acting [R12][
 - A legal duty of candour to patients [organisations and professionals] [R173-183][
 - Banning of “gagging clauses” in “compromise” agreements [R175][
 - Assessment of nursing applicants for compatible values and compassion [R188, 191]
 - Enhancement of nurse leadership capability at all levels[R195-197][
 - Strengthening of nursing professional voice [R201-206].
8. The great majority of my recommendations were accepted and steps taken to implement them. I draw particular attention to the following developments:
- a. The creation of a legal duty of candour, aligned with obligations under commissioning arrangements. Compliance is overseen by the CQC.
 - b. An enhancement of the requirement that directors of healthcare providers be fit and proper persons and are disqualified from being such if, among other things, they have committed serious mismanagement or misconduct in office.
 - c. An improved system of Inspection and rating of all NHS providers by CQC. A significant amount of information on which assessments are made derives from staff.

The Freedom to Speak Up Review

9. In 2014 Jeremy Hunt asked me to undertake a review of whistleblowing in the NHS, principally as a result of a number of reported experiences of staff who had suffered serious adverse consequences as a result of raising concerns. Although I received some helpful contributions from sources in Scotland, my remit was limited to considering the situation in England. On considering the evidence submitted to me I found that:

- raising concerns could be a “harrowing and isolating process with reprisals”;
- bullying and oppressive behaviour were common;
- there was a lack of support for staff and confidence that there would be any effective action when concerns were raised;
- concerns were often handled poorly;
- people who spoke up too often suffered a devastating impact as a result of doing so;
- employers often felt challenged in how to separate safety concerns from disciplinary issues, culpability and responsibility;
- the area was not helped by an adversarial legalistic culture

The accounts offered by staff and former staff were often of considerable concern. A small selection of quotes from the evidence included in the report make the point”

- *I have often been so depressed by this experience that I have often considered suicide. I live in fear that the hospital will carry out its threat to sue me and take my home from me if I don't pay their costs quickly. I have lost all faith in the NHS and the employment tribunal system (which I believe colludes with these big employers to cover up their abuses of whistleblowers).*
- *...false allegations made under the cover of whistleblowing have left myself and a number of my colleagues deeply traumatised.*
- *Colleagues often quietly agreed with my concerns but refused to speak out in fear of reprisals*
- *(There is) a culture of delay, defend and deny.*

10. I set out 16 Principles which I considered should inform and support a change of culture to make speaking part of the normal business of healthcare rather than a dangerous activity resulting in little action other than detrimental treatment for the member of staff brave enough to raise a concern. In summary they were:

1. Every organisation involved in providing NHS healthcare should actively foster a culture safety and learning in which all staff feel safe to raise concerns.
2. Raising concerns should be part of the normal routine business of any well-led NHS organisation.
3. Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4. All employers of NHS staff should demonstrate through visible leadership at all levels in the organisation that they welcome and encourage the raising of concerns by staff.
5. Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from improvements made in response to the issues identified.
6. There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7. All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.

8. When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigation to establish the facts.
9. Consideration should be given at an early stage to the use of expert interventions to resolve conflicts rebuild trust or support staff who have raised concerns.
10. Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
11. All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.
12. Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13. All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14. Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns. There should be personal and organisational accountability for
 - a. Poor practice in relation to encouraging the raising of concerns and responding to them
 - b. The victimisation of workers for making public interest disclosures
 - c. Raising false concerns in bad faith or for personal benefit
 - d. Acting with disrespect or other unreasonable behaviour when raising or responding to concerns.
 - e. Inappropriate use of confidentiality clauses.
15. There should be an independent National Officer resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:
 - a. Review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice.
 - b. Advise NHS organisations where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect.
 - c. Act as a support for local Freedom to Speak Up Guardians

- d. Provide national leadership on issues relating to raising concerns by NHS workers
 - e. Offer guidance on good practice about handling concerns
 - f. Publish reports on the activities of this office.
 - 16. There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.
 - 17. CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
 - 18. All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
 - 19. All principles in this report should apply with necessary adaptation in primary care.
 - 20. Legal protection for those who make public interest disclosures should be enhanced by extension of the prescribed bodies for this purpose and the extension of protection to student in nursing and medicine.
11. Implementing the recommendations associated with these principles not been as expeditious as some expected, but in my view there has been significant progress:
- a. I believe that every NHS Trust has now appointed a Freedom to Speak Up Guardian. A variety of approaches has been taken to the functions of the post, the experience and background of the persons appointed and the support offered. Time will help in the assessment of which approaches work better than others.
 - b. The post of National Freedom to Speak Up Guardian has been set up and is funded and appointed jointly by CQC, NHS Improvement and NHS England. While the post is hosted by CQC the Guardian works independently. An appointment has been made: Dr Henrietta Hughes. I respectfully suggest that she is asked to offer the Committee a summary of the work she has been undertaking, but it includes a number of events bringing together the local Guardians enabling them to share good practice, challenges, and to set up self-support networks.
 - c. NHS England is working on a support scheme for staff who have lost their jobs as a result of speaking up.
 - d. Many trusts have reviewed their whistleblowing policies to ensure consistency with the Principles.
 - e. The case review function of the National Guardian's Office is being developed and may be expected to commence operation in the near future.

Conclusion

12. I hope this short statement indicates the areas in which I may be of assistance to the Committee and I am naturally content to be asked to expand on any particular point.

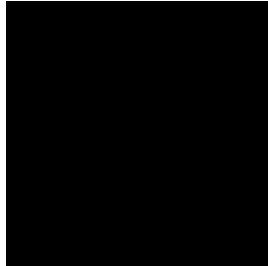
6 June 2017

SIR ROBERT FRANCIS QC

Declaration

I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true.

Signed:



Print Name: SIR ROBERT FRANCIS KC

Date: 14 July 2025

The Vale of Leven Hospital Inquiry Report

The Rt Hon Lord MacLean
Chairman

The Vale of Leven Hospital Inquiry Report

The Rt Hon Lord MacLean
Chairman

Laid before the Scottish Parliament by the Scottish Ministers
under section 26 of the Inquiries Act 2005.

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Chairman's letter to the Cabinet Secretary

The Vale of Leven Hospital Inquiry

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Cabinet Secretary for Health and Wellbeing
St Andrew's House
Regent Road
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November 2014

Dear Cabinet Secretary

On 21 August 2009, I was appointed by the then Cabinet Secretary for Health and Wellbeing to hold a public inquiry into the occurrence of *Clostridium difficile* infection at the Vale of Leven Hospital from 1 January 2007 onwards, in particular between 1 December 2007 and 1 June 2008, and to investigate the deaths associated with that infection.

The Terms of Reference were very wide-ranging and I have addressed these, I hope, comprehensively, as can be seen from the Report which I now present to you.

Yours sincerely,

RNM MacLean

Rt Hon Lord MacLean
Chairman

Foreword

The evidence adduced by the Inquiry was concluded on 28 June 2012. In July 2012 I entered hospital for what was then regarded as a fairly routine operation. The operation itself was concluded successfully but shortly thereafter my condition began to deteriorate as a result of an infection of unknown aetiology which necessitated a prolonged period of intensive care and hospitalisation for a total of five months. I may say that the irony of this was not lost on me during the time I remained in hospital. The experience did, however, enable me better to understand the plight of those who suffered from *C. difficile* infection and in some cases died from it, in the Vale of Leven Hospital.

I narrate all this, not in anyway to evoke sympathy for myself but in order to pay tribute to the Inquiry team who responded so superbly to the crisis they then had to face, namely carrying on the work of the Inquiry effectively without its Chairman. A central core of the staff, made up of the Secretary, leading Counsel to the Inquiry, and its Principal Solicitor, visited me regularly in hospital, consulted me there, and received instructions from me. After my discharge from hospital the same work was carried on during my convalescence at home. In order to ensure that Mr Neil, the Cabinet Secretary who succeeded Ms Sturgeon, was aware of the predicament I was in, I wrote a personal letter to him on 17 January 2013. He replied to this letter on 21 March 2013 and from the terms of that letter I believe he ultimately came to understand the problems I had had.

On 29 July 2009 I met the then Cabinet Secretary for Health and Wellbeing, Ms Nicola Sturgeon, in Glasgow. She thanked me for taking over from Lord Coulsfield. We discussed the terms of the remit. She was very keen on a time limit because, as she said, she wanted a short and sharp inquiry. She expected a report and recommendations on her desk by October 2010. In light of my previous experience as Chairman of two other Inquiries and membership of another (none of which had any time restriction) I demurred to such a time limit and explained that I did not consider it possible to fulfil the terms of such a wide remit within that time scale. I preferred a time limit of “as soon as possible”. The Cabinet Secretary, however, insisted, with the qualification that the Inquiry could always apply for an extension. I am clear that this was a mistake, for the reasons that are given more fully in the Report itself and summarised in the Introduction.

The result was that, as each so-called deadline approached and was not fulfilled, there was a familiar chorus of criticism from certain quarters. Significantly, none of it came from any representatives of Core Participants. Nevertheless, the Inquiry team had to face this criticism and respond to it as best they could, when, in my opinion, they were absolutely blameless.

If anything, the whole experience shows the futility of imposing time constraints on an Inquiry like this, simply because one cannot at the outset know what lies ahead of an Inquiry's investigation. My illness was just one aspect of this. Indeed, I doubt whether, unless in wholly exceptional circumstances, an Inquiry set up under the Inquiries Act should be limited in point of time.

I should add that, in my not inconsiderable experience, it is very rare to have such a cohesive and united unit as the entire Inquiry team. That is probably due to the quite exceptional skills of leadership demonstrated by the Secretary, Julie-Anne Jamieson who kept the show on the road, as it were, and maintained in the face of considerable difficulties, the high level of morale which has persisted to the end. She was exceptional.

I take this opportunity to express my gratitude to my single-minded and devoted Inquiry team. I am grateful to all those in the team who so faithfully assisted me.

A handwritten signature in black ink that reads "R. N. M. MacLean". The signature is written in a cursive, slightly informal style. Below the signature, there are three small dots arranged horizontally.

Lord MacLean
November 2014

How to read the Report

Availability of the Report

The Inquiry Report is published by the Inquiry in a printed version and on the Inquiry website <http://www.valeoflevenhospitalinquiry.org>

The printed version

The printed version of the Report consists of two parts; the Executive Summary and the main body of the Report. The Executive Summary includes the Inquiry's key findings and recommendations.

The website version

Both parts of the Report are available electronically, in pdf and html versions, on the Inquiry website.

Structure of the Report

The Report comprises 18 Chapters that deal with topics identified in the title to each individual Chapter and an additional Chapter, Chapter 19, containing a brief conclusion and the recommendations. Many of the topics are interrelated and have been discussed in separate chapters for ease of presentation. An attempt has been made to keep repetition to a minimum but inevitably some evidence is referred to in more than one Chapter.

The Report has been written with the intention that the Chapters be read sequentially. It has not been entirely practicable to narrate events in chronological order but to the extent possible the Report follows a natural sequence. Chapter 3, for example, provides information on *Clostridium difficile* required for a proper understanding of what follows, and subsequent chapters set out much of the historical background to events at the Vale of Leven Hospital.

The Inquiry is nevertheless conscious that some readers may wish to refer only to particular Chapters. Care has therefore been taken to make individual Chapters as accessible as possible, for example by explaining the role of each person mentioned in the Chapter, and by cross referring to matters covered in other Chapters.

Readers may also find it helpful to refer to the timeline in Appendix 9 as part of the background to the establishment of the Inquiry.

Chapters 3 to 18 contain the Inquiry's conclusions on the material considered in each Chapter. In shorter Chapters these conclusions are at the end, but in longer Chapters they are to be found at the end of each Section.

Recommendations by the Inquiry are found at the conclusion of the Chapter from which they are derived. A full list of recommendations is also to be found at Chapter 19.

References

Each document on the Inquiry database is identified by a three-letter prefix and an eight digit number. The prefix indicates the origin or the nature of the document, for example, GGC for items provided by Greater Glasgow Health Board, and WTS for witness statements. The first four digits form the document reference number, and the last four digits indicate the page number within the document.

Many footnotes in the pdf and html versions of the Report are hyperlinked to the document itself. In a number of instances there is no hyperlink. This is because the document is of a sensitive or confidential nature and has not been made publicly available. An example of this would be a patient's medical records.

Some documents have parts which have been redacted by the Inquiry. Again, this will be due to the sensitive or confidential nature that part of the document.

Use of Tables

Tables are used in some Chapters to present information. On occasion, information contained in a Table has been highlighted as being of particular importance to the issue being discussed.

“Focus period” and “early period”

The Inquiry’s remit extended from 1 January 2007, but with a particular emphasis on 1 December 2007 to 1st June 2008. This later period is referred to in the Report as the “focus period”. Because patient records for that period were available the Inquiry was able to carry out a more detailed examination of patient treatment during that period, instructing expert reports in respect of each patient. Many patient records for the “early period” were no longer available, so that only a more limited examination of patient treatment could be carried out.

A list of those patients for whom individual expert reports were commissioned is at Appendix 1.

Names and designations

Each person mentioned in the Report is identified by his or her full name and given a designation, which may be as a patient or relative, or by reference to job title or profession. Witnesses who gave oral or written evidence to the Inquiry are in addition listed in Appendix 5, while experts instructed by the Inquiry are listed in Appendix 4.

Patients who did not make contact with the Inquiry or who wished to remain anonymous have been allocated a number (patients in the early period) or a letter (patients in the focus period).

Reference to “the Board”

The term “Board” can have different meanings. Firstly, each of the corporate bodies charged with delivery of NHS care in Scotland is called a Board, or Health Board. Secondly, each of these corporate bodies is itself governed by a Board, consisting of senior members of staff and other non-executive Directors.

The Inquiry has sought throughout the Report to make clear in which sense the term is used in its particular context, but readers should be alert to the distinction. Ultimately, of course, the Board in the sense of the governing body is responsible for the actions of the corporate body as a whole.

Scottish Ministers

“Scottish Government” is the executive branch of government in Scotland, responsible for the central administration of devolved matters such as health. The term has been used since 2007, and was formally adopted in 2012. It replaces the term “Scottish Executive”, which was in use immediately following the establishment of the Scottish Parliament. Before devolution the executive branch of government was known as the “Scottish Office”. All three terms are used in the Report, according to the timing of events, but have essentially the same meaning.

The term “Scottish Ministers” refers collectively to those holding ministerial office in Scotland. Ministers are ultimately responsible for the actions of the administration. Use of this term in the Report is intended to reflect that responsibility.

Other investigations

Chapter 17 of the Report examines the investigations undertaken by NHS Greater Glasgow and Clyde after the Vale of Leven Hospital *C. difficile* infection problem became apparent in June 2008. These were the Independent Investigation and the Outbreak Control Team reports. In addition, an Independent Review of cases of *C. difficile* infection was carried out by Professor Cairns Smith following upon an announcement of an Independent Review by the Cabinet Secretary on 18 June 2008. The reports of these investigations are referred to in several chapters of the Report although the reports of the NHSGGC investigations are not examined until Chapter 17.

Chapter 1

Introduction

Summary

Serious failures

Between 1 January 2007 and 1 June 2008, 131 patients who were or had been patients in the Vale of Leven Hospital (VOLH) tested positive for *Clostridium difficile* Infection (CDI). Of that number, 63 patients tested positive in the period from 1 December 2007 to 1 June 2008. During that particular period 28 of those 63 patients died with CDI as a causal factor in their deaths, either as the underlying cause of death or as a contributory cause of death. Another three patients who died in the course of June 2008 also had CDI as a causal factor in their deaths. In the period 1 January 2007 to 31 December 2008 the total number of deaths identified by the Inquiry in which CDI was a causal factor was 34. These figures are particularly damning when considered in the context of the VOLH, a hospital with around 136 beds in 2008.

CDI can be a devastating illness, particularly in the frail and elderly. It can lead to malnutrition and dehydration unless carefully managed. The frequency of diarrhoea, the impact upon patient dignity, and the challenges presented to staff are some of the factors that highlight the absolute necessity of treating CDI as a serious illness. Sadly, for reasons I set out in detail in this Report, there were deficiencies in medical and nursing care at the VOLH that seriously compromised the care of this group of patients. Furthermore, the infection prevention and control practices and systems were seriously deficient.

Governance and management failures resulted in an environment where patient care was compromised and where infection prevention and control was inadequate. The important principle of Board to ward and ward to Board means that there must be an effective line of reporting, accountability, and assurance. This was lacking for the VOLH. There were failures by individuals but the overall responsibility has to rest ultimately with NHS Greater Glasgow and Clyde (NHSGGC).

It is highly likely that there were a number of undeclared outbreaks of CDI transmission in the VOLH between 1 January 2007 and

1 June 2008. Many patients were exposed unnecessarily to CDI and had to suffer the humiliation and distress often associated with the infection.

Scottish Ministers have a duty to promote the improvement of the physical and mental health of the people of Scotland. The Scottish Government is the executive branch of government in Scotland. The duty to promote the health of the people of Scotland is discharged through Health Boards, particularly within the context of healthcare acquired infections such as CDI. There was a failure to have in place an inspection regime that could provide the necessary assurance that infection prevention and control was being properly managed and important policies and guidance implemented.

Inadequate attention was given by the Scottish Government and NHSGGC to the reports about other outbreaks in the United Kingdom. These identified failures similar to many of the failures at the VOLH discovered in the course of the Inquiry. Repeated warnings over a number of years about the importance of prudent antibiotic prescribing had no apparent impact. The Scottish Government failed to monitor the implementation of the prudent prescribing message and to remedy the failure by NHSGGC to implement that message.

Prolonged uncertainty over the future of the VOLH had damaging effects on recruitment, staff morale, and the physical environment of the VOLH. The hospital environment was not conducive to good patient care. It is hardly credible that in 2007 and 2008 a care environment existed in which gaps in floor joints were covered in adhesive tape. There was a lack of wash-hand basins in wards and toilets, and commodes were not fit for purpose.

A lack of strong management as well as personal and system failures contributed to the development of a culture in the VOLH that had lost sight of what is of the very essence of a hospital – a caring and compassionate environment dedicated to the provision of the highest possible level of care.

Background to the Inquiry

Creation of the Inquiry

On 22 April 2009 the then Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, announced to the Scottish Parliament that a Public Inquiry would be held into the “outbreak” of *Clostridium difficile* at the VOLH. She explained that this would commence at the conclusion of ongoing investigations by the police and the Health and Safety Executive, and of any prosecutions resulting from those investigations. At the same time the Cabinet Secretary announced that the Rt Hon Lord Coulsfield had agreed to chair the Inquiry.

The C.diff Justice Group, which represents a number of surviving and deceased patients, was influential in the establishment of the Inquiry. In January 2009 the Group lodged a petition with the Scottish Parliament Public Petitions Committee calling for a public inquiry to ensure that lessons were learned across the NHS and that further deaths from *C. difficile* were minimised. The petition was considered by the Petitions Committee on 27 January 2009 and formally closed on 1 November 2011.

The Group’s determination to have a public inquiry has been fully vindicated by the Inquiry’s findings of significant failures from which important lessons must be learned.

In June 2009 the Lord Advocate intimated that there would be no criminal proceedings and steps were then taken to establish an Inquiry Team and define its Terms of Reference. The statements obtained by the police were passed on to the Inquiry Team.

Lord Coulsfield subsequently withdrew from the Inquiry for health reasons, and my appointment was announced in his place on 21 August 2009.

The Inquiry was formally set up on 1 October 2009. The procedure of the Inquiry was subject to the Inquiries Act 2005 (the 2005 Act) and the Inquiries (Scotland) Rules 2007 (the 2007 Rules).

No other person was appointed to sit with me. The important task of fulfilling the

Terms of Reference has therefore been my sole responsibility. In carrying out that responsibility I have been greatly assisted by my Assessors and the members of the Inquiry Team.

Appointment of Assessors

To assist me in my task I appointed two Assessors, under a power granted to me under section 11 of the 2005 Act. A summary of their qualifications and experience is set out in Appendix 2. The purpose behind their appointment was that of providing me with advice on matters within their own areas of professional expertise, which included nursing and medical expertise and also expertise in infection prevention and control.

The Assessors were appointed on 14 October 2009. They participated in the preparations for the oral hearings and attended the oral hearings, and I was able to rely on their advice in the course of the drafting of the Report. Their joint contribution to the Inquiry process proved invaluable, as nursing and medical matters and issues of infection prevention and control became central to the work of the Inquiry. I am extremely grateful to them for that contribution and for the commitment they continued to make to an Inquiry process that took longer than anticipated.

Meeting with NHS Greater Glasgow and Clyde Board members

Lord Coulsfield and the Secretary to the Inquiry met with NHSGGC Board members on 11 June 2009. That was an informal meeting and was not part of the evidence gathering process. It was agreed at that meeting that there could be a single point of contact within the Board for the Inquiry. I, however, did not consider it necessary to have a further meeting with Board members.

Meeting with patients/relatives

Lord Coulsfield met patients and relatives on 12 June 2009, and following my own appointment as Chairman I decided that it would also be appropriate for me to have a similar meeting. That meeting took place on 25 September 2009, and was attended by one former patient and 17 relatives of

patients. I found the meeting to be highly productive, and I gained the clear impression that the patient and relative group as a whole was anxious to be as helpful as possible to the Inquiry. Quite understandably they wanted to find out why CDI became such a problem in the VOLH.

The scope of the Inquiry

Terms of Reference

The Terms of Reference agreed with the Cabinet Secretary were in the following terms:

- a) To investigate the circumstances contributing to the occurrence and rates of *C. difficile* infection at the Vale of Leven Hospital from 1 January 2007 onwards, and any increases in such rates during that period and in particular between 1 December 2007 and 1 June 2008, with particular reference to the circumstances which gave rise to deaths associated with that infection.
- b) To investigate the management and clinical response at the Vale of Leven Hospital to the *C. difficile* infection rates during that period and to any such increases, and the steps taken to prevent or reduce the risk of spread or recurrence of the infection.
- c) To investigate the systems in place at the Vale of Leven Hospital to identify and notify cases, increased rates of infection outbreaks and deaths associated with *C. difficile* infection, including the action taken to inform patients, their relatives and the public and the steps taken at the Vale of Leven and in NHSScotland generally for recording such incidents including for the purposes of death certification.
- d) To investigate the actions of NHS Greater Glasgow and Clyde in response to the occurrence of *C. difficile* infection at the Vale of Leven Hospital, including informing patients and their relatives of the risks of such infection and the measures that should be taken to assist prevention and control.

- e) To investigate the governance arrangements of NHS Greater Glasgow and Clyde in relation to, and the priority given to, the prevention and control of the infection.
- f) With reference to experience within and beyond Scotland of *C. difficile*, to establish what lessons should be learnt and to make recommendations.
- g) To report by 30 September 2010 unless otherwise provided by the Cabinet Secretary for Health and Wellbeing.

The Cabinet Secretary granted several extensions to the reporting date in accordance with paragraph (g) of the remit.

The breadth of the Terms of Reference

What is significant about the Terms of Reference is their breadth. I have already made the point in the Foreword that I did not consider it possible to report by a specified date, initially 30 September 2010. The Cabinet Secretary's response was the addition of the provision in paragraph (g) for extending the time limit. That did not allay my concerns. While it is readily understandable that the responsible Minister should wish an inquiry to report at the earliest reasonable opportunity, until the work of an inquiry is well under way any prediction about a time limit cannot be accurate and may be totally unrealistic. The Inquiry Team must conduct an initial investigation. Only once that initial stage is substantially complete will it become apparent what further investigation is necessary. A further factor that could not have been foreseen at the outset was that of the problems encountered in the recovery of documents, discussed later in the Report. These problems became a running sore that bedevilled the work of the Inquiry even into 2012.

For reasons set out in this Report, including the nature and extent of the Terms of Reference and the size of the task that emerged, the successive deadlines were impossible to meet. When that was apparent to me, I notified the Cabinet Secretary at the

earliest opportunity. As it turned out, because of the amount of work involved in the initial investigation, the first phase of oral hearings did not take place until June 2010, just four months before the original latest reporting date of September 2010.

The first application for an extension of time was in fact made on 10 December 2009, and following that the reporting date was extended to 31 May 2011. Subsequent extensions were necessary to allow the Inquiry to carry out as thorough an investigation as possible into the terms of the remit. The final phase of oral hearings was not completed until June 2012.

The lesson to be learned from this experience is that, except in circumstances where the issue is clear and the remit is a relatively narrow one, specific deadlines should not be imposed on public inquiries of this kind. A formula “as soon as possible” or even “as soon as practicable” should be seen as a much better option. No inquiry Chairman would fail to respond to that form of remit in a timeous manner. Unrealistic deadlines of the kind contained in the Terms of Reference create unrealistic expectations in the minds of those waiting for the Report to be published. They also create undue and unfair pressure on the Inquiry Team.

The broad nature of the remit as set out in paragraphs (a) to (g) of the Terms of Reference reflects the Cabinet Secretary’s intention, when the setting up of the Inquiry was announced in the Scottish Parliament on 22 April 2009, that relevant lessons “must be learned by everyone in the NHS”.

Interpretation of the Terms of Reference by NHS Greater Glasgow and Clyde

On 11 May 2011 the NHS Central Legal Office (CLO), acting on behalf of NHSGGC, delivered a Note to the Inquiry intimating an objection to evidence being led on aspects of the quality of nursing care provided to patients covered by the remit. That Note was revised on 12 May 2011. The principal thrust of the objection was in the following terms:

“On the ground of fairness specified in s.17 of the Inquiries Act 2005 (“the 2005 Act”), and also in reference to the need (s.17(3) of the 2005 Act) to avoid any unnecessary cost (whether to public funds or to witnesses or others), GGHB respectfully submits that no evidence should be allowed or taken into account concerning various aspects of the quality of nursing care (“the aspects objected to”) at the Vale of Leven Hospital in the period to date, namely hydration of patients; preparation of fluid balance charts and completion of these; nutrition of patients; completion of nutrition assessments and food charts, and the need to involve a dietician; weighing of patients; guarding against and dealing with skin and pressure damage, and taking tissue viability precautions; carrying out manual handling risk assessments; carrying out falls risk assessments; avoiding patients being injured through falling; providing proper pain relief; completion of care plans (except for care plans relevant to the contraction of *Clostridium difficile* illness or the mortality rate there from); assessing the mental state of patients and meeting their mental health needs; the quality of the personal care given to patients; Do Not Attempt Resuscitation (“DNAR”) decisions; and providing end of life care pathways”.¹

Ruling on NHS Greater Glasgow and Clyde’s objection

With little hesitation I repelled the objection taken on behalf of NHSGGC. The solicitor to NHSGGC was advised of my ruling and my reasons by letter dated 12 May 2011.² I concluded that the issues of concern raised in the nursing expert reports were in areas of nursing care which might be directly relevant to the circumstances contributing to the occurrence and rates of CDI at the VOLH. It has to be emphasised that good nursing care lies at the very heart of the appropriate management of patients who contract CDI. That care does not just begin when the diagnosis of CDI has been confirmed. Patient care has to be seen as a dynamic

¹ [INQ05480002-03](#)

² [INQ05610001](#)

process that involves regular assessment and reassessment. A patient who develops CDI may require to be managed not just for the direct effects of the infection itself, for example by the administration of antibiotics, but also for other aspects of care on which CDI might have an impact, such as hydration, nutrition, pressure management, and the risk of falls and impaired mobility due to the debilitating nature of the condition. While Do Not Attempt Resuscitation (DNAR) decisions may be only indirectly linked, these decisions can be relevant to the care of patients suffering from CDI.

Renewal of the objection

At the oral hearing on 23 August 2011 Counsel for NHSGGC renewed the objection to the leading of evidence on certain aspects of care.³ By this time almost all the evidence of the nursing experts had been led. At this point the challenge was more restricted in nature, with the focus now only on some aspects of care. For example, it was not now being suggested that the nursing management of hydration and nutrition was not relevant to the issues that I required to examine.⁴

Having heard the argument on this renewed objection I again refused to sustain it. It was in principle the objection that had been taken earlier and repelled, and no good reason was advanced for its renewal after almost all the nursing evidence had been led. It had been clear in advance from the nursing expert reports what evidence was going to be led. As I have already explained, there are aspects of nursing care that cannot be divorced from consideration of how a patient suffering from CDI is being managed. Hydration and nutrition are clear examples, and no doubt that is why NHSGGC did not renew its objection to those aspects of care at the oral hearing. Counsel for NHSGGC argued that the Inquiry should focus only on the care planning relevant to the contraction or persistence of CDI,⁵ but the fallacy underlying that argument is the assumption that the care planning for a patient who is suffering from CDI can be properly managed without regard to all that patient's problems.

Furthermore, I was satisfied that the issue of whether any aspects of patient management were outwith the Terms of Reference was a matter that could be determined at the end of the evidence without causing any material delay to the progress of the Inquiry. In addition, most of the nursing expert evidence having been led, I was of the view that, in fairness to nurses whose standard of care had been criticised, they should be given the opportunity to respond to that criticism.

The focus and early period division

The Terms of Reference stipulate in paragraph (a) that the starting date for my investigation of the circumstances contributing to the occurrence and rates of CDI is 1 January 2007. There is no specified end date, but that same paragraph does provide that particular attention is to be directed to the period from 1 December 2007 to 1 June 2008. This period had been looked at by other Inquiries. In this Report I have labelled the period from 1 January 2007 to 30 November 2007 the “early period”, and the period from 1 December 2007 to 1 June 2008 the “focus period”.

Clostridium difficile infection

Clostridium difficile

Clostridium difficile (*C. difficile*) is a bacterium that can cause infection in the colon. Up to 4% of healthy adults carry *C. difficile* in the colon.⁶ That percentage may increase to 50% in hospital, particularly in the elderly and newborn infants. These patients may not have the infection, but clearly the risk of the infection developing increases significantly in a hospital environment. There are numerous different strains of *C. difficile*, and some strains are said to be more virulent than others. These strains are normally referred to as “hypervirulent” strains because they produce high levels of toxins. It has to be stressed, however, that any strain of *C. difficile* has the potential to cause severe infection.

To acquire the organism, spores must enter the mouth and be swallowed. Many people are exposed to spores, but *C. difficile* generally does not colonise in healthy people and

³ [TRA00290073-109](#)

⁴ [TRA00290100](#)

⁵ [TRA00290081](#)

⁶ [TRA00090019](#)

cause infection. This is because the normal healthy bacteria in the colon protect against the development of the infection. It is when these protective mechanisms are disrupted that *C. difficile* can colonise in the colon and result in infection. This disruption is usually caused by the administration of antibiotics in the treatment of another infection, for example, a urinary tract infection. This is particularly so when patients are treated with broad spectrum antibiotics, because these antibiotics eradicate many normal bacteria in the colon, making the colon more susceptible to the development of CDI. This is why prudent antibiotic prescribing is so important in patient management. An infected patient will normally develop diarrhoea, and in a hospital there is the risk of the environment being contaminated, with other patients being put at risk. Good hand hygiene is important as a preventative measure.

From an infection prevention and control perspective, the isolation of a symptomatic patient from other patients is important. Unfortunately, as set out in the Report, the general practice in the VOLH was not to isolate patients until the infection was actually diagnosed by means of a positive laboratory result. This practice meant that other patients continued to be placed at risk of cross infection.

CDI symptoms

There are a variety of symptoms associated with CDI. I have already mentioned diarrhoea, which when caused by CDI is often described as “explosive”. Symptoms can also include abdominal pain, fever and nausea. In some cases the colon can become severely inflamed, a condition known as pseudomembranous colitis. This can become acute, resulting in toxic megacolon - acute distension of the colon. CDI must therefore be regarded as a serious illness that can be life-threatening, and I have already set out the number of patients covered by my remit who died with CDI involved in the death. The elderly are particularly vulnerable. Professor George Griffin, Professor of Infectious Diseases Medicine at St George’s University, London, whose evidence is considered later, provided the following graphic description of the impact of CDI:

“*C. difficile* is very unpleasant for patients. It is exceedingly unpleasant and distressing for relatives to see an old, loved patient in a bed in a pool of faeces. It is very difficult for nursing staff to have to clean a patient nine, ten times a day who is demented, immobile, (and) can’t help the nurse with moving”.⁷

For a patient to contract CDI in a hospital setting, a setting where the patient expects to be protected and safe, is especially tragic. CDI can deny an elderly patient a peaceful and uncomplicated death, and that is one particular reason, among others, why what was allowed to happen in the VOLH should never be allowed to happen again.

The Vale of Leven Hospital

Changes in hospital management

The Vale of Leven District General Hospital (this is its full title) is one of the smaller hospitals in the National Health Service in Scotland. It is located in the town of Alexandria, West Dunbartonshire. In 2002 the VOLH delivered a broad range of acute hospital services, and the bed complement was in the region of 234, but by 2008 this had been reduced to around 136.

Prior to 1 April 2006 the VOLH was managed by NHS Argyll and Clyde. By 2005 NHS Argyll and Clyde had incurred a cumulative budget deficit of £82 million, and on 19 May 2005 the then Minister for Health and Community Care announced in a statement to the Scottish Parliament that NHS Argyll and Clyde was to be dissolved. The administrative boundaries of Greater Glasgow Health Board (GGHB), also then known as NHS Greater Glasgow, and of NHS Highland were to be changed to allow them to take over responsibility for managing the delivery of the health services in Argyll and Clyde.

Following upon an integration process NHS Argyll and Clyde was dissolved on 1 April 2006. From that date a number of hospitals, including the VOLH, became the full responsibility of GGHB, which became known as NHS Greater Glasgow and Clyde (NHSGGC).

7 [TRA00730030-31](#)

Full integration of services did not, however, take place immediately, and a Clyde Acute Directorate was created to manage services in the former Argyll and Clyde hospitals now managed by NHSGGC, including the VOLH. Mrs Deborah den Herder was appointed as the Director of the Clyde Acute Directorate, although she did not take up her post formally until 1 October 2006.

Reduction in services

In the years up to 2007 and 2008 a significant reduction in the services provided at the VOLH had taken place. These are set out in Chapter 8. By then the future of the hospital had been uncertain over a prolonged period of time. This uncertainty had a damaging impact on recruitment and morale as well as on the hospital's physical environment. It also compromised patient care.

CDI at the VOLH

Discovery and extent of the problem

The problem with CDI in the VOLH was not apparent until May 2008. Those who worked in the VOLH did not appear to identify CDI as a particular problem over the period from 1 January 2007 to May 2008, even although a significant number of patients suffered from the illness during that period. As set out in the Report, the discovery of the extent of the problem was partly due to a press enquiry by a local newspaper requesting information on the number of cases of CDI at the VOLH in the six months prior to June 2008. Dr Brian Cowan, Medical Director and Acute Services Division Medical Director of Greater Glasgow and Clyde described his understanding of the position in the following way:

“Here was an outbreak which raged, or a series of outbreaks that raged, for a long period of time with a significant, highly significant, number of deaths”.⁸

In the period from 1 January 2007 to June 2008 there were 199 positive test results for *C. difficile* toxin from 131 patients in the VOLH, and in different wards at different times throughout that period there were patients suffering from CDI who were linked in time and place. Outbreak Policies in force

during that period⁹ made it clear that an outbreak consisted of two or more linked cases of the same illness, yet no outbreak was declared. The reasons for the failure to identify a problem include the dysfunctional nature of the Infection Control Team, the inadequacy of reporting systems and the failure of committee structures. Nevertheless, it is surprising that such a problem could effectively remain undiscovered for so long even in the face of such failures.

Levels of infection and fatality rates

As I set out at the beginning of this summary, in the period from 1 January 2007 to 1 June 2008 131 patients who were or had been in the VOLH tested positive for CDI. Although the focus of the Inquiry has been on the period up to 1 June 2008, patients continued to suffer from CDI until the end of 2008, but the rate was lower. The total number of patients covered by the Inquiry's remit who contracted CDI between 1 January 2007 and 31 December 2008 was 143.

I did not engage in a comparative exercise of CDI rates in Scottish hospitals, for such an exercise was outwith my remit. It is perfectly clear, however, that for a hospital the size of the VOLH the number of patients infected reveals that CDI had become a serious problem in the VOLH, even although that problem was not identified. The problem was compounded by the number of patients who died with CDI as the underlying cause or a contributory factor. In the six-month period from 1 December 2007 to 1 June 2008, CDI played a role in the deaths of 28 patients.

Death certification

Accuracy

Accuracy in death certification is important because it provides an understanding of the health needs of the population. There is also a personal need for family members to know why a relative has died. Of the 28 patients who died between 1 December 2007 and 1 June 2008 with CDI as the underlying cause or contributory factor, CDI was not mentioned in the death certificates of seven of these patients.

⁸ [TRA01230015](#)

⁹ [GGC00780145](#); [GGC27390001](#)

Death certification involves the exercise of professional judgement. Yet although in 2007 and 2008 the available guidance provided that it was “best if a consultant, general practitioner or other experienced clinician certifies the death”,¹⁰ it seems that in practice in Scotland consultants were rarely involved in death certification at that time.¹¹ Certainly in the cases examined from the VOLH the majority of the death certificates were signed by junior doctors without any recorded consultation with more senior medical staff.

New guidance

New guidance was issued on death certification after the emergence of the CDI problem at the VOLH. The most up-to-date guidance provides that death certificates for patients who have died in hospital should only be completed after discussion with a consultant. Ideally this should be the patient's named consultant.¹² Boards also have to ensure that there are systems in place to identify *C. difficile* associated deaths.¹³

Scotland should not have developed the practice of consultants generally not being involved in the death certification of their patients. Consultants are best placed to accurately assess why a patient has died. I certainly endorse the mandatory duty now imposed to involve consultants. Furthermore, if a patient dies with CDI either as a cause of death or as a contributing condition, relatives should be provided with a clear explanation about the role played by CDI in the patient's death.

Patient records

Examination of patient records by experts

In the interpretation of my remit I took the decision that the patient records of the patients who suffered CDI in the focus period should be subjected to careful scrutiny. This scrutiny had not been carried out during other investigations into the VOLH CDI problem. From that exercise it became apparent to me, with the assistance

of members of the Inquiry Team and my Assessors, that certain recurrent themes emerged. In order to explore those issues more fully, experts were commissioned in a number of disciplines so that the Terms of Reference could be properly complied with. The timescales involved in that process are set out in Chapter 2. I have already set out my reasoning for the division of cases into the early period and the focus period. Accordingly, expert reports were instructed on 1. medical care; 2. nursing care; 3. the prescription of antibiotics; 4. infection prevention and control; and 5. death certification for all patients who fell within the focus period. Patients for whom expert reports were obtained are listed in Appendix 1. Those patients and relatives who were core participants had an opportunity through their legal representatives to see these detailed reports.

A more restricted approach was taken in the early cases, but I still considered it necessary that, insofar as patient records were available, a nursing expert should examine these records to see whether trends apparent in the course of the focus period also existed in that early period.

Detailed examination of patient records, expert reports and all other evidence relevant to each patient's care was undertaken during the Inquiry's work in preparation of this Report. This approach reflected the approach taken during the oral hearings which involved detailed examination of patient care.

The results of that whole exercise are discussed in the Report. Suffice to say at this point that the unacceptable levels of care discovered were not the levels of care which I would have expected to find in any hospital in Scotland. That is why I have made firm recommendations in the Report which should be seen as fundamental to patient care. Ultimate responsibility for patient care in Scotland rests with the Scottish Ministers. To discharge that duty the necessary inspection and implementation systems must be capable of providing real assurance that patient care in Scotland is not at any risk of being compromised.

10 [INQ00790002](#)

11 [TRA01070009-10](#)

12 [INQ02980003](#)

13 [INQ02980005](#)

NHS Greater Glasgow and Clyde's position on the examination of patient records

In the course of submissions made on behalf of NHSGGC at the oral hearing on 13 June 2011 in connection with the legal representation of nurses, an issue addressed in Chapter 2, Counsel for NHSGGC made the following statement in connection with the reports of the nursing experts:

"The content of the reports came as somewhat of a surprise to Greater Glasgow Health Board".¹⁴

As discussed in Chapter 17, the remit of the Internal Investigation set up by NHSGGC in June 2008 did not cover an examination of patient care with particular reference to the medical records. Nor did the Independent Review chaired by Professor Cairns Smith, Professor of Public Health at the University of Aberdeen. That was not part of the remit of either investigation.

Limited reviews of patient records were undertaken during the Internal Investigation. A case note review of 45 patient records was also carried out by senior nurses as part of the Outbreak Control Team's investigations that commenced in June 2008 to obtain certain data in relation to matters such as age, date of admission and to which wards patients were admitted.¹⁵ So far as the Outbreak Control Team report discloses, the purpose of that review was to make a comparison between the status of the patients who died and the status of patients who survived. The report's conclusion was that patients who died were, on average, older than those who survived.¹⁶ In addition, on 16 June 2008¹⁷ two senior Consultant Physicians from outwith the Clyde division undertook a case review of 15 patient records where *C. difficile* had appeared on the death certificates to consider whether the death certification was appropriate.¹⁸ The Outbreak Control report describes this as a "brief review".¹⁹

I was surprised that NHSGGC had not taken steps to examine the patient records to evaluate the nature of care afforded to CDI patients, particularly the records of patients who died with CDI as a cause, or contributory cause, of death, in order to satisfy itself that there were no apparent deficiencies in care. I would regard such an examination as one that should be at the forefront of the thinking of any Health Board in the circumstances that had emerged in the VOLH by June 2008. Mr Robert Calderwood, Chief Executive of NHSGGC, did explain in his evidence that once the Independent Review was set up on 18 June 2008 NHSGGC was invited to assist with that Review and discontinue its own investigation,²⁰ but as already mentioned the Independent Review did not examine patient care in any detail.

Management

The importance of questioning

It was surprising how managers at different levels within an organisation like NHSGGC failed in one of the most fundamental aspects of management, namely to ask questions.

The culture

Quite apart from a number of individual failures to investigate and be aware of what was actually happening in the VOLH, it became apparent that there was a systemic failure. Ultimately this can only be described as a management culture that relied upon being told of problems rather than actively seeking assurance about what was in fact happening. To take an example from the evidence, a manager who has a responsibility to ensure the delivery of high quality care cannot fulfil that duty simply by relying on being told when a specific problem emerges and then reacting to the problem. Some managers with responsibilities for the VOLH also had responsibilities for other hospitals operated by NHSGGC, but the Inquiry's focus, of course, was only on the VOLH, and in consequence I cannot comment on their broader performance. Nor do I know how prevalent this style of management would be generally within NHSScotland. Nevertheless, the clear lesson to be learned is that an

14 [TRA00180010](#)

15 [TRA01140044-46](#); [GGC01480004](#)

16 [GGC00600047](#)

17 [GGC07260001](#)

18 [GGC07280001](#); [GGC0060058-59](#)

19 [GGC00600059](#)

20 [TRA01240116](#)

important aspect of management is to be proactive and obtain assurance that systems and personnel are functioning effectively.

Patients and families

Full co-operation

A Chapter in the Report has been devoted to the views of patients and families and their experiences at the VOLH. The oral evidence at the hearings from this group of witnesses was given in a measured and unexaggerated way. Those who provided written statements but were not called to give oral evidence co-operated fully with the Inquiry. These witnesses recognised the importance of having a local hospital and as a group wanted to support its continued existence.

The Inquiry's oral hearings began with the evidence of this group of witnesses. I was anxious that they should have an opportunity as early as possible to have their views expressed publicly. Much of the Inquiry's work was still to be done at that time, and that meant that when they gave their evidence they were not aware of the extent and range of criticisms that were to be made subsequently by the experts.

A common theme

A common theme from this group's evidence was the desire to have answers to what went wrong at the VOLH. A significant number of this group of witnesses had been actively engaged in a campaign for a public inquiry, and it became clear during the evidence that fundamental to their thinking was the desire that others should not be made to suffer in the same way that patients suffered in the VOLH as a result of contracting CDI. Although this group of witnesses was reluctant to be critical of the care provided to patients, many of the descriptions provided did show that there were failures in basic nursing care. Some witnesses attributed poor care to the nursing staff being too busy to render the necessary quality of care. Being busy is not an excuse. If the right kind of care requires more staff, then arrangements should be in place to have an adequate number of staff available.

Poor communication

Relatives were critical of poor levels of communication. This was particularly the case in relation to the presence and nature of CDI. One witness only became aware that his mother had been diagnosed with CDI when he saw *C. difficile* mentioned on her death certificate. Some relatives were told that it was a "wee bug". That is not an apt description of what can be a life-threatening infection. Mixed messages were provided to relatives who took patients' soiled laundry home to wash. Good communication and candour are important aspects of care.

Nursing and medical care

Nursing failures

In the Report it has been necessary to mention nursing failures. There were individual failures caused by a number of factors, including pressures of work, lack of training, and inadequate support. Poor leadership also contributed to an inadequate standard of nursing care. The individual nurses concerned may have been doing their best. What I have sought to identify is how, in a care environment that does not promote good quality care, nursing standards can deteriorate and become unacceptable. The message to be conveyed on this issue is one of the absolute importance of good quality nursing care.

There were a significant number of cases in which there were delays of over 24 hours between the taking of a specimen for laboratory analysis and the commencement of treatment. What was totally unacceptable were the delays in the commencement of treatment **after** the ward was aware of the positive result. Delay in the commencement of treatment in such circumstances represents an inexcusable level of patient care. Such failures would inevitably compromise patient care.

Medical care

The deficiencies that existed in relation to medical staffing are set out in Chapter 14. In effect, there was a layer of middle grade medical staffing missing, with the result that the brunt of the day to day care had to be borne by inexperienced junior doctors and that consultants were overstretched. The

medical review of patients suffering from CDI was inadequate, and for many patients there was no evidence that a proper clinical assessment of the patient's condition had been made. Scrutiny of antibiotic prescribing disclosed that many aspects of practice were poor. There were instances of antibiotics being prescribed when no antibiotic was necessary, and of the continued prescribing of antibiotics in cases where a laboratory test demonstrated that the organism was resistant to that choice of antibiotic.

Overall it is likely that patient care was compromised by the inadequate standard of medical care.

Infection prevention and control

Significant failures

Clearly infection prevention and control practices and systems had to be fully investigated by the Inquiry. Again experts were commissioned to assist the Inquiry in this task. The Chapter in the Report on infection prevention and control is one of the major Chapters, and there can be little doubt that the significant deficiencies in infection prevention and control practices and systems discovered by the Inquiry had a profound impact on the care provided to patients in the VOLH.

Local failures

There were personal failures by the senior nurse responsible for infection prevention and control in the VOLH. The failure not to consider as a real possibility that the number of cases with CDI was a result of cross infection was inexplicable. Over the period from 1 January 2007 to 1 June 2008 there were a number of opportunities presented when cross infection should have been actively considered.

The Infection Control Doctor

Dr Elizabeth Biggs was the Infection Control Doctor for the VOLH at least from 1 January 2007 up to early February 2008. Dr Biggs was based at the Inverclyde Royal Hospital (IRH) but was responsible as Infection Control Doctor for that hospital, the Royal Alexandra Hospital (RAH) and the VOLH. The main thrust of the evidence was that she did not attend the VOLH during that period.

Dr Biggs was under a duty to take a lead role in the effective functioning of the Infection Control Team. It is clear that Dr Biggs was unhappy with her general position and lacked professional line management support, but that does not excuse her attitude. Dr Biggs' attitude to her role as Infection Control Doctor for the VOLH was wholly inappropriate and professionally unacceptable.

Failure to address Dr Biggs' behaviour

Dr Biggs had raised issues in a number of emails and failure to address these, and to ensure an effective leader of the Infection Control Team was in place, was a serious management failure. One witness described Dr Biggs' behaviour as "accepted behaviour".²¹ Such an attitude is to be deplored. Accepted behaviour that puts patients at risk has no place in any Health Board's philosophy.

System failures

The failure to meet of committees within the infection control structure meant that the structure became unfit for purpose. This was compounded by the fact that the reporting systems within the infection control system itself and under the clinical governance arrangements in place at the time were inadequate. Adequate reporting systems must ensure that there is ward to Board and Board to ward accountability. Appropriate systems would have identified the local failures at the VOLH and the failure of Dr Biggs to carry out her duties. That in turn would have identified the problem with CDI in the VOLH much sooner and saved many patients from suffering from the infection and its consequences.

National structures and systems

Structures

In order to orientate the reader of the Report, some information is provided in Chapter 6 on how the National Health Service in Scotland has been structured. In summary, ultimate responsibility for the promotion and improvement of the physical and mental

21 [TRA01260022](#)

health of the people of Scotland rests with the Scottish Ministers. The Scottish Ministers discharge that duty through Health Boards. The Scottish Government is the executive branch of government in Scotland. There are a number of organisations that provide support including NHS National Services Scotland (NSS) of which Health Protection Scotland (HPS) forms part. The Scottish Government Health Directorate (SGHD) provides the central management of the NHS in Scotland. The Cabinet Secretary for Health and Wellbeing is the Minister responsible for the SGHD.

Systems

The impact of healthcare acquired infections (HAIs) on patients has been well recognised since at least the 1990s. The HAI Task Force was created in January 2003 in recognition of the ongoing challenges presented by HAI. Its primary responsibility is to advise on the development and delivery of Scottish Government policy in order to minimise HAIs. There is no doubt that the HAI Task Force has carried out some excellent work, including the implementation of the system of mandatory reporting of all positive tests for *C. difficile* toxins to HPS on a weekly basis since September 2006. This is in effect a national surveillance system in Scotland that provides information on the extent of CDI at a national level and allows a comparison to be made of trends and data over time and between Health Boards. It is to be emphasised that the system is not designed to identify the prevalence of CDI in a particular hospital.

The Scottish Government also set performance targets that Health Boards are expected to meet. These are known as Health Improvement, Efficiency, Access and Treatment (HEAT) Targets. In November 2006 the Scottish Government announced a HEAT Target for *Staphylococcus aureus* bacteraemia (including MRSA and MSSA). The target was an overall reduction of 30% in such cases by 2010, and that target was achieved by September 2009.

The importance of the HEAT Target system lies in the fact that it places an onus on Health Boards to meet the targets by having,

for example, effective infection prevention and control methods in place. CDI was only made a HEAT Target in 2009 in response to the discovery of the CDI problem at the VOLH. Had CDI been a HEAT Target earlier, that might have raised awareness of the infection, but it is to be stressed that the HEAT Target system was not designed to be a surveillance system of the kind that Boards had to have in place. Although there was no evidence that in the period prior to 1 June 2008 any consideration was being given to making CDI a HEAT Target, that is not a criticism because it was necessary to have adequate data available for comparative purposes, and as I have already indicated the system for mandatory surveillance did not come into operation until September 2006. The introduction of CDI as a HEAT Target in 2009 was an appropriate response by the Scottish Government to the emergence of the CDI problem at the VOLH.

Healthcare Environment Inspectorate

Prior to June 2008 there was no system of independent inspection dedicated to the infection prevention and control of HAI. Following upon the discovery of the CDI problem in VOLH the Cabinet Secretary had a number of meetings with family members of patients who had contracted CDI who made clear to her the view that there should be an independent inspectorate in place to review the actions taken in hospitals in relation to HAIs. This led to the establishment of the Healthcare Environment Inspectorate (HEI) in April 2009. The HEI carries out announced and unannounced inspections and publishes inspection results on its website. The inspection team measures hospitals against standards that are designed to minimise the risk of infection to patients, visitors and staff, based on evidence, best practice and expert opinion. The Health Board concerned must respond to any issues raised by the inspection process.

Inspections of the VOLH in 2011 and 2012

It is worthy of note that an announced inspection of the VOLH took place on 10 and 11 August 2011, and that an unannounced inspection took place there on 7 June 2012. The unannounced inspection in June 2012 concluded that the hospital was clean and

well maintained and that education in infection prevention and control was being well promoted. There is no doubt that had there been an inspection regime of that kind in 2007 and 2008, and had an inspection of the VOLH been carried out over that period, the conclusions would have been very different to the conclusions arrived at in 2012.

The absence of an inspection system – a failure

Since devolution the SGHD and other agencies have produced a significant amount of material for Health Boards on HAIs. For example, the Scottish Infection Manual published in July 1998 sent out a clear message on the importance of good infection prevention and control. Furthermore, the importance of prudent antibiotic prescribing had been well known at least since the 1990s. There was no doubt that the message on the importance of having sound systems in place to combat HAIs was a message that had been repeated many times over the years because of the importance attached to it. In such circumstances it is surprising and indeed regrettable that an effective inspectorate system had not been put in place prior to 1 June 2008. This is dealt with in detail in the Report, and represents a failure on the part of the Scottish Government.

Antibiotic prescribing

Prudent prescribing

The importance of prudent antibiotic prescribing had been recognised in Scotland for many years prior to 2007 to 2008. In a letter dated 21 May 1999²² addressed to a number of people, including Health Board General Managers and Chief Executives, the Scottish Office Department of Health included prudent antibiotic prescribing as an important goal in the reduction of ill health from hospital acquired infection. That message was subsequently repeated over a number of years. An Action Plan²³ published in 2002 by the then Scottish Executive again emphasised the importance of prudent antimicrobial use. A guide on the prudent use

of antibiotics published in 2005²⁴ highlighted as a challenge the inadequate supervision of prescribing and the inappropriate choice of antibiotics by junior doctors. Even as late as March 2008, shortly prior to the emergence of the problem with CDI at the VOLH, another Action Plan was launched by the then Cabinet Secretary for Health and Wellbeing.²⁵ This echoed the theme that had emerged in Scotland at least by 1999, and had been repeated over the years, that antibiotic prescribing was not being carried out in a prudent way.

Inadequate response to the prudent prescribing message

Reference has already been made to the failures in the prescribing of antibiotics in the VOLH, failures that persisted until the emergence of the CDI problem in May 2008. The repeated messages on prudent prescribing had not had an effective impact in the VOLH by June 2008. Dr Andrew Seaton, a Consultant Physician in Infectious Diseases and General Medicine in NHSGCC, said in evidence that what was happening in the VOLH in relation to antibiotic prescribing “was applicable to all our hospitals in Greater Glasgow and Clyde and, indeed, almost certainly all our hospitals in Scotland”.²⁶ It is not within my remit to consider the position of other hospitals in Scotland, but what was perfectly apparent to me was that there had been what I describe in the Report as a mismatch between expectation and implementation. There are two targets for criticism here – NHSGCC for failing to respond to the messages being sent on the importance of prudent prescribing, and the Scottish Government for failing to identify and remedy the failure to comply with the prudent prescribing messages.

Outbreaks elsewhere

Paragraph (f) of the Terms of Reference did permit the Inquiry to see what lessons could be learned from experience of CDI in and beyond Scotland. I was, however, of the view that that paragraph did not provide

22 [INQ04540001](#)

23 [GOV00360072](#)

24 [GOV00360003](#)

25 [GOV00360040](#)

26 [TRA01150114](#)

an open ended platform from which to look at the detail of how outbreaks of CDI were handled in other hospitals. That would have been an enormous task. In light of the Terms of Reference as a whole I was of the clear view that it would be outwith their scope to embark upon a critical analysis of the infection control policies of other organisations, the governance arrangements of such organisations and the handling of any outbreaks. What I did find useful was to have regard in particular to the available reports on CDI outbreaks in England, and compare the conclusions arrived at with the conclusions I have arrived at in connection with the VOLH. What was striking was the similarity of the problems identified in these reports and the problems identified by this Inquiry. Lessons had not been learned from these reports. This is considered in Chapter 18.

Scrutiny of other hospitals

There was regular traffic of patients to the VOLH from other hospitals. In particular, patients covered by the remit were transferred from the RAH, or transferred from the VOLH to the RAH. For that reason it became necessary for the Inquiry to examine some aspects of the treatment of those patients at the RAH. As discussed later in the Report, I concluded that the prescription and administration of antibiotics to patients prior to admission to the VOLH were relevant to my remit whether that occurred at another hospital or in the community under the authorisation of general practitioners. That did not mean, however, that I considered it to be within my remit to conduct an examination of practices, policies and patient care at any other hospital, or in the community.

The proceedings

Inquisitorial proceedings

In Scotland, legal proceedings are generally conducted by way of adversarial process. For example, in a civil litigation the parties to the litigation identify the issues that are of concern to them and decide what evidence to lead in support of their respective positions. Generally a witness led by one party can then be cross-examined by the other party and, if

necessary, re-examined. The judge presiding over the case has no direct part to play in that process. The judge's role is to ensure that parties conduct the case in accordance with the rules and the judge only intervenes in the evidence to seek clarification or further explanation. At the end of a case parties make submissions on the facts and the law to advance their respective positions and, ultimately, the judge decides the case by making findings in fact and law.

The purpose of an inquiry of this kind is quite different. The process is an inquisitorial one. Section 17 of the 2005 Act provides as follows:

“(1) Subject to any provision of this Act or rules under Section 41, the procedure and conduct of an inquiry are to be such as the Chairman of the inquiry may direct.

“(3) In making any decision as to the procedure or conduct of an inquiry the Chairman must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or to others)”.

In an inquiry of the kind that I have conducted it was for me to decide who would give evidence to the Inquiry and what areas should be subject to investigation, all within the parameters of the Terms of Reference. It was not in any way part of my function to resolve issues as a judge might resolve issues between parties in a litigation. The role of Core Participants is quite different to the role played by parties to litigation. Indeed their role should be seen as being one where they are under a duty to assist the Inquiry in responding to its Terms of Reference. As I said at the preliminary hearing on 1 February 2010, the focus of the Inquiry was on investigating, and the Inquiry's questions were to be about finding out what happened, why it happened and, importantly, how to make a difference for the future.

Furthermore, the extent to which Core Participants may question witnesses is significantly constrained by the 2007 Rules. Rule 9 provides:

“(1) Subject to paragraphs (2) to (5), where a witness is giving oral evidence at an inquiry hearing, only –

- (a) the inquiry panel;
- (b) counsel to the inquiry;
- (c) if counsel has not been appointed, the solicitor to the inquiry; or
- (d) persons entitled to do so under paragraphs (2) to (4), may examine that witness.

(2) Where a witness, including a Core Participant, is being examined at an inquiry hearing, the Chairman may direct that the recognised legal representative of that witness may examine the witness”.

There are other provisions in the 2007 Rules regulating the examination of witnesses, but the clear message is that it is for the Chairman to decide whether a witness should be examined by a Core Participant or any other party representing a person.

Standard of proof

The 2005 Act and the 2007 Rules are silent on the standard of proof an inquiry under the 2005 Act should apply when making its findings. I have already mentioned Section 17, which provides that the procedures and conduct of the Inquiry are to be such as I may direct. Furthermore, as I have explained, I must act with fairness. It is worth pointing out that Section 2 of the 2005 Act provides that “an inquiry panel is not to rule on and has no power to determine, any person’s civil or criminal liability”. It is not the function of an inquiry under the 2005 Act to determine the rights and obligations of any parties. In the light of these provisions I considered it to be appropriate to apply the civil standard of proof, a standard of proof on the balance of probabilities.

Expert assistance

The contribution made by all the experts commissioned by the Inquiry cannot be overstated. An inquiry of this kind, with Terms of Reference that required investigation of a range of different factors leading to the development of the problem with CDI, could not perform its function without expert input from a number of different disciplines. I am extremely grateful to all the experts who assisted the Inquiry. Details of the experts are provided in Appendix 4.

Chapter 2

How the Inquiry worked

Introduction

The intention of this Chapter is to set out some aspects of the work undertaken by the Inquiry in preparation for the oral hearings, during the oral hearings and subsequently when the Report was being prepared.

2.1 Inquiry procedures

The Inquiries Act 2005 and the Inquiries (Scotland) Rules 2007

Section 17 of the Inquiries Act 2005¹ (the Act) provides that, subject to the Act itself and to the Inquiries (Scotland) Rules 2007² (the Rules), “the procedure and conduct of an inquiry are to be such as the chairman of the inquiry may direct”.

Guidance on procedures was published on the Inquiry website. As the Chairman explained there, in order to operate most efficiently and effectively an Inquiry needs to operate flexibly. Procedures need to be adopted or adapted to enable this. The Chairman also set out a number of broad principles for the conduct of the Inquiry:

“The Vale of Leven Hospital Inquiry is a public inquiry. It aims to be as open, accessible and transparent as possible.”³

The hearings of the Inquiry (at which witnesses give oral evidence) are designed to:

- deal with the issues in the most effective and efficient way, ensuring that all relevant issues are publicly explored,
- ensure that the material on the Inquiry website allows the public to be kept as fully informed as possible as the Inquiry proceeds,
- ensure that those who are witnesses are afforded a fair opportunity to give their evidence,
- ensure that Core Participants are given a fair opportunity, commensurate with the need for hearings to progress efficiently and with all reasonable speed, to participate in the process”.⁴

Core Participants

The Rules permit the Chairman to designate a person as a Core Participant in the Inquiry, but only with that person’s consent. The Rules also provide that:

“In deciding whether to designate a person as a core participant the chairman must have particular regard for the desirability of including as core participants persons who-

- (a) played, or may have played, a direct and significant role in relation to the matters to which the inquiry relates;
- (b) have a significant interest in an important aspect of the matters to which the inquiry relates; or
- (c) may be subject to significant or explicit criticism-
 - (i) during the proceedings at the inquiry, or
 - (ii) in the report (or any interim report) to be delivered under section 24 of the Act (submission of reports)”.⁵

The bodies and persons granted designation as Core Participants in the Inquiry by the Chairman are listed in Appendix 3.

A number of the individuals designated as Core Participants were former patients. Some were members of the families of patients who had died or were unable themselves to participate due to age or infirmity.

In a number of instances the Inquiry initially received applications from several individuals in respect of the same patient. The Chairman took the decision as a matter of fairness and practicality that only one person would be granted Core Participant status in respect of any individual patient. In the event families were able to reach agreement among themselves as to who should be the Core Participant, and it was not necessary for the Chairman to select any person in preference to another.

Applications were received from a small number of witnesses or potential witnesses

1 Inquiries Act 2005 (c. 12)
 2 The Inquiries (Scotland) Rules 2007 (S.S.I. 2007/560)
 3 [INQ05650001](#)
 4 [INQ05650001](#)

5 Rule 4(2)

who were or had been employees of NHSGGC, but the Chairman took the decision that the role of these individuals was not such as to justify the granting of Core Participant status.

An application from one further individual was declined on the grounds that he had failed to satisfy any of the particular criteria specified in the Rules.

Having been granted Core Participant status, Tayside Health Board elected not to be represented at the first stage of the Inquiry hearings. They later intimated that they considered it unnecessary to remain a Core Participant, and the Chairman decided that Tayside Health Board should cease to be a Core Participant with effect from 10 December 2010.

Document recovery

Around 10,000 documents were recovered by the Inquiry in the course of its investigation. Of these, 5,000 documents were considered to be relevant to the Inquiry's Terms of Reference and were included in the Inquiry document management system. The documents on the document management system comprised 100,000 pages. Most of the documents recovered came from public bodies, and of these the majority came from NHSGGC.

The Inquiry began the document recovery process by sending informal requests to a number of public bodies in October 2009, inviting them to provide relevant documents. As part of that exercise the Solicitor to the Inquiry wrote to NHSGGC on 16 October 2009 and invited them to produce all documents in the custody or control of NHSGGC which fell within the Terms of Reference. The Solicitor to the Inquiry set out in that letter that the documents should be the originals or best available copies of those documents, accompanied by an inventory listing them. NHSGGC was asked to deliver all the relevant documents within four weeks of the receipt of the letter or, if this was not possible in view of the volume of material, to advise the Solicitor to the Inquiry of what additional time would be required.

Difficulties over production of documentation

Thereafter difficulties were encountered over the supply of documentation by NHSGGC. The inventory requested in the Solicitor to the Inquiry's letter of 16 October 2009 was not produced. The Inquiry instead prepared its own inventory of material produced, and provided that to NHSGGC on 20 November 2009. NHSGGC were asked to confirm that it was accurate and to add to it any documentation provided after that date. NHSGGC did not respond to this request, although further emails containing further documents continued to be received by the Inquiry.

On 11 December 2009 the Chairman wrote to the Solicitor for NHSGGC expressing his disappointment over the manner in which the production of documents was being managed. He set out a number of the difficulties in his letter, including discrepancies between the names of documents and their content, lack of confirmation of the number and name of documents, and the apparent lack of relevance to the Terms of Reference of some of the documents supplied. Another of the difficulties concerned an encrypted hard-drive that had been provided by NHSGGC without any instructions as to its encryption or format or as to what it contained.

In the same letter, the Chairman added that he was reluctant to issue a formal Notice to NHSGGC under Section 21 of the Act compelling it to produce documents, and sought an assurance that all documents requested together with a full inventory of all documents supplied would be delivered by 18 December 2009. No reply was received to the Chairman's letter of 11 December 2009. Accordingly on 7 January 2010 a Notice in terms of Section 21 of the 2005 Act was served on NHSGGC.⁶ That Notice set a deadline of 18 January 2010 for the production of documents. Subsequently, a further extension was given to 1 February 2010.

6 [INQ05510001](#)

Continuing difficulties with the production of documents

The difficulties over the recovery of documents from NHSGGC did not abate. As the Inquiry's work continued it was apparent that there was relevant documentation that should have been available but had not been produced. For example, in the period 1 April 2010 to 4 August 2010 some 60 or so requests were made by email by the Inquiry to NHSGGC to provide additional information or documentation. These included requests for documentation relating to the Infection Control Manual, Risk Registers, patient records, job descriptions, and clinical governance papers and minutes. This pattern continued.

In mid February 2011 it was apparent to the Inquiry that a significant number of laboratory reports detailing the results of tests for *C. difficile* toxin were missing from the patient records. It was only then that, at the request of the Inquiry, NHSGGC made available computer records in the form of spreadsheets providing highly significant information on the results of tests. There were other items missing from the patient records that were only supplied when specifically requested. Even through 2011 and 2012 requests for documents were being made by the Inquiry. A significant number of documents relevant to the work of the Inquiry were provided by NHSGGC over that period.

Problems with document content

The quality of the photocopying of patient records supplied by NHSGGC was extremely poor. Many dates were obscured in the copying process and items omitted. This, together with records out of chronological order and instances of poor record keeping, frequently made it difficult to ascertain what was missing, and entailed detailed enquiry to obtain fully legible copies and discuss whether:

- pages had not been copied;
- pages had existed but could not be traced; or
- patient records had ever existed.

The Inquiry readily acknowledges that NHSGGC devoted considerable time and effort to rectifying problems as they arose, but it is regrettable that no quality assurance process appears to have been carried out by NHSGGC at the original copying stage. Nor did it seem that lessons were being learned, as copies of patient records received in 2012 still had dates and notes which were obscured.

Failures by NHSGGC

The work of the Inquiry would have been greatly assisted, and its duration reduced, had NHSGGC:

- recognised at the outset the size of the task it faced;
- taken adequate steps to review what range of material was relevant to the Inquiry's Terms of Reference;
- established adequate management systems for the transfer of material; and
- put in place quality assurance measures for copying of documents.

The lesson to be learned from this experience is that, in an inquiry of this kind, a holder of documents should put in place a system dedicated to identifying relevant documents and a system of quality assurance designed to ensure that when documents are produced they are in a complete form and legible.

The Inquiry does, however, appreciate the work and the unfailing courtesy and helpfulness of those employees of NHSGGC who were responsible for handling the hundreds of different requests for documents that ultimately had to be made as the Inquiry progressed.

Witness statements and the statement taking process

The Inquiry engaged a number of statement takers, including lawyers and former police officers, to take statements from witnesses whose evidence appeared relevant to the Inquiry. The statement takers worked under the general supervision of the Solicitor and Deputy Solicitor to the Inquiry, and were given training and guidance to ensure that relevant issues were addressed and that each statement was comprehensive. In many

instances Counsel to the Inquiry provided details of issues to be addressed in taking the statements. Some statements were also taken by Junior Counsel and by the Solicitor and Deputy Solicitor, particularly in the later stages of the Inquiry.

The Inquiry sent letters to all those from whom they wished to take statements. The Inquiry had no power to compel a witness to meet with a statement taker, and engagement in this statement taking process was therefore voluntary. That was made clear to all potential witnesses, and almost all those asked to meet with statement takers were fully co-operative.

It was of course necessary for the Inquiry to seek the assistance of NHSGGC managers to arrange to take statements from those witnesses still in the employment of NHSGGC. For many the process had to be scheduled around or during working time. The Inquiry acknowledges the commitment of Ms Anne Harkness, Director of the Rehabilitation and Assessment Directorate, in putting arrangements into place to allow this to happen.

In a few cases where witnesses delayed in providing statements the Chairman made further use of his powers under Section 21 of the Act to require the witness to supply his or her own statement. A statement provided directly by a witness was of course less valuable to the Inquiry in that it did not necessarily address the issues of interest to the Inquiry in a satisfactory manner.

Each witness was offered the opportunity to have his or her own legal adviser, a colleague, or a union representative present when a statement was being given. In the case of nursing staff employed by NHSGGC, however, the Chairman refused to sanction attendance at interview of a solicitor acting on behalf of NHSGGC. The position adopted by a NHSGGC legal representative at that time was that no conflict of interest existed between NHSGGC and its employees, and that it would be appropriate for the Solicitor for NHSGGC to be present. The Chairman decided that witnesses should provide their statements in as free an environment as possible, and considered that the presence of an employer's legal

representative, rather than the witness's own representative, might inhibit the statement taking process.

After interview, the statement taker produced a draft statement. This was supplied to the witness, who was invited to make any corrections. Once satisfied with the final version the witness was asked to sign a copy.

The Inquiry used statements as the evidence of witnesses whom it was not necessary to call to give oral evidence. Where a witness did give oral evidence, he or she was asked to expand upon aspects of the statement rather than to repeat its contents.

Some witnesses were asked to give supplementary statements providing further detail on aspects of their earlier statements.

Preliminary hearing

No provision is made in the Act or in the Rules for a preliminary hearing, but using the broad procedural powers available to him the Chairman instructed that a preliminary hearing should take place at Dumbarton Sheriff Court on 1 February 2010. The process of designating Core Participants had not begun, but representatives of interested parties were invited to attend. The preliminary hearing proved a useful tool in engaging those parties and in raising public awareness of the Inquiry both locally and nationally. It also provided a focus of attention for local people, since it had by then become apparent that the main hearings would have to take place outwith the Dumbarton area. The Inquiry is grateful to the Sheriff Clerk at Dumbarton and his staff for allowing the use of court facilities for this hearing.

Appointment of experts

The ingathering of documents has already been discussed. Patient records were not received by the Inquiry until after 18 January 2010.⁷ The Inquiry reviewed the patient records and identified the need for an in-depth analysis by experts. Areas identified that required to be investigated included medical and nursing care. On 21 April 2010

7 [GGC33110001](#)

Dr Sheldon Stone was invited to assist the Inquiry in its consideration of the medical care given to CDI patients. Professor Brian Duerden was invited at the same time to provide expert assistance in relation to infection prevention and control. Mrs Christine Perry was also invited to be an expert to the Inquiry. At that time it was thought that her focus would be on nursing care. Later, on 4 June 2010, Mr Alex Smith was invited to assist the Inquiry's consideration of management issues.

By 17 June 2010 these experts had agreed to assist the Inquiry, although from October 2010 Dr Stone was unable to continue because of the nature of the commitment necessary. The Inquiry acknowledges the contribution of Dr Stone in first identifying many of the issues surrounding patient care that feature in the Report.

It became apparent that examination of the patient records with the necessary scrutiny required the number of cases allocated to a particular expert to be limited. That meant that a number of experts had to be commissioned in the areas of nursing, microbiology and medicine. That commissioning process continued through 2010 and up to March 2011.

The instruction of a number of experts in each field enabled the Inquiry to allocate cases from different wards to different experts. This allowed the Inquiry to see if there were common trends identified by the experts, and provided the Inquiry with an important cross-check of an individual expert's conclusions. Trends did emerge, and these trends are discussed in other Chapters of the Report.

Oral hearings

Oral hearings took place over 126 days from 7 June 2010 to 28 June 2012.

The first phase of oral hearings began on 7 June 2010, and was devoted to the evidence of patients and family members. As a sign of respect, hearings opened with a minute's silence in memory of those patients who died. The decision was taken to commence hearing oral evidence even although much of the

Inquiry's investigative work remained outstanding, and in particular expert input into areas of interest to the Inquiry was far from complete. Nevertheless, the Inquiry considered it to be important to hear from this group of witnesses as soon as possible after their signed statements had been completed.

Preparation of witnesses

As explained previously, Core Participants had full access to all documents on the Inquiry document management system, and those witnesses called to give oral evidence were able to use these in preparation for giving evidence.

Where necessary, and where requested, the Inquiry provided witnesses with information on the scope of questions which might be put to them, as well as copies of any documents to which they might be referred in the course of their evidence.

In the case of nursing staff, assistance in preparation was provided by the Royal College of Nursing (RCN). Members of the medical staff sought assistance from their own professional bodies.

Representation of witnesses

A number of patients and their relatives who gave evidence were represented by Messrs Thompsons, Solicitors, and by Senior and Junior Counsel instructed by them.

Guidance protocol

A protocol providing guidance on witnesses and the taking of evidence was published on the Inquiry website in December 2009, well in advance of the commencement of the oral hearings on 7 June 2010.⁸ That guidance reflected the terms of the Rules in explaining how evidence at the oral hearings would be managed. It also gave notice that anyone having a sufficient interest in the evidence of a witness should submit any line of questioning they wished Counsel to the Inquiry to put to the witness one week in advance of the witness giving evidence. The principle behind that provision was to allow Counsel to the Inquiry sufficient time to consider the lines of questioning proposed.

8 [INQ05660001](#)

In practice, there had to be flexibility. Many of the written questions suggested were in any event pursued by Counsel to the Inquiry in his own examination of the witness. As the Inquiry progressed, however, written questions were submitted at an increasingly late stage, including on the eve of the witness giving evidence or indeed even during the witness's evidence. This became very difficult to manage, particularly as on occasions hundreds of written questions were submitted. Unless reasonable notice is given, an arrangement where Core Participants submit written questions of the kind and quantity received by the Inquiry is not particularly helpful, and can hinder the progress of the Inquiry.

The Chairman did allow parties to conduct some oral examination of witnesses when it was evident that there was a reasonable basis for that to be done. Although the Act⁹ provides that the procedure and conduct of the Inquiry shall be such as the Chairman directs, and the Chairman had directed that all questions should be submitted to Counsel to the Inquiry, the Act also provides that the Chairman must act with fairness.¹⁰ When the Chairman considered it fair to do so he did allow a certain amount of leeway to parties in the questioning of witnesses.

Written questions and answers

In the case of some witnesses, mainly experts instructed by the Inquiry, each witness was asked to provide written responses to questions from other parties after giving oral evidence. These written answers were then published on the Inquiry website along with transcripts of the oral evidence of the witness.

Publication of evidence

A full transcript of each day's evidence was published on the Inquiry website, usually by about 18:00 on the same day.

Access to hearings

All hearings were held in public, and no application was made to hold any part of the hearings in private.

Restriction on publication

The Act permits the Chairman in certain circumstances to make a Restriction Order restricting the disclosure or publication of any evidence or documents given, produced or provided to an Inquiry.¹¹ The Chairman made one such order in the course of the Inquiry. Where patients had died, no issue of disclosure of personal data or sensitive personal data under the Data Protection Act 1998¹² arose. In the case of living patients whose cases were examined by the Inquiry, most gave consent to the use of records and to their identification. In three instances, however, patients were unable to grant consent. The Chairman considered that in order to fulfil the remit of the Inquiry it was necessary for their records to be examined at the hearings, but made an order that these patients should be referred to in public documents as Patients A, B and C. A further patient was later designated as Patient D.

Nurses contacted to obtain statements

Between 27 April and 9 December 2010 the Inquiry contacted 45 potential nurse witnesses. This number does not include Infection Control Nurses or nursing staff above Senior Charge Nurse level. The Inquiry took statements from 26 nurses and supplementary statements from five of those nurses. Nineteen nurses did not provide statements. The Inquiry excused two of these nurses from participation on medical grounds and the remaining 17 nurses could not be traced or failed to respond to requests. Where witness statements were taken, nurses were permitted to read and correct them before signing. It was not considered necessary to obtain statements from domestic staff or nursing auxiliary staff.

The evidence of the nurses and their legal representation

The Inquiry's original plan was that the oral evidence of nurses would begin on 31 May 2011 in the course of the session that was to commence on 16 May 2011. The first two weeks of that session from 16 May 2011 were to be dominated by nursing expert evidence. Citations were sent out to nurses on

9 Section 17(1)
10 Section 17(3)

11 Section 19
12 Data Protection Act 1998 (c. 29)

22 April 2011, with one of the nurses due to start her oral evidence on 31 May 2011. As matters developed, and as recounted later in this Chapter, because of the nurses' lack of preparation their evidence eventually had to be postponed to 23 August 2011.

Royal College of Nursing: initial involvement

The Royal College of Nursing (RCN) is the largest union and professional body for nurses in the United Kingdom, and provides support to its members including legal advice and representation. Shortly before the Inquiry was officially set up on 1 October 2009, the RCN, through their solicitors, expressed interest in participating in the Inquiry, but early in 2010 a solicitor acting on behalf of the RCN indicated that the RCN did not intend to apply for Core Participant status.

Subsequent RCN involvement

No further contact was made by the RCN with the Inquiry until March 2011. As already explained, at that time the plan was that nurses would be giving evidence to the Inquiry from 31 May 2011. It is clear that some nurses, on being contacted to give evidence, had made contact with the RCN seeking support. In the meantime the RCN had been provided with a summary of nursing expert reports by the Solicitor for NHS GGC. The RCN on 10 May 2011 submitted an application for Core Participant status, the purpose in so doing being to gain access to expert reports and witness statements. That application was granted by the Chairman on 13 May 2011.

No representation by the RCN

At the Inquiry hearing on 16 May 2011, Mr Dickson, Solicitor appeared on behalf of the RCN. He intimated that the RCN did not intend to represent their members who were due to give evidence to the Inquiry.¹³ Rather, the intention was that nurses who were to give oral evidence would be supported by being fully prepared to give their evidence.¹⁴ Thereafter the RCN held group information sessions with nurses due to give oral evidence, providing information on such matters as the nature of the Inquiry, the main

criticisms in the nursing expert reports, and the procedure for giving evidence at the Inquiry.

The NHS GGC position on representation

The first indication that NHS GGC would not be representing the nurses employed at the VOLH was provided in a Note submitted on behalf of the NHS GGC Board on 2 June 2011. In May 2010 the solicitor for NHS GGC had intimated that he would be representing the interests of nurse witnesses unless a clear conflict of interest emerged. Prior to June 2011 there was no suggestion from him that the position had changed.

Shortly before the start of the oral hearing of 6 June 2011, a written submission was lodged with the Inquiry Counsel. Counsel for NHS GGC was invited to address the Inquiry on the NHS GGC Board's position. Counsel then submitted that in his opinion there was a potential conflict of interest between NHS GGC and its nursing staff, and indeed between the nurses themselves.¹⁵

At the start of the oral hearing on 9 June 2011 Counsel for NHS GGC intimated that, having taken the advice of the Dean of the Faculty of Advocates the previous evening, he had been advised that there was a potential conflict of interest between the NHS GGC Board and its nursing staff.¹⁶ The Solicitor for NHS GGC had sought and received similar advice from his professional body, the Law Society of Scotland, and also from the senior legal adviser to the NHS in Scotland.¹⁷ It followed that Counsel and the other members of the legal team for NHS GGC could not provide any advice or assistance to the nurses who were to be called to give oral evidence. In intimating this position Counsel for NHS GGC described it as "an unfortunate development".¹⁸

It was indeed highly unfortunate. By this time a significant amount of nursing expert evidence had been led. Nursing expert reports containing criticisms of nursing care had been available to NHS GGC from early April 2011

¹³ [TRA00090004](#)

¹⁴ [TRA00090003](#)

¹⁵ [TRA00140002](#)

¹⁶ [TRA00170001](#)

¹⁷ [TRA00170002](#)

¹⁸ [TRA00170001](#)

and, in any event, most of the proposed areas of criticism had been intimated to NHSGGC on 17 March 2011.¹⁹ It had been obvious for some time that nurses were to be criticised for the care of patients suffering from CDI. It was now obvious that no assistance had been provided by NHSGGC to its nursing staff to prepare them to give evidence and to respond to the criticisms being made of the quality of nursing care.

Had a full examination of the patient records been carried out when the CDI problem emerged, the kind of potential conflict intimated by Counsel for NHSGGC in June 2011 might have been recognised much sooner. Steps of the kind that were ultimately taken to protect the interests of nurses could then have been taken. The failure of NHSGGC to carefully examine the patient records in June 2008 left the nursing staff in an unfortunate position, but a position that was ultimately rectified.

Assistance to nurses by the Inquiry

When it became evident that the nurses were not to be provided with legal representation by their employer or by the RCN, the Inquiry's Witness Liaison Manager made visits to the VOLH on 16 and 21 June 2011 and to the Royal Alexandria Hospital (RAH) on 22 June 2011 to meet with nurses. Nurses were given the option of meeting at the hearing venue at Maryhill if they preferred.

The Witness Liaison Manager met with 18 nurses individually during that period. At those meetings the nurses were provided with a list of the patients with CDI in their ward. They were given copies of patient records of those patients and other documents that might be referred to in evidence. They were provided with copies of timeline charts which provided information on when patients were confirmed with CDI, and an explanation of how to interpret the charts. Each nurse received a copy of the Statement of Principal Issues for Nursing Staff²⁰ prepared by the Inquiry outlining issues that might be addressed in hearings. Nurses also had access to the transcripts of evidence led

to date. Most nurses made use of this facility and read the evidence of other nurses and the evidence of patients and relatives.

The Inquiry arranged three familiarisation visits for the nurses at the hearing venue in Maryhill on 20 April, 26 April and 3 June 2011. These visits were attended by 17 nurses. Some nurses who attended the venue in Maryhill prior to giving evidence were able to listen to evidence being given at that time by other nurses.

Further representations by the RCN

The RCN decision not to represent any nurses, communicated at the oral hearing of 16 May 2011, of course came at a time before Counsel for NHSGGC intimated the Board's position on 9 June 2011. Following this disclosure, Mr Dickson again attended the Inquiry's oral hearing on 14 June 2011 to provide further clarification of the role the RCN would play now, particularly since NHSGGC was not going to advise or represent nurses. Mr Dickson explained that the RCN were not representing any individual nurse or group of nurses because it was considered there could be conflicts between different nursing groups.²¹ Mr Dickson did outline the information sessions that had been held with nurses, but he made it clear that he himself would not be in attendance at the oral hearings when RCN members were giving their evidence. That meant that if a nurse had a problem in connection with giving evidence no advice would be available to that nurse.

Although it came rather late in the day, the input that was now being provided by the RCN was to be welcomed, since up until this time the nurses had not been provided with assistance in preparing to give evidence to the Inquiry. The evidence of nurses due to be led in May had been postponed to 13 June 2011 and then to 4 July 2011 for reasons unconnected with the issue of representation, but as already mentioned the nurses were unfortunately not then ready to give evidence to the Inquiry. That evidence was then further postponed to 23 August 2011. Time was lost, but an adjustment to the order of witnesses was possible and that did mitigate the position.

¹⁹ [INQ05490001](#)

²⁰ [INQ05360001](#)

²¹ [TRA00190124-126](#)

Financial support for legal representation of nurses

The RCN decided not to provide financial assistance to nurses to enable them to obtain legal advice from a separate legal firm. The RCN is only obliged to provide financial assistance to nurses in the event of a clinical negligence claim, so the decision on whether to support members involved in a public inquiry financially was a matter entirely for the RCN's discretion. The Chairman considered that as a matter of fairness any nurse who might be subject to criticism should have legal advice and representation available. In due course, the Chairman granted a number of applications from nurses for funding for legal representation.

Delay and expense

The decision of NHSGGC not to advise or represent the nursing staff resulted in some delay in the proceedings of the Inquiry, but not a material delay that affected the Inquiry's timescale. As a matter of fairness to nurses who might be subject to criticism, appropriate arrangements had to be put in place to protect their interests. Additional public expense was incurred through the provision of independent legal advice to nurses and on legal representation at the oral hearings, but no doubt if NHSGGC had taken a different stance a year earlier additional expense would have been incurred in any event. The whole process, however, could have been managed differently by NHSGGC. As it was, because of the Chairman's desire to make progress as quickly as possible, a number of different solicitors became involved acting for different nurses.

The nurses' oral evidence

Ten nurses gave oral evidence. It was considered important, where possible, to obtain oral evidence from SCNs on wards where CDI had been identified as a problem. It was also considered to be beneficial to hear evidence from some Staff Nurses on those wards. From the evidence given by those nurses, it did not appear that any nurse's position had been unfairly compromised by a lack of advice.

Extended statement procedure

The Inquiry identified five nurses from whom it was necessary to take further evidence in the form of extended statements. These nurses were interviewed by Inquiry Counsel, and a written record was taken of each witness's evidence which the witness checked and signed. The legal representatives of Core Participants to the Inquiry were also permitted to provide lists of questions to be put to those witnesses. Funding was provided for these nurses who wished to have legal representation.

The doctors who gave evidence and legal representation

The Inquiry obtained statements from 14 doctors who worked at the VOLH during the focus period. Eight of those also gave oral evidence.

All of the doctors who gave oral evidence were members of a professional union which provided legal representation for them.

Assistance given to medical witnesses by the Inquiry

All doctors who gave evidence at the Inquiry's oral hearings had access through their legal representatives to the Inquiry's database of evidence, which included patient records and the statements of other witnesses.

In addition, the Inquiry provided doctors giving evidence with a list of the CDI patients about whom they might be asked. Prior to giving evidence they were provided with copies of timeline charts prepared by the Inquiry which detailed which patients were confirmed with CDI and when that confirmation was made. They were also given an explanation of those charts by the Witness Liaison Manager before they gave evidence. Some doctors attended the hearing venue in Maryhill prior to giving evidence and were able to listen to evidence being given by other medical witnesses.

List of witnesses

Details of all witnesses who provided statements and gave oral evidence are set out in Appendix 5.

Key witnesses who did not give evidence

Three key witnesses, Mrs Deborah den Herder, Dr Elizabeth Biggs and Dr Elizabeth Jordan were unable to give evidence and the reasons for this are discussed later in this Chapter.

Mrs Deborah den Herder

Chapter 9 explores the background leading to the dissolution of NHS Argyll and Clyde on 1 April 2006 and the creation of the Directorate of the Acute Division (the Clyde Acute Directorate). Mrs den Herder took up the post of Director on 1 October 2006, a post that carried with it significant responsibility for healthcare in the Clyde area including the VOLH. The Inquiry therefore took the view that it would be desirable for Mrs den Herder to give evidence to the Inquiry.

Requests for a statement

By letter dated 29 June 2010 Mrs den Herder was invited to provide a statement to the Inquiry. At that time Mrs den Herder was living in the Netherlands, having resigned from her post as Director of the Clyde Acute Directorate in July 2008. On 6 July 2010 Mrs den Herder made a telephone call to the Inquiry office and spoke to the Witness Liaison Manager. In the course of that conversation she confirmed that she was living in the Netherlands. Her position was that she was not able to give a statement to the Inquiry. She said that she had suffered serious illness and had little recollection of anything that would be of particular assistance to the Inquiry. She followed that telephone conversation with a letter dated 30 July 2010 confirming that she was unable to contribute usefully to the Inquiry.

The Inquiry wrote again to Mrs den Herder on 28 September 2010. In that letter she was invited to reconsider providing a statement to the Inquiry. It was suggested that this could be carried out in the Netherlands at her convenience. No response to that letter was received.

Request to give evidence

As the Inquiry progressed it became more and more evident that Mrs den Herder, as the Director of the Clyde Acute Directorate, could

be in a position to provide important assistance to the Inquiry. Another letter on the Chairman's behalf was sent to her on 17 November 2011, again to her address in the Netherlands. In that letter Mrs den Herder was asked to confirm whether she was prepared to give evidence to the Inquiry.

Mrs den Herder's response to the Inquiry

Mrs den Herder responded in an email dated 2 February 2012 to which a letter was attached. By this time she had moved to live in Beijing, China. In her letter she said that she had only just received the letter of 17 November 2011 and had not received the previous letter of 28 September 2010. She explained that she had not lived in the Netherlands since the summer of 2010. In her letter of 2 February 2012 Mrs den Herder provided some information about her health, which should remain confidential, and she repeated her position that she had no recollection of events at the VOLH. She apologised for not being more helpful.

Mrs den Herder did not accept the invitation made in the letter of 17 November 2011 to give evidence to the Inquiry. Another letter dated 26 March 2012 was emailed to her and a further letter was sent by email dated 8 June 2012, towards the end of the oral hearings. The intention at this time was to invite Mrs den Herder to elaborate upon what she had mentioned in previous correspondence about the stress and "burnout" she experienced during her time as Director of the Clyde Acute Directorate. Mrs den Herder responded to that letter by email and attached a letter dated 22 June 2012. In the email itself, Mrs den Herder said that she had taken time to try to recollect the events of 2008 and the circumstances of her appointment. It is certainly the case that in the six page letter attached to the email Mrs den Herder does provide some detailed information on these issues, and in particular discloses that the nature of her post was causing significant stress that ultimately resulted in what she referred to as "burnout". This is considered in more detail in Chapter 9. In that letter Mrs den Herder asked to put on record her sincere regret for the incidents which occurred at the Vale of Leven Hospital in 2008.

Final correspondence

Mrs den Herder was sent another letter by email dated 20 August 2012. In that letter she was invited to respond to evidence provided to the Inquiry by certain witnesses. She was provided with hyperlinks to the transcripts of these witnesses' evidence, and also reminded that all the oral evidence heard by the Inquiry was available on the Inquiry website as were the witness statements. Mrs den Herder responded to that request by letter dated 13 September 2012. Her letter is discussed in Chapters 9 and 15 of the Report.

It was evident from the contents of Mrs den Herder's last two letters of 22 June and 13 September 2012 that by that time she was able to recollect events and respond to issues raised in the evidence, no doubt with the assistance of the materials available to her on the Inquiry website. The Chairman, however, took the view that the detailed information provided by her in those two letters could only be relied upon if the information was already available to and accepted by the Inquiry.

It is unfortunate that Mrs den Herder was not able to provide a witness statement or oral evidence to the Inquiry, but it must be stressed that the Inquiry had no powers to compel her to do so as she resided outwith Scotland.

Dr Elizabeth Biggs

During the period 1 January 2007 to early February 2008 Dr Elizabeth Biggs was the Infection Control Doctor (ICD) for the VOLH. She was also the ICD for the RAH and the IRH where she was based. As set out in this Report Dr Biggs failed in a serious way to carry out her responsibilities as the ICD for the VOLH.

Initial contact with Dr Biggs

When Dr Biggs was first contacted it appeared that she would be able to give evidence to the Inquiry. By email dated 9 February 2010 the solicitor for NHS GGC indicated that Dr Biggs would be a witness at the Inquiry. A letter from the Inquiry dated 21 June 2010 to Dr Biggs requested that she provide a statement of her evidence to the Inquiry. Subsequently Dr

Biggs forwarded to the Inquiry a letter from a General Practitioner (GP) setting out medical reasons, which should remain confidential, for seeking to have Dr Biggs' participation in the Inquiry postponed. On 5 October 2010 the Deputy Solicitor to the Inquiry wrote to the GP asking for an update as to whether Dr Biggs was fit to give a statement or oral evidence to the Inquiry. A response dated 14 October 2010 was received from the GP to the effect that Dr Biggs remained unfit to give evidence of any kind at that point in time. The GP provided contact details of a colleague should the Inquiry require a specialist opinion, and the Deputy Solicitor wrote to the specialist medical practitioner on 20 October 2010. By letter dated 4 November 2011 the specialist medical practitioner confirmed that Dr Biggs was unable to give evidence and indicated that to do so would be detrimental to her health. The Chairman agreed that the situation should be reviewed once the Inquiry reached the relevant chapter of evidence.

Further contact with Dr Biggs

One year later, the Inquiry reviewed the situation prior to leading evidence on microbiology and infection control issues. The Deputy Solicitor wrote to the GP on 18 November 2011 requesting an update on whether Dr Biggs was fit to give a statement or evidence to the Inquiry. The GP responded on 7 December 2011 to say that Dr Biggs remained unfit to give evidence and questioned whether she would ever be fit to engage with the Inquiry.

In March 2012, evidence critical of Dr Biggs was emerging during oral hearings, and the Chairman was concerned that for reasons of fairness Dr Biggs should be legally represented. He was also of the view that, if Dr Biggs wished to be excused attendance from the Inquiry, it would be appropriate for her to be examined by a specialist medical practitioner instructed by the Inquiry. The Solicitor to the Inquiry wrote to the GP on 5 April 2012 explaining the workings of the Inquiry, including the warning letter process, and suggesting that the GP discuss with Dr Biggs her participation in the Inquiry. The Solicitor to the Inquiry also advised that Dr Biggs should consult with her professional association and perhaps obtain legal advice.

Finally, he conveyed the Chairman's view that Dr Biggs should be reviewed by a specialist medical practitioner instructed by the Inquiry.

The GP telephoned on 26 April 2012 to say that Dr Biggs had been advised to contact the Medical and Dental Defence Union of Scotland (MDDUS) of which she is a member. Since by 14 May 2012 the Inquiry still had not had contact from Dr Biggs or a representative, the Solicitor to the Inquiry wrote again to the GP asking if there had been any progress. The following day the Inquiry received a letter from Dr Biggs' solicitors confirming that they were acting for her on the instruction of the MDDUS and requesting that the Inquiry only contact Dr Biggs through them. Correspondence followed between the Solicitor to the Inquiry and Dr Biggs' legal representatives outlining arrangements for access to documents and the engagement of a specialist medical practitioner to review Dr Biggs' ability to give evidence.

Independent Medical Review

A specialist medical practitioner was approached, and with Dr Biggs' agreement an appointment was arranged. On 25 May 2012 the Solicitor to the Inquiry wrote a letter of instruction to the specialist medical practitioner outlining what was required, and requesting that if the doctor thought that Dr Biggs was unfit to give oral evidence to the Inquiry a "Soul and Conscience Certificate" should be submitted.

The independent medical review dated 4 June 2012 concluded that Dr Biggs was unfit to attend the Inquiry or to provide a statement, but that she was fit to instruct her solicitors. Core Participants' legal representatives were advised of this on 11 June 2012.

Dr Elizabeth Jordan

Dr Elizabeth Jordan was the Associate Medical Director for Clyde Directorate until 12 August 2007. She left for Australia soon afterwards. Because she was living in Australia, and because she had left some time before the CDI problem had emerged, she was not contacted by the Inquiry until a late stage in the proceedings. It was only once her name had been mentioned several times in oral evidence that the Inquiry took the decision to

make contact with her. On 7 June 2012 the Secretary to the Inquiry wrote to NHSGGC to obtain contact details. An email was then sent to Dr Jordan on 12 July 2012 outlining the reasons for contact and seeking the best contact address for future correspondence, to which she responded.

The Solicitor to the Inquiry emailed Dr Jordan on 4 October 2012 to request her assistance, and attached a number of documents for her to consider along with a list of questions. The questions covered Dr Jordan's remit including her responsibilities for the VOLH, her knowledge of the difficulties with Dr Biggs, the arrangements for the secondment of Ms Marie Martin, the medical staffing arrangements at the VOLH, and questions about the Clinical Governance Committee.

Dr Jordan replied on 7 November 2012 saying that she was unable to assist the Inquiry due to the time which had elapsed since she had left for Australia. Her memory of structures and processes was such that she did not believe that she could validly respond to questions relating to that time.

It is unfortunate that Dr Jordan was not able to provide a witness statement or oral evidence to the Inquiry but the Inquiry had no powers to compel her to do so as she resided outwith Scotland.

Closing submissions

The Rules²² permit Core Participants to make opening and closing statements to the inquiry.

At the close of hearings on 28 June 2012 the Chairman intimated that the Inquiry would circulate a draft list of topics to be addressed in closing submissions. A number of additions to this list were proposed by Core Participants and certain amendments were made in the light of these. The final list was published on the Inquiry website.

Core Participants were invited to make written closing submissions through their legal representatives, and all did so with the exception of the Royal College of Nursing and Health Facilities Scotland. Other parties

wishing to make written submissions were invited to apply to the Chairman for leave to do so, and applications were allowed, again through legal representatives, in respect of the following:

Dr Javed Akhter
 Dr Elizabeth Biggs
 Dr Afaq Khan
 Mrs Jean Murray
 Mr Thomas Walsh

Once all the submissions were received, the Inquiry circulated submissions to all the parties concerned and provided them with the opportunity to make written responses to other parties' submissions. Following completion of that exercise the decision was taken that no further oral hearing was necessary.

Counsel to the Inquiry did not consider it necessary to make a closing submission on behalf of the Inquiry.

Warning letters

The Rules²³ provide that "The inquiry panel must not include any significant or explicit criticism of a person in the report (and in any interim report) unless –

- (a) the chairman has sent that person a warning letter; and
- (b) the person has been given a reasonable opportunity to respond to the warning letter."

Issue of warning letters

In accordance with the Rules, warning letters were sent out to a number of individuals and organisations because the Inquiry was considering making significant or explicit criticism of them in the final Report. They were all offered the opportunity to respond to the warning letters within a specified time, and the Chairman granted extensions of the time limit where that was necessary. The warning letters included a schedule summarising the nature of the proposed criticism and providing references to evidence that supported the criticism being made.

Confidentiality of warning letters

The Rules provide that the recipient of a warning letter may disclose it to the recipient's recognised legal representative.²⁴ Otherwise the contents of a warning letter are subject to an obligation of confidence owed separately by the Inquiry to the recipient and by the recipient to the Chairman.²⁵ That obligation of confidence may, however, be waived,²⁶ and the Chairman granted a number of applications for waiver to assist recipients in preparation of responses to the warning letters.

Responses to warning letters

All but one of the recipients of warning letters responded to their letters. The Chairman was able to give careful consideration to all the responses made and was able to take them fully into account in the final Report.

It is to be noted that in a number of the responses recipients maintained that the specific criticism proposed had not been put to them in the course of the oral hearings. This reveals a misunderstanding of the nature of the inquisitorial process, and confuses it with the adversarial process that normally exists in a court setting. The whole purpose of the warning letter process is to give notice to individuals and organisations of potential criticism, so that they have the opportunity of making an appropriate response to that proposed criticism. The warning letter process itself ensures fairness for anyone who may be criticised.

2.2 Inquiry organisation and administration

The Inquiry Team

Details of the members of the Inquiry Team are outlined in Appendix 2.

Inquiry premises - Lothian Chambers

The Inquiry leased office premises from Edinburgh City Council at Lothian Chambers, George IV Bridge, Edinburgh. These had

23 Rule 12(7)

24 Rule 12(6)

25 Rule 13(1)

26 Rule 13(2)

previously been occupied by the ICL Public Inquiry. The Inquiry would like to thank Edinburgh City Council for this office accommodation and Scottish Courts Service for providing the Inquiry's IT support.

Accommodation for hearings

All oral hearings were held at Maryhill Central Community Halls, Maryhill Road, Glasgow.

Before selecting premises in Glasgow the Inquiry actively sought a suitable venue for hearings in the Dumbarton or Vale of Leven area. Two potential sites were visited by members of the Inquiry, but it quickly became apparent that neither of these could accommodate the number of Core Participants and members of the public who might attend. Furthermore, the Inquiry was acutely aware that adaptation of premises to form a suitable chamber for hearings as well as ancillary and office accommodation would cost a significant sum and would take a considerable time to complete.

The hall at Maryhill had previously been adapted for the ICL Inquiry, and immediately prior to use by this Inquiry was being used for hearings by the Fingerprint Inquiry. This meant that there were cost efficiencies, as the venue had already been refurbished and furniture and some other equipment could be re-used. The Inquiry appreciates the assistance provided by all the staff and management at Maryhill Central Community Halls. Although that venue involved additional travel for any patients and families living in the Vale of Leven area who wished to attend, it was readily accessible by public transport.

A venue in the west of Scotland did of course also mean daily travel for members of the Inquiry based in Edinburgh.

Document management system

In its early stage the Inquiry engaged a specialist consultant, Mike Taylor, of I-lit, to advise on the procurement of a document management system and court reporting system. Tenders were invited for supply of these services, and following this, a contract for the court reporting system was awarded to Merrill Corporation and a contract for the

document management system was awarded to Bramble, which sub-contracted the service to Merrill Corporation.

An electronic document management system was established, and those documents recovered which were considered relevant to the Inquiry, as well as documents created in the course of the Inquiry such as spreadsheets and timelines, were uploaded to this.

Access to documents

Access to the document management system was available to the Inquiry using secure connections over the internet, both in the Inquiry Office and at remote locations. Core Participants could also access the document management system over the internet.

Document display at hearings

During public hearings at Maryhill Community Central Halls the Inquiry was able to use the Merrill Corporation "Trial Director" system of document display. The hearing chamber was fully equipped with all the necessary cabling and hardware to display document images to the Chairman, Counsel, Core Participants' legal representatives and witnesses. The process allowed individual documents to be called up on screens positioned in front of users. In addition, a number of screens were positioned in the chamber that allowed the public to view the images.

Merrill Corporation provided software to enable the display of individual pages using the specific reference and pagination number for each document. Merrill Corporation also provided a trained operator who displayed the documents used in the oral hearings.

Registration with Information Commissioner's Office

The Inquiry registered as a data controller with the Information Commissioner's Office on 4 January 2010. A meeting was also held with the Information Commissioner's Office on 17 March 2010 to discuss how the Inquiry could ensure best practice with regard to handling data under the Data Protection Act 1998.²⁷ This was particularly important given

27 Data Protection Act 1998 (c. 29)

that the Inquiry held patient records. The Inquiry developed a security policy and regularly reviewed data protection issues at team meetings. A security log was maintained to ensure that any potential breaches of the policy were identified and promptly resolved.

Website

In October 2009, soon after it was established, the Inquiry set up a website, www.valeoflevenhospitalinquiry.org. This site was used extensively to provide information to potential Core Participants, witnesses and other interested parties, particularly in the initial stages of the Inquiry. Among the items posted on the website in the initial stages were:

- Background information on the Inquiry Team
- Core Participants
- A list of “Frequently Asked Questions”
- Guidance on witnesses, Core Participants, funding for legal representation, documents, procedures
- Application forms for Core Participant status, funding, travel and subsistence expenses, and compensation for loss of time
- Key documents, including the Inquiries Act 2005, the Inquiries (Scotland) Rules 2007, the Scottish Ministers’ Determination on Costs, and the Inquiry’s Terms of Reference
- Press releases

As mentioned earlier in this Chapter, as the Inquiry hearings progressed, transcripts of each day’s proceedings were published on the website, as were context setting documents and witness statements.

Public relations

Given the significant media interest in the work of the Inquiry, the BIG Partnership was appointed through a procurement process to deliver a media and public relations strategy for the duration of the Inquiry.

The BIG Partnership was commissioned to prepare press releases and to pro-actively engage the media at critical points in the Inquiry’s lifespan. These included the call for evidence, launch of the Inquiry’s website, the

start of public hearings, and subsequent extensions to hearings. In addition, the Big Partnership represented the Inquiry at the oral hearings and at other meetings, preparing and handling media briefings as required. They also provided a media monitoring service on press coverage for the Inquiry and on any related articles on *C. difficile* and infection control issues. The Inquiry found the engagement of an external agency valuable in ensuring that the media and the public in general were kept informed of the Inquiry’s progress, while at the same time allowing Inquiry Team members to concentrate their efforts on the work of the Inquiry.

Visits to the VOLH

The Chairman, Assessors and other members of the Inquiry Team, as well as a number of the expert witnesses, visited the Vale of Leven Hospital to familiarise themselves with the facilities with which the Inquiry is concerned. Due to the numbers involved, and to the availability of personnel, a number of visits had to take place. The Inquiry wishes to record its appreciation to NHSGGC for putting in place arrangements for these visits, as well as to staff on duty at the hospital itself for their unfailing courtesy and assistance.

Relationship with Scottish Government: the Sponsorship Team and the Core Participant Team

The Inquiry was established by Scottish Ministers. To facilitate the establishment of the Inquiry and to provide support for administrative matters relating to the Inquiry, including the selection of office premises, certain aspects of staffing and financial support, Scottish Government set up the Vale of Leven Hospital Sponsorship Team. The Inquiry wishes to express its thanks to the Sponsorship Team for their support and assistance throughout the period of the Inquiry.

A Management Agreement²⁸ was put in place between Scottish Government and the Inquiry which set out the division of roles and responsibilities where not already specified in the Act and Rules, and outlined the day to day liaison arrangements. The Agreement was

28 [INQ05670001](#)

published on the Inquiry website and was updated during the course of the Inquiry.

It must be stressed, however, that in its investigations and in compiling its report the Inquiry acts independently of government.

Scottish Ministers as Core Participants

Following the establishment of the Inquiry the Scottish Ministers applied on 22 December 2009 to be designated as a Core Participant. The Chairman decided that that application should be granted, and intimation of that decision was made on 7 January 2010. That meant that the Scottish Ministers had the same status as all other Core Participants to the Inquiry.

Soon afterwards, in the course of the Inquiry's initial investigations, it became apparent that this dual role of Scottish Ministers presented both the Inquiry and the Scottish Government with certain difficulties over communication and confidentiality. In particular, in the course of the Inquiry's work certain information would require to be shared with the Sponsorship Team which it would not be appropriate to divulge to Core Participants generally. At the same time, it would be inappropriate for one Core Participant to be privy to information concerning the Inquiry which was not shared with other Core Participants. A structure was therefore required that kept the two interests of Scottish Ministers separate.

The Solicitor to the Inquiry raised this issue with the Solicitor to the Scottish Government in a letter dated 9 April 2010. The Solicitor to the Scottish Government replied on 22 April 2010 advising that immediate steps were being taken to ensure that Sponsorship roles and Core Participant roles would rest with separate individuals within the Health Directorate, with separate reporting lines to senior management. A note was attached setting out details of the proposed structure. The Sponsorship Team would continue in the role of supporting the functioning of the Inquiry. The Core Participant Team was to be guided by the provisions in the Act and the Rules and by the Inquiry's protocols, all subject to an obligation of confidence owed to the Chairman.

The Chairman was satisfied that this arrangement would ensure that the position of the Scottish Ministers as Core Participants was the same as that of other Core Participants. The Management Agreement between Scottish Government and the Inquiry was updated to reflect the new arrangements. This kind of arrangement could provide an appropriate model for future inquiries in which the sponsoring body is also a Core Participant.

Cost of the Inquiry

Section 17(3) of the Act requires the Chairman to avoid unnecessary expense.

Sections 39 and 40 put an obligation on Ministers to meet certain expenses. The Minister set maximum hourly rates for legal teams in terms of Section 39 and the expenses of witnesses were covered in terms of Section 40. The document entitled Scottish Ministers' Determination,²⁹ which sets out the qualifications and conditions for legal representation, was published on the Inquiry website.

The Inquiry's final expenditure will be published on the Inquiry website on conclusion of the Inquiry.

Governance

Governance of the Inquiry budget involved:

1. Monthly meetings with the Sponsorship Team to discuss expenditure in the preceding month.
2. Discussion between members of the Inquiry Team and a report to the Secretary, before the monthly meeting with the Sponsorship Team.
3. Quarterly submissions by the Inquiry to the Sponsorship Team of both expenditure to date and a forecast of the Inquiry's estimated total expenditure.
4. Inclusion of Finance as a standing item on the agenda for the regular Monitoring Meetings between the Inquiry and Sponsorship Teams.

29 [INQ05680001](#)

5. Audits by the Inquiry Team of all expenditure, with a composite document of these audit reports to be passed to Scottish Government at the end of the Inquiry.

Work with the National Records of Scotland

The Rules³⁰ require the Chairman to consult the Keeper of the Records of Scotland on the manner and format of creating, maintaining and then transferring the record of the Inquiry on completion of the Inquiry. To comply with that requirement the Inquiry engaged in a series of meetings with National Records of Scotland (NRS, formerly known as NAS). The first meeting was held in October 2009, and discussions and negotiations throughout the course of the Inquiry to establish what will be handed over to NRS to constitute a formal record of the Inquiry for archiving purposes.

NRS made clear that they will require documentation which influenced the findings in the Inquiry Report and which informed the Inquiry in reaching the conclusions arrived at. Any documents supplied to NRS will become part of their Digital Data Archive.

To identify the material required, the Inquiry conducted audits of all documents that it held, broadly covering electronic files, the document management system and hard copy documents. NRS staff also visited the Inquiry office to inspect the documentation and to discuss these in more detail. The Inquiry will in due course provide a Schedule of Documents to NRS, and a complete set of documents held on the document management system will also be supplied by Merrill Corporation to NRS at the end of the Inquiry.

At the end of the Inquiry, the Inquiry website will continue to be maintained by Scottish Courts Service, and ultimately will be incorporated into the NRS archives.

30 Rule 16

Chapter 3

Healthcare Associated Infection
and *Clostridium difficile*

Introduction

This Chapter sets the context by explaining Healthcare Associated Infection and the relationship between antibiotics and the bowel flora. The Chapter goes on to provide an explanation of *Clostridium difficile*: what it is, how it is spread, how *C. difficile* infection (CDI) is diagnosed and treated, and what precautions should be taken to prevent the occurrence and spread of CDI. Developments for future treatment of CDI are also considered.

3.1 Healthcare Associated Infection

Definition

Healthcare Associated Infection (HAI) is defined as infection acquired as a result of a healthcare intervention either in hospital or in a community setting. HAIs are recognised worldwide as a major public health problem affecting both morbidity and mortality. Increased risk of acquiring an HAI is associated with, for example, extremes of age, obesity, complexity of procedures, the underlying medical problem, and co-morbidities. HAIs can prolong inpatient stays in hospital or even result in death, and are a significant financial drain on the healthcare system.¹

The range of HAIs includes Urinary Tract Infection (UTI), Respiratory Infection (RI), Gastrointestinal Infection (GI, e.g. diarrhoea), Surgical Site Infection, and life-threatening Blood Stream Infection. The most common HAIs are UTI, RI and GI.

By no means are all HAIs preventable. But various sources indicate that a significant number of HAIs could be prevented by good infection prevention and control practice and good antibiotic stewardship.²

How common are Healthcare Associated Infections?

A survey of the prevalence of HAIs in acute hospitals in Scotland conducted between October 2005 and October 2006 found that 9.5% of inpatients were affected. A

similar but not entirely comparable survey conducted in Scottish acute hospitals in March 2011 yielded a prevalence of 4.9%. The improvement in prevalence is thought to reflect the implementation of the national programme of targeted HAI interventions in the intervening period.³

3.2 Antibiotics and the bowel flora

The development of antibiotics

Antibiotics are chemicals that show selective toxicity to bacteria. There is no doubt that their introduction over the past 60 years has been one of the major advances in medical science. Their use has opened up all forms of surgery, and the treatment of overt infections has allowed the advancement of cancer therapy without fear of excessive mortality from super-infection. But as with most medical treatments, the use of antibiotics is not without risks. These risks have to be balanced against the potential therapeutic advantages of antibiotic use in specific circumstances.

Resistance to antibiotics

Like all life forms, bacteria have a need to survive. They are particularly adept at becoming resistant to the use of antibiotics. Well known examples of acquired resistance that may adversely affect treatment include the meticillin resistant *Staphylococcus aureus* (MRSA) and multiple resistant Gram negative organisms.

Antibiotics also affect environmental bacteria including those that make up the normal bowel flora of animals and humans. It is unusual for a specific antibiotic to be only active against one particular bacterial species or group of species. Treatment of a specific infection with an antibiotic will therefore also be likely to have an effect on other bacteria that are normally present, for example in the respiratory tract or bowel.

The relationship between the body's bacterial flora and the individual patient is delicate, and the use of antibiotics is likely to upset this balance and allow more resistant

¹ [GOV00460003-04](#)

² [GOV00460003-04](#); [EXP02830012](#)

³ [GOV00460001](#); [GOV00460003](#); [GOV00510001](#); [INQ05220001](#)

organisms to grow in greater numbers. Alteration of the bowel flora with antibiotic use may result in self-limiting diarrhoea, which is the body's defence mechanism for upset of the normal balance. Sometimes the diarrhoea may be the result of a bacterial super infection caused by the overgrowth of a normally suppressed organism such as *C. difficile*.

The increasing bacterial resistance to antibiotics is a threat to the ability to treat infections.⁴ Whilst ongoing research continues to seek new antibiotics, it is important that the effectiveness of current drugs is not compromised by inappropriate and over-use of antibiotics. This has resulted in far-reaching guidelines for treatment of specific infective situations. Good antibiotic stewardship should have the dual effect of prolonging the usefulness of antibiotics and of reducing adverse side-effects such as *C. difficile* associated diarrhoea (CDAD).⁵

3.3 *C. difficile* – What is it?

The nature of the organism

The bacterial genus *Clostridium* is widely distributed in nature and includes a number of organisms that can cause disease in humans. These include *Clostridium perfringens* (*welchii*), *Clostridium tetani*, and *Clostridium botulinum*.

The clostridia are characterised as Gram-positive rod-shaped anaerobic spore-bearing organisms. That is, they stain darkly with Gram's stain. The descriptive "anaerobic" means that these organisms can only reproduce in the absence of oxygen. Such environmental conditions exist in deep necrotic wounds (for gas gangrene) or in the gut. The organisms survive the adverse conditions of oxygen absence by producing spores which are able to survive in air and in dry conditions for long periods. They are also resistant to certain antibiotics and many disinfectants.

Disease is usually a result of the organisms multiplying under ideal anaerobic conditions

such as poorly stored food, deep necrotic wounds, and the lower bowel. The organisms produce powerful exotoxins (toxins released by bacteria) that affect the body in ways characteristic of the particular species. Toxins produced by *C. perfringens* are responsible for food poisoning and gas gangrene, and the neurotoxins (toxins which attack the nervous system) of *C. tetani* and *C. botulinum* lead to tetanus and botulism respectively.

C. difficile is carried in the bowel of up to 4% of healthy adults, and under normal circumstances the organism does not cause symptoms in these people. The organism is in relatively small numbers and is held in check by the interaction of the other bacterial flora that make up the normal bowel flora of the healthy adult. If the organism becomes predominant, toxins may be produced that will lead initially to diarrhoea. If untreated the disease may lead to death of the bowel wall, septicaemia (blood poisoning), and death. Multiplication of the organism may be triggered by the use of broad spectrum antibiotics for suspected infection by other bacteria.

C. difficile, as spores, is also found widely in the environment, including soil and standing water, and in the vicinity of symptomatic patients. In hospital up to 50% of patients, particularly the elderly and newborn infants, may carry *C. difficile*, although in infants it is seldom responsible for symptoms. The carriage rate in care home residents will also be higher than the community background level of up to 4%.

C. difficile produces two major toxins known as A and B. These have a serious effect on the mucosal wall of the large bowel (which is exposed to the contents of the gut), leading to inflammation and tissue damage. The consequence of this damage is to allow leakage of fluid into the lumen of the bowel resulting in profuse CDAD. In severe cases the lining of the bowel may slough off and become detached, a condition known as pseudomembranous colitis. This condition is life threatening and requires urgent surgical intervention to remove the affected bowel.⁶

⁴ [EXP00690011](#); [EXP00600004-06](#)

⁵ [EXP00600005](#)

⁶ [EXP00600001](#)

Identification of ribotypes

There are numerous different strains of *C. difficile*, and it is important to identify which strains are prevalent in society, including the closed environment of a hospital or care home. This is significant for epidemiological purposes, both to identify probable incidents of cross infection and to identify hypervirulent strains that may incidentally be circulating. Ribotyping is the most common method used to identify specific strains of *C. difficile*, and routine typing of strains is carried out using the Polymerase Chain Reaction (PCR) technique to identify specific ribotypes.

In any given situation designated as an “Outbreak” it is likely that more than one ribotype will be circulating. Typing tests can demonstrate with certainty that two strains are different, but it is more difficult to state that two strains are the same. The term “indistinguishable” is used to reflect the fact that the strains examined cannot be separated on the basis of current specific testing protocols.

3.4 How *C. difficile* is spread

C. difficile is able to remain in the environment in the form of spores. Because these spores are resistant to drying, to many chemical disinfectants and to disinfection by boiling, they may persist in the environment and contaminate surfaces and other objects

such as clothing and door handles. A symptomatic patient may shed vast numbers of spores as a result of the diarrhoea. Hands of patients, staff and visitors who are in contact with these surfaces may transfer the spores to vulnerable individuals. Ingested spores may lead to symptomatic infection. The role of contamination of the ward air in the transmission of spores is much less certain, but this probably also occurs.⁷

For infection to result from ingestion of the spores of *C. difficile* certain risk factors are required, in particular increasing age, severe underlying disease, prolonged antibiotic therapy or specific antibiotics associated with CDI, and a weakened immune system. Drugs to reduce gastric acidity (proton pump inhibitors) may play a role, but this is not proven.

The incubation period for CDAD is imprecise. The onset of diarrhoea in susceptible patients is typically during, or shortly after, receipt of a course of antimicrobial treatment, but may occur from a few days to as long as 12 weeks after the termination of the therapy.

One problem important for epidemiological purposes is that of defining where acquisition of the organism occurred: in the community or in hospital. The “Guidance on Prevention and Control of *Clostridium difficile* Infection (CDI) in Care Settings in Scotland” (2014 edition)⁸ gives the following definitions:

“Definition of community associated CDI

This is a CDI patient with onset of symptoms while outside a hospital and without discharge from a hospital within the previous 12 weeks - or with onset of symptoms within 48 hours following admission to a hospital without stay in a hospital within the previous 12 weeks.

Definition of healthcare associated CDI

Healthcare associated CDI is defined as when a CDI patient has had onset of symptoms at least 48 hours following admission to a hospital or up to four weeks after discharge from a hospital.

Definition of unknown cases of CDI

This is a CDI patient who was discharged from a hospital 4 to 12 weeks before the onset of symptoms”.⁹

⁷ [EXP00600002](#)

⁸ [INQ05570001](#)

⁹ [INQ05570018](#)

Although the time interval used in some areas varies between 48 and 72 hours,¹⁰ it is noted that the definition of 48 hours was used in the VOLH at the time.¹¹

Antibiotics associated with CDAD

The particular antibiotics associated with CDAD are the cephalosporins, co-amoxiclav (and other broad spectrum penicillins), clindamycin, and ciprofloxacin (and other fluoroquinolone antibiotics). These are collectively referred to as the “four Cs”. It is worthy of note, however, that any antibiotic may result in CDAD, so the reasons for prescribing antibiotics need to be assessed against the risks of inappropriate prescription of these valuable and occasionally life-saving drugs. Antibiotic prescribing guidelines have been developed to assist appropriate prescribing and are commonplace in healthcare settings.

Broad spectrum antibiotic treatment is a major risk factor for *C. difficile* infection and the resulting CDAD. The elderly, incontinent patient with explosive diarrhoea from CDAD, disseminating spores into the environment, is a major risk factor in the spread of *C. difficile* and CDAD by cross infection.

Hypervirulent strains

These are strains of *C. difficile* that produce high levels of the toxins. The 027 (027/NAPI/BI) strain was associated originally with major outbreaks in North America and Western Europe, but 027 is now worldwide in distribution. Infection with the strain was also associated with increased severity of disease and higher mortality. Apart from the toxins A and B associated with CDAD, this strain also produces a binary toxin whose role in CDAD is uncertain. The 027 strain is also particularly associated with resistance to ciprofloxacin and other fluoroquinolone antibiotics. But it is important to be aware that, while 027 has often been described as a hypervirulent strain, **any** strain of *C. difficile* can produce severe CDAD.¹²

3.5 Laboratory diagnosis of *C. difficile* infection

No absolute test

There is no test that is both 100% sensitive and also 100% specific. This means that the laboratory must be aware of the reliability of any test and ensure that the likely prevalence of both false positive and false negative tests is appreciated. This is particularly important with regard to the diagnosis of CDAD in a patient with diarrhoea, where failure to repeat a negative result in the presence of persisting symptoms may lead to failure to initiate specific therapy.

It is also important that the laboratory attempts, to the best of its ability, to confirm a positive result by other tests in order to ensure that a patient is not given unnecessary and potentially harmful antibiotics. False negative results may also lead to the failure of infection control precautions. Symptomatic patients with diarrhoea should be adequately isolated until an infectious cause is firmly excluded, and if necessary there should be repeat testing of samples if a cause is not identified or excluded.

Types of tests

At present there are four groups of tests available for the diagnosis of CDAD.

1. Glutamate Dehydrogenase (GDH) Detection Tests: GDH is a surface expressed enzyme common to both *C. difficile* strains that produce toxins and those strains that do not produce toxins. They are useful screening tests, but because they detect the presence of the organism it is necessary to perform a toxin test on positive specimens. The presence of CDAD is associated with toxin production, not merely the actual presence of the organism. There are two types of tests for GDH: test well based and membrane based. In general, test well based tests are more sensitive but less specific than membrane tests, and membrane tests are more specific but less sensitive than test well based tests.

10 [TRA01060082-85](#)

11 [TRA01000088](#)

12 [INQ03140001](#); [INQ03150001](#); [INQ05290001](#); [INQ02890014](#)

2. Toxin A and B Detection Tests (CDT): these tests detect production of both Toxin A and Toxin B. They fall into two types: Enzyme Immuno-Assay (EIA) based tests, or cytotoxin-based assays. The latter are deemed the current “Gold Standard”, but are time consuming and expensive. They are also not perfect. EIA based tests are generally thought to have a sensitivity of some 60%.
 3. Polymerase Chain Reaction (PCR) tests: these techniques are used to detect the conserved genes for toxin production. They are very sensitive, but identification of the relevant gene does not necessarily indicate that the gene is being expressed and therefore that toxin is being produced. The clinical relevance of PCR positive toxin negative strains is the subject of much discussion. The facilities to carry out molecular tests such as PCR are not widely available outside major hospitals and reference laboratories.
 4. Culture for the organism: the growth and isolation of the organism using agar culture takes several days. Isolation of the organism is necessary to allow typing of the isolated strain by ribotyping or other molecular techniques. The simple isolation of the organism gives no information on whether it was producing toxin and therefore causing symptoms in the patient. To further complicate matters, more than one ribotype may be present in an individual, or reinfection may be with an identical or different strain.
- The following recommendations are contained in the consensus guidance produced by representatives of the Scottish Microbiology and Virology Network (SMVN), the Scottish Salmonella, Shigella and Clostridium difficile Reference Laboratory (SSSCDRL) and Health Protection Scotland (HPS), published by HPS in December 2012 as the “Recommended protocol for testing for *Clostridium difficile* and subsequent culture”:

1. Any *C. difficile* toxin immunoassay (i.e. EIA or membrane assay) being used should be one of the better performing assays.
2. Diarrhoeal stool samples should be tested by an initial sensitive screening test (GDH test or toxin B gene PCR test). As with any other test, laboratories will have to satisfy themselves that any specific assay chosen as part of the algorithm is of an acceptable quality and performance standard.
3. Those samples which are screen-negative do not require further testing, and can be reported at this point e.g. "*C. difficile* screening test negative".
4. Initial screen-positive faecal samples should be tested for the presence of *C. difficile* toxin on the same sample. Samples which are also positive in this toxin assay can then be reported accordingly e.g. "*C. difficile* toxin positive". Only those stool samples which are positive in **both** the initial screening test **and** the subsequent toxin test are eligible for reporting under mandatory surveillance of CDI.
5. Some samples which are positive in the initial screening test will fail to confirm in the subsequent toxin assay. This may be due to the following:
 - Toxin concentration is below limit of detection (false-negative toxin test)
 - Toxin concentration yields a result within manufacturers indeterminate range (indeterminate toxin test)
 - Toxin is absent (true-negative toxin test). This may be due to the presence of *C. difficile* which are non-toxigenic or not expressing the toxin gene

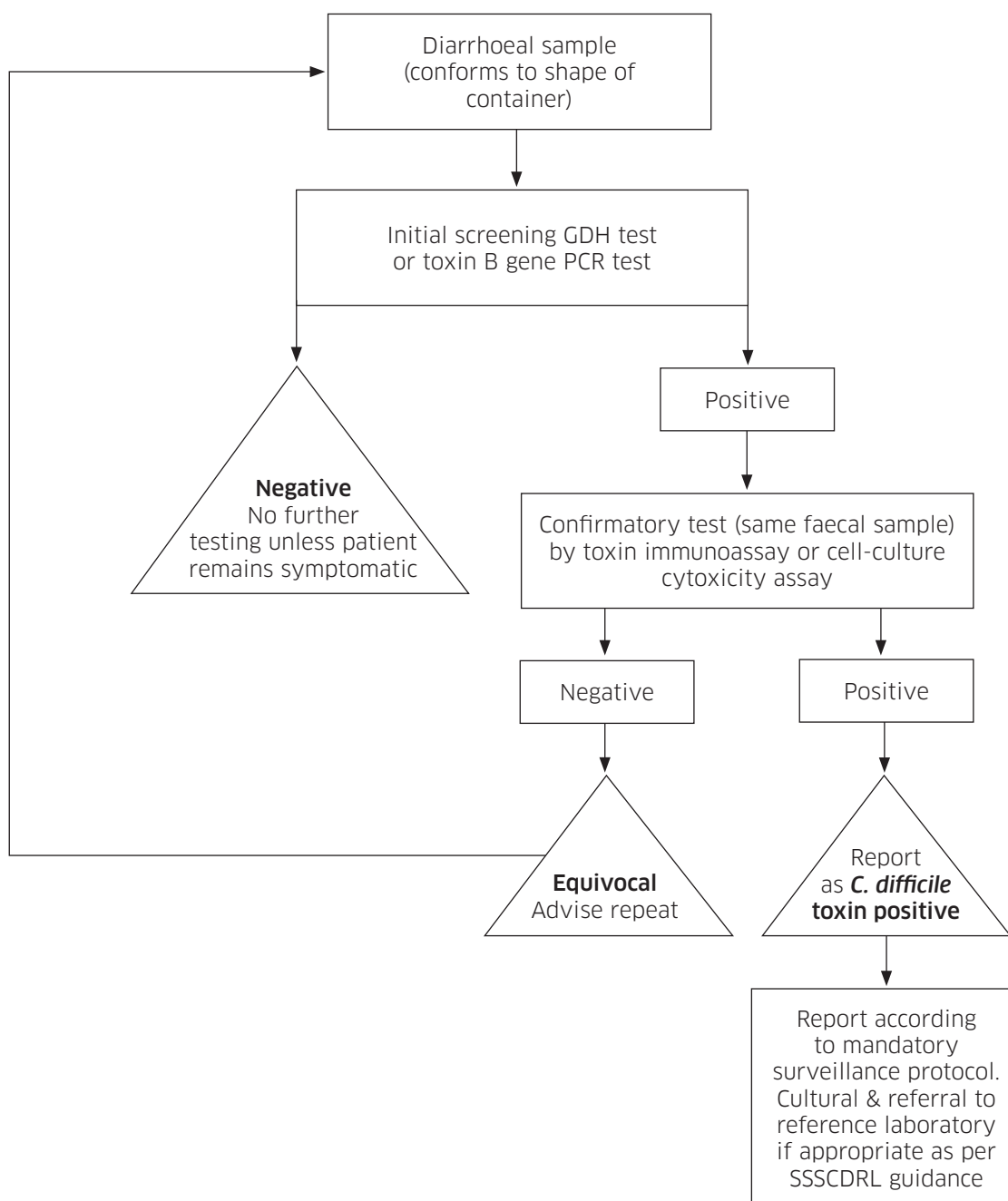
Occasionally the screening test may be positive in the absence of viable *C. difficile* organisms (false positive screening test) 6. These discrepant results should then be reported as equivocal e.g. "Equivocal result: *C. difficile* screening test positive but *C. difficile* toxin could not be detected in this sample. Advise repeat sample if patient remains symptomatic".

6. The use of an initial sensitive screening test will increase the Negative Predictive Value of the algorithm. The use of a confirmatory test (on the same faecal sample), as part of the diagnostic algorithm, will increase the accuracy of toxin-positive results. This algorithm was found to have the best clinical utility in the largest diagnostic algorithm study that has been performed to date. In this study, only algorithms that included a toxin test provided an acceptably high specificity in comparison with the gold standard of a well-performed cell-culture cytotoxicity test. This guidance is compatible with current ESCMID (European Society for Clinical Microbiology and Infectious Diseases) guidance. The guidance will be revised on an ongoing basis to take account of further diagnostic developments.
7. All of these assays will fail to detect some true toxin positive samples. If there remains a strong clinical suspicion of CDI then a repeat faecal sample should be sent and tested, and the need for empirical treatment considered.
8. Diagnosis of CDI is based on both the clinical presentation and the results of any laboratory tests; i.e. laboratory test results should not be interpreted without reference to clinical features. Issuing interpretative comments with reports may aid clinicians in understanding the significance of results.¹³

The protocol also provides an algorithm for testing faecal specimens, although only intended as a guide to be adapted to local

circumstances. This is reproduced in Figure 3.1.

Figure 3.1 Current recommendations for testing faecal specimens¹⁴



As indicated previously, PCR detects the presence of the genes coding for the toxin. It does not indicate that the organism is producing toxin. Thus, the test may over diagnose the presence of CDAD.

Clearance testing

Individuals can remain toxin positive for some weeks following the resolution of symptoms. Repeat testing of toxin positive samples is therefore **not** recommended.

3.6 Precautions against occurrence and spread of *C. difficile* infection

Transmission

C. difficile can be transmitted to individuals by a number of routes including direct hand to mouth spread, contamination of hands from surfaces contaminated with spores, and ingestion of airborne spores.

Good and appropriate hand hygiene is essential to prevent or reduce contamination. So too is good maintenance of the healthcare environment. The thorough cleaning of all areas is necessary to prevent contamination of surfaces.

As explained in paragraph 3.4, CDAD will only occur in individuals who are receptive to infection with the spores. This will include the elderly, the severely ill, and those patients receiving broad spectrum antibiotics. Good antibiotic stewardship with the reduced deployment of broad spectrum antibiotics will reduce the selection pressure on the bowel flora and the risk of overgrowth with toxin producing *C. difficile*.

How to prevent cross infection

The main way to prevent cross infection is to isolate the patient in a single room. In a proven outbreak situation it may be necessary to cohort patients because of a lack of single rooms, but this should always be a last resort, and under no circumstances should asymptomatic patients be in the same area as symptomatic patients.

Good hand hygiene practice is essential, using soap and water. Alcohol gels are not effective against *C. difficile* spores.

Appropriate personal protective equipment must be used by all persons entering the room. This will include gloves, aprons and gowns.

There should be regular cleaning of the patient environment with chlorine-based disinfectants. Once CDI patients have been discharged or transferred, the area should be cleaned. The use of controlled hydrogen peroxide vapour should be considered.

Dedicated equipment should be used with the infected patient. This would include blood pressure cuffs, stethoscopes, thermometers and commodes. Once the patient has been discharged, equipment should be decontaminated before return to use.

Definition of an outbreak

Any unexplained incident of loose stools (that is, where the specimen takes up the shape of the container; Bristol Stool Classification types 6 or 7) should be assumed to be infective until an alternative cause is confirmed. Two or more episodes of loose stools within 24 hours are classified as diarrhoea.

In the VOLH the definition of a potential outbreak of CDI included “two or more linked cases of unexplained illness (or isolates), which indicates the possibility that they may be due to a known or unknown infectious agent”.¹⁵

The presence of an outbreak can be confirmed once linked cases of infection with indistinguishable organisms are demonstrated. But the problem of defining an outbreak lies with the definition of “indistinguishable organisms”. As discussed previously, there are a number of different strains of *C. difficile*. These can be differentiated by several techniques, of which ribotyping is the most widely used for epidemiological purposes. And sporadic cases of CDAD will occur from time to time in the healthcare setting against the background of known carriage of the organism in various populations. So while on occasion two or more cases may occur concurrently, this does

15 [GGC27390003](#)

not necessarily mean that cross infection has occurred. The increased incidence may reflect a background of increasingly susceptible patients with other risk factors such as excessive use of broad spectrum antibiotics.

For a formal outbreak to be declared, epidemiological evidence is necessary to demonstrate that a single ribotype is being transmitted between patients as a result of failure of general infection control measures against a background of susceptible patients. An observed increase in CDAD may be due to an increase in background level of CDAD, or a result of cross infection. In many circumstances both situations will be identified at the same time.

A Health Board Outbreak Policy should be available to guide staff. Frequent support from the Infection Control Team will be required by both the Infection Control Doctor and the Infection Control Nurses. An Outbreak Control Committee should be convened to supervise control of the outbreak, to handle media and public relation concerns, and to review events once the outbreak is controlled and stopped.

3.7 Treatment of *C. difficile* infection

Existing good practice

National and local guidelines should be followed. The following is a broad outline of approaches to therapy:¹⁶

- Urgently review antibiotic chemotherapy and stop any non-clostridial antibiotics as soon as possible unless this would further endanger the patient's wellbeing
- Stop the use of anti-peristaltic agents, opiates and proton pump inhibitors
- Assess the severity of infection
- Primary or first recurrence
 - In cases of mild to moderate infection, commence treatment with oral or (exceptionally) intravenous metronidazole
 - In cases of severe infection, commence oral vancomycin (intravenous vancomycin does not reach the intestinal lumen and is not effective)
- Second or subsequent relapse
 - Prolonged use (for more than ten days) of vancomycin
 - Consider tapering (decreasing) doses of vancomycin
- Ensure that patient is hydrated and accurately monitor fluid input and output
- Ensure that the patient's comfort and dignity are preserved at all times
- Monitor progress of the patient. A surgical opinion should be sought if the patient's condition deteriorates and the development of pseudomembranous colitis is suspected.

Options for future treatment

Future treatment options include new specific antibiotics for CDAD treatment, super-colonisation with non-toxigenic strains of *C. difficile* for prevention of CDAD in susceptible patients, faecal transplants for recurrent infection, and immunotherapy.¹⁷

Of particular interest is the macrocyclic antibiotic fidaxomicin. This compound has a very narrow spectrum of activity which includes *C. difficile*, but it does not disturb the normal bowel flora. This may serve both to treat CDAD and to reduce the likelihood of recurrence. Studies are in hand to evaluate the place of this drug in the management of complicated CDAD.¹⁸

The use of vaccines in the prevention of CDAD is attractive, but to date no vaccine has proved to be of significant benefit. A number of clinical trials are in progress.

16 [EXP00600006](#)

17 [EXP00600007](#)

18 [EXP00600007](#)

3.8 Conclusion

There is no doubt that CDAD is a significant cause of morbidity and mortality in the elderly, the immunosuppressed, and severely ill patients on broad spectrum antibiotic chemotherapy. Diarrhoea in these groups of patients must be taken seriously, and attempts made urgently to establish firstly whether or not infection is involved, and secondly, if infectious, the specific cause. It is essential that *C. difficile* infection is confirmed or ruled out at the earliest possible moment.

Patients with diarrhoea must be isolated as soon as possible until infectious diarrhoea has been excluded or treated and symptoms resolved. Antibiotics specifically for CDAD must be commenced as soon as diagnosis is confirmed by the laboratory. Treatment should be guided by a locally approved accepted algorithm to ensure efficient use of specific antibiotics. Other antibiotics should be reviewed and stopped unless there are overriding clinical reasons to continue. Anti-diarrhoeal medication and proton pump inhibitors should also be stopped.

Diagnostic testing should use recognised test platforms and the testing algorithm should conform to National Guidelines.

In the light of ongoing research into the future of specific antibiotic treatment, vaccine development and the use of faecal transplants, there should be a regular review of local protocols for the management of CDAD.

Chapter 4

The number of patients with
CDI and those who died

Introduction

The focus of this Chapter is on the patients who contracted *C. difficile* infection (CDI) during the relevant period and the number of patients who died with CDI as a causative factor in their deaths.

4.1 Discovery of the problem

The research project

In the week beginning 7 April 2008 a specialist biomedical scientist¹ at the Scottish Salmonella, Shigella and *C. difficile* Reference Laboratory, who was engaged in an academic research project, obtained two results for the type 027 strain of *C. difficile* toxin from stool specimens. These had been taken from two patients at the Royal Alexandra Hospital (RAH) in August and September 2007 and stored pending investigation as part of the research project.² A senior Infection Control Nurse at the RAH was informed of these results,³ on or about 28 April 2008,⁴ and Dr Linda Bagrade, then Consultant Microbiologist and Infection Control Doctor for the RAH and the Vale of Leven Hospital (VOLH), was aware of the results by late April 2008.⁵

Coincidentally, an isolate from a stool sample taken from a deceased patient during a post-mortem⁶ on 17 March 2008 was sent for ribotyping, and was also discovered to be the 027 strain.⁷ The patient had died in the VOLH on 9 March 2008, but as was then the usual practice the post-mortem was carried out at the Western Infirmary in Glasgow. In the post-mortem report⁸ the cause of death was as follows:

- 1a: Septicaemia due to
- 1b: Pseudomembranous colitis due to
- 1c: *Clostridium difficile* infection

The Western Infirmary presumably made the request for ribotyping because, as narrated in the post-mortem report, the deceased had

a history of CDI requiring hospital treatment for approximately five weeks.⁹ The formal report¹⁰ of the result from the Reference Laboratory dated 7 April 2008 was sent to the Western Infirmary, the hospital which had made the request, not to the VOLH.

Two further isolates from a patient at the RAH were tested at the Reference Laboratory in April and the 027 strain identified. The first was from a specimen taken from the patient during surgery on 9 April 2008,¹¹ and the second from a specimen provided by the same patient on 20 March 2008.¹² Formal reports of these results dated 30 April 2008¹³ were sent to the RAH, although it appears that the Infection Control Team (ICT) at the RAH were made aware of the results two days earlier on 28 April 2008.¹⁴

Initial response

Initially the focus was on the RAH, but by mid-May¹⁵ there was growing recognition that there was a problem with CDI at the VOLH. At a meeting of the Infection Control Working Group on 14 May 2008¹⁶ it was minuted that:

“there have been five cases (four patients and one member of staff) in the last nine months in the RAH and VOL”.¹⁷

That same day a special meeting chaired by Dr Bagrade was convened to consider the five cases.¹⁸ On 21 May 2008 a meeting chaired by Mr Thomas Walsh, NHSGCC Infection Control Manager, was held in the RAH regarding cases of *C. difficile* 027 in the RAH and the VOLH.¹⁹ By that time the number of cases identified with the 027 strain had risen to six (five patients and one member of staff)²⁰ and there was a possible link between two patients and the staff member.²¹ A further meeting took place on

1 [WTS02100003-04](#)
 2 [GGC09020001](#)
 3 [WTS02100004](#)
 4 [GGC09020002](#)
 5 [TRA01020102](#); [WTS01930009](#)
 6 GGC00300014
 7 GGC23680002
 8 GGC00300012

9 GGC00300012
 10 GGC23680001-02
 11 GGC23700001
 12 GGC23690001
 13 GGC23690002; GGC23700002
 14 [GGC09040002](#)
 15 [TRA01020103](#)
 16 [GOV00650002](#)
 17 [GOV00650004](#)
 18 [GGC01310001](#)
 19 [GOV00650009](#)
 20 [GOV00650010](#)
 21 [GOV00650004](#)

28 May 2008, again chaired by Mr Walsh,²² by which time the number of CDI cases identified in the RAH and the VOLH with the 027 strain had risen to seven (six patients and one member of staff).

The look back exercise

Following considerable media interest, on 5 June 2008 Ms Sandra McNamee, the NHSGGC Infection Control Nurse Consultant, passed on to the ICT a press enquiry from the Dumbarton and Vale of Leven Reporter²³ which requested information on the number of cases of all strains of CDI at the VOLH in the previous six months and the number of deaths resulting.²⁴ That request provoked a review of all cases of CDI at the VOLH with a focus on the period 1 December 2007 to 31 May 2008, and it only then became evident that there had been a persistent problem with CDI and associated deaths during that period. Once that became apparent, the decision was taken on 9 June 2008 to set up an Outbreak Control Team (OCT) to investigate the position at the VOLH.

On the same date Mr Robert Calderwood, then Chief Operating Officer, Acute Services, commissioned an internal investigation into certain aspects of the CDI problem as it was then perceived by NHSGGC.²⁵

First Outbreak Control Team meeting

At the first Outbreak Control Team (OCT) meeting on 10 June 2008²⁶ 54 patients were identified as testing positive for CDI in the previous six months at the VOLH.²⁷ Of those, 16 deceased patients had CDI referred to on their death certificates. By the date of the publication of the OCT Report²⁸ in October 2008 the number of identified CDI patients from 1 December 2007 to 31 May 2008 had risen to 55.²⁹ By then it was also thought that CDI had contributed to the deaths of 18 patients.³⁰

What the previous discussion highlights is that the CDI problem at the VOLH was not initially identified at the VOLH or even within the Clyde Area. It came to light as a result of a combination of external events including an incidental research project and a press enquiry by a local newspaper.

4.2 Number of CDI cases

Epidemiological difficulties

The science relating to CDI has already been discussed in Chapter 3, where the system of ribotyping is explained. Because the problem with CDI was not identified until May 2008, many stool samples from the early part of the Inquiry focus period had already been destroyed. Consequently no ribotyping could be carried out in those cases.

Identifying where patients acquired the infection also gives rise to difficulties. Although an examination of the prevalence of CDI in the RAH was not part of the Inquiry's remit, it is clear that there were patients at the RAH who suffered from CDI during the relevant period. In addition, some patients who were transferred from the RAH to the VOLH received antibiotics in the RAH which might have predisposed them to acquiring CDI. It was therefore not possible, with the information available to the Inquiry, to carry out a detailed epidemiological analysis to show (a) where patients acquired the infection, or (b) whether any predisposing antibiotics were given in each patient's case. Patients were regularly moved between wards within the VOLH and transferred between the RAH and the VOLH.

Nevertheless, it has been possible to arrive at a number of conclusions in relation to (a) the numbers of patients covered by the Inquiry remit and (b) where the CDI might have been acquired. It is to be noted that, as discussed elsewhere in the Report, the conditions in the VOLH in the period 1 January 2007 to 1 June 2008 were ripe for cross contamination. Patients were rarely isolated when they first displayed symptoms of infection. Instead, staff waited for a confirmed diagnosis of CDI.

22 [GOV00650012](#)

23 [GGC09040002](#)

24 [GGC05670002-03](#)

25 [GGC00610002](#)

26 [GOV00650016](#)

27 [GOV00650018](#)

28 [GGC00600001](#)

29 [GGC00600005](#)

30 [GGC00600005](#)

Included in the remit are patients who the Inquiry considers acquired the infection at the VOLH or who in any event were treated for the infection at the VOLH.

***C. difficile* “focus” patients – 1 December 2007 to 1 June 2008**

In the focus period (1 December 2007 to 1 June 2008) 63 patients have been identified as falling within the Inquiry’s remit. Of that number, 55 patients have been identified as likely to have acquired the infection within the VOLH. Nine of those patients probably acquired the infection in the VOLH, but were diagnosed in the community. This was usually after being discharged from the VOLH, and usually involved a re-admission to the VOLH after the onset of the infection. There were also patients within this group of 55 who acquired the infection at the VOLH, but who were not diagnosed as positive until being transferred to the RAH. The remaining eight patients may have acquired the infection in the VOLH, the RAH or the community. But in each of these cases either the onset of the infection or the CDI diagnosis was at the VOLH.

The period 1 January 2007 to 30 November 2007

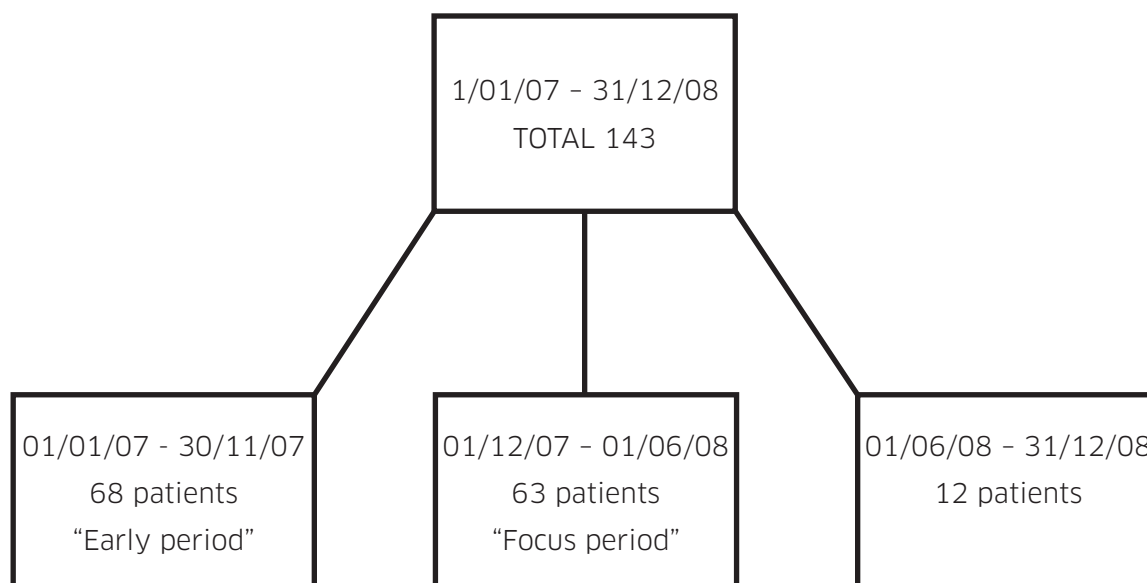
In the early period (1 January 2007 to 30 November 2007) 68 patients at the VOLH suffered from CDI. The family members of two of these 68 patients became Core Participants in the Inquiry and the medical records of these patients were subsequently examined by the experts commissioned by the Inquiry, who produced reports. Records were recovered for a further 37 of the 68 patients for that period, although nursing notes were missing from four sets of those records. No records for the remaining 29 of the 68 patients were available to the Inquiry.

The period 1 June 2008 to 31 December 2008

In the period 1 June 2008 to 31 December 2008 12 further patients at the VOLH tested positive for CDI. A number of patients who tested positive during the focus period tested positive again after 1 June 2008, but these patients are not included in this group of 12.

The figures for all three periods are set out in Figure 4.1.

Figure 4.1 Patients with CDI



4.3 Number of *C. difficile* deaths

Inquiry analysis

The Inquiry asked Professor George Griffin, Professor of Infectious Diseases Medicine at St George's Hospital, University of London, to carry out an analysis of patients covered by the Inquiry's remit who contracted CDI and subsequently died. He was asked to determine whether CDI was a causal factor in their deaths, either as the underlying cause of death or as a contributory cause of death. He examined the case records, prepared a report for each of the 43 patients who died, and also produced an overview report summarising his findings.³¹

Professor Griffin had carried out a similar exercise for an Inquiry into CDI in Northern Ireland in 2010.³²

When preparing reports for this Inquiry Professor Griffin did not see the reports produced by other experts commissioned by the Inquiry prior to the completion of his work. But after he had completed his work he did review such reports as a cross-check and in order to make a comparison. In 90% of the cases reviewed there was agreement on CDI as a cause of death.³³

In one of the cases where there was some disagreement, Professor Griffin had looked at records that had not been available to the other Inquiry medical expert.³⁴ In another case, where the Inquiry medical expert who had looked at the records could not express a view, Professor Griffin did consider that there was sufficient information available upon which to base an opinion.³⁵

The comparative exercise in such cases, where clinical judgement plays an important role, lends force to Professor Griffin's analysis.³⁶

Number of deaths between 1 December 2007 and 1 June 2008

There were 31 patients who died during the Inquiry focus period of 1 December 2007 and 1 June 2008. Of these, 28 patients had CDI as a causal factor in their deaths either

as the underlying cause of death or as a contributory cause of death.

Of these 28 patients, 26 acquired the infection at the VOLH and the remaining two acquired the infection either at a nursing home or the RAH. But both suffered the onset of the infection at the VOLH, where they eventually died.

Numbers of deaths before 1 December 2007

The patient records in the early period were not scrutinised by medical and nursing experts in the same fashion as the patient records in the focus period. As explained previously, many were unavailable, and Professor Griffin was therefore not in a position to carry out the same exercise for the early period as for the focus period. He did, however, consider the role CDI played in the deaths of the two patients in the early period whose family members were Core Participants. Professor Griffin concluded that CDI was a causal factor in the death of one of those patients, who had initially contracted CDI at the RAH. She remained infected and undiagnosed as a CDI patient in the VOLH despite suffering from loose stools, and died in the VOLH in October 2007. He did not find CDI a causal factor in the other patient's death.

Deaths after 1 June 2008

Professor Griffin examined records of ten further patients, who died after 1 June 2008. All these deaths occurred among patients from the focus period rather than among the 12 who first tested positive after 1 June.

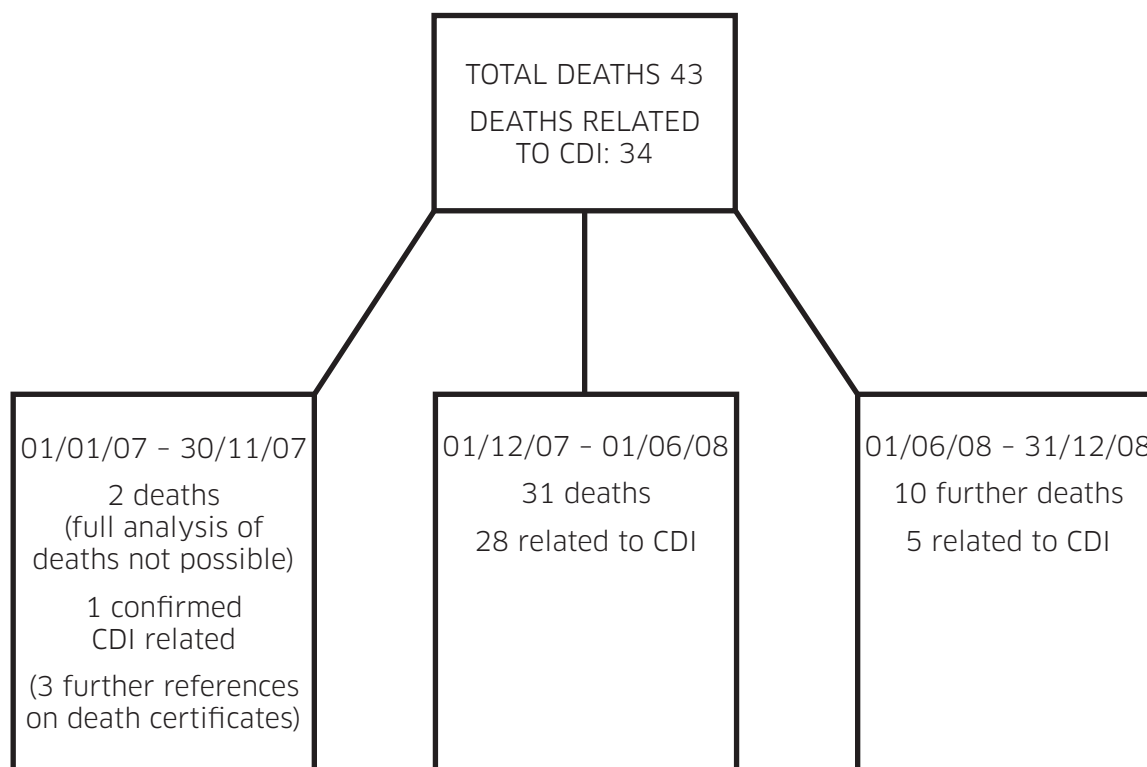
Professor Griffin concluded that CDI was a causal factor in five of those ten deaths. Three of those five patients died during June 2008. He also concluded that CDI played a role in the deaths of two patients who died in the VOLH after June 2008, one in November 2008 and one in January 2009, but who had first contracted CDI prior to June 2008. The patient who died in January 2009 had *Clostridium difficile* enteritis entered on his death certificate as a contributory cause of death.

Professor Griffin concluded that CDI was not a causal factor in the five remaining deaths that occurred after 1 June 2008.

The figures for all three periods are set out in Figure 4.2.

31 [EXP02780001](#)
 32 [TRA00730023](#)
 33 [TRA00730036](#)
 34 [TRA00730036-37](#)
 35 [TRA00730037](#)
 36 [TRA00730036](#)

Figure 4.2 Deaths related to CDI



Total number of deaths

There is therefore a total of **34 patients** identified by the Inquiry in whose deaths CDI was a causal factor, either as a cause of death or as a contributory cause of death. Twenty-eight of these were in the focus period, providing a sharp contrast with the 18 identified during that period in the Outbreak Control Team Report.³⁷

In addition, while Professor Griffin could not carry out a full analysis of deaths during the early period, it is to be noted that, aside from the two cases he did examine, the death certificates of an additional three patients in the early period contained references to CDI as being involved in the patients' deaths.

Age range and health

The age range of those who died with CDI as a causal factor in their deaths was 56 to 94 years. Of these patients 60% were over

the age of 80. Many of them had chronic co-morbidities. This means that they had one or more diseases in addition to their primary disease or disorders. As Professor Griffin explained, such patients are clinically very vulnerable. Small fluctuations in their clinical state caused by an infection such as CDI can have profound effects.³⁸

Comparison with death certificates

Of the 28 patients who died during the focus period with CDI as a causal factor in their deaths, seven³⁹ patients did not have *C. difficile* enteritis entered on their death certificates.

Of the six patients who died outwith the focus period with CDI as a causal factor in their deaths, three patients did not have CDI entered on their death certificates.

This comparison is revisited in Chapter 16.

37 [GGC00600005](#)

38 [EXP02780003](#)

39 [EXP02780006](#)

4.4 Conclusion

The total number of patients covered by the Inquiry's remit who contracted CDI in the period 1 January 2007 to 31 December 2008 was 143.

There were 43 patients included in the Inquiry's remit who died having suffered from CDI. **CDI was a causal factor in the deaths of 34 of these patients**, either as a cause of death or as a contributory cause of death.

In relation to the early period, the figure is an underestimate since many records were unavailable. CDI was mentioned in the death certificates of three further patients who died in the early period.

As discussed in Chapter 5, what was significant about the CDI problem at the VOLH was that it persisted undetected for the whole of the period from 1 January 2007 to 1 June 2008, and this despite the fact that there were a significant number of deaths in which *C. difficile* was a causal factor. In the language of Dr Brian Cowan, Medical Director of the Acute Division:

“here was an outbreak which raged, or a series of outbreaks that raged, for a long period of time with a significant, highly significant, number of deaths”.⁴⁰

No doubt many of the patients had significant co-morbidities and shortened lifespans. But it was the fact that they were so vulnerable and frail that made the suffering inflicted by CDI so devastating. The evidence provided to the Inquiry by patients and relatives, discussed in Chapter 11, underlines the lack of dignity suffered by patients in their final period of life and the enormous distress caused to the relatives. The impact of *C. difficile* on patients was described by Professor Griffin in the following way:

“*C. difficile* is very unpleasant for patients. It is exceedingly unpleasant and distressing for relatives to see an old, loved patient in a bed in a pool of faeces. It is very difficult for nursing staff to have to clean a patient nine, ten times a day who is demented, immobile, can't help the nurse with moving”.⁴¹

CDI can deprive the elderly patient of a peaceful uncomplicated death. These are reasons why CDI must be regarded as a serious infection in its own right.

Recommendations which are relevant to this Chapter are set out in other Chapters of this Report.

40 [TRA01230015](#)

41 [TRA00730030-31](#)

Chapter 5

C. difficile infection rates
and undeclared outbreaks

Introduction

One of the striking aspects of the evidence available to the Inquiry was that no *C. difficile* infection (CDI) outbreaks were declared at the Vale of Leven Hospital (VOLH) prior to June 2008. This was despite the high number of CDI cases diagnosed and the number of known CDI patients present on the wards. There were a number of opportunities to identify a CDI problem in the period beginning 1 January 2007. This Chapter considers when potential outbreaks may have occurred and what information was available at that time.

5.1 Definition of an outbreak

Greater Glasgow Health Board Infection Control Committee produced an Outbreak Policy which was regularly updated. The Outbreak Policy¹ issued in July 2006, which remained in place until December 2007,² contained a definition of an outbreak as:

“two or more linked cases (or isolates) of unexplained illness, which indicates the possibility that they may be due to a known or unknown infectious agent identified in healthcare premises”.³

In the updated December 2007 Outbreak Policy⁴ an outbreak was defined to include:

“two or more linked cases of the same illness (i.e. associated in person, place or time)”.⁵

The Infection Control Guidelines⁶ produced in 2001 for use at the VOLH under Argyll and Clyde NHS Trust defined an outbreak as “two or more cases of infection caused by an identical organism in the same ward or unit.”⁷ This was prior to the dissolution of NHS Argyll and Clyde. There is uncertainty whether the Argyll and Clyde definition or the 2006 NHSGGC definition was applied at the VOLH prior to December 2007, but that is of little significance since the general

principle of all three definitions is that two linked cases of an infection such as *C. difficile* would represent a possible outbreak. An example of two linked cases would be two cases in the same ward at about the same time, and this was well understood by the Infection Control Nurses⁸ at the VOLH. It is of note, however, that although both the NHSGGC policies stipulated that “healthcare workers must follow this policy”,⁹ as discussed in Chapter 15, not all healthcare workers were in fact aware of the definition of an outbreak.

The outbreak procedure

The 2001 Infection Control Guidelines¹⁰ required that a number of people, including the Medical Director,¹¹ be notified if there was the suspicion of an outbreak of an infectious disease. The Medical Director had in turn to inform the Chief Executive and/or the Chairman.¹² These guidelines also envisaged that an Outbreak Control Team would be set up.¹³ Both the Greater Glasgow Health Board Outbreak Policy issued in June 2006 and the Outbreak Policy in place from December 2007 stipulated that all reports of possible outbreaks had to be investigated.¹⁴

Detailed guidance was provided in all these documents as to how such investigations should be conducted and what control measures should be put in place. This included, for example, the closure of wards, depending upon the scale of the problem.¹⁵ The Outbreak Policy in place from December 2007 also outlined a communication chain of those who were to be informed, including, “if appropriate, the Chief Officers of NHS Greater Glasgow and Clyde Board”.¹⁶

The philosophy contained in the guidance was repeated in the evidence of the Infection Control experts commissioned by the Inquiry, Professor Brian Duerden¹⁷ and Mrs Christine

1 [GGC27390001](#)
2 [TRA00320003](#)
3 [GGC27390003](#)
4 [GGC00780145](#)
5 [GGC00780148](#)
6 [INQ03960001](#)
7 [INQ03960107](#)

8 [TRA00950033](#); [TRA01010039-40](#)
9 [GGC27390002](#); [GGC00780147](#)
10 [INQ03960001](#)
11 [INQ03960107](#)
12 [INQ03960115](#)
13 [INQ03960107](#)
14 [GGC27390002](#); [GGC00780147](#)
15 [GGC27390007](#); [GGC00780149](#)
16 [GGC00780154](#)
17 [TRA01050058](#)

Perry.¹⁸ Once it is apparent that there **may** be an outbreak, it is necessary to presume that there **is** an outbreak and investigate, and if necessary close a ward to further admissions.¹⁹

The point is made in the introduction to this Chapter, and bears repetition, that despite all the guidance in place no CDI outbreaks were declared at the VOLH between 1 January 2007 and 1 June 2008. None of the investigations expected by the Outbreak Policy were undertaken and no ward was ever closed.

5.2 The number of CDI results

Testing

Between 1 January 2007 and 1 June 2008 there was a total of 929 reported *C. difficile* toxin test results for VOLH patients from the Laboratory there. Table 5.1 sets out this total number by positive and negative test results. It also divides these results between the early period (1 January 2007 to 30 November 2007) and the focus period (1 December 2007 to 1 June 2008).

Table 5.1 All positive and negative CDI test results

	Early period	Focus period	Total period 1 January 2007 to 1 June 2008
Positive results	109	90	199
Negative results	432	298	730
Total results	541	388	929

For a hospital the size of the VOLH this Table discloses a high level of activity in the testing for *C. difficile* toxin during these periods.

Between 1 January 2007 and 1 June 2008 there was a total of 199 *C. difficile* toxin positive results at the VOLH. Table 5.2 sets

out those positive testing results broken down by each ward. It is clear that CDI was present on the wards throughout the early and focus periods, particularly wards F, 3, 6, 14 and 15, which have been the primary focus of the Inquiry's investigations.

¹⁸ [TRA01050030](#)

¹⁹ [TRA01050030](#); [TRA01050022-23](#)

Table 5.2 Positive CDI results by ward

Ward	Early period	Focus period	Total period
F	12	16	28
3	16	11	27
5	11	2	13
6	22	25	47
14	24	17	41
15	11	11	22
4/CCU	5	2	7
HDU	3	1	4
MAU	0	2	2
Fruin	0	3	3
Outpatient	1	0	1
Unknown ward	4	0	4
TOTAL	109	90	199

Pattern of CDI in the VOLH

As described in his report²⁰ and evidence,²¹ Professor Christopher Robertson, a Statistician commissioned by the Inquiry, investigated the pattern of diagnoses of CDI in the VOLH in the period from 1 January 2007 to 1 June 2008. He looked at three periods of particular interest: January to June 2007, July to November 2007 and December 2007 to June 2008.

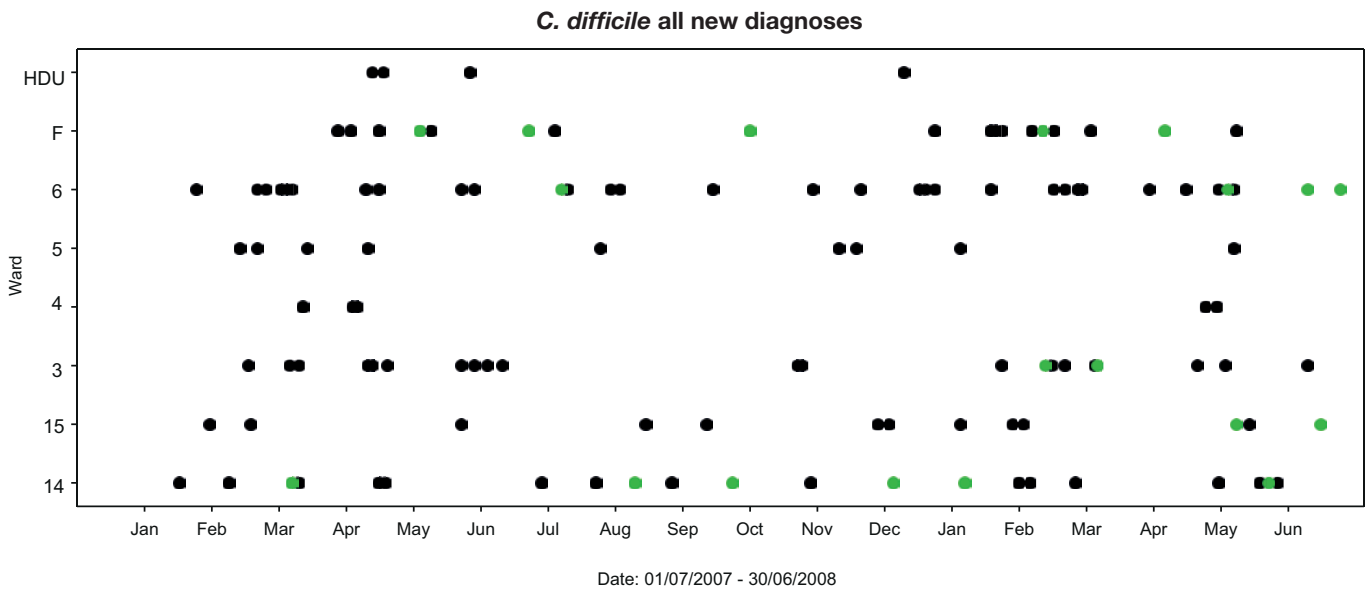
Some patients tested positive for *C. difficile* toxin more than once, so Professor Robertson had to attempt to distinguish between a positive CDI result that indicated a new infection of a patient and a result that indicated the ongoing infection of a patient who had tested positive for CDI previously. He adopted the approach that a new infection occurred when the positive result was more than 28 days after the previous positive result.²²

²⁰ [EXP02840001](#)

²¹ [TRA01080001](#)

²² [EXP02840007](#)

Figure 5.1 New diagnoses of CDI by ward



Black spots show the first positive CDI result. Green dots show a presumed new infection in a previous CDI patient. Only results at the VOLH are shown.

Figure 5.1 sets out the pattern of all new diagnoses of CDI by the ward where the patient was diagnosed. It is evident from this statistical presentation that CDI was present throughout the whole period from January 2007 to June 2008.²³ Testing for *C. difficile* toxin occurred in virtually all wards in the hospital, especially wards 3, 5, 6, 14, F and HDU.²⁴ When two similar periods of time are compared: January to June 2007 and December 2007 to June 2008, no significant difference in the rates of CDI is found.

Potential outbreaks

The Inquiry can only identify where **potential** CDI outbreaks occurred. This is because, as explained in Chapter 3, there are a number of different strains of *C. difficile*. Two CDI patients may contract different strains of the infection, and in this scenario there would not in fact be an outbreak. As Mrs Perry explained:

“without further strain testing (ribotyping) of *C. difficile* samples, it is not possible to definitively state that an outbreak has occurred”.²⁵

No investigations were made at the time. It is therefore only possible to identify retrospectively where outbreaks **may** have occurred. Nevertheless, any such potential outbreak should have activated the VOLH’s outbreak procedures, and subsequent testing would have identified whether patients had contracted the same strain of *C. difficile*.

Instances of potential CDI outbreaks have now been identified using laboratory testing data, hospital admission spreadsheets and patients’ records available to the Inquiry. These data were collated and categorised by the Inquiry, and analysed by Professor Robertson to identify instances of two or more CDI patients associated in time or place, which would in turn identify any potential outbreak.

23 [TRA01080012](#)

24 [TRA01080016](#)

25 [INQ03970001](#)

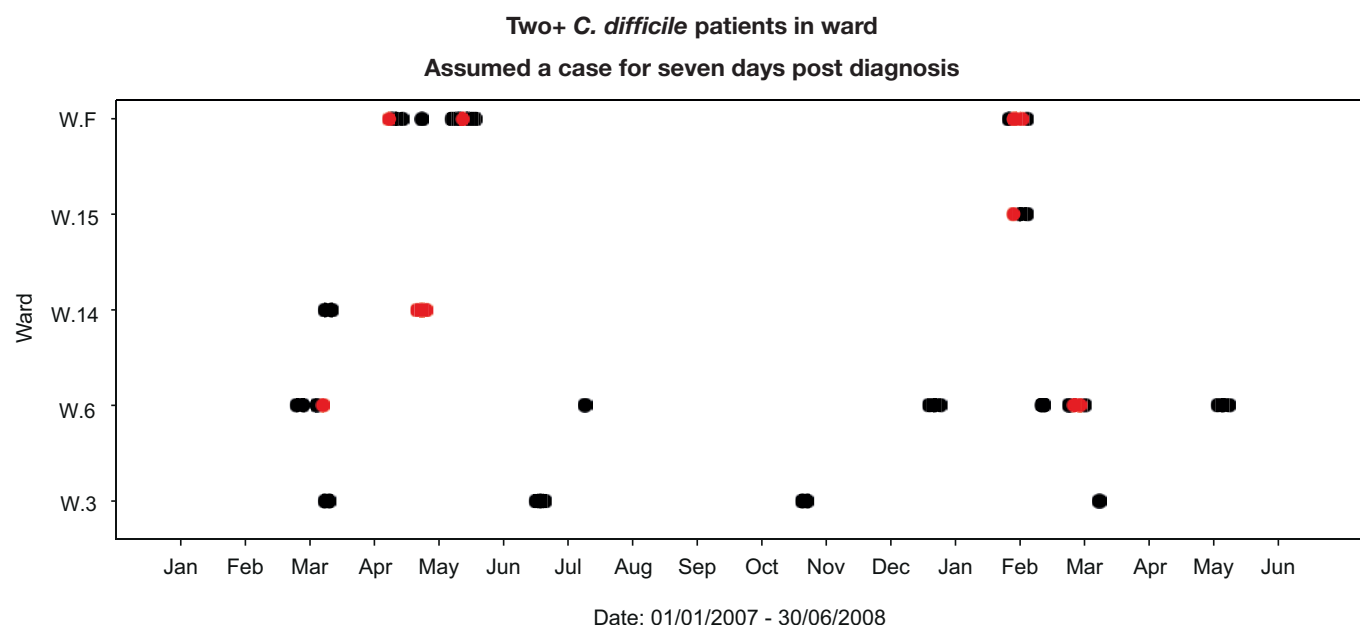
Professor Robertson emphasised that, due to limitations in the available data, a number of qualifications had to be borne in mind when investigating whether there were potential outbreaks in particular wards. There were some patients where it was difficult to identify from the medical records their precise date of admission to the VOLH. There were other patients who moved between wards and it was not clear when that occurred.²⁶ Professor Robertson also had to make a number of assumptions in his analysis about the length of time a patient remained symptomatic with CDI after any positive test. Without access to the individual patient records, his general assumption was that the symptomatic period was seven days.²⁷

Even with the assumption that the symptomatic period only lasted for seven days, Professor Robertson suggested that there were potential outbreaks in wards 3, 6, 14, 15 and F in the period January 2007 to June 2008.²⁸

Figure 5.2 sets out Professor Robertson's statistical analysis of the times when the number of positive cases on a ward represented a potential outbreak. A black spot illustrates when two patients were positive on the same ward at the same time, and a red spot illustrates when there were three or more patients positive on the same ward at the same time.

Even allowing for the limitations in the data, Professor Robertson's general conclusion was that it seemed likely that there had been a number of occasions when the numbers of CDI patients in a particular ward exceeded the number required to constitute an outbreak.²⁹ In particular, this occurred in wards F, 14, 6 and 3 during January to June 2007 and in wards F, 15, 6 and 3 during December 2007 to June 2008.

Figure 5.2 Potential outbreaks



A black spot shows when there are two CDI patients on the ward on the same date. A red spot indicates three or more CDI patients. No potential outbreaks were observed in any ward not listed.

²⁶ [TRA01080042](#)

²⁷ [TRA01080043](#); [EXP02850037](#)

²⁸ [TRA01080046](#)

²⁹ [EXP02850052](#)

Length of time patients were CDI symptomatic

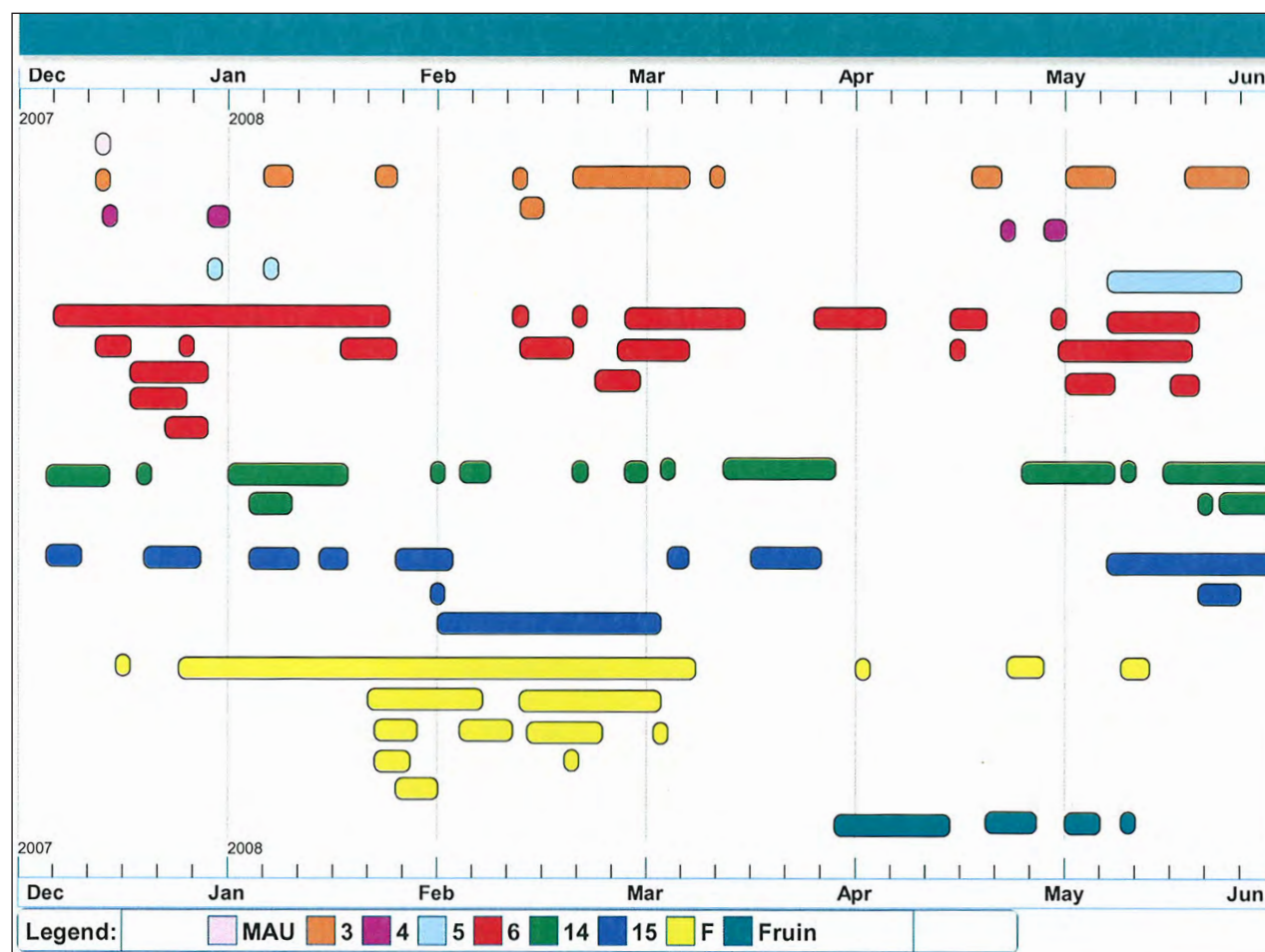
While Professor Robertson's analysis is based on estimates of the length of time patients were symptomatic, the Inquiry carried out a further analysis of patients from the focus period to see if any conclusions could be drawn from the **actual** length of time patients were confirmed as being symptomatic for CDI. This was done by examination of entries in the patient records, although that too introduces an important qualification, since it is clear that there were deficiencies in record keeping at the VOLH. This is discussed further in Chapters 12 and 14. It is also apparent that parts of the patient records supplied to the Inquiry by NHSGGC were missing.

The Inquiry found that in the focus period there were 90 instances when patients tested positive for *C. difficile* toxin. For the following analysis, 17 of those results have been discounted because they came from the subsequent re-testing of a patient already

confirmed as having contracted CDI. A further three results have been eliminated because it has not been possible to ascertain from the patient records when each patient stopped being symptomatic. That means that 70 *C. difficile* toxin positive results form the basis of the analysis.

Figure 5.3 contains a presentation of the Inquiry's analysis of the **actual** length of time each CDI patient remained symptomatic from the date his or her CDI result was known by ward staff. Each entry represents an individual patient and how long that patient was symptomatic on a particular ward. It is also clear how many patients were symptomatic on a ward on a particular date. The presence of two or more patients on the same ward on the same day signifies a potential outbreak on that ward. More than 70 results are recorded, because patients who moved ward may appear more than once.

Figure 5.3 The number of days patients were symptomatic



There is a timescale running along the top and bottom from 1 December 2007 to 1 June 2008. Each colour block shows a separate symptomatic CDI patient. The length of the block shows the number of days that patient was symptomatic. Each ward has a different colour shown on the legend above. From mid December 07 ward 4 also comprised CCU and HDU.

Professor Robertson carried out analyses using periods ranging from three to ten days,³⁰ with a particular focus on seven days. But of the 70 positive results included in the Inquiry's analysis, there were only 38 CDI results (54%), representing 37 patients, where the patient was symptomatic for ten days or less. Ten days is the normal period for initial antibiotic treatment with metronidazole.

The Inquiry's analysis revealed there were 32 results (46%) where patients were symptomatic for more than ten days. These 32 results accounted for 29 different patients, since three patients had two separate episodes of CDI with symptomatic periods of greater than ten days. A closer

analysis of cases where patients were symptomatic for longer than ten days revealed:

- Eighteen patients were symptomatic for between 11 to 19 days
- Eight patients were symptomatic for between 20 to 29 days
- Six patients were symptomatic for more than 30 days

A high number of patients therefore remained symptomatic and a risk to other patients for lengthy periods of time. Table 5.3 sets out the 32 results of patients who remained symptomatic for more than ten days and the wards in which they were diagnosed.

30 [TRA01080043](#)

Table 5.3 Patients symptomatic more than ten days

	Ward	First symptomatic	Last symptomatic	Total days symptomatic
Patient B	6	14/12/07	25/12/07	11
Isobel Cameron	14	03/12/07	14/12/07	11
Mary Broadley	15	16/12/07	27/12/07	11
Elizabeth Valentine	6	16/02/08	28/02/08	12
John Boyle	15	22/01/08	03/02/08	12
Mary Millen	F	30/01/08	11/02/08	12
Margaret Dalton	6	17/12/07	31/12/07	14
Patient A	6	06/05/08	20/05/08	14
David Somerville	15	07/02/08	21/02/08	14
Charles Cook	14	07/05/08	22/05/08	15
Christina Miller	6	20/03/08	05/04/08	16
Janet Fitzsimmons	14	22/04/08	08/05/08	16
Martha McGregor	6	19/02/08	07/03/08	17
Isabella Lettis	14	01/01/08	18/01/08	17
William Hunter	3	18/02/08	07/03/08	18
George Drummond	3	19/04/08	08/05/08	19
Moira McWilliams	6	25/02/08	15/03/08	19
Mary Burns	6	05/12/07	24/12/07	19
Jacqueline Patrick	5	06/05/08	26/05/08	20
Coleman Conroy	14	08/03/08	28/03/08	20
Ellen Gildea	F	11/02/08	04/03/08	22
Mary Hamilton	F	01/02/08	23/02/08	22
Rosa Rainey	F	16/01/08	07/02/08	22
Irene Harnett	Fruin	13/04/08	06/05/08	23
Moira McWilliams	6	24/04/08	19/05/08	25
Alister Brand	F	07/02/08	03/03/08	25
Margaret Kelly	Fruin	25/03/08	26/04/08	32
Margaret Gaughan	15	30/01/08	03/03/08	33
Margaret Stevenson	14	15/05/08	18/06/08	34
David Somerville	15	01/05/08	21/06/08	51
Anne Agnew	14	08/05/08	29/06/08	52
Patient C	F	24/12/07	08/03/08	75

Six patients were symptomatic for more than 30 days. Of those, three patients were symptomatic for three times the normal period of initial antibiotic treatment. Three patients were symptomatic for more than five times the period that would be expected.

The most extreme case was that of Patient C, who was symptomatic for some 75 days in the period 24 December 2007 to 8 March 2008. This was a patient who for a period of time only received a sub-therapeutic dose of vancomycin, and it was of no surprise to an Inquiry expert microbiologist that her CDI persisted.³¹ The patient was also prone to wander, and posed a serious cross infection risk to other patients.

Of the six patients symptomatic for more than 30 days, two were patients in ward 14, two were patients in ward 15, and Patient C was in ward F.

Given that 46% of the positive test results analysed disclosed that these CDI patients remained symptomatic for in excess of ten days, Professor Robertson's conclusions on analysis of the number of instances of potential CDI outbreaks in Figure 5.2, based on an estimate that patients were symptomatic for seven days, were indeed conservative. It is clear that there were in fact more occasions than those identified by him upon which two or more patients were symptomatic for CDI on the same ward at the same time. Each occasion should have identified a potential outbreak and triggered the outbreak procedure.

5.3 Wards with CDI patients – the early period

Position during the early period generally

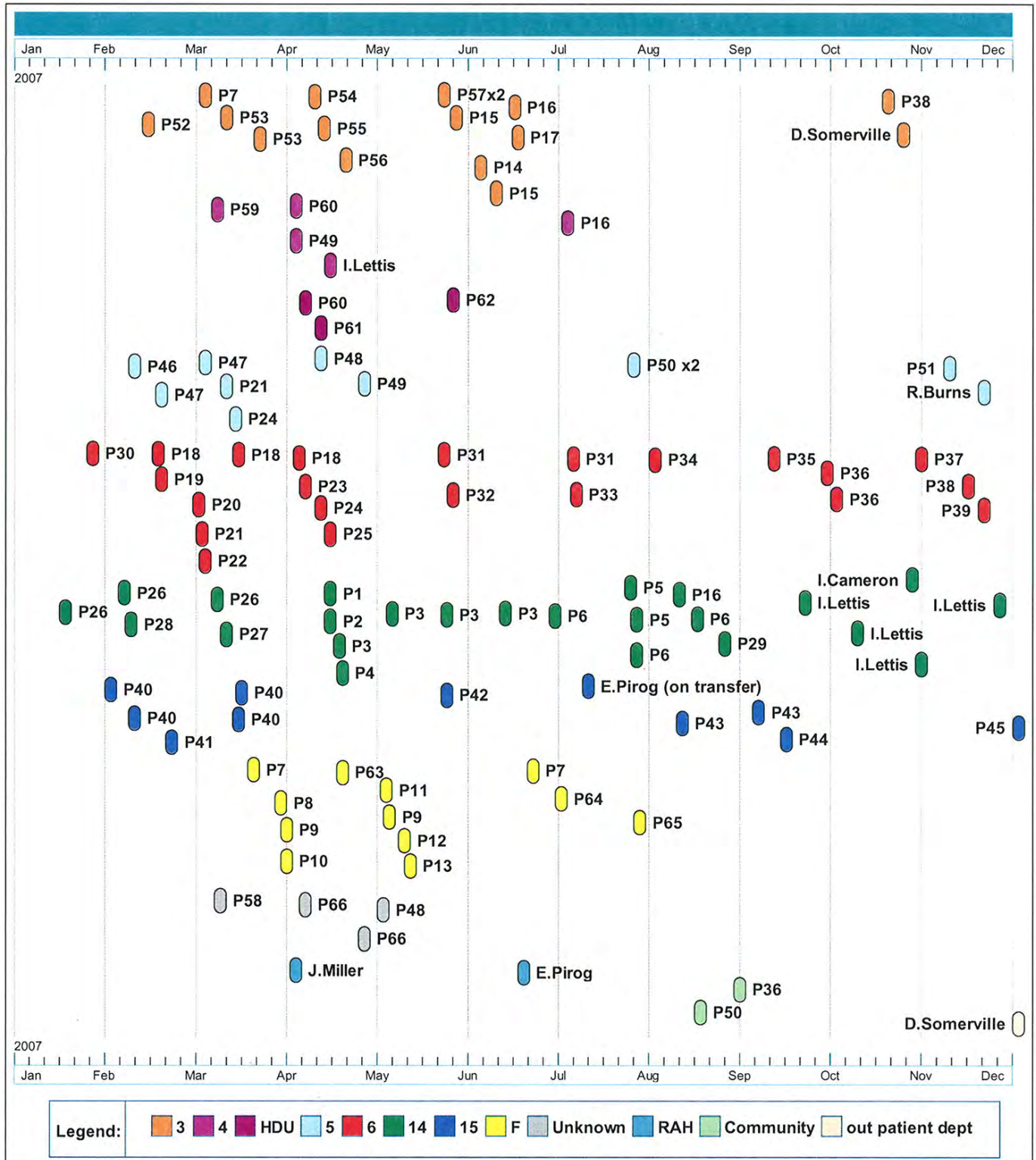
As identified by Professor Robertson, there were a number of instances during the early period when at least two patients were suffering from CDI in the same ward at the same time in the VOLH. An impression of the problem overall can be gained from Figure 5.4, which sets out all *C. difficile* toxin positive results in the early period from 1 January to 30 November 2007. Each entry identifies the patient and the date the ward became aware of the positive CDI result, and the wards are colour coded to indicate the ward the patient was on at the time.

Figure 5.4 shows that the problem was not confined to one ward. Most of the wards were affected. It is very likely that the regular movement of patients between wards only served to exacerbate the risk of cross infection from ward to ward.³²

31 [TRA00600129](#)

32 [TRA01060044](#)

Figure 5.4 *C. difficile* toxin positive test results 1 January 2007 to 30 November 2007



There is a timescale running along the top and bottom from 1 January to 30 November 2007. Each ward has a different colour shown on the legend above. Each colour bar shows the date the ward was aware of the CDI result for the named patient. Some patients are represented by a number to protect their anonymity. Results obtained in the RAH, the community, the Outpatient Department and an unknown ward are also shown.

Missed opportunities to investigate in the early period

The Inquiry is able to conclude that in the period 1 January 2007 to 30 November 2007 there were several occasions when the number of patients suffering from CDI in different wards at the VOLH should have been fully investigated. The following analysis by ward is based on all the information available to the Inquiry, including medical records, where available, and on Infection Control Cards on which the Infection Control Nurses themselves recorded patient information.

Ward 14

According to what was recorded in the Infection Control Database held at the VOLH, three patients tested positive for *C. difficile* toxin in the period 11 to 19 April 2007. Another patient also tested positive during

that period whose name and details do not appear on the database material made available to the Inquiry. Table 5.4 sets out the information on these patients the Inquiry has extracted for ward 14 from a number of sources, and it can be seen from this presentation that in the period 13 to 17 April 2007 the ward was aware of four patients testing positive for *C. difficile* toxin. Patients from the early period are identified by a patient number rather than by name.

Patient 1 had been on the ward for about two weeks. Patient 2 had been on the ward for nearly three months. The Infection Control Card for Patient 1 recorded that the patient was in a four-bedded bay with other positive patients. The Infection Control Card for one of the other patients recorded that the patient was in a four-bedded bay because there was no side room available.

Table 5.4 CDI patients on ward 14 in April 2007

	Admission to VOLH	Admission to ward 14	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 1	19/03/07 to ward 3	28/03/07	unknown	13/04/07	13/04/07	17/04/07
Patient 2	12/01/07 from RAH to ward 5	15/01/07	unknown	13/04/07	13/04/07	17/04/07
Patient 3	10/04/07 from WIG* to ward 14	10/04/07	unknown	16/04/07	14/04/07	17/04/07
Patient 4	21/03/07 to ward 6	13/04/07	16/04/07	17/04/07	16/04/07	19/04/07

*Western Infirmary, Glasgow

Subsequently, in July 2007, two other patients in ward 14 tested positive for *C. difficile* toxin, one of whom tested positive twice in respect of specimens collected in a three-day period. Table 5.5 presents the details relating to those patients who tested positive in July 2007. Patient 5 had been

in ward 14 for about a month and Patient 6 for about six weeks. The Infection Control Card for Patient 5 indicates that this patient was being accommodated in a four-bedded bay with one other patient who had tested positive for *C. difficile* toxin.

Table 5.5 CDI patients on ward 14 in July 2007

	Admission to VOLH	Admission to ward 14	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 5	26/06/07 from RAH to ward 14	26/06/07	unknown	23/07/07	20/07/07	24/07/07
Patient 6	08/06/07 from RAH to ward 14	08/06/07	23/07/07	unknown	23/07/07	25/07/07
Patient 5	26/06/07 from RAH to ward 14	26/06/07	unknown	unknown	23/07/07	25/07/07

There were therefore two separate instances of two or more CDI patients on ward 14 at the same time, each of which should have alerted the ward to a potential outbreak and prompted investigation procedures.

Ward F

In ward F the ward was aware of three patients being positive for *C. difficile* toxin between 27 and 29 March 2007. Each of these patients had been in ward F for more than a month.

Subsequently, in May 2007, four patients tested positive for *C. difficile* toxin on dates closely associated in time. Patient 9 and Patient 11 had been in ward F for several months. Patient 12 and Patient 13 had been in the ward for about two weeks.

Table 5.6 sets out the position in ward F in March and May 2007. The Infection Control Cards of patients 12 and 13 recorded that these patients were being nursed in a room with other patients who had tested positive for *C. difficile* toxin.

Table 5.6 CDI patients on ward F in March and May 2007

	Admission to VOLH	Admission to ward F	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 8	09/02/07 to ward 6	20/02/07	26/03/07	27/03/07	26/03/07	28/03/07
Patient 9	19/01/07 from RAH to ward 6	26/01/07	29/03/07	29/03/07	29/03/07	02/04/07
Patient 10	unknown	21/02/07	29/03/07	29/03/07	29/03/07	02/04/07
Patient 11	09/02/07 from Beatson to ward 6	18/02/07	unknown	02/05/07	02/05/07	04/05/07
Patient 9	19/01/07 from RAH to ward 6	26/01/07	unknown	03/05/07	02/05/07	04/05/07
Patient 12	20/04/07 to ward 4	26/04/07	unknown	08/05/07	06/05/07	10/05/07
Patient 13	17/04/07 to ward 4	22/04/07	unknown	unknown	07/05/07	10/05/07

There were therefore two separate instances of two or more CDI patients on ward F at the same time, each of which should have alerted the ward to a potential outbreak and prompted investigation procedures.

Ward 3

Table 5.7 sets out the position in ward 3 in June 2007. Once again patients tested positive for *C. difficile* toxin on dates closely associated in time and place. Patient 15 and Patient 16 had been in the ward for several weeks. Patient 14 and Patient 17 had been discharged from the VOLH earlier, one of them from ward 3 just three days before re-admission to the same ward.

According to the Infection Control Database, Patient 16 and Patient 17, whose formal positive reports from the laboratory are

both dated 15 June 2007, were being accommodated in a multi-bed bay where all the patients were *C. difficile* toxin positive. Likewise the Infection Control Cards for Patient 16 and Patient 17 note they were being nursed in a four-bedded bay where all the patients were positive for *C. difficile* toxin. Similarly, the Infection Control Cards for Patient 14 and Patient 15, whose formal reports are dated 6 and 12 June respectively, indicate that they too were being nursed in a four-bedded bay and that all the patients in that bay were positive for *C. difficile* toxin.

There was therefore a clear instance of ward 3 being aware of two or more CDI patients on the ward at the same time. This should have alerted the ward to a potential outbreak and prompted investigation procedures.

Table 5.7 CDI patients on ward 3 in June 2007

	Admission to VOLH	Admission to ward 3	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 14	01/06/07 to ward 3 (previously discharged 15/05/07)	01/06/07	unknown	unknown	02/06/07	06/06/07
Patient 15	17/05/07 to ward 4	19/05/07	unknown	08/06/07	07/06/07	12/06/07
Patient 16	21/05/07 to ward 3	21/05/07	unknown	14/06/07	13/06/07	15/06/07
Patient 17	11/06/07 to ward 3 (previously discharged 08/06/07)	11/06/07	unknown	unknown	12/06/07	15/06/07

Ward 6

Table 5.8 sets out the position in ward 6 in February, March and April 2007. Again it can be seen that there were patients over that period whose positive results were closely associated in time. Patient 18 tested toxin positive on three separate occasions during that period. One patient had been transferred from the Royal Alexandra Hospital (RAH) the day before the positive sample was collected

on the ward. Patient 23 was transferred from the RAH two days before the sample was described in the report as “collected”.

During this period there are clear instances of two or more CDI patients on ward 6 at the same time. Despite this, no outbreaks were declared and no Outbreak Policy investigations were ever initiated.

Table 5.8 CDI patients on ward 6 from February to April 2007

	Admission to VOLH	Admission to ward 6	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 18	08/02/07 to ward 6 (Previous discharge 01/02/07)	08/02/07	unknown	15/02/07	14/02/07	17/02/07
Patient 19	05/02/07 from RAH to ward 6	05/02/07	unknown	16/02/07	15/02/07	19/02/07
Patient 20	07/02/07 from RAH to ward 6	07/02/07	unknown	unknown	21/02/07	27/02/07
Patient 21	26/02/07 from RAH to ward 6	26/02/07	unknown	01/03/07	28/02/07	05/03/07
Patient 22	17/02/07 to ward 4	21/02/07	unknown	unknown	28/02/07	02/03/07 (Transferred to RAH 01/03/07)
Patient 18	08/02/07 to ward 6 (Previous discharge 01/02/07)	08/02/07	12/03/07	13/03/07	12/03/07	16/03/07
Patient 18	08/02/07 to ward 6. (Moved to ward 15 13/03/07)	28/03/07	29/03/07	unknown	29/03/07	03/04/07
Patient 23	03/04/07 from RAH to ward 6	03/04/07	04/04/07	05/04/07	04/04/07	09/04/07
Patient 24	08/04/07 to ward 6	08/04/07	unknown	10/04/07	08/04/07	11/04/07
Patient 25	21/03/07 to HDU	24/03/07	13/04/07	13/04/07	13/04/07	17/04/07

Figure 5.5 shows that the CDI problem was not confined to one ward. Most of the wards were affected, ward 6 and ward F in particular. As with the early period, it is very likely that the regular movement of patients between wards only served to exacerbate the risk of cross infection from ward to ward. The Inquiry is able to conclude that in the focus period, just as in the early period, there were several occasions when the number of patients suffering from CDI in different wards at the VOLH should have been investigated in accordance with outbreak procedures. The following analysis by ward during the focus period is based on all the information available to the Inquiry including medical records where available and Infection Control Cards.

Ward 6

Table 5.9 sets out some details of patients who tested positive for *C. difficile* toxin on ward 6 in December 2007. For Catherine Stewart, Julia Monhan and Agnes Burgess the conclusion entered into the Infection Control Database was that the infection was community acquired. This is understandable when their admission dates are considered. Nevertheless, Julia Monhan and Agnes Burgess had been patients in ward 6 of the VOLH earlier in December 2007 and Catherine Stewart had been a patient in the RAH until 29 November 2007.³³ These circumstances should have prompted closer scrutiny.

Table 5.9 CDI patients on ward 6 in December 2007

	Admission to VOLH	Admission to ward 6	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Mary Burns	05/12/07 from RAH	05/12/07	05/12/07	06/12/07	05/12/07	07/12/07
Catherine Stewart	11/12/07 to MAU	12/12/07	12/12/07	12/12/07	11/12/07	14/12/07
Margaret Dalton	18/11/07 to ward 4 (Moved to HDU 19/11/07)	03/12/07	17/12/07	17/12/07	17/12/07	19/12/07
Patient B	07/12/07 to ward 6	07/12/07	15/12/07	17/12/07	15/12/07	17/12/07
Julia Monhan	Previously discharged 07/12/07. then <i>C. difficile</i> + in community	21/12/07	21/12/07	22/12/07	21/12/07	24/12/07
Agnes Burgess	20/12/07 to ward 3 (previously discharged 07/12/07)	21/12/07	22/12/07	24/12/07	22/12/07	24/12/07

The other three patients were considered to have acquired the infection in hospital.³⁴ Mary Burns had been transferred from RAH to the VOLH on 5 December 2007, with diarrhoea. She had previously tested positive³⁵ for *C. difficile* toxin twice while in the RAH. Margaret Dalton and Patient B had been patients in ward 6 for a sufficiently long period of time for the infections to be considered hospital acquired infections. The

ward also became aware of their positive results on the same day (17 December 2007).

Table 5.10 sets out details of patients who tested positive for *C. difficile* toxin on ward 6 in February 2008. In that period there are CDI patients closely associated in time and place, which should have identified a potential outbreak.

Table 5.10 CDI patients on ward 6 in February 2008

	Admission to VOLH	Admission to ward 6	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Jean Beattie	09/02/08 to ward 6 (previously discharged 07/02/08)	09/02/08	09/02/08	11/02/08	09/02/08	13/02/08
Annie Shaw	19/01/08 to ward 6 (transferred to RAH 28/01/08)	08/02/08	18/02/08	19/02/08	18/02/08	20/02/08
Elizabeth Valentine	08/02/08 to ward 6	08/02/08	21/02/08 x2	22/02/08	21/02/08	25/02/08
Martha McGregor	20/01/08 to ward 6	20/01/08	25/02/08	25/02/08	25/02/08	27/02/08
Moir McWilliams	14/02/08 from RAH to ward 6	14/02/08	25/02/08	26/02/08	26/02/08	28/02/08

34 INQ02970001

35 GGC26320029; GGC26320063

Table 5.11 provides details of CDI patients on ward 6 in April and May 2008. Once again there are patients who are closely associated

in time and place. This should have identified potential outbreaks and activated Outbreak Policy investigations.

Table 5.11 CDI patients on ward 6 in April and May 2008

	Admission to VOLH	Admission to ward 6	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Mary McDougall	10/04/08 to MAU 11/04/08 to ward 4	12/04/08	unknown	14/04/08	10/04/08 (MAU)	14/04/08
Annie Johnson	11/03/08 to ward 6	11/03/08	10/04/08	unknown	10/04/08	14/04/08
Margaret Kelly	01/08/07 to ward 4 (various wards) (transferred to Fruin 19/03/08)	14/04/08	14/04/08	15/04/08	14/04/08	16/04/08
Doris Smith	28/04/08 to ward 6 (previously discharged 18/04/08)	28/04/08	28/04/08	28/04/08	28/04/08	30/04/08
Moira McWilliams	14/02/08 from RAH	14/02/08	29/04/08	29/04/08	29/04/08	01/05/08
Muriel Waddell	22/04/08 to ward 6	22/04/08	unknown	01/05/08	unknown	02/05/08
Patient A	06/05/08 to ward 6 (previously discharged 25/04/08)	06/05/08	06/05/08 x2	07/05/08	06/05/08	09/05/08
Moira McWilliams	14/02/08 from RAH to ward 6	14/02/08	unknown x2	09/05/08	06/05/08	09/05/08
Muriel Waddell	22/04/08 to ward 6	22/04/08	14/05/08	16/05/08	14/05/08	19/05/08
Patient A	06/05/08 to ward 6 (previously discharged 25/04/08)	06/05/08	19/05/08	19/05/08	19/05/08	22/05/08

Ward F

Table 5.12 sets out details of patients who tested positive for *C. difficile* toxin in ward F in January and February 2008. The ward was aware of five patients testing positive between 9 and 25 January 2008. Each of these patients had been admitted to the ward at least several weeks before the positive results were obtained. The ward was aware on 9 January 2008 that Patient C tested positive for *C. difficile* toxin. As described earlier in this Chapter this patient was prone to wandering, and remained symptomatic for a very long period of time. She tested positive again in early February.

These five patients were closely linked in time and place. This cluster of infection should have been identified as a potential outbreak and outbreak procedures activated.

The position became more acute in February when there were still a number of CDI patients in the ward. It was at this time that an asymptomatic patient was admitted to a bay in which there were at least two symptomatic CDI patients,³⁶ putting her at risk of cross infection. That patient did subsequently contract CDI, and tested positive for *C. difficile* toxin on 18 February 2008. This episode is discussed in Chapter 15.

Table 5.12 CDI patients on ward F in January and February 2008

	Admission to VOLH	Admission to Ward F	Medical records		Laboratory report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient C	09/12/07 to ward 6	14/12/07	unknown	09/01/08	09/01/08	11/01/08
Rosa Rainey	27/12/07 to ward 6	28/12/07	18/01/08	21/01/08	18/01/08	21/01/08
Mary Hamilton	27/12/07 to ward 6	28/12/07	21/01/08	22/01/08	21/01/08	24/01/08
Alister Brand	18/12/07 from RAH to ward 5	30/12/07	unknown	22/01/08	21/01/08	24/01/08
Sarah McGinty	03/12/07 to ward 6	04/12/07	25/01/08	25/01/08	25/01/08	28/01/08
Mary Millen	18/12/07 to ward 3	03/01/08	03/02/08	04/02/08	03/02/08	06/02/08
Patient C	09/12/07 to ward 6	14/12/07	05/02/08	06/02/08	05/02/08	11/02/08
Alister Brand	18/12/07 from RAH to ward 5	30/12/07	07/02/08	unknown	07/02/08	12/02/08
Mary Hamilton	27/12/07 to ward 6	28/12/07	11/02/08	13/02/08	10/02/08	13/02/08
Jessie Jones	02/02/08 from RAH to ward F	02/02/08	unknown	18/02/08	16/02/08	20/02/08
Alister Brand	18/12/07 from RAH to ward 5	30/12/07	22/02/08	22/02/08	22/02/08	25/02/08
Patient C	09/12/07 to ward 6	14/12/07	25/02/08	25/02/08	25/02/08	28/02/08

Lack of ribotyping

As mentioned previously, because no investigations were made at the time, only potential outbreaks can be identified by the Inquiry. Such investigations would have included ribotyping, which is the most widely used technique for identifying different strains of *C. difficile*.

As Professor Duerden explained,³⁷ it is only by ribotyping that scientific proof can be obtained that patients who are closely linked in time and place are infected with the same strain of CDI, since there are a number of different strains of *C. difficile*, and two or more patients who have CDI may not necessarily have the same strain. This is explained more fully in Chapter 3. No investigations were carried out at the time into the cases of CDI that existed in the VOLH in the period from 1 January 2007 to May 2008, so no ribotyping was carried out which would have confirmed or negated the existence of a specific ribotype outbreak.³⁸ The Inquiry is restricted, therefore, to identifying where potential outbreaks occurred. Any potential outbreak should have nonetheless activated outbreak procedures.

When investigation did take place in May 2008 there were only isolates from 16 patients available for ribotyping. Testing of those revealed that 14 patients had ribotype 027, one patient had ribotype 078 and one had ribotype 106.³⁹ Professor Duerden was of the opinion that, because 14 of the 16 isolates that were later ribotyped were of the 027 strain, it was likely that the majority of the cases in the VOLH had been caused by the same strain of *C. difficile*.⁴⁰

The lack of response to the persisting CDI problem is discussed in Chapter 15.

The analysis of the Infection Control Database

As well as the information available to nursing staff and the Infection Control Team on the wards, there was additional information available to the Infection Control Team in their Infection Control Database. The database is discussed further in Chapter 15. The information on that database had been entered by the Infection Control Nurses at the VOLH, and was therefore known to them at the time it was entered.⁴¹ Mrs Perry carried out an analysis on behalf of the Inquiry⁴² based on the data stored on the Infection Control Database, and as presented by Mrs Perry they show that in the period from 1 January 2007 to 30 April 2008 there were a number of potential outbreaks in different wards at the VOLH which should:

“have prompted the initiation of outbreak actions whilst investigating if the cases were the same strain”.⁴³

It is to be noted that Mrs Perry was relying solely on the information contained in the Infection Control Database for this analysis. In particular she was relying on the accuracy of the description that the CDI was hospital acquired. The conclusion as to whether or not the infection was hospital acquired was arrived at by the Infection Control Nurse when she put the information into the database.

37 [TRA01050058](#)

38 [TRA01050058](#)

39 [INQ01660001](#)

40 [TRA01050059](#)

41 [INQ02970001](#)

42 [INQ03970001](#)

43 [INQ03970002](#)

5.5 Conclusion

The Inquiry's analysis of the patient records, Mrs Perry's analysis of the Infection Control Database, and Professor Robertson's statistical interpretation all support the conclusion that there were a number of occasions between 1 January 2007 and 1 June 2008 when at least two patients linked in time and place were suffering from CDI. **It is inconceivable that there were no outbreaks of CDI in the VOLH during that time.** Because no appropriate investigations were carried out into cases of CDI, it is impossible to say exactly when the outbreaks actually occurred. But it can be said with confidence that outbreaks did occur in 2007 and 2008.

If the outbreaks which clearly did occur in 2007 had been identified at the time, this would have raised the profile of CDI. The investigations required under the Outbreak Policy would have been put in place. It is reasonable to assume that the impact of the continuing problem that persisted, certainly to June 2008, would have been significantly reduced. Patients would not have continued to suffer the distressing and unpleasant consequences of infection. CDI would not have been a causal factor in so many deaths. Even if the cases of CDI in early 2008 had been properly investigated, that the impact of the infection in the VOLH would have been reduced. These omissions were serious failures.

Chapter 6

National structures and systems

Introduction

This Chapter looks at the national structures in place that formed an integral part of the National Health Service in Scotland in the period 1 January 2007 to 1 June 2008, as well as the systems in place during that period and the relevant developments since June 2008. It considers the role played by Scottish Ministers and other agencies in relation to health and the monitoring of healthcare associated infections, but with a particular focus on *C. difficile*.

6.1 Relevant parties and agencies

Duties of Scottish Ministers

Scottish Ministers have a duty under legislation¹ to promote the improvement of the physical and mental health of the people of Scotland. Scottish Ministers have a wide remit and may do anything which they consider is likely to assist in discharging that duty.² The Scottish Government (formerly known as the Scottish Executive) is the executive branch of government in Scotland.

Health Boards

It is through Health Boards that Scottish Ministers discharge many of their statutory functions relating to health. As at January 2007 there were 14 territorial Health Boards and a number of Special Health Boards. These Health Boards were also under a general statutory duty to promote the improvement of the physical and mental health of the people of Scotland.³ That general duty is linked to a duty of quality under which each Board has an obligation to put and keep in place arrangements for the purpose of monitoring and improving the quality of the healthcare it provides to individuals.⁴

Healthcare Improvement Scotland

Between January 2007 and June 2008 NHS Quality Improvement Scotland (NHS QIS) was a Special Health Board for the whole of Scotland. Its remit was to ensure the quality of healthcare provided by NHSScotland. On 1 April 2011 Healthcare Improvement Scotland (HIS) was created, with the general duty of furthering improvement in the quality of healthcare in Scotland, and on that date NHS QIS was dissolved,⁵ with all property rights and liabilities of NHS QIS being transferred to HIS.

NHSScotland

The Regional and Special Health Boards and HIS make up what is generally known as NHSScotland.

Common Services Agency

The Common Services Agency (CSA) was originally created by the National Health Services (Scotland) Act 1972,⁶ and retained under the National Health Services (Scotland) Act 1978.⁷ The CSA is now known as NHS National Services Scotland (NSS), providing strategic support services and expert advice to NHSScotland and in particular to NHS Boards. NSS is under a similar duty of quality to that of Boards⁸ and is accountable to the Scottish Government.⁹

Health Protection Scotland

Health Protection Scotland (HPS) is a division of NSS and is therefore accountable to NSS.¹⁰ HPS was established on 1 April 2005 to strengthen and co-ordinate health protection in Scotland.¹¹ The HPS remit also includes the provision of expert advice on policy development¹² and specific duties

1 National Health Service (Scotland) Act 1978 (c. 29), s. 1A(1) as inserted by the National Health Service Reform (Scotland) Act 2004 (asp 7), s. 9(1); S.S.I 2004/361, art. 2(c)
 2 National Health Service (Scotland) Act 1978 (c. 29), s. 1A(2) as inserted by the National Health Service Reform (Scotland) Act 2004 (asp 7), s. 9(1); S.S.I 2004/361, art. 2(c)
 3 National Health Service (Scotland) Act 1978 (c. 29), s. 2A as inserted by the National Health Service Reform (Scotland) Act 2004 (asp 7), s. 9(2); S.S.I 2004/361, art. 2(c)
 4 National Health Service (Scotland) Act 1978 (c. 29), s. 12H as inserted by the Health Act 1999 (c. 8) s. 51; S.S.I 1999/90, art. 2(a), Sch. 1

5 National Health Service (Scotland) Act 1978 (c. 29), s. 10A(1) as inserted by the Public Services Reform (Scotland) Act 2010 (asp 8), ss.108, 134(7); S.S.I 2011/122, art. 2, Sch.
 6 National Health Service (Scotland) Act 1972 (c. 58), s. 19(1)
 7 National Health Service (Scotland) Act 1978 (c. 29), s. 10(1)
 8 National Health Service (Scotland) Act 1978 (c. 29), s. 12H as inserted by the Health Act 1999 (c. 8), s. 51; S.S.I 1999/90, art. 2(a), Sch. 1
 9 [TRA01090116](#)
 10 [TRA01090116](#)
 11 [TRA01090115-116](#)
 12 [HPS02910003](#)

in relation to outbreaks,¹³ all set out in a Memorandum of Understanding in March 2007¹⁴ between the then Scottish Executive Health Department and HPS. HPS has about 110 staff with different fields of expertise, including consultant medical staff, consultant nurses, scientific staff and statisticians.¹⁵

HPS is divided into three main clinical groups. One of these is the healthcare associated infection, antimicrobial resistance, infection control and decontamination group,¹⁶ which in 2007 to 2008 was led by Professor Jacqui Reilly.¹⁷

Scottish Government Health Directorate

The Scottish Government Health Directorate (SGHD) provides the central management of the NHS in Scotland by way of a Management Executive that oversees the work of the Health Boards. The SGHD is also responsible for the development and implementation of policy in health and community care. The Cabinet Secretary for Health and Wellbeing is the Minister responsible for the SGHD.

In 2007 to 2008 Dr Kevin Woods was the Director General of the Health and Social Care Directorate within the Scottish Executive, later the Scottish Government. His role involved supporting and advising the Cabinet Secretary on NHS policy and putting the policy into effect. He was also the Chief Executive for NHSScotland, and as such led the central management of NHSScotland and was accountable to the Scottish Government for the performance of the service. Paul Martin, later Professor Martin, was the Chief Nursing Officer and Interim Director for Health Workforce, with responsibilities that included providing advice to Ministers on all matters relating to nursing, midwifery and allied health professionals. Professor Martin was the lead in the development and implementation of the Scottish Government Healthcare Associated Infection Action Plan.¹⁸

NHS Education for Scotland

NHS Education for Scotland (NES) was established on 1 April 2002.¹⁹ Its aim is to provide better patient care by designing, commissioning, quality assuring and, where appropriate, providing education, training and life-long learning to the NHS workforce in Scotland.

An example of the work of NES is its significant involvement²⁰ in the Scottish Executive Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection²¹ which was issued in May 2004. Its involvement in the section dealing with staff education in particular is clear. The statement that “HAI is everybody’s business”²² appears in that section of the report, and is repeated in other policy documents.

One of the key educational resources produced by NES was the Cleanliness Champions Programme, first launched in September 2003.²³ This Programme, which is explained in more detail in Chapter 15, is designed to provide education in the basic principles of prevention and control of infection.

6.2 Systems

Healthcare Associated Infection Task Force

The background and key recommendations of “The Watt Group report”²⁴ (a review of the outbreak of salmonella at the Victoria Infirmary, Glasgow, between December 2001 and January 2002) are explored in Chapter 7. The Watt Group report led to the creation of the Healthcare Associated Infection (HAI) Task Force in January 2003, following an announcement made by the then Minister for Health and Community Care in November 2002.²⁵ Its creation was a reflection at a policy level of an understanding of the growing challenges around HAI.²⁶ The Task

13 [HPS02910006-08](#)

14 [HPS02910001](#)

15 [TRA01090114](#)

16 [TRA01090117](#)

17 [TRA01090117](#); [TRA01090113](#)

18 [TRA01080063-64](#)

19 [NES00240006](#)

20 [NES00240009](#)

21 [GOV00090001](#)

22 [GOV00090008](#)

23 [NES00240010](#)

24 [GOV00130001](#)

25 [TRA01080062](#)

26 [TRA01080063](#)

Force was initially chaired by the Chief Medical Officer, and has been chaired since April 2005 by the Chief Nursing Officer. It is a multi-agency advisory body,²⁷ and is responsible for advising on the development and delivery of Scottish Government policy to minimise healthcare associated infections.

The membership of the Task Force is drawn from a wide range of expertise including medical directors, nurse directors and consultant microbiologists.²⁸ The relationship of HPS with the Task Force was characterised by Professor Martin as one in which HPS provided the “science”²⁹ for the work of the Task Force. At the time of its creation the intention was that the Task Force would carry out a three-year programme up to November 2005,³⁰ but it became evident that its work in the area of HAI should continue, and the then Minister for Health and Community Care agreed to that. The remit of the Task Force was altered, and the first meeting of a modified HAI Task Force took place on 20 March 2006.³¹

A second delivery plan was drawn up for the period April 2006 to March 2008.³² *C. difficile* infection (CDI) was identified as a priority in that plan, and HPS was charged with developing programmes for its reduction.³³ Professor Martin, Chief Nursing Officer at the time, recalled that there were references “specifically and directly to the actions around *C. difficile*”³⁴ at most Task Force meetings after this date.

The HAI Task Force report on the Scottish Executive’s two HAI programmes (“Action Plans”) between January 2003 and March 2008 was published in June 2008.³⁵ This document collated the outcomes from the two Action Plans and highlighted progress against particular actions.³⁶

A new HAI delivery plan³⁷ was developed in April 2011 and builds on earlier programmes. The current plan includes non-NHS care settings such as care homes. The plan also supports the Quality Strategy³⁸ of patient-centred, safe and effective care.

The Task Force relationship with Health Protection Scotland

Much of the HAI work of HPS is carried out in conjunction with the HAI Task Force. HPS and other members of the HAI Task Force propose project work to the Task Force.³⁹ Proposals are considered by the Task Force, and then discussed with the HAI Policy Team at Scottish Government level. In her evidence Professor Reilly used the introduction of the mandatory surveillance system for CDI on 1 September 2006 to illustrate the practical operation of this system.

The background to mandatory reporting

In 2004 and 2005⁴⁰ the emerging literature in medical journals raised awareness of the concern with CDI in hospitals. At that time Health Boards reported cases of CDI on a voluntary basis. Around 2004 there appeared to be about 4,500 cases of CDI across Scotland per year,⁴¹ and there were five CDI outbreaks in that year, three hospital related and the other two in care homes.

In 2004 the scale of the CDI problem had been recognised in England and mandatory reporting had been introduced.⁴² A protocol for a surveillance system for Scotland was developed in late 2004 and early 2005 and was included in the HAI Task Force programme of work in 2005. The protocol represented the advice of HPS that mandatory reporting should be introduced in Scotland.⁴³

The Task Force gave approval in principle in September 2005,⁴⁴ and a business case for funding the project was then submitted

27 [WTS01670002](#)

28 [TRA01080064](#)

29 [TRA01080065](#)

30 [WTS01670003](#)

31 [GOV01310001](#)

32 [GOV00150001](#)

33 [GOV00150008](#)

34 [TRA01080136](#)

35 [GOV00710052](#)

36 [TRA01080066](#)

37 [GOV01460001](#)

38 [GOV01460001](#)

39 [TRA01100121](#)

40 [TRA01090119](#)

41 [TRA01090119](#)

42 [TRA01090121](#)

43 [TRA01100121](#)

44 [TRA01100121](#)

by HPS to the HAI Task Force. Funding was approved by the Scottish Government in May 2006,⁴⁵ which enabled HPS to develop the surveillance protocol in July 2006.⁴⁶ In a letter⁴⁷ dated 10 July 2006 the then Scottish Executive Health Department gave notice to all Health Board Chief Executives that Health Boards had to have systems in place from July 2006 for collecting the CDI data, and that surveillance of CDI was to be mandatory from 1 September 2006.

Reporting of positive specimens

Since 1 September 2006 specimens of diarrhoea from patients aged 65 years or over in healthcare settings have to be tested for *C. difficile* toxin.⁴⁸ The results of all positive tests for *C. difficile* toxins have to be sent to HPS on a weekly basis.⁴⁹ The intention behind this system is the national surveillance of CDI in Scotland. It is also to look at the burden of CDI at a national level and to compare trends in the data over time and between Health Boards.⁵⁰ The system is not designed to monitor the prevalence of CDI in a particular hospital.⁵¹

The data collected are reported by HPS in its quarterly and annual reports by reference to each NHS Board.⁵² The first quarter for which data were available was October to December 2006.⁵³ In the quarterly report for the period January 2007 to March 2007⁵⁴ HPS concluded in its summary of CDI rates in Scotland that there had been a 50% increase in cases for that quarter (from 1,204 to 1,775) compared to the previous quarter. When hospital activity in both acute and non-acute hospitals was taken into account, this translated into a 29% increase in prevalence of disease.

From 1 April 2009 surveillance for CDI has included the collection of data for those aged 15 and above, rather than those over 65.

The Scottish Salmonella, Shigella and *C. difficile* Reference Laboratory

The Scottish Salmonella, Shigella and *C. difficile* Reference Laboratory (the Reference Laboratory) was originally known as the Scottish Salmonella Laboratory and was based at Stobhill Hospital in Glasgow. The part of the Reference Laboratory that focuses on CDI opened in November 2007.⁵⁵ Previously this service had been provided by the Cardiff Anaerobic Laboratory in Wales, but such a service was required in Scotland because of the introduction of mandatory surveillance of CDI in September 2006. It was important to have a clear picture of the epidemiology of CDI in Scotland,⁵⁶ so the ribotyping of isolates had to be available to enable outbreaks to be identified and to allow for the identification of emerging strains. The Cardiff Laboratory did not have the capacity to type all such requests from Scotland.⁵⁷

The establishment of the Reference Laboratory was part of the HAI Task Force's 2005 to 2008 Programme.⁵⁸ Certain referral criteria have been devised for submitting isolates, including the suspicion that an outbreak may have occurred or that the infection is the 027 strain.⁵⁹

6.3 Accountability and monitoring

Meetings with the Cabinet Secretary

The Cabinet Secretary, accompanied by Dr Woods and senior officials, met with Health Board Chairpersons on a two-monthly basis.⁶⁰ Dr Woods gave an example of one such meeting that took place on 26 November 2007. Prior to that meeting the Cabinet Secretary had addressed a conference of medical and nursing directors on the subject of patient safety and HAI, and at the meeting with the Health Board Chairpersons the Cabinet Secretary took the opportunity of conveying to them the importance she attached to the management of HAI.⁶¹

45 [TRA01100121](#)
46 [GGC15380001](#)
47 [GOV00430001](#)
48 [GGC15380009](#)
49 [TRA01090124](#)
50 [TRA01090132-133](#)
51 [TRA01090128](#)
52 [TRA01100104](#)
53 [HPS03090002](#)
54 [HPS03090001](#)

55 [TRA01220004-05](#)
56 [INQ04170003](#)
57 [TRA01100122](#)
58 [TRA01080063-65](#); [TRA01100132](#)
59 [INQ04170009-10](#)
60 [TRA00970075-76](#)
61 [TRA00970077](#)

Meetings with Chief Executives

Dr Woods and senior officials, including the Chief Nursing Officer, also met with Health Board Chief Executives. At these meetings issues of particular importance to the Scottish Government would be discussed, including HAI.⁶²

Annual review process

The other main aspect of accountability at a senior management and government level was the annual review and associated meetings that took place each autumn. That review involved the Cabinet Secretary, Dr Woods and senior officials. It included meetings with professional leaders, with trade unions and with patients chosen by an independent body,⁶³ designed to inform the Cabinet Secretary and government officials of how well the particular Board was doing from the perspective of these different groups. Part of the time was also spent in public, discussing an agenda that focussed on issues that Scottish Ministers considered of particular importance⁶⁴ and the process concluded with a question and answer session during which members of the public had the opportunity to submit questions to the Cabinet Secretary and to the Health Board Chairpersons. Following the annual review, the Cabinet Secretary wrote to the Chairpersons of the Health Boards summarising the main points discussed and actions agreed.

Annual review 2007

Following the annual review in October 2007, the Cabinet Secretary recorded in a letter to the Chairman of NHS Greater Glasgow and Clyde (NHSGGC)⁶⁵ dated 13 November 2007 that:

“over the last year you had also completed the development of single system working across the Glasgow and Clyde area. This would ensure consistent infection control practice and enable more effective monitoring of performance”.⁶⁶

In his evidence Mr Robert Calderwood, currently Chief Executive, NHSGGC but then Chief Operating Officer, Acute Services, explained that:

“in relation to this particular paragraph in that letter, the annual review, it is my understanding that this was related to healthcare acquired infection and the work that the Board had taken forward to move to single system working for policies and procedures in this area”.⁶⁷

He accepted that at that time there was not a single system in place. That system did not come into place until after June 2008, when the problem with CDI at the VOLH had been recognised. He offered the explanation that the context of the reference in the Cabinet Secretary’s letter was “the infection control manual and the successful rollout of the manual across Greater Glasgow and Clyde”,⁶⁸ but this does not fit with the terms of the Cabinet Secretary’s letter, which clearly records that NHSGGC had completed the development of single system working within the context of effective monitoring.

Statement of internal control

The role of the Clinical Standards Board for Scotland (CSBS) is set out in Section 6.5. Its HAI standards, published in December 2001,⁶⁹ include standards of accountability within Health Boards, and Standard 1 in that section states:

“Responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters throughout the organisation”.⁷⁰

The standards also provided that the Chief Executive of each Health Board was responsible for ensuring a safe, effective and clean physical environment of care in healthcare facilities, and had to be able to account for the overall management of infection control.⁷¹ The Scottish Government⁷² expected this duty to be discharged by the

62 [TRA00970076](#)

63 [TRA00970073](#)

64 [TRA00970073](#)

65 [INQ00820001](#)

66 [INQ00820005](#)

67 [TRA01240055](#)

68 [TRA01240055](#)

69 [GOV00160001](#)

70 [GOV00160028](#)

71 [GOV00160028](#)

72 [TRA00970012](#)

Health Boards putting an effective process of clinical governance into place, and this is examined in Chapter 10. As part of the Scottish Government's annual auditing process of Health Boards, Chief Executives were required to sign a Statement of Internal Control⁷³ as part of the annual accounts to confirm that they had effective processes in place for clinical governance, including appropriate mechanisms in place for HAI.⁷⁴ There was no suggestion in the Statement of Internal Control for the year ending 31 March 2008, which formed part of the annual accounts for NHS GGC, that an effective system of clinical governance was not in place.⁷⁵ The Statement of Internal Control was signed by Mr Tom Divers, the Chief Executive, who was dependent upon information provided to him.

6.4 Health Improvement, Efficiency, Access and Treatment (HEAT) Targets and CDI guidance

Performance targets

Health Improvement, Efficiency, Access and Treatment (HEAT) Targets were performance targets set by the Scottish Government, and in 2007 and 2008 there were approximately 28 HEAT Targets that Health Boards were expected to meet.⁷⁶ Health Boards prepared local delivery plans that included their response to these HEAT Targets, and these delivery plans were submitted to Scottish Ministers for comment and approval.

MRSA

In November 2006 the Scottish Government announced a HEAT Target for *Staphylococcus aureus* bacteraemia (including MRSA and MSSA) of an overall 30% reduction in Scotland. This was to be achieved by 2010, and the reduction figures were to be compared with the levels that were in place from 2005 to 2006.⁷⁷ That target was in fact reached by September 2009, and the trend has continued to be a downward one.⁷⁸

Health Boards were expected to meet the target by having in place effective infection prevention and control methods. This included ensuring that there was local compliance with good practice through their infection prevention and control systems from Board to ward and ward to Board.⁷⁹

There was no dispute in the evidence that there was no HEAT Target for CDI in 2007 and 2008. Professor Martin said in evidence that *C. difficile* was not included as a HEAT Target because in the context of the HEAT Target system it was not then considered to be a "priority".⁸⁰ Dr Woods explained that HEAT Targets were chosen because the Scottish Government wanted there to be a quantitative measure of judging the effectiveness of policy being put into practice in "priority areas".⁸¹ Professor Martin did expect that introducing MRSA as a HEAT Target would have a positive impact on infection prevention and control generally,⁸² and Dr Woods expressed a similar view.⁸³

Reporting of HEAT Target rates

Ms Marie Martin, General Manager, Diagnostics for Clyde, explained how the reporting of MRSA rates was carried out in practice within the Clyde Directorate.⁸⁴ She reported the rates on a quarterly basis to Mrs Deb den Herder, Director, Clyde Acute Services. This information was reviewed by Mr Calderwood,⁸⁵ who reported through NHS GGC to the Scottish Government to enable the HEAT Target to be monitored. Ms Martin suggested that CDI should probably have been included in this system of reporting, but, as Mr Calderwood explained, the CDI rates were not reported in that way because CDI was not then a HEAT Target.⁸⁶

CDI as a HEAT Target

Following on from the report of the Independent Review chaired by Professor William Cairns Smith, Professor of Public Health at the University of Aberdeen, into

73 [TRA01080149](#)
74 [TRA01080150](#)
75 [GGC31970017](#)
76 [TRA01250041-42](#); [WTS00880001](#)
77 [TRA01090039](#)
78 [TRA00980136](#)

79 [TRA01090039](#)
80 [TRA01090042](#)
81 [TRA00970079](#)
82 [TRA01090040-41](#)
83 [TRA00970079-81](#)
84 [TRA01160096-97](#)
85 [TRA01240068-69](#)
86 [TRA01240069-71](#)

CDI at the VOLH between December 2007 and June 2008,⁸⁷ published in August 2008, the Scottish Government set a HEAT Target for CDI in 2009. The target was a reduction of CDI rates of at least 30% by 2011.

Had CDI been a HEAT Target in 2007 and 2008, information relating to the rates of CDI would have been reported in the same manner as rates of MRSA.⁸⁸ That is not, however, to say that any reporting of CDI rates as part of the HEAT Target would have revealed the CDI problem at the VOLH. The HEAT Target system was not designed to be an HAI surveillance system or to replace adequate surveillance systems by NHSGGC. The inclusion of CDI in the HEAT Target might nevertheless have raised awareness of and increased the priority given to the infection.

6.5 The review system

Introduction

The Clinical Standards Board for Scotland (CSBS) was established as a Special Health Board in April 1999. Its remit was to develop and run a national system of quality assurance of clinical services, with the aim of promoting public confidence in NHSScotland.⁸⁹

The standards

Following concern about the rise in the rate of healthcare associated infection, the then Scottish Executive Health Department set up a Working Group⁹⁰ in November 2000, chaired by Mr Richard Carey, Chief Executive of Highland Acute Hospitals NHS Trust. The aim of the Group was to provide guidance to NHSScotland on assessing and managing risks relating to HAI, and its report is considered in more detail in Chapter 7. Following on from the report⁹¹ of the Carey Group of April 2001, in June 2001 the CSBS established the HAI Reference Group⁹² under the Chairmanship of Dr David Old. Its remit was to build upon the work carried out by the Carey Group and finalise HAI related standards.

Following extensive consultation, CSBS first published its standards for HAI Infection Control in December 2001.⁹³ At the heart of the document was an overarching standard to ensure that the risk of infection is controlled.⁹⁴

The 15 standards covered all aspects of infection control and included:

- Accountability at different levels within an NHS Trust
- Processes for planning and development
- Infection Control Programme
- Policies, procedures and guidance/guidelines
- Microbiology services
- Surveillance
- Infection Control report
- Legislation and guidance
- Education
- Monitoring and review
- Internal audit
- Hand hygiene

A revision of these standards was published in March 2008.⁹⁵ The main aims of the standards were to ensure that Trusts and Boards could and did comply with their statutory duty of quality,⁹⁶ and to have in place “a managed environment which minimised the risk of infection to patients, staff and visitors”.⁹⁷

The review process

Following the publication of the standards, CSBS undertook a process of review of all Trusts and Boards. Trusts and Boards were invited to submit self-assessments on how well they were performing against the standards, and thereafter CSBS carried out “peer review” visits⁹⁸ to validate and expand upon the information provided in the self-assessment process. It is important to note that this was not an inspection regime of

87 [GOV00030001](#)
 88 [TRA01240068-69](#)
 89 [INQ03760005](#)
 90 [GOV00160013](#)
 91 [GOV00010001](#)
 92 [GOV00160015](#)

93 [GOV00160001](#)
 94 [GOV00160017](#)
 95 [INQ00840001](#)
 96 [TRA00970010](#)
 97 [GOV00160017](#); [INQ03760009](#)
 98 [INQ03760009](#)

individual hospitals. The visit to the Trust or Board involved meeting key personnel of the service under review and speaking with local stakeholders about the services provided, as well as including a visit to ward and departmental areas to learn how infection prevention and control measures were being adopted into clinical practice.⁹⁹

Review of Argyll and Clyde

The operation of this review process can be seen from the way the then Argyll and Clyde Acute Hospitals NHS Trust was reviewed. A review visit took place on 3 July 2002,¹⁰⁰ at which time there were four hospital sites within the Trust:

- Inverclyde Royal Hospital, Greenock
- Lorn and Islands District General Hospital, Oban
- Royal Alexandria Hospital, Paisley
- Vale of Leven District General Hospital, Dumbarton.

Of these, the Review Team only visited a high dependency/intensive therapy unit and a surgical ward, both of them at Inverclyde Royal Hospital.¹⁰¹

In 2002 the Review Team found that the Trust met 24 out of 69 criteria.¹⁰² Of the remaining 45 criteria, 42 were not met and three were “not met (insufficient evidence)”.¹⁰³ Following an update review on 12 May 2004,¹⁰⁴ which involved consideration of a submission made by the Trust, a further three criteria were met. The Trust therefore met 27 out of 69 criteria. No further reviews or assessments took place prior to June 2008.

National overview

In January 2003 CSBS (by then subsumed under NHS QIS)¹⁰⁵ published a National Overview reporting on performance across Scotland against the standards. A number

of key recommendations were made in relation to accountability, infrastructure, monitoring, review and audit. That National Overview concluded that “the real challenge for NHSScotland is to introduce a culture of surveillance and vigilance.”¹⁰⁶

6.6 Healthcare Environment Inspectorate

A planned new approach to scrutiny

In the aftermath of the discovery of the CDI problem at the VOLH the Cabinet Secretary had a number of meetings with families, some attended by Dr Woods.¹⁰⁷ A number of those present made clear to the Cabinet Secretary their view that there needed to be an inspectorate in place¹⁰⁸ which could independently review the actions being taken in hospitals.

Following the publication in August 2008 of the report of the Independent Review, the Scottish Government concluded that, in the context of infection prevention and control, the “quality of the care environment and the application of hygiene and cleanliness standards”¹⁰⁹ required a particular focus. The Cabinet Secretary wanted to put in place a:

“more transparent process of external assurance that will provide reports to the public that the care environment is clean and safe and that processes are in place to prevent, detect and tackle HAI”.¹¹⁰

The Scottish Government Healthcare Policy and Strategy Directorate issued a consultation paper¹¹¹ on 11 November 2008 setting out proposals for the role of the Healthcare Environment Inspectorate (HEI). In this paper the Scottish Government recognised that the “disaggregated nature of the existing approaches”¹¹² did not provide the appropriate level of scrutiny and coherence.

99 [INQ03760087-89](#)

100 [QIS00440016](#)

101 [QIS00440016](#)

102 [QIS00020004](#)

103 [QIS00020004](#)

104 [QIS00020003-04](#)

105 [INQ03760001](#)

106 [INQ03760013](#)

107 [TRA00970104](#)

108 [TRA00970104-105](#)

109 [GOV01010002](#)

110 [GGC16330003](#)

111 [GOV01010001](#)

112 [GOV01010002](#)

A relative's perspective

The first relative to give oral evidence to the Inquiry was a member of the teaching profession. She drew a powerful comparison between the inspection regime faced on the one hand by schools and by care homes, and on the other hand by hospitals.¹¹³ She was able to download from the internet an Inspection report for the local primary school and a local care home. She could access an Inspection report on the VOLH tea bar. She was also able to access the CSBS report of 2002 and the subsequent review, and was “devastated”¹¹⁴ to see that so large a number of standards continued to be described as “not met”.¹¹⁵ Her view was that it was “shocking”¹¹⁶ that a “robust inspection process”¹¹⁷ had not been in place.

Healthcare Environment Inspectorate methodology

The Healthcare Environment Inspectorate (HEI) was established in April 2009¹¹⁸ and was based within NHS QIS, which later became HIS.¹¹⁹ As the HEI Inspection Methodology¹²⁰ discloses, the HEI was to undertake at least one unannounced inspection of all acute hospitals across NHSScotland every three years. Its focus was to reduce the HAI risk to patients through a “rigorous inspection framework”.¹²¹ The aims of the HEI are described as follows:

- To provide public assurance and protection
- To restore public trust and confidence
- To contribute to the prevention and control of HAI
- To contribute to improvement in the healthcare environment including infection control, cleanliness and hygiene, and the broader quality improvement agenda across NHSScotland

An important aspect of the HEI's strategy is the use of an open and transparent method

for inspecting hospitals and the publication of inspection results on its website.

In her evidence¹²² Mrs Susan Brimelow, Chief Inspector for HEI, explained that the HEI was independent of the Scottish Government and of the Health Boards.¹²³ HEI is, however, part of HIS and is not an independent body in the strict sense.

Use of standards

Mrs Brimelow provided some insight into the standards against which hospitals were measured, namely the “Standards – March 2008, Healthcare Associated Infection (HAI)”¹²⁴ published in March 2008. By way of example, standard 3 provides as follows:

“The NHS Board has policies, procedures and guidelines which create a healthcare environment that minimises the risk of infection to patients, visitors and staff, and are based on evidence, best practice and expert opinion”.¹²⁵

Unannounced inspection

Mrs Brimelow explained that an unannounced inspection was one where no notice is given of the proposed inspection. Instead the Inspection Team arrive at the hospital and inform the site manager¹²⁶ that they are there to carry out an inspection. Both announced and unannounced inspections generally took two days to complete but could take longer depending on circumstances.¹²⁷

After the inspection process

Once initial feedback is given by the Inspectors, the Health Board must begin drafting a healthcare improvement plan to address the issues raised. Once the Inspection report is made available to the Health Board, the improvement plan addressing the recommendations made must be developed.¹²⁸ Mrs Brimelow saw this as a very important part¹²⁹ of the process. There

113 [TRA00010080-81](#)

114 [TRA00010083](#)

115 [QIS00020004](#)

116 [TRA00010084](#)

117 [TRA00010084](#)

118 [INQ00880002](#); [TRA01090059](#)

119 [TRA01090058](#)

120 [INQ00880001](#)

121 [INQ00880002](#)

122 [TRA01090058](#)

123 [TRA01090058](#)

124 [INQ00840001](#)

125 [INQ00840014](#)

126 [TRA01090061-62](#)

127 [TRA01090063](#)

128 [TRA01090069](#)

129 [TRA01090069](#)

is then a follow-up process where, 16 weeks after the inspection, and often less than 16 weeks,¹³⁰ the HEI ask the Health Board to disclose what progress has been made. The Inspection report itself is published within six to eight weeks following the inspection, and can be accessed by the public on the HEI website.

Where issues require immediate attention, Mrs Brimelow explained that such issues are often addressed before the Inspection Team leave the hospital in question.¹³¹ A draft Inspection report is made available to the

Chief Executive of the Health Board within four weeks. This is designed to produce a system of “real-time reporting”.¹³²

Healthcare Environment Inspectorate powers

The HEI’s powers include an “escalation” process.¹³³ Table 6.1 sets out the different levels involved. Level 1 is the least serious and level 4 is the most serious. Mrs Brimelow said that it had been necessary in the past to invoke level 1, but level 4 had never been invoked. Between each level there would be ongoing dialogue with the NHS Board.

Table 6.1 HEI Inspection methodology

Level	Issue	Action
1	Improvement Action Plans are not taken forward within the required timeframes.	Regional Inspector will arrange to meet senior staff from the NHS Board with warning of further action.
2	Improvement Action Plans are inadequate and/or not produced within the required timeframe.	Formal written warning of non-compliance sent to NHS Board from Regional Inspector with timeline for resolution, procedure for escalation and sanctions. This document will be publicly available. Chief Inspector informs HIS Board of significant concerns.
3	Improvement Action Plans are not taken forward and this poses a threat to patient safety and public health.	Letter of non-compliance sent by Chief Inspector to the Scottish Government and Cabinet Secretary for Health and Wellbeing supported by requirements for action. This document will be publicly available. The Scottish Government issues a warning to NHS Board with a timeline for resolution.
4	Serious issue identified during inspection.	Formal letter from Chief Inspector, including supporting evidence, sent to the Scottish Government outlining recommendations for action.

¹³⁰ [TRA01090070-71](#)

¹³¹ [TRA01090070-71](#)

¹³² [TRA01090071](#)

¹³³ [TRA01090067](#); [TRA01090071](#); [INQ00880008](#)

Scope of the inspection regime

An important aspect of the inspection regime is the fact that the inspections are not simply concerned with infection control systems. They inspect patient care and in particular the care being given to patients suffering from an HAI. The medical records are examined to check if appropriate care plans are in place. In the case of a patient suffering from CDI the Inspectors check, for example, to see if a stool chart is being maintained.

The Inspectors also examine the medical records to satisfy themselves about antimicrobial stewardship.¹³⁴ They do not make clinical judgements about whether an antibiotic should or should not have been prescribed, but they do check to see if antibiotics are being managed appropriately.

In so far as systems are concerned, the Inspectors check to see if appropriate inspection systems are in place.

The aspects of the inspection process referred to in the previous three paragraphs are of particular relevance to the manner in which patients suffering with CDI were managed in the VOLH in the period 1 January 2007 to 1 June 2008. As discussed in Chapter 12, an examination of the records of patients who suffered from CDI in the period 1 December 2007 to 1 June 2008, as well as of the records available for the period 1 January 2007 to 30 November 2007, disclosed significant failures in the keeping of written care plans and stool charts.

Between the first inspection on 29 September 2009 and Mrs Brimelow giving evidence to the Inquiry on 22 May 2012 HEI had carried out 101 inspections. Of these, 46 were announced inspections and 43 were unannounced inspections. The remaining 12 had been follow-up inspections, the majority of which were unannounced.¹³⁵

The VOLH influence

Mrs Brimelow explained how what happened at the VOLH influenced the methodology adopted by HEI during inspections.¹³⁶ She had read the transcripts of the evidence given to the Inquiry by patients and families in order to see what their issues were and what their experiences had been, either as patients or as visitors to the VOLH. This resulted in the Inspection Team putting on a “patient’s lens”¹³⁷ when they carried out hospital inspections.

The VOLH inspections

HEI first inspected the VOLH on 10 and 11 August 2011. That was an announced inspection. The report¹³⁸ of that inspection discloses that staff were complying with the relevant HAI standards. Having regard to the evidence gathered by the Inquiry referred to in other Chapters of this Report, had such an inspection been carried out in the period 1 January 2007 to 1 June 2008 the conclusions would have been markedly different.

An unannounced inspection¹³⁹ of the VOLH by HEI took place on 7 June 2012. Overall the Inspection Team found evidence that NHSGGC was complying with the “majority of NHS QIS HAI standards to protect patients, staff and visitors from the risk of acquiring an infection.”¹⁴⁰ The hospital was generally found to be clean and well maintained, and education in infection prevention and control was being well promoted. The inspection did make two requirements that NHSGGC had to comply with, one relating to hand hygiene, where NHSGGC was required to:

“ensure that all staff and volunteers comply at all times with national guidance relating to hand hygiene. This will reduce the risk of infections and cross contamination for patients and the public”.¹⁴¹

Two of the instances giving rise to this requirement were the failure of three doctors

¹³⁴ [TRA01090073-74](#)

¹³⁵ [TRA01090082](#)

¹³⁶ [TRA01090084](#)

¹³⁷ [TRA01090084](#)

¹³⁸ [GGC30680001](#)

¹³⁹ [INQ04450001](#)

¹⁴⁰ [INQ04450006](#)

¹⁴¹ [INQ04450012](#)

to practise hand hygiene during a ward round on Lomond ward and the failure of nursing staff in Lomond ward and ward 6 to practise hand hygiene following contact with patients or their environment.¹⁴² NHSGGC was presented with an Improvement Action Plan¹⁴³ containing a specified timescale during which the actions planned were to be met.

Sanctions

The HEI regime does not have an enforcement process of the kind found in other inspection regimes such as the inspection regime employed by the Care Inspectorate (formerly the Care Commission). Under the legislation¹⁴⁴ governing that regime, an improvement notice enforcement procedure can be invoked. Mrs Brimelow did not consider that such an enforcement process was necessary, since experience had shown that when HEI had published reports expressing concern the Scottish Government had acted swiftly in response.

The one area where Mrs Brimelow considered that HEI powers could be improved was if she had the power to stop admissions to a ward.¹⁴⁵ There had been instances where she had concern about the risks to patients and in those circumstances such a power might have been useful to her.

6.7 Conclusion

CDI HEAT target

CDI was only made the subject of a HEAT Target in the aftermath of the discovery of the problem with CDI at the VOLH. To have had this in place from 1 January 2007 to 1 June 2008, it would have been necessary to have adequate data available for comparative purposes, but as discussed earlier in this Chapter the system for mandatory surveillance did not come into operation until September 2006. There was no evidence that in the period prior to 1 June 2008 any consideration was being given to

making CDI a HEAT Target, but in any event only one annual report on the incidence of CDI following upon the introduction of mandatory surveillance was available at that stage. The introduction of CDI as a HEAT Target in 2009 was an appropriate and timely response by the Scottish Government to the disclosure in June 2008 of the CDI problem at the VOLH.

Monitoring

Dr Woods observed that:

“in something as large and complex as the National Health Service there is a limit to what the central administration ... can actually actively monitor day to day”.¹⁴⁶

That is obviously correct. He maintained that a clear message¹⁴⁷ on the importance placed upon combating HAI had been sent to Health Boards. This was a message that had been repeated over and over again because of the importance attached to it. The monitoring that included the annual review process did provide the SGHD with some comfort that appropriate systems were in place for infection prevention and control. Nevertheless, as the Cabinet Secretary's letter¹⁴⁸ of 13 November 2007 disclosed, there was scope for misunderstanding and confusion, for the development of single system working had not been completed across NHSGGC by then.

Although the process or review undertaken by CSBS included an investigatory element, it was not an inspection system. Nonetheless that process did disclose significant failures in infection prevention and control within the Argyll and Clyde Trust in July 2002 against the standards in force at the time. In the main those failures remained unaddressed at the time of the follow-up review in May 2004,¹⁴⁹ almost two years later. Furthermore, as the National Overview report:¹⁵⁰ “Improving Clinical Care in Scotland” discloses, there were significant deficiencies in infection prevention and control in Health Boards

¹⁴² [INQ04450008](#)

¹⁴³ [INQ04450021](#)

¹⁴⁴ Regulation of Care (Scotland) Act 2001 (asp 8), s. 10; Public Services Reform (Scotland) Act 2010 (asp 8), s. 62(1)

¹⁴⁵ [TRA01090084](#)

¹⁴⁶ [TRA00970133](#)

¹⁴⁷ [TRA00970069](#)

¹⁴⁸ [INQ00820001](#)

¹⁴⁹ [QIS00020004](#)

¹⁵⁰ [INQ03760001](#)

throughout Scotland. It could be argued that that in itself it should have prompted a more proactive response.

As discussed in Chapter 7, since devolution the SGHD and other agencies have produced a significant amount of policies, instruction and guidelines to Health Boards on HAI, including guidelines on the use of antibiotics. It was the increasing rates of CDI that prompted the introduction of Scotland's national surveillance programme. Professor Martin maintained that CDI "was at the forefront of the thinking of the Task Force"¹⁵¹ in 2006. Against that background, and given the importance placed on HAI in healthcare premises by the Scottish Government and other agencies, consideration needs to be given to whether a regime such as the HEI regime should have been introduced earlier in Scotland.

In September 2007 the Crerar Review on "Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland"¹⁵² was published. This had been commissioned as part of wider public service reform. It described the core purpose of external scrutiny as including the provision of an "independent assurance that services are well-managed, safe and fit-for-purpose."¹⁵³ The principles of external scrutiny should include independence and transparency. Furthermore, despite the primary responsibility for improvement resting with the Health Board, external scrutiny is seen as a catalyst for improvement by influencing behaviour and culture.¹⁵⁴

In his evidence Professor Martin said that the lack of an inspection system prior to the creation of HEI was "probably a weakness in the system that the Inspectorate has helped to fill".¹⁵⁵ Dr Woods acknowledged that the HEI could have been put in place at any time in the preceding ten years.¹⁵⁶ He explained that the route adopted in Scotland in relation to quality improvement was built on setting

standards, promoting professional review, peer review analysis, the construction of professional consensus and the clinical governance processes developed by Health Boards. The position was different in England and Wales where, since 2001 by virtue of the Health Act 1999¹⁵⁷ and subsequent legislation,¹⁵⁸ there had been a body with an inspection function (now the Care Quality Commission).

Dr Woods was correct in pointing out that despite the existence of an inspectorate in England significant outbreaks of CDI still occurred. These include Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust (2004 and 2005)¹⁵⁹ and Maidstone and Tunbridge Wells (2005 to 2006).¹⁶⁰

Nevertheless, it is regrettable that an effective inspectorate system had not been put in place prior to 1 June 2008. Indeed it is surprising, against the background already noted of how seriously HAI was regarded, that an inspection regime of that kind was not created. This represents a failure on the part of the Scottish Government. There is a real possibility that, if an effective regime of the kind now in place had existed in the period 1 January 2007 to 1 June 2008, the scale of the CDI problem that developed would have been significantly reduced. Its creation would almost certainly have raised awareness of HAI throughout Scotland. If an inspection had been carried out during that period, and the position had been as discovered by the Inquiry, the VOLH would have been subjected to serious criticism and a speedy response from NHSGGC would have been necessary. The swift response in setting up the HEI in the aftermath of the discovery of the problem with CDI at the VOLH was highly appropriate.

The Inquiry does consider that it is vital that there is an effective independent body responsible for hospital inspection and monitoring of standards. As already noted,

151 [TRA01090042](#)

152 [INQ04520001](#)

153 [INQ04520013](#)

154 [INQ04520028](#)

155 [TRA01080148](#)

156 [TRA00970107](#)

157 1999 (c. 8), ss. 19-23, Schedule 2

158 Health and Social Care (Community Health and Standards) Act 2003 (c. 43) and the Health and Social Care Act 2008 (c. 14)

159 [INQ02890001](#)

160 [INQ02870001](#)

the HEI is not a truly independent body, but it is clear that it operates in an independent and transparent way. The Inquiry does not see any need to make any recommendations on the status of the HEI.

It is important that an organisation such as the HEI is given appropriate powers to take proactive action to protect patient safety. Considerable pressure exists on staff and managers within hospitals not to close wards to admissions if they can avoid doing so. The Inquiry recommends that the powers of the HEI should be extended to include a power to close a ward to admissions, following discussion with those on site, if there is a real risk to the safety of patients.

6.8 Recommendations

Recommendation 1: Scottish Government should ensure that the Healthcare Environment Inspectorate (HEI) has the power to close a ward to new admissions if the HEI concludes that there is a real risk to the safety of patients. In the event of such closure, an urgent action plan should be devised with the Infection Prevention and Control Team and management.

Chapter 7

National policies and guidance

Introduction

This Chapter examines some aspects of the national policies and guidance on healthcare associated infection (HAI) in place prior to 1 January 2007. It also reviews aspects of the policies and guidance developed since June 2008 in response to events at the Vale of Leven Hospital (VOLH). The Chapter looks at whether the guidance at the time was generally adequate, and specifically whether there were failures in the provision and implementation of *C. difficile* guidance. Other policy issues are considered in Chapters in which they have particular relevance.

7.1 National guidance on the prevention and control of *C. difficile* before 2008

Background

Concern about the prevention and control of infection is not new. Infection prevention and control was high profile and on the policy agenda for some years prior to the VOLH outbreak. In 1997 to 1998 the House of Lords Select Committee on Science and Technology published a report entitled “Resistance to Antibiotics and other Antimicrobial Agents”.¹ This contained a clear message that infection control should be central to the day to day running of hospitals:

“purchasers and commissioning agencies should put infection control and basic hygiene where they belong, at the heart of good hospital management and practice, and should direct resources accordingly”.²

The “Scottish Infection Manual”,³ produced by the Scottish Office Department of Health Advisory Group on Infection and published in July 1998, set out the roles and responsibilities of Health Boards, Trusts, hospitals and other healthcare providers in relation to infection control. Under reference to the Select Committee, the Manual reinforced the message that infection control should be at the heart of hospital management.

The Scottish Office Department of Health responded to the Select Committee report by issuing a letter to Health Boards and Trusts in May 1999.⁴ In the letter the NHS in Scotland made a commitment to taking action to reduce the emergence and spread of antimicrobial resistance. This was to be achieved through:

- Strengthening infection control processes
- More effective antimicrobial prescribing
- Improving data and surveillance of resistant organisms and antimicrobial usage

The Carey report

In April 2001 a Joint Scottish Executive Health Department (SEHD) and NHSScotland Working Group, chaired by Richard Carey, Chief Executive of the Highland Acute Services NHS Trust, published a report entitled “Managing the Risk of Healthcare Associated Infection in NHSScotland”. Known as the Carey report,⁵ it recommended that there should be a common approach to managing the risk of HAI at local and national level, and that the risk management of HAI should be based on the Australian/New Zealand 4360:1999 model, which is outlined in Figure 7.1.⁶ There are six interrelated processes which involve:

1. Communicating and consulting with relevant stakeholders on risks and related matters
2. Establishing the context for risk management
3. Identifying potential hazards
4. Assessing risks
5. Treating risks
6. Monitoring and reviewing the quality and effectiveness of risk management

1 [INQ04790001](#)

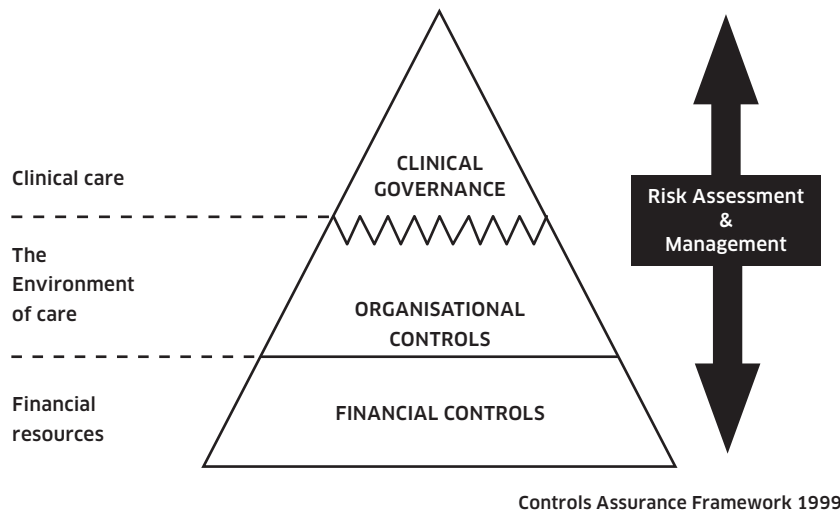
2 [INQ04790067-68](#)

3 [GOV00940001](#)

4 [INQ04540001](#)

5 [GOV00010001](#)

6 [GOV00010015](#)

Figure 7.1 Australian/New Zealand 4360:1999 model

The Carey report recommended that NHSScotland should promote a culture which encourages openness and the sharing of information on risk. It also identified the need for NHS Trusts to review their Infection Control Teams to ensure that they could monitor the risk management of HAI and assess their performance against the standards. In June 2001 the Scottish Executive wrote to all NHS Trusts and the Clinical Standards Board for Scotland (CSBS) requiring them to implement the report's recommendations.⁷

Towards the end of 2004, the HAI Task Force produced a consultation document called "The Risk Management of HAI: a Proposed Methodology for NHSScotland".⁸ The risk based methodology was piloted in NHSScotland under the direction of Health Protection Scotland (HPS) to test how applicable the methodology was and how easy it was to use. The final document was amended as a result of the consultation and the pilot phase. "The Risk Management of HAI: A Methodology for NHSScotland" was then published in November 2008.⁹

The approach of NHS Greater Glasgow and Clyde (NHSGGC) to the risk management of HAI is considered in Chapter 10.

The Watt Group report and Ministerial Action Plan

The Watt Group report has been referred to in Chapter 6. Established following an outbreak of salmonella infection at the Victoria Infirmary in Glasgow in late 2001 and early 2002, the Watt Group had as its remit to make recommendations to help reduce the risk of further outbreaks and to improve the management of such outbreaks. The group, chaired by Dr Brian Watt, a retired Consultant Microbiologist, published its report in 2002, and made 47 recommendations which the Group urged the then Scottish Executive to implement as a whole.¹⁰

A key recommendation was the adoption of a common classification system for outbreaks to be used in deciding the action and communication required during an infection incident. The Watt Group report contains a risk matrix,¹¹ which is a colour-coded method for determining how significant the risk is, and is still in use today. The risks range from high risk to very low risk. Table 7.1 shows a simplified version of the risk matrix.

⁷ [GOV00060001](#)

⁸ [INQ03820004](#)

⁹ [INQ03930001](#)

¹⁰ [GOV00130001](#)

¹¹ [GOV00130044](#)

Table 7.1 The risk matrix

	Risk category	Action required	Communications
	Red – High Risk	Implement a Board major incident or outbreak plan	Full communications Scottish Government, HPS and other national bodies
	Orange – Moderate Risk	Implement a Board incident or outbreak plan	Full communications Scottish Government, HPS and other national bodies
	Yellow – Low Risk	Implement a Board incident or outbreak plan	Health Board communications, Scottish Government, HPS
	Green – Very Low Risk	Investigation and monitoring by Infection Control Team	Health Board communications

In response to the Watt Group report, the SEHD published a Ministerial Action Plan.¹² This included the conclusions from the Watt Group report as well as recommendations from an HAI Convention held in Edinburgh in June 2002. The Action Plan: "Preventing Infections Acquired while Receiving Healthcare" was published in October 2002 to cover the period 2002 to 2005.¹³ The newly created Task Force, which is discussed in Chapter 6, was to be led by the Chief Medical Officer and would oversee the implementation of the Watt Group recommendations. Health Boards were asked to consider as a matter of priority how they would best implement these.¹⁴

NHSScotland Code of Practice

One of the first publications of the HAI Task Force, in 2004, was "The NHSScotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection".¹⁵ The Code of Practice includes the following guidance:

"Service users, staff and visitors have a right to, and expect, a safe physical healthcare environment. Key to ensuring this safety at all times is cleanliness of the facilities where healthcare is delivered".¹⁶

The responsibility of all staff in delivering the Code of Practice is emphasised. Specific responsibilities are outlined for the Infection Control Team, Infection Control Committee, Risk Management Committee and the Senior Manager with overall responsibility for infection control. Professor Martin, Chief Nursing Officer in the Scottish Government, described the Code as the "foundation of modern policy, in terms of the management of HAI in Scotland".¹⁷

Cleaning

Thorough cleaning and good maintenance of the hospital environment are vital in preventing infection and in controlling the spread of infection where it does occur. A number of policy and guidance documents on cleaning have been made available to NHS Boards over recent years.

In April 2000, Audit Scotland published "A Clean Bill of Health? – A review of domestic services in Scottish hospitals".¹⁸ This made a number of recommendations on improving cleaning in Scottish hospitals, and highlighted the important role which domestic services play in infection control. CSBS (now Healthcare Improvement Scotland (HIS)) produced standards in cleaning services in June 2002.¹⁹ Audit Scotland then published a follow-up review of cleaning services,

¹² [GOV00100001](#)

¹³ [GOV00100001](#)

¹⁴ [GOV00070001-02](#)

¹⁵ [GOV00090001](#)

¹⁶ [GOV00090019](#)

¹⁷ [TRA01080069](#)

¹⁸ [INQ05160001](#)

¹⁹ [INQ05190001](#)

including performance against the CSBS cleaning standards, in 2003.²⁰

The “NHSScotland National Cleaning Services Specification”²¹ was published in 2004 and set out requirements for:

- Performance management including daily service monitoring
- Staff training and development
- Cleaning services specifications which are detailed descriptions of tasks and quality standards for each area

The Specification was updated in 2009 and included colour coding to indicate what cleaning equipment should be used.²² NHSScotland also published a second version of the monitoring framework for the National Cleaning Services Specification in February 2007,²³ which provided a standard template for the review of systems, policies and procedures.

The Cleanliness Champions Programme

The Cleanliness Champions Programme (CCP) mentioned in Chapter 6 was an important feature of the HAI Task Force. Developed by NHS National Education for Scotland (NES), with expert advice from HPS on the content of the programme,²⁴ it was launched in September 2003 as part of the first HAI Task Force Action Plan.²⁵ It was designed to provide education in the basic principles of infection prevention and control. Hand hygiene was at the heart of the Programme.²⁶

As Professor Martin recalled in his evidence, the SEHD wanted to create a group of staff who were not necessarily clinical or infection control qualified staff:

“They needed to be staff who were willing to participate in the Cleanliness Champions training and to take on the role about promoting good practice and challenging poor practice in and around the health systems”.²⁷

In August 2004, the SEHD introduced a “Framework for Mandatory Induction Training in HAI for NHSScotland”.²⁸ This was designed to complement and strengthen a range of initiatives such as the work of the HAI Cleanliness Champions. The following year, SEHD considered that it would be a good leadership example if all G grade staff (ward sister/charge nurse) were also trained as Cleanliness Champions.²⁹ The Chief Nursing Officer therefore issued a letter dated 18 March 2005 requiring that all G grade nurses undertake the CCP.³⁰ The SEHD later offered funding to Health Boards of £200 for each Cleanliness Champion trained between November 2005 and March 2006. Professor Martin explained that the additional funding was to encourage Health Boards to progress staff through the training rather than use staffing issues as an excuse for not implementing the programme.³¹

It is a computer based programme which when introduced consisted of 11 separate units, including units on “The Chain of Infection” and “the Importance of Hand Hygiene”.³² The programme’s two main themes are safe practice and safe environment.³³ The online learning period was expected to take approximately 16 - 20 hours, and the CCP could be completed in around 16 weeks. Some changes to the programme have been introduced in the current version (version 3).³⁴

Cleanliness Champions Co-ordinators were also created in each Health Board area. They were responsible for driving forward the delivery of the training and ensuring that there were adequate numbers of staff trained across the Board areas. The HAI Task Force received regular updates on implementation from NES, which monitored the numbers of Cleanliness Champions by Board as well as the time taken for completion of the training. NES would ensure that they were supporting Boards to deliver the programme and would look at each Board’s development plans.³⁵

20 [INQ05170001](#)
 21 [HFS00070001](#); [HFS00070009-22](#)
 22 [HFS00170001](#)
 23 [GOV00400001](#)
 24 [WTS01830005](#)
 25 [NES00240010](#)
 26 [TRA00970052-53](#); [NES00240010](#)
 27 [TRA01080111-112](#)

28 [GOV00040003](#)
 29 [TRA01080112-113](#)
 30 [GOV00440011](#)
 31 [TRA01080113](#)
 32 [INQ01330003](#)
 33 [INQ01330003](#)
 34 [INQ05390001](#)
 35 [TRA01090034-35](#)

Records kept by NES and data reports sent by NES to SEHD allowed for comparisons to be made between Boards' use of the Cleanliness Champions Programme.³⁶ It was noted by NES and SEHD that three Health Boards were falling short of the set targets for Cleanliness Champions uptake. NHSGGC was one of the Boards supported to meet its target.³⁷

NHSGGC had a target of achieving 983 Cleanliness Champions by April 2008.³⁸ The Chairman's self-assessment in the 2008 Annual Review noted that this target was exceeded in March 2008 and stood at 1,193.³⁹

An early evaluation of the programme: "The Cleanliness Champions Programme Evaluation", published in March 2006,⁴⁰ concluded that the CCP had the potential to be one of the most important elements in the range of activities taken forward by the HAI Task Force. It was important in changing culture, and there was a strong argument for further investment in and expansion of the programme. In his expert report⁴¹ Professor Brian Duerden, an infection control expert commissioned by the Inquiry, also noted that the training package had been well implemented and well received throughout Scotland. The implementation of the programme in the VOLH itself is considered in Chapter 15.

National hand hygiene campaign

Professor Martin emphasised in his evidence⁴² the importance of hand hygiene in tackling HAI:

"Hand hygiene is central to any infection prevention and control system or process, no matter the bug or the infection".

In October 2005 Andy Kerr MSP, the Minister for Health and Community Care, took part in the launch of the World Health Organisation Global Patient Safety Challenge. At this event, the Minister launched a National Hand Hygiene Campaign involving NHSScotland

and the general public, and HPS was charged with overseeing the development and delivery of the campaign on behalf of the HAI Task Force. A letter was sent to Health Boards on 18 October 2006 advising that a public media campaign would be launched at the end of January 2007 and would run for four to six weeks.⁴³ Running alongside this would be an awareness campaign aimed at NHS staff, patients and visitors, which would run until March 2008. To support the implementation of the campaign, total funding of around £2 million was made available for each Health Board to employ a Local Co-ordinator until March 2008. In a further letter⁴⁴ the SEHD provided a job description for the Local Co-ordinator role and outlined the funding allocation for each Health Board.

Following publication of the HAI Prevalence Study in July 2007,⁴⁵ Nicola Sturgeon MSP, Cabinet Secretary for Health and Wellbeing, made it clear that she wanted a more intensive programme of work to tackle the rates of HAI.⁴⁶ The National Hand Hygiene Campaign continued as part of the three-year HAI Delivery Plan from 2008 to 2009, but the focus shifted to improving hand hygiene compliance. This was to support the Cabinet Secretary's target of achieving at least 90% compliance with hand hygiene by November 2008. Funding for the Local Co-ordinator posts was to continue until March 2010, with a possibility of extension until 2011.

The Scottish Patient Safety Programme

The Scottish Patient Safety Programme was launched in 2007, and had its origins in some work being promoted by a London based health policy organisation known as the Health Foundation which researches ways to improve healthcare. A programme was introduced in three hospitals across the UK, including Ninewells Hospital in Dundee, and the success of the programme in Ninewells encouraged the SGHD to develop a Patient Safety Programme across acute hospitals in Scotland.⁴⁷

36 [NES00240015](#)

37 [NES00240011](#)

38 [COF00050004](#)

39 [QIS01560052](#)

40 [INQ01900001](#)

41 [EXP02830009](#)

42 [TRA01080106](#)

43 [GOV00420001](#)

44 [GOV00480001](#)

45 [GOV00460001](#)

46 [GGC14430002](#)

47 [TRA00980131-132](#)

The Programme brought together a range of measures to promote patient safety, with the aim of creating an organisational culture of patient safety. Around a quarter of the work streams were concerned with HAI, and the work of the HAI Task Force was aligned with the Programme.⁴⁸ In his evidence Dr Cowan explained that as part of the Scottish Patient Safety Programme Senior Health Board Managers now visit hospital sites along with their Medical Directors.⁴⁹

7.2 The role of Health Protection Scotland in developing guidance on *C. difficile*

An important role

As discussed in Chapter 6, HPS was charged with delivering many aspects of the HAI Task Force Action Plans, and provided expert advice on policy development. Certain aspects of the influence of HPS on the development of surveillance systems have been considered in Chapter 6. HPS also disseminated research and best practice in infection control at a UK and international level. For example, the World Health Organisation Guide, “Prevention of Hospital Acquired Infections”,⁵⁰ was considered by HPS and the HAI Task Force at various points prior to May 2008.⁵¹

Health Protection Scotland weekly reports

HPS and its predecessors have been involved in raising awareness of *C. difficile* in Scotland since 1994.⁵² Since that time Health Boards have provided voluntary reports of *C. difficile* infection (CDI) which have appeared in the HPS weekly reports. In her evidence⁵³ Professor Jacqui Reilly, Head of Group for Healthcare Associated Infection, HPS, explained that CDI was considered to be an organism which caused concern in the broadest sense, but the concern did not have a particular focus. A weekly report in September 2006 demonstrates that there was awareness of the CDI 027 strain,⁵⁴

highlighting research presented at the English Health Protection Agency Conference which showed that only a quarter of the healthcare associated CDIs were caused by the 027 strain. This was the strain which caused most of the outbreaks at the Stoke Mandeville Hospital in England.

Prevalence survey of Healthcare Associated Infections

The HAI Task Force was concerned to ensure that it had good baseline statistics and information on the trends of HAI which would then allow it to assess the impact of the measures introduced. In May 2004 HPS identified the need for more surveillance of HAI, and proposed that it undertake a prevalence survey of all HAI, including CDI. The HAI Task Force agreed to the survey and funding was made available. The survey was carried out by HPS between October 2005 and September 2006, covering all acute hospitals in Scotland as well as a sample of community based hospitals, and the results of the survey were published in July 2007.⁵⁵ It found that 15.4% of HAI patients in acute hospitals acquired gastrointestinal infections. The most frequently occurring organisms where data existed included *C. difficile*, and patients in the Care of the Elderly and General Medicine Specialties accounted for 92% of the CDIs found. *C. difficile* was identified as a priority area for future incident surveillance.

Health Protection Scotland shared website

The HPS shared website was a section on the NHS internal website, established in 2007 as part of the HAI Task Force's second Delivery Plan. The Project Initiation Document⁵⁶ for Task 14.4: “Develop Programme for Reduction of *C. difficile*” made specific provision for this, and in her evidence⁵⁷ Professor Reilly outlined the purpose of the shared website, which allowed professionals to share research and best practice. There was also a discussion forum which allowed Infection Control Teams in different Health Boards to communicate with each other and with HPS, and a specific network was set up for *C. difficile*. HPS wrote

48 [TRA01100131](#)

49 [TRA01220158](#)

50 [INQ03830001](#)

51 [TRA01100122](#)

52 [TRA01090118](#)

53 [TRA01090118](#)

54 [GOV01110001-04](#)

55 [GOV00460001](#)

56 [HPS00250001-04](#)

57 [TRA01100043-46](#)

to Health Board Infection Control Managers in August 2007 to let them know about the website and inviting relevant staff to register. Registration was on a voluntary basis, and about six staff from NHS GGC were registered on the site. An email alert was sent to registered users to let them know when new information became available.

Awareness of the 027 strain of *C. difficile*

HPS first became aware of the 027 strain in 2006, when a case from Glasgow was ribotyped by the Cardiff Reference Laboratory.⁵⁸ It seemed that this case concerned a patient who had previously been in hospital in England. The next case it became aware of was in 2007. The “Annual report on the Surveillance of *Clostridium difficile* Associated Disease in Scotland” (2007) mentioned both of these cases as the first examples of 027 in Scotland.⁵⁹

The HPS weekly report of 7 November 2007 mentioned a case of 027 from a hospital in the west of Scotland, describing it as the second reported case of 027 in Scotland.⁶⁰ According to Professor Reilly, the purpose of the alert was to increase awareness within Health Boards that 027 was circulating, and to encourage them to send severe cases of CDI related to suspected outbreaks to the Reference Laboratory for ribotyping.⁶¹

The Project Initiation Document for the *C. difficile* Reduction Programme mentioned the emergence of a new hypervirulent strain 027, which was thought to cause more severe disease.⁶² According to the published literature at the time, it was thought that 027 was potentially more transmissible than other ribotypes or strains of *C. difficile*. More recent literature suggests, however, that ribotype 027 is not necessarily more virulent or transmissible than other ribotypes.⁶³

Professor Reilly emphasised that HPS takes a broad approach to infection prevention and control which prepares for all organisms

as they emerge. This is in recognition that “organisms do come and go”.⁶⁴ She also made clear that CDI should be seen as a serious illness regardless of the ribotype.⁶⁵

In May 2008 HPS sent a letter to Infection Control Managers reminding them of the actions to take when there is a suspected case of CDI, regardless of ribotype. It also outlined the necessary steps when dealing with the 027 ribotype.⁶⁶ The letter was prompted by outbreaks related to the 027 strain in Scotland,⁶⁷ which at that time included the emergence of the VOLH CDI problem. In her evidence Professor Reilly said that, had HPS been aware of an earlier outbreak in Scotland, a similar process would have been adopted.⁶⁸

Clostridium difficile associated disease care bundle

HPS published the “*Clostridium difficile* associated disease (CDAD) bundle” (the care bundle) in March 2008. The infection control measures within the care bundle were not new, and would probably have been in local Health Boards’ policies for Infection Control, but the purpose of the care bundle was to focus on these measures and act as a prompt for staff at the point where they were dealing with a patient with CDI.⁶⁹

The care bundle included five measures:⁷⁰

1. Isolating patients until they are at least 48 hours symptom free
2. Stopping inappropriate antibiotics
3. Checking healthcare workers remove gloves and aprons after dealing with each patient
4. Checking that the CDAD patient’s immediate environment has been cleaned with a chlorine based solution
5. Ensuring healthcare workers wash hands with liquid soap and water after leaving a CDAD patient’s room

58 [TRA01100018-19](#)

59 [HPS00310004](#)

60 [INQ03650001](#)

61 [TRA01100024](#)

62 [HPS00250001](#)

63 [TRA01090141](#)

64 [TRA01100021](#)

65 [TRA01100018](#)

66 [HPS00730001](#)

67 [TRA01100023](#)

68 [TRA01100027](#)

69 [TRA01100013](#)

70 [HPS01650001](#)

Professor Reilly explained that in January 2007 SGHD had advised that the Department of Health in England and Wales was looking at implementing high impact interventions for *C. difficile*, and asked if HPS would consider doing something similar. The process began in January 2007 and was built into the Project Initiation Document, which was submitted in the summer of 2007. The CDAD care bundle was tested in a number of Health Boards during 2007, including NHSGGC,⁷¹ before being delivered in March 2008.⁷² All Health Boards had access to the care bundle as it was available on the HPS website from that point.⁷³

Professor Martin confirmed that the CDAD care bundle had been in preparation before the HAI Task Force was aware of the events at the VOLH.⁷⁴ At the HAI Task Force meeting on 27 May 2008⁷⁵ it was agreed that the CDAD care bundle was so important that it should be introduced as quickly as possible, and that it should be co-ordinated with the Scottish Patient Safety Programme to ensure consistency with its care bundle approach.

7.3 Developments from June 2008 onwards

Introduction

A number of *C. difficile* related guidance documents were being developed in the early part of 2008, but not finalised by June 2008, at which point SGHD and other national bodies became aware of the outbreak at the VOLH. Production and dissemination of some key guidance documents were accelerated as a result of the VOLH experience.

Checklist for preventing and controlling *C. difficile* associated disease

HPS developed a checklist⁷⁶ for preventing and controlling *C. difficile* associated disease to ensure adequate governance of *C. difficile* at all levels within Health Boards. According to Professor Reilly, the checklist was being discussed early in 2008 by the HPS internal

C. difficile Infection Team in response to some of the lessons learnt from the *C. difficile* outbreaks in England.⁷⁷ It was produced earlier than planned in light of the outbreak at the VOLH and was tested with NHSGGC. The final version was published in September 2008 and shared with all NHS Boards. The creation of the checklist is examined in greater detail in Chapter 18.

Information for patients

The NHS Quality Improvement Scotland (QIS) (now Health Improvement Scotland (HIS)) HAI standards⁷⁸ require Health Boards to provide patient information, so that there was an expectation that patient leaflets would be available within Health Boards. Despite this, the lack of information provided to relatives regarding the washing of patients' clothing was highlighted in the August 2008 report of the Independent Review into the outbreak of *C. difficile* at the VOLH,⁷⁹ and Professor Reilly told the Inquiry that HPS was subsequently asked in the light of the Independent Review to produce a template for a patient laundry leaflet and share it across Boards to strengthen existing information.⁸⁰

Root Cause Analysis tool

Root Cause Analysis is a structured technique used within the NHS to analyse serious adverse events and establish what went wrong. The General Action Plan for HAI,⁸¹ developed for Health Boards in June 2008, included the introduction of a *C. difficile* Root Cause Analysis Tool to investigate adverse outcomes, including death. Professor Martin agreed that such a tool was not being used routinely in Scotland at the time of the VOLH outbreaks, nor had a policy been issued to Health Boards at this time,⁸² although a *C. difficile* Tool had been introduced in England as a result of the Maidstone and Tunbridge Wells report.⁸³ It was then decided that as part of the response to the VOLH outbreaks HPS should develop a similar tool in Scotland.

71 [TRA01090143](#)
72 [TRA01100006](#)
73 [TRA01100010](#)
74 [TRA01080134-135](#)
75 [GOV00740009](#)
76 [HPS01590002-03](#)

77 [TRA01090149](#)
78 [INQ00840012](#)
79 [GOV00030012](#)
80 [TRA01100041](#)
81 [GGC14470006](#)
82 [TRA01080136-138](#)
83 [INQ02870001](#)

The Quality Strategy

A more recent development in Scotland is the Quality Strategy,⁸⁴ launched in 2010. It promotes safe, effective, person-centred care and builds on the theme of creating a quality culture within the NHS. Safe care is defined as avoiding “injury or harm to people from healthcare they receive” and providing an “appropriate clean and safe environment” for the delivery of healthcare at all times. Professor Reilly explained that the HAI Task Force philosophy fits with this strategy. It reflects best practice for infection control as outlined by the World Health Organisation and European requirements for infection control.⁸⁵

7.4 Was the guidance on HAI adequate?

Range of guidance

A range of guidance on HAI was in place at the time of the VOLH outbreak. Indeed, Scotland was considered to be a leader in tackling infection control. Dr Woods recalled a conference in 2005 where the World Health Organisation’s leading Infection Control Expert, Professor Pittet, said that Scotland was at the forefront of infection control measures in Europe in tackling HAIs.⁸⁶ The HAI Task Force was seen as being unique in taking a countrywide approach to tackling HAI.

Dr Woods’ letter of 27 June 2008

On 27 June 2008,⁸⁷ shortly after the outbreak at the VOLH, Dr Woods wrote to Health Board Chief Executives reminding them of their responsibilities. The Appendix to Dr Woods’ letter lists guidance relevant to HAI, and that list extends to six pages, a clear indication of the extent of the information available.

Dr Woods considered that a clear message was being provided to Boards in relation to the management of HAI. As he said:

“it was a message that was repeated over and over again because of the importance we attached to it”.⁸⁸

This consistent message spanned different political administrations.⁸⁹ The repetition of the message did not necessarily reflect dissatisfaction with the Boards. Instead:

“it reflected a determination to make sure that it remained very firmly at the front of the leadership of these organisations’ minds”.⁹⁰

The Inquiry is satisfied that there was adequate guidance on HAI available to Health Boards.

7.5 The provision of *C. difficile* guidance

Pre 2008 *C. difficile* guidance

In her evidence Professor Reilly explained that guidance on standard infection control precautions was in place from February 2006.⁹¹ This covered all organisms of concern including *C. difficile*. Prior to this, there was UK guidance produced by the Department of Health in 1994⁹² which was relevant to Scotland. Additionally, HPS published transmission-based precautions which focused specifically on *C. difficile*. These outlined the additional measures which should be put in place when dealing with a patient who was known or thought to have CDI.⁹³

The 2008 *C. difficile* guidance

Professor Reilly explained in her evidence that HPS was represented on a European working group developing the first European guidance focusing on the specific topic of CDI.⁹⁴ The plans to produce Scottish guidance were outlined in the Project Initiation Document mentioned in Section 7.2, which was sent to the HAI Task Force in 2007, and which contained a two-year programme of work including the development of *C. difficile* specific guidance.⁹⁵ The European guidance was due to be produced in 2008, and the publication of the Scottish guidance was planned for 2009. HPS expected to

84 [GOV01460001](#)

85 [TRA01100131](#)

86 [WTS01200002-03](#)

87 [GOV00200001](#)

88 [TRA00970069](#)

89 [TRA00970077](#)

90 [TRA00970078](#)

91 [TRA01090135](#)

92 [INQ01700001](#)

93 [HPS00330001](#)

94 [TRA01090137](#)

95 [HPS00250001](#)

review the European guidance following its publication to check that there was sufficient evidence to support the recommendations and to adapt it to the Scottish context, ensuring that Scottish policies on infection control were referred to.

The guidance was actually published in October 2008. Professor Reilly explained that its publication was brought forward at the request of the Scottish Government as a result of the emerging O27 outbreaks which were reported to HPS in May 2008.⁹⁶ Production of the guidance in a shorter timescale meant that the normal consultation process which would take place was reduced, and following production of the guidance in October 2008 a fuller consultation took place to ensure that it was fit for purpose. The guidance was revised in light of the consultation and re-issued in September 2009.⁹⁷ The changes made were minor, and the guidance did not change significantly from the earlier version.

The equivalent guidance in England was published by the Health Protection Agency in January 2009.⁹⁸

7.6 The monitoring of the implementation of guidance

Additional resources

Professor Martin explained in his evidence that the HAI Task Force could release additional resources to support Health Boards in implementing new work.⁹⁹ Funding for Infection Control Managers, Nurse Consultants and Hand Hygiene Co-ordinators was an example of such support. A sum of £40,000 was provided to each of the mainland Scottish Health Boards and £20,000 to each of the island Health Boards to support the appointment of dedicated Infection Control Managers.¹⁰⁰

How was the implementation of policy and guidance monitored?

Chapter 6 outlines the accountability systems in place in 2007 and 2008. Dr Woods described the process for the monitoring of policy,¹⁰¹ in which monthly meetings were held with Chief Executives which covered current performance, future policy and the experience of putting policy into practice. The Chief Nursing Officer held monthly meetings with the Nurse Directors within each Health Board, and these would include discussion on HAI.¹⁰² As part of this ongoing dialogue between Government and Health Boards, complementary meetings were held between the Scottish Government and Chairs of the Health Boards. HAI issues formed part of these discussions. For example, at the meeting on 26 November 2007, Ministers made clear that HAI was a top priority for Government.¹⁰³

The annual review process introduced by the then Minister for Health and Community Care, Andy Kerr MSP, provides a formal process for asking Health Boards what they are doing to deliver their responsibilities. HAI has been an agenda item under both political administrations. Nevertheless, Professor Martin thought that the SGHD would only become aware that a policy had not been put in place if they specifically asked the question at the time of the annual review.¹⁰⁴ Dr Woods, on the other hand, explained that there were sources of intelligence for the SGHD to monitor compliance with standards. If they became aware of a deficiency, this would be flagged as an issue and followed up at the next review.¹⁰⁵

As discussed in Chapter 6, Health Improvement, Efficiency, Access and Treatment (HEAT) targets cover a range of areas relating to efficiency improvements and patient access to treatment, and Health Boards are measured against these targets. The HEAT target for *C. difficile* was not introduced until April 2009.¹⁰⁶

96 [TRA01100016](#)
 97 [INQ03600001](#)
 98 [INQ02440001](#)
 99 [TRA01080068](#); [TRA01080093](#)
 100 [GOV00440001](#)

101 [TRA00970075- 76](#)
 102 [TRA01090036](#)
 103 [WTS01200006](#)
 104 [TRA01080096](#)
 105 [WTS01200007-08](#)
 106 [GOV01430001](#)

Inadequate implementation tools

Although there was a range of guidance available at a national level, the persisting CDI problem in the VOLH over the period January 2007 to June 2008 shows that not enough attention was paid to the implementation of such guidance on *C. difficile*. At the meeting of the HAI Task Force on 4 July 2008,¹⁰⁷ after the events at the VOLH, members raised concerns that, although good guidance was in place across Scotland, the tools for implementation were not always in place.

In his witness statement¹⁰⁸ Professor Martin noted that: “there was a shift from policy development to supporting policy delivery in the second plan”. The SGHD would not become too involved in delivery issues, as this was not their responsibility, but they could provide levers such as additional resources to effect change. In contrast, the SGHD took a prescriptive approach to NHSGGC in response to the Independent Review report of the VOLH outbreak. They issued a specific action plan with timescales for completion and a more general action plan for all Health Boards to respond to. Professor Martin explained that an unusually firm line was taken, and the language used by him in his evidence reflected this: “No more excuses, just get on and get this done”.¹⁰⁹ This was not a specific response to reluctance on the part of NHSGGC, but arose from a general observation that policies were difficult to implement across Scottish Health Boards.

In his evidence, Dr Woods acknowledged that although there was a lot of guidance available prior to events at the VOLH, something still went wrong. In his view it is important that good processes are in place to ensure that guidance is implemented at a local level. It can be achieved through:

- Training
- Review processes
- Clinical leadership
- Early warning system
- External review¹¹⁰

The suggestion is that guidance and tools were fragmented and were not easily accessible in one place.

7.7 Conclusion

There was a considerable range of policies and guidance on HAI and *C. difficile* available from the mid 1990s onwards. Scottish Government and national organisations such as HPS took the threat of HAIs seriously.

The challenge for Health Boards is to ensure that policies are put into place every day for every patient. NHS staff should be aware of policies on infection control and *C. difficile* and understand how they relate to their day to day work. Staff should also be actively involved in the review of policies and ongoing improvement.

Although a number of monitoring systems were in place, as explored in Chapter 6, there was inadequate external scrutiny of HAI until the creation of the Healthcare Environment Inspectorate in April 2009. This was a weakness in the system.

The introduction of policies and guidance on HAI should be adequately policed by or on behalf of the Scottish Government.

Policies and guidance relevant to *C. difficile* were in place and available to Health Boards in 2007 and 2008. Specific Scottish guidance on *C. difficile* was not pulled together in one place until October 2008, when HPS produced guidance on the prevention and control of *C. difficile*.

The production of the 2008 *C. difficile* guidance is fully examined in Chapter 18. The production of the checklist, as discussed in Chapter 18, should have occurred earlier than it did. This, however, does not diminish NHSGGC’s responsibility to take the threat of *C. difficile* seriously. NHSGGC did, after all, have their own *C. difficile* policy within the Infection Control Manual.

During the Inquiry’s oral evidence, it was suggested by legal representatives of patients and relatives that Health Boards might benefit from a local HAI Task Force,

¹⁰⁷ [GOV01420003](#)

¹⁰⁸ [WTS01670004](#)

¹⁰⁹ [TRA01080132](#)

¹¹⁰ [WTS01200009](#)

with links to the national HAI Task Force.¹¹¹ Professor Martin was very responsive to this idea, and said that if a local Task Force reflected the membership of the national Task Force and included representatives from local communities it could be a very positive development for Scotland. The Inquiry supports this suggestion. A local HAI Task Force could provide reassurance to the general public that HAI is a priority within their Health Board area.

7.8 Recommendations

Recommendation 2: Scottish Government should ensure that policies and guidance on healthcare associated infection are accompanied by an implementation strategy and that implementation is monitored.

Recommendation 3: Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart.

Recommendation 4: Scottish Government should develop local Healthcare Associated Infection (HAI) Task Forces within each Health Board area.

¹¹¹ [TRA01090019-20](#)

Chapter 8

Changes in services at the
Vale of Leven Hospital
from 2002

Introduction

Chapter 9 examines the process of integration of NHS Argyll and Clyde with Greater Glasgow. It is important to be aware, however, that significant developments took place at the Vale of Leven Hospital (VOLH) in the years before and after that integration. As an introduction to a review of the integration process, the Inquiry has found it helpful to set out these developments, since they serve to place in context certain events which the Inquiry has examined in the course of its investigations and which are directly related to matters within the Inquiry's Terms of Reference.

8.1 Prolonged uncertainty

Background

In 2002 the Vale of Leven District General Hospital (this is its full title) was one of the smaller hospitals in the NHS in Scotland delivering a broad range of acute hospital services. The hospital's "front door" was an Accident and Emergency (A&E) Department which dealt with well over 20,000 attendances each year. The Lead Clinician was an Associate Specialist. The A&E Department provided the triage (the process of determining priority of treatment for patients) for the Acute Medical and Acute Surgical receiving units, whose specialties included an inpatient gynaecology unit. The hospital also had an inpatient Maternity unit, with a small specialist Medical Paediatric unit operating in support.¹ The VOLH was used for placement of nurses in training, although the extent of this has not been explored by the Inquiry.

Even by 2002, however, concerns had arisen about the sustainability of such a range of services at the VOLH. Attempts had been made for a number of years to develop "a sustainable strategy"² for the VOLH. A project known as the Vale of Leven Project was undertaken from 1999 to 2001 to consider how best to develop the VOLH and its clinical services, and this identified key issues in relation to each of the specialties provided at the hospital. The conclusion arrived at was that important services provided at the VOLH were no longer viable, primarily because of

a lack of medical staff. By December 2002, surgical services at the VOLH were close to total collapse because it was not possible to recruit surgeons to replace those who left to take up other positions or who retired.³

Reduction in services

Between 2002 and 2004 a significant service reconfiguration took place in NHS Argyll and Clyde involving, in particular, the VOLH and the Royal Alexandra Hospital (RAH). This was to address the challenge of providing sustainable and safe specialist Acute Clinical services for the local population. Surgery and urology services were transferred from the VOLH to the RAH in 2003.⁴ Following upon a major review of maternity services in NHS Argyll and Clyde in 2003, consultant-led obstetric and gynaecology services for the VOLH catchment area were also transferred to the RAH, while a community midwifery service was developed at the VOLH.⁵ In January 2004 A&E services were transferred to the RAH, although other unscheduled medical admissions were maintained for the time being, as was a separate minor injuries unit.⁶ These changes occurred without public consultation or being put to the Scottish Government.⁷

Impact upon anaesthetic services

The reconfiguration of services meant that the level of activity at the VOLH was significantly reduced. That reduction in activity meant that the anaesthetic service was not sustainable beyond the short-term. This in turn cast doubt upon the sustainability of the remaining unscheduled medical admissions to the VOLH.⁸ In June 2004 Dr Geoffrey Douglas, Clinical Director for Anaesthetics, wrote to the Chief Operating Officer of NHS Argyll and Clyde and to the then Minister for Health and Community Care, Malcolm Chisholm, informing them that the anaesthetic service could not be sustained beyond the short-term because of the impact of the reconfiguration of the former service provision at the VOLH.⁹ The reason for this was that:

¹ [GGC32180003](#)

² [GGC18250021](#); [TRA00980003](#)

³ [GGC18250021](#)

⁴ [GGC03430001](#)

⁵ [GGC03430001](#)

⁶ [GGC03430001](#)

⁷ [TRA00980039](#)

⁸ [QIS01190052](#); [GGC03430001](#)

⁹ [QIS01190052](#)

“there was simply not the volume of work that would allow anaesthetists to maintain their skills base or provide adequate training workload to sustain training accreditation”.¹⁰

8.2 Shaping the Future

The consultation process

In 2004 the NHS Argyll and Clyde Board produced a public consultation paper entitled “Shaping the Future”.¹¹ The consultation period was initially intended to run from 14 June to 17 September 2004, although it appears to have continued into 2005.¹² The central theme of that paper was the development of the RAH as the major acute hospital for Argyll and Clyde. The key proposals for the VOLH included the transfer of geriatric and dementia beds from other hospitals to the VOLH,¹³ the retention of the midwife-led maternity service, and a renal dialysis service.¹⁴

There were two proposed options for future services at the VOLH. The first option was that the VOLH could become an Ambulatory Care and Diagnostic Centre for non-inpatient activity,¹⁵ provided by NHS Greater Glasgow, which was to include a nurse-led minor injuries service. All inpatient services would be in Glasgow. The second option was the development of an intermediate hospital which integrated ambulatory care with intermediate care beds and services.¹⁶ Patients who required major acute inpatient care would be transferred to the RAH.

The consultation paper proposed significant changes not only at the VOLH but across the whole Argyll and Clyde area, including the closure of hospitals.¹⁷ It was proposed that the reconfiguration of services would be substantially completed by the end of April 2007.¹⁸

These options proved to be highly controversial, however, and no final strategy was concluded before the proposed dissolution of NHS Argyll and Clyde was announced in May 2005.

8.3 Lomond Integrated Care Model

A new approach to admissions

Some 6,000 unscheduled admissions continued to take place at the VOLH every year through the Medical Assessment Unit (MAU). The fragility of the anaesthetic service led to steps being taken to devise a model of care, known as the Lomond Integrated Care Model (the Care Model), that would allow such unscheduled medical care to be retained at the VOLH in the absence of on-site anaesthetic support.¹⁹ This model had been developed by the Lomond Integrated Care Steering Group, a group that included care physicians, nurses, allied healthcare professionals (AHPs), and members of the public.²⁰ The Care Model had four key elements:

1. An assessment and scoring system enabling patients likely to require intensive or anaesthetic care to be identified and **either** bypass the VOLH and be admitted direct to RAH **or** be rapidly transferred from the VOLH to the RAH
2. A nurse practitioner “hospital at night” team, which could safely and effectively provide cover out of hours with medical input from a primary care physician
3. A retrieval service to ensure that patients requiring a more acute level of care than could be provided at VOLH could safely be transferred to RAH
4. The early transfer to VOLH of patients living in the catchment area, for ongoing care and rehabilitation, after an acute episode of care in another hospital²¹

In essence, this model of care used general practitioners (GPs) with additional skills and training as primary care physicians at VOLH to manage emergency admissions without

¹⁰ [GGC18220106](#)

¹¹ [INQ05340001](#)

¹² [GGC03430002](#)

¹³ [INQ05340041](#)

¹⁴ [INQ05340042](#)

¹⁵ [INQ05340046](#)

¹⁶ [INQ05340046](#)

¹⁷ [INQ05340041](#)

¹⁸ [INQ05340049](#)

¹⁹ [QIS01190053](#)

²⁰ [GGC18220101](#)

²¹ [GGC03800101](#)

the support of anaesthetists. It was partially implemented in January 2006, with the focus on testing elements 1 and 3 of the care model. At this stage, however, the Care Model depended on the presence of a senior house officer (SHO) working overnight with the primary care physician, as well as on-call and on-site anaesthetic cover. The anaesthetic cover was dependent in turn upon input from three long-term Consultant Locum Anaesthetists who could have left with only one month's notice.

At the heart of the Care Model was the desire to retain a significant number of unscheduled medical admissions at the VOLH.²² Under this model it was anticipated that 85% to 88% of such admissions would continue. The rapid retrieval service referred to in element 3 of the model was to support the transfer from the VOLH of those patients requiring anaesthetic input. The introduction of the model was to be phased, and initially on-site anaesthetic cover was to be retained, the intention being that cover would subsequently move to on-call, off-site cover.²³

By the time NHS Argyll and Clyde was dissolved, the Care Model had been launched as a pilot at the VOLH,²⁴ but it had not been fully implemented and on-site anaesthetic cover was still available.

On-site anaesthetic cover

At the date of the dissolution of NHS Argyll and Clyde (1 April 2006), NHSGGC was intent on fully implementing the Care Model.²⁵ The next stage of the model was to involve the withdrawal of the on-site, out-of-hours anaesthetic cover for the VOLH.

At a meeting with VOLH consultants in July 2006,²⁶ significant issues were raised concerning the clinical safety of moving to the next stage of the model without anaesthetic cover. The conclusion arrived at was that the model was not sustainable without cover from the wider group of physicians at the RAH. Further discussion

took place involving the RAH consultants in August 2006, and the clear consensus was that providing unscheduled care at the VOLH without anaesthetic cover was not a safe system of work.²⁷ This inevitably meant that the Care Model could not proceed as originally conceived.

At a meeting on 21 September 2006²⁸ it was reported to the Minister for Health and Community Care that the model developed was not safe without anaesthetic input. The anaesthetic input at the VOLH was fragile, being based on the use of locum doctors and without any possibility of recruiting permanent consultants to the posts.²⁹ At the end of that meeting the Minister appeared to accept that the anaesthetic cover was not sustainable. Nevertheless, at a subsequent meeting on 2 October 2006 attended by Dr Woods and by Mr Alastair Brown, Head of Performance Management at the Scottish Executive Health Department (SEHD), Mr Divers was told that NHSGGC must carry out a full option appraisal of the change before embarking on a public consultation. A health needs assessment was also to be carried out for the population of West Dunbartonshire.³⁰ No decision on the future of unscheduled medical care at the VOLH could therefore be taken until the outcome of these was known.³¹

8.4 A new strategy

The NHS Greater Glasgow and Clyde proposal

NHSGGC established a substantial planning and community engagement process to consider the future of services in the Clyde area.³² By June 2007 that process had been completed and an NHSGGC paper, "Clyde Health and Service Strategies: Outcome of Reviews and Proposals for Consultation",³³ was presented to the NHSGGC Board at its meeting on 26 June 2007.³⁴ Those proposals consisted of an extensive programme for

22 [TRA00980006](#)

23 [QIS01190053](#)

24 [GGC18220099](#); [QIS01190053](#)

25 [GGC18220099](#)

26 [GGC18220103](#)

27 [GGC18220104](#)

28 [GGC32180009](#)

29 [GGC32180009](#)

30 [TRA00970144](#)

31 [GGC32180010](#)

32 [GGC18220004](#)

33 [GGC01720005](#)

34 [GGC01720001](#)

change, including the withdrawal of the Care Model at the VOLH and the transfer of unscheduled medical care to the RAH. The Board approved the proposals as the basis for formal public consultation and for external review.³⁵

With the change in administration following elections in May 2007, Nicola Sturgeon came into post as Cabinet Secretary for Health and Wellbeing. Her health policy included the delivery locally of as many services as possible and extensive consultation when changes were being proposed.³⁶ She also wanted to pursue a policy of independent scrutiny for proposals of the kind being put forward by NHSGGC.³⁷ The reason for that approach was a widespread feeling in parts of Scotland, reflected in comments made in the Scottish Parliament, that Health Boards were not good at consulting with communities over major service changes.³⁸ That, therefore, was the background to the NHSGGC Board's decision at its meeting on 26 June 2007 to embark upon public consultation and external review.

The Independent Scrutiny Panel

The proposals accepted by the Board at its meeting on 26 June 2007 were thereafter reviewed by the Independent Scrutiny Panel, chaired by Professor Angus Mackay.³⁹ The Panel's report records that the Panel was created by the Cabinet Secretary for Health and Wellbeing:

“to consider and report on the options prepared for public consultation by NHS Greater Glasgow and Clyde with respect to the future health provision in the Clyde area, including those services provided at the Vale of Leven (VoL) Hospital in Alexandria”.⁴⁰

In its report, published on 30 November 2007,⁴¹ the Panel raised questions about NHSGGC's methodology in arriving at its conclusions, and in particular NHSGGC's

failure to take greater steps to convince stakeholders of the benefits of its preferred option.⁴² While not challenging the conclusion that anaesthetic services at the VOLH were in the long-term unsustainable, the report recommended the development, appraisal and presentation of the following options for public consultation:

1. The status quo
2. The status quo for a specified period with continuance of anaesthetic support to permit evaluation of the predictive scale (to identify patients for transfer to RAH)
3. The transfer of unscheduled medical admissions to RAH
4. The transfer of unscheduled medical admissions to another Glasgow hospital

The Panel summarised its position in the following way:

“The Panel feels that more effort could have been made to provide a vision for the Vale of Leven in the medium to longer term”.⁴³

As Dr Woods explained, the Panel was not convinced NHSGGC had done enough to explore the options that might be available for the VOLH.⁴⁴

NHS Greater Glasgow and Clyde's response

The conclusions of the Independent Scrutiny Panel were considered by the Board at its meeting on 18 December 2007, and a motion in favour of following the Panel's recommendation was heavily defeated.⁴⁵ The Board concluded that the Panel was sending conflicting messages,⁴⁶ especially as the Panel agreed with NHSGGC's conclusion that current anaesthetic provision was unsustainable.⁴⁷ The Board decided that in fact the Panel's clinical conclusions supported NHSGGC's proposals on integrated care and unscheduled medical admissions at the VOLH,⁴⁸ and that plans should be developed

35 [GGC01720011](#)
 36 [TRA00980027](#)
 37 [TRA00980028](#)
 38 [TRA00980028](#)
 39 [GGC18240072](#)
 40 [GGC18240026-27](#)
 41 [GGC18240026-27](#)

42 [GGC18240055](#)
 43 [GGC18240054](#)
 44 [TRA00980018](#)
 45 [GGC01750007](#)
 46 [GGC01750010](#); [TRA00980024](#)
 47 [GGC01750009-10](#)
 48 [GGC01750010](#)

to transfer unscheduled medical admissions from the VOLH to the RAH.⁴⁹ Following meetings between NHSGGC officials and the Scottish Government, however, and a direct instruction from the Cabinet Secretary,⁵⁰ the Board's position changed. At its meeting on 22 January 2008, the Board was presented with,⁵¹ and accepted, a recommendation to reverse its earlier decision and initiate a period of public consultation as soon as possible.⁵²

Over the following five months NHSGGC embarked on a public consultation process on service areas in Clyde other than unscheduled medical care at the VOLH.⁵³ In relation to unscheduled medical care, NHSGGC had discussions with the Independent Scrutiny Panel on how best to proceed with this aspect of the consultation process.⁵⁴ As at February 2008 material was being drafted in liaison with the Scottish Health Council in anticipation of the public consultation that was to be held.⁵⁵ That drafting process was still going on in April 2008.⁵⁶ At a public meeting held on 18 June 2008, when challenged about the future of all services at the VOLH, Mr Divers made a commitment that NHSGGC would publish a public consultation document on all services in autumn 2008.⁵⁷

The anaesthetic review

In June 2008, while NHSGGC was preparing for that consultation, the Cabinet Secretary for Health and Wellbeing commissioned an Independent Review into the sustainability of anaesthetic services at the VOLH. The Review Team, chaired by Professor Chris Dodds of Aberdeen University, produced a report entitled the "Independent External Clinical Review of Anaesthetic Services at the Vale of Leven Hospital",⁵⁸ which concluded that the continued provision of anaesthetic services at VOLH was unsustainable in the short,

medium or long term. In contrast to NHSGGC's previous proposal that all unscheduled medical admissions should go to the RAH, however, this review concluded that the optimal solution was the retention of selected unscheduled admissions at the VOLH, with all other unscheduled medical admissions diverted to a suitably equipped hospital such as RAH.⁵⁹

8.5 The Vision for the Vale

The uncertainty resolved

In September 2008 NHSGGC approved and published its consultation document "Vision for the Vale of Leven Hospital",⁶⁰ with the consultation period running from 31 October 2008 to 30 January 2009. This followed a period of pre-consultation engagement during which emerging plans were shared with stakeholders. The Vision for the Vale document in effect incorporated the recommendations of the Independent Review as the model for unscheduled medical admissions.⁶¹

A meeting of the NHSGGC Board was held on 24 February 2009 to consider the recommendations that came out of the consultation process.⁶² The Board approved the conclusion that the level of anaesthetic service required to support the current model of unscheduled medical care was unsustainable. It also approved the development of alternative arrangements that would maintain about 70% of the current level of unscheduled medical admissions without anaesthetic cover. This was in line with the conclusion in the Vision for the Vale consultation document that unscheduled medical admissions could continue at the VOLH at that level. It is to be noted that this differs substantially from NHSGGC's proposal in 2006 and 2007, which was effectively to transfer all such admissions to the RAH.⁶³ Figure 8.1 sets out the impact on unscheduled medical care recommended and adopted by NHSGGC.

49 [GGC01750010](#)

50 [GGC01760011](#)

51 [GGC03860001](#)

52 [GGC01760013](#)

53 [GGC32180013](#)

54 [GGC01770008](#)

55 [GGC01770008](#)

56 [GGC01780004](#)

57 [GGC32180013](#)

58 [INQ04500001](#)

59 [INQ04500029](#)

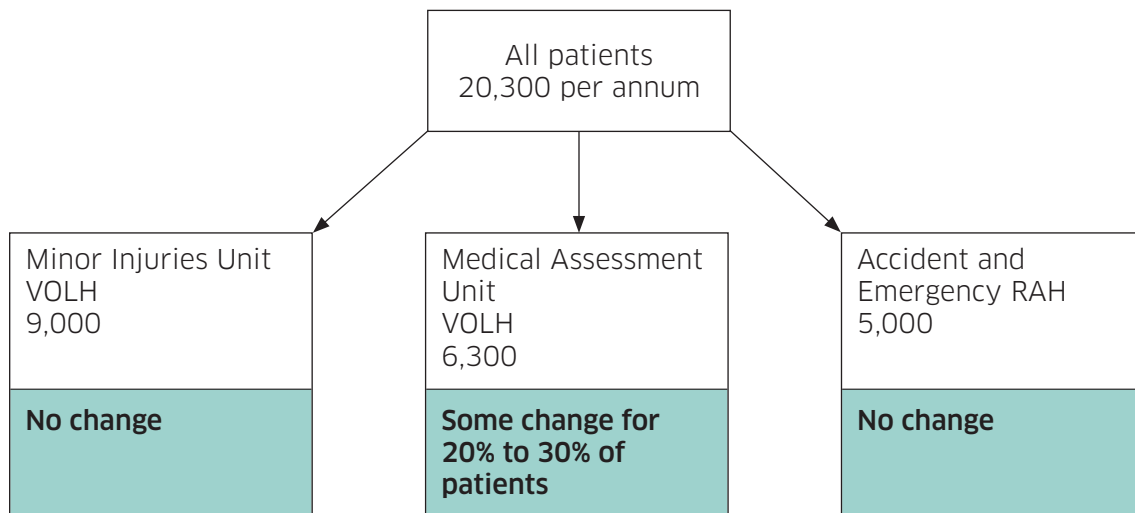
60 [QIS01190001](#)

61 [GGC02450001](#)

62 [QIS01170006](#)

63 [TRA00980036-38](#)

Figure 8.1 Impact on unscheduled medical admissions



The uncertainty surrounding the level of unscheduled medical care (and the services required to support that) was therefore finally resolved after many years.

Microbiology and infection control services

From 2002 onwards there was continuing difficulty in maintaining microbiology and infection control services in Clyde Area. In the course of 2002, Dr Stephanie Dancer, Consultant Microbiologist at the VOLH, resigned, and NHS Argyll and Clyde was unsuccessful in filling the post, which remained vacant. In addition, Dr Anne Eastaway, Consultant Microbiologist at the RAH, left in 2005. This left two of the five Consultant Microbiologist posts in the Clyde area vacant. The impact on microbiology and infection control services at the VOLH is examined in Chapter 15.

Impact of changes

Tables 8.1 to 8.3 record the range of inpatient services and the number of beds available at VOLH in 2002,⁶⁴ 2008⁶⁵ and 2012.⁶⁶ The psychiatric wards (Fruin and Christie wards) are not included in the Tables.

**Table 8.1: VOLH:
Bed complement at 31 March 2002**

Specialty	Bed Numbers
General medicine	70
General surgery (including gynaecology)	51
Obstetrics	19
Medical paediatrics	6
Geriatric medicine	88
Total	234

**Table 8.2: VOLH:
Bed complement at March 2008**

Specialty	Bed Numbers
Emergency medicine (including CCU)	52
Surgery/anaesthetics	20
Rehabilitation assessment	64
Total	136

**Table 8.3: VOLH:
Bed complement at April 2012**

Specialty	Bed Numbers
Emergency medicine (including CCU)	39
Surgery/anaesthetics	10
Rehabilitation assessment	41
Total	90

⁶⁴ [GGC32180003](#)

⁶⁵ [GGC11320005](#); [TRA00900045](#); [GGC32180005](#)

⁶⁶ [GGC32180003-05](#)

A comparison between Table 8.1 and Table 8.2 shows that the changes introduced by NHS Argyll and Clyde described previously had a profound impact on the nature of services delivered from the hospital and on its bed complement. There was a marked reduction in the number of acute beds by the point in 2008 at which the public consultation paper on unscheduled medical care was being developed.

8.6 Conclusion

Prolonged uncertainty over the range of services to be provided at the VOLH, the future of anaesthetic cover, and the future of the hospital itself, had a damaging effect on recruitment, on staff morale, and on the physical environment of the hospital.

This state of affairs should not have been permitted to continue for as long as it did.

In addition to, and perhaps due to, this broad uncertainty over the provision of services at VOLH, unsuccessful recruitment led to uncertainty over provision of microbiology and infection control services at VOLH, with only temporary arrangements in place.

It may well be that a change of political administration in 2007 caused additional delay in a final decision being reached. The new administration decided to subject the proposed changes to independent scrutiny and extensive consultation. It is regrettable that this scrutiny and level of consultation did not take place at an earlier stage. Nevertheless, the result of that whole process was ultimately the development of the “Vision for the Vale” and the retention of the VOLH as a hospital that could perform an important role for the local community.

8.7 Recommendations

Recommendation 5: Scottish Government should ensure that where any uncertainty over the future of any hospital or service exists, resolution of the uncertainty is not delayed any longer than is essential for planning and consultation to take place.

Recommendation 6: Scottish Government should ensure that where major changes in patient services are planned there should be clear and effective plans in place for continuity of safe patient care during the period of planning and change.

Chapter 9

The creation, leadership and
management of the Clyde
Directorate

Introduction

The intention in this Chapter is to consider some limited aspects of the integration process that impact upon the Inquiry's Terms of Reference following upon the dissolution of NHS Argyll and Clyde. It will also examine the approach taken to management and leadership within what became known as the Clyde Acute Directorate, often referred to as the Clyde Directorate.

9.1 The dissolution of NHS Argyll and Clyde

The dissolution decision

The Scottish Parliament Audit Committee's Report on the NHS Argyll and Clyde 2003-04 Annual Accounts,¹ published on 16 March 2005, was highly critical of NHS Argyll and Clyde and its Board. Indeed it was also critical of the then Scottish Executive Health Department (SEHD). On 19 May 2005 the Minister for Health and Community Care, Malcolm Chisholm, announced in a statement to the Scottish Parliament that NHS Argyll and Clyde was to be dissolved. The administrative boundaries of NHS Greater Glasgow (Greater Glasgow Health Board) and NHS Highland were to be changed to allow them to take over responsibility for managing the delivery of health services in the relevant areas of Argyll and Clyde.²

A public consultation took place on what the new administrative boundaries for NHS Greater Glasgow and NHS Highland should be, but not on the actual decision to dissolve.³ Following this, dissolution occurred on 1 April 2006 with the coming into force of the National Health Service (Constitution of Health Boards) (Scotland) Amendment Order 2006.⁴ From that date Greater Glasgow Health Board (GGHB) took over a significant part of NHS Argyll and Clyde's responsibilities. GGHB has since used the descriptive name of NHS Greater Glasgow and Clyde (NHSGGC).

There is no doubt that the process before and after dissolution was a highly complex one. It involved the application of considerable expertise by many of those in senior management positions within NHSGGC.

9.2 Integration

The financial crisis

As explained in the paper prepared for the Inquiry by Mr Thomas Divers, the Chief Executive of NHSGGC from 2001 to 2009, the financial problems of NHS Argyll and Clyde had developed over several years and were acute by the date of dissolution.⁵ In 2004 to 2005 NHS Argyll and Clyde had exceeded its revenue resource limit by almost £30 million, representing 6% of its annual revenue. Health Boards were at that time required to live within their revenue limit, with any expenditure in excess of the limit to be paid back to the SEHD from the following year's allocation. NHS Argyll and Clyde had been unable to pay back sums of overspend, and in four years the cumulative deficit had reached £82 million.

The Minister for Health and Community Care agreed to write off that part of the debt, and asked GGHB to develop a recovery plan to return expenditure in Argyll and Clyde to a balanced position within three years of 1 April 2006. Some further transitional funding was provided to allow time for preparation of a recovery plan and to avoid adverse impact on services to patients during this period.

The integration process up to 30 March 2006

GGHB produced a paper on 14 November 2005 entitled "Integrating Argyll and Clyde: NHS Greater Glasgow Proposals".⁶ It contained a recommendation that all acute services within the Argyll and Clyde areas that were to become the responsibility of GGHB be initially incorporated as a single Directorate of the Acute Division of Greater Glasgow.⁷ The position of this new Clyde Acute Directorate within the overall structure is illustrated by the Acute Services Division Management Structure for November 2007.⁸

1 [INQ05310001](#)

2 [GOV00870007](#)

3 [GOV00870005](#)

4 [INQ05320001](#)

5 [GGC32180002](#)

6 [GGC21480001](#)

7 [GGC21480003](#)

8 [GGC02700001](#)

Mr Divers discusses the options in his paper at paragraph 4.7.⁹ On the one hand, immediate full integration would complete the restructuring process. This would bring with it the perceived benefits of the Greater Glasgow model in ensuring equality of care and resource use. On the other hand, a major programme of restructuring was already being implemented in Greater Glasgow. There was a risk that adding any further restructuring to that might prove unmanageable. In addition, the structured recovery plan that was envisaged in order to achieve “a balanced position”¹⁰ in Clyde would be easier to implement if the budgetary resources of Greater Glasgow and of Clyde were not rolled together in one set of accounts. It was thought too that this arrangement would maintain organisational stability through existing local relationships. The objective was to achieve full integration within three years. Any reference to integration taking place on 1 April 2006 (in the sense that NHS Argyll and Clyde ceased to exist from 1 April 2006) should therefore be understood in that light.

The Transition Steering Group

A group known as the Transition Steering Group was formed in August 2005. The main role of that group, outlined in the minute of its initial meeting on 30 August 2005, was to lead on the development of a Transition and Migration Plan¹¹ to take the existing organisation towards the implementation of the new organisational arrangements. The group was chaired by Mr Divers and met regularly from mid 2005 to mid 2006.

Elizabeth Anne Hawkins was appointed Transition Project Director with effect from 1 November 2005, although by the time of her appointment the project and planning work had been under way for some time.¹² Her principal responsibility was that of staffing arrangements and the reorganisation of managerial posts. She remained with the project until the summer of 2006, but after 1 April 2006 each Directorate was responsible for its own area.¹³

The Inquiry has had sight of a significant number of documents including check lists,¹⁴ plan updates¹⁵ and board papers.¹⁶ These all formed part of an ongoing analysis of the potential effects of integration and the preparation for integration. It is clear, in brief, that extensive and careful preparation was carried out prior to the transition date.

The soundness of the creation of the interim Clyde Acute Directorate

The Inquiry finds that the interim creation of a Clyde Acute Directorate was a sound decision in the circumstances. In his report, Mr Alex Smith, an NHS management expert commissioned by the Inquiry, agreed that it had “obvious merit”.¹⁷ The objective was to identify early opportunities for consolidation of management arrangements across the new Health Board. In the interim, however, this arrangement allowed the newly constituted NHSGGC to address staff concerns and uncertainties following the dissolution of NHS Argyll and Clyde. It also provided an opportunity to consider fully future organisational arrangements.

The integration process from 1 April 2006

As explained previously, NHS Argyll and Clyde was dissolved on 1 April 2006, and the areas identified for incorporation into GGHB became the responsibility of that Board with effect from that date. But the integration process was not then complete, indeed it was not intended to be complete for a further three years, and the Clyde Acute Directorate had only been created as an interim measure. The Clyde Acute Directorate was also in a somewhat anomalous position within the Acute Division as a geographically based directorate, whereas the other directorates within the Division were service based.

The Transition Steering Group continued to meet formally until 23 May 2006.¹⁸ A meeting scheduled for 20 June 2006 did not take place,¹⁹ although by then a separate group was established, known as the Clyde

9 [GGC32180008](#)

10 [GGC32180008](#)

11 [GGC21280001](#)

12 [WTS01800002](#)

13 [WTS01800004](#)

14 [GGC21520001](#); [GGC21920001](#); [GGC21910001](#)

15 [GGC21490001](#)

16 [GGC21890001](#); [GGC18170001](#)

17 [EXP02800006](#)

18 [GGC21970001](#)

19 [GGC21970003](#)

Transition Review Group, which first met on 25 April 2006. NHSGGC have suggested that the Transition Steering Group “became”²⁰ the Transition Review Group, with an emphasis on “service strategies”²¹ and any remaining human resource issues. This was also chaired by Mr Divers, and membership included most of those who had been members of the Transition Steering Group. The minutes of the meeting of 25 April 2006 record its purpose as one of ensuring that:

“all integration matters were managed during the transition period and that a corporate view was taken on the many inter-linked issues which would need to be considered over the coming weeks and months”.²²

At that first meeting on 25 April 2006 the plan appears to have been that there would be five further meetings over the next five months,²³ but in fact the group met on only three further occasions, on 25 May, on 22 June, and finally on 14 September 2006. The agenda for the meeting of 14 September 2006 did raise as an issue the requirement for further meetings,²⁴ although in the minutes it has been noted that a further meeting “should take place late November early December”.²⁵ Apparently such a meeting did take place on 28 November 2006, although no minutes were taken.²⁶ By then of course Mrs den Herder had taken up her position as Director, Clyde Acute Services, NHSGGC, which included chairing the Clyde Acute Senior Management Team.²⁷

It is apparent from the minutes of those three meetings²⁸ of the Clyde Transition Review Group that much of the focus was upon such issues as management, finance and staffing, although by the time of the final meeting many operational matters and patient services issues were also coming under discussion. At the meeting of 25 May 2006

it was noted that the reporting arrangements for infection control nurses had been established through Ms Marie Martin, General Manager, Diagnostics for Clyde.²⁹

Absence of audit

Mr Smith notes the absence of a formal post-implementation independent audit or review. He considers that this would be expected given the extensive transitional arrangements in place for such a major organisational change.³⁰ An internal audit did take place, but the scope of this was limited to:

“an independent high level information gathering exercise to assist management in determining areas of potential for releasing savings within non-clinical areas”.³¹

In essence it was an audit of the cost reduction and efficiency savings programme adopted as part of the recovery plan referred to earlier in this Section.

9.3 Impact of integration on the Vale of Leven Hospital (VOLH)

Consequences for management of infection control

The establishment of the Clyde Acute Directorate meant that infection prevention and control management within that Directorate initially remained separate from infection prevention and control management in the rest of Greater Glasgow. As part of the continuing process of integration, however, in September 2007 the Rehabilitation and Assessment areas of the Clyde Acute Directorate were integrated into the NHSGGC Rehabilitation and Assessment Directorate (RAD).

As a result, from that point Ms Anne Harkness, Director of RAD, became responsible for wards 14, 15 and F at the VOLH.³² Mrs Elizabeth Culshaw, who had been General Manager for Rehabilitation and Assessment within the Clyde Acute Directorate since April 2006, ceased to

20 [GGC33050001](#)

21 [GGC33050001](#)

22 [GGC21990001](#)

23 [GGC21990006](#)

24 [GGC22040001](#)

25 [GGC22050004](#)

26 [GGC33050001](#)

27 [GGC22530001](#)

28 [GGC22010001](#); [GGC22030001](#); [GGC22050001](#)

29 [GGC22010005](#)

30 [EXP02800007](#)

31 [GGC22630009](#)

32 [TRA01180090](#)

be responsible to Mrs den Herder and instead reported to Ms Harkness.³³ Staff in the remaining parts of the Clyde Acute Directorate remained under the management of Mrs den Herder. Included among these was Ms Martin, who had responsibility for infection prevention and control and was also line manager for Dr Elizabeth Biggs, the Infection Control Doctor for the Clyde Sector. It is to be noted that Ms Martin therefore retained the role of line manager for infection prevention and control in the Rehabilitation and Assessment wards.

The Clyde Acute Directorate Infection Control Team remained under separate line management up to Directorate level, but above that level responsibility rested with Mr Robert Calderwood as the Chief Operating Officer of NHSGGC. Furthermore, with the integration into the RAD on 1 September 2007, Ms Harkness had ultimate professional responsibility for infection prevention and control throughout the newly expanded directorate despite not having actual line management responsibility for infection prevention and control staff.³⁴

Implications for infection prevention and control with earlier integration

The problems with infection prevention and control existed long before integration was contemplated. The Inquiry detected no signs that NHS Argyll and Clyde managers had attempted to address in any systematic way the issues raised in either the Clinical Standards Board for Scotland (CSBS) report of 2002,³⁵ published in January 2003, or the follow-up report of 2005.³⁶ These issues are fully considered in Chapter 15, and for present purposes it is sufficient to note that significant failures were identified in 2002 and remained unaddressed in 2005. It is also of note that the Dissolution and Integration Checklist and Risk Log maintained by NHS Argyll and Clyde³⁷ makes no specific mention of infection prevention and control, but does refer to governance issues. Under governance

issues (for the periods both before and after 31 March 2006) it does list:

“loss of control over business as usual (to 31/03/06): – Managers become distracted by requirements of dissolution/integration process”.³⁸

Dr Brian Cowan, Medical Director of the Acute Division of NHSGGC, agreed in his evidence to the Inquiry with the proposition that the establishment and maintenance of a separate Clyde Acute Directorate contributed to the outbreaks going undetected. He said:

“I think....if we had had the Glasgow management team of Isabel Ferguson (General Manager for Laboratory Medicine NHSGGC), Annette Rankin, working as a team, as a group, together with the co-ordinating infection control doctor, looking after the whole of Glasgow and Clyde, that some of the abnormal behaviour, if I could classify it as that, of Dr Biggs and possibly some of the failures to identify raised incidences of *C. difficile* would have been spotted”.³⁹

Dr Cowan believed that full integration at an earlier stage would have resulted in earlier recognition that the Clyde infection prevention and control system was defective. There is little doubt that that is so. Nevertheless, this does not lead the Inquiry to conclude that the decision to establish a separate Clyde Acute Directorate was wrong. Neither was this Dr Cowan’s view, for he agreed with the view expressed by Mr Smith and by Mr Divers that there were sound reasons for it.⁴⁰ So if the establishment of the Clyde Acute Directorate was an acceptable measure in principle, the reasons for the failure in infection prevention and control practices and surveillance must lie elsewhere.

33 [TRA01170008](#)

34 [TRA01180098-99](#); [TRA01160158](#)

35 [QIS00010001](#)

36 [QIS00020001](#)

37 [GGC21520001](#)

38 [GGC21520004](#)

39 [TRA01230016](#)

40 [TRA01230016](#); [GGC32180008](#)

9.4 Leadership of the Clyde Directorate

Experienced leadership

As Mr Smith remarks, the new Clyde Acute Directorate required highly experienced leadership and strong management over a considerable time frame in order to achieve successful integration.⁴¹ In the light of this it was unfortunate that the recruitment process for the Director was delayed. Mrs den Herder was not interviewed until 19 June 2006,⁴² and only took up post formally on 1 October 2006,⁴³ although she chaired at least one Directorate meeting in September 2006.⁴⁴ To fill the gap, Ms Karen Murray was appointed interim Director from 1 April 2006, but she departed to a new post on 31 July 2006.

Karen Murray

Ms Murray was well acquainted with the issues surrounding service provision at the VOLH from previous roles within NHS Argyll and Clyde. In 2003 she became the Divisional Director for Lomond and Argyll, a post which gave her line management responsibility for the hospital manager at the VOLH.⁴⁵ She had a sound understanding of the issues surrounding service provision at the VOLH, having prepared a paper on the future of anaesthetic services there for NHS Argyll and Clyde in 2004.⁴⁶

On 25 July, prior to her departure, Ms Murray provided a detailed list of handover issues to Mr Calderwood.⁴⁷ She also provided an updated document the following month.⁴⁸ The list covers 28 issues, some broken down into separate sections. These include staffing, management processes, financial planning, and performance management. A number of issues are directly concerned with patient care, such as the Lomond Integrated Care Pilot and waiting times, although infection prevention and control does not feature as a specific item on the list. The Lomond Integrated Care Pilot is discussed in Chapter 8.

Item one on the handover list records that seven reports had been completed for Clyde. On 9 January 2006, Dr Elizabeth Jordan, then Medical Director, NHS Argyll and Clyde, produced an end of year report on the work of the NHS Argyll and Clyde Healthcare Governance Committee.⁴⁹ The intention of the report was to provide an end of year position statement to NHS Greater Glasgow and NHS Highland on the Healthcare Governance position within NHS Argyll and Clyde.⁵⁰ It explained that the Healthcare Governance Committee discharged its function in 2005 to 2006 in terms of national guidance, and effectively operated as a committee of assurance for the NHS Argyll and Clyde Board.⁵¹ The report also noted that responsibility for Healthcare Governance accountability would pass to the new organisation, and set out priority transitional work plans for this process.⁵² Mr Smith described this report as a:

“summary of activities over the year; risk registers, key ongoing issues/work and issues to be considered for inclusion in the future work programme”.⁵³

He saw this handover as intended to ensure “safe and comprehensive continuity of governance and accountability with effect from 1 April 2006”.⁵⁴

Following Ms Murray’s departure, no further interim Director was appointed in her place. Instead, responsibilities were passed to individual Directorate General Managers, who reported direct to Mr Calderwood.⁵⁵ This meant that continuity of leadership was missing during this period of transition.

9.5 The leadership of Mrs den Herder

According to Mr Calderwood, no formal documented handover to Mrs den Herder took place on her appointment.⁵⁶ He used the document supplied by Ms Murray to brief

41 [EXP02800005-06](#)

42 [TRA01240032](#)

43 [TRA01240047](#); [TRA01240033](#)

44 [GGC32820001](#)

45 [WTS01960002](#)

46 [WTS01960002](#)

47 [GGC21860001](#)

48 [GGC21860008](#)

49 [GGC21570001](#)

50 [GGC21570003](#)

51 [GGC21570003](#)

52 [GGC21570006](#)

53 [EXP02800011](#)

54 [EXP02800011](#)

55 [TRA01240034](#)

56 [TRA01240048](#)

Mrs den Herder, as Mrs den Herder herself confirms.⁵⁷ It appears that Ms Murray may also have participated in a brief handover.⁵⁸ As part of her induction to the organisation, it does appear that Mrs den Herder would in addition have had meetings with Directors and other key staff to discuss their roles and responsibilities.⁵⁹ She would also have had available to her the reports on Clyde including Dr Jordan's end of year report and the minutes of the Transition Steering and Review Groups.

Furthermore, at the meeting of the Clyde Acute Operational Management Group on 24 August 2006⁶⁰ (referred to erroneously in the action notes as the meeting of 29 August 2006) the items in the Clyde handover list of issues were considered individually and updated. This group became the Clyde Acute Senior Management Team after Mrs den Herder was in post. Mrs den Herder chaired the next meeting of the group on 21 September 2006, at which the action notes from the meeting of 24 August 2006 were considered.⁶¹

Mrs den Herder's concerns

According to Mrs den Herder, she was aware of the risk to patient safety at the VOLH even before she took up post, through attendance at a number of meetings.⁶² She certainly lost no time in identifying the need for effective management at the VOLH, because the minutes of the second meeting she attended as Chair of the Clyde Acute Senior Management Team, on 19 October 2006, record that she:

"indicated that there is a need for more concentrated Senior Management Team representation on VOL site".⁶³

Mrs den Herder later became sufficiently concerned to present a paper in February 2008 to the Acute Management Team: "The Vale of Leven Hospital - Maintaining Patient

Safety",⁶⁴ in which she articulated a number of live concerns over staffing and patient safety. This led to the establishment of the Vale of Leven Governance Group,⁶⁵ which met monthly from April 2008.⁶⁶ The concerns expressed by Mrs den Herder, however, related to levels of staffing – both medical and nursing – and to patient care, particularly in relation to the range of services available and the transfer of patients. They did not extend to infection prevention and control issues.

The restricted range of Mrs den Herder's concerns is reflected in the notes of the new Governance Group itself.⁶⁷ Only two meetings of that group took place prior to June 2008,⁶⁸ and the subject of infection prevention and control does not appear to have featured at those meetings, although mention is made of the outbreak in the action notes for the meeting of 20 June 2008.⁶⁹ Indeed in both her letters to the Inquiry of 22 June 2012⁷⁰ and later on 13 September 2012⁷¹ Mrs den Herder makes clear that the principal issue for senior managers at the time was that of the safety of medical receiving arrangements for unscheduled medical care.

It is surprising that, despite such concerns and her specific observations about a senior management presence, Mrs den Herder herself was not often at the VOLH.⁷² Mr Calderwood expected that she would attend the VOLH "on a relatively regular basis".⁷³ On the other hand, she had a wide range of responsibilities, and there was other management presence there. Ms Martin, for example, was normally there once a week, at least until her secondment.⁷⁴

57 [INQ04960003](#)
58 [WTS01960004](#)
59 [GGC33060001](#)
60 [GGC22950001](#)
61 [GGC32820001](#)
62 [INQ04960001](#)
63 [GGC22530006](#)

64 [GGC04520001](#)
65 [INQ04480001](#)
66 [GGC04490002](#)
67 [GGC30420001](#); [GGC30430001](#); [GGC30440001](#)
68 [GGC30420001](#); [GGC30440001](#)
69 [GGC30430002](#)
70 [INQ04240003](#)
71 [INQ04960005](#)
72 [GOV00890120](#)
73 [TRA01240046-47](#)
74 [TRA01160007](#)

Ms Harkness said this of a manager's responsibilities:

"I think, as a director responsible for a service as large as mine, the degree to which I can get out and about at individual ward level is inevitably limited, but I would accept it is something I would expect managers to do. They should be out proactively talking to staff and they should be picking up issues, both through informal and formal structures, and the formal governance and committee structure is very much that: it is formal, it is about making sure actions have been taken and noting that. You would expect that to be enhanced by operational discussions".⁷⁵

Mrs den Herder mentions in her letter of 22 June 2012 that she first received statistical data about infection rates in May 2008.⁷⁶ She does not suggest that she had sought such information previously. Nor had she sought any audit of infection prevention and control systems.⁷⁷

Within a number of months of taking up post Mrs den Herder should have been fully cognisant of the critical issues within the Clyde Acute Directorate. She had certainly recognised one of these – the need for effective management – at an early stage. Later she recognised the risks to patient safety at the VOLH. Although it did not happen until early 2008, she took appropriate steps in instigating the establishment of the VOLH Governance Group to monitor these. It concentrated on issues such as the safety of the Lomond Integrated Care Model referred to in Chapter 8 and on transfer to other hospitals.

Failures in leadership

Why Mrs den Herder did not afford greater priority to infection prevention and control remains without a satisfactory answer. Her performance plan for 2006 to 2007 does make reference to healthcare acquired infection (HAI), although this is in the context of ensuring that action plans are in place following outbreaks and environmental audits

and of monitoring the overall incidence of HAI within surgical areas.⁷⁸ Perhaps more significantly, her Personal Objectives for 2007 to 2008 include the following objective:

"Reinforce surveillance arrangements within Clyde to reduce the number of patients acquiring HAI with particular emphasis on tackling the incidence of MRA bacteraemia throughout the year".⁷⁹

There is no evidence that any action was taken in response to that objective in the VOLH prior to the introduction of Statistical Process Control (SPC) charts in April/May 2008.

The role of the Infection Control Manager for NHSGGC within the Clyde Acute Directorate is examined in Chapter 15. As discussed in Chapter 10, however, Mrs den Herder retained responsibility for infection prevention and control within her Directorate, and was answerable to Mr Calderwood.⁸⁰ Despite that, she had no apparent awareness of infection prevention and control issues, or the management of these, or of the steps being taken to monitor infection levels. She describes the "managerial focus on the large financial deficit and the projects intended to address this...".⁸¹ She did of course identify the importance of certain patient safety issues to the extent of establishing the Vale of Leven Governance Group, but its focus was not infection prevention and control. The Inquiry notes too that infection prevention and control issues, other than staffing issues, do not feature prominently in the letters it received from Mrs den Herder. These letters do not suggest that wider infection control issues were a high priority for her. She was, for example, unaware that the Clyde Infection Control Support Group (the Support Group) had ceased to meet.⁸²

There is no doubt that, in this as well as in other aspects of her work, Mrs den Herder was let down by other members of her management team, who should have noted the failure of the Support Group. But

⁷⁵ [TRA01180112-113](#)

⁷⁶ [INQ04240004](#)

⁷⁷ [INQ04960003](#)

⁷⁸ [GGC21930006](#)

⁷⁹ [GGC24320014](#)

⁸⁰ [TRA01240052-53](#)

⁸¹ [INQ04960005](#)

⁸² [INQ04960006](#)

given her responsibilities she should have exercised greater scrutiny of the structures in place. She should have been in a position to identify the fact that crucial meetings had ceased to take place. She should have identified the critical state of affairs in infection prevention and control.

Unfortunately, Mrs den Herder's limited engagement with infection prevention and control also meant that she did not have a full grasp of the impact of Dr Biggs' behaviour on infection prevention and control and patient safety within the Clyde Acute Directorate. As she explained in her letter of 13 September 2012, the "key failures" were not known to her.⁸³ Again in this she was let down by others, but she had ultimate responsibility for infection prevention and control in the Directorate. Had she taken a greater interest in infection prevention and control matters she would have had a better grasp of the true position.

This limited engagement with infection prevention and control is likely to have contributed to a failure on the part of Mrs den Herder to ensure that Ms Martin's infection prevention and control duties continued to be carried out to the full during her secondment. The circumstances surrounding that secondment are fully explained in Chapter 15. Mrs den Herder wrote on 8 October 2007 to "all staff, Clyde Laboratory Services" concerning the secondment, and in that letter she intimates that Ms Martin had agreed to lead the implementation of the Picture Archiving and Communications System (PACS) within Clyde. She continues:

"I recognise that Marie will require to be supported in various aspects of her management role to provide sufficient time to enable her to undertake the PACS work".⁸⁴

Despite this, no evidence was produced to the Inquiry to suggest that the necessary level of support was forthcoming. Mrs den Herder must have been aware that the solution – that Ms Martin should retain responsibility for infection control issues in

the absence of cover from elsewhere – was an unsatisfactory one. It required careful management. It was a matter which, as Director, she should have kept under careful scrutiny in order to reassure herself that infection control issues were accorded the attention they needed. In this case she owed a particular duty to Ms Martin and to others in the Clyde Acute Directorate to set out in writing which responsibilities remained with Ms Martin and who would undertake those of which she had been relieved. That is to be expected of a competent senior manager.

As Mrs den Herder points out,⁸⁵ and as Mr Calderwood accepts,⁸⁶ the Clyde Acute Directorate was not directly comparable with other Directorates within NHSGGC. Because it was geographically defined rather than service based, the range of services for which she was responsible, and the targets introduced in relation to some of these, proved a considerable burden. Mr Calderwood acknowledges that, whereas other Directors would be accountable for a restricted number of HEAT Targets, she was responsible for all such targets within Clyde.⁸⁷ Indeed he likened her role with its range of clinical services to his own position at that time as Chief Operating Officer.⁸⁸

The Inquiry finds it unnecessary to express a view on whether Mrs den Herder's post was overloaded with responsibility. But as Mr Calderwood concedes, Mrs den Herder was "carrying a significant responsibility".⁸⁹ This was against the following background:

- The disadvantages faced by Mrs den Herder coming into post six months after the dissolution of NHS Argyll and Clyde
- Demands placed on Mrs den Herder in relation to a multiplicity of targets
- The outstanding issues over VOLH services
- Failure by a number of other managers within Clyde Directorate reporting to Mrs den Herder to give infection prevention and control issues the level of attention required

83 [INQ04960003](#)

84 [GGC32630001](#)

85 [INQ04240003](#)

86 [TRA01240049](#)

87 [TRA01240049-50](#)

88 [TRA01240043](#)

89 [TRA01240050](#)

It is therefore perhaps unsurprising that Mrs den Herder did not **initially** give priority to infection prevention and control at the VOLH. But she had the opportunity over a number of months to identify and familiarise herself with the critical issues facing the Clyde Acute Directorate. She should therefore have been in a position in the course of 2007 to acquaint herself with the outstanding deficiencies in the management of infection prevention and control and to tackle them.

Mrs den Herder resigned her post in July 2008 at least in part because of “stress and burnout”.⁹⁰ Mr Calderwood confirmed in evidence that Mrs den Herder told him in April 2008 that she wanted to leave her post earlier than had originally been envisaged,⁹¹ and that stress was one of the reasons why she wanted to leave.⁹² Inevitably such stress levels would have had an effect upon her performance as Director of the Clyde Acute Directorate.

9.6 Other managers in the Clyde Directorate

Marie Martin's management role

The working relationship between Ms Martin and Dr Biggs in particular is considered in greater detail in Chapter 15. This Chapter seeks only to examine certain aspects of Ms Martin's management role.

Ms Martin reported to Mrs den Herder. She was responsible for laboratories and radiology, and her remit included infection prevention and control.⁹³ She was line manager for Ms Annette Rankin, Head Infection Control Nurse for NHSGCC. On her own admission, Ms Martin was clearly heavily reliant upon Infection Control Doctors and Nurses alerting her to any problem. In her own words, “they were the people who really understood”.⁹⁴ An example of this is that she was not aware of any problem over wash-hand basins until Dr Linda Bagnade took up post as Infection Control Doctor at the VOLH in February 2008, because no one had previously brought it to her attention.⁹⁵

Ms Martin was also line manager for Dr Biggs from April 2006,⁹⁶ and would see Dr Biggs once or twice a month. Yet she was unaware that Dr Biggs had no job description as Infection Control Doctor until September 2007.⁹⁷ The background to this is explored in Chapter 15.

In her evidence Ms Martin explained that she thought that Dr François de Villiers, Consultant Microbiologist at the IRH, had responsibility as Infection Control Doctor at the VOLH. This again is considered in greater detail in Chapter 15, but it was not the case. Her lack of understanding of this area of responsibility, despite also being line manager for Dr de Villiers, is a matter of concern.

While Ms Martin had some awareness of the monitoring of infection carried out by Infection Control Nurses, and knew of the T-card system and database described in Chapter 15,⁹⁸ she was not aware of how *C. difficile* cases were recorded at ward level or how they were monitored.⁹⁹ To a degree that may reflect the fact that there was no requirement to report such figures upwards through the management structure (as was the case with MRSA).¹⁰⁰ Nevertheless, it remains of concern to the Inquiry that the General Manager with responsibility for infection prevention and control had such a limited grasp of monitoring arrangements. It is worthy of note that included in her Personal Objectives for 2007 to 2008 was the following objective:

“Provide audit information on Hospital Surveillance across Clyde and action plan required to address Hospital acquired infection rates ...”¹⁰¹

Melanie McColgan

The Clinical Service Manager for Clyde Acute Directorate from January 2008 was Ms Melanie McColgan. While not based at the VOLH, she attended there regularly, usually one day a week. Her responsibilities

90 [INQ04240005](#)
 91 [TRA01240050](#)
 92 [TRA01240051-52](#)
 93 [TRA01160001](#)
 94 [TRA01160018](#)
 95 [TRA01160077](#)

96 [TRA01160033](#)
 97 [TRA01160033](#)
 98 [TRA01160106](#)
 99 [WTS00810009](#)
 100 [TRA01160102-103](#)
 101 [GGC24360010](#)

encompassed wards 3, 6 and the Critical Care Unit (CCU).¹⁰² Her job description included responsibility:

“for ensuring robust and auditable systems are in place to enable the successful monitoring of performance and the early identification of problem areas within the Directorate”.¹⁰³

She saw her responsibilities for infection control as part of her wider governance responsibilities. She would have taken action had any issues been brought to her attention.¹⁰⁴

Infection prevention and control was not on the agenda of operational meetings Ms McColgan attended.¹⁰⁵ She did not know who the Infection Control Doctor was during her early period at the VOLH.¹⁰⁶ She was concerned about norovirus rates, because these were brought to her attention, but she took no steps to check infection rates for CDI or to check that proper infection prevention and control systems were in place.¹⁰⁷ She believed they were, because she was receiving information about norovirus. She did not visit the Infection Control Team office, and did not know what she would have found there.¹⁰⁸ From June 2008 she received infection prevention and control audits.¹⁰⁹

As pointed out, Ms McColgan took up her post in January 2008. It is clear she took much at face value in the period initially following this, and relied upon systems being in place. At that stage she had little alternative, and the Inquiry does not criticise her for adopting that approach. Had she been longer in post, however, the Inquiry would have expected her to be more familiar with systems in place and to have identified issues of concern, and to place less reliance on being told what was wrong when it went wrong.

Elizabeth Culshaw

Mrs Culshaw was General Manager for the Rehabilitation and Assessment areas within the Clyde Acute Directorate from April 2006. Responsibility for this area of work passed to RAD in September 2007, and Mrs Culshaw then reported to Ms Harkness rather than to Mrs den Herder,¹¹⁰ but her job did not change.

Mrs Culshaw had responsibilities across five hospital sites within Clyde, including wards 14, 15 and F at the VOLH.¹¹¹ Among the responsibilities set out in her job description was to:

“ensure the delivery of high quality patient care, taking account of standards and guidance including hospital acquired infection”.¹¹²

Mrs Culshaw was not based at the VOLH, and her direct contact with wards there was through Ms Elizabeth Rawle, Lead Nurse for the Rehabilitation and Assessment Directorate.¹¹³ Mrs Culshaw explained during her evidence that her duty was to be aware of underlying issues or trends, but that her responsibilities for infection prevention and control were “indirect”.¹¹⁴ She had no contact with the Infection Control Team. She only became involved if and when there was an issue. Infection prevention and control was not a standing item on the agenda of the RAD Senior Management Team prior to June 2008.

Mrs Culshaw was aware of cases of CDI, but she took no active steps to ascertain the level of the problem because it was not highlighted to her as an issue by anyone else.¹¹⁵ Her “understanding” was that the reporting systems were not in place and data were unavailable.¹¹⁶ She was unaware that the data were in fact available at the VOLH.¹¹⁷

Mrs Culshaw unfortunately relied simply on being told that there was a specific problem over infection prevention and control. Even

¹⁰² [TRA01170018](#)

¹⁰³ [GGC30240003](#)

¹⁰⁴ [TRA01170019](#)

¹⁰⁵ [TRA01170021](#)

¹⁰⁶ [TRA01170035](#)

¹⁰⁷ [TRA01170028-29](#)

¹⁰⁸ [TRA01170051-52](#)

¹⁰⁹ [TRA01170043](#)

¹¹⁰ [TRA01160128](#)

¹¹¹ [TRA01160129](#)

¹¹² [GGC30280003](#)

¹¹³ [TRA01160131](#)

¹¹⁴ [TRA01160140-142](#)

¹¹⁵ [TRA01160149-150](#)

¹¹⁶ [TRA01160144-145](#)

¹¹⁷ [TRA01160145](#)

when she was informed, her response was limited. On 15 March 2007, in the context of an outbreak of CDI in ward 7 at the RAH, she was alerted by Dr Syed Ahmed, Consultant in Public Health Medicine and Clinical Consultant in the Public Health Protection Unit, NHSGGC,¹¹⁸ to an audit report that “basic infection control principles are not being followed rigorously.” She in turn alerted managers at that hospital, but did not think to check the position at the VOLH. Asked to explain her reasons, she provided the following explanation:

“Because this was highlighting a particular issue in a particular ward, that there had been an outbreak of *C. difficile*, so I addressed the issues there rather than on other sites”.¹¹⁹

Unfortunately the Inquiry heard evidence of another instance, this time at the VOLH, where Mrs Culshaw did not pursue the matter beyond the immediate issue in question. When dealing with a letter of complaint in January 2008 involving a patient suffering from CDI at the VOLH, she did not raise the question of whether there were other cases at the same time. Her explanation for this during her evidence was that no one mentioned other cases to her.¹²⁰

The Inquiry would have expected a competent manager with the responsibilities of Mrs Culshaw to make further enquiries in both instances, particularly since one of the objectives in her list of Personal Objectives for 2007 to 2008 was to “Ensure robust measures [were] in place to prioritise HAI within Clyde RAD”.¹²¹ The absence of data in itself should have been a warning to Mrs Culshaw of potential problems. But she did not pursue this further, and made no enquiry to ascertain the number of cases involved. She did not take active steps to inform herself. Had she done so she would have discovered that such data could in fact be found on the computer system.

Elizabeth Rawle

Ms Rawle was Clinical Services Manager/Lead Nurse in RAD, based at the VOLH. She had a clinical responsibility to deliver rehabilitation services.¹²² She was quite regularly on the wards. She was aware of raised rates of CDI, and in particular of a cluster of cases in January or February 2008, but she was told by Sister Laura Gargaro, Senior Charge Nurse in ward F, that this was “explainable”.¹²³ Ms Rawle did not know who the Infection Control Doctor at the VOLH was in 2007 to 2008 and had never met her.¹²⁴ She saw no reason to discuss CDI with Mrs Culshaw because, as she said in her evidence, “there was *C. difficile* in all of the hospitals”.¹²⁵

Had Ms Rawle been better informed, or had she pursued matters further by posing certain pertinent questions, the outbreak at VOLH early in 2008 might well have been identified sooner. But her limited understanding of the seriousness of CDI led her not to challenge Sister Gargaro, and gave her no reason to involve Mrs Culshaw. Her attitude reflected a general approach to infection prevention and control that placed exclusive reliance on the Infection Control Nurses. It is worth recalling here that the “Annual Infection Control Report 2007/08” for NHSGGC contains the following statement:

“Good practice in Infection Prevention and Control clearly does not rest solely within the domains of our Infection Control Committees and Teams. Everyone has Infection Prevention and Control responsibilities”.¹²⁶

Management and Dr Biggs

The role of Dr Biggs is examined in detail in Chapter 15 and is only considered here in relation to the managers with whom she interacted professionally.

It was apparent to a number of managers that Dr Biggs was discontented with her position as Infection Control Doctor. More importantly, it should have become apparent that she was

¹¹⁸ [GGC15450001](#)

¹¹⁹ [TRA01170005-06](#)

¹²⁰ [TRA01160154](#)

¹²¹ [GGC24370011](#)

¹²² [TRA00890086-87](#)

¹²³ [TRA00890106](#)

¹²⁴ [TRA00890101](#)

¹²⁵ [TRA00890104](#)

¹²⁶ [COF00030003](#)

not fulfilling that role. With the departure of Dr Geoffrey Douglas, Consultant Anaesthetist and Clinical Lead at the VOLH, in April 2006 there was no Clinical Director to exercise oversight of her as he had done.¹²⁷ Line management responsibility remained with Ms Martin,¹²⁸ but due to her lack of attention to infection control matters she did not play an effective role. Dr Biggs' attempts to raise the issues which she thought affected her role as Infection Control Doctor were largely unsuccessful.

As discussed in Chapter 15, Dr Biggs' position was clearly a dysfunctional one. The period from April 2006 onwards was a critical one for Clyde, and management systems needed to be in place and fully functioning to address any problems. This was a key issue for infection prevention and control, and it was not dealt with effectively by management over an extended period.

9.7 Conclusion

The integration process

It is impractical, even with the benefit of hindsight, to conclude with any certainty that specific aspects of the integration process were crucial to the outbreaks of CDI at the VOLH or to the failure to identify them.

There is little doubt that in certain respects the integration process was carefully planned and that the necessary management structures were in place. The Inquiry accepts the views of Mr Divers¹²⁹ and Dr Cowan,¹³⁰ that the decision to establish a separate Clyde Acute Directorate as part of the integration process was, in principle, a sound one. These are views supported by Mr Smith's report to the Inquiry.¹³¹

The Inquiry endorses the view expressed in Mr Smith's report that a post-implementation audit or review by an independent party would have been desirable.¹³² What the outcome of any such review would have

been in late 2006 cannot be ascertained, as the Inquiry has not scrutinised the infection prevention and control position in the VOLH prior to January 2007. Nonetheless it is at least possible that the CSBS report of 2002 (published in January 2003)¹³³ and the follow-up report of 2005,¹³⁴ both of which highlighted glaring deficiencies in infection prevention and control in Argyll and Clyde, would have prompted some further investigation.

Leadership

What is clear is that the Clyde Acute Directorate suffered from a lack of continuity of leadership through its initial stages. In his report Mr Smith remarks upon the significance of the leadership of the Directorate in terms of the new organisational arrangements.¹³⁵ The appointment of an interim director, and the lack of any individual in that post for two months during August and September 2006 after Ms Murray's departure, are matters that were not conducive to strong leadership. Mr Smith identified the need for:

“highly experienced leadership and strong management in the Clyde Directorate over a considerable time frame reflecting the complexity, sensitivity and challenge of the transition”.¹³⁶

It is unfortunate that the permanent Director for Clyde was not in place at least from 1 April 2006.

Had a permanent Director been in place earlier, then it is at least possible that clinical governance and infection prevention and control issues would have come to the attention of the Director and to other senior managers at an earlier stage. It is by no means certain that these issues would have been recognised at an early stage by Mrs den Herder, given her failure to identify them in the months after she took up post. Even so, the lack of continuity in management was a failure in the integration process after 1 April 2006, particularly since, as Mr Calderwood

¹²⁷ [TRA01160014-15](#)

¹²⁸ [TRA01260045](#)

¹²⁹ [GGC32180007-08](#)

¹³⁰ [TRA01230016](#)

¹³¹ [EXP02800006](#)

¹³² [EXP02800007](#)

¹³³ [QIS00010001](#)

¹³⁴ [QIS00020001](#)

¹³⁵ [EXP02800008](#)

¹³⁶ [EXP02800005](#)

acknowledged, the post was one where Mrs den Herder was “carrying a significant responsibility”.¹³⁷ This included achieving certain targets in a number of different areas because her directorate was a geographical one in contrast to other directorates, which were service based.

As discussed earlier in this Chapter, it is evident that Mrs den Herder failed to afford sufficient priority to infection prevention and control issues after she became Director of the Clyde Acute Directorate. The infection prevention and control system broke down with a failure of the committee structure and a dysfunctional Infection Control Doctor. These were issues Mrs den Herder should have become aware of and dealt with.

Role of other managers

The managerial role played by Ms Martin in relation to infection prevention and control, and her failures in that role, are considered in Chapter 15.

A number of other managers had infection prevention and control responsibilities at the VOLH. Unfortunately, as evidenced earlier in this Chapter, in many instances managers in Clyde did not see infection control as an issue with which they should be routinely engaged. They tended to wait to be told that a problem existed. They did not understand surveillance systems and did not take the steps to be reasonably expected of a manager to inform themselves. They had a limited understanding of infection prevention and control issues.

This management approach to infection prevention and control is but a further manifestation of a culture that viewed infection prevention and control as being of low priority, notwithstanding NHSGGC’s statement in the 2007/08 Annual Infection Control Report that everyone had infection prevention and control responsibilities. Ultimately, the Board of NHSGGC has to bear responsibility for the development of this culture.

Had these managers been more knowledgeable, and had they been more proactive within their own spheres of responsibility, it is likely that they would have found that CDI rates were indicative of a CDI problem in the VOLH. They might have also discovered that essential infection prevention and control measures were not in place.

9.8 Recommendations

Recommendation 7: In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.

Recommendation 8: In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.

¹³⁷ [TRA01240050](#)

Chapter 10

Clinical governance

Introduction

This Chapter examines what is involved in the term “clinical governance” by reference to national policy and policy developed by NHS Greater Glasgow and Clyde (NHSGGC), and considers the impact of NHSGGC’s approach to clinical governance upon the occurrence and rates of *C. difficile* infection (CDI) at the Vale of Leven Hospital (VOLH).

10.1 National policy

The concept of clinical governance

A natural starting point is to examine what is said on clinical governance in national policy. In October 2005 NHS Quality Improvement Scotland (NHS QIS) published a document entitled “Clinical Governance and Risk Management: achieving safe, effective, patient-focused care and services”.¹ One of the purposes of this publication was to set national standards for clinical governance for Health Boards across Scotland, a matter for which NHS QIS was responsible.² Clinical Governance is defined in this document as:

“the system through which NHS organisations are accountable for continuously monitoring and improving the quality of their services and safeguarding high standards of patient-focused care and services”.³

The NHS QIS publication also provides the following explanation by way of background:

“The concept of clinical governance was introduced to NHSScotland in the Scottish Executive white paper *Designed to Care* (SEHD, 1997) to ensure that quality of care is given the same prominence as other key drivers such as finance and staffing. It has been described as “corporate accountability for clinical performance” and is the system for making sure that healthcare is safe and effective, and that patients and the public are involved”.⁴

Quality assurance

The NHS QIS document makes the need for monitoring clear. The standards for clinical

governance and quality assurance set out there include the following requirement:

“There are effective organisational systems and processes for monitoring and reporting on the effectiveness of quality assurance and improvement processes at individual, team, operational unit/ service (i.e. community health partnership, divisions) and corporate levels”.⁵

Policing the standards

NHS QIS introduced a review process that consisted of a number of key parts. First, there was to be local self-assessment by Boards. Second, a pre-visit analysis report was produced by NHS QIS after the self-assessment had been received, and given to the particular Board for comment. Third, once the analysis report had been agreed, that report was sent to an external peer review team (the review team) together with the self-assessment and supporting evidence.⁶ Thereafter, the review team visited the Board and spoke to local stakeholders, for example staff, about the services provided.

The review team combined several separate areas of expertise and was led by an experienced reviewer. The team included healthcare professionals and members of the public. Team members had no connection with the Board under review.

NHSGGC was reviewed in the second half of 2006, with a Review visit taking place on 27 September 2006,⁷ and the NHS QIS report of the findings of the peer review was published in April 2007.⁸ Overall, in its assessment of assurance and accountability, the review team saw evidence of much work under way “to drive the clinical governance and quality assurance agenda”.⁹ It did, however, note that at the time of the visit:

“clinical governance and quality assurance systems and processes were not monitored throughout the Board area”.¹⁰

1 [INQ04970001](#)

2 [INQ04970009](#)

3 [INQ04970008](#)

4 [INQ04970009](#)

5 [INQ04970018](#)

6 [INQ04970007](#)

7 [QIS02560032](#)

8 [QIS02560001](#)

9 [QIS02560014](#)

10 [QIS02560025](#)

10.2 Clinical governance in NHS Greater Glasgow and Clyde

NHS Greater Glasgow and Clyde policy

In December 2006 NHSGGC produced a Clinical Governance Framework document setting out its main commitments, general policy requirements and organisational arrangements on clinical governance.¹¹ In this, clinical governance was defined and the concept explained in the following terms:¹²

“By ‘clinical governance’ we basically mean putting in place effective arrangements to improve public and staff confidence in the safety and quality of the health care that we provide. At NHS Greater Glasgow and Clyde...we will show that improving the safety and quality of the care we provide is an important concern for all our staff and everyone who works with us”.

The Clinical Governance Framework document went on to emphasise the importance of putting and keeping in place monitoring arrangements in order to improve the quality of health care provided.¹³

Clinical governance is not part of operational management. Ms Anne Harkness, Director of the Rehabilitation and Assessment Directorate, was asked in the course of her evidence at the Inquiry’s public hearings to distinguish the two. She explained:

“We would use the term ‘governance’ to describe the kind of high-level systems and processes that you would have in place to check that actions were being taken and to report that back as part of a routine process”.¹⁴

She went on to explain that operational management would include the day to day involvement with patients, and in the context of cases of CDI the monitoring of the number of cases in a ward.¹⁵

In summary, then, the underlying aim of clinical governance is patient safety and good

quality care. In practical terms it is about systems – systems of monitoring and of reporting.

Accountability

The Clinical Governance Framework document also sets out responsibility for the delivery of clinical governance in the following way:

“The Chief Executive has overall responsibility for making sure that we deliver clinical governance and will carry out this responsibility by delegating to our general managers”.¹⁶

A committee known as the Clinical Governance Committee (CG Committee) was to be integral to the delivery of clinical governance. It was to be that Committee’s responsibility to oversee the Clinical Governance Framework and assure the NHSGGC Board that it was working effectively. The Committee was also to ensure that appropriate systems were in place for monitoring the clinical governance arrangements.¹⁷ Further details on the CG Committee’s role is set out in the next Section (10.3).

The key role to be played by management was described as follows:

“Clinical governance responsibilities are a specific part of the role of our senior staff, directors and other general managers. These specific responsibilities are set out clearly in their job descriptions”.¹⁸

More detailed policy

Along with the Clinical Governance Framework document NHSGGC published a more detailed policy in December 2006 in a document entitled the Clinical Governance Strategy and Framework.¹⁹ This was described as:

“the policy and guidance that our organisation will use to meet the requirements of our clinical governance framework”.²⁰

11 [GGC18510001](#)

12 [GGC18510001](#)

13 [GGC18510001](#)

14 [TRA01190001](#)

15 [TRA01190004-05](#)

16 [GGC18510002](#)

17 [GGC18510002](#)

18 [GGC18510002](#)

19 [GGC18460001](#)

20 [GGC18510001](#)

The scheme of accountability set out there was more detailed. That document repeated that the Chief Executive was charged with overall responsibility for the delivery of clinical governance, while within the Acute Services Division accountability for the delivery of clinical governance rested with the Chief Operating Officer.²¹

The document also emphasised that responsibility for clinical governance was to be an explicit component of the role played by senior staff, with that responsibility clearly defined in job descriptions.²² While responsibility in the first instance lay with general management, this was to be supplemented by the Clinical Governance Implementation Group (the CG Implementation Group), linked to the oversight role of the CG Committee, and assurance provided using the following means:

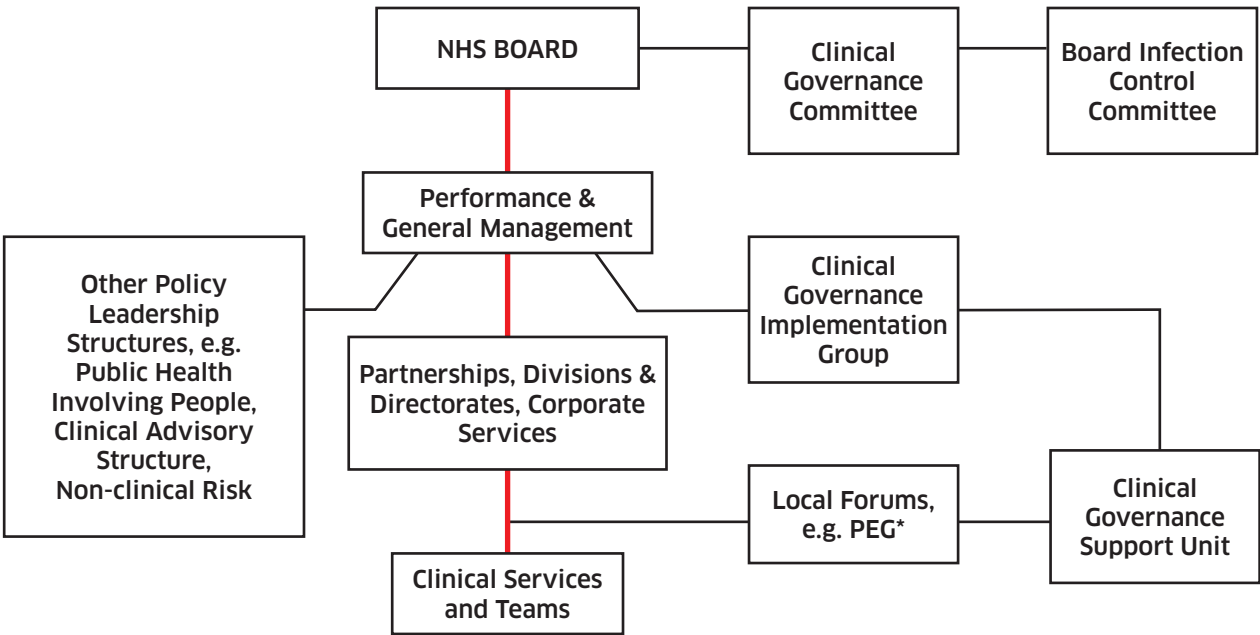
- The CG Implementation Group and CG Committee would obtain assurance on the standards of clinical quality through reports from clinical services and their supports

- Monitoring reports reviewing progress against local clinical governance development plans would be co-ordinated through the CG Implementation Group
- The Acute Services Division and Partnerships were to ensure regular reports reflecting progress and clinical governance activity were published
- A variety of other internal and external mechanisms would be used to monitor and review the effectiveness of clinical governance²³

A Clinical Governance Support Unit was charged with providing specialist advice and practical support in the development of safer and more effective care. This group was to work closely with clinical services.²⁴

Figure 10.1 has been derived from the “Clinical Governance Strategy and Framework”²⁵ document to display the structure.

Figure 10.1 Clinical Governance Structure



*PEG – Professional Executive Group

21 [GGC18460007](#)
22 [GGC18460007](#)

23 [GGC18460010](#)
24 [GGC18460008](#)
25 [GGC18460006](#)

Figure 10.1 expresses the primary line of accountability for quality of care through general management arrangements. This is represented here by the red line. The Clinical Governance Strategy and Framework document describes this as the “core structure of accountability”, but one supported by “extended structures”.²⁶

10.3 Clinical governance structures at divisional level

Number of directorates

Responsibility for the Clyde Acute Directorate and the Rehabilitation and Assessment Directorate lay within the Acute Services Division of NHSGGC of which they formed part. In 2007 to 2008 there was a total of nine directorates in the Acute Services Division.²⁷

The Clinical Governance Committee (CG Committee)

The CG Committee was a formal committee of the NHSGGC Board, with a membership consisting of non-executive directors who were also members of the NHSGGC Board, and met every two months. Its objectives were set out in the “Clinical Governance Strategy and Framework” document in the following terms:

“The purpose of the Clinical Governance Committee is to assist the NHS Board to deliver its statutory responsibility for the quality of healthcare that it provides. In particular, the Committee will seek to provide assurance to the Board that an appropriate system for monitoring and development is in place, which ensures that clinical governance and clinical risk management arrangements are working effectively to safeguard and improve the quality of clinical care. This includes affirming that NHS Greater Glasgow and Clyde:

- Has established clear lines of responsibility and accountability for the overall quality of care that it provides or commissions

- Has in place a soundly based clinical governance framework including strategy and local development plans
- Has in place reporting arrangements which ensure that the Board and Clinical Governance Committee are fully informed on the development of clinical governance
- Is taking all reasonable steps to prevent, detect and rectify irregularities or deficiencies in the quality of care provided or in the clinical governance framework
- Is doing its reasonable best to meet its objectives of improving health and tackling inequalities whilst protecting patients, staff, the public and other stakeholders against risks of all kinds”.²⁸

As set out in the Clinical Governance Strategy and Framework document its remit was to:

“provide an independent judgement on how the Board as a whole is managing the issues of strategy, performance and stewardship of public resources as they relate to the safety and quality of clinical care”.²⁹

It also had broad powers to:

“operate as necessary in order that it is confident that clinical governance and clinical risk management arrangements are working effectively to safeguard and improve the quality of clinical care”.³⁰

According to Mr Calderwood, the role of the CG Committee was to assure the Board of the effectiveness of the clinical governance arrangements in place.³¹ And as Dr Brian Cowan, Board Medical Director and Medical Director of the Acute Division, explained:

“It is a scrutiny committee, in the sense of non-executives at that committee can hold people like myself and the Chief Executive to account for what is happening in the organisation, and the committee... one of

²⁶ [GGC18460006](#)

²⁷ [GGC02700001](#)

²⁸ [GGC18460015](#)

²⁹ [GGC18460016](#)

³⁰ [GGC18460016](#)

³¹ [TRA01240006](#)

the ways it went about its work was to bring the directors and the associate medical directors to the committee, in turn, to describe issues and problems they were having directly to the committee".³²

Clyde representation on the Clinical Governance Committee

The membership list of the NHSGGC Clinical Governance Committee for 25 April 2006³³ records that a member for Clyde had still to be appointed and that a vacancy existed for a lay member. The Internal Audit report of 2007 to 2008 on Clinical Governance Committee Reporting Arrangements, published in March 2008,³⁴ notes that there is no designated non-executive Board representative from Clyde. It recommends that the need for such a post be reviewed.³⁵ The Inquiry has found no evidence to indicate that such a review took place, and no appointment was ever made.

Mr Alex Smith, an NHS management expert commissioned by the Inquiry, in his report to the Inquiry, records that:

"Given the strong case for the retention of Clyde as a distinct directorate from 1 April 2006 and the challenge of the transition, a non-executive appointment on the Greater Glasgow and Clyde Board Clinical Governance Committee with a Clyde focus would have been desirable for the key period through to full integration".³⁶

Mr Calderwood was asked about this observation in the course of his evidence at the Inquiry's public hearings. He provided the following answer:

"I don't think you need someone who has a geographical residence within former Clyde to discharge the non-executive director responsibility of clinical governance".³⁷

Dr Cowan did say, however, that, in contrast to the other Board sectors, the Associate Medical Director of Clyde was invited to attend every meeting of the CG Committee. This was because at the time of the dissolution of Argyll and Clyde in April 2006 it was acknowledged that he (Dr Cowan) and others on the CG Committee would not be as familiar with clinical governance issues in Clyde.³⁸ That practice is evident from the minutes of the CG Committee.³⁹

The Clinical Governance Committee's performance of its role - 2007 to 2008

At the CG Committee meeting of 20 February 2007⁴⁰ Mr Andrew Crawford, the Head of Clinical Governance, submitted a detailed paper reporting on developments and issues associated with the management of clinical governance in NHSGGC.⁴¹ That paper confirms to the CG Committee that the key groups in the clinical governance structure were in place through which clinical governance objectives and priorities were "set, monitored and reported".⁴² Reference is made to the key groups, including the Clinical Governance Forum in each directorate.

Clinical Governance Committee and infection prevention and control

There was a reporting line from the infection prevention and control committee structure to the CG Committee. The Board Infection Control Committee (BICC) reported to the CG Committee.⁴³ This was an important link in connection with monitoring infection prevention and control issues. As discussed in Chapter 15, the Acute Control of Infection Committee (ACIC) for the Clyde Sector reported to the BICC, and was in a position to alert the BICC of any problems with CDI, and in particular the existence of an outbreak.

32 [TRA01220082](#)

33 [GGC21540001](#)

34 [QIS00900001](#)

35 [QIS00900009](#)

36 [EXP02800013](#)

37 [TRA01240042](#)

38 [TRA01220109](#)

39 [GGC18370001](#); [GGC29060001](#); [GGC28400001](#); [GGC28370001](#); [GGC28360001](#); [GGC28350001](#); [GGC18320001](#)

40 [GGC18370001](#)

41 [GGC18370005](#)

42 [GGC18490001](#)

43 [TRA01130013](#)

Reports and presentations to the Clinical Governance Committee

At the CG Committee's meeting of 20 February 2007 the minutes of the BICC were received together with a summary paper highlighting key issues.⁴⁴ The minutes of the CG Implementation Group were also received, again with a paper on key issues.⁴⁵ The receipt by the CG Committee of the minutes of the BICC and the CG Implementation Group accompanied by papers on key issues occurred at every meeting of the CG Committee in the period January 2007 to June 2008.

At the CG Committee meeting of 17 April 2007⁴⁶ Dr Robin Reid, who at that time was the Associate Medical Director in the Diagnostics Directorate, provided a detailed presentation on the structure of clinical governance within that Directorate.⁴⁷ At that same meeting Mr Tom Walsh, Infection Control Manager, and Ms Sandra McNamee, the NHSGGC Infection Control Nurse Consultant, submitted for consideration a draft of the Annual Infection Control Programme for 2007 to 2008.⁴⁸

At the CG Committee's meeting of 26 June 2007⁴⁹ Mr Crawford is noted to have reported that the Clinical Governance Support Unit had received around 20 Annual Clinical Governance Reports from individual directorates and partnerships.⁵⁰ It was decided that in view of the volume of material the reports would be placed on a CD Rom and distributed to members, with each report to be reviewed by two members, an allocation that was to be organised by Mr Crawford.⁵¹

The Infection Control Annual Report for 2006 to 2007 was presented by Mr Walsh to the CG Committee meeting of 21 August 2007.⁵²

At the CG Committee meeting of 18 December 2007 presentations were provided on Clinical Governance in the Clyde Acute Directorate and in the Rehabilitation and Assessment Directorate (RAD). By this time Clyde Rehabilitation and Assessment had been integrated into the Greater Glasgow RAD. The presentation on behalf of the Clyde Acute Directorate was given by Dr John Dickson, the Associate Medical Director for Clyde. Among the challenges identified by him were the range of specialities to be covered within the geographical area and finding the means of supporting even prioritised audits.⁵³ The presentation on behalf of the RAD was given by Dr Margaret Roberts, then the Associate Medical Director in the RAD. She advised that Clinical Governance was a standing item at monthly Directorate meetings. Among the challenges identified by her was the incorporation of Clyde.⁵⁴

This pattern of Clinical Governance presentations being given to the CG Committee was repeated at meetings of the CG Committee in 2008.⁵⁵

In his report⁵⁶ Mr Smith took as an example of the role of the CG Committee the minutes of the meeting of 5 February 2008.⁵⁷ In his view the minutes reflected a well attended meeting of non-executives with several senior clinical staff in attendance. He thought that the agenda was comprehensive and covered, by rotation, major directorate reviews.⁵⁸ He concluded that in terms of clinical governance, NHSGGC had:

“developed a comprehensive framework, through its Clinical Governance Committee and Chief Executive's general management arrangements to maintain the safety and quality of the healthcare provided”.⁵⁹

The management arrangements are considered below.

44 [GGC18370006](#)

45 [GGC18370006](#)

46 [GGC29060001](#)

47 [GGC29060002](#)

48 [GGC29060005](#)

49 [GGC28400001](#)

50 [GGC28400005](#)

51 [GGC28400005](#)

52 [GGC29040001](#); [GGC29040006](#)

53 [GGC28370003](#)

54 [GGC28370002](#)

55 [GGC28360001-03](#); [GGC28350001-04](#); [GGC18320001-04](#)

56 [EXP02800001](#)

57 [GGC28360001](#)

58 [EXP02800012](#)

59 [EXP02800025](#)

The Clinical Governance Implementation Group

The Clinical Governance Implementation Group (CG Implementation Group) met every two months and reported to the CG Committee. It was responsible:

“on behalf of the Chief Executive, for developing policy and establishing decisions on strategic priorities deemed essential to clinical governance and the attainment of its goals”.⁶⁰

Among the items expected to feature in the agenda of its meetings was:

“receipt of appropriate information from committees/groups underpinning clinical governance”.⁶¹

In practice, then, the role of the CG Implementation Group was largely to facilitate the CG Committee’s fulfilment of its remit. For example, the presentations made to the CG Committee on 18 December 2007 on clinical governance had been arranged by the CG Implementation Group at its meeting on 14 November 2007.⁶²

Dr Cowan, who chaired the CG Implementation Group, explained that infection prevention and control was not a regular topic for discussion. This was because infection prevention and control, unlike many of the other services, had its own Board Infection Control Committee (BICC). This is discussed further in Chapter 15. The BICC reported directly to the CG Committee,⁶³ and prior to June 2008 it provided an annual report to the CG Committee.⁶⁴

There was some reference to infection prevention and control at the CG Implementation Group meeting of 14 March 2007,⁶⁵ but, so far as the Inquiry can ascertain, there was no further specific reference at any meetings prior to June 2008.

Dr Cowan usually attended the CG Committee meetings. He also saw the minutes of the BICC and the Acute Control of Infection Committee (ACIC).⁶⁶

Senior management groups

Whereas the role of the CG Committee was to provide assurance to the Chief Executive and the Board that appropriate systems were in place to deliver the clinical governance agenda of ensuring that healthcare was safe and effective, it was the role of management to put in place systems that were operating effectively. Within the Acute Services Division at the senior management level the two groups discussed below had responsibilities for clinical governance. Mr Calderwood chaired both groups and was in a position to report from them to the Chief Executive on any issues of concern that he considered he himself could not handle.⁶⁷

The Acute Operational Management Group

At divisional level the Acute Operational Management Group was, according to its terms of reference:

“responsible for ensuring the arrangements are in place within the directorates for the implementation of strategy and policy within the Acute Services Division”.⁶⁸

In defining the group’s purpose, the terms of reference provide that:

“The Operational Management Group will focus its work plan around the key issues for the Division in terms of:

- Corporate Governance
- Clinical Governance
- Staff Governance
- Financial Governance
- Service Development”

60 [QIS02360001](#)
 61 [QIS02360001](#)
 62 [GGC32790001](#); [GGC32790003](#)
 63 [TRA01220103](#)
 64 [WTS01890008](#)
 65 [GGC32770001](#); [GGC32770003](#)

66 [TRA01220104](#)
 67 [TRA01220106](#)
 68 [GGC31860001](#)

They go on to say that:

“operational implementation will be delegated to the Directorate Management Teams or an individual Member of the Operational Management Group”.⁶⁹

Dr Cowan explained that the primary focus of the Acute Operational Management Group was on managerial issues rather than clinical issues.⁷⁰ As already mentioned, this group was chaired by Mr Calderwood, with a membership made up mainly of senior managers.⁷¹ It did not report to any other body.⁷² There is evidence of clinical governance issues being discussed at meetings in the second half of 2007 and in 2008,⁷³ and there was some reference to infection prevention and control issues at the meetings of 8 March 2007,⁷⁴ 11 October and 13 December 2007,⁷⁵ but otherwise infection prevention and control was not mentioned at meetings in the period January 2007 to 1 June 2008.

The Acute Strategic Management Group

According to its terms of reference the Acute Strategic Management Group (Acute SMG) was:

“responsible for the development of strategy and policy for the Acute Service Division within the framework of NHS Board policy and strategy”.

It was “a management Group/Committee and (had) no reporting relationship to any other Committee”.⁷⁶ It had a responsibility to:

“ensure that strategies, plans and policies are developed locally in such a way as to ensure, within the Division, effective and efficient.....Clinical Governance”.⁷⁷

The Acute SMG was also chaired by Mr Calderwood. In contrast to the Acute Operational Management Group, it did have a specific clinical focus,⁷⁸ with a membership consisting of managers (Directors) and Associate Medical Directors,⁷⁹ and was the senior management group in the Acute Division. Mrs Deborah den Herder, Director Clyde Acute Services and Ms Anne Harkness, Director of Rehabilitation and Assessment, Acute Services, were members, as was Dr Cowan.

Infection prevention and control issues were considered by the Acute SMG. Quarterly reports on infection prevention and control were presented by Dr Reid as Chairman of the ACIC.⁸⁰ In his report to the Acute SMG meeting of 27 September 2007,⁸¹ Dr Reid raised as an issue the need to gather consistent data across the whole of NHSGGC and then “provide it in a meaningful manner”.⁸² At the Acute SMG meeting of 24 April 2008⁸³ Dr Reid reported that Statistical Process Control charts were being “circulated to wards”.⁸⁴ There is no reference to CDI until the meeting of 26 June 2008.⁸⁵

Clinical governance reports were presented on a regular basis to the Acute SMG, a number of them by Dr Cowan.⁸⁶

In summary, the Acute Operational Management Group, and in particular the Acute SMG, did hold some responsibility for the development and operation of clinical governance. It did not, however, form part of a formal reporting chain on clinical governance arrangements that involved either the CG Committee or the CG Implementation Group.⁸⁷

69 [GGC31860007](#)

70 [TRA01220107](#)

71 [GGC02650001](#)

72 [TRA01220107](#)

73 [GGC02630004](#); [GGC02170004](#); [GGC02120005](#);

[GGC02010003](#); [GGC02040006](#); [GGC02030005](#);

[GGC02160005](#); [GGC02080004](#); [GGC02680005](#);

[GGC02090004](#)

74 [GGC02620001](#)

75 [GGC02170001](#); [GGC02120001](#)

76 [GGC31860001](#)

77 [GGC31860002](#)

78 [TRA01220107](#)

79 [GGC01390001](#)

80 [TRA01220105](#); [GGC01430005](#); [GGC02380005](#)

81 [GGC01430001](#)

82 [GGC01430005](#)

83 [GGC02380001](#)

84 [GGC02380005](#)

85 [GGC02390002](#)

86 [GGC01390005](#); [GGC01380002](#); [GGC01150005-06](#);

[GGC01360004-05](#)

87 [TRA01180101-103](#)

Clinical governance at divisional level

It is clear that, because of the reporting link between the BICC and the CG Committee, at divisional level NHSGGC had appropriate structures in place to obtain assurance that effective systems were in place for the management of infection prevention and control. What is also clear from the analysis in Chapter 15 is that at the level of the Clyde Sector there were system and personal failures that resulted in the infection prevention and control system becoming dysfunctional for the VOLH, unbeknown to the ACIC, the BICC and the CG Committee.

10.4 Clinical governance in the Clyde Acute Directorate

As set out in Chapter 9, although the integration process was not intended to be completed for a further three years after 1 April 2006, Clyde Rehabilitation and Assessment was integrated into the Glasgow Rehabilitation and Assessment Directorate on 1 September 2007. From that date the clinical governance reporting lines at directorate level changed. One line led to Mrs den Herder as the Director of the Clyde Acute Directorate and the other to Ms Harkness as Director of the Rehabilitation and Assessment

Directorate (RAD). As Ms Harkness acknowledged, from 1 September 2007 she and Mrs den Herder had parallel but separate responsibilities within the VOLH for different wards.

The respective job descriptions for Mrs den Herder⁸⁸ and Ms Harkness⁸⁹ placed identical responsibilities for clinical governance upon them in the following terms:

“Lead the clinical governance agenda within the Directorate to ensure highest possible quality of patient care is achieved including issues such as Hospital Acquired Infection [HAI] and compliance with standards and guidelines”.⁹⁰

This Section will explore to what extent they fulfilled that duty.

The Clyde clinical governance structures

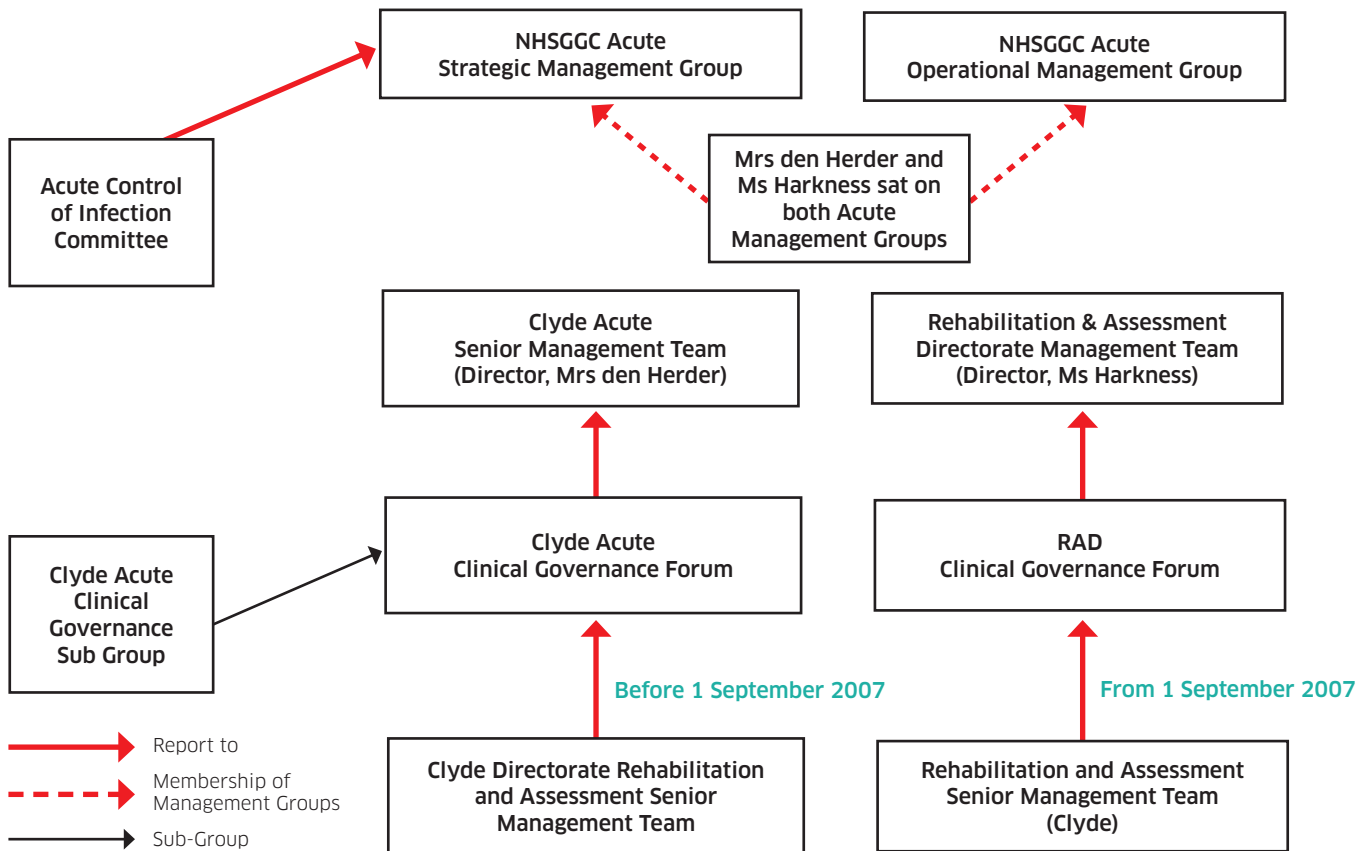
Figure 10.2 sets out the clinical governance structures within Clyde. Because from 1 September 2007 the reporting lines ended at the two separate director levels, the clinical governance structure appears to be a complicated one with separate reporting lines for the Clyde Acute Directorate, chaired by Mrs den Herder, and for the RAD, chaired by Ms Harkness.

88 [GGC33030001](#)

89 [GGC18570001](#)

90 [GGC33030003](#); [GGC18570003](#)

Figure 10.2 Flow of Clinical governance information in Clyde 2007-2008



Clyde Clinical Governance Framework meeting

A Clyde Clinical Governance Framework meeting was held on 11 July 2006 (the Framework meeting). This appears to have been an *ad hoc* meeting attended by senior clinicians and managers, and its stated purpose was to discuss the way forward for clinical governance in the Clyde Acute Directorate,⁹¹ which at that time included Rehabilitation and Assessment. Dr Elizabeth Jordan, then the Associate Medical Director, chaired the meeting and explained the clinical governance structure put in place across NHSGGC. In particular, she informed the meeting that, while a Clinical Governance Committee had been formed at Board level,⁹² it was up to directorates and specialty groups to devise clinical governance structures below this. It had been decided that one Clinical Governance Forum should be formed for the Clyde Acute Directorate.⁹³

Dr Jordan identified the key role of the group as:

“to ensure that things that go wrong in other organisations aren’t (happening) and can’t happen in Clyde”.⁹⁴

It was agreed at this meeting that clinical directors and general managers should be members of the Forum. A draft Clyde Acute Clinical Governance Plan was circulated⁹⁵ to members, and a decision was taken to circulate the draft for wider consultation in the Clyde Acute Directorate.⁹⁶

A group known as the Clyde Acute Clinical Governance Forum in fact already existed prior to the meeting of 11 July 2006. It had met on 27 March 2006,⁹⁷ apparently not for the first time, since the minutes of

91 [GGC19880002](#)

92 [GGC19880003](#)

93 [GGC19880003](#)

94 [GGC19880003](#)

95 [GGC19880002](#)

96 [GGC19880002](#)

97 [GGC19860001](#)

that meeting make reference to an earlier meeting. It met again on 19 June 2006.⁹⁸ Many who attended those meetings were also at the Framework meeting.

The reconstituted Clyde Acute Clinical Governance Forum

A meeting of the reconstituted Clyde Acute Clinical Governance Forum (Clyde Acute Forum) took place on 29 August 2006,⁹⁹ and at that meeting Dr Jordan tabled the Clyde Acute Forum draft constitution. It was agreed that the Clyde Acute Forum would report to the Clyde Acute Senior Management Team (SMT), chaired by Mrs den Herder, rather than to the Associate Medical Director.¹⁰⁰

The draft constitution

The draft constitution of this reconstituted body (the version provided to the Inquiry is designated a “final draft” dated 21 September 2006) lists among its aims:

“(to) ensure that safe and appropriate systems are in place to deliver high quality, safe and effective care and services”.¹⁰¹

Specific objectives of the Clyde Acute Forum included:

- Providing assurance to the Board that systems are in place for promotion and support of clinical governance within the Clyde Acute Directorate and to monitor the performance of these systems
- Alerting the Associate Medical Director of issues of concern that cannot be resolved locally
- Reviewing and ensuring compliance with national standards¹⁰²

The fundamental role of the Clyde Acute Forum was said to be:

“to seek assurances, monitor performance and offer support on all governance matters in the Directorate”.¹⁰³

Under the draft constitution, responsibility for the delivery of clinical governance within Clyde Acute Directorate lay with the associate medical director and general managers.¹⁰⁴ The terms of the draft constitution also reflect the decision noted previously that the Clyde Acute Forum was to report to the Clyde Acute SMT (referred to in the draft constitution as “the Clyde Acute Management Group”).¹⁰⁵

The draft constitution also listed those who were to be the “core membership”¹⁰⁶ of the Clyde Acute Forum, and included an infection control representative. Those key members of the Clyde Acute Forum were expected to attend every meeting or “send a deputy”.¹⁰⁷

Reporting lines are laid down in the draft constitution for reporting from the different clinical directorates. At that time Rehabilitation and Assessment was still within the reporting structure of the Clyde Acute Directorate. Mrs Elizabeth Culshaw, General Manager for the Rehabilitation and Assessment Directorate, chaired the Rehabilitation and Assessment (Clyde) Senior Management Team meetings, and was identified as the person responsible for reporting on behalf of that Senior Management Team.¹⁰⁸

Provision was also made in the draft constitution for reports to be made available to the Clyde Acute Forum on nine issues. Included in the nine reports to be provided to the Clyde Acute Forum was an Infection Control report by an “Infection Control Representative”¹⁰⁹ who was not identified. The persons responsible for the other reports were identified.

The functioning of Clyde Acute Clinical Governance Forum

In 2007 the Clyde Acute Clinical Governance Forum (Clyde Acute Forum) was normally chaired by Miss Aileen White, Consultant Surgeon at RAH. It was to meet on a quarterly

98 [GGC19870001](#)

99 [GGC19890001](#)

100 [GGC19890002](#)

101 [GGC18450002](#); [GGC29150002](#); [TRA01000039](#)

102 [GGC18450002](#)

103 [GGC18450002](#)

104 [GGC18450002](#)

105 [GGC18450003](#)

106 [GGC18450003](#)

107 [GGC18450003](#)

108 [GGC18450006](#)

109 [GGC18450006](#)

basis.¹¹⁰ As already mentioned, an Infection Control report was among the standing items on its agenda.¹¹¹

The first meeting of the Clyde Acute Forum for 2007 was on 27 March 2007.¹¹² In the minutes for that meeting it has been noted that there was no update for infection prevention and control. An “Infection Control Representative [was] to be invited to attend future meetings”.¹¹³ This repeated identical notes made in minutes of meetings of the Clyde Acute Forum in 2006.¹¹⁴ The note is again repeated in the minutes for the meeting of 19 June 2007,¹¹⁵ although at that meeting Ms Marie Martin, General Manager, Diagnostics, did provide an infection prevention and control update¹¹⁶ to the effect that infection prevention and control had been fully integrated “in terms of Acute Services”¹¹⁷ and that Ms Annette Rankin had been appointed Head Nurse for Infection and Control. Ms Rankin attended the following meeting of the Clyde Acute Forum on 18 September 2007, and presented the infection prevention and control report.¹¹⁸ That was the first infection prevention and control report presented. Ms Rankin attended the meeting of 11 December 2007¹¹⁹ and again presented the infection prevention and control report.¹²⁰

At the next meeting of the Clyde Acute Forum on 11 March 2008 Ms Rankin was not in attendance, and intimated her apologies for her non-attendance. In her absence there was no update for infection prevention and control, despite the draft constitution envisaging that in such circumstances a deputy would attend. That meant that in the year March 2007 to March 2008 only two infection prevention and control reports were presented by a key member of the Infection Control Team.

In Chapter 15 the point is made that the Clyde Infection Control Support Group (the

Support Group) chaired by Dr Elizabeth Biggs, the Infection Control Doctor, had stopped meeting after its meeting on 10 July 2007.¹²¹ A meeting planned for 9 October 2007 did not take place. Nor did any further meetings take place until May 2008, when Dr Linda Bagrade, the replacement Infection Control Doctor for the VOLH, arranged a meeting.¹²² Ms Rankin did not, for example, raise the fact that the Support Group had ceased to meet at the meeting of the Clyde Acute Forum she attended on 11 December 2007.¹²³ Furthermore, as discussed more fully in Chapter 15, neither did Mrs Catherine MacGillivray, Head of Nursing for Clyde Acute, who was a member of the Clyde Acute Forum and also the Support Group, who was aware that the Support Group had ceased to meet and who, like Ms Rankin, attended the Clyde Acute Forum meeting on 11 December 2007.¹²⁴

When the Internal Investigation described in Chapter 17 took place Miss White explained to the Internal Investigation Team that the Clyde Acute Forum had requested minutes of local infection control meetings. What is significant is that according to the notes of her interview she was not aware that “the IC Committee” had ceased to meet. Although the Clyde Acute Forum was not receiving minutes from that committee, members assumed that meetings were continuing to take place.¹²⁵

The Inquiry concludes from the foregoing narrative that until September 2007, when Ms Rankin first attended the Clyde Acute Forum and reported on infection prevention and control, there was a protracted period of time when there was no Infection Prevention and Control Team representative in attendance at the Clyde Acute Forum meetings. Infection prevention and control was not viewed as a high priority among those involved in clinical governance.

The Clyde Acute Forum meetings were generally not well attended.¹²⁶

110 [GGC18450004](#)

111 [TRA01000041](#)

112 [GGC20740001](#)

113 [GGC20740007](#)

114 [GGC19860007](#); [GGC19870006](#)

115 [GGC29260001](#); [GGC29260006](#)

116 [GGC29260001](#)

117 [GGC29260003](#)

118 [GGC03780009](#)

119 [GGC15400001](#)

120 [GGC15400005](#)

121 [GGC20940001](#)

122 [GGC13390002](#)

123 [TRA01000039-41](#)

124 [GGC15400001-08](#)

125 [GOV00890126](#)

126 [GGC20740001](#); [GGC29260001](#); [GGC03760001](#)

The Clyde Acute Clinical Governance subgroup

The draft constitution envisaged that between the meetings of the Clyde Acute Forum a subgroup of the Forum would meet at six-weekly intervals.¹²⁷ This was also chaired by Miss White.¹²⁸ The draft constitution did not specify that infection prevention and control would be a standing item.¹²⁹

From January 2007 and prior to June 2008 there were ten meetings of the subgroup. Infection prevention and control did not become a standing item on the agenda until a decision was made to that effect on 17 July 2007.¹³⁰ Before then the only reference to infection prevention and control had been at the subgroup's meeting of 29 May 2007,¹³¹ and related to infection within Surgery and Anaesthetics.¹³² At the meetings of 28 August 2007,¹³³ 20 November 2007,¹³⁴ and 29 January 2008,¹³⁵ Mrs Jean Murray, interim Lead Nurse for Infection Control, did provide verbal reports on infection prevention and control issues, but *C. difficile* infection is not mentioned. By the date of the subgroup's meeting of 29 April 2008¹³⁶ Mrs Murray had retired and there was no infection prevention and control report presented.¹³⁷

There is no suggestion in the minutes that the subgroup at any time enquired as to the adequacy of infection prevention and control systems in place at the VOLH. Nor is there any suggestion that it became aware of the failure in the infection prevention and control committee structure and lack of input from the Infection Control Doctor.

For a significant number of the subgroup meetings there was poor attendance.¹³⁸

127 [GGC18450004](#)
 128 [GGC03670001](#)
 129 [GGC18450006](#)
 130 [GGC03630001](#); [GGC03630006](#)
 131 [GGC03640001](#)
 132 [GGC03640003](#)
 133 [GGC03620001](#); [GGC03620004](#)
 134 [GGC03600001](#); [GGC03600003](#)
 135 [GGC16970012](#); [GGC16970015](#)
 136 [GGC15410001](#)
 137 [GGC15410001-05](#)
 138 [GGC03630001](#); [GGC03620001](#); [GGC03610001](#);
[GGC03600001](#); [GGC16970003](#); [GGC16970012](#);
[GGC15410001](#)

Clyde Acute Senior Management Team

The Clyde Acute Senior Management Team (Clyde Acute SMT) met monthly, and was normally chaired by Mrs den Herder. Some members of the Clyde Acute Forum, for example, Ms Martin, Dr Jordan and Mrs MacGillivray, were also members of the Clyde Acute SMT,¹³⁹ and Dr John Dickson became a member in September 2007 after he became Associate Medical Director.¹⁴⁰ The Clyde Acute SMT discussed clinical governance issues such as patient safety, waiting times, child protection and blood transfusion,¹⁴¹ but none related to infection prevention and control until the meeting of 5 June 2008, just after the CDI problem at the VOLH was identified.¹⁴² One important qualification to that is the fact that action notes after September 2007 up until the meeting on 3 April 2008 are missing and were not available for scrutiny.¹⁴³

As noted earlier, the Clyde Acute Forum reported to the Clyde Acute SMT.¹⁴⁴ In the action notes of the Clyde Acute SMT meeting of 20 February 2007 it has been noted, under reference to clinical governance, that "Liz will bring minutes of quarterly CG Forum to this meeting".¹⁴⁵ That is a reference to Dr Jordan and the minutes of the Clyde Acute Forum, and although subsequent action notes do not make any reference to the minutes of the Clyde Acute Forum there is no reason to conclude that the minutes were not produced. The cross-membership of the Clyde Acute Forum and Clyde Acute SMT also provided an informal route for the passage of information.

The lack of infection prevention and control input disclosed by the action notes of the Clyde Acute SMT suggests that it did not recognise infection prevention and control as an integral part of clinical governance. The minutes of the Clyde Acute Forum should have made apparent to the SMT the extent to which infection prevention and control matters were not receiving the attention they required.

139 [GGC32140001](#)
 140 [GGC04550001](#)
 141 [GGC04630003](#); [GGC04640002-03](#)
 142 [GGC04620002](#)
 143 [GGC32110001](#)
 144 [GGC18450003](#)
 145 [GGC32140002](#)

In the action notes of the Clyde Acute SMT's meeting of 20 September 2007¹⁴⁶ it has been noted that Mr Walsh was to attend the next meeting set for 18 October 2007 "to discuss National HAI Prevalence Study".¹⁴⁷ The action notes of the meeting of 18 October 2007 are missing and have not been seen by the Inquiry. Those action notes do, however, appear to have been available to the Internal Investigation Team, which extracted from them the information that Mr Walsh and Ms

Rankin had attended and had discussed the HAI prevalence study.¹⁴⁸ The role played by the Internal Investigation Team is considered in Chapter 17.

Table 10.1 is a revised version of a Table contained in the Internal Investigation report. Under the heading of clinical governance it highlights that only the action notes of 18 October 2007 had a reference to infection prevention and control.¹⁴⁹

Table 10.1 Clyde Acute Senior Management Team action notes

Date	Note in action notes
1/5/08	• Child Protection • Blood TAG Compliance
3/4/08	• VoL Governance Group established (no reference to VoL control of infection issues) • Child Protection • Paediatric Minor Injuries • Unscheduled Care • Dermatology • Blood Tag Compliance
18/10/07	Tom Walsh, control of Infection Manager and Annette Rankin, Head of Nursing for Infection Control, attended the meeting to discuss the HAI prevalence study, which reported that hospitals in Clyde had generally been around or below the national average.
21/8/07	Modernising Medical Careers
26/6/07	Consent Policy Child Protection
24/5/07	Clinical Governance Annual report Child Protection
19/4/07	Child Protection
15/3/07	Nil to report
20/2/07	Incidents Production of minutes
18/1/07	Exception Reporting Absence figures

¹⁴⁶ [GGC04550001](#)

¹⁴⁷ [GGC04550007](#)

¹⁴⁸ [GGC00610006](#)

¹⁴⁹ [GGC00610006](#)

In summary, ten sets of action notes of the Clyde Acute SMT meetings have been reviewed in the period covered by the Inquiry remit. One had a reference to infection prevention and control specifically linked to the National Prevalence Study results.

Mrs den Herder's responsibility

Mrs den Herder's duty to lead the clinical governance agenda with a particular focus on HAI, as set out in her job description, has already been described in this Chapter. That duty reflected the clinical governance structure set out in the Clinical Governance Strategy and Framework document, in which the delivery of clinical governance was to be achieved through general management.¹⁵⁰ Subject to the qualification already mentioned that not all the action notes are available, there appears to have been little attention paid to infection prevention and control as an aspect of importance to clinical governance at the Acute SMT meetings chaired by Mrs den Herder. Furthermore, the repeated references made in the minutes of the Clyde Acute Forum about the lack of infection prevention and control input should have been identified by her. That position should have been remedied long before Ms Rankin first attended a meeting of that group in September 2007. In the later part of 2007 and early 2008 there was some infection prevention and control input provided by Mrs Murray at the meetings of the subgroup, but there is no evidence of any real focus at any level, and particularly at Mrs den Herder's level, on the operation of the infection prevention and control systems, particularly insofar as they affected the VOLH.

10.5 Clinical governance in the Rehabilitation and Assessment Directorate

Full integration

Clyde Rehabilitation and Assessment was fully integrated with NHSGGC in September 2007, and Ms Harkness, who had been director of the Greater Glasgow directorate since October 2005, became the director of

the extended Rehabilitation and Assessment Directorate (RAD).¹⁵¹ At the VOLH, wards 14, 15 and F were in the new RAD. The Senior Management Team for Rehabilitation and Assessment (Clyde) therefore reported to the Clyde Acute Forum until September 2007 and thereafter to the RAD Clinical Governance Forum.¹⁵²

The Rehabilitation and Assessment Senior Management Team

Mrs Culshaw chaired the Rehabilitation and Assessment Senior Management Team (SMT) meetings and was a member of the Clyde Acute Forum until September 2007. The Rehabilitation and Assessment SMT tended to meet at least monthly.¹⁵³

In the period from January 2007 up to September 2007 during which the SMT reported within the Clyde Acute Directorate structures, the action notes available of the SMT meetings disclose that occasionally issues relating to infection prevention and control did feature. In March 2007 there were outbreaks of MRSA and CDI identified in ward 7 of the RAH. The concern expressed by Dr Syed Ahmed, Consultant in Public Health Medicine and Clinical Consultant in the Public Health Protection Unit, NHSGGC, in his email of 15 March 2007 to Mrs Culshaw and her inadequate response to that email have already been discussed in Chapter 9. That outbreak had been referred to at the meeting on 13 March 2007¹⁵⁴ and again on 11 April 2007.¹⁵⁵ As previously mentioned in Chapter 9, Mrs Culshaw said in evidence that there had been a discussion at the meeting in March about the outbreak.¹⁵⁶ Having become aware of the failures in the RAH, Mrs Culshaw did not check to see if there were infection prevention and control issues at the VOLH. Mrs Culshaw's position was that she had raised the profile of this infection prevention and control issue within the Senior Management Team.¹⁵⁷ She believed that as she had raised the RAH issue at the meeting,

¹⁵⁰ [GGC18460006](#)

¹⁵¹ [TRA01180087-88](#)

¹⁵² [GGC03780001](#); [GGC03780003](#); [GGC15400003](#)

¹⁵³ [GGC19320001](#); [GGC19340001](#)

¹⁵⁴ [GGC19260001](#); [TRA01170005](#)

¹⁵⁵ [GGC19280001](#)

¹⁵⁶ [TRA01170005](#)

¹⁵⁷ [TRA01170006](#)

the manager responsible at local level, in this instance Ms Elizabeth Rawle, Lead Nurse for the Rehabilitation and Assessment Directorate, would be aware there was an issue at other sites within the Clyde Sector. Ms Rawle had not in fact attended the meeting of 13 March 2007.¹⁵⁸

Although infection control was listed on the agenda for the meeting of the Rehabilitation and Assessment SMT held on 25 May 2007, the action notes for the meeting do not refer to infection prevention and control. Nor do the action notes of SMT meetings after April 2007 disclose any references to infection prevention and control as a topic that had been discussed¹⁵⁹ until the meeting of 7 August 2007, when there was some discussion in connection with the Cleanliness Champions Programme.¹⁶⁰ It is to be noted that some of the action notes of meetings are missing, although the agendas for some of these meetings have been made available.

After the integration of Clyde Rehabilitation and Assessment with Greater Glasgow RAD in September 2007, Mrs Culshaw's group became the Rehabilitation and Assessment Directorate SMT (the RAD SMT) and reported to the RAD Clinical Governance Forum,¹⁶¹ of which she became a member.¹⁶² The role played by that group is discussed later in this Chapter.

There appear to have been infection prevention and control issues discussed at the meeting of the RAD SMT on 25 September 2007,¹⁶³ and again at the meeting held on 9 October 2007.¹⁶⁴ Thereafter until the meeting of 10 June 2008,¹⁶⁵ when the CDI problem at the VOLH had become public, there appears to have been little focus on infection prevention and control at the meetings of this group.

It is perfectly apparent that there was no system of management in place at this level

that could monitor adequately that infection prevention and control was being properly managed in the VOLH. Mrs Culshaw accepted in evidence that, had appropriate reporting systems been in place, she would have become aware of the scale of CDI at the VOLH sooner than she did. She, like a number of others, was relying on the introduction of the Statistical Process Control (SPC) Charts described in Chapter 15 to produce data on the number of CDI cases.¹⁶⁶ As discussed in other Chapters, Mrs Culshaw was unaware that the data on numbers of patients who contracted CDI at the VOLH were available. She should have made herself aware of the actual position.

Rehabilitation and Assessment Directorate Clinical Governance Forum

The RAD Clinical Governance Forum (the RAD Forum) met every two months, and was chaired by Dr Roberts.¹⁶⁷ Minutes of meetings of that group are available from 22 August 2007, and a further four meetings took place prior to June 2008. Ms Harkness did not attend the RAD Forum, but the group she chaired, the RAD Management Team, did receive the minutes of the RAD Forum.¹⁶⁸

There is some reference in the minutes of the meeting of 17 October 2007 to HAI, and to CDI in particular, concerning the collection of data on CDI.¹⁶⁹ There is no reference to infection prevention and control in the minutes of the next meeting, which took place on 12 December 2007, but at the meeting after that, on 13 February 2008,¹⁷⁰ a number of infection prevention and control issues were discussed, including local infection control audits and CDI SPCs.¹⁷¹ The following observations have been recorded in the minutes:

"It was agreed there would be discussion as to how more meaningful information could be achieved and how this would be taken forward".¹⁷²

158 [GGC19260001](#)

159 [GGC19300001](#); [GGC19320001](#); [GGC19340001](#)

160 [GGC19360001](#)

161 [TRA01160128](#); [TRA01160139-140](#)

162 [GGC02740001](#); [GGC02750001](#)

163 [GGC19390001](#)

164 [GGC19410001](#)

165 [GGC19630001-02](#)

166 [TRA01160144-146](#)

167 [GGC02780001](#)

168 [TRA01180104](#)

169 [GGC02760001](#); [GGC02760003](#)

170 [GGC02740001](#)

171 [GGC02740003](#)

172 [GGC02740003](#)

HAI was also discussed at the following meeting held on 16 April 2008,¹⁷³ with a particular focus on the Annual Infection Control Programme.¹⁷⁴ At that meeting Dr Roberts is noted as advising the meeting that the Vale of Leven Governance Group had been formed and would provide regular reports to the RAD Forum.¹⁷⁵

It is clear that by February 2008 the RAD Forum had realised the importance of infection prevention and control issues to clinical governance. This recognition simply highlights the previous general lack of monitoring of the reporting systems in place. It implies ignorance of whether the systems were sufficiently effective to comply with NHSGGC's stated policy on clinical governance.

In contrast to the meetings of the Clyde Acute Forum, the meetings of the RAD Forum were generally well attended.¹⁷⁶

Rehabilitation and Assessment Directorate Management Team

Ms Harkness chaired the RAD Management Team meetings after integration on 1 September 2007. These meetings were normally held monthly.¹⁷⁷ The membership included Mrs Culshaw, the Chair of the RAD Senior Management Team meetings, and Dr Roberts, the Chair of the RAD Forum,¹⁷⁸ although Mrs Culshaw may not have attended until early 2008.¹⁷⁹

In her evidence Ms Harkness said that the RAD Management Team meetings were a forum for discussion on infection prevention and control prior to April 2008.¹⁸⁰ She drew attention to the minutes of the meeting of 19 September 2007, and to the record made there of a briefing provided by Ms Rankin on the HAI Prevalence Survey¹⁸¹ that was

published in July 2007.¹⁸² At that September meeting there was some discussion in connection with the standardising of information regarding HAI. It was noted that regular charts were being produced for the North Sector of NHSGGC.¹⁸³ It has been noted that the ACIC would be asked to produce a standard set of reports on HAI.

The history of the development and production of the SPC Charts is discussed in Chapter 15. Suffice to say at this point that it was only in May 2008 that Ms Harkness first received a standard infection prevention and control report.¹⁸⁴ This included matters such as details of environmental audits, an update on the numbers who had completed the Cleanliness Champions Programme, information on hand hygiene, and SPC Charts.¹⁸⁵

As discussed in Chapter 15, SPC Charts were not available in the VOLH until May 2008.¹⁸⁶ Information on the rates of infection was available, however, as was information on the other issues contained in that first infection prevention and control report. SPC Charts, as explained in Chapter 15, present a retrospective picture. They are not a substitute for monitoring patients in real time. Somewhat tellingly Ms Harkness said that after June 2008 not only was the retrospective situation considered at the RAD Management Team meetings but the current situation was also checked.¹⁸⁷

There was some discussion about infection prevention and control at the RAD Management Team meeting of 31 October 2007 in connection with ward closures¹⁸⁸ and the need for guidance from the Infection Control Team for staff entering closed wards.

Ms Harkness accepted that infection prevention and control did not feature in the minutes of the RAD Management Team meeting from November 2007 until

173 [GGC02750001](#)

174 [GGC02750002-03](#)

175 [GGC02750006](#)

176 [GGC02730001](#); [GGC02740001](#); [GGC02750001](#)

177 [GGC02420001](#); [GGC02520001](#)

178 [GGC02520001](#); [GGC02760001](#)

179 [GGC02740001](#)

180 [TRA01180104](#); [GGC32070001](#)

181 [GOV00460001](#); [GOV00510001](#)

182 [GOV00460002](#)

183 [GGC32070002](#)

184 [TRA01180106](#)

185 [TRA01180107](#)

186 [TRA01180144](#)

187 [TRA01190019](#)

188 [GGC02420002](#)

28 May 2008.¹⁸⁹ Four meetings of the RAD Management Team had taken place over that six to seven month period.

The RAD Management Team minutes for the meeting of 28 May 2008 provide an example of good clinical governance of infection prevention and control. The issue under review was that of patients suffering from MRSA infection in a ward in the RAH. An action plan was discussed, and a decision was made that the RAD Clinical Governance Group was to monitor the implementation of the action plan and report back.¹⁹⁰ This was before Ms Harkness was aware of the CDI problem at the VOLH.¹⁹¹

A similar approach is evident from the minutes of the RAD Management Team meeting of 30 July 2008,¹⁹² after the VOLH CDI problem had been made public. At that meeting infection prevention and control reports were considered, with decisions made on monitoring action plans and implementing policy.¹⁹³

The approach to clinical governance in relation to infection prevention and control evident at the RAD Management Team meetings of 28 May 2008 and 30 July 2008 is not apparent in the minutes of earlier meetings of that group.

Ms Harkness' responsibility

Ms Harkness did receive the minutes of the ACIC,¹⁹⁴ but certainly prior to June 2008, as discussed in Chapter 15, there was nothing in those minutes to alert her to the failures at the VOLH. She was not made aware prior to June 2008 of the CDI problem in the VOLH.¹⁹⁵

Ms Harkness was an impressive witness and gave her evidence with commendable clarity. Nonetheless, Ms Harkness, as the director of the RAD, was right in accepting that she should have been made aware of the CDI levels in wards for which she

had responsibility.¹⁹⁶ She was also right in accepting some responsibility after 1 September 2007 for the failure to identify outbreaks of CDI at the VOLH.¹⁹⁷ In her favour is the fact that she had only been responsible for the rehabilitation and assessment wards in the VOLH for a relatively short period before the outbreaks came to light.

The clinical governance arrangements within the RAD, for which she has to bear ultimate responsibility, were not sufficiently effective to ensure the "highest possible quality of patient care"¹⁹⁸ in relation to HAI, and in particular CDI Ms Harkness was perfectly candid in accepting that the absence of the provision of routine infection prevention and control information was a "gap"¹⁹⁹ in the governance arrangements for her as the director of the RAD.

10.6 Reporting from the Clyde Sector

Separate lines of reporting

As mentioned earlier in this Chapter, after 1 September 2007 the Clinical Governance Forums for the Clyde Acute Directorate and for the Rehabilitation and Assessment Directorate reported separately to the Management Team meetings for these two directorates chaired respectively by Mrs den Herder and Ms Harkness.

Lack of formal reporting

There was no formal reporting line from the Clyde Acute SMT or the RAD Management Team to the Acute Strategic Management Group (Acute SMG) or the Acute Operational Management Group, although Mrs den Herder and Ms Harkness were members of the Acute SMG and the Acute Operational Management Group. The Acute SMG in particular was a forum where clinical governance issues, including infection prevention and control, were discussed.

NHSGGC has maintained that the Clinical Governance Implementation Group (CG Implementation Group) received reports

189 [TRA01180105; GGC02540001](#)

190 [GGC02540001-02](#)

191 [TRA01180132-133](#)

192 [GGC08550036](#)

193 [GGC08550036](#)

194 [TRA01180119](#)

195 [TRA01180110](#)

196 [TRA01180110](#)

197 [TRA01190015-16](#)

198 [GGC18570003](#)

199 [TRA01190020](#)

from each Clinical Governance Forum, and mentioned the Clyde Acute Forum as an example of this line of reporting.²⁰⁰ The minutes of the CG Implementation Group do not refer to such reports. Furthermore, as discussed earlier in this Chapter, the draft constitution of the Clyde Acute Forum specified that the group would report to the “Clyde Acute Management Group”²⁰¹ which seems to be a reference to the Management Team meetings chaired by Mrs den Herder.

Ignorance of system failures

It will be evident from the discussion in this Chapter of the roles played by the Clinical Governance Committee (CG Committee) and the Clinical Governance Implementation Group (CG Implementation Group) that those groups were unaware of the system failures for the VOLH. Ms Harkness was a member of the CG Implementation Group, as was the Associate Medical Director for the Clyde Acute Directorate, but those links did not serve to inform the CG Implementation Group because of the lack of focus on infection prevention and control as an integral aspect of clinical governance within the Directorates.

10.7 The Clinical Governance Committee and NHS Greater Glasgow and Clyde

As Medical Director in 2007/08,²⁰² Dr Cowan was responsible for providing advice to the Chief Executive and Chief Operating Officer, with a particular focus on clinical governance.²⁰³ He oversaw the clinical governance system and attended the CG Committee meetings.²⁰⁴ He first became aware of the CDI problem at the VOLH on 9 June 2008. He was “horried at the news”²⁰⁵ because he was told that there had been “an outbreak going on for six months” which “at least no-one above Clyde had known about.”²⁰⁶ Dr Cowan made the point that the previous week he had attended a “Clyde Governance” meeting and that no issue

had been raised in connection with infection prevention and control or *C. difficile*.²⁰⁷ His reaction was expressed in the following manner:

“...we were no longer going to just encourage people to implement infection control measures, we were going to tell them to implement them and monitor them more effectively”.²⁰⁸

The oversight role of the CG Committee for effective clinical governance has already been described. As observed at the beginning of this Chapter, this group required confirmation that there was an:

“appropriate system in place for monitoring and developing our clinical governance and risk management arrangements”.²⁰⁹

The clinical governance committee structures themselves were in place and cannot be criticised. The CG Committee had an important reporting line to infection prevention and control from the BICC and received other forms of infection prevention and control input as set out earlier in this Chapter. Had the relevant information on the VOLH CDI problem reached the ACIC, the BICC and the CG Committee, NHSGGC and its Board would have been in a position to respond. The infection prevention and control failures that deprived the ACIC and the BICC of that information are discussed in Chapter 15. Had the clinical governance arrangements at directorate level functioned effectively, the problem would have become apparent, and again the CG Committee and the Board would have become aware of the CDI problem at the VOLH.

In this connection Dr Cowan provided a rather telling insight. He was asked what the main lessons were for him, the Board and senior management from what happened at the VOLH. In his reply Dr Cowan included as a lesson learned never to underestimate the effects of “two massive mergers”.²¹⁰ The “merger” with Clyde is considered in Chapter 9. The other merger he had in mind was the restructuring that had occurred in Glasgow

²⁰⁰ [GGC33100001](#)

²⁰¹ [GGC18450003](#)

²⁰² [TRA01220078](#)

²⁰³ [TRA01220080](#)

²⁰⁴ [TRA01220081-82](#)

²⁰⁵ [TRA01220094](#)

²⁰⁶ [TRA01220094](#)

²⁰⁷ [TRA01220094](#)

²⁰⁸ [TRA01220095](#)

²⁰⁹ [GGC18510002](#)

²¹⁰ [TRA01220156](#)

in 2005.²¹¹ A second lesson that Dr Cowan identified was:

“never to think that your safety margin is the fact that people will carry on doing what they have been doing and that that will keep you going until you can get your new reporting systems up and running, and that is where I think we got caught ... in Clyde”²¹²

Another point made by Dr Cowan was that NHSGGC was:

“caught out as an organisation, in not realising with the huge changes that a number of ... reporting systems were relying on the old systems that had been there ... and (the) new amalgamated reporting systems were taking longer ... to come onstream”.²¹³

He went on to say that NHSGGC:

“missed just how things were being delayed, simply because of the massive number of things we were trying to deal with because of the amalgamation”.²¹⁴

Of course when he gave his evidence Dr Cowan was speaking with the benefit of hindsight, but he nevertheless identified how important aspects of infection prevention and control had gone badly wrong in relation to the VOLH.

Dr Cowan gave his evidence with commendable candour and it was obvious that he had been “shocked”²¹⁵ when he discovered in June 2008 that:

“an infection could rage away for as long as six months and no-one would report it up the system”.²¹⁶

The reference to six months is explained by the fact the focus then was on the period December 2007 to May 2008. In fact, as discussed in this Report, the CDI problem in the VOLH had emerged much earlier in 2007 and remained undetected within the clinical

governance structure for much longer than the six months mentioned by Dr Cowan.

Dr Cowan’s commitment to the proper management of infection prevention and control was obvious. Furthermore, the Inquiry can sympathise with the nature of the workload undertaken by NHSGGC. The role played by the dissolution of Argyll and Clyde and the integration process, discussed in Chapter 9, was an important one, and having effective systems in place to manage infection prevention and control in the Clyde Sector inherited by NHSGGC would take time. Nonetheless the clinical governance arrangements in place within Clyde itself so far as the VOLH was concerned were not sufficiently effective to provide the responsible directors, Mrs den Herder and Ms Harkness, with the necessary assurances that the infection prevention and control arrangements were operating effectively.

Inevitably with such a large organisation as NHSGGC the information made available to the CG Committee was limited to the issues deemed to be of importance. The CG Committee did have infection prevention and control input provided to it but, as it turned out, that input did not alert it to the VOLH CDI problem to allow it to perform its scrutinising role effectively. That is why the Inquiry endorses the changes made to the processes after June 2008, which established infection prevention and control as a standing agenda item at every meeting of the CG Committee and reporting by the BICC to the CG Committee at each of its meetings.²¹⁷

10.8 Changes in clinical governance since 2008

The Head of Clinical Governance at NHSGGC, Mr Andrew Crawford, has explained certain changes in reporting practices since the VOLH CDI problem emerged. For example, infection prevention and control is now a standing item on the CG Committee agenda, and the BICC now reports to the CG Committee at each meeting instead of annually.²¹⁸

NHSGGC has in addition provided the Inquiry with certain information on changes in

211 [TRA01220152](#)

212 [TRA01220156-157](#)

213 [TRA01220151](#)

214 [TRA01220151](#)

215 [TRA01220094](#)

216 [TRA01220095](#)

217 [WTS01890008](#)

218 [WTS01890008](#)

clinical governance since 2008. In 2009 the Acute Division established an acute clinical governance committee to consider issues of clinical risk and patient safety, including infection prevention and control. The purpose of establishing this committee was to allow more time and debate on these issues than before.²¹⁹ A report of issues from the acute clinical governance committee is made to the CG Implementation Group. The Inquiry welcomes the changes made by NHSGGC as representing a more effective focus on issues of infection prevention and control.

10.9 No non-executive director for Clyde

There was no designated non-executive director for Clyde on the CG Committee. It appears from the membership list that the intention was to make such an appointment, and the reasons for not doing so are unknown. But the Inquiry finds that Mr Calderwood's response – that geographical residence is not essential to carrying out the duties of non-executive director – misses the point on two counts. The first of these is that the Clyde Acute Directorate was unique in NHSGGC in being a geographically defined directorate. The second is that for Mr Smith the particular issue of concern was not geographical residence; it was that there was no non-executive director on the CG Committee with an identifiable **specific interest in or responsibility for** Clyde during a period of organisational change. The Inquiry considers that to be a justified concern. It cannot be said with any certainty that the presence of such a person would have led to more questions being raised about the effectiveness of clinical governance within the Clyde Sector, but the absence of a member with a particular Clyde remit undoubtedly reduced the probability that such questions would be asked.

10.10 Conclusion

This Chapter is concerned with clinical governance issues alone, with a particular focus on the CDI problem at the VOLH. The question of whether infection prevention and

control structures should have identified the CDI problem at the VOLH, and the extent to which they did not do so, is considered in Chapter 15.

In relation to infection prevention and control at the VOLH, the Inquiry finds that NHSGGC's clinical governance system was not operating effectively. It is clear to the Inquiry that, had the clinical governance system been operating effectively, it would have identified the CDI problem in the VOLH. It is inconceivable that an effective clinical governance system would have failed to identify the inadequate input from the Infection Control Doctor, the failure of the infection prevention and control committee structure, and the failures to declare outbreaks of CDI discussed in Chapter 15. The level of reporting and monitoring necessary to identify the sort of failings that led to the levels of CDI at VOLH, was simply not in place. This meant that the Clinical Governance Committee and ultimately the Board remained in ignorance of the system failures within the Clyde Sector.

Had the clinical governance structures at directorate level been effective, the problems with infection prevention and control relating to the VOLH would have come to the attention of senior personnel both within the Acute Directorate and latterly the RAD. It is worth repeating that from 1 September 2007 there were two parallel directorates in the VOLH, and the fact that senior management in both directorates did not identify the CDI problem does emphasise that infection prevention and control was not regarded as integral to clinical governance. Appropriate monitoring within the Acute Directorate should have identified problems by mid-2007 at the latest. The precise impact of earlier detection cannot of course be measured, but it is reasonable to conclude that had action been taken, many cases of CDI could have been prevented.

10.11 Recommendations

Recommendation 9: Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level.

219 [GGC32220316](#)

Chapter 11

The experiences of patients
and relatives

Introduction

This Chapter examines the evidence provided to the Inquiry by patients, relatives and friends of patients at the VOLH (the patient and relative group). It concentrates mainly on the focus period of 1 December 2007 to 1 June 2008. The intention is to look at the evidence through the eyes of the patient and relative group and narrate some of their experiences. The Chapter will then identify issues that have emerged from an analysis of the documentation and of the evidence.

11.1 Sources of evidence

Written and oral evidence

In total 71 people in the patient and relative group provided written statements to the Inquiry. Thereafter the Inquiry selected a number of those who had given statements to provide additional assistance to the Inquiry in the form of oral evidence at the Inquiry's public hearings at Maryhill.

Unfortunately it was only possible to obtain statements from eight patients. Many of the patients who suffered from *C. difficile* infection (CDI) were elderly and, as discussed in Chapter 4, had chronic co-morbidities. Many patients had died, while others were unable to provide statements or give oral evidence due to age or illness. Sixty one further written statements were obtained from relatives and friends of the 63 focus patients.

The Inquiry has considered all of the written witness statements provided by the patient and relative group. It also heard oral evidence from 25 of the witnesses who had provided a written statement. Three of them were patients and 22 were relatives or friends of patients.

Although primarily concerned with the 63 patients who contracted CDI between 1 December 2007 and 1 June 2008, the Inquiry also looked at the treatment of CDI patients from 1 January 2007 to 30 November 2007. The patient records that were available for these patients were examined to assess their nursing management. Two statements were obtained from relatives for that early period before December 2007, and one of those relatives also gave oral evidence to the Inquiry.

Of the 63 focus patients, 24 patients had no involvement with the Inquiry either personally or through their families. Some were unable to participate because they had died or were too unwell. Some patients and relatives declined to participate in the Inquiry. Others simply did not respond to the Inquiry's request for assistance. Having approached them, the Inquiry took the decision not to pursue those patients or relatives who expressed a wish not to become involved or did not respond.

The Inquiry also had access to police statements taken as part of the police investigation prior to the establishment of the Inquiry. There were 86 police statements from the patient and relative group available.

The evidence of patients and families was based on recollections of conversations and experiences that occurred several years before they gave evidence to the Inquiry. Individual recollection of detail will vary, and memories are naturally selective. A few witnesses were able to refer to notes to assist their recollection. Some of the events were clearly so distressing that relatives were able to be clear in their recollections despite the passage of time.

Acceptance of the evidence of the patient and relative group

Without exception, the Inquiry was impressed by the care and candour displayed in the oral evidence provided by the patient and relative group of witnesses. In giving their evidence they were asked to recall events that were highly distressing. In many cases the patient involved had died. There was no exaggeration in their evidence, which was presented with dignity. Those witnesses who provided written statements but did not give oral evidence co-operated fully with the Inquiry and endeavoured to provide as accurate accounts as possible of their experiences.

Many witnesses clearly wanted to support their local hospital. In their evidence many witnesses did not criticise directly the care given by nursing staff, believing that any deficiencies in care could be explained by the nursing staff being overworked and understaffed. Some of the incidents described

by relatives were of concern to the Inquiry and raised issues of the nurses' ability to provide fundamental and basic nursing care.

The context of the patient and relative group evidence

The evidence of the patient and relative group was given prior to the evidence of the nursing and medical experts. This group had not had the benefit of reading the reports or the conclusions of experts commissioned by the Inquiry, which covered the nursing and medical care provided to patients, or of hearing them give evidence. The patient and relative group was also unaware of the scale of the problem with CDI at the VOLH.

11.2 The patients' and relatives' expectations

C.diff Justice Group

The relatives of a number of patients who died were instrumental in bringing about this Inquiry. There were 15 families involved in setting up the C.diff Justice Group. The creation of this Group is considered in Chapter 1.

The search for answers

The patient and relative group wished to obtain answers, in particular, to two questions:

- Why were there so many deaths in which CDI was implicated?
- Why was the extent of the problem with CDI not addressed by NHSGGC prior to June 2008?

Some extracts from the evidence which encapsulate that message are set out below.

"We did it because we want answers, because nobody has ever been truthful with us. We don't know why our family (member) died, we have never been told why. What happened at the Vale happened, and we feel that we deserve the answers".¹ Relative

"As you know, we've campaigned for two years to be able to get here today, and I think what we want most out of this is closure, that's what the families are looking for. And to get that, what we need is the answers to what actually went wrong at the Vale. One of the big questions that we have got from what happened at the Vale is why a bug or an infection like this was allowed to run rampant throughout the hospital for six months undetected. In fact, when it did actually come out, we were told that they knew about all 55 cases but couldn't link them. That shows to us that there's been a massive systems failure, not only at the Vale of Leven Hospital but throughout the systems in the NHS, and we feel that that's the lessons that need to be learned here to make a difference and hopefully save lives in Scotland".² Relative

"...when you have to go into hospital, you should feel that you are going into a safe and clean environment, and if you are just going in for tests – my mum went in for tests. She might have had cancer, she would have died eventually, but she wouldn't have died that horrendous death through the C. diff if there'd been procedures set in place. Nobody goes into hospital and expects not to come out because they catch some fatal disease, and I feel very strongly about that".³ Relative

"We are saddened by the fact that in his 90 years, the one and only time dad required hospital care he was badly let down by the NHS and as a result lost his life. We as a family would expect that recommendations already made and any further recommendations resulting from this Inquiry are carried out in full, regularly monitored and regular reviews carried out. This tragedy cannot be allowed to happen again".⁴ Relative

1 [TRA00020042](#)

2 [TRA00020082](#)

3 [TRA00030131](#)

4 [TRA00020115](#)

"I certainly personally would not like another family to go through the final hours of someone dying with this (*C. difficile*) as a contributory factor or the main factor of a death, because it's certainly not very pleasant, and if it can stop that happening by being stricter with the controls, keeping people isolated, then that's really what I would like from the outcome of this...There is every possibility probably he would have died anyway, but this certainly assisted him going a bit quicker, and I certainly wouldn't want that to happen to anybody else..."⁵ Relative

The other sentiment expressed by the patient and relative group was that others should not be made to suffer in a similar way. This commendable attitude demonstrates that it was not simple self-interest that drove the campaign for an Inquiry.

11.3 Patient care

No direct criticism

In general, as already mentioned, many in the patient and relative group did not criticise the nursing staff directly. Yet witnesses described incidents which indicated that the basic care of patients was not being addressed by nursing staff. Deficiencies in personal care were not attributed to deliberate neglect by nursing staff. There was a perception of a shortage of nursing staff on the wards and an impression that nurses were overworked. This convinced relatives that nurses were providing optimum care in difficult circumstances. Nonetheless, there was a notable consistency in descriptions from witnesses about personal care of patients. The same descriptions were made about patients in different wards.

Descriptions of failures in care

Many of the incidents described by the patient and relative group represented examples of failures in basic nursing care, whatever the explanation. One witness described the care given to her mother, who had just suffered a stroke, in the following way:

⁵ [TRA00040151](#)

"I just felt as if she was just – it's not very nice to say this, but I just felt as if she was left in a wheelchair, left to get on with whatever. They just left her alone...I don't think she got the care that she deserved... when we used to go up to the hospital we had to clean her, and we had to comb her hair and fix her hair and tidy her up a little bit...it was quite upsetting because that wasn't my mum. My mum always kept herself neat and tidy, and to see her in that condition, it wasn't very nice for us to see her that way".⁶ Relative

Some patients in different wards were described by relatives as having dirty fingernails. One witness said that his mother's fingernails were always dirty and that he took wet wipes in to clean her hands. He found "material"⁷ under his mother's fingernails.

Another witness said that her father's fingernails were "always filthy".⁸ She said that previously he had always been meticulous about his hand cleanliness:

"...one of the things I remember is my father was meticulous about keeping his hands and his nails clean, and in hospital his nails were always filthy and I was always having to clean them for him, and my mother used to do that as well".⁹ Relative

One relative said that when cutting her mother's fingernails she found faeces under her nails.¹⁰ Another witness described smelling faeces on her mother-in-law's hands.¹¹

One patient who was in isolation complained to her daughter that she had no means of washing her hands after she used the commode. The daughter described the position in the following way:

⁶ [TRA00020031](#)

⁷ [TRA00050115](#)

⁸ [TRA00040060](#)

⁹ [TRA00040060](#)

¹⁰ [TRA00010066](#)

¹¹ [TRA00020059](#)

“...she wasn’t offered any way of washing her hands after she had used the commode, and I had given her hand wipes and hand gel for her own personal use, but underneath her fingernails you could see excrement, and I used to go frequently with a face cloth and water, soapy water.... and wash her hands and face and try to clean her nails”.¹² Relative

When asked how often she needed to wash her mother’s hands and face and clean her nails, she said she did this on a daily basis for the full month her mother was in the VOLH.¹³ She did accept that she did not mention to the nursing staff that she had found excrement under her mother’s fingernails, but in any event the nursing staff should have identified that failure in hygiene for themselves and addressed it.

The following description was provided by another witness:

“Well, near enough on every visit we’d go up and see my mum and we had to use baby wipes on her to clean her up because she had dinner on her, either on her face or on her chin or down her front. So we had to clean her up... that was on several occasions that happened”.¹⁴ Relative

Another witness provided the following description of her mother’s appearance:

“..when we went up she would have dried food around her mouth, her lips would be quite dry and chapped, she would just be not clean looking, she just didn’t look clean. So we would go up and we would, like, wash her face with wipes, we would put moisturiser on her hands and on her face, we’d put lip salve on her lips just to kind of freshen her up”.¹⁵ Relative

That same witness also gave the following evidence:

“I think in the whole time she was in the hospital, so we’re talking about maybe eight, nine weeks, they washed her hair twice. She had never–she hadn’t had a bath. As you’ve seen, they’re saying they’re bed bathing her, but that’s not the same”.¹⁶ Relative

The descriptions provided by relatives were not restricted to issues of personal hygiene. Witnesses described taking wipes to the VOLH to wipe down tables and trays because they felt they were not clean.¹⁷ One family group noted that their mother’s catheter bag was usually full at visiting times. They brought this to the attention of nursing staff on more than one occasion. They also saw what were described as puddles at the side of the bed on the floor in the vicinity of the catheter bag. Nurses eventually strapped the bag to the patient’s leg, and the patient subsequently developed sores on her leg where the bag was located.¹⁸

The family of this patient also discovered that she had egg in her mouth from a previous mealtime, and described that discovery in the following way:

“We went in to see my mum and she was sleeping, so I went over ... and then the next minute she just opened her eyes and coughed, which at the time I didn’t know what it was, it appeared to be egg. She had been sleeping with egg in her mouth”.¹⁹ Relative

One witness said that when she visited her mother in ward 6 she saw that her mother had no water beside her bed. That prompted her to take bottles of water to the ward for her mother to drink.²⁰ This was a course of action also adopted by other witnesses.²¹ Another witness described how she went to the nurses’ station to ask for a jug of water for her mother as she knew she could

12 [TRA00030108-109](#)

13 [TRA00030109](#)

14 [TRA00020023](#)

15 [TRA00020051](#)

16 [TRA00020057](#)

17 [TRA00010146](#)

18 [TRA00020051-52](#)

19 [TRA00020013](#)

20 [TRA00010109](#)

21 [TRA00320116](#); [TRA00370046](#)

become dehydrated. This request was refused by the nurses, who said she already had a glass of water.²² Thereafter this witness took water into the VOLH for her mother. One relative was told by another patient that her mother had shouted for an hour and a half for a drink one night but no one had come to attend to her.²³ Another witness described patients shouting to be taken to the toilet and nurses not being able to assist as they were dealing with other patients.²⁴

One patient on ward F rang her bell to catch the attention of nurses because she was concerned about other patients in her bay who were incapable of calling for assistance themselves. She was told by staff to stop doing so.²⁵ This particular patient had been accustomed to having a wash before breakfast at home. Nursing staff were asked to attend to this, but apparently it was never done.²⁶

Some relatives did not witness a real difference in care when patients were diagnosed with CDI.²⁷

“And nobody came to us after she was diagnosed with *C. difficile* and said “She’s got this, we need to make changes in the way that we handle her.” Nothing. There was absolutely no difference in the care and no difference in what was expected from us”.²⁸ Relative

Unacceptable failures in care

Patients should be clean and well cared for by nursing staff. Relatives should not find patients with dirty fingernails. There is no excuse for this poor level of care. Cleanliness can be described as “fundamental care”: a basic level of care that is essential to patient physical and psychological wellbeing. The evidence of a lack of basic personal care raises issues regarding the overall quality of nursing care. The nursing care is considered in more detail in Chapter 12.

11.4 The patients’ and relatives’ view on staffing

Staffing numbers

Many relatives assumed that the nurses’ failures to render basic care was due to a shortage of nursing staff on the wards and because nurses were overworked. There was a belief that nursing staff were doing the best they could in difficult circumstances.

The position was described by one witness in the following way:

“I thought the staff were severely understaffed. If you look at ward F, it is quite a big ward. It was constantly filled at the time we were in, and most times we would see two staff nurses and two auxiliaries that were dealing with that full ward, which is why we think they only had kind of the time to be able to go round each of these patients and give them the medical care they needed, they did not have the time to do the personal care. I don’t think it’s that they neglected the patients or they didn’t want to do it, they physically were unable to give the patients the personal care they needed”.²⁹ Relative

Staff on ward 6 were described as “always on the move”³⁰ or “run off their feet”.³¹ One witness described nurses as “firefighting”.³²

One relative expressed the view that the nursing staff on ward 6 appeared to be young, inexperienced and not properly supervised. She said her mother had to remind them when she needed medication, inhalers or oxygen as they would forget that those tasks needed to be done. Instead of doing one thing at a time, it seemed that they were trying to do half a dozen things at once. This was how she described the position in evidence:

22 [TRA00070148](#)
 23 [TRA00030041](#)
 24 [TRA00030057](#)
 25 [TRA00070048](#)
 26 [TRA00070073-74](#)
 27 [TRA00050110](#)
 28 [TRA00020067](#)

29 [TRA00020073-74](#)
 30 [TRA00010049](#)
 31 [TRA00010029](#); [TRA00010109](#); [TRA00010147](#);
[TRA00030070](#); [TRA00040097](#)
 32 [TRA00050109](#)

“She had to, [her mother] actually, on one occasion, remind the staff that she needed a blood test before she could be released, and they had to be reminded. One thought the other had done it, and the other thought that the other nurse had done it, and nobody had done it at all...”³³ Relative

Another relative spent time with her mother outwith normal visiting times. Nursing staff told her they were grateful that she could come in and sit with her mother because they were so short staffed.

More than one witness described an elderly relative as not wishing to bother nursing staff because the nursing staff were too busy.

Being busy is not a legitimate excuse for the failures in basic care described by relatives. Staffing is also considered in Chapter 12.

Staff morale

Some witnesses formed some impression of staff morale, and thought staff morale was very low.³⁴ One witness said that the general opinion from the staff was that the VOLH was being run down and due to close.

One patient described staff morale in the following way:

“At times morale—I would say that morale was very low as well in the ward, or generally in the hospital, because of the uncertainty surrounding jobs and their future”.³⁵ Patient

by nurses and doctors, and witnesses who were able to obtain information only did so due to persistence. One witness said that information was never volunteered, and that if information was required it was necessary to go and ask.³⁶

The following two witness accounts in particular illustrate the general theme of a lack of communication:

“We were never ever told anything that was going on with my mum. We always had to go and ask things, like did my mum have a good night’s sleep? Did she eat her dinner? We never found out”.³⁷ Relative

“We felt that we were a pest to the staff, because every visit we would ask questions like “How’s she doing? Has she been to the toilet?” We would just ask questions, and although to the staff they were probably trivial questions that didn’t mean much, to us they were really important to know how she was doing, just in even everyday things. But we never felt as though the staff could actually sit down with us and say, “This is what’s happening, this is where we are with your mum. You actually felt as though you were intruding in kind of the system they’d set up when you actually went forward to ask about anything...”³⁸ Relative

One witness thought that the nurses had no time to speak to the relatives. Another witness said it was “rare”³⁹ to be able to pin a nurse down.

One relative resorted to reading her father’s records kept at the bottom of his bed in an attempt to obtain information about his condition, but the notes were taken away when the nurses became aware of this. Thereafter this relative had to go to the nurses’ staff room in order to attract the attention of nursing staff. Usually all she managed to obtain was a brief update. On one occasion the emergency team had been called overnight to attend her father, but the

11.5 Communication

General communication

There was a real concern expressed by the patient and relative group about a general lack of communication from nursing and medical staff.

Deficiencies in communication did not appear to be confined to any particular ward. Information was not readily provided

33 [TRA00070008-09](#)

34 [TRA00010070](#); [TRA00040100](#); [TRA00050109](#); [TRA00010081](#)

35 [TRA00040100](#)

36 [TRA00050061](#)

37 [TRA00020031-32](#)

38 [TRA00020074-75](#)

39 [TRA00040061](#)

family were not contacted by the hospital and advised of this development at that time.⁴⁰

There were also difficulties in obtaining information from medical staff. One witness said that on several occasions the family had asked to speak to a doctor. During the period of 18 months that the patient was in the VOLH they were unable to do so.⁴¹

One witness, whose mother was critically ill, made an appointment to see Dr Javed Akhter, a Locum Consultant Physician. He arrived for the meeting and waited for an hour, but Dr Akhter did not attend the appointment.⁴² Despite the best efforts of nursing staff and his secretary, Dr Akhter could not be found. Dr Akhter later told the witness that he had been on a ward round, although the witness had been told by the nurses that Dr Akhter had not been on that ward. Dr Akhter did later have a meeting with him.

From the evidence of relatives, it was apparent that there was a lack of proper discussion with them about decisions not to resuscitate and DNAR orders.

Importance of communication

Communication is an integral and important element of patient care. Poor communication reflects an attitude that presents a barrier to the provision of good and consistent care. Patients, and where appropriate relatives, have a right to be involved in decisions about care. This is enshrined in the guidance issued both by the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC).⁴³

There was difficulty obtaining information from nursing staff at evening visiting time because this coincided with shift changes when nurses were engaged in handover. There has to be communication between nursing staff during a shift change. Nonetheless, for many relatives visiting time will be the only time they are present with the opportunity of obtaining an update on a

patient's care and likely to seek information. It is important that arrangements are made for a member of staff to be available for family members seeking information.

Communication regarding CDI

There was a lack of communication about CDI. The tenor of the evidence was that CDI did not appear to be considered by nursing staff to be a significant risk. Some witnesses described being told that it was a "wee bug".⁴⁴

The following extract from the evidence of one witness is a typical example of the evidence on this subject:

"She never gave us any inclination of the dangers of *C. diff* or what to do or that it was life-threatening. *C. diff* didn't appeal to me at that time. I thought it was just a bug because she never explained to me what it was".⁴⁵

Relative

One witness asked a member of the nursing staff if CDI could be life-threatening, and was told that it could be, but that her father would be fine because he was on antibiotics.⁴⁶ He subsequently died. *Clostridium difficile* Enteritis is listed on his death certificate as the cause of death⁴⁷ and Professor George Griffin, an infectious diseases expert commissioned by the Inquiry, agreed with this conclusion.⁴⁸

Obtaining information from medical staff was difficult. One witness said that she was unable to speak to a doctor after her mother was diagnosed with CDI. She was given no indication of what the outcome could be or how the infection was being treated. She went on the internet to obtain information and was "horrified"⁴⁹ when she learned what the infection could involve. When her mother's condition deteriorated she asked again to speak to a doctor. She was told that the consultant was too busy to speak to her and that there were no other doctors

40 [TRA00030162-163](#)

41 [TRA00040061](#)

42 [TRA00050088-89](#)

43 [INQ00270018-22](#); [INQ01970004-05](#)

44 [TRA00010122](#); [TRA00010123](#); [TRA00010152](#); [TRA00030025](#); [TRA00030141](#); [TRA00040027](#); [TRA00040038](#)

45 [TRA00020019](#)

46 [TRA00020097-98](#)

47 SPFO0020001

48 EXP02590006

49 [TRA00010130](#)

available. Eventually she spoke to a junior doctor, who asked her if she realised that her mother was dying because of the CDI.⁵⁰ She had not realised her mother was dying and described the doctor as being “brutal” in telling her that her mother would not be resuscitated.⁵¹

Another witness asked to see a doctor after her father had been diagnosed with CDI, and was told that she would have to make an appointment. Even then she was told there was no guarantee that she would be able to see a doctor, as doctors were very busy and were not always available at visiting times.⁵²

A similar experience was described in the following way by another relative:

“they all just said he had an infection. Nobody told us what infection he had, and he was always just going for a scan or just going for this. On several occasions I asked to speak to a doctor, and on not one occasion in the whole time, in the whole period he’d been in and out of the Vale, did I ever get to speak to a doctor...There was never anybody available. And the nurses were so busy that it was very rare you could pin a nurse down to speak to a nurse either”.⁵³ Relative

This particular patient had been an inpatient on a number of occasions over a period of about 18 months.

Other witnesses described not being aware that their relatives had CDI until their relative had died. One witness said he was unaware that his mother had been diagnosed with CDI until he saw *C. difficile* on the death certificate. Another witness only found out that her father had been diagnosed with CDI when the police contacted her six months after her father’s death.⁵⁴ Another witness had a similar experience, only becoming aware that his mother had suffered from CDI at the time of the police investigation in

2009.⁵⁵ His mother had tested positive for CDI on two occasions on ward F⁵⁶ in January and February 2008. One witness was not told at VOLH that her father had CDI and it was only when he was transferred to the Royal Alexandra Hospital (RAH) that she discovered that he had the infection.⁵⁷

The lack of information provided on CDI by nursing staff was unacceptable. It is important that, where appropriate, relatives are aware of the diagnosis of CDI and also the implications of the diagnosis. This enables relatives to co-operate with staff in implementing infection control measures.

Information leaflets about CDI

Many family members were not given information leaflets about CDI after a relative was diagnosed with the infection.⁵⁸ In instances where a leaflet was provided no additional explanation was given,⁵⁹ although in ward 14 a witness did receive a leaflet and also a full explanation from the nurse.⁶⁰

One witness explained that she was not given an information leaflet when her mother was in ward F. Her sister asked for a leaflet and was told there was no leaflet available,⁶¹ although later that day she was given one. Her point was that she had to ask for it rather than it being handed to her as a matter of course.

Relatives of patients suffering from CDI should be provided with an understanding of the nature of CDI, particularly if they need to manage a patient’s laundry. A proper understanding can be helpful in the enforcement of infection prevention and control precautions. Leaflets can be useful in reinforcing information but should not be used as a substitute for discussion.

50 [TRA00010132](#)
51 [TRA00010137](#)
52 [TRA00040038-39](#)
53 [TRA00040061-62](#)
54 [TRA00040052](#)

55 [WTS00410004](#)
56 [GGC00260020](#); [GGC27230014](#)
57 [TRA00050040-42](#)
58 [TRA00010037](#); [TRA00020033](#); [TRA00030123](#);
[TRA00040044](#); [TRA00050054-55](#); [TRA00050144](#);
[TRA00070003](#)
59 [TRA00050112](#); [TRA00030022-23](#)
60 [TRA00050085-86](#)
61 [TRA00070138](#)

11.6 Ward fabric and cleanliness

A poor hospital environment

The patient and relative group painted a picture of a hospital that was run down. As discussed below, there was also evidence that the hospital environment was not particularly clean. Many witnesses were local people who had experience of the hospital over many years and who noted a significant change in its state. Witnesses who had been familiar with the hospital from years previously were shocked at its state.⁶²

One witness who had personal experience of working in hospitals expressed the following opinion:

“Well, I just feel from my own experience of working in hospitals, you know, I’m going back 25, 30 years ago, when we used to have matrons and hospitals smelt of hospitals, everything sort of smelt of disinfectant and everything was always being cleaned and we were meticulous about hygiene, and in the Vale I didn’t ever really see any evidence of that. Even there was plaster falling off the walls, the buildings weren’t maintained properly. ...there was always a stench of urine and/or faeces and nothing ever looked particularly clean. There was never any time where every holder for hand gel had actually hand gel in it”.⁶³ Relative

Another witness presented the following picture:

“I don’t personally believe that the hospital was filthy or dirty. I believe that it was run-down, and the fabric of the building was quite shabby, which obviously gave it a generally unkempt look, but for something to be aged and dated doesn’t necessarily mean it’s dirty. So my personal feelings were that there was nothing I thought in the hospital that looked really, really dirty”.⁶⁴ Relative

It must be borne in mind that the evidence on this issue was provided by witnesses who were only on the premises at visiting times, although some witnesses were present for

lengthy periods, usually when a patient was nearing death.

One relative who was retired and did spend more time at the hospital provided this description:

“During the day when I was there, cleaners would be about. To me, it seemed very hit and miss. They’d come along and do a bit of mopping. They never seemed to move anything. They just basically cleaned what they saw. There was never any effort to clean above head height. The curtains didn’t look very clean, the windows were not very clean”.⁶⁵ Relative

The outward appearance of the hospital was described as poor, tired looking and in need of repair and decoration. There was a general feeling that the hospital was being “run down”.⁶⁶

The fixtures and fittings in ward 6 were described as old. There were chipped tiles, odd tiles missing, and sections of missing plasterboard. The window blinds in one patient’s room in ward 6 had slats missing. The effect of this was that people in the corridor could see directly into the patient’s room. The family did ask if they could be replaced, but they were told that money would not be available for that to be done. The nursing staff cut up a laundry bag and placed that over the slats to give the patient some privacy when getting dressed. The laundry bag remained there even after there had been a deep clean of the ward.⁶⁷

One patient summarised his view of the facilities in the following manner:

“The cabinets were probably the original cabinets since the place was built; the seating, I would say, was the original seating since the place was built; it was very old furniture; the commodes, as I say, were ancient; the windows were held open by a book because the mechanism wasn’t working properly in most of the windows”.⁶⁸ Patient

⁶² [TRA00010105](#); [TRA00010144](#);

⁶³ [TRA00040059-60](#)

⁶⁴ [TRA00020077](#)

⁶⁵ [TRA00050147](#)

⁶⁶ [TRA00010144](#); [TRA00010153](#); [TRA00020077](#);
[TRA00040141](#); [TRA00050106](#); [TRA00050147](#)

⁶⁷ [TRA00010063-64](#)

⁶⁸ [TRA00080025](#)

Another witness had a professional career working in building maintenance. He formed the impression that there had been a lack of funds spent on the fabric of the building, and described it as “really tired looking”.⁶⁹ He indicated that he could put his finger through the window frame in the isolation room.⁷⁰ He was shocked at the state of cleanliness, and described the cleaner washing a path down the middle of the corridor with no tables or chairs moved to enable the edges of the areas to be cleaned properly.

The television remote control in an isolation room in ward 3, where a patient suffering with CDI was being accommodated, was observed to be “really dirty round the buttons”⁷¹ with “particles of whatever people had on their fingers from all the times it had been used in previous months and years”.⁷²

There was one incident where a visiting relative lost a false nail in the ward. Two days later, when visiting her mother, she found the false nail on the floor beside the bed where she had previously been sitting.⁷³ Another witness described a sweet wrapper lying under her mother’s bed for a couple of days.⁷⁴

One witness described putting items back in her mother’s bedside cabinet and finding a yogurt tub and a small tub that contained mould.⁷⁵

One witness described seeing urine on the floor of ward 14. She said that the floor had been wiped but not cleaned and she could smell urine. She brought this to the attention of nursing staff, indicating that it still had not been cleaned. She described the “stench”⁷⁶ on the ward as “disgusting”.⁷⁷

Storage

Various items were stored within patient bays. One witness described boxes stored

opposite her mother’s bed in ward 6, piled up beside a fire escape. She said that when her mother was in isolation in ward 3 the room had boxes stacked up on either side.⁷⁸ The casing on the overhead light was also broken.⁷⁹

Another witness described an old Christmas tree and other items stored in the same area in ward 6. Her mother told her that she had difficulty getting to sleep due to the constant traffic of people obtaining supplies stored in the bay where she was being accommodated.⁸⁰ Jackets and bags belonging to staff were seen to be left in the TV room of ward 6.

Personal hygiene

Some witnesses provided descriptions of faeces on clothing. One witness described her father’s slippers as being badly soiled.⁸¹ They were washed under the shower and then placed on the radiator to dry. Her father also tried to get up at 06:00 every morning to have a shower when the shower was clean, because as the day went on he had a concern about the condition of the shower.⁸²

Another witness complained of dirty commodes.⁸³ This witness also recalled going into her mother’s room and finding her mother’s slippers covered in faeces. There were also faeces on the cord of her mother’s dressing gown. The slippers were on the floor and the dressing gown was lying across the bottom of the bed.

One patient provided a rather graphic picture of the shower area in one of the wards:

“...the shower cubicle, it was black. The mould on the floor, it was coming away from the walls. The shower tray, it was like lino type of material, and that was all loose around the edge. The walls were dirty. As I say, the toilet—I cleaned it every time before I used it and after I used it”.⁸⁴

Patient

69 [TRA00050106](#)

70 [TRA00050106](#)

71 [TRA00030175](#)

72 [TRA00030175](#)

73 [TRA00030066](#)

74 [TRA00070111](#)

75 [TRA00020023](#)

76 [TRA00040031](#)

77 [TRA00040031](#)

78 [TRA00010143](#)

79 [TRA00010143](#)

80 [TRA00010024-25](#)

81 [TRA00030165](#)

82 [TRA00030170-171](#)

83 [TRA00010028](#)

84 [TRA00040092](#)

The importance of the environment

The fabric and cleanliness of a hospital are important to patients and visitors. If a hospital is clean and well maintained⁸⁵ it will be seen as a safe environment. Visible cleanliness is also important from a psychological point of view for both patients and visitors. The fact that a patient thought it necessary to get up early to experience the benefit of a clean shower environment is a feature of unacceptable care.

11.7 Infection prevention and control issues

Hand hygiene

There was some variation in the evidence on hand washing, but it was clear that inadequate information was generally given on hand washing. This was a trend in a number of the wards.

Most witnesses were aware of the need to use hand gels when entering a ward. Some spoke of the presence of notices at entrances to wards advising on the use of hand gels. Some witnesses also spoke of visitors choosing to ignore the instruction to use hand gels when visiting the wards.⁸⁶

There was some evidence that the hand gel dispensers were left empty even when this was brought to the attention of nursing staff. Gel dispensers on each side of the door to ward F, just inside the ward, remained empty for three consecutive days despite relatives making several reports to nursing staff during that period.⁸⁷ There was no evidence that this was a widespread problem that existed in other wards.

There was a lack of information from staff to visitors that hand gels were not always effective. Many were not advised of the importance of the use of soap and water when a patient was diagnosed with CDI,⁸⁸ and

some witnesses did not realise that gels were ineffective against *C. difficile*.⁸⁹ One relative was specifically told to use hand gels when her father was diagnosed with CDI.⁹⁰

It can be difficult to ensure that all visitors will use the hand gels on entering a ward. It is, however, important to take steps to encourage their use, and to ensure that the dispensers are regularly filled.

Laundry

Heavily soiled laundry was being taken home by relatives of patients suffering from CDI. Few witnesses appeared to have been given clear instructions on how to deal with such laundry.⁹¹ Different and conflicting instructions were given in different wards.⁹² A number of relatives believed that in taking soiled laundry home they had exposed themselves and other members of their family to an unacceptable risk of infection.⁹³

There was a lack of consistency about the bags to be used to give relatives soiled laundry. Some witnesses were given soiled laundry in a black bin bag.⁹⁴ One relative said that her mother's laundry was always in a white bag with red writing on it saying "Patient's Clothing" even when the laundry was soiled with diarrhoea.⁹⁵ One witness described her father's laundry being left in his locker in a white plastic bag.⁹⁶ Another described a patient's clothing bag and a carrier bag being used.⁹⁷

One witness said that he could smell the soiled laundry when he went into his mother's room and that the bag would either be at the side of the bed or on the floor beside the radiator, which worsened the

85 [WTS00200002](#); [WTS00510015](#)
 86 [TRA00010142](#); [TRA00030105](#); [TRA00050076](#)
 87 [TRA00070026](#)
 88 [TRA00020019](#); [TRA00020067](#); [TRA00020099](#); [TRA00020150](#); [TRA00030027](#); [TRA00030033](#); [TRA00030146](#); [TRA00040012](#); [TRA00040024](#); [TRA00050052](#); [TRA00050086](#); [TRA00060120](#); [TRA00070106](#); [TRA00070139-140](#); [TRA00070179](#)

89 [TRA00010052](#); [TRA00070144](#)
 90 [TRA00040024](#)
 91 [WTS00020007](#); [WTS00030006](#); [WTS00050006-08](#); [WTS00230011](#); [WTS00290009](#); [WTS00390012](#); [WTS00590007](#); [WTS00600005](#); [WTS00630013](#); [WTS00500010](#)
 92 [TRA00010061](#); [TRA00020029](#); [TRA00020055-56](#); [TRA00020102](#); [TRA00020145-146](#); [TRA00030034-35](#); [TRA00030164-166](#); [TRA00040033-34](#); [TRA00050103-105](#); [TRA00070008](#); [TRA00070183-184](#)
 93 [TRA00070105](#); [TRA00030129-130](#); [TRA00030111-115](#)
 94 [TRA00020102](#)
 95 [TRA00020034-35](#)
 96 [TRA00030166](#)
 97 [TRA00070184](#)

smell.⁹⁸ He was given white bags and also red bags. He was told to put the red bag into the washing machine and that it would dissolve. Another witness described putting the soiled laundry bag into the boot of the car and driving home with the car windows open because of the stench from the soiled laundry.⁹⁹

A number of witnesses steeped the soiled laundry.¹⁰⁰ Others washed it separately from the family wash and some put it through a boil wash.¹⁰¹ One witness described putting the dirty laundry in the bath to “dissolve the diarrhoea”¹⁰² before she put it into her washing machine.

The following description was provided by one witness:

“...on one particular day I picked up my mum’s laundry to take it home and I could smell something from the bag, it was quite strong and it was diarrhoea, it was all over her clothes. I got it home and I was actually going to throw the clothes in the bin because they were that bad, but I decided to rinse off the diarrhoea and put them into the washing machine...”¹⁰³

Relative

Another relative who was given no instructions on how to deal with contaminated laundry provided the following description:

“...the laundry by this time was getting steadily worse. I mean, beyond belief. I wouldn’t like to wish this on anyone. It was like going back to having a baby. I had to purchase a separate bucket. I had to scrape it off, rinse it out, and nothing removed these stains. I purchased Napisan, which is what I used to do when I had my children years ago, which is a nappy steriliser, mixed it up in the bucket, put the laundry in there, left it overnight, and then had to boil wash it. And sometimes even that was not enough to

remove these stains, it was such a disgusting mess. And on occasions I eventually had to throw the laundry out”.¹⁰⁴

Relative

On one occasion one of the nurses said to this witness as she was leaving the ward that she should put red laundry bags straight into her washing machine as there was a special bacterial agent in it.¹⁰⁵ The witness was referring to the red alginate bags which should not have been given to relatives to take home as they were designed to dissolve at high temperatures in industrial machines. The witness was unaware of that, and when she opened the machine at the end of the wash she could not find the bag and was concerned that it was stuck in the filter of the machine. When she discussed the incident with nurses she was surprised that the nursing staff did not seem to be aware of how to treat contaminated laundry.¹⁰⁶

Letter of complaint on laundry

A letter of complaint dated 24 January 2008 to the VOLH Divisional Services Manager reflects a number of the issues raised in evidence by witnesses about laundry. The patient concerned tested positive for CDI in January 2008. The letter set out how different family members were given differing advice on laundry while the patient was in ward F and expressed concern over “the lack of information and guidance offered by the staff”.¹⁰⁷ It concluded by asking the hospital to be “transparent about situations such as this in the future.”¹⁰⁸

The response by Ms Anne Harkness, Director of Rehabilitation and Assessment, asserted that:

“staff have been reminded of the importance of providing clear and accurate guidance to relatives with respect to the laundering of clothing”.¹⁰⁹

98 [TRA00050103](#)
99 [TRA00030166](#)
100 [TRA00030034-35](#)
101 [WTS00420005](#)
102 [TRA00020035](#)
103 [TRA00020027-28](#)

104 [TRA00030111-112](#)
105 [TRA00030113](#)
106 [TRA00030114](#)
107 [GGC23530001](#)
108 [GGC23530002](#)
109 [GGC23540001](#)

Despite that assurance, no instructions on how to deal with the laundry were given to the family members of several patients who tested positive for *C. difficile* in ward F between 4 February 2008 and 1 June 2008.¹¹⁰

Dealing with soiled laundry was an unpleasant and distressing experience for relatives.

Wearing of gloves and aprons

There was inconsistent advice given to relatives on whether they should wear gloves and aprons when visiting patients with CDI. Some relatives were asked to do so,¹¹¹ but most were not.¹¹² Initially members of one family were told to wear gloves and aprons when their father was isolated. Later they were told they did not need to do so. Later still they were told to wear gloves but not aprons.¹¹³

Most witnesses said that the nursing staff did wear aprons and gloves when dealing with patients, although many did not witness the patient being cleaned or changed. One witness was able to contrast the staff at the VOLH with the staff at the RAH, having noted that some of the nurses in the VOLH did not wear plastic aprons or gloves as the nurses at RAH did.¹¹⁴

One witness was aware that nursing staff did not wear gloves and aprons at a time when her mother was being barrier nursed,¹¹⁵ although generally the evidence suggested that nursing staff did wear aprons and gloves when dealing with patients suffering from CDI. The evidence of relatives is limited by the fact that they were not often present when patients were being changed or washed.

Isolation of patients/notices

There was evidence from relatives that patients with CDI were not moved into single rooms as soon as they suffered from diarrhoea. Patients were only moved after the diagnosis was confirmed. This evidence is fully supported by analysis of the patient records, and was a practice accepted by the nursing staff who gave oral evidence. Isolation practices are discussed further in Chapter 15.

A number of witnesses did not recall seeing a notice outside their relative's isolation room advising visitors to speak to nursing staff prior to entering the room.¹¹⁶ One witness, who was a qualified nurse, recalled his mother being in an isolation room prior to her death. He assumed it was for terminal care¹¹⁷ but subsequently learned she had CDI. He was not aware of any sign outside the room.

Even when patients were in isolation, strict isolation procedures were not always followed.¹¹⁸ Doors of isolation rooms were left open,¹¹⁹ and at least one area used for isolation did not have a door.¹²⁰

One witness recalled a cleaner coming into her father's isolation room when family members were present. The cleaner mopped the floor and then moved to clean outside on the general ward. She did not see the cleaner change the water.¹²¹

Another witness described the tea lady coming in and out of the isolation room at a time when her relative was diagnosed with CDI.¹²²

Movement of patients

Patients were moved frequently within wards¹²³ and also between wards.¹²⁴ Some relatives were not given information as to

110 [TRA00030035](#); [WTS01460008](#); [WTS00410005](#); [WTS00610006](#)

111 [TRA00020133-134](#); [TRA00020145](#); [TRA00030095](#); [TRA00010020-21](#); [TRA00010042-43](#); [TRA00020099](#)

112 [TRA00040062](#); [TRA00040141](#); [TRA00030026](#); [TRA00030144](#)

113 [WTS00050006](#); [TRA00020098-101](#)

114 [TRA00010141](#)

115 [TRA00020017](#); [TRA00020022](#); [TRA00020036](#); [TRA00020076](#)

116 [TRA00010041](#); [TRA00030104-105](#); [TRA00030175-176](#); [TRA00040041](#); [TRA00040148](#); [TRA00050064](#); [TRA00070178](#); [TRA00080023](#) [TRA00050095](#)

117 [TRA00070178](#)

118 [TRA00030103-105](#); [TRA00010143](#)

119 [TRA00070178](#); [TRA00080034](#)

120 [TRA00010086](#); [TRA00290033](#)

121 [TRA00040028-29](#)

122 [TRA00020109](#)

123 [TRA00010008-13](#); [TRA00010116](#); [TRA00030080-83](#); [TRA00030144-145](#); [TRA00060037-38](#);

[TRA00060128-131](#)

124 [TRA00010116-117](#)

why the patient was moved.¹²⁵ To determine from the medical records when patients were moved between wards has been difficult, as reasons for the move are often not apparent on reading the patient records.

Witnesses recalled patients wandering about freely. More than one witness mentioned a particular patient who was allowed to wander around the ward and who would go in and out of patients' rooms and sit at the nurses' station.¹²⁶ There was another patient who got into bed with other patients and wore their clothes.¹²⁷ One witness did raise with the nurses the fact that this patient was allowed to wander in the ward despite having CDI,¹²⁸ but the nurses' response was that they could not contain her.¹²⁹

Patients were placed in rooms where one or more patients had CDI. One witness recalled her father having diarrhoea and being moved into a room on his own. Later on in the day another patient was moved into the room. The patient had been admitted to the hospital with chest pains. There was no suggestion that he was suffering from CDI, but there was nowhere else to put him.¹³⁰ Two patients were moved into a four-bedded bay where there were other symptomatic patients.¹³¹ The location of patients suffering from CDI is revisited in Chapter 15.

One family did raise the issue of CDI on ward F in February 2008. Their mother had been transferred from another hospital to ward F, and she was placed in what was at the time a four-bedded bay. The family complaint was that she had been transferred into a bay where there were other patients who were suffering from CDI when she herself was not symptomatic.¹³² The placement of an asymptomatic patient into a bay where there was at least one symptomatic patient was a serious failure in care placing the patient at unacceptable risk. This incident is considered more fully in Chapter 12.

The movement of patients within hospital settings may be necessary, and patients may need to be moved between wards, and to different beds within wards, but movement of patients is particularly relevant to issues of infection prevention and control. Where there is infection within a ward, or where a patient is infected and requires to be moved, this must be handled with care and by suitably experienced members of staff.

Bed spacing

There was criticism by some of the witnesses of the lack of space between patients' beds. It is to be noted that these witnesses have approached this from a lay perspective, and the issues they raised related more to access and privacy.

One patient who was admitted to ward 6 said that the beds were so close together patients could touch each other.¹³³ There was no room for a seat between the beds for visitors.

Another witness said that it was not possible to place a plastic bucket type chair between the beds in ward 6. The beds were so close together that her mother could have held hands with the patient in the next bed.¹³⁴ She also described a time when her mother was moved to ward 4 and a patient in the next bed to her mother had died. She said that the bed spacing and the curtain arrangement allowed her to see the covered body of the deceased patient in the next bed. Her mother was also able to see this and found it very distressing.¹³⁵

There was evidence from one witness about the difficulties she encountered in preparing her father for bed in a bay in ward 15 because the beds in that bay were so close together.¹³⁶

There also appeared to be bed space issues in ward 3. One relative explained that in ward 3, where her father was a patient, the spacing between beds was so tight that people moving between the two beds pulled out his oxygen without realising that had

125 [TRA00010110](#); [TRA00010163-164](#); [TRA00010125](#); [TRA00060038](#); [TRA00060130](#)

126 [TRA00040032-33](#); [TRA00050010](#)

127 [TRA00020064-65](#); [TRA00020029-30](#); [TRA00030063](#)

128 [TRA00070072](#)

129 [TRA00410168](#)

130 [TRA00030142](#)

131 [TRA00020072](#); [TRA00070021](#); [TRA00070043-46](#)

132 [TRA00070087-88](#)

133 [TRA00020120](#)

134 [TRA00010014](#)

135 [TRA00010058](#)

136 [TRA00040034-35](#)

happened.¹³⁷ This meant that he could be without oxygen for hours until he started to feel unwell and a nurse checked his oxygen level. This witness also said that she could place a small plastic chair in between the beds, but that her knees would be touching one bed with her back touching the other bed.¹³⁸

It is clear that in some areas of the hospital the beds were so close together that access and privacy were affected. If relatives had difficulty placing chairs between beds, it does raise an issue of how nursing staff would be able to use equipment in the area.

11.8 Conclusion

The patient and relative group wanted to have a public inquiry because they wished a full examination of why there were so many deaths in which CDI was implicated. This group also wished to understand how the CDI problem had gone unnoticed for such a significant period of time. From an analysis of the evidence of relatives the two main areas of concern were personal care of patients and communication from both nursing and medical staff.

Relatives described serious deficiencies in communication on the part of both nursing and medical staff at VOLH. Communication on aspects of CDI was poor.

Relatives did describe incidents which raised significant concerns about the quality of nursing care in a number of wards. The evidence of patients with faeces under fingernails is of particular concern. Patients are entitled to expect to be clean and cared for when they go into hospital. This is a fundamental aspect of care. Some of the events described by relatives confirm the serious deficiencies found on detailed examination of patient notes by the expert witnesses, many of which are considered in Chapter 12. There should be no acceptance of a culture of poor care. It is important that standards are set and that these standards are enforced.

11.9 Recommendations

Recommendation 10: Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where appropriate, relatives should also be involved.

Recommendation 11: Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.

Recommendation 12: Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.

¹³⁷ [TRA00030173](#)

¹³⁸ [TRA00030173-174](#)

Chapter 12

Nursing care

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Introduction

This Chapter of the Report examines the evidence on the nursing care provided to the patients with *C. difficile* infection (CDI) at the Vale of Leven Hospital (VOLH) during 2007 and 2008. There will be a particular emphasis on the focus period (1 December 2007 to 1 June 2008) but where patient records were available consideration is given to the early period (1 January 2007 to 30 November 2007).

12.1 The Nursing and Midwifery Council Code of Conduct

The Nursing and Midwifery Council

The Nursing and Midwifery Council (NMC) is the national regulator for nurses and midwives in the UK and is independent of Government. Its main statutory objective is to safeguard the health and wellbeing of members of the public using or needing the services of nurses and midwives.¹

The NMC monitors national education and training requirements and maintains a register of nurses, public health nurses and midwives in the UK. It sets standards for nurses and midwives for the provision of safe and appropriate care. It has the power to remove a nurse or midwife from the register and can also restrict the right to practise. It is important to emphasise that this is a UK-wide organisation.

The Nursing and Midwifery Council Code provisions

The Inquiry used the standard requirements set out in the NMC Code of Conduct (the NMC Code) in place from 2007 to May 2008² as a basic guide and benchmark. The NMC Code provides that nurses are personally accountable for their practice.³ The following provisions focus on particular aspects of care:

“1.4 You have a duty of care to your patients and clients, who are entitled to receive safe and competent care”.⁴

“3.1 All patients and clients have a right to receive information about their condition. You must be sensitive to their needs and respect the wishes of those who refuse or are unable to receive information about their condition. Information should be accurate, truthful and presented in such a way as to make it easily understood”.⁵

“4.4 Health care records are a tool of communication within the team. You must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. It should be consecutive, written with the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. It should provide clear evidence of the care planned, the decisions made, the care delivered and the information shared”.⁶

“6.1 You must keep your knowledge and skills up-to-date throughout your working life. In particular, you should take part regularly in learning activities that develop your competence and performance”.⁷

“6.5 You have a responsibility to deliver care based on current evidence, best practice and, where applicable, validated research when it is available”.⁸

“8.1 You must work with other members of the team to promote health care environments that are conducive to safe, therapeutic and ethical practice”.⁹

1 [EXP00640003](#)
2 [INQ01970001-09](#); [INQ00310001-07](#)
3 [INQ01970003](#)
4 [INQ01970004](#)

5 [INQ01970004](#)
6 [INQ01970006](#)
7 [INQ01970006](#)
8 [INQ01970007](#)
9 [INQ01970007](#)

Additional record keeping advice

In 2007 the NMC issued further advice for nurses on record keeping. The following extract highlights the importance of this:

“Record keeping is an integral part of nursing, midwifery and specialist community public health nursing practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.

Good record keeping helps to protect the welfare of patients/clients by promoting:

- high standards of clinical care
- continuity of care
- better communication and dissemination of information between members of the inter-professional health care team
- an accurate account of treatment and care planning and delivery
- the ability to identify risks and detect problems, such as changes in the patient/client’s condition at an early stage
- the concept of confidentiality”.¹⁰

The 2007 advice makes this further point:

“The quality of a registrant’s record keeping is a reflection of the standard of their professional practice. Good record keeping is a mark of a skilled and safe practitioner, while careless or incomplete record keeping often highlights wider problems with that individual’s practice”.¹¹

That advice also stresses the importance of auditing patient records.

Nurses’ view on compliance with the Nursing and Midwifery Council Code

The nurses who gave oral evidence at the Inquiry hearings accepted that they had a professional duty to comply with the NMC Code when providing nursing care to patients at the VOLH. Having reviewed patients’ records, they accepted that there had been

failures to comply with the NMC Code. This is developed in later Sections of this Chapter.

As the guidance provided to nurses emphasises, record keeping is an integral part of nursing practice. If widespread failures can be identified there can be little doubt that care has been compromised.

12.2 Use of nursing experts

Nursing experts

The Inquiry commissioned seven independent nursing experts to provide professional opinions on the quality of nursing care given to patients who suffered from CDI during the focus period. The nursing experts were not given access to the statements obtained from VOLH nursing staff, nor were they present during the evidence of nursing staff. The nursing expert opinion was based solely on their analysis of patient records. Sixty-three cases were distributed so as to ensure as far as possible that the nursing experts reviewed a cross-section of cases from different wards.

Quality of care in nursing is not simply a Scottish question, and the Inquiry was therefore anxious to have views from a number of different geographical perspectives. Of the experts who were commissioned, one is based in Scotland, two are based in Northern Ireland and the remaining experts are based in England. It was clear on meeting with the nursing experts that acceptable standards of nursing care did not differ in the different countries, which is not surprising because, as already mentioned, the NMC Code, which provides guidance on professional standards, applies UK-wide.¹²

Instructions given to nursing experts

The nursing experts were instructed to review the full patient records and Infection Control Cards of the patients allocated to them. To ensure consistency of approach and compliance with the Inquiry’s Terms of Reference they were provided with a template¹³ setting out areas to focus upon when reviewing the patient records. They

¹⁰ [INQ02090001](#)

¹¹ [INQ02090001](#)

¹² [INQ01970001](#)

¹³ [INQ05420001](#)

were asked to use the professional standards issued to each registrant by the NMC, and in particular the NMC Code, as a benchmark for the standard of care expected from nursing staff.

The nursing experts were instructed not to discuss their conclusions with each other during the preparation of their reports, so that they formed their own independent views of the nursing care. There was nevertheless a consistency in the views of the nursing experts on the nursing deficiencies identified. The nursing expert opinions are discussed in detail in the following specific Sections.

Use of patient records to audit patient care

Retrospective audit of patient records against pre-determined criteria is a recognised and accepted approach in the analysis of adverse events,¹⁴ and can help ensure quality of care.¹⁵ This was the approach adopted in the Northern Ireland *C. difficile* Public Inquiry.¹⁶

This kind of audit, particularly if it covers a number of weeks or months, allows the reviewer to form a view on the adequacy of the record keeping and the plan of care individualised to that patient. Valid inferences about the consistency and

quality of that patient's care can be drawn. Where a number of patient records are being reviewed, it may also be possible to make valid inferences about quality of care generally in a hospital.

The early CDI cases

To fulfil the Inquiry remit it was necessary to ascertain whether some of the themes identified by the nursing experts in the focus period were evident in the early period of 1 January to 30 November 2007.

As discussed in Chapter 4, 68 patients contracted CDI in the early period. Records for 37 patients were recovered from NHSGCC. The remaining patient records had been destroyed in accordance with NHSGCC's Records Management Policy. Nursing records were missing from four sets of patient records and they were therefore not considered. In addition to considering patient records in the focus period, one of the nursing experts, Mrs Lynne Phair, was instructed to review the remaining 33 sets of patient records.

The wards in which patients were accommodated during this early period are set out in Table 12.1:

Table 12.1 Early period CDI patients and wards

	Ward 3	Ward 4	Ward 5	Ward 6	Ward F	Ward 14	Ward 15	Total
Number of patients	3	1	5	9	5	6	4	33

¹⁴ [INQ05150001](#); [INQ05140001](#)

¹⁵ [INQ02090003](#)

¹⁶ [INQ04460067](#)

The standard applied to analysis of the early cases

The standard applied on review of the patient records in the early period was again that of proper nursing practice as outlined in the NMC Code.¹⁷ Mrs Phair was asked to focus on the management of CDI and prepared a report¹⁸ summarising her views.

The patient records of these early cases were also reviewed to establish whether key nursing documentation was in place and completed correctly. A judgement was made on the completeness of the nursing records using five descriptor codes designed to reflect the required standard of record keeping described in NMC guidelines.¹⁹

The infection control nursing expert

The Inquiry asked the infection control nursing expert, Mrs Christine Perry²⁰ to prepare a report reviewing some aspects of nursing care during the focus period. She advised the Inquiry primarily on infection control issues, but given her nursing experience she was in a position to provide valuable assistance in areas of general nursing practice.

Mrs Perry attended a number of meetings with the Inquiry Team and visited the VOLH. She had access to witness statements, evidence transcripts, patient records, documents and policies. She did not have access to the nursing expert reports on individual patients and was not asked to consider individual patient records or comment on individual patient care.

She addressed the following issues for the focus period:

- Staffing and management structures
- Infection control
- Hygiene/cleanliness
- Communication

This Chapter will consider the issues in her report relevant to the ward nurses.

Patient records used by experts – general comments

The difficulties in the recovery of documents have already been described in Chapter 2, and the nursing experts encountered significant problems working with the copy patient records provided by NHSGCC. In a number of cases the photocopying was poor. In some cases entries were illegible and information was cut off when photocopied. In a significant number of cases records were found to be missing. Some patient records were provided out of sequence. Some missing records were found. In some cases, however, it was clear that notes had been made but were missing from the patient records.

These factors, combined with poor recording of the care given, lack of signatures and poor documentation of transfer between wards, made the task of identifying a clear timeline of patient care and movement difficult. On occasions it was not possible to identify which member of the nursing team had completed documentation or cared for the patient because some entries were unsigned. The Inquiry Team spent a great deal of time cross-checking medical records with other documentation in attempting to establish a patient's history in the VOLH.

In addition, although the Inquiry focused on one relatively small hospital, the nursing documentation varied from ward to ward. There appeared to be material differences in the documentation used by the wards in the Acute Directorate, the wards in the Rehabilitation and Assessment Directorate (RAD), and Fruin ward. Staff used different pre-prepared charts and, where care planning was evident, different methods of care planning. Entries within the progress sheets also differed.

Many patients' records were voluminous. This, together with the lack of standardisation and structure and missing documentation, made the task of analysing the patient records particularly difficult.

¹⁷ [INQ01970001](#)

¹⁸ [EXP02790001](#)

¹⁹ [EXP02790003](#)

²⁰ [INQ03880001](#)

12.3 Overall view of nursing experts

Expert overview of the standard of nursing care in the focus period

This Section considers the view expressed by nursing experts generally on the nursing care given at VOLH. Specific aspects of care are addressed later in this Chapter. The view of the nursing experts, from their analysis of the patient records at the VOLH during the focus period (1 December 2007 to 1 June 2008), was that overall the standard of nursing care was poor.

General comments from nursing experts for the focus period

It is worthwhile highlighting some general comments made by the nursing experts following review of all their cases.

“My general impression when considering all ten reports that I have completed is that there was a lack of attention to detail. There clearly appears to be a lack of supervision and routine checking by both the registered nurses and ultimately the nurse in charge to ensure that the required standards were being met”.²¹

“Having reviewed ten individual cases as part of the Vale of Leven Hospital Inquiry, it is my expert opinion that the nursing care of these ten patients was poor overall and lamentable at worst... In conclusion, it is my expert opinion that these patients’ significant nursing needs were consistently not met by the nursing staff. Moreover, it is my expert opinion that patients were placed at considerable risk due to the poor standards of care given. Consequently it is my expert opinion that, on the basis of the evidence I have seen thus far, the evidence would appear to suggest that the Vale of Leven Hospital failed to ensure that care to these vulnerable people was delivered to an acceptable standard”.²²

“Overall, nurses failed to demonstrate by their recording that they had provided adequate nursing care. The outcomes of some nursing care were poor and in some areas there was evidence of neglect. Nurses did not adequately assess, plan, evaluate or monitor patients’ care to ensure that their care needs were fully met”.²³

“The nursing staff regularly failed to carry out care that it is reasonable to have expected them to do, and failed to take action to prevent adverse consequences occurring ... In conclusion it is the expert’s opinion that these patients’ nursing needs were neglected by the nursing staff; and the nurse in charge of the wards neglected his/her duty of care to ensure that care was delivered to an acceptable standard”.²⁴

Expert overview of the standard of nursing care in the early period

As mentioned earlier in this Chapter, Mrs Phair was asked to comment on the standard of nursing care at the VOLH of the 33 patients in the early period (1 January 2007 to 30 November 2007) for whom nursing records were available.

Mrs Phair concluded that the patient records reflected a pattern similar to that of the 12 cases she had reviewed from the focus period. The following extracts from her report summarise her conclusions:

“There was no set pattern or clear rationale why some patients had records and assessment undertaken and why others did not. It was not always possible to establish from the medical and nursing notes the progression of a condition. Sometimes the diagnosis of *C. difficile* was not mentioned at all... Care plans did not always reflect the complex needs of the patient and the impact the *C. difficile* would have on the person..... The complex nature of patients’ conditions and the impact of the *C. difficile* on their overall ability, and wellbeing or deterioration and distress, did not appear to be considered in a consistent or methodical manner”.²⁵

21 [EXP01030002](#)

22 [EXP01050004-05](#); [TRA00220087-88](#)

23 [EXP00720006](#); [TRA00280085](#)

24 [EXP00660003](#); [TRA00480057](#)

25 [EXP02790006](#)

“At no time did the records indicate that the nurses were assessing, monitoring or caring for the complications of *C. difficile* and review the risks such as the possibility of confusion, immobility, increased risk of pressure ulcers, possible abdominal pain and the general debilitating effects of *C. difficile*”.²⁶

“It is my professional opinion that the standard of nursing care and record keeping, for 79% of the patients in this audit fell below an acceptable standard”.²⁷

General response of the Senior Charge Nurses to expert evidence

In oral evidence the Senior Charge Nurses (SCNs) were asked to comment on the care given based on their review of the patient records and their own recollection of the patients. The SCNs had read the nursing expert comments on the patient care for their patients and they were aware of the individual criticisms. They did accept that there were deficiencies in note taking and in the preparation of care plans, but they insisted that proper patient care was given.

Overall view

It is clear from the analysis of the patient records that there were serious deficiencies evident not just in the focus period but also in the early period. Moreover, the deficiencies identified were not restricted to one particular ward or individual but were widespread. Some of the deficiencies identified were significant and were likely to affect patient care. The SCNs must accept some of the responsibility for the culture that prevailed at the time. Equally Nursing Management must bear responsibility. By “Nursing Management” the Inquiry means those managers with a professional accountability for nursing. Ultimately the NHSGCC Board also has a responsibility to ensure compliance with standards.

During oral evidence nurses did appear to change their position from that set out in their written statements. Prior to giving oral evidence no member of nursing staff

raised the issue of an inability to keep patient records. Yet in their oral evidence the position appeared to be that where there were deficiencies in record keeping this was due to pressure of work,²⁸ and that despite such deficiencies the care was given. The Inquiry does not accept that all the deficiencies in record keeping could be explained by pressure of work, and this is dealt with later in this Chapter.

It should also be noted that the deficiencies identified were not found in Fruin Ward, which was governed by a different directorate, although only two sets of records of patients nursed in that ward were examined.

12.4 Record keeping

The Nursing and Midwifery Council Code – the standard of record keeping

This Section considers record keeping by nurses against the backdrop of the requirements found in the NMC Code and NMC advice. As set out earlier in this Chapter, the NMC Code and associated advice provide a clear message on the importance of a high standard of record keeping in patient care.²⁹

Principles behind record keeping

The record of a patient’s stay in hospital is an essential clinical tool. Collectively, the patient record forms a permanent record of the patient’s condition and the treatment given. It should contain reasons for decisions made. Properly maintained patient records enable the nurse, or any member of the healthcare team, to reconstruct the essential parts of patient contact without reference to memory. Nursing is not a memory game.³⁰ The records should be sufficiently comprehensive to permit any member of the team caring for a patient to continue the care. Good record keeping assists with communication between members of the healthcare team. As the NMC Guidance stipulates, record keeping is an integral part of good patient care. Good record keeping protects patients and it is not

²⁶ EXP02790006

²⁷ EXP02790006

²⁸ TRA00370021; TRA00390043-44; TRA00410068-69; TRA00450023-24; TRA00460081-82

²⁹ INQ02090001

³⁰ TRA00250012

an optional extra. Mrs Catherine MacGillivray, Head of Nursing for the Clyde Acute Directorate in 2007 and 2008, provided this explanation in evidence:

“Well, I see that nursing documentation is very much part of nursing care. Nursing documentation is not an add-on to nursing care; it is part of it”.³¹

She went on to emphasise that nursing documentation was an aid to “good nursing care and it aids continuity of care”.³²

The format of patient records

The NMC does recognise that in the absence of national agreement on the format of nursing records there will be variations in style and format. It does, however, emphasise that whatever the format used, records must follow a logical and methodical sequence with clear milestones and goals. Nursing records should be kept in such a manner that any member of the healthcare team can be informed of a patient’s care and needs so as to be in a position to care for the patient.³³

Expert views – the focus period

All the nursing experts were critical of the standard of record keeping in the focus period. Professor Anthony Palmer concluded that in all ten cases he reviewed the nursing records were of poor professional quality and several patient records were wholly inadequate.³⁴ Of the 12 cases reviewed by Mrs Phair in the focus period, she considered two sets of patient records to represent satisfactory record keeping. The remaining ten sets of patient records were poor and inadequate.³⁵

Most of the patient records reviewed had nursing entries in the progress sheets, but often these did not relate to the care plan. There were cases where there were gaps in the daily progress notes. One nursing expert identified a case in which there was a gap of four days, and where the patient could not have been described as “stable with no ongoing issues or problems”.³⁶

The view of the ward nurses

The nurses who gave oral evidence to the Inquiry accepted that they did have a professional responsibility to maintain accurate patient records. One SCN explained the nurse’s responsibility in the following way:

“Every nurse has a responsibility to ensure that they maintain records of that standard, and it was my responsibility, as a supervisor and leader of the area, to ensure that was maintained”.³⁷

Nurses did not disagree with the view of the nursing experts that the record keeping was not of the standard required by the NMC Code and Guidance. The SCNs who gave evidence said that they had been surprised at the omissions in record keeping found when they reviewed the patient records.³⁸

One SCN accepted that it was her responsibility to look at documentation to confirm that it complied with the Guidance issued by the NMC.³⁹ She said that often she would look at patient records and talk to nurses if charts were not completed properly. She was disappointed to see that there were nursing documents that were not accurately completed.⁴⁰

This SCN did not accept that the record keeping on her ward was careless. She described it as “incomplete”.⁴¹ She maintained that it was necessary to look at the wider picture, by which she meant the activity levels on the ward, staffing levels and the type of patients on the ward.⁴² Other nurses also suggested activity levels as a reason why there were deficiencies in record keeping.⁴³

Another SCN provided the following evidence:

“I don’t think it (record keeping) became separate, but it was never seen by my staff as being as important as the care

31 [TRA00900157-158](#)

32 [TRA00900158](#)

33 [INQ02090001-02](#)

34 [EXP01050002](#)

35 [EXP00660001](#); [TRA00480053](#)

36 [EXP01030002](#); [TRA00350121](#)

37 [TRA00410050](#)

38 [TRA00400041](#)

39 [TRA00450005](#)

40 [TRA00450005-06](#)

41 [TRA00450024](#)

42 [TRA00450024](#)

43 [TRA00370021](#); [TRA00390043-44](#); [TRA00410068-69](#); [TRA00450023-24](#); [TRA00460081-82](#)

giving, being at the bedside. Despite many conversations—really, many conversations—about the real need to ensure that we did record problems, that we reviewed our interventions, I have to accept that there was an – an absence of record keeping. I just have to accept that and take responsibility for that”.⁴⁴

Although nurses generally appeared to accept that the standard of record keeping was poor, as already mentioned they did not accept that the appropriate patient care was not given. The mantra was that the care was given but was not recorded. This view expressed by one SCN was a typical response:

“Our record keeping was deficient in some instances...but I firmly believe that my nursing staff gave the very best of care within the Code of Conduct”.⁴⁵

This evidence was echoed by other SCNs.⁴⁶

Auditing

The NMC Guidance provides the following advice on auditing:

“Audit is one component of the risk-management process, the aim of which is the promotion of quality ... Audit can play a vital part in ensuring the quality of care being delivered to patients/clients”.⁴⁷

The Guidance adds that auditing of records can identify areas for staff training and development.

Mrs MacGillivray provided some evidence about how it was expected that patient records would be audited. She explained that there was a programme through which nurses from other sites, either the Royal Alexandra Hospital (RAH) or the Inverclyde Royal Hospital (IRH) went to the VOLH to conduct external audits.⁴⁸ She also said that audits were carried out by nurses within the VOLH,⁴⁹ but in fact there was no auditing carried out by the SCNs at the VOLH prior to April or May 2008.

44 [TRA00290024](#)
45 [TRA00310090](#)
46 [TRA00380029](#)
47 [INQ02090003](#)
48 [TRA00900073](#); [TRA00900156](#)
49 [TRA00900155-156](#)

Auditing at the VOLH

Ms Judy Taylor, Senior Nurse, Professional Practice,⁵⁰ was based at the VOLH for a number of years prior to June 2008.⁵¹ She explained that there had been a system of peer audits of patient records in place that involved nurses from a different ward looking at the patient records of another ward and testing the notes by reference to the NMC Guidelines.⁵² These audits did not look in any depth at the actual care given or whether care plans and other assessments were in place. No peer audits had been carried out since 2003⁵³ and Ms Taylor said that, although there was a reference in her statement to “periodically” carrying out “care planning sessions and audits of nursing documentation”,⁵⁴ she did not in fact think that any audits were done from 1 January 2007 to April or May 2008.⁵⁵ For most of 2006 she was not present at the VOLH as she was recovering from an accident, but on her return she did not see any audits for that period.⁵⁶ There was no cover for some aspects of her work when she was off work.

Audits in April or May 2008

There was an audit carried out in the VOLH in April or May 2008.⁵⁷ Ms Taylor took part in that audit, which was carried out over a period of about two weeks.⁵⁸ The patient records of 43 patients from a number of wards were examined and a number of issues raised in this Chapter were identified in that audit. An admission assessment on the risk of pressure damage (Waterlow Score) was only recorded in 33% of cases.⁵⁹ An Activities of Daily Living Assessment was completed for 70% of cases.⁶⁰ Deficiencies were evident in care planning.⁶¹ An admission nutritional score was recorded in only 33% of cases.⁶²

50 [TRA00910045](#)
51 [TRA00910046-48](#)
52 [TRA00910055-56](#)
53 [TRA00910056](#)
54 [WTS02130003](#)
55 [TRA00910058](#)
56 [TRA00910058-59](#)
57 [INQ03530001](#); [TRA00910087](#)
58 [TRA00910088](#)
59 [INQ03530002](#)
60 [INQ03530002](#)
61 [INQ03530002-03](#)
62 [INQ03530003](#);

Ms Taylor said that she would have produced an “Action Plan” following the audit.⁶³ The Inquiry has not seen this, and the handwritten Action Plan produced by her on the day she gave evidence on 29 February 2012, which included the instruction that “care planning sessions”⁶⁴ were to be provided, had only been written by Ms Taylor within the previous two months in an attempt to recall what had been done.⁶⁵ She thought that that would have formed part of the feedback she would have given at the time⁶⁶ but was unsure as to what did in fact happen.⁶⁷ Another audit was to be carried out in December 2008 but Ms Taylor had not seen any evidence of such an audit being carried out.⁶⁸ Ms Taylor would have expected the senior nursing staff to carry out spot checks from time to time to see how the nurses were performing in relation to record keeping.⁶⁹

It is to be noted that the notes of the Professional Nursing Forum Meeting held on 20 May 2008 record that an “external” audit of nursing notes had been completed at the VOLH.⁷⁰ There was no evidence of such an audit taking place and Ms Taylor was surprised at the suggestion in Mrs MacGillivray’s evidence⁷¹ that such an audit had taken place.⁷² Mrs MacGillivray was relying on the record of the meeting of 20 May 2008, but having regard to the timing of that entry it seems more likely that it was referring to the internal audit described by Ms Taylor.⁷³

Although auditing of patient records was part of the job descriptions of SCNs in charge of wards,⁷⁴ there was no evidence that such auditing occurred. Sister Lesley Fox, ward sister in ward F, explained her position in this way:

“I did no individual audit (of records) on the ward. I was never asked to do so, and it had never been requested of us, and we didn’t do audit. There was, from time to time, peer audit done, but there was very little audit at all at the time”.⁷⁵

Sister Fox went on to explain that by “very little” she really meant “none at all”.⁷⁶

Some SCNs did, however, complete patient records themselves and were involved in the preparation of inadequate assessments and care plans. Given these factors, and the extent of the problem, it does seem surprising that the SCNs had not identified the inadequacies in record keeping.

The Inquiry had no evidence on the position on auditing in Fruin ward.

Examination of records in the early period

Of the 33 sets of patient records Mrs Phair reviewed in the early period, she only considered record keeping to be of a good standard in two cases. In 13 cases it was adequate. In 18 cases the standard of record keeping was considered to be poor or inadequate.⁷⁷

Conclusion on record keeping

The examination of the patient records in the VOLH disclosed poor record keeping in a number of wards over a lengthy period of time. A culture had developed in which record keeping was not considered to be a priority. This becomes even more evident later in this Chapter when certain aspects of care, for example care planning and patient assessments, are examined. One approach taken by nursing staff in oral evidence was that record keeping was not an integral component of patient care. They argued that with small wards they were fully aware of the needs of their individual patients without having detailed and complete patient records. This was a seriously flawed approach. As Mrs MacGillivray correctly observed, nursing documentation is very much part of nursing care. Isolated omissions would be perfectly

63 [TRA00910094](#); [TRA00910101](#)
64 [INQ03530004](#); [TRA00910097](#)
65 [TRA00910097-98](#); [TRA00910001](#)
66 [TRA00910098-99](#)
67 [TRA00910100](#)
68 [TRA00910101](#)
69 [TRA00910110](#)
70 [GGC08600014](#)
71 [TRA00900157](#)
72 [TRA00910060](#); [TRA00910060-61](#)
73 [TRA00930052-55](#)
74 [INQ01160001](#)

75 [TRA00290028](#)
76 [TRA00290028](#)
77 [EXP02790004](#); [EXP02790009](#)

understandable in busy wards, but that was not the position in the VOLH. The failures in record keeping discussed in this Section and later in this Chapter were widespread across wards. They were significant and must have contributed to failures in patient care.

SCNs in the VOLH failed to identify poor record keeping on their wards. The absence of a functioning system of audit is not an excuse for this failure, although a functioning system of audit would have assisted in the identification of the deficiencies apparent and such a system should have been in place. Nonetheless, given the extent of the deficiencies identified, the SCNs should have identified these deficiencies and responded to them.

A lack of a proactive approach by Nursing Management contributed to the culture of poor record keeping. The NHSGGC Board has to accept ultimate responsibility for the failures identified in this Section, given its duty to ensure compliance with standards.

12.5 Nursing aspects of infection prevention and control

Nurses' frontline role

It is nurses who plan and deliver the most direct and personal care. To deliver care to an acceptable standard for patients with CDI, nurses must have the relevant knowledge and skills. They have a crucial role in recording information that can assist in the diagnosis, treatment and management of CDI patients. This Section examines nursing involvement in certain aspects of infection prevention and control relevant to patients who contracted CDI.

Information ward nurses should have known about CDI

Nurses on the wards would normally have a different level of knowledge and training from that of the Infection Control Nurses (ICNs). One of the nursing experts commissioned by the Inquiry, Ms Annette Jeanes,⁷⁸ said that she would expect the nurses on the ward to know the following facts:

- *C. difficile* has been the cause of death in a number of outbreaks of infection
- Elderly patients and patients on antibiotics are more at risk than others of developing *C. difficile*
- The principal characteristics of *C. difficile* are persistent foul smelling diarrhoea, possibly a raised temperature, abdominal pain or discomfort
- Symptoms of deterioration include severe abdominal pain, rectal bleeding, dehydration and weight loss
- Rapid identification and treatment are important and early isolation into a single room can prevent the transmission of the infection to other patients
- Hand hygiene is important in the control and prevention of spread of infection
- Cleanliness including careful and regular cleaning are important in the control and spread of infection, particularly the cleaning of toilets and commodes which may become heavily contaminated

Role of the ward nurse in management of the patient with CDI

Mrs Jeanes set out a number of aspects of patient management for the ward nurse in the management of a patient with the diagnosis of CDI:

- Careful documentation of diarrhoea/bowel movements to monitor for improvement or deterioration
- Careful monitoring of liquid and food intake to ensure that the patient is nourished and hydrated
- Careful monitoring of pain and discomfort to ensure that *C. difficile* infection is not progressing to a serious complication
- Attention to the hygiene needs of the patient and in particular to ensure that diarrhoea is cleaned away rapidly and the sacral skin is protected
- Isolation of the patient and the adoption of infection control precautions to protect others in the ward from infection

78 [EXP00680014](#); [TRA00100075-76](#)

- Careful discussion with relatives to inform them of the patient's condition and to protect them from acquisition of the infection
- Careful liaison with medical and other staff to ensure that nothing is done to exacerbate the condition, e.g. the prescription of antibiotics or laxatives
- Regular liaison with infection control to ensure that all that can be done is in place, particularly to prevent further transmission of the infection⁷⁹

Policy provisions

The *C. difficile* Policy in the Infection Control Manual⁸⁰ was available for use by the nurses on the ward. It provides a detailed summary of the symptoms of CDI and identifies those persons most at risk,⁸¹ although it does not make clear what signs and symptoms would indicate deterioration in the patient's clinical condition and when concerns should be raised.⁸² It explains what precautions are to be taken but does not offer any guidance on specific nursing care.⁸³ It does identify the need to inform the patient and next-of-kin of the condition.⁸⁴

Evidence of nurses on knowledge of CDI

In evidence some of the nurses said that they considered CDI to be a serious illness. One Deputy SCN provided this explanation in her extended witness statement:

"It was always taken seriously but I would say we have learnt a lot since then – I think we have learnt how serious the consequences can be. We were always aware that, I mean it wouldn't change our practice, we have changed the ways we speak to the families about it and I would say maybe the info we give out would be different as well".⁸⁵

Two nurses did accept, however, that they were not aware of the significance of the infection. A Staff Nurse told the Inquiry:

"I wasn't aware it was as serious as it was. I am now, but wasn't at that time. I didn't know surgical intervention was part of the management".⁸⁶

Another Deputy SCN said in her witness statement:

"I would tell patients or families that the patient had an infection in his or her stomach, possibly related to antibiotic usage. At the time I was not aware of how serious *C. diff* can be".⁸⁷

These statements are consistent with the evidence of relatives, who gained the impression that nursing staff did not appear to consider that CDI was a major illness. It was described to some relatives by nursing staff as "a wee bug".⁸⁸

Training of staff

Prior to June 2008 the majority of nursing staff at the VOLH had no formal training on CDI. Even if such training might not have enhanced a nurse's state of knowledge, it would have reinforced awareness of the seriousness of CDI. Some attempt to raise awareness had been made, for example in April 2007 there was a "Bug of the Month" newsletter circulated by the Infection Control Service in Clyde giving information to staff on CDI. This explained that the condition could be fatal,⁸⁹ and under the heading "PREVENTION" it emphasised the importance of isolating patients with *C. difficile* diarrhoea and good infection control practices.

Some VOLH staff had completed the Cleanliness Champion Programme, which is described in greater detail in Chapter 15, but the uptake was poor. Across the wards of interest to the Inquiry, there were 96 nursing staff. Of those, 12 nurses, including four SCNs and five Deputy SCNs, had completed the Cleanliness Champions Programme prior to 1 June 2008.

79 [EXP00680014-15](#)

80 [GGC00780252](#)

81 [GGC00780253](#)

82 [GGC00780252-257](#)

83 [EXP00680015](#)

84 [GGC00780255](#)

85 [WTS02250037](#)

86 [WTS02190007](#)

87 [WTS01080012](#)

88 [TRA00010122](#); [TRA00010123](#); [TRA00010152](#); [TRA00030025](#); [TRA00030141](#); [TRA00040027](#); [TRA00040038](#)

89 [GGC17790003](#)

The view of the nursing experts on nursing care of CDI in the focus period

The nursing experts were critical of the nursing management of patients who had CDI. From review of the nursing records they considered that there was little to suggest that the nurses were aware that CDI was a serious condition to be managed separately, and in addition to, other conditions.

In the case of one patient Mrs Phair concluded that the diagnosis and management of the CDI “appeared to be a side (almost irrelevant) issue for the nursing staff”.⁹⁰ In the case of another patient she said that the nursing care for CDI was non-existent and fell far below an acceptable standard.⁹¹

Nine patients suffering from CDI were said by Mrs Phair to have received poor or inadequate nursing care. Two patients did not appear to have received any nursing care for their infection. She concluded that overall the care was extremely poor. In her opinion:

“The distress and debilitating nature of *C. difficile* was not mentioned and did not appear to be considered by the nursing staff. When there were assessments and care plans they were extremely limited and focused on the rudimentary aspects of the medical care of *C. difficile*”.⁹²

Professor Palmer summarised his view in relation to the ten patients he reviewed in the following manner:

“Nine of these patients received poor or inadequate nursing care. One patient received care that I consider was reasonable, although not comprehensive. Invariably there was no clear nursing care plan or evidence of the nursing management plan aimed at managing the broader consequences and possible complications associated with a *C. difficile* infection. Indeed, it is my expert opinion that the care of the *C. difficile* infections appeared to be secondary and almost inconsequential to the ongoing identified

medical needs of each patient. Moreover, the serious nature of the infection does not appear to have been recognised throughout the vast majority of the nursing records”.⁹³

Mrs Jeanes’ conclusion was as follows:

“Overall the prevention and nursing management of the *C. difficile* infection in the cases reviewed was inadequate and did not protect patients from complications associated with the infection nor optimise recovery from the infection”.⁹⁴

Although laxatives are contraindicated for patients with CDI, there were cases where laxatives continued to be prescribed and administered to patients with diarrhoea and CDI. In half of the cases reviewed by Mrs Jeanes laxatives continued to be prescribed and administered when a patient had diarrhoea.⁹⁵ This was unacceptable care.

Mrs Jeanes also noted that the monitoring of pain and discomfort was variable and generally poor.⁹⁶ This could be explained by poor record keeping, but could also suggest a lack of knowledge on the part of the nurses.

Awareness of the number of patients on wards with CDI in the focus period

Nursing staff, with the possible exception of those in ward F, did not appear to have any awareness that there was a significantly higher than average number of patients with CDI in their wards. Some were shocked when the numbers were eventually discovered.⁹⁷

Ward F staff did appear to have some awareness of an increase in numbers of patients with CDI. One SCN explained:

“the figures (of *C. difficile*) that I had at the time were the highest I have ever had in ward F”.⁹⁸

90 EXP00080013; TRA00480057

91 EXP00370010; TRA00190065

92 EXP00660002; TRA00480056

93 EXP01050004; TRA00220086-88

94 EXP00680016; TRA00180060

95 EXP00680016; TRA00180063

96 EXP00680015; TRA00180058-59

97 WTS02190008; WTS02260025; WTS02300034

98 TRA00410127

She said she had a vague recollection of a member of staff suggesting to her that they had a higher incidence of CDI.⁹⁹

The evidence provided by one Staff Nurse was that she did consider at the time that there was a higher than average incidence of patients with CDI in ward F.¹⁰⁰ She thought there were four patients who were positive at the same time and said that the Infection Control Team were helpful in providing advice.¹⁰¹

A Deputy SCN in ward F said that she could vaguely recall talking at the desk with colleagues about how many patients there were with CDI.¹⁰² She explained her position in the following way:

“I would find it hard to believe that no-one in the ward noticed that we had a problem, from the ward sister to the auxiliary”.¹⁰³

One SCN said that she had many conversations with Infection Control and that they did not suggest to her there was an outbreak.¹⁰⁴ She provided this explanation in her oral evidence:

“I wasn’t aware that it was a particular problem. I was concerned. We would- -yes. I was very concerned when- -when I was in discussion with infection control, but did I think that there was a particular problem? I have to say no”.¹⁰⁵

This SCN went on to say:

“Each and every case, each and every patient, was discussed with infection control and the information that we would give, the information they would give to us, my expectation would be that it would be infection control that would declare outbreak”.¹⁰⁶

An SCN on a different ward said:

“So I think it’s my responsibility to speak to infection control and let them know of the numbers, and I think ultimately they declare the outbreak”.¹⁰⁷

The Inquiry gave nurses charts completed for each ward detailing patients who had samples sent for testing for *C. difficile* toxin. The SCNs said they were surprised at the volume of samples sent for testing and the numbers of patients with CDI on their wards.

Outbreak Policy

The two successive versions of the Outbreak Policy in the Infection Control Manual¹⁰⁸ in 2007 and 2008 make specific reference to duties upon healthcare workers, which includes nursing staff, to follow the Policy, follow the advice of the Infection Control Team, and report to the Infection Control Team if they suspect there may be an outbreak.¹⁰⁹ This Policy and its application are considered from the infection control perspective in Chapter 15.

Evidence of an outbreak from ward nurses

Nursing staff generally did not appear to consider that there were outbreaks of CDI during the early and focus periods. The position adopted was that it was the duty of the ICN to declare an outbreak, and if this was not done then that was the end of the matter.

One SCN interpreted the guidance in the Outbreak Policy as stating that if she had two or more cases of CDI then that would fit into the generic description of an outbreak. She indicated that she did not think that she had an outbreak at any time after December 2007 in ward 6.¹¹⁰ She said that she had many discussions with ICNs and that they did not suggest that there was an outbreak on her ward although they were fully aware of the number of patients in the ward with diarrhoea and diagnosed with CDI. In her oral evidence this SCN did accept that there had been an outbreak on her ward in March or April 2008.¹¹¹

99 [TRA00440052](#)

100 [WTS00670005](#)

101 [WTS00670005](#)

102 [WTS02250049](#)

103 [WTS02250049](#)

104 [TRA00300114](#)

105 [TRA00310137](#)

106 [TRA00330006](#)

107 [TRA00440054](#)

108 [GGC00780145](#); [GGC27390001](#)

109 [GGC00780147](#)

110 [TRA00300114](#)

111 [TRA00300121](#)

The nursing perspective

The question of whether in fact there were outbreaks of CDI at the VOLH is considered in Chapter 5. What is clear is that the SCNs considered their role was simply to advise the ICNs of diarrhoea and take samples when there was unexplained diarrhoea. Sadly, they did not feel they had a role to play in questioning any decision made by the ICN on whether they did in fact have an outbreak on a ward.

One SCN did say that when there were four people diagnosed with CDI at one time she had a conversation with Mrs Helen O'Neill, the Infection Control Nurse, who advised that the cases could be explained by antibiotic use. The SCN thought that this conversation had occurred in January 2008.¹¹² She said she raised the possibility of closing the ward. She also recalled her own staff raising the issue of ward closure with her.¹¹³

Ward nurses do have an important role to play when there is a potential outbreak. Nursing records are an essential source of information when an outbreak is suspected and investigated. From the analysis of patient records in the VOLH it is clear that important information would not be available for many patients because of deficiencies in record keeping by nursing staff.

Interaction with Infection Control Team

Effective management of a patient with CDI requires a good working relationship and dialogue between the nursing staff involved in the direct care of the patient and the Infection Control Team. The nursing staff thought that the Infection Control Team consisted only of the ICNs. Of those, they had more contact with Mrs O'Neill than Mrs Jean Murray, particularly after Mrs Murray took up the post of Interim Lead Infection Control Nurse for Clyde.¹¹⁴ They had no contact with Dr Elizabeth Biggs, who was the Infection Control Doctor up to February 2008.

Infection Control Nurses' presence on the ward

The role of the ICNs included providing guidance to the ward nurses on the management of the patients with CDI and ensuring that appropriate plans of care were devised and maintained. Most of the nursing staff said that the ICNs did have a presence on the wards, although in fact there is little evidence in the patient records to support this. With a few exceptions the patient records did not record that an ICN had attended to review the patient and there was no evidence of plans of care in the patient records following review by an ICN. In short, there was no evidence from the patient records that the ICNs were closely involved in the management of patients with CDI.¹¹⁵

The Fruin ward operated a different system. That ward was part of a different corporate structure from the rest of the VOLH wards and was covered by a different Infection Control Team. A VOLH ICN would only be called upon if the Fruin ICN was not available, although the Deputy SCN in Fruin ward recalled Mrs O'Neill being involved in the ward. She said that the ICN normally responsible for Fruin ward did review patients, and there was evidence in the patient records that this ICN did make entries in the patient records and put in place care plans for patients with CDI.¹¹⁶

Access to T-cards

The ICNs recorded information about patients with CDI on yellow T-cards, a system examined in Chapter 15. These cards were not retained on the ward and were not part of the patient records. The nursing staff on the ward did not have access to these cards, and the T-cards were not designed to provide information to ward nurses. This is why it was important that a separate record was made in the patient records to enable those rendering care on the ward to have access to the information provided by the Infection Control Team.

¹¹² [TRA00440049-53](#)

¹¹³ [TRA00440050-51](#)

¹¹⁴ [TRA01010012](#)

¹¹⁵ [EXP01050004](#); [EXP00720013](#); [EXP00730013](#); [EXP00590014](#); [EXP01030007](#); [EXP00680016](#); [EXP00660002-03](#); [TRA00350146](#)

¹¹⁶ [WTS02200003](#)

Representation at meetings

The SCNs attended bed management meetings with the ICNs. Mrs O'Neill attended a number of the Sisters' meetings¹¹⁷ prior to June 2008, but it seems Mrs Murray only attended the Sisters' meeting of 26 July 2007 at which she announced that she had been appointed as the Interim Lead Infection Control Nurse for the Clyde Division.¹¹⁸ There was in addition an infection control link nurse system in operation during the early and focus periods, under which the link nurse for each ward was supposed to attend meetings and communicate information on infection prevention and control to ward staff. This can be a perfectly good system if it operates properly, but unfortunately that was not the case. The failures in the system are considered in Chapter 15.

It is clear that there were a number of opportunities for ward nurses and ICNs to discuss patients with diarrhoea and CDI, but this did not result in the problem being identified at an earlier point in time. Nor did these opportunities appear to have had an impact on the ward nurses' knowledge of the condition or of how to manage patients with CDI properly.

Interaction with Infection Control Nurses concerning patients with diarrhoea

As far as the nursing staff were concerned, they considered that they complied with their duty to keep the ICNs fully advised of infection control issues on the wards. In particular they said they told the ICNs about

patients with diarrhoea and those with a confirmed diagnosis of CDI.

One SCN said that the ICNs were made fully aware by telephone and at the bed meeting of the number of patients on her ward suffering from unexplained diarrhoea.¹¹⁹ Her position in evidence was that:

"..all the diarrhoea was discussed with infection control, all patients with diarrhoea".¹²⁰

The ICNs did not accept that they were advised of all patients who had diarrhoea. Their position was that they were advised when a positive diagnosis was made. The Inquiry does not accept that nurses contacted the ICNs in the case of every patient who had potentially infectious diarrhoea.

Early cases and records of Infection Control Nurses' involvement

There was an Infection Control Card available for 27 of the 33 patients from the early period whose records were available for review.¹²¹ Yet only eight of those cards contained a record that the ICNs had visited the patient in the ward.

The Loose Stools Policy

Table 12.2 sets out the Loose Stools Policy in the Infection Control Manual. It was of particular relevance to the nursing management of patients with CDI.¹²² This Policy provided the following direction to ward nurses on the management of patients with potentially infectious diarrhoea:

Table 12.2 The Loose Stools Policy

Accommodation (Patient placement)	Place a patient who could contaminate the environment with faeces in a single room. If the patient is clinically unsuitable for isolation, a risk assessment must be undertaken, by the clinical team, in conjunction with a member of the Infection Control Team (ICT). Babies and children will be isolated if they have symptoms suggestive of an infectious disease which can spread person-to-person. The ICT will advise if necessary. If a single room is not available, consult a member of the ICT and, if applicable, bed manager.

117 [GGC04020001](#); [GGC14800001](#); [GGC14810001](#); [GGC03950001](#)

118 [GGC03970001-02](#)

119 [TRA00300115](#)

120 [TRA00300120](#)

121 [EXP02790004](#); [EXP02790008](#)

122 [GGC00780259](#); [GGC27590001](#)

Evidence of the ward nurses on isolation of patients during the focus period

In the signed witness statements provided prior to the oral hearings, and initially in oral evidence, the SCNs said that the practice was to isolate patients when they had potentially infectious diarrhoea. In her witness statement one SCN made the following assertion:

“If a patient was suspected of having *C. diff* they would be moved immediately to a single room, whether or not a positive *C. diff* result had come back from the laboratory”.¹²³

The view of the nursing experts on isolation practices on the ward for the focus period

The nursing experts had difficulty identifying when some patients first had diarrhoea and when some patients were isolated. The date of isolation should have been clear from the patient records. Where it was possible to identify when a patient was isolated, in the majority of cases this did not occur until after there was a diagnosis of CDI. This is considered further in Chapter 15.

The nursing experts were critical of the isolation practices.

“Generally, patients were not proactively isolated when they were symptomatic. That usually occurred after the positive result but this was not always documented. It was often not clear whether someone was isolated or not or when they were moved in or out of isolation. In one case there was a very high suspicion of *C. difficile* infection and this was widely documented. Despite this, even that patient was not proactively isolated”.¹²⁴

“In half the cases reviewed patients were not isolated rapidly to prevent the transmission of *C. difficile* and were potentially transmitting *C. difficile* to other patients in the interim period of time.... In most cases there was no reference in the nursing notes to risks and any extra precautions taken to prevent the transmission of *C. difficile*”.¹²⁵

The use of notices

Nurses said in evidence that when a patient was isolated with CDI notices were always in place asking visitors to contact nursing staff before entering the room. Yet few family members recalled seeing notices outside rooms.¹²⁶

Care planning for patients with loose stools

The Loose Stools Policy envisaged that a care plan would be instituted for patients with loose stools, but it was clear from the evidence of nurses that the necessary care plans were rarely prepared. Care planning for CDI is considered later in this Chapter.

Isolation in the early period

Mrs Phair reviewed the patient records in the early period to ascertain whether patients were appropriately isolated as outlined in the Policy. The trends on isolation practices identified in the focus period were again evident in the early period, with isolation mainly dependent upon a positive diagnosis being made.

Laundry Policy

The Laundry Policy in the Infection Control Manual¹²⁷ provided that relatives who took home used and fouled laundry should be given this in a plastic bag and not an alginate bag.¹²⁸ Relatives were to be told before they took laundry home if it was heavily contaminated.¹²⁹ There was also an instruction that staff should not sluice out clothing in clinical areas.¹³⁰

Evidence of nurses on laundry

The nurses' evidence was that they were aware of, and complied with, the laundry instructions in the Policy. Some nurses said that relatives were given alginate bags and advised that the alginate bag could be put directly into the washing machine. One nurse said:

“If the clothing was soiled with faeces then the nurse who identified it would place it in an alginate bag and then double bag it in a plastic bag”.¹³¹

¹²³ [WTS00960014](#)

¹²⁴ [EXP01030007](#)

¹²⁵ [EXP00680015](#)

¹²⁶ [TRA00010033](#); [TRA00030104-105](#); [TRA00040148](#)

¹²⁷ [GGC00780136](#)

¹²⁸ [GGC00780141](#)

¹²⁹ [GGC00780141](#)

¹³⁰ [GGC00780141](#)

¹³¹ [WTS00780003](#)

Another nurse said:

“If the clothing was soiled it was put into an alginate bag and then another separate patient laundry bag. Relatives were advised that the alginate bag could go straight into the washing machine and to take care when decanting it out of the patient laundry bag”.¹³²

Another nurse provided this evidence:

“I used to sluice patients’ soiled clothing and put it into a patient laundry bag. I had been doing that for years and was never told not to”.¹³³

Nurses also said that relatives were given clear instructions on how to deal with laundry.¹³⁴

Relatives’ evidence on laundry

The evidence of some relatives suggested that nurses on the ward were either unaware of the Laundry Policy or chose to ignore it. Some described receiving alginate bags but said that they were not always given information on how to use the bag.¹³⁵ Some were not clear whether the bag could be placed into the washing machine.¹³⁶ Some relatives described finding fouled laundry left out for them without any prior warning from staff.¹³⁷

Advice leaflets on laundry

There was evidence of a leaflet being available for relatives to inform them on how to deal with soiled laundry.¹³⁸ Many relatives were not given this leaflet and some nursing staff said they did not have the leaflet available on the ward.¹³⁹

The use of Personal Protective Equipment

The evidence of nurses was that Personal Protective Equipment (PPE) was used when

dealing with patients with CDI.¹⁴⁰ This did not seem to be disputed by the patients and relatives, although only two patients gave evidence and relatives tended only to be present at visiting times. If a patient required to be changed when a relative was visiting the relative usually left the room. There was, however, evidence that domestic and support staff did enter isolation rooms without PPE to clean or provide meals.¹⁴¹

One Deputy SCN described a situation where personal protective equipment was used, but was ineffective. The patient had explosive diarrhoea and the nursing staff used sheets to cover themselves to try and keep clean:

“We had to improvise to try and keep ourselves clean. She was in room 16 at the time, bed 3. There was very little space. There were four beds occupied in there at the time... I can remember like it was yesterday”.¹⁴²

This nurse said everything had to be scrubbed down, including the bed frame, locker and radiator. The patient’s bed had to be stripped down. The patient had to remain in the bay as there was nowhere else to put the patient. This episode does highlight the time-consuming nature of the management of patients with CDI and the distress and lack of dignity associated with the infection.

Aspects of hand hygiene

There were three aspects to the issue of hand hygiene at the VOLH during the early and focus periods. The first was the lack of wash-hand basins. The second was whether staff washed their hands appropriately when dealing with patients. The third was the provision of information on appropriate hand washing to visitors of patients who had CDI. This Section reviews hand hygiene as it relates to the nurses on the wards.

Wash-hand basins

It is clear that there were insufficient wash-hand basins in certain wards¹⁴³ even although some members of the nursing staff did not appear to be aware of this deficiency. Sister

132 [WTS00730003](#)

133 [WTS00690005](#)

134 [TRA00370137-138](#); [TRA00410025](#); [WTS01010005](#)

135 [TRA00020102](#); [TRA00070183-184](#); [TRA00010060-61](#)

136 [TRA00030034-35](#); [TRA00070146-147](#)

137 [TRA00020028](#); [TRA00020102](#); [TRA00020056](#);

[TRA00030164-165](#)

138 [TAY0040009-10](#)

139 [TRA00960018](#); [WTS01160012](#)

140 [TRA00300125-127](#); [TRA00400150-151](#)

141 [TRA00020109](#); [TRA00040028-29](#)

142 [WTS02250046-47](#)

143 [GGC11050003-04](#); [GGC07560002](#)

Fox was of the view that ward 6 did have sufficient wash-hand basins, although further sinks were installed following the walk round discussed in Chapter 15.

Advice to relatives on hand hygiene

The evidence of the relatives was that they were not given consistent and accurate information on proper hand washing by nursing staff when there was a diagnosis of CDI. By the time they gave evidence the nursing staff were aware that soap and water required to be used to wash hands where a patient had CDI. The evidence of the relatives, as discussed in Chapter 11, was that nursing staff did not always appear to be aware of this fact. The Inquiry accepts the evidence of the relatives on this issue.

Conclusions on nursing aspects of infection prevention and control

As discussed later in this Chapter, nurses did not recognise the importance of the monitoring of fluid balance, nutrition, pain, bowel movements, and pressure care, or the relevance of falls risk assessments and moving and handling assessments in the management of patients with CDI. Furthermore, as discussed in Chapter 13, the delays identified in the administration of antibiotics prescribed for patients diagnosed with CDI were unacceptable. It is clear to the Inquiry that nurses were not fully aware at the time of the potential seriousness of CDI as an illness, particularly in the elderly and vulnerable. Ultimately this comes down to a lack of proper education, training and supervision. The lack of nursing knowledge compromised patient care.

Any advice given by the ICNs ought to have been detailed in the patient records and in the care plans. The need for continuity of care in the case of a patient with CDI cannot be overemphasised. The absence of direction from the ICNs within the notes would have compromised patient care.

Nurses have an important role to play where there is a potential outbreak of CDI. Good record keeping will assist in the investigation and management of a suspected outbreak. Deficiencies in record keeping meant that important information was not available. These deficiencies should have been

identified by the SCNs. Nursing staff should have been trained to ensure they were fully aware that information specified in the Infection Control Manual required to be recorded for patients with CDI.

It was clear from the expert nurse analysis of the records, and accepted by the SCNs, that patients were not being isolated when they became symptomatic. The SCNs were aware of this practice at the time. They should have complied with the Isolation Policy and ensured that staff on their wards complied with the Policy. If they were unable to comply due to shortage of isolation rooms this should have been brought to the attention of Nursing Management and the Bed Manager, with arrangements made to reduce the risk of cross-infection.

Nursing Management appeared to be unaware that patients were not being isolated appropriately. Had they been more proactively involved in the management of the wards they would have become aware of this practice. Ignorance is not an excuse in a situation where managers could with reasonable diligence have obtained the knowledge.

Care planning for patients with loose stools was inadequate. SCNs should have ensured that there was adequate and appropriate care planning for patients with loose stools. The absence of a functioning system of audit contributed to these failures.

There was evidence from relatives that appropriate notices were not visible outside isolation rooms. Notices were either not placed at all times or were placed in such a way that they were not obvious to those entering isolation rooms.

The Laundry Policy was not complied with. Nursing staff did not know how best to deal with soiled laundry. There were failures in communication of information on laundry to relatives. This would suggest that there was a lack of appropriate training.

Nursing staff failed to ensure that the correct information on hand washing was provided to relatives.

Nursing Management and ultimately the NHSGC Board have to accept responsibility for the failures identified in this Section.

12.6 Isolation issues specific to ward F

The patient Jessie Jones

Mrs Jessie Jones was transferred from the Western Infirmary and admitted to ward F, bay 16 at the VOLH on 8 February 2008.¹⁴⁴ There were three other patients in the bay when Mrs Jones was admitted, two of whom had previously tested positive for CDI, and there was at least one symptomatic patient in the bay at that time.¹⁴⁵ Mrs Jones was not symptomatic for CDI on admission, but later contracted CDI.¹⁴⁶

Bay 16 was normally used as a three-bedded bay but when necessary a fourth contingency bed could be installed, and that was the position when Mrs Jones was admitted.

Evidence of Sister Gargaro

Sister Laura Gargaro's evidence about the admission of Mrs Jones was contradictory and unsatisfactory. In her witness statement her position was as follows:

"On 8th February, the two previously infected patients were 48-hour free of symptoms and were therefore deemed to be low risk... Therefore on the day of Jessie's admission to ward F the four-bedded area had no positive *C. diff* patients. On 8th February at the morning bed meeting I again made our concerns known as one of the patients could become positive again and we had difficulty in managing her barrier procedures due to her wandering and confusion".¹⁴⁷

Initially in evidence Sister Gargaro said that when she was aware of the potential transfer of Mrs Jones she attended the bed management meeting with the intention of having the fourth contingency bed removed.¹⁴⁸ Sister Gargaro made a number of differing comments on her knowledge of CDI patients in bay 16 at the time she attended the bed management meeting, but her final position seemed to be that she was unaware that there was a symptomatic patient in

bay 16 at the time she attended the bed management meeting.¹⁴⁹ She accepted that perusal of the patient records would have confirmed there was a symptomatic patient in the bay. She suggested that she may not have had time to look at the patient records prior to the meeting, or she may have been given erroneous information as she had just returned from leave. She had been aware prior to her leave that there was a symptomatic patient in the bay.

Evidence about the call to ward F requesting information

Mrs Jones' daughter telephoned ward F on 18 February 2008 after her mother had been admitted and specifically asked if there were any infections such as MRSA, Norovirus and CDI in ward F. She was told "categorically" that there were no hospital infections.¹⁵⁰

Sister Gargaro accepted that this call was made and that it was incorrect to suggest there were no hospital infections in ward F.¹⁵¹ Sister Gargaro provided the following explanation:

"...my staff do not feel it's appropriate to discuss any conditions that other patients may have and to only discuss the condition of their particular relative at the time".¹⁵²

It is correct that information about particular patients cannot be disclosed, but if a relative wishes to ascertain whether there is an infection such as CDI present on a ward this information should be given honestly by staff.

When Mrs Jones' daughter found out that there was CDI on the ward, and indeed in the bay where her mother had been placed, she asked Mrs Murray why her mother had been admitted to a potentially life-threatening ward. She was told that the ward was under pressure from the Western Infirmary as they needed beds, and that they had nowhere else to put her mother.¹⁵³

144 EXP01960006; TRA00430083; WTS02250051

145 TRA00430122

146 GGC21010087

147 GGC14500001

148 TRA00430113

149 TRA00430125-127; TRA00430153-156

150 WTS01520005; TRA00070042

151 TRA00430103

152 TRA00430099; GGC14500001

153 WTS01520007

Involvement of the Bed Manager

The Bed Manager at VOLH was Ms Isobel Law, whose responsibilities included managing the admission and transfer of patients and allocation to specific wards.¹⁵⁴ Ms Law said that she was unaware of the infection status of the patients on the ward.¹⁵⁵ She did recall a discussion about the admission of Mrs Jones in which Sister Gargaro wanted the contingency bed removed. She said that the decision to keep the bed and admit Mrs Jones would have been made by one of the Lead Nurses.¹⁵⁶ She thought Mrs Murray was also involved.¹⁵⁷

Sister Gargaro's responsibility

As mentioned previously, Sister Gargaro's position appeared to be that she was unaware there was a symptomatic patient in the bay. When she returned from leave, and prior to going to the bed management meeting, Sister Gargaro should have ascertained the infection control status of patients on her ward. If she did attend the meeting in ignorance of the infection control status of her patients she should not have accepted a transfer into the bay until she had satisfied herself that it was safe to accept a patient. She was well aware that there had been symptomatic patients, particularly in that bay, prior to her leave. In such circumstances asymptomatic patients would be exposed to a contaminated environment which would place them at risk. As the SCN Sister Gargaro should have been aware of this risk and she should have checked before accepting a transfer into the bay.

Meeting with the Lead Nurse

The relatives of Mrs Jones had a meeting with the Lead Nurse, Mrs Elizabeth Rawle, and also made a formal complaint.¹⁵⁸ The essence of the complaint was that Mrs Jones had been placed in a four-bedded bay in ward F in an area where patients were already known to be infected with CDI.

Response to the complaint

Sister Gargaro provided a response¹⁵⁹ to the complaint in September 2008 which was used by the then Chief Operating Officer, Acute Services, Mr Robert Calderwood, in responding to the complaint. Sister Gargaro said in her response that when Mrs Jones was admitted to the four-bedded area there were no positive patients in the bay. She eventually accepted in evidence that this was palpably wrong.¹⁶⁰

Sister Gargaro accepted that when preparing the response she had access to the relevant patient records and initially could not offer an explanation why she misled Mr Calderwood.¹⁶¹ Later in evidence she suggested she must have misinterpreted the nursing notes when she made her response.¹⁶² She said that she did not review the microbiology results.

Conclusion on the admission of Mrs Jones

In her role as the nurse in charge of the ward Sister Gargaro failed to take proper care not to expose Mrs Jones to the risk of CDI. Prior to her leave she was well aware that there had been patients in the ward, and in that particular bay, who had been positive for CDI.

The Jones' family complaint was poorly managed. A complaint of this nature should not have been investigated by the SCN alone, but by a more senior member of the management team such as the Clinical Nurse Manager.

The information given to the relatives in the response was incorrect, and this should not have occurred. Sister Gargaro either failed to answer the complaint honestly or failed properly to peruse the information available to her, and as a result provided inaccurate and misleading information to relatives. Either course of action was unacceptable and was a serious failure by her.

¹⁵⁴ [WTS00890005](#)

¹⁵⁵ [TRA00890034](#)

¹⁵⁶ [TRA00890034](#)

¹⁵⁷ [TRA00890034-35](#)

¹⁵⁸ [GGC14490001](#)

¹⁵⁹ [GGC14500001](#)

¹⁶⁰ [TRA00440042-44](#)

¹⁶¹ [TRA00430135-137](#)

¹⁶² [TRA00440037-40](#)

Sister Gargaro's evidence on the admission of Mrs Jones and the investigation of the complaint was unsatisfactory. It was necessary to adjourn the Inquiry during her evidence, and the Chairman permitted her to consult with her Solicitor during the adjournment. This was done in the interests of fairness to enable Sister Gargaro to have the benefit of legal advice given the nature of the contradictory evidence she gave. Following a brief adjournment Sister Gargaro indicated that she did not wish to change any of the evidence given.¹⁶³ She did emphasise that she provided a copy of her written response to the complaint voluntarily.¹⁶⁴

When relatives or patients raise issues, these should be addressed fully and honestly. Senior management, and ultimately the Board, have a responsibility to ensure that the complaints process is properly managed. In his oral evidence Mr Calderwood said that he responded to the complaint in good faith at the time and the Inquiry has no reason to doubt that. On learning of the error he apologised to the family for misleading them.¹⁶⁵

12.7 Nursing assessments and care planning in the focus period

The nursing assessment

When a patient is admitted to hospital a nursing assessment should be carried out. This is an important aspect of nursing care and enables the nurse to plan the patient's care in an effective way.

Nursing expert Mrs Sharon Stower described the purpose of the nursing assessment in the following manner:

"Nursing assessment is a systematic, deliberate and interactive process that underpins every aspect of nursing care. It is the process by which the nurse and patient together identify needs and concerns and is seen as the cornerstone to individualised patient care. It is the only way the uniqueness of each patient can be recognised and considered in the care process".¹⁶⁶

She emphasised that effective patient assessment is integral to the safety, continuity and quality of patient care. The assessment provides baseline information on which to plan the interventions and outcomes of the care to be achieved. She explained that:

"It facilitates evaluation of the care given and it is a dimension of care that influences a patient's outcome and potential survival".¹⁶⁷

The nursing expert Mr William Evans provided this evidence:

"It is essential that nursing assessments are completed in order that a full and accurate picture of the patient's situation, abilities and problems is obtained. It is difficult to plan care appropriately without accurate baseline assessment".¹⁶⁸

There were appropriate pro forma assessment forms available to nursing staff. The issue under consideration here is the failure by nursing staff to complete these assessments.

Activity of Daily Living Assessments

An Activity of Daily Living Assessment should be performed when a patient is admitted to hospital. This assessment and the initial nursing assessment underpin the care planning and allow the nurse to gather vital information about the patient which then informs the care planning. The assessments provide a benchmark to gauge progress or deterioration of the patient.

Deficiencies in the initial assessments

The nursing experts noted that many basic details were often not recorded in initial assessments. Sections were not completed. Assessments were not signed or dated and the information that was provided did not always give an accurate picture of the patient.

The most common details omitted were the patient's weight, an assessment of the risk of pressure damage, and baseline observations

163 [TRA00440046-47](#)

164 [TRA00440049](#)

165 [TRA01240100](#)

166 [EXP00590004](#); [TRA00160133-134](#)

167 [EXP00590004](#)

168 [EXP00700029](#)

of temperature, pulse, respiration and blood pressure. The pain score/comments on sleeping patterns Sections were usually blank.

Professor Palmer said that of the ten patients he reviewed not one of them had an adequate or satisfactory assessment.¹⁶⁹ Six of the patients he reviewed had an assessment which was of a significantly poor professional standard.¹⁷⁰

Nutritional assessments

Patients with diarrhoea as a result of CDI, particularly elderly patients, can become nutritionally depleted very quickly. This has an impact on their ability to survive the infection. Loss of appetite and nausea can also be symptoms associated with CDI, and for a variety of reasons many elderly patients will already be nutritionally depleted when they enter hospital.

Nutritional screening

Nutritional screening is a simple procedure conducted by nursing staff when a patient is admitted to hospital. A basic nutritional screening should document a patient's recent unintended weight loss, appetite and ability to eat. Patients should be weighed on admission and thereafter throughout their stay in hospital.¹⁷¹

Nutritional screening can be contrasted with a nutritional assessment, which is a more detailed and specific evaluation of a patient's nutritional status usually conducted by an expert such as a dietician.

Nutritional assessment documentation in the VOLH

In the VOLH during 2007 and 2008 there were standardised nutritional assessment forms available but they had not been distributed to all wards. The Clyde Acute Directorate did not have pre-prepared nutritional assessment forms,¹⁷² although the Rehabilitation and Assessment Directorate did have these.

The expert view on the standard of nutritional assessment

The nursing experts were critical of the standard of nutritional assessment of the patients reviewed. Professor Palmer identified one patient who was malnourished/emaciated on admission and had not been eating and drinking.¹⁷³ There was no evidence in the nursing records of any care plan to improve this patient's nutritional state. Nor was there evidence that the patient was weighed or that a nutritional chart was maintained to monitor dietary intake. He described this failure as significantly below the standard to be expected.¹⁷⁴

Mrs Jeanes noted that one patient was not deemed to be at risk when her nutrition was assessed despite having lost more than six kilograms in a few weeks.¹⁷⁵ Another patient had no nutritional assessment, little documentation of food intake, no food charts and no record of the food she enjoyed or preferred.¹⁷⁶ An elderly patient had a weak left hand and impaired sight, yet there was no documented assessment of this patient's ability to eat unaided, no record of food intake, no food chart, and the patient was not weighed during her stay.¹⁷⁷

In one case the patient's weight was not regularly documented even though there was a specific request and a care plan intervention for that to be done.¹⁷⁸

In the case of one patient who had diarrhoea and who was intermittently nauseous, vomiting, and declining food, there was no nutritional assessment or any record of actions needed to optimise nutritional intake. She was not weighed. She was given medication to control nausea but no plan of care was instituted to ensure that her mouth was clean and comfortable. Towards the end of her life she was either not being given fluids on medical instructions or not taking fluids, and there is no evidence that regular mouth care was given.¹⁷⁹

169 [EXP01050002](#)

170 [EXP01050002](#); [TRA00220087-89](#)

171 [INQ02450148](#)

172 [TRA00290134-135](#)

173 [EXP00020019](#); [TRA00200079](#)

174 [EXP00020024](#); [TRA00200082](#)

175 [EXP00680018](#); [TRA00120142-143](#)

176 [EXP00680019](#); [TRA00120065-66](#)

177 [EXP00220017](#); [TRA00120066](#)

178 [EXP00150011](#); [TRA00350059-60](#)

179 [EXP00280011](#); [TRA00100157-159](#)

In the review of all his cases Professor Palmer concluded:

“The needs of the patients indicated that a nutritional assessment and care plan was required. Only two nutritional assessments or care plans were considered adequate. The remaining eight assessments or care plans were either absent or inadequate”.¹⁸⁰

Mrs Jeanes concluded:

“The systematic planning and documentation of efforts to improve nutritional intake including the maintenance of food charts was generally poor”.¹⁸¹

Deficiencies noted in nutritional assessments

The nursing experts identified a number of failures:

- Assessments were undated, incomplete or inaccurately scored when they were completed
- Completion of assessments was delayed
- Initial assessments when completed were not regularly re-assessed
- There were delays in patients being referred to a dietician
- Food charts were not implemented even when requested by a dietician
- When food charts were commenced they were poorly completed or stopped too soon
- Patients were not being routinely weighed on admission or regularly weighed thereafter¹⁸²

Evidence of nurses on nutritional assessments and weighing patients

The nurses who gave oral evidence accepted that patients were not always weighed on admission and that some patients who should have been weighed after admission were not weighed regularly thereafter. They offered

various explanations for these failures. One explanation was that there was a lack of appropriate equipment to weigh patients. On one ward the SCN explained that frail patients were not weighed as they did not have the appropriate scales. A tombola was organised to collect money to purchase scales.¹⁸³ The Deputy SCN on ward 6 said that they obtained chair scales after June 2008 after a few years with no scales. Scales had been bought from Argos with ward funds but there were no funds for more expensive scales.¹⁸⁴

Moving and handling assessments

It is important to know how to move and handle a patient safely, in order to avoid causing harm to the patient and to prevent back strain and injury to staff. Moving and handling assessments are of particular relevance to the management of elderly patients with CDI. These patients often become rapidly debilitated and need changed and cleaned more frequently. Often their skin is vulnerable to damage associated with poor moving and handling techniques.

Some patients did have a moving and handling care plan although no risk assessment seemed to have been performed.¹⁸⁵ A risk assessment should have been performed to assist and inform the development of the appropriate care plan for the patient.

View of the expert witnesses on moving and handling assessments

The nursing expert witnesses were critical of the attention to moving and handling issues. According to Mrs Jeanes:

“Generally the attention to moving and handling issues was not well documented and it is not clear if this was a lack of documentation and attention or poor practice in the organisation”.¹⁸⁶

Out of 63 focus patients, only 16 had a moving and handling assessment in the patient records. Of the 47 patients who

180 [EXP01050003](#)

181 [EXP00680019](#)

182 [EXP00020024](#); [EXP00050027](#); [EXP00670025](#); [EXP00720009](#); [EXP00200017](#); [TRA00190077](#); [TRA00100014](#); [EXP00100018](#); [EXP00340012](#); [TRA00340008-09](#); [EXP00120022](#); [EXP00090016](#); [TRA00180065-66](#); [TRA00190031](#); [TRA00270079](#); [TRA00270157](#); [TRA00170028](#); [TRA00360046](#); [EXP00040022](#); [EXP00170041](#)

183 [TRA00360048-49](#)

184 [TRA00360047-49](#)

185 [GGC00110158](#)

186 [EXP00680018](#); [TRA00180065](#)

did not have an assessment in the patient records, for 13 there was mention of the need for assessment in the patient records, but there is no record that one was carried out.

Main deficiencies identified in the moving and handling assessments

The main criticisms in the cases reviewed were as follows:

- There was no evidence of a moving and handling assessment for patients with significant moving and handling needs
- For patients assessed as requiring assistance to mobilise it was not clear what actions were taken
- Patients were assessed as requiring assistance to mobilise but this was not included in the patient care plan
- There were delays in assessments being undertaken, sometimes weeks after admission¹⁸⁷

Falls risk assessments

Patients with CDI, particularly if they are elderly, are at risk of falls. The debilitation associated with CDI renders a fall more likely, and when a patient has CDI a fall can occur in the rush to a toilet. A falls risk assessment should be performed to identify which patients are likely to fall and to intervene to prevent falling or reduce the risk of falls. A fall for an elderly patient can be fatal.

View of the nursing experts on falls risk assessment

Some of the criticisms by the nursing experts highlighted serious failures. Mrs Phair noted one patient who had suffered a stroke and required physiotherapy for whom there was no record of a falls risk assessment.¹⁸⁸ Another patient was admitted with dizziness and a stroke. She was at risk of falls yet no falls risk assessment was prepared. She had a number of falls when she was a patient. Mrs Phair said that when this patient contracted CDI her risk of falls increased because of

the debilitating nature of the infection. Yet despite that increased risk no falls risk assessment or care plan was prepared.¹⁸⁹

This was the conclusion arrived at by Mrs Jeanes:

“Generally the recognition of risk of falls and attention to preventing falls was not well documented and it is not clear if this was a lack of documentation and attention or poor practice in the organisation”.¹⁹⁰

Professor Palmer identified one patient who had been assessed wrongly as at “high risk” of falling and who should in fact have been put in the “very high risk” category. Despite having numerous falls, which were documented, he noted that nursing staff failed to introduce a reasonable regime of supervision and observation. His opinion was that the precautions introduced to prevent the patient falling “were wholly inadequate” and “grossly negligent”.¹⁹¹ This patient subsequently had a significant fall resulting in a fractured femur¹⁹² that later contributed to the patient’s death.¹⁹³

Main deficiencies identified with the falls risk assessments

The main deficiencies relating to falls risk assessments identified by the experts were as follows:

- When a falls risk assessment was performed the scoring was inaccurate
- There was no evidence of re-assessment in many instances
- Failure to perform a falls risk assessment when it was required
- Failure to re-assess when a patient had frequent falls
- Identification of a patient and risk of falls but failing to introduce precautions to minimise the risk¹⁹⁴

187 [EXP00590013](#); [EXP00680018](#); [EXP00720012](#); [EXP00730010-11](#); [EXP01030006](#); [EXP01050004](#); [TRA00160143](#); [TRA00180065](#); [TRA00240061-62](#); [TRA00350138](#)

188 [EXP00090016](#); [TRA00170085](#)

189 [EXP00030022](#); [TRA00170034](#)

190 [EXP00680018](#); [TRA00180065](#)

191 [EXP00750022](#)

192 [TRA00210004-05](#)

193 [EXP00750022](#); [TRA00210032-33](#)

194 [EXP01030006](#); [EXP00240022](#); [EXP00330026](#); [TRA00250118-119](#); [TRA00350114-115](#)

Care planning

Care planning is a term used to describe the process of assessing a patient's needs:

"prescribing care, delivering and documenting the care delivered, evaluating the effectiveness of that care and changing the care plan as needs change".¹⁹⁵

The care plan is the written record of this process. It is a prescription of care for the patient and is one of the most important aspects of planning nursing care.

The ability to prepare an appropriate care plan is a core skill. If there is no care plan, or where the care plan is poorly prepared or incomplete, it becomes difficult for nurses and other members of the healthcare team (doctors, physiotherapists, occupational therapists) to deliver consistent and co-ordinated care. The provision of appropriate and adequate care plans for a patient is not an optional extra but a mandatory professional responsibility.

On this issue Mrs Jeanes provided this explanation:

"Nursing care plans are important as they offer an opportunity to individualise care, take into account all the problems present and help ensure continuity of the care delivered".¹⁹⁶

The Standards of Proficiency for pre-registration nursing education from the NMC provide that a nurse should be able to:

"Undertake and document a comprehensive, systematic and accurate nursing assessment of the physical, psychological, social and spiritual needs of patients, clients and communities" and

"Formulate and document a plan of nursing care, where possible in partnership with patients, clients, their carers and family and friends, within a framework of informed consent".¹⁹⁷

Methods of care planning

In the VOLH different wards used different methods of care planning. There are several acceptable methods of recording patient care, for example core or standardised care plans, individualised care plans and care pathways. Of importance is the information contained within the care plan. Whatever the approach chosen, it must provide a systematic framework that can be used by all those involved in a patient's care to provide a consistent, comprehensive and accurate account of the patient's care.

Expert view on the standard of care planning

Generally the professional expert witnesses were critical of the lack of proper care planning. The following views are typical.

"In general, care plans were poorly completed and did not reflect all of the patients' problems and there was little evidence that they were reviewed appropriately. They were often not numbered and nursing evaluation sheets rarely related to the care plan".¹⁹⁸

"In my expert opinion none of the care plans (ten cases were reviewed) were considered professionally adequate. Eight patients had care plans in place but were considered of poor quality or inadequate and two patients had care plans which were considered wholly inadequate".¹⁹⁹

"In all the records I reviewed none of the care plans reflected all the problems and requirements of the patient at the time of assessment. In most of the plans the planned interventions did not give sufficient detail of the planned care to ensure risks were identified and minimised or that subsequent care was consistent..... It is not clear how care could be delivered appropriately and consistently without regular assessment of problems and the planning of care to be delivered. There was little evidence that care plans were used to guide the care given and generally they were not referred to in the regular evaluation".²⁰⁰

195 [EXP00640009](#)

196 [EXP00680005](#)

197 [INQ05350004](#)

198 [EXP01030003](#); [TRA00350127](#)

199 [EXP01050002](#)

200 [EXP00680006-07](#)

“It is my expert opinion that the absence of specific nursing care plans aimed at addressing the significant problems that were present for (the patient) represents nursing care that falls significantly below the standard expected of a competent nursing team. Indeed it is my expert opinion that the absence of a nursing care plan in this instance represents wholly inadequate nursing care which would expose the organisation and individual practitioners to claims of negligence”.²⁰¹

Mrs Phair concluded that for the 12 patients she reviewed in the focus period the care planning, as disclosed by the patient records, was inadequate.²⁰²

Deficiencies identified in care planning

The deficiencies found by the nursing experts concerning the care planning reviewed can be summarised as follows:

- Care plans were not completed in a timely fashion
- Care plans were not dated
- Goals in care plans were vague
- Care plans consisted of a checklist of tasks done or to be done
- There was a lack of nursing focus
- Ward 6 used a “medical model” of care planning which is not a recognised method
- Care plans were not initiated where appropriate to address significant nursing needs of patients

The nursing evidence on care planning

Ward 6 initially used the well recognised Roper Logan and Tierney (RLT) model for care planning and then moved to a “medical model”.²⁰³

Sister Fox, the SCN for ward 6, explained her position in the following way:

“In the past we did start out with a nursing model. Over time- -and I clearly saw that when I looked into the notes- -over time,

that model changed, and it did become much more of a medical model of care, and I can only accept that and take responsibility for that”.²⁰⁴

The medical model of care planning simply listed the medical instructions on the care plan documentation. From a review of patient records in ward 6 this practice had been followed for some time. This is not an appropriate model of care planning.

Sister Fox maintained that the medical model of care planning did not affect patient care. This was her position:

“What we did not do at all times, was the actual written documentation, but we certainly discussed the patients’ care, we knew what the patients needed and we communicated this to one another within the team”.²⁰⁵

This was her explanation for the care planning failures:

“..every care plan that I looked at, every single one that I looked at, there were absences, and I can only say that it is – it’s as a result of barriers that are put in our way, it is extreme – absolutely extreme activity levels”.²⁰⁶

The Lead Nurse responsible for a number of wards in the VOLH including ward 6 said that she was not aware that ward 6 had moved away from the RLT model of care planning.²⁰⁷

Another SCN said that she was aware of the RLT model of care planning but said the method used in her ward was more of a problem solving approach.²⁰⁸ She provided the following explanation of care planning on her ward:

“When a patient was admitted to the ward, their presenting problem, we would plan for that problem, and use a care plan for that problem, and then we would use sort of progress charts to evaluate”.²⁰⁹

201 EXP00750017

202 EXP00660001; TRA00480053-54

203 TRA00290013-14

204 TRA00290016-17

205 TRA00290067

206 TRA00290016

207 TRA00930076-77

208 TRA00450009-10

209 TRA00450009

Another SCN accepted in evidence that she had found incomplete care plans on her ward when she reviewed the patient records prior to giving evidence. She offered as an explanation the fact the ward was going through a period of transition because they had only recently moved onto a 12-hour shift pattern. Previously they had worked with a named nurse philosophy, with the named nurse taking responsibility for the generation of the care plan.²¹⁰

Care planning for patients with CDI

Nurses accepted that a patient with CDI should have a care plan prepared for that condition. It was also accepted by SCNs that care plans had not been prepared for many of the patients who contracted CDI.²¹¹ There was no pro forma *C. difficile* care plan in use at the VOLH during the early and focus periods for patients diagnosed with CDI²¹² although the *C. difficile* Policy did envisage that a care plan would be available.²¹³

One SCN said in evidence that the only care plans she could find on review of the patient records were for patients whose presenting problem was CDI.²¹⁴ For those who later developed the infection when on the ward she said there was not a formal written care plan.²¹⁵ She provided the following explanation:

“I think a lot of the time it was due to high activity levels in the ward. You know, the ward was very busy and the nurses were always very busy, so it wasn’t that they weren’t consciously thinking of the plan that needs to be put in place, and they were using the progress notes to note things rather than to do a separate care plan”.²¹⁶

She maintained that on her ward the nurses were “giving the care and the care was there in place”.²¹⁷

One Deputy SCN explained that there should have been care plans for patients with CDI on her ward, but accepted that “as you can see from the notes, they are sadly lacking”.²¹⁸ She was asked whether it was the practice on her ward to prepare care plans for patients with CDI and her position was as follows:

“It doesn’t look like it. To be honest we were quite shocked to see in the notes some patients didn’t have a care plan. Generally the staff were very good at doing care plans. It was time-consuming. I can only think that it was pressure at work. I didn’t know at the time that they hadn’t been done”.²¹⁹

One SCN provided this explanation:

“My explanation (for the lack of care plans) would be that all of the staff knew what the patient would require, and they would have felt that what they had written was sufficient and adequate. That is my explanation. We now have- -we have now quite specific care plans for both loose stools and *C. difficile*, which we didn’t actually have at that time”.²²⁰

In response to questions about the lack of care plans for patients with CDI in isolation this SCN said:

“I suppose there was an assumption on the nursing – on the part of the nursing staff that it was enough to say that the patient had *C. diff* and was in isolation. Because what was written in the narrative would have indicated what was happening with the patient. The information was there, it just wasn’t in the form of a care plan”.²²¹

Conclusions on nursing assessments and care planning in the focus period

Examination of the patient records disclosed that nursing assessments made on admission to the VOLH were generally poorly completed. These deficiencies should have been discovered by the SCNs. A functioning system of audit would also have identified these failures.

210 [TRA00410055](#)

211 [TRA00440071](#); [TRA00290067](#)

212 [TRA00380133](#); [TRA00300136](#)

213 [GGC00780254](#)

214 [TRA00450010](#)

215 [TRA00450010](#)

216 [TRA00450010-11](#)

217 [TRA00450012](#)

218 [WTS02250042](#)

219 [WTS02250044](#)

220 [TRA00300136](#)

221 [TRA00310028-29](#)

Among the areas of real concern is that of the inadequate care planning practices that developed on a number of wards. This resulted in CDI not being viewed as a condition that required to be addressed separately from other medical issues. Had Nursing Management been more proactive, the inadequacies in care planning would have been identified. The medical model of care planning that became the norm in ward 6 did not form a proper basis for patients to be given appropriate and consistent care. This approach represented a serious failure in nursing care for which Sister Fox has to accept direct responsibility.

The *C. difficile* Policy envisaged that a pro forma care plan for CDI would be available and NHSGGC should have ensured that such a pro forma care plan was available. The absence of a pro forma care plan is not, however, a legitimate excuse for the failures to put care plans in place for patients with CDI.

12.8 Nursing notes and charts in the focus period

Nursing evaluation records

The nursing evaluation records are an important part of the patient records and are the direct responsibility of the nurses caring for the patients.

A patient's condition should be recorded in the nursing evaluation records. These are separate from the care plan and the nursing assessments. In the VOLH (except Fruin) the practice was for nursing information to be contained in nursing evaluation records while the medical input to the patient's records was in a separate part. In Fruin ward the system was different. The records were multi-disciplinary and any person involved with the patient would note his or her observations chronologically. The records were viewed "as a patient journey".²²² Gaps were not identified in the notes examined from Fruin ward.

Evidence of nurses on the nursing evaluation records

Nursing staff generally were of the view that the patient care was well described in the evaluation records.²²³ One SCN said that although there were omissions in care planning on her ward she was of the view that the care was well described in the evaluation records.²²⁴

Another SCN said that there was a point in time when she became aware that there were gaps in the evaluation records. She had discussed this with nursing staff and the explanation she was given for the gaps was pressure of work and the fact they had one trained nurse for 12 patients.²²⁵ She agreed that gaps found of five days, ten days and 20 days in the records of patients in her ward were not acceptable.²²⁶

The expert witnesses on assessment of the evaluation records

The nursing evaluation records were found by the nursing experts to be generally of an inadequate standard. Many evaluation records provided little information of value in determining the condition of the patient.

Mrs Jeanes criticised the nursing evaluations records as echoing the conclusions of medical staff. Rarely did they include any indication of what input the nursing staff had in the clinical decision-making process.²²⁷

Mrs Jeanes expected that the nursing evaluation records would be checked regularly by the person in charge of the ward to ensure that they were an accurate reflection of the care and progress. She said that there was no evidence from the nursing records that this had been done.

Nursing handovers

At the end of each shift the nursing staff handed over information on patients to the shift coming on duty. This was done using a handover sheet.

222 [WTS02200015](#)

223 [TRA00410056-58](#); [TRA00430024](#)

224 [TRA00290014](#)

225 [TRA00390056](#)

226 [TRA00390156-157](#); [TRA00400051](#)

227 [EXP00680008](#)

Information obtained by the nurse during the shift was noted on the handover sheet. On many occasions this information had not been entered into the patient records. The handover sheets were not retained.²²⁸

One deputy SCN explained in her witness statement that at handover on her ward she would write information about her patients on a separate sheet and transfer that information into the nursing notes. She then shredded the sheet of paper. She also explained that:

“There was lots of information to communicate, which is why handovers took so long”.²²⁹

One SCN said that they:

“very much depended on handover being robust and all the communication within the team to make sure we shared the information widely”.²³⁰

Another SCN explained her position at handover in the following way:

“...we had very strong teamwork within ward 6 and handover took so long because every patient was discussed totally individually, important information was given then, it would have just been far better that all of that verbal communication had been documented, but, unfortunately, time just did not allow it”.²³¹

The nursing handover in the evening coincided with the evening visiting period and was a time identified by relatives when it was difficult to contact nursing staff for information.

Patient observations

The recording of a patient's baseline temperature, pulse, respirations, oxygen saturations and blood pressure is an important feature of the treatment of a patient with CDI. It enables the medical and nursing staff to assess the response to treatment and a patient's overall condition.

Such observations are basic and easily obtainable indicators of critical illness. The frequency of assessment is dictated by the patient's clinical condition.

Deficiencies identified in recording of observations

The expert nursing witnesses were critical of the standard of observations. There were a number of issues identified by them:

- There was no clear rationale for the frequency of observations in individual patients
- The frequency of recording did not always reflect the severity of the patient's condition and need for monitoring
- Some patients on wards did not have observations taken for several days at a time
- There was a failure to comply with medical instructions about the frequency of observations
- Where observations were abnormal there was no indication this was appreciated or acted upon

Expert view on recording of observations

Mr Evans said that vital signs were not adequately recorded in the majority of the cases he examined.²³² In one case he noted:

“The patient was *C. difficile* positive and symptomatic and there is no evidence of regular observations, overall, to accurately monitor her condition. There are specific examples of where the patient's condition required regular observations and they were not recorded for three days, in one instance, and nine days in another. Her treatment plan, at one stage, depended on observation of her temperature. The chart showed that it was only recorded once that day. Observations were not recorded then for 17 days, and on that day the temperature was not even recorded. The overall standard of observations of vital signs with this patient was totally inadequate”.²³³

228 [TRA00290129-130](#)

229 [WTS02250015](#)

230 [TRA00420017](#)

231 [TRA00290027](#)

232 [EXP01030003](#); [TRA00350124-125](#)

233 [EXP00240024](#); [TRA00250095](#)

Professor Palmer noted in the cases he reviewed that there were patients where observations were required but not recorded for significant periods of time. One patient had no observations recorded for several days at a time despite the fact he had undergone major surgery. Professor Palmer was “alarmed” that on the occasions observations were completed they were not completed adequately or competently.²³⁴

Recording of pain levels

Pain levels were rarely recorded. Nor were there attempts to measure pain systematically.²³⁵ The nursing staff did not appear to consider that the monitoring and recording of pain was an important aspect of patient care.

The monitoring of pain for CDI patients is an essential element of care. An increase in pain can be an early warning of progression of the infection. Good practice would be to ask the patient to identify the source of pain and use comparators such as a scale of pain.

Mrs Stower was critical of the monitoring of pain in the patient records she reviewed. Patients scored “0” in relation to pain when in the clinical records it was noted the patients were complaining of pain and had been given analgesia for pain relief.²³⁶

Mrs Jeanes noted that one patient was given analgesia including paracetamol, co-codamol, co-dydramol and diamorphine, with no attempt to monitor or measure pain.²³⁷ She said it was unclear if staff understood the effects and potential side-effects of the analgesic drugs used.²³⁸ Drugs which could cause nausea should be accompanied by the administration of drugs to control nausea, but this was not done. She said that the pain of one patient was so poorly monitored and documented that it was unlikely that medical staff could be given a clear and consistent picture of the pain the patient experienced.²³⁹

Overall, Mrs Jeanes arrived at the following conclusion on the pain management of patients:

“The absence of regular assessment and monitoring of pain and the lack of a consistent and coherent strategy for the management of the pain and use of analgesics in some patients was exceedingly poor practice”.²⁴⁰

Recording of bowel movements

CDI can range from mild to very severe, with ulceration and bleeding from the colon (colitis) and at worst perforation of the intestine leading to peritonitis. Recording of bowel movements is recognised as important in monitoring the treatment of the condition.

Documentation for recording bowel movements – the Bristol Stool Chart

Bowel movements can be recorded in a fluid chart, but a detailed stool chart provides a more comprehensive picture of consistency, volume and other characteristics. A widely used method of charting stools is the Bristol Stool Chart,²⁴¹ which is a medical aid designed to classify faeces into seven groups and has been recognised as a useful tool in evaluating the effectiveness of treatment for CDI. Figure 12.1 sets out the form of the Bristol Stool Chart.

234 EXP00400020; [TRA00200051](#)

235 [TRA00350053](#); [TRA00350120](#)

236 [EXP00590008](#); [TRA00160138-140](#)

237 EXP00260022-23

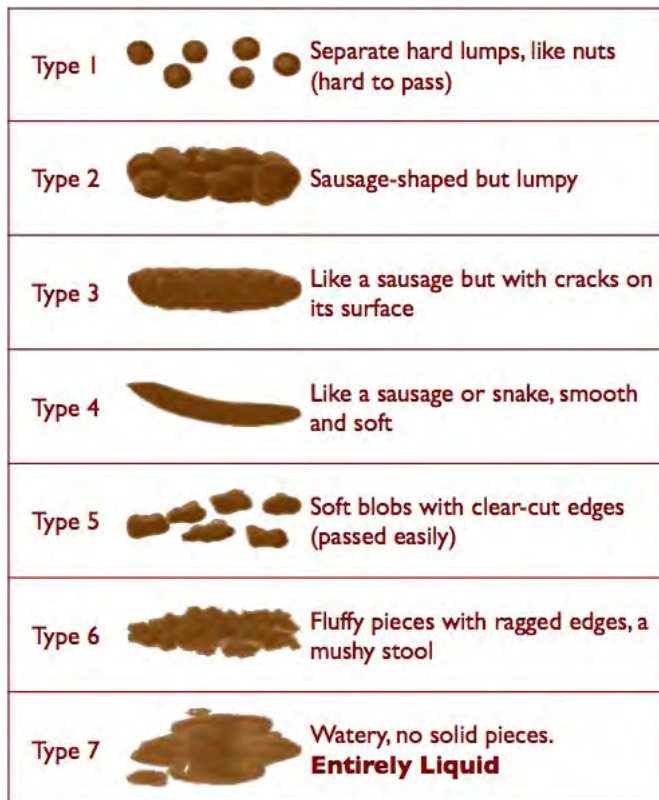
238 [TRA00180059](#)

239 EXP00260021-24

240 [EXP00680013](#); [TRA00180058-59](#)

241 [INQ00020001](#)

Figure 12.1 Bristol Stool Chart



- Type 1 to 2 indicate constipation
- Type 3 to 4 are ideal stools as they are easier to pass, and
- Type 5 to 7 may indicate diarrhoea and urgency

The view of HPS

Professor Jacqui Reilly from HPS explained that the use of the Bristol Stool Chart is not a key recommendation in the guidance on CDI published in September 2009.²⁴² The guidance is as follows:

“Healthcare staff may find it useful to use the Bristol Stool Chart to assess the severity of diarrhoea”.²⁴³

The unanimous view of the nursing experts, however, was that the use of a chart like the Bristol Stool Chart was an important monitoring tool for patients suffering from CDI. NHSGGC’s Loose Stools Policy, effective from December 2007, identifies the Bristol Stool Chart as the appropriate monitoring tool to use.²⁴⁴ The weight of the

evidence supports the value from a nursing perspective of the use of a monitoring tool like the Bristol Stool Chart.

Evidence of nurses on charting of stools

All the nurses who gave oral evidence accepted that they should have been charting the stools of patients with diarrhoea and CDI.

Sister Fox suggested in her witness statement that in ward 6 the Bristol Stool Chart was used.²⁴⁵ Initially she said in her oral evidence that the Bristol Stool Chart was used in ward 6, at least from December 2007.²⁴⁶ She said there was a laminated copy of the Bristol Stool Chart both in the sluice area and in the “Really useful” folder.²⁴⁷ She expected that her nurses would refer to it when describing a patient’s stools. Subsequently she accepted in oral evidence that on review of the patient records this was not the case. Her explanation at that time was that the information would be contained in the narrative in the evaluation sheets.²⁴⁸

Another SCN from another ward accepted that stool charts were poorly completed and provided the following explanation:

“Yes, a lot of the stool charts were poorly completed, yes...I think we were aware of the situation at the time. We have certainly been able to document the stools in detail through the nursing narrative, so we were taking serious consideration at that point, but we just can’t evidence it on a stool chart”.²⁴⁹

Bowel Function Chart

Some wards at the VOLH used a Bowel Function Chart to record episodes of diarrhoea. This is not a stool chart. It allows the nurse to identify a date where there has been a bowel movement but it does not enable the nurse to record the nature of the diarrhoea or the number of episodes. This type of chart was not adequate as a method of recording information on the bowel movements of patients suffering from CDI.

²⁴² [TRA01100123](#)

²⁴³ [HPS01860027](#)

²⁴⁴ [GGC27590008](#)

²⁴⁵ [WTS00960013](#)

²⁴⁶ [TRA00310001](#); [TRA00310105-106](#)

²⁴⁷ [TRA00300145](#)

²⁴⁸ [TRA00300147-148](#)

²⁴⁹ [TRA00440064-65](#)

Other charts

On occasions a stool chart was used which did have sections to describe the nature of the stool. The chart did not provide a Bristol Stool type classification but because the nurse was required to document details of the stool this chart would assist in the management of the patient.

The expert view on the recording of stools

The nursing expert witnesses were critical of the practices at the VOLH on the recording of stools in patients with diarrhoea. The following criticisms were typical of the views expressed by the nursing experts:

“Overall, the completion of stool charts was inadequate to determine the extent of diarrhoea in terms of volume and frequency”.²⁵⁰

“The NMC Code states that there is a duty “to act to identify and minimise the risk to patients and clients”. The lack of systematic and clear recording of the frequency, quantity and characteristics of bowel movement did not act to reduce the risks of *C. difficile*, anaemia and dehydration. This was poor practice”.²⁵¹

“All patients required a stool chart. None of the patients I reviewed had stool charts that were considered to be completed to a satisfactory or adequate standard. In two cases the stool charts appear to be missing or were not completed. Eight patients had charts in place, which were considered to be poor or inadequate because the nurses failed to provide sufficient detail or the stool charts were not completed during episodes of infection”.²⁵²

“It was extremely difficult to establish the severity of her diarrhoea during her episode of *C. difficile* and it was impossible to identify when she was asymptomatic. It was also unclear when she actually commenced the symptoms of *C. difficile*”.²⁵³

Fluid balance

Fluid balance is the maintenance of the correct amount of fluid in the body. Fluid balance can be affected where a patient has diarrhoea as a consequence of CDI. Dehydration can contribute to the development of urinary tract infections, constipation, and the increased risk of pressure ulcers and falls.

Fluid balance charts

The fluid intake and output of patients are recorded by nurses on fluid balance charts. The charts are designed to monitor the amount of fluid input and output over a 24-hour period²⁵⁴ and are used to assess patient hydration. Accurate recording is important for patient wellbeing. Medical staff rely upon information contained within fluid balance charts to inform decisions on care.²⁵⁵

Nursing expert, Ms Elaine Connolly provided this important description of the role of fluid balance charts in patient management:

“The role of the nurse in the management of fluid balance in both maintaining an accurate record of the patient’s fluid intake and output and reconciling the totals at the end of each 12-hour period is vital. This information is the key to the patient’s care delivery and is a record which enables other professionals involved in the patient’s care to make appropriate decisions”.²⁵⁶

Nurses therefore have a responsibility to ensure that those at risk of dehydration, or who become dehydrated during their admission to hospital, are identified, monitored and adequately hydrated.²⁵⁷ Dehydration can occur quickly in those with diarrhoea as a result of CDI, particularly the elderly.

Poor documentation on fluid balance charts, poor assessment of hydration and lack of monitoring of fluid intake are factors that can increase the mortality of patients. As explained by Mrs Phair:

250 [EXP00680017](#); [TRA00180063](#)

251 [EXP00340014](#); [TRA00100125](#)

252 [EXP01050003](#)

253 [EXP00040023](#); [TRA00170148-149](#)

254 [EXP00640019-20](#)

255 [EXP00770013](#)

256 [EXP00520028](#)

257 [EXP00720010](#); [EXP00730009](#)

“A reduction in body fluids can have major effects on the body: a reduction of 5% will cause thirst, a reduction of 8% will cause illness; and a 10% reduction in fluid can cause death (Carol 2000)”.²⁵⁸

Expert review of fluid recording

The nursing experts were critical of the monitoring of fluid balance in the cases reviewed. Professor Palmer noted that in one case the fluid balance charts did not demonstrate that a patient had been receiving appropriate amounts of fluids either intravenously or through a nasogastric tube prior to a significant deterioration in his condition.²⁵⁹

If correct, the fluid balance charts in another patient with active CDI suggested that her fluid intake was grossly inadequate in the face of a specific medical direction on the charts to “push fluids”.²⁶⁰

In his overview report Professor Palmer summarised the position as follows:

“The standard of fluid balance recording overall was lamentable and, on several occasions, professionally negligent.... There are several examples where the evidence would suggest that patients did not receive adequate fluids throughout a 24-hour period, or indeed over several days in succession”.²⁶¹

Mrs Jeanes was also highly critical of the fluid balance recording in the cases she examined. In one patient she noted that the fluid charts and nursing evaluation record did not always match. She explained that:

“Urine output was also poorly recorded at times and it is unclear when she had a urinary catheter in place and if this always drained anything. Intravenous fluids were also missed from the fluid charts and on the whole the fluid charts were of very limited value in clinical decision making”.²⁶²

Mrs Phair noted that fluid balance charts were completed erratically in the case of one patient despite the fact the medical staff had prescribed the need for accurate and detailed fluid balance charts.²⁶³ In this case there were many days where there was no chart completed at all and no evidence that the patient was ever offered a drink.²⁶⁴

Mr Evans summarised the position from the cases he reviewed in the following way:

“The overall standard of fluid balance recording was very poor”.²⁶⁵

The nursing experts also observed that the failures in fluid balance recording were not picked up by the SCNs on the wards.

Deficiencies in fluid balance recording

Listed below are examples of specific deficiencies identified by the nursing experts in fluid balance recording.

- Instances where patients were on fluid restriction and recording was poor²⁶⁶
- Input and output were at times blank or incomplete²⁶⁷
- Charts were continued for a frequency inappropriate to a patient’s needs²⁶⁸
- 24-hour totals were not calculated²⁶⁹
- There were no fluid balance charts for patients who should have had fluid balance charts²⁷⁰
- IV fluids were not appropriately added to the input column²⁷¹
- Charts were not properly maintained even when medical staff had asked for charts to be maintained²⁷²

263 EXP00170038; TRA00480036-37

264 EXP00170038

265 EXP01030005; TRA00350133

266 EXP00060017; EXP00390011; EXP00590009; TRA00150044-45; TRA00160140

267 EXP01030005; EXP00570014; TRA00350133; TRA00260123; TRA00230151

268 EXP01030005; TRA00350133

269 EXP01030005; EXP01050003; EXP00570014; EXP00710029; TRA00350133

270 EXP01030005

271 EXP01030005

272 EXP00200015

258 EXP00640019

259 EXP00670017

260 EXP00450016; TRA00200032

261 EXP01050003; TRA00220086

262 EXP00260027; TRA00120006-07

- One patient had 23 fluid balance charts and not one was completed adequately²⁷³
- Patients had two fluid balance charts for the same date²⁷⁴
- One patient who was in renal failure did not have properly completed fluid balance charts²⁷⁵

The nursing evidence on fluid recording

The nurses who gave evidence accepted that there were deficiencies in the monitoring of fluid balance in the records they reviewed.

Having reviewed the fluid balance charts on her ward, one SCN provided this evidence:

“I have read many of the documents with regard to each and every patient that has been looked at within the Inquiry, and there are some charts which are absolutely fine. Unfortunately, the majority of charts are not, and I can only accept that. I must accept that criticism”.²⁷⁶

The nursing staff accepted that it was important to keep accurate fluid balance charts for patients, particularly for patients with CDAD. They did not accept that patients were not given fluids.

The nursing staff also maintained that it is often extremely difficult to keep accurate fluid balance charts. That is undoubtedly correct.

One SCN explained her own approach, and that of her staff in the following way:

“I do not believe that my staff willingly, wantonly – and myself – failed to complete these charts properly. We had many discussions – many discussions – in the ward, where it was highlighted that the fluid balance charts needed to be much more accurately maintained, and this would improve, and then, for whatever reason, it didn’t happen”.²⁷⁷

A number of possible explanations were given in an attempt to justify the failure to complete accurate fluid balance records. Some of these are as follows:

- Poor levels of staff²⁷⁸
- Dependency of patients²⁷⁹
- Access to charts²⁸⁰
- Distractions with other patients or tasks²⁸¹
- Forgetting the amount taken when distracted²⁸²
- Patient continence²⁸³

Recognition of inadequacy of the fluid recording

From the evidence, there was some recognition around early 2008 that fluid balance charts were not being completed accurately. The issue was raised at the Sisters’ Meetings,²⁸⁴ and at the Sisters’ Meeting of 28 February 2008 concern was expressed that “(fluid balance) charts were not being filled in correctly and in some cases not at all”.²⁸⁵ Somewhat tellingly, this information was not provided from monitoring by SCNs but as feedback from GPs.

Medical staff had also highlighted the inadequacy of fluid balance recording on some wards.²⁸⁶ Nursing staff were reminded by SCNs that it was important to keep accurate fluid balance charts, but after some initial improvement this was not maintained.²⁸⁷

Conclusions on nursing notes and charts in the focus period

There were serious failures in the recording of patient information in the nursing records. There were unacceptable gaps in these records. The extent of the failures in important areas such as the recording of fluid balance and the charting of loose stools was such that there must have been an impact

273 EXP00010016

274 EXP00480023-24; EXP00580035

275 EXP00150011; [TRA00350060](#)

276 [TRA00290010](#)

277 [TRA00290011](#)

278 [TRA00450024](#)

279 [TRA00450024](#); [TRA00460082-84](#)

280 [TRA00420084-85](#); [TRA00420096-97](#)

281 [TRA00460082-83](#)

282 [TRA00460082-84](#)

283 [TRA00380028](#)

284 [TRA00450026](#); [TRA00310054-56](#); [TRA00420080-81](#); [TRA00380156-158](#)

285 [GGC14790003](#)

286 [TRA00340023-26](#); [TRA00370091](#)

287 [TRA00370002-03](#)

on the ability of the nurses on the wards to provide safe and consistent care. The serious failures identified in the recording of observations represent poor nursing care.

The handover practices adopted meant that information handed over did not enter the patient records. The SCNs were aware of this practice and they should not have allowed it to continue.

It is for the SCNs to lead the care given on their wards. They should have ensured that all nurses on the ward were aware of the importance of maintaining proper records on the aspects of basic care identified in this Section.

The extent of the failures discloses a serious lack of understanding of the important role played in patient care by good record keeping.

The lack of proactive involvement of nurse managers in the wards meant that Nursing Management was unaware of the extent of the nursing problems in the VOLH. Had there been a functioning system of audit the failures identified in this Section would have been identified and remedial action taken.

Nursing Management and ultimately the Board must accept responsibility for the failures identified in this Section.

12.9 Pressure damage in the focus period

General principles of pressure and wound management

When patients remain in the same position for periods of time, the points of the body which are in contact with a surface, such as a mattress or chair, may be at risk of pressure damage. This risk is exacerbated by the shearing action of movement across the skin when the patient is moved, particularly when moisture is present from body substances such as sweat, urine or diarrhoea. The risk is also increased with poor hydration, poor diet, peripheral oxygenation, circulation and other conditions such as diabetes.²⁸⁸

Immobile, sick and weak patients are unable to move effectively and are dependent on their carers to assist them. They are at particular risk of sustaining pressure damage. Patients who have CDI with profuse diarrhoea are particularly vulnerable to skin damage.²⁸⁹ Incontinence may also exacerbate existing skin damage. The importance of moving and handling techniques in avoiding skin damage has been considered in Section 12.7.

The development of pressure damage

Pressure damage first becomes evident as a redness of the skin which causes discomfort. Untreated, this early damage can continue to develop and can cause open painful wounds that are difficult to treat and can lead to more serious complications. Nursing care is designed to prevent pressure damage where possible.²⁹⁰ In frail, elderly patients action to prevent pressure damage must be taken rapidly as damage is likely and is difficult to cure.

Assessment of the risk of pressure damage

The cardinal rule is to avoid pressure damage wherever possible. Early assessment of the risk to the patient is imperative so that appropriate measures can be put in place to prevent pressure damage or at least reduce the risk.

The risk of pressure damage must be assessed on admission to hospital and thereafter at regular intervals based on the initial risk assessment. This risk is assessed by using a number of established criteria such as the Waterlow Score. The Waterlow Score provides an estimated risk for the development of a pressure sore in a given patient and is the most frequently used system in the UK. As with all risk assessment scoring systems, it is a tool to assist the nurse and must be used in conjunction with the nurse's professional judgement.

The Waterlow assessment allows the nurse to take steps to prevent pressure damage. In some cases this can be achieved by ensuring

288 [EXP00680010](#)

289 [EXP00680010](#); [EXP00720004](#); [EXP00730007](#)

290 [EXP00680010-11](#)

that regular positional changes occur and by optimising mobility for those at minimal risk. Patients with a high degree of risk of pressure damage require more extensive interventions. These can include pressure-relieving mattresses, regular and documented turning or positional changes, and scrupulous monitoring and documentation of pressure points to identify potential damage at an early stage.

Hydration, oxygenation and nutrition are important in ensuring that skin remains in good condition. Where early skin damage is present (redness) the normal treatment is to relieve the pressure and, in patients at risk of damage, apply a thin protective layer or dressing. All assessments and re-assessments must be documented and the plan of care adjusted accordingly.²⁹¹

The Waterlow Score

A Waterlow Score²⁹² document was available to nurses in the VOLH during the early and focus periods as a guide to assess the risk of pressure damage. Since June 2008 a new pro forma document²⁹³ has been available.

In using the Waterlow Score the following areas are assessed for each patient and assigned a value:

- Build/weight for height
- Skin type/visual risk areas
- Sex and age
- Malnutrition Screening Tool
- Continence
- Mobility

Additional points are assigned to selected patients in special risk categories for:

- Tissue malnutrition
- Neurological deficit
- Major surgery or trauma

A total Waterlow Score of 10 to 14 indicates that there is a risk of pressure damage. A high risk score is 15 to 19. A very high risk exists at scores of over 20. In relation to frequency of review, the Waterlow document used at the VOLH contained the information in Table 12.3.

Table 12.3 Recommended/documentation of risk status

Recommended/documentation of risk status		
Score on Admission	Category	Frequency of Assessment
Under 10	At Low Risk	ONLY if the patient's general condition changes
10 to 14	At Risk	At least WEEKLY; sooner if the patient's general condition changes
15 to 19	At High Risk	EVERY SECOND DAY; sooner if the patient's general condition changes
Over 20	At Very High Risk	DAILY, or as the patient's general condition changes

²⁹¹ EXP00680011; EXP00640012-14

²⁹² INQ01030001-02

²⁹³ INQ01050001-02

Evidence of nurses on the use of the Waterlow scoring system

It was accepted by nursing staff that the Waterlow scoring system should have been used as part of the patient admission process to assess the likely risk of pressure damage to a patient, and that the patient required to be re-assessed on a regular basis in accordance with the guidance in Table 12.3.

Sister Fox, who was the designated VOLH Tissue Viability Nurse (TVN), maintained that all nurses would be familiar with the Waterlow Score and that it was an integral part of nursing. She said laminated copies of the Waterlow Score Tool were displayed around the nursing stations on her ward.²⁹⁴

The clear message from the nurses' evidence was that assessments were being done, but not recorded. Nursing staff accepted in evidence that review, as suggested in the document in Table 12.3, was not documented and in some cases not performed in compliance with the guidance.²⁹⁵

Evidence of nurses on recording of pressure damage and wounds

Where a patient has pressure damage there should be clear documentation of the damage in the patient records. Sister Fox said in her witness statement that:

“a wound management care plan would be created, as a matter of course, for each patient ...”²⁹⁶

Nursing staff did accept that care plans should have been completed where there was pressure damage. These should clearly document the nature of the damage and the plan of care. Sister Fox said in her witness statement that the nurses would describe or map out the wound in the care plans. She maintained that the kind of information that would be recorded would be the depth, size and colour of the wound and the amount, smell and colour of the exudate.²⁹⁷

As a matter of fact, the Waterlow scoring system documentation was not being used in ward 6 during the early and focus periods. Sister Fox provided an erroneous signed statement to the Inquiry that claimed the Waterlow scoring system was used in ward 6 and that there was regular review. In her oral evidence she accepted that, having reviewed the patients' notes, there was no evidence that this was the case.²⁹⁸ Nevertheless, she maintained that patients were assessed and that the principles of the Waterlow scoring system were in fact applied, linking the failure to use the appropriate documentation to the level of activity on ward 6 at the time.²⁹⁹

Sister Fox said in oral evidence that she took photographs of some patient wounds in her role as TVN but later shredded these photographs.³⁰⁰ She was aware the photographs were part of the patient records but her understanding at the time was that they should be destroyed when no longer required for patient care.

The expert view on pressure and wound management

The nursing expert witnesses identified a lack of pressure wound management charts for patients with pressure damage and also a lack of care planning for pressure damage.

In the opinion of Professor Palmer the care provided for pressure damage was of a poor standard.³⁰¹ For example, he noted that in one case a patient did develop a sacral sore and that nursing staff failed to introduce an appropriate plan of nursing to deal with the healing and management of the sore. The nursing staff also failed to address the measures necessary to prevent the development of further sores. He noted that there were a number of cases where patients were displaying early but significant signs of pressure damage with little evidence that the nursing staff introduced precautionary measures.³⁰²

294 [WTS01870005](#)

295 [TRA00360017](#); [TRA00370128](#); [TRA00410037-38](#)

296 [WTS01870006](#)

297 [WTS01870007](#)

298 [TRA00300002](#); [TRA00300028](#)

299 [TRA00300029](#)

300 [TRA00300048-49](#)

301 [EXP01050003](#)

302 [EXP01050003](#)

Mrs Jeanes identified one patient with leg lesions with no plan of care.³⁰³ Another patient had groin wounds, and while there was a plan of care for her it was not systematically utilised and evaluated.³⁰⁴ Another patient had necrotic pressure points but the documentation was too poor to judge if actions taken to deal with the pressure damage were effective.³⁰⁵ Mrs Jeanes was highly critical:

“The assessment, planning, prevention and management of pressure damage in some patients was lamentable”.³⁰⁶

Mrs Stower was also critical of the care on pressure damage:

“I am highly critical of the standard of assessment, planning, evaluation and review of the nursing care relating to this group of patients skin/pressure management and the lack of involvement of the TV (Tissue Viability) Specialist Nurse (who should be the expert in this field). This was a group of frail elderly patients, whose overall health and wellbeing was further compromised by *C. difficile* diarrhoea, which in most cases was a contributory factor to their deteriorating skin viability. I was saddened that some of these patients' care was so lacking, that they would have suffered from the pain and discomfort of excoriated skin, deep sores, and matted scalp hair...”.³⁰⁷

Mr Evans identified examples in the cases he reviewed of patient wounds being treated with products that were not in the nursing formulary and of formulary products being used inappropriately on wounds.³⁰⁸

In one patient at least 11 products were used for pressure damage, often with no rationale, no plan, and no assessment of progress. Mrs Jeanes provided this opinion in the case of this patient:

“Whilst it is clear that many nursing staff made efforts to manage the pressure damage, the lack of consistency in approach was poor practice, although the record keeping is so poor that it is difficult to determine exactly what was done at times. The use of specialist knowledge in pressure damage prevention and management is not documented. It is unclear if staff understood the need to escalate issues for specialist help and advice, or if specialist help was not available”.³⁰⁹

Deficiencies in pressure management

The following issues were identified by the nursing experts:

- Failures to assess a patient for the risk of pressure damage
- Failures in documentation of the risk which included incorrect scoring
- Failures to review assessments appropriately when assessments were made
- Failures to prepare appropriate care plans when there was a risk
- Failures to identify patients with early but significant signs of pressure damage
- Failures to obtain a pressure relieving mattress where it was required
- Failures to use the appropriate products
- Failures to document wounds appropriately
- In one patient who was critically ill there was no assessment of the risk of pressure damage and no recorded assessment of pressure points³¹⁰

Turning charts

A turning chart allows nursing staff to record positional changes to patients who have sustained, or are at risk of sustaining, pressure damage. The chart provides a plan of care that is dedicated to a turning programme appropriate for the patient. Positional changes are clearly recorded by all those dealing with the patient.

303 EXP00220016; [TRA00120062-63](#)

304 EXP00230025; [TRA00180056](#)

305 EXP00680010; [TRA00180056](#)

306 EXP00680012; [TRA00180058](#)

307 EXP00590007-08; [TRA00160138](#)

308 EXP01030004; [TRA00350131](#)

309 EXP00390022; [TRA00110067-71](#)

310 EXP00660001; EXP00680007; EXP00720008; EXP00730007; EXP01050002; [TRA00350130-131](#); [TRA00180057](#); [TRA00220114](#); [TRA00160156-157](#); [TRA00160136-138](#); [TRA00240057](#); [TRA00350131](#)

Turning charts were not in use at the VOLH during the early and focus periods.³¹¹ One SCN provided the evidence that although there were no turning charts available “patient turning was seen as a basic nursing duty”.³¹² It was suggested that references to turning would be made in the patient’s care plan.³¹³ Sister Fox said that she did not consider that it was within her remit to introduce turning charts to her ward or to the hospital, despite her role as TVN for the hospital.³¹⁴ That is a perfectly understandable position because she was not a dedicated TVN. A turning chart is now included in the care bundle for tissue viability.³¹⁵

The clear message from the nurses’ evidence was that despite the absence of turning charts patients were turned regularly and appropriately. This meant that the nurse had to remember when a patient had been turned and what the previous position had been.³¹⁶ Nurses did not accept that any patient sustained pressure damage as a result of failure by a nurse to institute and follow a proper turning regime.

Tissue Viability Nurse

The VOLH did not have a dedicated TVN during the early and focus periods. The role of TVN was performed between January 2007 and June 2008 by Sister Fox,³¹⁷ who was given a job description for the position.³¹⁸ She was also the SCN for ward 6, a busy medical ward, and accepted that she could not provide the service a dedicated TVN³¹⁹ practitioner would provide. Nor did she have formal training for such a role.³²⁰

Around June 2008 the role of the TVN at VOLH was reviewed and thereafter Sister Fox resigned from the position, which was then shared between TVN specialists from the IRH and the RAH.³²¹

311 [TRA00300032](#); [TRA00380089-90](#); [TRA00430021](#); [TRA00450043](#)

312 [WTS01870009](#)

313 [WTS01870009](#)

314 [TRA00300033-34](#)

315 [INQ01070001](#); [WTS01870009](#)

316 [TRA00320096-99](#); [TRA00410014](#); [TRA00430022](#); [TRA00450044-45](#)

317 [WTS01870001](#); [TRA00290005](#)

318 [INQ01020001](#)

319 [TRA00300033](#)

320 [TRA00300044](#); [TRA00300044-45](#)

321 [WTS01870004](#)

The use of pressure relieving mattresses

Nursing staff said that they had access to pressure relieving mattresses and had no difficulty in obtaining such mattresses.

It was accepted that where a pressure relieving mattress was in use this should be evident from the patient records.³²² On review of the patient records it was often impossible to ascertain if a specialist mattress was ordered, when this type of mattress was used, and for how long the mattress was in use.³²³

Number of patients with pressure damage

The nursing experts were able to identify 37 patients in the focus group of patients who suffered pressure damage. The number is likely to be higher because poor record keeping meant that the experts could not ascertain the position for a significant number of patients. Nor is it possible to say how many patients were suffering from some pressure damage on admission to the VOLH.

Conclusions on pressure damage in the focus period

Pressure and tissue management at the VOLH was poor. Inevitably this would have had an impact on care. Sister Fox was placed in a very difficult position because she had responsibility for a busy medical ward in addition to her duties as a TVN, and the Inquiry considers that it would be unfair to criticise her for failures in pressure damage management. As SCN and as TVN for the hospital, however, Sister Fox should have known that a failure to follow the Waterlow system of assessment was unacceptable.

Given the importance of tissue viability, a nurse who was a SCN on a busy ward should not have been selected as the TVN for the VOLH. There also appears to have been a lack of any assessment of her work in the role of TVN. The nurse selected for the role of TVN ought to have had the appropriate experience and training and to have been provided with sufficient time to perform the role properly.

Nursing Management and ultimately the NHSGCC Board have to accept responsibility for the failures identified in this Section.

322 [TRA00410015](#)

323 [TRA00300038-39](#); [TRA00340092-94](#)

12.10 Nursing care in the early period

Similar trends

The work undertaken by Mrs Phair in connection with the early period has already been described. Mrs Phair had access to 33 sets of patient records. Sixty-eight patients tested positive for CDI during the early period.

The trends evident on basic aspects of nursing care were also present in the early period.

Nursing care assessments

The review of the nursing assessments carried out disclosed that in 32 of the 33 patient records the nursing assessment was either poorly completed or not present when it should have been.³²⁴

Nutritional assessments

Nutritional assessments in the early period were only completed to a satisfactory standard for three patients. Ten patients had poorly completed assessments and a further 20 had no assessment or care plan.³²⁵ This was a similar pattern to that found in the focus period.

Moving and handling assessments

Only five patients in the patient records reviewed had satisfactory moving and handling assessments.³²⁶ There were no records of assessments for 25 patients who should have had assessments.³²⁷

Falls risk assessments

Only four patients had a satisfactory falls risk assessment.³²⁸ There was no evidence of falls risk assessments for 26 patients and falls risk assessments for a further three patients were inadequate.³²⁹

Care planning for patients with CDI

Mrs Phair also looked at care planning for CDI for patients in the early period. She was of the view that only two patients had a satisfactory care plan in place for the management of the infection. Nine patients

had no care plan in place at all and 22 had care plans that were inadequate.³³⁰

Stool and fluid balance charts

Mrs Phair concluded that in the cases she reviewed stool charts did not exist or were not completed correctly for 32 patients out of the 33 patient records examined.³³¹ Fluid balance charts were either not completed properly or did not exist.

Pressure management

It was clear from the review of pressure risk assessment that there were deficiencies similar to those discovered in the focus period. Only three patients had a satisfactory pressure risk assessment. Fifteen patients had an inadequate assessment and/or no care plan. Fifteen had no assessment or care plan at all.³³²

12.11 Staffing issues and care

Apparent shortage of nurses

A number of relatives expressed the view that there appeared to be a shortage of nurses and that nurses were “run off their feet”.³³³ This is considered in Chapter 11. Nursing staff also contended that deficiencies in record keeping could be explained, at least in part, by the fact that they were busy.³³⁴

The importance of adequate staffing

Adequate staffing of nurses on wards is not only dependent on having the correct number of nurses but also on having the correct skill mix to carry out the care appropriate to the level of patient dependency. There are no nationally set mandatory nursing levels.

Adequate nurse staffing levels are important for ensuring patient safety and quality of care. There is a direct link between low staffing and increased levels of pressure ulcers, medication errors, falls and healthcare associated infections.³³⁵ Conversely, good staffing levels promote good levels of care.

³²⁴ [EXP02790005](#); [EXP02790008](#); [TRA00480052-53](#)

³²⁵ [EXP02790005](#)

³²⁶ [EXP02790005](#)

³²⁷ [EXP02790011](#)

³²⁸ [EXP02790011](#)

³²⁹ [EXP02790011](#)

³³⁰ [EXP02790005](#)

³³¹ [EXP02790005](#)

³³² [EXP02790005](#)

³³³ [TRA00030070](#); [TRA00040097](#); [TRA00010029](#);
[TRA00010107](#)

³³⁴ [TRA00370065-66](#); [TRA00460033](#); [TRA00460081-82](#)

³³⁵ [EXP02820008](#); [INQ03810007](#); [INQ03810028](#)

Tools used as a guide to assessment of nurse staffing levels and ratios

There is a variety of methods that can be used to guide nurse staffing levels and ratios. A commonly applied tool in the UK is the Hurst Model.³³⁶ The 2006 Royal College of Nursing report, "Setting Appropriate Ward Nurse Staffing Levels in NHS Acute Trusts",³³⁷ recommends a skill mix of 65% registered nurses and 35% nursing assistants.³³⁸ Apart from the correct skill mix, available staffing levels will vary depending on vacancies due to turnover of staff, maternity leave and sickness. To account for this and for protected time for training and development, the Royal College of Nursing (RCN) also recommends that a predictable absence allowance of 25% is built into ward nursing numbers.³³⁹

Evidence of the ward nurses on staffing

The evidence of nurses was that they were extremely busy on the wards. One SCN accepted in evidence that there could be a delay in patients being cared for because the staff were so busy.³⁴⁰ Other SCNs said there were absences and they relied heavily on bank staff.³⁴¹ One SCN stated that she had regular discussions with her manager about the fact that staff on her ward were overly busy.³⁴²

One of the SCNs described the position on staff in the following way:

"We could have done with more staff yes. Our patients were very dependent, even when not medically unwell. Due to stroke or dementia our patients would require input that took a lot of time. It was very heavy work, both physically and mentally demanding".³⁴³

Review of whether the issue of lack of staff had previously been raised as a problem

As mentioned on several occasions in this Chapter, the SCNs argued that the burden

on nursing staff could explain the significant failures identified in record keeping and apparent deficiencies in care. This explanation for poor record keeping was first raised when the SCNs gave evidence. The Inquiry is not aware of any meeting where it was suggested that nurses could not complete records due to lack of staff.

Neither the NHSGGC Internal Investigation report³⁴⁴ nor the Independent Review³⁴⁵ chaired by Professor Cairns Smith suggested that poor staffing levels were seen as having an adverse impact upon record keeping or care. When the Internal Investigation Team interviewed the SCNs for wards 3, 4, 6, 14, 15 and F. SCNs did not raise staffing levels as an issue preventing them from performing all their duties. The following extract has been taken from the Internal Investigation report:

"WARD STAFFING LEVELS

The purpose of this Section is to confirm that the VOL had no problem with nurse staffing levels.

This can be evidenced from the interviews with all Ward Managers (SCNs) and Lead Nurses/CSMs (Clinical Service Managers) who confirmed:

- They did not have staffing problems
- They had a low turnover of staff
- Their sickness absence was well controlled
- They never had cause to raise staffing issues to the general management level"³⁴⁶

Expert review of staffing levels

Mrs Perry reviewed the staffing ratios for all wards and considered that they were acceptable for the number and nature of patients on the ward.³⁴⁷ She prepared a Table setting out the staffing levels in wards from January 2007 to April 2008 which is reproduced in Table 12.4.

336 [EXP02820007](#)

337 [INQ01990001](#)

338 [INQ01990005-06](#); [EXP02820012](#)

339 [EXP02820007](#)

340 [TRA00290017-18](#)

341 [TRA00360009](#); [TRA00450030-31](#); [TRA00460150](#)

342 [TRA00310130-131](#)

343 [WTS02250019](#)

344 [GGC00610001](#)

345 [GOV00030001](#)

346 [GGC00610017](#)

347 [EXP02820008](#)

Table 12.4 Mrs Perry's review of staffing levels

Ward	Whole time equivalent nursing staff budget	Number of beds	Skill mix (%) registered/unregistered
3	25.33	20	61/39
4	18.87	10	71/29
5	26.71	20	66/34
6	27.40	22	61/39
F	22.18	16	52/48
14	27.30	24	45/55
15	27.23	24	40/60
Fruin	23.36	24	36/64

The staffing levels demonstrate that the scheduled number of nurses to beds did not fall below one nurse to four patients with the exception of night duty, where it is common across the NHS to have lower staffing numbers.³⁴⁸ The figures for staffing at VOLH did include a 22.5% allowance in numbers for predictable absence. According to Mrs Perry the ratio of one nurse to four patients for day shifts is accepted professionally as a reasonable benchmark.³⁴⁹

Mrs Perry's view was that the ratio of registered/trained to untrained staff on the medical wards was appropriate, aligned to the RCN benchmarks, and therefore unlikely to have contributed to poor clinical care and spread of infection.³⁵⁰

Mrs Perry also looked at levels of sickness absence and the use of bank and agency staff. She concluded that the use of bank and agency staff was at the level expected in the NHS and that bank and agency staff were used appropriately.³⁵¹

The staffing ratio does not, however, take account of a situation where a number of patients become unwell with profuse diarrhoea

and require additional nursing input.³⁵² In particular, the ratios for the Rehabilitation and Assessment wards do not take account of the fact that some patients in those wards were medically unwell and required nursing rather than rehabilitation care.

Staff morale

Some nursing staff described morale as low due to overwork. The nurses were aware that there was uncertainty over the future of the hospital. Yet nursing staff did not believe that low morale or uncertainty about the future of the VOLH affected the quality of patient care.

An SCN had this to say on the uncertainty over the future of the VOLH:

"I don't think it impacted on morale on a day to day basis when the staff were working. I think it was just a threat that was hanging over them over a period of a long time, and they were almost used to it. But when they came into work, it certainly didn't reflect on their performance when they were there".³⁵³

The Deputy SCN of Fruin ward, when asked if she thought that staff morale was affected by the dissolution of Clyde, expressed the following view:

348 [GGC24580001](#)

349 [EXP02820008](#)

350 [EXP02820013](#)

351 [EXP02820012](#)

352 [TRA01040009-13](#)

353 [TRA00440069](#)

“Yes, we were all scared for our jobs. We thought we would be transferred to Gartnavel. We stated our case to Cabinet Secretary for Health Nicola Sturgeon and after she came back and said we could stay where we were. We felt the hospital was getting down graded all the time. The hospital was getting run-down”.³⁵⁴

Appropriate staffing levels

The definition of a safe level of nursing staff varies in different situations. There must be a balance between the level of the nursing staff and the needs of the patients on the wards. It is not simply an issue of numbers. It is also critical that the nursing staff are competent to provide the care required by the patients on their particular ward.

The issue of safe and adequate nurse staffing is a controversial one and is the subject of significant debate. Studies³⁵⁵ do demonstrate a direct correlation between inadequate nurse staffing levels and

- Patient mortality
- Patient satisfaction
- Adverse patient outcome
- Patient recovery
- Errors in treatment³⁵⁶
- Where staffing levels are inadequate this also can have an affect on nursing morale and increased nurse turnover rates.

Conclusions on staffing

The staffing levels at the VOLH were in accordance with nationally approved standards in 2007 and 2008 but that does not mean that staffing levels were safe. At times when there are outbreaks of infections such as CDI the demands upon staff are increased. Also, where patients in a rehabilitation ward are acutely unwell and are kept in that ward rather than transferred to an acute ward, it is highly likely that the staffing levels will be inadequate. Some nurses working in a rehabilitation setting may not have the necessary skills to nurse

acutely ill patients. When staffing levels are inadequate, or nurses do not have the necessary skills to nurse patients, it is the responsibility of the SCN to raise this with Nursing Management.

Nursing Management must be directly involved in the wards for which they have responsibility. They must be aware when staffing levels require to be addressed.

12.12 Overall conclusions on nursing care

This Chapter has identified a catalogue of failures in fundamental aspects of nursing care.

The Inquiry accepts the evidence of the nursing experts. They carried out a careful and detailed examination of the patient records and many of the deficiencies they identified were not disputed by the nurses in their evidence. Each nursing expert identified similar failures across different wards in the VOLH, a consistency that reinforces the soundness of their conclusions.

The focus of the Report is of course on CDI, and the review of patient records has disclosed serious deficiencies in the nursing care given to patients with CDI in the VOLH. Care was deficient at the most basic levels, and also in more specialised management of patients. It is worthy of note that the deficiencies identified were not restricted to one particular ward. Nor were they restricted to the focus period. Standards of nursing care had been permitted to lapse over a period of time. The SCNs must be primarily to blame for the deficiencies on their own wards. Indeed in some cases it is clear that SCNs participated in the poor care. The SCNs should have led by good example. They had a duty to identify deficiencies in nursing care on their wards.

The conclusion that the standard of nursing care was poor is supported by other deficiencies noted in other Chapters of this Report. For example, in Chapter 11 evidence of failures in basic care, including faeces found under nails, has been identified. Furthermore, as discussed in Chapter 13,

³⁵⁴ [WTS02200019](#)

³⁵⁵ [INQ03810001](#)

³⁵⁶ [INQ03810001](#)

there were serious delays in commencing treatment for CDI even after a diagnosis had been confirmed.

Having reviewed patient records prior to giving evidence, the SCNs accepted that there were deficiencies. They sought to explain the deficiencies by the levels of activity on the wards. It may be that on occasion notes were not made because staff were busy, but that explanation does not excuse the significant deficiencies found. It is simply not a convincing explanation that, notwithstanding the serious failures identified in this Chapter, the care was in fact given.

It would be simplistic, however, to suggest that all blame should lie with the SCNs. For proper care to be delivered Nursing Management also has a role to play. That role must be a proactive one. There was no evidence that Nursing Management was proactively involved in the management of the wards for which they had responsibility. Their total ignorance of the extent of the problems discovered on analysis of the patient records is demonstrative of their lack of involvement on the wards. Had Nursing Management been more proactively involved on the wards under the managers' care, and ensured that regular auditing of records was undertaken, deficiencies could have been identified.

Ultimately, NHSGGC must accept responsibility for the failures identified in this Chapter.

12.13 Recommendations

Recommendation 13: Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board.

Recommendation 14: Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records. Health Boards should ensure that there is an effective system of audit of patient records, and that there is effective scrutiny of audits by the Board.

Recommendation 15: Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure.

Recommendation 16: Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team.

Recommendation 17: Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient's status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously.

Recommendation 18: Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.

Recommendation 19: Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in the patient notes and are included in care planning for the patient.

Recommendation 20: Health Boards should ensure that where a patient has, or is suspected of having, *C. difficile* diarrhoea a proper record of the patient's stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance.

Recommendation 21: Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods.

Recommendation 22: Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.

Recommendation 23: Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN.

Recommendation 24: Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient.

Recommendation 25: Health Boards should ensure that every patient is assessed for risk of pressure damage on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit.

Recommendation 26: Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient's condition. Compliance should be monitored by a system of audit.

Recommendation 27: Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit.

Recommendation 28: Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support.

Recommendation 29: Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays.

Recommendation 30: Health Boards should ensure that where patients require fluid monitoring as part of their clinical care, nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period.

Recommendation 31: Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes (due to acuity and/or dependency), an agreed review framework and process should be in place to ensure that the appropriate skills base and resource requirements are easily provided.

Recommendation 32: Health Boards should ensure that there is a straightforward and timely escalation process for nurses to report concerns about the staffing numbers/skill mix.

Recommendation 33: Health Boards should ensure that where a complaint is made about nursing practice on a ward this complaint is investigated by an independent senior member of Nursing Management.

Chapter 13

Antibiotic prescribing

Introduction

This Chapter explores the background to the recognition of the importance of prudent antibiotic prescribing and whether action could have been taken before June 2008 to address the prolonged, excessive and inappropriate prescription of certain antibiotics at the VOLH. The Chapter also considers the timescales involved in the creation of an Antimicrobial Management Team (AMT) by NHS Greater Glasgow and Clyde (NHSGGC) and the impact of the VOLH experience on antibiotic prescribing after June 2008.

13.1 Antimicrobial policy and prudent prescribing

A starting point

An important milestone in addressing antibiotic policy in the UK is the House of Lords Select Committee on Science and Technology Report dated 17 March 1998, “Resistance to Antibiotics and other Antimicrobial Agents”.¹ Another important milestone is the report produced by the Standing Medical Advisory Committee of the Department of Health for England and Wales, “The Path of Least Resistance”, also in 1998.² In the latter report the following observations are made about *C. difficile* and about antibiotic prescribing practice in general:

“*Clostridium difficile* can become established in the gut only when the normal bacterial flora has been disrupted by antibiotics”.³

“Taking antibiotics unnecessarily does you no good and damages them for anyone else”.⁴

“It makes sense to cherish your bacterial flora”.⁵

The position in Scotland in 1999

In a letter⁶ dated 21 May 1999 addressed to Health Board General Managers and Chief Executives of NHS Trusts, among others, the Scottish Office Department of Health set out the action to be taken by the NHS in Scotland in response to the House of Lords report. The goals for NHSScotland included:

- A reduction in ill-health from communicable disease, including hospital acquired infection; and
- A contribution to the control of antimicrobial resistance

Annex 1 to the letter described the strategy as one that needed to address three key elements:⁷

- Infection control;
- Prudent antimicrobial use; and
- Surveillance of resistant organisms and antimicrobial usage

One of the particular steps highlighted as part of that strategy was the reduction of “inappropriate antimicrobial prescribing”.⁸

The Antimicrobial Resistance Strategy and Scottish Action Plan 2002

After devolution, the then Scottish Executive produced a report in 2002 with the title “Antimicrobial Resistance Strategy and Scottish Action Plan”⁹ (the 2002 Action Plan). The 2002 Action Plan took account of the sources mentioned earlier as well as recommendations from the World Health Organization (WHO) and the European Conference on “The Microbial Threat”.¹⁰ It was a three-year plan¹¹ and its aims included:

- The reduction of unnecessary and inappropriate use of antimicrobials; and
- The monitoring and provision of data on resistant organisms, associated morbidity and antimicrobial usage¹²

1 [INQ04790001](#)

2 [INQ05080001](#)

3 [INQ05080102](#)

4 [INQ05080100](#)

5 [INQ05080100](#)

6 [INQ04540001](#)

7 [INQ04540003](#)

8 [INQ04540004](#)

9 [GOV00360072](#)

10 [GOV00360077](#)

11 [GOV00360077](#)

12 [TRA01100113](#)

The strategy set out in the 2002 Action Plan comprised three elements:

- Prudent antimicrobial use;
- Surveillance, including surveillance of antimicrobial usage; and
- Infection control to reduce the spread of infection¹³

This was in effect a repetition of the strategy set out in the Scottish Office Department of Health letter of 21 May 1999.

As part of that strategy the Scottish Medicines Consortium was established to co-ordinate across Scotland work done to evaluate new medicines, new formulations and new indications for existing medicines, including antimicrobial agents, in terms of clinical and cost effectiveness.¹⁴

The guide to Antimicrobial Prescribing Policy and Practice in Scotland – 2005

A guide to the prudent use of antibiotics, “Antimicrobial Prescribing Policy and Practice (APP&P) in Scotland”¹⁵ (the 2005 guide), was produced for NHSScotland by the Scottish Medicines Consortium in August 2005. It highlighted a number of challenges faced in antimicrobial prescribing, including:

- Evidence of wide variation in antimicrobial prescribing and practice;
- Concern about insufficient liaison between microbiologists, clinicians, and pharmacists; and

- Concern about inadequate supervision of prescribing and the inappropriate choice, duration of treatment and records of administration by junior doctors.¹⁶

By letter dated 5 September 2005¹⁷ the then Scottish Executive made Boards aware of the availability of the 2005 guide, describing the recommendations contained in it as “a key clinical governance issue and a major public health imperative”.¹⁸

Key areas

The 2005 guide identified several key areas of practice and made a number of recommendations. One of those recommendations was that a multi-disciplinary Antimicrobial Management Team (AMT) should be formed by each Health Board¹⁹ to be responsible for implementing antimicrobial policy and practice. One of the key areas identified was the importance of auditing as a tool in maintaining the safe and cost-effective use of antibiotics,²⁰ and the AMT was to play a critical role in the evaluation of appropriate auditing systems. Ward-based antimicrobial pharmacists were to take the lead in co-ordinating the implementation and audit of antimicrobial practice and to report to the Chief Pharmacist.²¹ Figure 13.1 sets out the proposed structure.²²

13 [GOV00360079](#)

14 [GOV00360090](#)

15 [GOV00360003](#)

16 [GOV00360009](#)

17 [GOV00360001](#)

18 [GOV00360002](#)

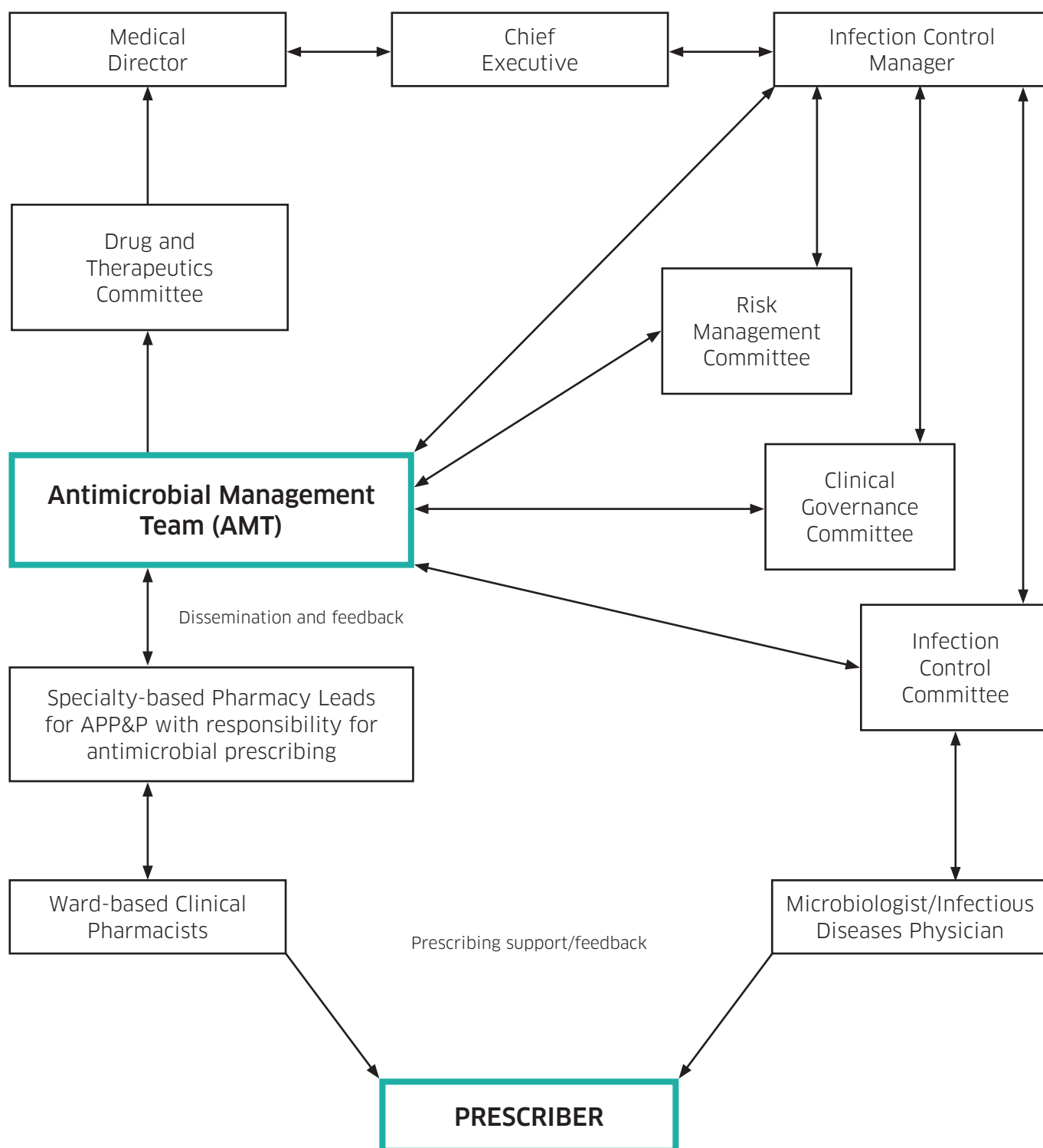
19 [GOV00360012](#)

20 [GOV00360017](#)

21 [GOV00360022](#)

22 [GOV00360022](#)

Figure 13.1 Model antimicrobial prescribing practice pathway in acute hospitals



Another key area of practice identified was to:

“Define the minimum dataset requirements and standard procedures for collecting information related to antimicrobial consumption and quality of prescribing at an organisational level and/or ward specific level”.²³

The 2005 guide noted that monitoring of hospital consumption of antibiotics was one of the key recommendations of the 1998 House of Lords report.²⁴ It also noted that six years on from that report the UK had no routine data on antimicrobial use in hospitals, in contrast to 23 out of 31 other European countries,²⁵ and recommended that all acute hospitals should analyse and report antimicrobial use. It also recommended that a national agency should collate and report antimicrobial utilisation trends across Scotland,²⁶ and the National Medicines Utilisation Unit (NMUU) was set up in 2005 for this purpose.

A letter from the Scottish Executive Health Department to Chief Executives of NHS Boards dated 5 September 2005 introduced the 2005 guide and described the intention behind it as follows:

“Antimicrobial Prescribing Policy and Practice in Scotland sets out recommendations for good practice relating to health care structures and lines of responsibility, data requirements for monitoring resistance and antimicrobial use at local and national levels, issues relating to audit and performance management, and requirements for education and training. It also provides guidance on the development and monitoring of local antimicrobial prescribing policies and formularies”.²⁷

13.2 The 2008 Action Plan

Background

In December 2005 the Healthcare Associated Infection (HAI) Task Force decided to reconvene a Steering Group²⁸ to update the 2002 Antimicrobial Resistance Strategy and Scottish Action Plan. The intention was to invite comments from all interested parties with a view to producing a consultation document. The remit²⁹ of that group included the following areas:

- Assessing the progress of the implementation of the 2002 Action Plan, and producing a successor document;
- Assessing the progress of the 2005 guide and identifying outstanding actions required to achieve a number of goals including the promotion of prudent antimicrobial prescribing; and
- The development of an updated Antimicrobial Resistance Strategy and Action Plan for delivery to NHSScotland by April 2007³⁰

The first meeting of the Steering Group took place on 30 January 2006,³¹ and at that meeting the impact of the 2002 Action Plan was described in the following way:

“Problems encountered in the implementation of ARSSAP (Antimicrobial Resistance Strategy and Scottish Action Plan) 2002, include the fact that it was launched without specific responsibilities or overseeing group being identified; lack of progress on prescribing information systems for secondary care; no single focus for driving the agenda forward; and rapidly growing antimicrobial resistant threats since 2002”.³²

In his evidence, Dr Kevin Woods, Director General for Health, Scottish Government, agreed that the 2002 Action Plan “had not really produced much by way of results”.³³

23 [GOV00360016](#)
 24 [GOV00360016](#)
 25 [GOV00360016](#)
 26 [GOV00360016](#)
 27 [GOV00360001](#)

28 [GOV00360126](#)
 29 [GOV00360049](#)
 30 [GOV00360165](#)
 31 [GOV00360119](#)
 32 [GOV00360120](#)
 33 [TRA00970089](#)

The launch of the 2008 Action Plan

The Steering Group completed its work in November 2006 and produced “The Scottish Management of Antimicrobial Resistance Action Plan” (ScotMARAP), which was submitted to the then Scottish Executive.³⁴ The peer review draft of that document was circulated by Mr Paul Martin, then Chief Nursing Officer, Scottish Government, by letter dated 7 December 2007.³⁵ Included on the circulation list were the area drug and therapeutic committees and Infection Control Managers.³⁶ In the peer review draft³⁷ the following observations were made:

“It is known that a significant proportion of current antimicrobial usage in hospitals is not ‘prudent’; this is mainly an issue of excessive use (use of an antimicrobial where not necessary or prolonged courses), or inappropriate choice of (or incorrect dosing of) antimicrobial agent for treatment or prevention of the relevant infection”.³⁸

In March 2008 the then Cabinet Secretary for Health and Wellbeing launched the “Scottish Management of Antimicrobial Resistance Action Plan”³⁹ (the 2008 Action Plan), which was to replace the 2002 Action Plan. The description on practice just quoted from the peer review draft was repeated in the final version.⁴⁰

The 2008 Action Plan and prudent prescribing

The 2008 Action Plan again emphasised the importance of prudent prescribing and proposed that all Boards should immediately set up Antimicrobial Management Teams (AMTs)⁴¹ where these were not already in place. It noted that NHS Boards were “moving towards implementing some of the major recommendations” contained in the 2005 guide and that the Steering Group had observed that progress in this area had been “slow and patchy”.⁴²

The original Task Force target of delivery of an updated Antimicrobial Resistance Strategy and Action Plan to NHSScotland by April 2007 was not met.

The 2008 Action Plan echoed the theme that had emerged in Scotland by at least 1999,⁴³ and had persisted over the years,⁴⁴ that it was known that antibiotic prescribing was not being carried out in a “prudent”⁴⁵ way. It also recorded that, although a key role for the NMUU since its establishment in 2005 had been to develop systems to collect and collate information on antimicrobial prescribing, particularly within hospitals:⁴⁶

“The UK lags behind much of Europe in being able to access these hospital data, and in Scotland this represents the major outstanding task within (the 2002 Action Plan)”.⁴⁷

The expectation of the 2008 Action Plan was that the NMUU would work closely with the Scottish Medicines Consortium and Health Protection Scotland to carry out a number of specific tasks, including reporting the usage of “agreed key antimicrobials in target groups across NHS Boards”.⁴⁸

One of the initiatives in the 2008 Action Plan was the establishment of the Scottish Antimicrobial Prescribing Group (SAPG),⁴⁹ which was set up as a national clinical multi-disciplinary forum with representation from Boards. It was formed in March 2008,⁵⁰ and its primary function was to co-ordinate and deliver a national framework for antimicrobial stewardship in Scotland so as to improve the quality of antimicrobial prescribing and management.

34 [GOV00360166](#)

35 [GOV00360168](#)

36 [GOV00360169](#)

37 [GOV00360170](#)

38 [GOV00360175](#)

39 [GOV00360040](#)

40 [GOV00360045](#)

41 [GOV00360061](#)

42 [GOV00360049](#)

43 [INQ04540001](#)

44 [GOV00360079](#); [GOV00360009](#)

45 [GOV00360045](#)

46 [GOV00360058](#)

47 [GOV00360058](#)

48 [GOV00360058](#)

49 [GOV00360053](#)

50 [TRA01100113](#)

13.3 Significant failures in implementation and monitoring

The Scottish Government letter of 8 July 2008

After the problem with *C. difficile* infection (CDI) at the VOLH came to light, the Scottish Government wrote to NHS Board Chief Executives and others on 8 July 2008 highlighting the following points among others:

“One key intervention in managing both problems (MRSA and *C. difficile*) is to robustly address the issue of prudent prescribing of antimicrobials within NHS Scotland, and this Letter seeks the immediate implementation of our national policies in this area”.⁵¹

“SAPG has advised that not every Board has an established Antimicrobial Management Team (AMT) as set out in APP&P (Antimicrobial Prescribing Policy and Practice) and ScotMARAP (Scottish Management of Antimicrobial Resistance Action Plan), and some of those which have been set up do not cover primary care prescribing. As an immediate intervention to reduce the risks from *C. difficile*, we accept SAPG’s recommendation that all Boards should immediately establish an AMT which covers primary and secondary care prescribing activities”.⁵²

Failure of the message on prudent prescribing

The message on the importance of prudent prescribing had certainly not reached the VOLH prior to June 2008, despite its repetition over the preceding years. Dr Seaton explained the position in the following way:

“My take on the situation was that what had happened or was happening, in the Vale of Leven, was applicable to all our hospitals in Greater Glasgow and Clyde and, indeed, almost certainly all our hospitals in Scotland. That was the big important message to me. So this was the catalyst for me, for change of not just guidance for that specific hospital, but for all our hospitals and board”.⁵³

It is not within the Inquiry’s remit to dwell on what was happening in other hospitals across Scotland. Dr Seaton was, however, in a position to speak about the general position with some authority.

As Dr Seaton explained, a culture had developed in which clinicians had come “under the spell of broad spectrum antibiotics”⁵⁴ and were using them in situations where broad spectrum antibiotics were not any more effective against those infections that were sensitive to narrow spectrum antibiotics. The VOLH experience became a catalyst for change, but change in antimicrobial practices should have happened long before it did. As explored in Chapter 18, the reports into the CDI outbreaks at the Stoke Mandeville and Maidstone and Tunbridge Wells Hospitals published in 2006 and 2007 should in any event have prompted an examination of antibiotic prescribing practice. As documented elsewhere in this Report in relation to other aspects of infection prevention and control, a pattern had developed of policy and/or guidance being issued on behalf of the Scottish Government and of significant delay in its implementation.

It may be that financial constraints played some part in such delays. There is no reason to doubt either the assertion of Dr Brian Cowan, Board Medical Director and Medical Director of the Acute Division, that new guidance provided by NHSScotland on infection prevention and control after June 2008 “invariably”⁵⁵ came with supportive finance, or his suggestion that that was something that did not “tend to happen before”.⁵⁶ An example of that approach is the instruction in the Scottish Government’s letter of 8 January 2008 to Boards which did not have an AMT in place to establish an AMT “immediately”.⁵⁷ This instruction was accompanied by a pledge of supportive funding.⁵⁸

The recognition of the need for prudent antibiotic prescribing and the implementation

51 [GOV00360037](#)

52 [GOV00360038](#)

53 [TRA01150114](#)

54 [TRA01150117](#)

55 [TRA01220146](#)

56 [TRA01220146](#)

57 [GOV00360038](#)

58 [GOV00360038](#)

of that policy produced an ineffective response by the NHSGGC Board over a period of several years. The failure to implement the prudent prescribing message should have been identified and remedied at an earlier stage by the Scottish Executive and later the Scottish Government. These failures are made more acute by the inadequate response to the warnings on imprudent antibiotic prescribing contained in the reports of the outbreaks at Stoke Mandeville (2006) and Maidstone and Tunbridge Wells (2007) Hospitals, discussed more fully in Chapter 18.

13.4 The Antimicrobial Management Team

The AMT in Greater Glasgow and Clyde

As already mentioned, the recommendation to set up AMTs was contained in the 2005 guide⁵⁹ published in September of that year.⁶⁰ Dr Seaton had been a member of the working group that drafted the 2005 guide as had Mr Scott Bryson, a pharmaceutical advisor to Greater Glasgow Health Board.⁶¹ Thereafter Dr Seaton formed a short-life working group⁶² together with Dr Bill Anderson, then Infection Control Manager for GGHB, Mr Bryson and Ms Ysobel Gourlay, a Pharmacist,⁶³ to develop a business case for the funding of their AMT.

In January 2006 a proposal for AMT funding was submitted to the GGHB Prescribing Management Group. In June 2006 the final business case for the establishment of the AMT was submitted to Mr Robert Calderwood, then Chief Operating Officer, Acute Services and currently Chief Executive, NHSGGC.⁶⁴ The conclusion of the business case emphasised that the creation of an AMT was “critical to prudent use of antimicrobials within NHS hospitals”.⁶⁵

Mr Calderwood confirmed that he had received a business case for the AMT in late June or early July 2006.⁶⁶ This was

considered in September 2006 by the Acute Strategic Management Group,⁶⁷ which concluded that the issue was too important to defer until the next financial year even although the budget for 2006 to 2007 had already been set, and the decision was taken to release funds so that the team could be established. Approval was given in about November 2006,⁶⁸ and interviews for the AMT posts took place in around April 2007.⁶⁹ By June 2007 the members of the core team, including Dr Seaton, were in place, although the team of antimicrobial pharmacists necessary for the development of the programme⁷⁰ was not in place.

The AMT timescale – no undue delay

The NHSGGC AMT was not established until June 2007, but the timetable set out previously shows that there was no undue delay on the part of the NHSGGC Board in its creation. That was largely due to Dr Seaton’s diligence in following through the recommendations of the working group, of which he had been a member, and to the Board’s provision of the necessary support.

Dr Seaton thought that NHSGGC was ahead of other Health Boards in the appointment of its AMT.⁷¹ In fact Dr Martin Connor, a microbiology expert commissioned by the Inquiry, gave evidence that NHS Dumfries and Galloway had established its AMT earlier, with a first minuted meeting on 18 April 2006.⁷² Dr Seaton also pointed out that it was only after the VOLH problem became apparent that the Scottish Government instructed categorically that every Board had to have an AMT, and that central funding was not available until that point.⁷³

The priority for the AMT

From June or July 2007 the priority for the NHSGGC AMT was to unify antibiotic prescribing guidance across the Health Board.⁷⁴ This led to production of the

59 [GOV00360003](#)

60 [GOV00360001](#)

61 [GOV00360035](#)

62 [INQ04070001](#)

63 [WTS01620001](#)

64 [GGC15970044](#); [TRA01150094](#)

65 [GGC06070009](#)

66 [TRA01240102](#)

67 [TRA01240103](#)

68 [TRA01240103](#)

69 [INQ04070002](#)

70 [TRA01150098-99](#)

71 [TRA01150148](#)

72 [TRA00630091](#)

73 [TRA01150148](#)

74 [TRA01150099](#)

“Infection Management Guideline: Empirical Antibiotic Therapy”.⁷⁵ Those guidelines were approved in December 2007⁷⁶ and available in the VOLH in February 2008,⁷⁷ and were designed to improve the consistency of antimicrobial prescribing. There was, however, no antimicrobial pharmacist employed to promote, monitor and encourage adherence to the guidelines,⁷⁸ and only one of the senior doctors at the VOLH seemed to be using them.

The position after June 2008

Following the discovery of the CDI problem in the VOLH an Outbreak Control Team was set up and met for the first time on 10 June 2008.⁷⁹ Later that day Dr Syed Ahmed, Consultant in Public Health Medicine and Clinical Consultant in the Public Health Protection Unit, NHSGGC, who had chaired that first meeting, contacted Dr Seaton to invite input from the AMT in addressing the issues faced at the VOLH. The AMT was asked to undertake three tasks:

- Review of prescribing practices in the VOLH in order to ascertain the volume of prescribing;
- Assessment of whether treatment of *C. difficile* infected patients could be improved; and
- Rapid review of guidance and the introduction of more restrictive prescribing guidelines⁸⁰

Revised guidelines

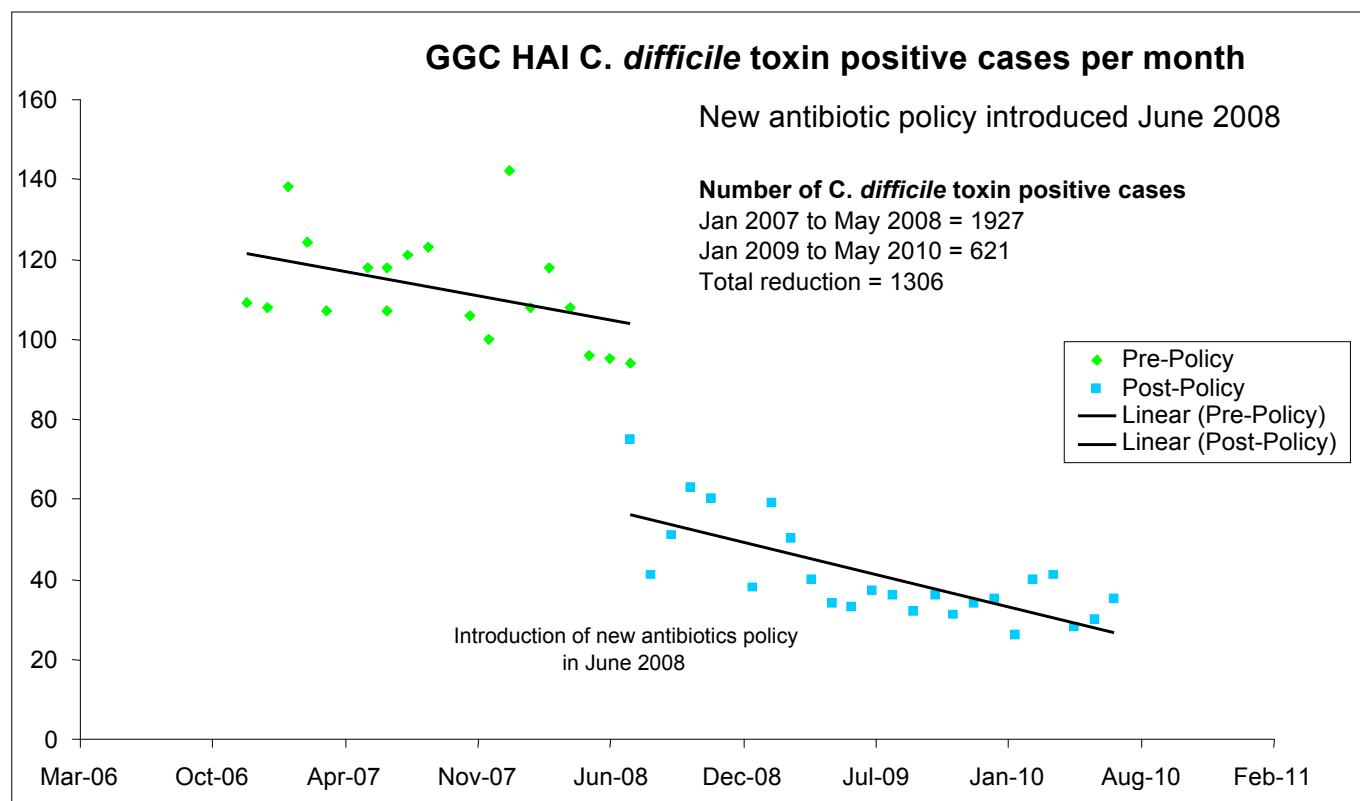
By 19 June 2008 the prescribing guidelines had been revised and new guidelines put into immediate effect. Among the main modifications to existing guidelines were the following:

- Emphasis given to considering whether antimicrobial therapy was required;
- Prescribers had to review the need for antimicrobial therapy on a daily basis;
- Cephalosporins were to be avoided except on the advice of a microbiologist;
- Empirical co-amoxiclav was to be restricted to severe community acquired pneumonia, infected human or animal bites, peri-anal infections and spontaneous bacterial peritonitis;
- Empirical oral ciprofloxacin was to be restricted for use in pyelonephritis; and
- Clindamycin was to be restricted to severe Group A streptococcal infections, necrotising fasciitis and severe soft tissue infections in parenteral drug users.⁸¹

The AMT's reaction was swift and effective. Figure 13.2⁸² illustrates the dramatic impact on the number of CDI cases in the Board area even in the relatively short term. This resulted from, at least in part, the introduction of the new antibiotic policy.

75 [GGC22180001](#)
 76 [TRA01150099](#)
 77 [TRA01150100](#)
 78 [TRA01150135](#)
 79 [GGC11140001](#)
 80 [TRA01150112-113](#)

81 [GGC13550002-03](#)
 82 [INQ00630001](#)

Figure 13.2 Greater Glasgow and Clyde Health Board *C. difficile* toxin positive cases

Antimicrobial pharmacist

The 2005 guide envisaged that antimicrobial pharmacists would play an important role in prudent prescribing, particularly in auditing the use of antibiotics. Yet there was no auditing of antibiotic use in the VOLH in the period 1 January 2007 to 1 June 2008, and although new guidelines were available in the VOLH in February 2008 NHSGGC did not then have an antimicrobial pharmacist in place to promote, monitor and encourage adherence to them. Dr Seaton explained that in early 2008 the antimicrobial stewardship programme was not complete and the resources were not in place.⁸³ A person already working in the VOLH was appointed in January 2009 as Antimicrobial Pharmacist to cover the VOLH and the RAH.⁸⁴

13.5 Conclusion

It is evident that the importance of prudent antibiotic prescribing was recognised in Scotland for many years prior to June 2008. Important initiatives had taken place and recommendations had been made over a lengthy period, at least since the Scottish Office Department of Health letter of 21 May 1999 setting out a strategy of prudent antimicrobial use. The failure to implement guidance should have been identified by the Scottish Government and remedied.

If the starting point is seen as that letter of 21 May 1999, then it becomes obvious that there was a serious mismatch between expectation and implementation. That is illustrated by the culture of overprescribing and the other failures in prescribing described in Chapter 14, as well as by the failure to restrict use of broad spectrum antibiotics referred to in Chapters 14 and 18.

⁸³ [TRA01150135](#)

⁸⁴ [TRA01150138-139](#)

Largely due to the impetus provided by Dr Seaton, the recommendation for the creation of an AMT made in the 2005 guide was implemented by the Board in a reasonably expeditious manner. The fact that the AMT was not in place until June 2007 was due to the process involved, including finding the financial resources necessary for its creation. Because auditing was linked to the role to be played by the AMT and the appointment of antimicrobial pharmacists, there was no auditing of antibiotic prescribing in the VOLH in the period 1 January 2007 to 1 June 2008. Nevertheless NHSGGC was clearly ahead of many other Health Boards in Scotland. Even in July 2008 the Scottish Government had to instruct Health Boards to establish AMTs “immediately”.⁸⁵ That instruction itself highlights the mismatch between expectation and implementation, a mismatch that must be remedied.

13.6 Recommendations

Recommendation 34: Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay.

Recommendation 35: Scottish Government should monitor the implementation of policies and/or guidance on antibiotic prescribing issued in connection with healthcare associated infection and seek assurance within specified time limits that implementation has taken place.

85 [GOV00360038](#)

Chapter 14

Medical care

Introduction

This Chapter of the Report examines the evidence provided to the Inquiry by medical staff at the VOLH, with particular emphasis on the focus period, 1 December 2007 to 1 June 2008. It also examines the medical expert evidence on the quality of care given by the medical staff at the VOLH to the patients suffering from *C. difficile* infection (CDI), including antibiotic prescribing and aspects of the testing of stool specimens relevant to medical care.

14.1 Inquiry medical experts

Nursing experts

The Inquiry commissioned independent medical experts to provide a professional opinion on the quality of medical care given to patients who suffered from CDI at the VOLH in the focus period, including the use of antibiotics.

The Inquiry's medical experts can be divided into two broad groups: physicians and medical microbiologists.

The Inquiry Team met individually with each of the medical experts. In addition there were meetings with groups of experts. The discussions at these meetings included the identification of key themes and conclusions.

The approach adopted with the nursing experts to the manner in which individual cases were distributed was also followed with the medical experts. The cases were distributed so that each expert could review patient records from a number of different wards rather than focusing on one particular ward.

The physicians are detailed in Table 14.1 as are the number of cases each expert examined.

Table 14.1 Physicians commissioned by the Inquiry and their reports by ward

Name	Ward 3	Ward 4/HDU	Ward 5	Ward 6	Ward F	Ward 14	Ward 15	MAU	Fruin	Total
Mary Harrington	1	1		2		3	2	1		10
Mike Jones	4		1	5	1		1	1		13
James Reid		1	1	4	3	2	1			12
Ray Sheridan	2			3	2	3	1			11
Henry Woodford	1	1	2	4	2	2	3		2	17
Total	8	3	4	18	8	10	8	2	2	63

Table 14.2 Microbiologists commissioned by the Inquiry and their reports by ward

Name	Ward 3	Ward 4/HDU	Ward 5	Ward 6	Ward F	Ward 14	Ward 15	MAU	Fruin	Total
Martin Connor	1		1	4	4	3	4	1		18
Kevin Kerr	2	1	1	3		1	1			9
Alan MacDonald	2		1	2	1					6
Louise Teare	2			3		1	3			9
Rod Warren	1	2	1	4	3	3	2	1	2	19
Tim Wyatt				2		2				4
Total	8	3	4	18	8	10	10	2	2	65

Dr Jones was based in Scotland. The other physicians were based in England. Table 14.2 lists the microbiologists and the number of cases examined by each expert. Dr Wyatt worked in Northern Ireland. Doctors MacDonald and Connor were in practice in Scotland and the other microbiologists were based in England.

The difference in the total numbers in Tables 14.1 and 14.2 arises because there were insufficient patient records for the physicians to carry out an assessment of the medical care for two patients in the focus group. The patient records did allow the microbiologists to arrive at some conclusions on why and where the CDI was contracted.

Instruction given to medical experts

The medical experts were given the full patient records and Infection Control Cards of the patients allocated to them. A template¹ was provided identifying areas upon which the Inquiry wished the experts to focus. Again, as with the nursing experts, this was to ensure consistency of focus and review among the experts and to ensure compliance with the Terms of Reference of the Inquiry.

The experts were not given access to the statements obtained from medical or nursing staff. Nor were they present during the evidence of those staff. The expert opinion given was based solely on the patient records.

The Inquiry also asked the medical experts not to discuss their opinions with each other during the preparation of their reports.

14.2 Record keeping

General Medical Council standards

The medical experts were asked to use the professional standards issued by the General Medical Council (GMC) as a benchmark for the standard of care expected from medical staff. The GMC published "Guidance for Doctors" effective from 13 November 2006,² and for the purpose of this Chapter the following instructions contained in that guidance are worthy of note:

1 [INQ05400001](#)
2 [INQ00270003](#)

"2 Good clinical care must include:

- (a) adequately assessing the patient's conditions, taking account of the history (including the symptoms, and psychological and social factors), the patient's views, and where necessary examining the patient".³

"3 In providing care you must:

- (f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment".⁴

"Maintaining and improving your performance

- 17 You must make sure that all staff for whom you are responsible, including locums and students, are properly supervised".⁵

Use of patient records to audit patient care

As already mentioned, the medical experts based their views on an analysis of the patient records, the approach that was also followed by the nursing experts when analysing nursing care. The observation made in Chapter 12 that retrospective audit of patient records against pre-determined criteria is a recognised and accepted approach in the analysis of adverse events⁶ applies equally to this method of assessing medical care.

The difficulties experienced in the use of patient records have been fully explained in Chapter 12. Suffice to say at this point that the standard of record keeping and the fact that there were missing records and pages out of sequence made analysis of the records particularly difficult. All these factors mean that caution must be exercised when seeking to draw conclusions from the medical records alone. The medical experts did recognise the need for caution when only the patient records were being used to draw conclusions.⁷ The issue was explained by Professor Kerr in the following way:

3 [INQ00270009](#)
4 [INQ00270010](#)
5 [INQ00270016](#)
6 [INQ05150001](#); [INQ05140001](#)
7 [TRA00530197](#); [TRA00570116](#)

“The ability to assess the quality of care provided from the patient records does rely on the accuracy and completeness of the record, although accurate and complete medical notes are certainly a part of good quality care as defined in “Duties of a Doctor” (GMC 2006).⁸

Overall quality of record keeping

There was unanimity among the Inquiry expert physicians, however, that although there were clear examples of very good documentation the overall quality of the documentation was poor.⁹ Although the recording of a patient’s condition and assessment made by the consultants was generally adequate, the recording by junior doctors was poor.

The message for doctors who want to show that care of the necessary quality has been given is to make an accurate and complete record of that care. The interrelationship between care of the necessary quality and record keeping cannot be overemphasised. Good record keeping is an integral aspect of good care.

14.3 Medical staffing

Background

The decline of clinical services at the VOLH in the years prior to June 2008 has been considered in Chapter 8. Over that period different strategies were considered, including the Lomond Integrated Care Model, in an attempt to retain a level of unscheduled medical admissions at the VOLH.

Despite such efforts, years of uncertainty had a significant impact upon the recruitment of medical staff.¹⁰ Even as early as 2002, when Dr Stephanie Dancer, the resident microbiologist, left the VOLH,¹¹ her post was advertised but it was not filled.¹² Instead the work was undertaken by locums until the stopgap arrangement set out in Chapter 15 was devised in 2006. The uncertainty over the future of the VOLH became even more acute after the dissolution of NHS Argyll and Clyde on 1 April 2006.

Grades of doctor

In 2005 a programme entitled “Modernising Medical Careers” was introduced in the United Kingdom. The programme replaced the traditional grades of doctor below the level of consultant, and was a major reform which had a significant impact on the manner in which doctors are trained. Table 14.3 provides a summary of the changes.

⁸ [TRA00530197](#)

⁹ EXP01840001; EXP01850005; EXP01850014; EXP02050007; EXP02050007; EXP0204001-2; EXP02170005-06; EXP021700095

¹⁰ [INQ03390001](#)

¹¹ [TRA00850003](#)

¹² [TRA00850015](#)

Table 14.3 NHS medical career grades

	Old system Pre-2007		New system (Modernising Medical Careers)	
Year 1	Pre-registration House Officer (PRHO) (Junior House Officer) – one year		Foundation House Officer – two years (FY1 then FY2)	
Year 2	Senior House Officer (SHO) A minimum of two years, although often more			
Year 3			Specialty Registrar (StR) in a hospital speciality: six years	Specialty Registrar (GPST) in general practice: three years
Year 4	Specialist registrar – four to six years	GP registrar – one year		General practitioner (Total time in training: four years)
Year 5				
Years 6-8				General practitioner (Total time in training: five years)
Year 9	Consultant (Total time in training: minimum seven to nine years)			

Doctors at the VOLH

Table 14.4 sets out the consultants employed at the VOLH who gave oral evidence. It also identifies their particular specialisms and the

wards/department they were mainly concerned with in the period 1 January 2007 to 1 June 2008.

Table 14.4 Consultants employed at the VOLH and their specialisms

Name	Position	Specialism	Wards
Dr Fiona Johnston	Consultant	Elderly medicine	14, 15, 3, 4, 6, MAU
Dr Hugh Carmichael	Consultant	Gastroenterology	3, 4, 6, MAU
Dr Douglas McCruden	Consultant	Diabetes and Endocrinology	3, 4, 6
Dr Musa Al-Shamma	Consultant	Respiratory medicine	3, 4, 6
Dr Patricia Clarke	Consultant	Haematology	All wards (including the laboratory)

In addition to the consultants listed in Table 14.4 Dr Lance Forbat was employed at the VOLH up to December 2007 as a locum consultant specialising in cardiology.¹³ Between 1 January 2007 and 1 June 2008 Dr Javed Akhter was employed at the VOLH as a locum consultant specialising in care of

the elderly,¹⁴ and was also responsible for stroke patients.¹⁵ During the focus period Dr Akhter was primarily responsible for wards 14 and F (the stroke ward) but could also be responsible for patients in the acute wards.¹⁶

13 [WTS00950001](#); [GGC21720003](#)

14 [TRA00730054](#); [TRA00730056-57](#); INQ03110006

15 [TRA00730057](#)

16 [TRA00730057](#)

Role of General Practitioners

Between 1 January 2007 and June 2008 Dr Gordon Herd, a GP, had a commitment to ward 15 at the VOLH of three to three and a half hours per day, Monday to Friday.¹⁷ He looked upon Dr Johnston as his supervisor.¹⁸ Each Tuesday his partner in the GP practice, Dr Mark Garthwaite, would do a session in the morning.¹⁹ Dr Herd gave oral evidence to the Inquiry.

Dr Afaq Khan

Dr Afaq Khan was employed at the VOLH from 2 July 2007 to 14 March 2008 as a locum Senior House Officer (SHO).²⁰ He was based mainly in ward 14 assisting Dr Akhter, although from time to time he also assisted other consultants in other wards.²¹ Dr Khan also gave oral evidence.

Junior doctors

Table 14.5 sets out the junior doctor staffing numbers at the VOLH and their commitments.

Table 14.5 Junior medical staffing numbers at VOLH

Grade	Level of supervision	Number	Cover provided	Wards
FY1	Junior Supervised	6	Day and evening only	3, 4, 6, F, 14
FY2	Junior Supervised ²²	3	24 hour – provided GP on site	3, 4, 6, F, 14

Lack of middle grade medical staff

The Inquiry heard evidence from Drs Johnston, McCruden, Al-Shamma, Carmichael and Akhter of how, as consultants, they managed their respective workloads and responsibilities. A major problem for them was the lack of middle grade clinicians, which meant that a significant burden was borne by the junior doctors at FY1 or FY2 level.

In explaining the difficulties in working at the VOLH with no middle grade doctors, Dr Johnston provided the following explanation:

“I found it extremely difficult. I’d been a consultant in three different places. When I was a consultant in a hospital in Glasgow, I had the full team. We had ITU, my own registrar, and ward rounds were well informed. When I was a consultant in the Vale, carrying out all these duties across the patch, when I was on my medical receiving day, for example, I would often have to go to MAU to see patients with the juniors because they were very junior”.²³

¹⁷ [TRA00820001](#); [TRA00820005-06](#)

¹⁸ [TRA00820008](#)

¹⁹ [TRA00820006](#)

²⁰ [TRA00760003](#); [TRA00760005](#); INQ03070002

²¹ [TRA00760005](#)

²² [TRA00790131](#)

²³ [TRA00770018](#)

Dr Johnston contrasted this with her post as a consultant physician in geriatric medicine at Inverclyde Royal Hospital (IRH) at the time she gave her evidence:

“... my current allocation for rehabilitation patients, it’s still about seven minutes per patient, but I currently have one or two junior doctors supporting the ward round, I have a clinical pharmacist who has already gone through all the medications right back to primary care, and I have a nurse who has all the information and various tools ready on the ward round. So it is a much more effective ward round than I was able to do at the Vale”.²⁴

Dr Al-Shamma was also in a position to contrast his position as a consultant physician at the IRH with his earlier position in the VOLH as follows:

“The problem with our on call, when we are on call, all patients admitted would be under our care. So if it was a cardiology problem or GI or liver disease, or whatever, endocrine, they would be under my care until they are discharged, and I would follow them up, unless they are really complicated and require special input, I would follow them up at my medical clinic...

Now, comparing that with the current situation in IRH, so when I am on call, I would be in the medical ... I would be based in the medical assessment unit and what I normally do, when the patient is admitted, I would manage him initially and then say ‘Divert to the’ ... so if it was a gastrointestinal problem, I would say ‘Divert this patient to the gastro ward’, if it was cardiology, ‘Send him to the cardiology ward’, respiratory ‘Send him to my ward’.

So I can get 30 admissions in IRH, but probably, of those, three or four will end up on the respiratory ward and the rest will be diverted to different wards, and my sort of input towards those patients would finish by that time”.²⁵

The position in the VOLH was that the on-call physician admitting an acute medical patient retained responsibility for that patient throughout the period of the patient’s stay irrespective of the ward in which the patient was located.²⁶ This included Drs Johnston and Akhter, whose specialism was care of the elderly. Dr Johnston also contrasted the position in the VOLH at the time with other hospitals in Scotland:

“I was a consultant geriatrician at the Vale of Leven; the difference being that in most hospitals in which geriatricians have some involvement in medical receiving, that involvement stops at 24 hours and the patients are handed on to the next medical unit. So this is, I think, a unique position in Scotland at the time”.²⁷

Reasons for lack of middle grade doctors

Dr Carmichael explained that the reason there were no middle grade doctors such as registrars in the VOLH was that there were fewer such doctors available. The departure of the different specialist services from the VOLH also meant that the VOLH was being regarded less and less as a potential source of senior education.²⁸ The reality was that the VOLH was not seen as an attractive hospital in which to gain appropriate experience. The difficulties with recruitment and the uncertainty over the future of the VOLH have already been mentioned.

Dr McCrudden explained that for a time there was a first year specialist registrar at the VOLH. This grading was removed by the Post-Graduate Deanery because the volume of activity doctors had to undertake on the rota at the VOLH prevented them from furthering their medical career in other ways, for example by carrying out research.²⁹ The Deanery is responsible for overseeing post-graduate medical training and ensuring that training is delivered to the standards set by the GMC.

24 [TRA00770056](#)

25 [TRA00710023-24](#)

26 [TRA00710024](#)

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28 [TRA00830004](#)

29 [TRA00790126](#)

Lack of continuity of care

Dr Al-Shamma explained that in a 24-hour period in the VOLH more than 20 patients could be admitted for whom he would remain responsible and who would be “scattered all over the hospital”.³⁰ At the time he gave evidence Dr Al-Shamma was working at the IRH and he drew a comparison between that post, where junior doctors worked as part of a team, and the position in the VOLH, where the junior doctors tended to be based on particular wards and would be involved in the ward rounds with any consultant who had patients in that ward.³¹ Dr Al-Shamma expressed concern that the set-up in the VOLH led to a lack of continuity of care.³² This problem was recognised and according to Dr Al-Shamma was raised many times at meetings, but because of the circumstances at the VOLH there was no way round it.³³ Dr Al-Shamma did agree that because of this lack of continuity and care, note-taking by doctors was of particular importance. The clinical position needed to be expressed as clearly as possible for the incoming doctor, who might not know the patient at all.³⁴

Dr Johnston said that from her perspective there was a layer of medical staffing missing “that would have ensured more continuity of care”.³⁵

Junior doctor rotation and availability

The problem in the VOLH with lack of continuity of care was compounded by the fact that junior doctors allocated to the VOLH were there for a period of only three or possibly four months’ rotation before moving on to another hospital. This was in contrast to the position in the IRH at the time that Dr Al-Shamma gave his evidence, where junior doctors would remain for six months and indeed sometimes a whole year.³⁶ It seems, however, that rotations of three to four months in Scottish hospitals may not in fact be unusual because, as Dr Brian Cowan, Board Medical Director, explained,

NHS National Education Scotland imposed a national training scheme that changed the rotation periods from six months to either three or four months.³⁷

The factors which affected the recruitment of middle grade medical staff in the VOLH also had an impact upon the availability of junior doctors. Dr McCruden explained the position in the following way:

“Junior doctors’ posts in hospital were largely determined by national needs for the training of doctors, rather than the local service, but in order to provide service ... We received ... I think it was two extra new jobs to make the rotas work”.³⁸

He went on to say that the rotas were not “comfortable” for junior doctors, who were perhaps not getting enough experience and yet were very busy when on call.³⁹ It was for that reason that, after surgical and A&E services were withdrawn from the VOLH in the years prior to 2007, final year medical students from Glasgow University were no longer allocated to the VOLH for clinical teaching. The absence of such specialties meant that their education would have been prejudiced.⁴⁰

Dr McCruden also explained that it was not possible to achieve a one-year allocation for any of the rotating junior doctors at the VOLH because of the limited experience to which they would be exposed due to the limited number of specialties.⁴¹ Again this was in contrast to hospitals such as the IRH and the RAH, where there were examples in the core medical training rotation of doctors being appointed for a year at a time. Any change in the frequency of rotation would have involved the Post-graduate Deanery.⁴²

The rotation arrangements for junior doctors was focused on the individual training needs of those doctors, rather than reflecting patient need.⁴³ The Post-graduate Deanery

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 31 [TRA00710024](#)
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 35 [TRA00770084](#)
 36 [TRA00710031-32](#)

37 [TRA01230001-02](#)
 38 [TRA00790119-120](#)
 39 [TRA00790120](#)
 40 [TRA00790073](#); INQ03230005
 41 [TRA00790138](#)
 42 [TRA00790141](#)
 43 [TRA00790142](#)

only allocated the number of posts it did at the VOLH based on a short rotation of three to four months. Furthermore, without such a time restriction, applicants would not have applied for the posts because the training would have been inadequate.⁴⁴

Consultants' general responsibilities

The consultants who had greatest contact with patients who contracted CDI generally had fixed ward rounds twice a week.⁴⁵ Dr Johnston only had a formal weekly ward round on Mondays, but Dr Herd carried out an additional ward round on Thursdays in ward 15.⁴⁶ Consultants also had outpatient responsibilities.

The consultants' staff rota

The rota system in the VOLH involved six consultants covering the whole hospital when on call. In reality, because of holidays, the commitment to being on call was one in four or five.⁴⁷ The effect of the on-call commitment was that each of the six consultants (including locum consultant Dr Akhter) had a commitment of being on call one weekday and every fourth or fifth weekend.

Dr Carmichael was responsible for the organisation of the rota.⁴⁸ As he explained, the rota was primarily based on days when the individual consultants were best placed to undertake the duties involved. The weekday rota was from Monday to Thursday and the on-call weekend rota was from Friday to Sunday.⁴⁹ Dr Carmichael described the task of organising the rota as "an onerous and difficult juggling act at times".⁵⁰ If the proposed on-call duty clashed with another commitment, then it was for the consultant who had the clash to raise it with him in the first instance. According to Dr Carmichael, this was something that often occurred.⁵¹

Dr Carmichael explained that the on-call system meant that the consultant on call

would go into the VOLH on Saturday and Sunday mornings so that all new patients admitted over the weekend would have a consultant assessment following admission.⁵²

Clash between ward rounds and on-call duties

The pressures placed on the senior doctors because of their on-call duties for acute medical receiving have already been discussed in this Chapter. The position was particularly acute in the case of Dr Akhter, who also had responsibilities for elderly patients and for stroke patients in the VOLH. The impact of his on-call duties was such that he was not able to fulfil his ward round responsibilities as often as scheduled. The Inquiry was given a copy of Dr Akhter's monthly diary shortly before he gave evidence.⁵³ This was designed to show the extent to which his on-call duties clashed with his ward round responsibilities for wards 14 and F.

On the basis of that record, Dr Akhter's on-call duties during the focus period certainly did have a significant impact upon his ability to conduct ward rounds. Dr Akhter's expectation was that, at least for ward 15, Dr Herd, the GP allocated to that ward, would be carrying out a ward round on the day that Dr Akhter should have been there.⁵⁴ From the patient records examined, however, it does appear to be the case that ward rounds were missed in a number of wards. Dr Johnston described Dr Akhter's position as "unworkable".⁵⁵ Dr McCruden said that it did seem that Dr Akhter was under "substantial pressure".⁵⁶

Dr Johnston also made the point that in the VOLH the consultant did not know what was happening outwith visits to the ward.⁵⁷ Senior medical staff were dependent upon being told by junior medical staff and nursing staff of any patient who needed to be reviewed.

44 [TRA00790142](#)
45 [TRA00710006](#); [TRA00820155-157](#)
46 [TRA00770013](#)
47 [TRA00820159](#)
48 [TRA00830009](#)
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50 [TRA00830016](#)
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52 [TRA00830008](#)
53 [INQ03100001](#)
54 [TRA00750035-36](#)
55 [TRA00770086](#)
56 [TRA00800019](#)
57 [TRA00770059-60](#)

Weekend cover

At weekends the only medical cover provided at the VOLH during the day was by two doctors; one at FY1 level and the other above the level of FY2.⁵⁸ Overnight one junior doctor (FY2) and a GP would be in attendance.⁵⁹ As just mentioned, however, the consultant on call did attend the VOLH on Saturday and Sunday mornings.

Dr McCruden explained that “staffing at the weekend was recognised as being at a level that was desirable to be increased”.⁶⁰ The level of cover had remained unchanged over a long period.⁶¹

Furthermore, as discussed later, Dr McCruden said that if the staff on duty had trouble coping he was called in to assist.⁶²

Staffing problems

A number of the medical witnesses gave evidence of a general shortage of medical staff. Dr Al-Shamma said that they were working “under tremendous pressure” and had “too many patients to see”.⁶³ Dr Carmichael described the staffing problem as having arisen in the following way:

“...almost a threefold increase in admissions, and these admissions were becoming more elderly, more complicated, more co-morbidities, more interventions had developed over the years. So, all in all, the workload for medical and nursing staff had steadily increased, and I have to accept that the staffing, to some extent, had not kept up with that increased need”.⁶⁴

One of the difficulties identified by Dr Patricia Clarke was that of staffing the laboratory. Recruitment had been “frozen for five years”⁶⁵ with the filling of full-time posts not being permitted. This meant that people were “acting up”⁶⁶ over prolonged periods of time.⁶⁷

When the most senior person in haematology in the laboratory left, uncertainty over its future led to the second most senior person taking over that role, although not permanently appointed to the post.⁶⁸ There was a general policy that posts were not to be refilled so long as there was uncertainty over the future.⁶⁹

In describing the VOLH as an example of one where “management were trying to sell the unsellable”,⁷⁰ Dr Clarke provided the following explanation:

“...the official assurances that we appeared to be getting were that no-one was wanting to shut the Vale, that it would continue to be an important hospital, that services would be retained there, while, at the same time, we weren’t allowed to fill posts because there was uncertainty about whether we were going to keep those posts. So the two messages coming across seemed to be inconsistent”.⁷¹

Dr McCruden described the level of medical staffing as “not generous”⁷² and gave the example of being called at home on occasions with the plea “We’re having trouble coping with the amount of work”.⁷³ The result was that he could find himself working in the MAU on a Saturday night to help to clear the backlog of cases.⁷⁴ It seems that the consultants accepted that they had to manage their workloads as well as they could in circumstances where recruitment of additional staff was difficult.

Wards 14 and 15

The consultants responsible for wards 14 and 15 during the focus period were Drs Johnston and Akhter. The profile of these wards, part of the Rehabilitation and Assessment Department (RAD), was designed to be one of patients who were at a stage in their recovery at which they were being prepared for discharge. That profile was

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 59 [TRA00780145](#); [TRA00800001](#)
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 62 [TRA00790123-124](#)
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 64 [TRA00830007](#)
 65 [WTS01600008](#)
 66 [TRA00500014-15](#)
 67 [WTS01600008](#)

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 73 [TRA00790123-124](#)
 74 [TRA00790124](#)

suitable for the type of GP input to ward 15 provided by Dr Herd, and in his absence by Dr Garthwaite. Prior to April 2007 there was also a GP hospital practitioner with commitments to ward 14, but he retired and was not replaced.⁷⁵ Dr Khan was then employed as a locum SHO from 2 July 2007, a post he held until 14 March 2008. He assisted Dr Akhter in particular, and although he attended other wards when necessary his primary commitment was to ward 14.⁷⁶

As Dr Johnston explained, the level of medical cover for wards 14 and 15 suited: “a rehabilitation unit that was quietly turning over with not much contact with acute medicine...”.⁷⁷

Generally the staffing of wards 14 and 15 was “mainly geared to rehabilitation”⁷⁸ and not to looking after acutely ill patients. As discussed in Chapter 12, during the focus period acutely ill patients were transferred to these wards,⁷⁹ and in the absence of middle grade doctors there was increased pressure on Dr Johnston and on Dr Akhter.⁸⁰ Therefore, as Dr Johnston was concerned, the medical staff available for the RAD was inadequate.⁸¹ She felt under pressure because of the amount of work she had to do and the areas within the hospital she had to cover.⁸² Dr Johnston was of the view that the pressure that she was under would affect “the follow-through of the care”.⁸³

Staff morale

Some senior doctors who gave evidence did consider that the uncertainty over the future of the VOLH affected morale.⁸⁴ The threat of closure meant that morale was low.⁸⁵ According to Dr Johnston “uncertainty was the biggest problem with morale” because “They were waiting for the big answer for years ...”.⁸⁶

Dr Clarke also was of the opinion that the morale of staff was “very low”.⁸⁷ There had been changes in the VOLH and there was real uncertainty over whether the VOLH had any future at all.⁸⁸

Management awareness

The fact that Dr Akhter was not able to carry out ward rounds because of pressure of work was not communicated to management or to the Clinical Directors who had responsibilities for the VOLH.⁸⁹ That was unfortunate because at least that aspect of medical staffing could have been addressed.⁹⁰ Nor was any real concern over the provision of an appropriate level of care communicated to Dr John Dickson, the Associate Medical Director for Clyde who took over in September 2007.⁹¹ As set out in Chapter 2, his predecessor, Dr Liz Jordan, was unable to assist the Inquiry.

Senior managers were aware that a number of staffing issues had the potential to put the care of patients at the VOLH at risk. A paper by Mrs Deborah den Herder, Director for Clyde, dated 28 February 2008 addressed to the Acute Division Senior Management Group proposed measures to be put in place:

“to assure the Board that services at the Vale are safe until such time as permanent decisions are taken regarding its future”.⁹²

The background to that proposal was the continued uncertainty for the future of the VOLH. Under reference to “Staffing” Mrs den Herder went on to say:

“There are a number of staffing issues which contribute to fragility, and these affect each of the key groups of staff employed there”.⁹³

In the paper Mrs den Herder set out the difficulties in the recruitment of medical staff, in particular anaesthetists. She stated that junior staffing at the VOLH was “a significant

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81 [TRA00770083-84](#)
82 [TRA00770085](#)
83 [TRA00770087](#)
84 [TRA00800090-91](#)
85 [TRA00710111](#)
86 [TRA00770069](#)

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89 [WTS02280002](#); [WTS02270002](#)
90 [WTS02290001-02](#)
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cause for concern”,⁹⁴ although that was not elaborated upon. She also highlighted the “significant vacancy level” in the laboratory.⁹⁵ The proposal at that stage was that the Clyde senior management team together with the Board’s Medical Director, Nurse Director and the VOLH physician would meet on a monthly basis to consider all relevant issues.

Mrs den Herder’s paper was considered at a meeting of the Acute Strategic Management Group on 28 February 2008⁹⁶ chaired by Mr Robert Calderwood, then the Chief Operating Officer, and the proposed arrangements were discussed.⁹⁷ An update report on the issues identified by Mrs den Herder in her paper of 28 February 2008 noted that, as regards junior medical staff at the VOLH:

“The level of seniority, competence, ability to contribute to the out of hours rota and vacancies combine to create considerable risk”.⁹⁸

It is clear, therefore, that at least by February 2008 steps were being taken by management to monitor the provision of care at the VOLH while a decision on the future of the VOLH was awaited.

It is apparent to the Inquiry that the medical staff were working under a significant degree of pressure during the period of the Inquiry’s remit. As discussed later in this Chapter, the result was that certain aspects of patient care, such as the medical review and assessment of patients suffering from CDI, were below an adequate standard.

Conclusion on medical staffing

On inheriting the VOLH, NHS Greater Glasgow took over a hospital that for a number of years had suffered losses of services and serious mismanagement. Problems over the recruitment of medical staff had persisted long before NHS Greater Glasgow took over responsibility. The background to the dissolution of NHS Argyll and Clyde is considered in Chapter 8, but by April 2006

a layer of medical staffing was missing, the consultants were overstretched, and junior doctors bore the brunt of the ongoing day to day care of the patients suffering from CDI. The plan put in place in February 2008 was in effect a holding exercise, as the future of the VOLH had not been determined at that time.

The fact that this state of affairs existed should not be seen as a criticism of NHSGGC. The need for doctors to receive proper training, combined with the uncertainty over the future of the VOLH and the consequential difficulty in recruiting staff, placed NHSGGC in a difficult position. The plan adopted in February 2008 did recognise that careful monitoring of the situation was necessary if any impact on patient care was to be avoided. Notwithstanding such efforts, there were deficiencies in medical review and assessment, discussed later in this Chapter, that had a real impact on the care of patients suffering from CDI.

14.4 Medical management of CDI

The management of CDI generally

The thrust of the expert physicians’ evidence was that CDI was not well managed.⁹⁹ Antibiotic practices are considered later in this Chapter, as are delays in producing results and delays in commencing treatment of CDI patients. These matters aside, two areas of practice particularly commented upon by the medical experts were the frequency of review of patients and the nature of any review carried out.

Initial review of patients on diagnosis and assessment

There should be prompt review of a patient who tests positive for CDI. “Prompt” means that the patient should be seen that same day.¹⁰⁰ That review should include a clinical assessment of the patient’s condition. Although at the time a severity markers scoring chart was not available in the VOLH, that did not mean that a clinical assessment to assess the severity of the condition

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99 [TRA00530151-153](#); [TRA00510155-157](#); [TRA00590117](#); [TRA00510146-148](#); [EXP02040001-10](#)

100 [TRA00570088](#); [TRA00530152-153](#)

should not take place.¹⁰¹ Such an assessment would include an abdominal examination. A recurring theme that emerged from the medical experts' examination of the patient records was that of delays in medical intervention for patients who had tested positive for CDI. The impression gained was that the medical staff perhaps did not really recognise the severity of CDI as an illness.¹⁰² Dr James Reid advanced the following conclusion:

"They perhaps hadn't been alerted to the fact that *Clostridium difficile* was a life threatening infection, rather than just a nuisance and a minor complication of antibiotic therapy".¹⁰³

To an extent this chimed with some of the oral evidence given to the Inquiry by the doctors at the VOLH who were asked about the nature of CDI as an illness. This was Dr Johnston's evidence:

"I think our experience of *C. difficile* led us ... not have a ... you know, not that our approach was poor; but we simply hadn't seen what *C. difficile* can do. It's an important diagnosis. But until we went through that experience at the Vale, we were not aware of the potential".¹⁰⁴

She went on to say that she was not necessarily told at the time of diagnosis that one of her patients had contracted CDI, although she would have expected to be contacted at an early stage thereafter.¹⁰⁵ In the post she held at the time of giving evidence she would be contacted when a diagnosis had been made.¹⁰⁶ Dr McCrudden said that a patient diagnosed with CDI should be medically reviewed as soon as possible,¹⁰⁷ but he would not have expected to be called to review the patient at the time of diagnosis.¹⁰⁸

Medical review and assessment

There was a general acceptance by the VOLH consultants who gave evidence on the point that patients suffering from CDI should be reviewed regularly, which could mean on a daily basis.¹⁰⁹ Such a review should include an assessment of the severity of the infection.

The following summaries set out some examples of patients whose treatment was considered by the VOLH consultants during their oral evidence to the Inquiry, and for whom they accepted there had been a lack of medical review and assessment.

Mary Broadley was admitted to ward 15 on 23 November 2007¹¹⁰ and was thought to be suffering from CDI on 4 December 2007.¹¹¹ A note in the patient records for 5 December 2007 confirmed that she had tested positive for CDI.¹¹² A clinical examination of the patient should have been carried out at that time. There was no record in the clinical notes of such an examination. Following upon a short entry on 6 December 2007 "For sc.fluid"¹¹³ there was no further medical input until 13 December 2007.¹¹⁴ There was also a gap of two weeks between consultant ward rounds, a gap that could not be explained.¹¹⁵ This level of medical review was not acceptable care.¹¹⁶ The systematic management of an infection such as CDI required daily review.¹¹⁷ This patient tested positive for CDI again on about 17 December 2007. There was no evidence of a medical review of the patient's condition at that time. There was evidence of some medical input because there was a nursing note that a discussion took place with a microbiologist on 19 December 2007 to the effect that the patient was to be commenced on oral vancomycin.¹¹⁸ After

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107 [TRA00800083](#)
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[TRA00810071-72](#); [TRA00770101](#); [TRA00770141](#)
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113 [GGC00050030](#); [TRA00770100](#)
114 [GGC00050031](#); [TRA00770101](#)
115 [TRA00770101-102](#)
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117 [TRA00770103](#)
118 [TRA00770114](#); [GGC00050127](#)

17 December 2007 the next consultant review was on 31 December 2007. There was no evidence from the clinical notes that Mrs Broadley was medically reviewed in connection with her CDI prior to 31 December 2007.¹¹⁹ Mrs Broadley tested positive again for CDI, and the ward was aware of this on 14 January 2008.¹²⁰ There was no evidence from the clinical notes that a clinical assessment of the patient's condition was carried out.¹²¹ There were blood results relating to this patient in respect of a specimen collected on 19 December 2007.¹²² There should have been further blood sampling carried out, particularly as she had tested positive for CDI on three occasions, to allow the clinician some insight into the severity of the infection. That was not done. This should have been identified on ward rounds.¹²³

John Boyle, who was admitted to ward 15 on 10 January 2008¹²⁴ was known by the ward to be positive for CDI on 25 January 2008. That same day there was a note in the clinical notes indicating that the patient has been started on metronidazole.¹²⁵ That note was made by an FY1. There was no evidence of a medical review being carried out and in any event such review should have been by a more senior doctor.¹²⁶ There was no evidence of any medical review from the notes between 25 January 2008 and 28 January 2008.¹²⁷ There should have been further medical review during that time.¹²⁸ Because this patient's condition was deteriorating despite receiving metronidazole, antibiotic treatment should have been reviewed after discussion with a microbiologist. There was no evidence that that happened from the clinical notes.¹²⁹ This patient should also have had blood tests carried out by 18 January

2008 in order to assess the severity of his condition and manage any risks of dehydration. There was no evidence in the clinical notes to that effect.¹³⁰ There was no dispute that the standard of record keeping for this patient was poor.¹³¹

Evelyn Scott-Adamson was admitted to ward 15 on 17 December 2007.¹³² There were no entries in the clinical notes between 1 January 2008 and 9 January 2008.¹³³ The entry for 9 January 2008 records the fact that the patient fell and sustained injury. During that time the patient was suffering from diarrhoea and a sample was collected on 5 January 2008¹³⁴ because it was suspected that the patient might have been suffering from CDI. There was no evidence from the records that she was medically reviewed in relation to the diarrhoea. A doctor should have been involved with the patient in circumstances where the nursing staff were sending a sample for *C. difficile* toxin testing.¹³⁵

Agnes Burgess was admitted to the VOLH on 20 December 2007 and tested positive for CDI through a sample collected on 22 December 2007. The positive result was known to the ward in the evening of 24 December 2007. That should have prompted a medical review and an assessment of whether any medication should be stopped or changed.¹³⁶ There was no evidence that that happened.¹³⁷ There was no evidence of a medical review prior to 27 December 2007. There should have been a medical review after the positive result was known.¹³⁸ A junior doctor was contacted to write up a prescription for metronidazole but there was no evidence that the patient was examined.¹³⁹

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133 GGC27020014; GGC27020018; [TRA00780049-50](#)

134 GGC27920039

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137 [TRA00780087](#)

138 [TRA00780086-87](#)

139 [TRA00780091](#)

Elizabeth Valentine was admitted to ward 6 on 8 February 2008¹⁴⁰ and was known to be positive with CDI on 22 February 2008.¹⁴¹ A colonoscopy carried out on 21 February 2008 diagnosed that she was suffering from a severe pseudomembranous colitis of the entire colon.¹⁴² There was no reference in the clinical notes covering the period 22 to 25 February 2008 to the colitis. The colitis was a serious condition and should have been recorded in the clinical notes prior to 25 February 2008.¹⁴³ A clinical assessment should have been carried out on the patient by a doctor on 22 February 2008. There was no record that that happened.¹⁴⁴

Patient B was admitted to ward 6 on 7 December 2007¹⁴⁵ and developed loose stools by about 14 December 2007.¹⁴⁶ On 17 December 2007 the ward was made aware that she was suffering from CDI.¹⁴⁷ There was no senior doctor involvement with this patient between 8 December 2007 and 24 December 2007.¹⁴⁸ There was a note in the clinical notes that she was seen by a doctor on 17 December 2007 and that she was *C. difficile* toxin positive. There was no record at that time that a medical examination to assess the patient's condition was carried out.¹⁴⁹ Over that period Patient B should have been seen on four occasions by a senior doctor.¹⁵⁰ The lack of senior review was not appropriate.¹⁵¹ Although there was no record of an examination when the positive result was confirmed there had been an examination, including an abdominal examination, earlier that same day.¹⁵²

Mary Hamilton was admitted to the VOLH on 27 December 2007 and transferred to ward 6. She was known to be positive for *C. difficile* toxin on 22 January 2008.¹⁵³ There was no record of a medical review between 18 January and 23 January 2008.¹⁵⁴ She should have been assessed at the time the CDI diagnosis was confirmed.¹⁵⁵ She was seen on 23 January 2008 and it was noted in the clinical notes that the patient was suffering from CDI. It was only then that metronidazole was prescribed for that condition.¹⁵⁶ Had the patient been seen sooner then the treatment would have commenced earlier.¹⁵⁷ Mrs Hamilton tested positive for *C. difficile* toxin again, a result of which the ward was aware on 13 February 2008. There was no clinical acknowledgement of that positive result until 14 February 2008 when a note made by an FY1 doctor records that the patient was *C. difficile* toxin positive and metronidazole was prescribed.¹⁵⁸ She should have been seen on 13 February when the positive result was known.¹⁵⁹ There was no evidence of a clinical examination. Thereafter, the patient was reviewed by a senior doctor on 15 and 22 February 2008.¹⁶⁰ However, there was no record of a medical review contained in the clinical notes between 22 February 2008 and 11 March 2008.¹⁶¹ There should not have been such a gap. From the nursing notes it did appear that there were multi-disciplinary team meetings in relation to this patient on 26 February 2008 and 4 March 2008.¹⁶²

Muriel Waddell, who was admitted to the VOLH on 22 April 2008, was known to be *C. difficile* toxin positive from 1 May 2008.¹⁶³ On that date she was seen by a junior doctor but there was no evidence in the record made that a medical

140 [TRA00710112](#)
141 [TRA00710144-145](#)
142 GGC00800067
143 [TRA00710144](#)
144 [TRA00710155](#); [TRA00710159](#)
145 [TRA00720038](#)
146 GGC26380058
147 GGC26380060
148 [TRA00720048](#); [TRA00720051](#)
149 GGC26380017
150 [TRA00720050](#)
151 [TRA00720053](#)
152 GGC26380017

153 [TRA00810015](#); GGC00260055
154 [TRA00810025](#)
155 [TRA00810025](#)
156 GGC27230009
157 [TRA00810026](#)
158 GGC00260012
159 [TRA00810027](#)
160 [TRA00810029-30](#)
161 [TRA00810029-30](#)
162 GGC00260048; GGC00260047
163 [TRA00810038](#); [TRA00810042](#)

examination was carried out.¹⁶⁴ The patient was seen the following day by a senior doctor and, although there was no note made of an abdominal examination, his view was that he would have carried out such an examination.¹⁶⁵

Rosa Rainey was admitted to the VOLH on 27 December 2007.¹⁶⁶ She was known to be positive for *C. difficile* toxin on 21 January 2008 when a note to that effect was made in the clinical notes.¹⁶⁷ The next medical review did not take place until 23 January 2008. There should have been a further review before that date.¹⁶⁸ This patient was known to be *C. difficile* toxin positive again on 1 April 2008. On that date there was a note in the clinical records by a junior doctor confirming the positive result. The next entry was dated 8 February (sic) (it is clear that that should have been 8 April 2008) and it would have been desirable if there had been more frequent review.¹⁶⁹ This patient again tested positive for *C. difficile* toxin on 22 April 2008 and there was a note to that effect in the clinical notes made by a junior doctor. Again there was no note that a clinical examination was carried out.

Patient C was admitted to the VOLH on 9 December 2007, initially to ward 6, and then transferred to ward F.¹⁷⁰ She was known to be positive for CDI on 24 December 2007¹⁷¹ when in ward F.¹⁷² The patient was seen by a senior doctor on 18 December 2007 and seen again by a junior doctor (FY1) some time before 20 December 2007.¹⁷³ There was no evidence from the patient records that the patient was seen again until 8 January 2008.¹⁷⁴ There was no evidence of any medical review either by a senior or junior doctor. The dates of the normal weekly ward rounds may have coincided

with holiday periods¹⁷⁵ but it was not disputed that this patient should have been seen by a doctor and should have been medically assessed. The failure so to do was unacceptable practice.¹⁷⁶ Patient C was known to be *C. difficile* toxin positive again on 9 January 2008.¹⁷⁷ She was seen by a junior doctor on that date. There was no record made of a medical examination, although it was noted that the patient was not unwell.¹⁷⁸ The patient was not seen again until 14 January when a note was made by a junior doctor.¹⁷⁹ At that time she was described as “not improving”.¹⁸⁰ Once again there was no note made of a medical examination. This patient should have been seen on a more regular basis over this period.¹⁸¹ She was seen by a senior doctor on 15 January 2008 but there was no record made of an abdominal examination.¹⁸² The examination may have been carried out but not recorded.¹⁸³ After 15 January 2008 there was a gap of one week before the patient was seen again on 22 January 2008, according to the records. There should have been more regular medical reviews of this patient.¹⁸⁴ This patient again tested positive for *C. difficile* toxin, the result of which is known on 6 February 2008.¹⁸⁵ She was seen on that day but there was no record of a medical review after that date until 11 February 2008.¹⁸⁶ That would not be an acceptable level of medical review.¹⁸⁷ The patient was seen on 12 February but thereafter there was a gap of six days where there was no evidence of medical review.¹⁸⁸ During that period she continued to suffer from diarrhoea.¹⁸⁹ This patient was known to be positive for *C. difficile*

164 [TRA00810042-43](#)

165 [TRA00810043](#)

166 [TRA00810049](#)

167 GGC00490013

168 [TRA00810070-71](#)

169 [TRA00810072](#)

170 GGC26340019; [TRA00740008](#)

171 GGC26340172

172 [TRA00740010-11](#); SPF01390001

173 [TRA00740009-10](#); GGC26340025

174 [TRA00740010](#)

175 [TRA00740011-12](#)

176 [TRA00740016](#)

177 GGC26340025

178 GGC26340025

179 GGC26340026

180 GGC26340026

181 [TRA00740023](#)

182 [TRA00740029](#)

183 [TRA00740029](#)

184 [TRA00740034](#)

185 [TRA00740036-37](#)

186 [TRA00740041](#)

187 [TRA00740042](#)

188 [TRA00740043](#)

189 [TRA00740043](#)

toxin on 25 February 2008.¹⁹⁰ Despite that knowledge there is no evidence in the patient records of the patient being seen or examined on that day. The patient should have been medically reviewed on 25 February 2008 when the diagnosis was confirmed.¹⁹¹ Patient C was seen by a doctor on a ward round on 26 February 2008 but there was no evidence from the note made that a medical examination was carried out. The doctor considered that a clinical examination would have been carried out, although not recorded.¹⁹² According to the patient records the patient was not seen again until 4 March 2008, in the course of a ward round.¹⁹³ This patient should have been seen and clinically assessed between 26 February and 4 March 2008.¹⁹⁴ In the course of the month of March this patient was only seen on four occasions (4, 11, 18 and 25 March 2008).¹⁹⁵ There was no dispute that that was not acceptable practice.¹⁹⁶

Patient Isobel Cameron was admitted to ward 14 in the VOLH in October 2007 and was known to be positive on 26 October 2007 for *C. difficile* toxin.¹⁹⁷ There was a record that she was seen by a doctor on that date. But there was no record made of a clinical examination to assess the severity of the CDI.¹⁹⁸ There was no evidence of a further medical review until 29 October 2007. The patient should have been seen by a doctor over that period.¹⁹⁹ This patient was known to be positive again for *C. difficile* toxin on 5 December 2007.²⁰⁰ There was no record of a medical examination being carried out on that date. Such an examination should have been carried out.²⁰¹ Mrs Cameron was seen on 6 December 2007 but thereafter there was no note made in the patient records until 10 December 2007 when she was

seen in the course of a ward round.²⁰² She should have been reviewed by a doctor during that four day period.²⁰³ After 10 December 2007 there was no record made in the patient records of the patient being seen until 17 December 2007, a period of a week.²⁰⁴ On that occasion also she was seen in the course of the weekly ward round.²⁰⁵ Mrs Cameron continued to suffer from CDI over that period.²⁰⁶ Thereafter there was a gap of ten days where there was no entry in the records that this patient was seen by a doctor. The next entry on 27 December 2007 coincided with a ward round.²⁰⁷ The failure to review this patient over that period of time was unacceptable practice.²⁰⁸ This patient was known to be positive again on 4 January 2008, although there appears to be some confusion over the result.²⁰⁹ Despite that result Mrs Cameron was not seen by a doctor between 31 December 2007 and 7 January 2008.²¹⁰ The patient should have been medically reviewed over that period.²¹¹ When she was seen on 7 January 2008 there was no evidence in the record made that a clinical examination was carried out.²¹² Mrs Cameron was once again known to be *C. difficile* toxin positive on 8 January 2008.²¹³ She was not seen until 9 January 2008 when a note was made in the patient records that the patient was *C. difficile* toxin positive. There was no evidence in the record made that the doctor carried out a medical examination of the patient.²¹⁴ Such an assessment should have taken place.²¹⁵ The patient was next noted as having been seen in the course of a ward round on 14 January 2008, some five days later. At that time the note made included "Remains unwell.

190 [TRA00740056](#)
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196 [TRA00740061](#)
197 [TRA00740064](#); GGC00070031
198 [TRA00740064](#)
199 [TRA00740066](#)
200 [TRA00740067](#)
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202 GGC00070027
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206 [TRA00740070](#)
207 [TRA00740070](#)
208 [TRA00740072](#)
209 [TRA00740073](#)
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211 [TRA00740074](#)
212 GGC00070025
213 [TRA00740076](#)
214 [TRA00740076](#)
215 [TRA00740076-77](#)

For TLC”²¹⁶ Mrs Cameron died later that same day.²¹⁷ At no point in the records made in respect of this patient was there any evidence of a clinical review of the patient’s symptoms.²¹⁸ The only cause of death entered on the patient’s death certificate was *Clostridium difficile* colitis.²¹⁹

Sarah McGinty was admitted to the VOLH on 3 December 2007,²²⁰ having suffered a stroke and was noted by 21 January 2008 to be “much improved”.²²¹ By 25 January she was known to be *C. difficile* toxin positive. A note in the clinical notes on that date recorded the positive result but the FY1 doctor did not record whether a clinical examination of the patient was carried out.²²² At this time Mrs McGinty was beginning to become unwell.²²³ On 26 January 2008 she was seen by a doctor but there was no record made of a clinical assessment.²²⁴ This was unacceptable practice.²²⁵ As at 27 January 2008 the patient was becoming very unwell.²²⁶ She continued to deteriorate and died on 1 February 2008.²²⁷ This was a patient who in light of the deterioration, ought to have had a medical review by a senior doctor.²²⁸ There was no evidence from the records that Mrs McGinty was seen by a senior doctor after having contracted CDI, although there was a note that the day before she died a doctor did discuss the patient with a senior doctor.²²⁹

Ellen Pirog was a patient who had suffered serious orthopaedic injuries and who tested positive for *C. difficile* toxin in the RAH. She was transferred to the VOLH on 9 July 2007.²³⁰ This patient was admitted to ward 15. Although she

developed loose stools in the VOLH,²³¹ she was not tested for *C. difficile* toxin. This patient did suffer from CDI when in the VOLH.²³² Mrs Pirog died on 3 October 2007, having been a patient in the VOLH for almost three months. Over that period there were significant gaps in the patient’s clinical records where no record was made as to whether or not the patient was medically reviewed. There was no record of a medical review being carried out in the last eight days of Mrs Pirog’s life.²³³ This represented unacceptable practice.²³⁴ The patient was only seen by a consultant on two occasions during the patient’s stay in the VOLH, a situation which was totally unacceptable.²³⁵

Conclusion on medical management of CDI

It was the junior doctors who had by far the most involvement with patients. The repeated failure to note that an assessment of the patient’s condition had been made when CDI was contracted was a trend that suggested that no such assessment had been made. Examples of failures to carry out blood sampling to assess a patient’s condition also support the conclusion that the level of medical assessment was inadequate.

The frequency of medical review of this group of patients with CDI was also inadequate, at least according to the records. It may be that in some cases there was more regular review than has been recorded,²³⁶ although it is clear that there was a significant number of instances where there was no review. In addition, because junior doctors were to the forefront of care their inexperience resulted in failures to notify senior medical staff when senior medical involvement was necessary. The inadequacy of medical review and assessment is likely to have compromised patient care.

It is clear that the junior doctors at the VOLH were not properly supervised. This is not a criticism of the senior medical staff but

216 GGC00070025; [TRA00740077](#)

217 [TRA00740080](#)

218 [TRA00740082](#)

219 [TRA00740083](#)

220 [TRA00740104](#)

221 GGC00420013

222 GGC00420014; [TRA00740153](#)

223 [TRA00740153](#)

224 [TRA00740153](#)

225 [TRA00740153-154](#)

226 [TRA00740156](#)

227 SPF00250001

228 [TRA00750004](#)

229 [TRA00750004-05](#)

230 [TRA00750023](#)

231 [TRA00590021-24](#)

232 [TRA00590058-59](#)

233 [TRA00750034](#)

234 [TRA00750035](#)

235 [TRA00750037-38](#)

236 [TRA00820041](#)

simply a state of affairs brought about by the status of the VOLH as a hospital with an uncertain future. Services had dwindled and the VOLH had become a hospital that was unattractive both to medical staff with appropriate experience and to junior staff looking for that experience. The senior medical staff were exposed to pressures that limited their ability to provide the supervision that was necessary.

It is difficult to escape the conclusion that junior doctors were placed in a hospital where the training they received did not comply with necessary standards. Deficiencies in training can only result in compromised patient care. Good training is essential to good clinical care when junior doctors are providing the care. Ultimate responsibility for the situation in the VOLH rests with NHSGGC. While the Inquiry acknowledges that it may not be easy for a Board to scrutinise the levels of medical care provided, particularly where clinical judgement may be involved, nonetheless through appropriate systems, a Board can obtain assurance that the quality and safety of care meet the requisite standard. The VOLH did provide the Board with a real challenge, but that challenge should not have led to the standards of medical care provided to *C. difficile* infected patients being at unacceptable levels.

14.5 Do Not Attempt Resuscitation orders

Purpose

A Do Not Attempt Resuscitation (DNAR) order is a written record of a decision that if the patient suffers a cardiac arrest he or she will not be resuscitated.

The NHSGGC DNAR policy provided that a “DNAR decision” applied solely to cardiopulmonary resuscitation (CPR).²³⁷ All other treatment and care should be continued and should not be influenced by the DNAR decision.²³⁸ Furthermore, such a decision could only be taken in the best interests of the patient. Establishment of DNAR status was the responsibility of the consultant in charge. Even if the responsibility was

delegated to another senior doctor, the decision was to be discussed and agreed with the consultant.²³⁹

The policy also provided that a DNAR decision had to be reviewed regularly, which was defined as “no greater than seven days in Acute Areas or 28 days in Specialist Areas”.²⁴⁰ A review date had to be documented and signed.²⁴¹ The DNAR order form itself provided that a DNAR decision should be reviewed by the:

“consultant/lead GP at the earliest opportunity and should be reviewed 48-hourly for the first week and thereafter at least weekly...”.²⁴²

The policy also required that clinical practice in relation to DNAR decisions be “audited regularly, at least twice a year”.²⁴³

Do Not Attempt Resuscitation orders in the VOLH

Of the 63 patients in the focus group 36 patients had DNAR orders in their patient records. Of that number, 26 DNAR orders had been incorrectly completed. The following are examples of the deficiencies.

- The reason for the DNAR decision is not recorded in the order in at least two cases²⁴⁴
- A significant number of DNAR orders did not have a review date noted²⁴⁵
- Sections of the DNAR order designed to show if there had been discussion with family members were often left blank²⁴⁶

The families’ view on communication over this aspect of care is mentioned in Chapter 11.

239 [GGC04470016](#)

240 [GGC04470017](#)

241 [GGC04470017](#)

242 [GGC00090007](#)

243 [GGC04470017](#)

244 [GGC00030004](#); [GGC26340227](#)

245 [GGC00050010](#); [GGC00580223](#); [GGC00110005](#); [GGC00220012](#); [GGC00240004](#); [GGC00270065](#); [GGC00320056](#); [GGC00330003](#); [GGC21690003](#); [GGC00520005](#)

246 [GGC00020003](#); [GGC00030010](#); [GGC00500010](#); [GGC00580223](#); [GGC22480018](#); [GGC00080047](#); [GGC00110005](#); [GGC00160005](#); [GGC00170003](#); [GGC00190215](#); [GGC00220012](#); [GGC00270065](#); [GGC00280005](#); [GGC00330003](#); [GGC00340003](#); [GGC00420024](#); [GGC00460040](#); [INQ02360001](#); [GGC21690003](#); [GGC00520005](#); [GGC00530053](#)

237 [GGC04470015](#)

238 [GGC04470016](#)

There are instances where it was not apparent from the DNAR orders whether senior doctors were involved in the decision making process,²⁴⁷ although in the majority of cases senior doctors were directly involved or consulted.

There was no evidence that the auditing envisaged by the DNAR policy ever took place. Auditing would have identified the deficiencies that were apparent. The failure to audit is one for which management and ultimately NHSGGC are responsible.

14.6 Antibiotic prescribing

A culture of over-prescribing

The relevance of antibiotic therapy to *C. difficile* infection (CDI) is examined in Chapter 3, and the failure to heed the message of prudent prescribing is considered in Chapter 13. This Section considers first the guidelines and policies on the prescription of antibiotics available to the medical staff in the VOLH in the period from 1 January 2007 to 1 June 2008 and second the prescribing practices adopted by the medical staff at the VOLH for CDI and other conditions during the focus period. The prevailing evidence was of a culture of over-prescribing at the VOLH, and some detailed examples of prescribing practices are set out in this Section.

This Section also examines the delays between samples being obtained from patients, positive results being received, and treatment commencing.

Guidelines and policies

A number of different guidelines and policies on antibiotic prescribing were available to the VOLH medical staff including:

- The North Glasgow Acute Hospitals Prescribing Handbook 2007-2008²⁵⁰
- The Guide to First Line Antimicrobial Prescribing (1997 and 2000)²⁵¹
- The Greater Glasgow and Clyde Formulary (2007)²⁵²
- The British National Formulary (BNF) (2006)²⁵³

Use of guidelines and policies by the medical staff

Senior medical staff can rely on their own experience in the prescription of antibiotics. In contrast, junior staff have a greater need for guidelines and supervision. The evidence of the senior medical staff on the guidance available to them during this period can be summarised in the following way.

Dr McCruden thought that the Argyll and Clyde Drug Formulary 2006 looked familiar and that he did use it “from time to time”.²⁵⁴ He also used the BNF,²⁵⁵ and referred to guidelines called the “Guide to First Line Antimicrobial Prescribing”, apparently produced by Dr Dancer and revised by her in January 2000. He said that he had seen the Infection Management Guideline in draft but did not think that that document had reached the wards much before May 2008.²⁵⁶

Dr Carmichael also thought that the Argyll and Clyde Drug Formulary 2006 looked familiar but he was unsure when it was available.²⁵⁷ He had no recollection of using the Infection Management Guideline prior to June 2008, although he thought that there was an earlier version and that one would have been available to him.²⁵⁸ He did recall there being “several different types of guidelines around over that year or two” but he was unsure “which one was the formally accepted, current one”.²⁵⁹

247 GGC00580022; GGC00580313; GGC00240004; GGC00300016; GGC00340003; GGC27470001; GGC00530052; GGC00550003

248 [GGC21790001](#)

249 [GGC22180001](#)

250 [GGC21760001](#)

251 [INQ01300001](#); [INQ01310001](#)

252 [GGC18270001](#)

253 [INQ02940001](#)

254 [TRA00800045](#)

255 [TRA00800051](#)

256 [TRA00800050-51](#)

257 [TRA00830020](#)

258 [TRA00830020-21](#)

259 [TRA00830019](#)

Dr Johnston said that there were a number of guidelines available but that from October 2007 she used the Infection Management Guideline.²⁶⁰ That guideline was then in draft form²⁶¹ and was not issued in the VOLH until early February 2008,²⁶² and there is no suggestion that any other member of the senior medical staff used it prior to that date. She also identified the Greater Glasgow and Clyde Drug Formulary 2007 as a document that was available, and indeed said that it was kept in her office.²⁶³

Dr Al-Shamma said he used the Greater Glasgow and Clyde Formulary, the Argyll and Clyde Drug Formulary 2006 and the BNF.²⁶⁴ He did not use the Infection Management Guideline document before June 2008 and thought it was not available before then.²⁶⁵

Dr Akhter said he used the NHS Argyll and Clyde Drug Formulary 2006, although the version he had did not contain the appendices to the version previously made available to the Inquiry.²⁶⁶ He also used the BNF, but did not use any other guidance.²⁶⁷

Dr Herd said that he used the Greater Glasgow and Clyde Formulary and the BNF.²⁶⁸ He said that the Infection Management Guideline became available “latterly”²⁶⁹ but he could not remember when that was.

This summary of the evidence of senior medical staff discloses that in the period 1 January 2007 to 1 June 2008 a variety of different guidelines was in use at the VOLH. There was a lack of uniformity in approach from the senior medical staff and there were some differences between the guidelines. This situation should not have developed, and in a hospital like the VOLH clinicians should have been following one common agreed policy.

Junior medical staff

With the exception of Dr Khan, the picture for the junior medical staff is a more consistent one. Prior to February 2008, junior doctors were provided on induction with the North Glasgow Acute Hospitals Prescribing Handbook, the BNF and the Greater Glasgow and Clyde Formulary.²⁷⁰ In February 2008, junior doctors were provided with the Infection Management Guideline available at that time.²⁷¹ No member of the senior medical staff said that the North Glasgow Acute Hospitals Prescribing Handbook was being used.

The exception among the junior doctors was Dr Khan. He did not have an induction²⁷² and was not supplied with the junior doctors’ handbook that was normally supplied then.²⁷³ Nor was he provided with any of the prescribing guidelines that were available. During his period of employment at the VOLH he relied on his own experience and followed the guidance provided by the BNF (2006)²⁷⁴ or the guidance given by the consultant supervising him.

Empirical antibiotic therapy guidelines

From February 2008 the Infection Management Guideline was available in document and laminated poster form at the VOLH.²⁷⁵ According to Mr Scott Nicol, the Pharmacy Manager, the launch took place after a medical meeting attended by senior and junior medical staff.²⁷⁶ Mr Nicol expected that all doctors at the VOLH would use these guidelines, but the only clear evidence that these guidelines were in use by the senior medical staff prior to June 2008 came from Dr Johnston, who in fact had been using them even when they were in draft form.

It is important to note that the introduction of the Infection Management Guideline in February 2008 did not produce a real change in the prescribing of the more provocative

260 [TRA00770019-20](#)

261 [TRA00880059](#)

262 [TRA00880064](#)

263 [TRA00770023](#)

264 [TRA00710010-13](#)

265 [TRA00710011](#)

266 [TRA00730059](#)

267 [TRA00730070](#)

268 [TRA00820011](#)

269 [TRA00820010](#)

270 [TRA00880057-58](#)

271 [TRA00880064](#); [TRA01150100](#)

272 [TRA00760005](#)

273 [TRA00760005](#)

274 [TRA00760011-12](#)

275 [TRA00880059-60](#); [TRA01150100](#)

276 [TRA00880060](#)

antibiotics that predispose patients to CDI.²⁷⁷ That change came after June 2008.

Antibiotic prescribing prior to admission to the VOLH

So far as was possible, the Inquiry examined the pattern of antibiotic prescribing in the community for patients in the focus group for the six months prior to admission of each patient to the VOLH. As far as can be determined,²⁷⁸ at least 24 patients in the focus group received antibiotics in the community which may have predisposed them to CDI. Six of these patients were prescribed the narrow spectrum antibiotic, trimethoprim. Three of those six had been prescribed antibiotics some five months prior to admission. At least three additional patients had been prescribed predisposing antibiotics at the RAH before admission to the VOLH and received no further antibiotic treatment in the VOLH.

Antibiotics in the VOLH

The Inquiry has been able to ascertain from the patient records that 60 of the 63 patients in the focus group did receive antibiotics while in the VOLH. The three remaining patients did not receive any antibiotic therapy in the VOLH, although they did have antibiotics prescribed to them prior to their admission. While the picture is far from clear, it is therefore likely that more than half of the patients in the Inquiry's patient focus group were first prescribed antibiotics which predisposed them to CDI while they were in the VOLH. The antibiotics involved in the VOLH included third generation cephalosporins, quinolones and broad spectrum penicillins such as amoxicillin and co-amoxiclav (Augmentin).

A mixed pattern

Because of this mixed pattern of community and hospital prescribing, the role played by antibiotics prescribed outwith the VOLH also has to be recognised. There must have been cases where antibiotic prescribing in the community caused patients to become susceptible to contracting CDI following admission to the VOLH. Nevertheless, the

prescribing of antibiotics in the VOLH played a significant role in many of the patients in the focus group contracting CDI.

Antibiotics for conditions other than CDI – the expert evidence

The Inquiry medical experts, and in particular the microbiologists who examined the patient records of the focus group patients, identified some common areas for criticism in relation to antibiotic prescribing for conditions other than CDI. Once again, these criticisms have to be put in context, since the experts based their views on the patient records alone. One of the common themes that emerged was the inappropriate choice of antibiotic, although the poor documentation of the reasons for the choice of certain antibiotics might to some extent have contributed to this. In addition, the initial prescription of antibiotics in the VOLH was largely carried out by junior doctors, and as one of the Inquiry medical experts, Dr Harrington pointed out:

“there was an enthusiasm for starting antibiotic therapy before a clear diagnosis had been established which is understandable in inexperienced junior staff who are afraid that their patient will deteriorate unless treated immediately with powerful antibiotics”.²⁷⁹

Another expert, Dr Reid, drew this conclusion from his examination of the cases allocated to him:

“It was striking that there was a tendency to sort of, you know, shoot first and ask questions later when it came to antibiotics for suspected urinary tract infections”.²⁸⁰

From Dr Sheridan's perspective there was “scant evidence of any attempts to pursue a prudent antibiotic usage approach”.²⁸¹

Although senior review ought to have identified errors in prescribing by junior staff, the pressures on the senior medical staff already highlighted reduced the effectiveness of senior medical supervision.

277 [TRA00880050-51](#)
278 [INQ04700001](#)

279 [EXP02050005](#)

280 [TRA00530149](#)

281 [EXP01850001](#); [TRA00570078-79](#)

Some aspects of antibiotic practice

There was a significant number of instances where the reason for the choice of antibiotic was not apparent, or where it was evident that the antibiotic chosen was inappropriate. There was a general acceptance by the VOLH senior medical staff who gave evidence that the recording of the reasons why a particular antibiotic was chosen should have been better. There was also some acceptance that in certain cases the patient should not have been prescribed the antibiotic that was chosen. The following summaries set out some examples taken from the oral evidence in which the senior medical staff accepted criticism of the antibiotic treatment.

Elizabeth Valentine was prescribed and given ciprofloxacin when no such prescription should have been made. According to the oral evidence of the senior doctor responsible for the patient:

“that shouldn’t have happened ...Again this stems from the fact that junior doctors, middle grade, will change all the time and somebody will take an action without passing on the message to another person”.²⁸²

A urine sample taken from Mrs Valentine was reported as normal and at least at that stage the opportunity should have been taken to stop the antibiotic.²⁸³ The ciprofloxacin was continued for several days.²⁸⁴ Had the junior doctor recorded the prescription in the clinical notes the senior doctor would have become aware and stopped it.²⁸⁵ The subsequent change to Augmentin was likely to have been on the advice of the microbiologist, but the advice and the change were not recorded in the clinical notes.²⁸⁶ It also seems that this patient received lactulose after the diagnosis of *C. difficile* and that should not have happened.²⁸⁷

A decision taken in relation to Margaret Gaughan to change the antibiotic

therapy by prescribing ciprofloxacin, would not have been approved by the senior doctor if discussed with him.²⁸⁸ A combination of broad spectrum antibiotics prescribed while the patient was a patient in the Royal Alexandra Hospital (RAH) (moxifloxacin and cefaclor) was continued in the VOLH and that should not have happened.²⁸⁹ When the plan was changed to start ceftriaxone, an antibiotic recommended for a hospital-acquired pneumonia, the cefaclor was stopped but the moxifloxacin was not and that was an error.²⁹⁰

Sarah McGinty, who had a specimen of urine taken from her catheter, was prescribed trimethoprim when it was likely that she had asymptomatic bacteriuria.²⁹¹ Once the course had been completed and the report of a urine specimen indicated that the bacteria were resistant to trimethoprim, she was prescribed amoxicillin even although there were no clinical signs that she was suffering from a urinary tract infection. It was likely that Mrs McGinty had continuing asymptomatic bacteriuria.²⁹² The senior doctor in charge of this patient accepted in evidence that if the antibiotic prescription had been properly reviewed the antibiotic would have been stopped. Subsequently this patient was prescribed co-amoxiclav and clarithromycin for a chest infection. That combination may have been appropriate for a severe chest infection.²⁹³ There was no evidence of a severe chest infection and a narrower spectrum antibiotic would have been more appropriate.²⁹⁴ Once Mrs McGinty had been diagnosed with CDI, that antibiotic treatment should have been stopped or at least reviewed and modified.²⁹⁵ This was also a patient who was prescribed lactulose when she may have been suffering from diarrhoea. That should not have happened or at least the medication

282 [TRA00710117](#)
283 [TRA00710121](#)
284 [TRA00710122](#)
285 [TRA00710124](#)
286 [TRA00710131-132](#)
287 [TRA00710161](#)

288 [TRA00720016](#)
289 [TRA00720020-22](#)
290 [TRA00720023](#)
291 [TRA00740110-111](#)
292 [TRA00740113](#)
293 [TRA00740142](#); GGC00420012
294 [TRA00740144](#)
295 [TRA00740152](#)

should have been stopped when she had diarrhoea.²⁹⁶

Jessie Jones was prescribed ciprofloxacin for possible renal colic that was to be treated as if it were a complicated urinary tract infection.²⁹⁷ The results of tests should have led to the antibiotic being stopped or changed to a less broad spectrum antibiotic.²⁹⁸ The ciprofloxacin was in fact prescribed for eight days – the normal duration would be three days or five days for a severe infection.²⁹⁹

Ellen Gildea was prescribed co-amoxiclav for a suspected urinary tract infection on admission to the VOLH. The report on the urine sample was negative and the antibiotics should have been stopped once that information was available.³⁰⁰ There was an issue as to whether there was a delay in the information being made available to the ward. The patient continued to be prescribed co-amoxiclav from 30 January 2008 to 5 February 2008. The antibiotic was then stopped when she was reviewed by a senior doctor.

Mary Hamilton was prescribed ciprofloxacin and vancomycin with no reason given.³⁰¹ The ciprofloxacin should not have been started and furthermore, after a Laboratory Report showed that the bacteria were resistant to ciprofloxacin, it should have been stopped.³⁰² It was in fact continued for several days after production of the Laboratory Report.³⁰³

John Miller was appropriately started on co-amoxiclav for a suspected urinary tract infection. However, he continued to receive that antibiotic for ten days even although a Laboratory Report dated a week earlier indicated that the bacteria isolated were resistant to co-amoxiclav.³⁰⁴ There may have been undue delay in the

Laboratory Report becoming available, but the junior medical staff should have taken steps to determine the result.³⁰⁵

Dureena Chandayly was started on trimethoprim on admission to the VOLH for a suspected urinary tract infection. The Laboratory Report dated the following day indicated the culture was negative. She continued to receive trimethoprim for five days although the normal period according to the existing guidelines was three days.³⁰⁶ There may have been a delay in the Laboratory Report being available. Had the senior doctor involved been made aware of the result he would have stopped the antibiotic.³⁰⁷ Subsequently, the patient was prescribed co-amoxiclav for a pyrexia of unknown origin. The duration was too long and the opportunity should have been taken to review the prescription and stop it sooner.³⁰⁸

Janet Fitzsimmons, who presented with a number of problems, was prescribed Augmentin (co-amoxiclav) shortly after admission. There was no reference in the patient records to the potential sources of any infection.³⁰⁹ A Laboratory Report of a urine sample taken on admission disclosed that a fungal urinary tract infection was isolated.³¹⁰ It was not clear when that result was communicated to the ward but the Augmentin therapy should have been stopped. That did not happen for several days after the date of the Laboratory Report. Subsequently this patient was prescribed clarithromycin, a decision which was also debatable.³¹¹

296 [TRA00750022](#)

297 [TRA00750052-53](#)

298 [TRA00750058](#)

299 [TRA00750061](#)

300 [TRA00750074-77](#)

301 [TRA00810017](#)

302 [TRA00810018](#)

303 [TRA00810018](#)

304 [TRA00830070-72](#)

305 [TRA00830072](#)

306 [TRA00830095](#)

307 [TRA00830096](#)

308 [TRA00830099-100](#)

309 [TRA00830136](#)

310 [TRA00830138](#)

311 [TRA00830141](#)

Summary of trends of antibiotic prescribing for conditions other than CDI

There were many examples of appropriate prescribing of antibiotics for conditions other than CDI, particularly by the senior medical staff. There were also, however, many examples of inappropriate prescribing for such conditions. The trends can be summarised as follows.

- Poor documentation of choice, duration and reason for the prescription of antibiotics
- Continued prescription of antibiotics in cases where a laboratory test demonstrated the organism was resistant
- Prescription of antibiotics in cases where no antibiotic was necessary, for example, asymptomatic bacteriuria
- The prescription of loperamide and lactulose to patients who were suspected of having contracted CDI or indeed who had tested positive for *C. difficile* toxin
- The omission of doses from drug kardexes without explanation and the significant number of instances when an antibiotic was not given because it was not available

- Instances in which, even where antibiotics were appropriately prescribed, the course of treatment was protracted without any reason being recorded
- Failure to stop or to review antibiotic therapy once a patient had tested positive for *C. difficile* toxin

Antibiotic prescribing review

In response to the CDI problem that became apparent in June 2008, a rapid review of antibiotic use in Clyde hospitals was carried out by Dr Andrew Seaton, Consultant Physician in Infectious Diseases and General Medicine, and by pharmacist Ms Ysobel Gourlay in June and July 2008.³¹² Their analysis was constrained by time and lack of personnel and was limited to a review of commonly known agents known to predispose to CDI.³¹³ Nonetheless, they found higher volumes of co-amoxiclav, quinolones and cephalexin were dispensed in the VOLH compared with the other hospitals in Clyde relative to bed numbers.³¹⁴ The co-amoxiclav analysis³¹⁵ produced by their review is reproduced in Figure 14.1.

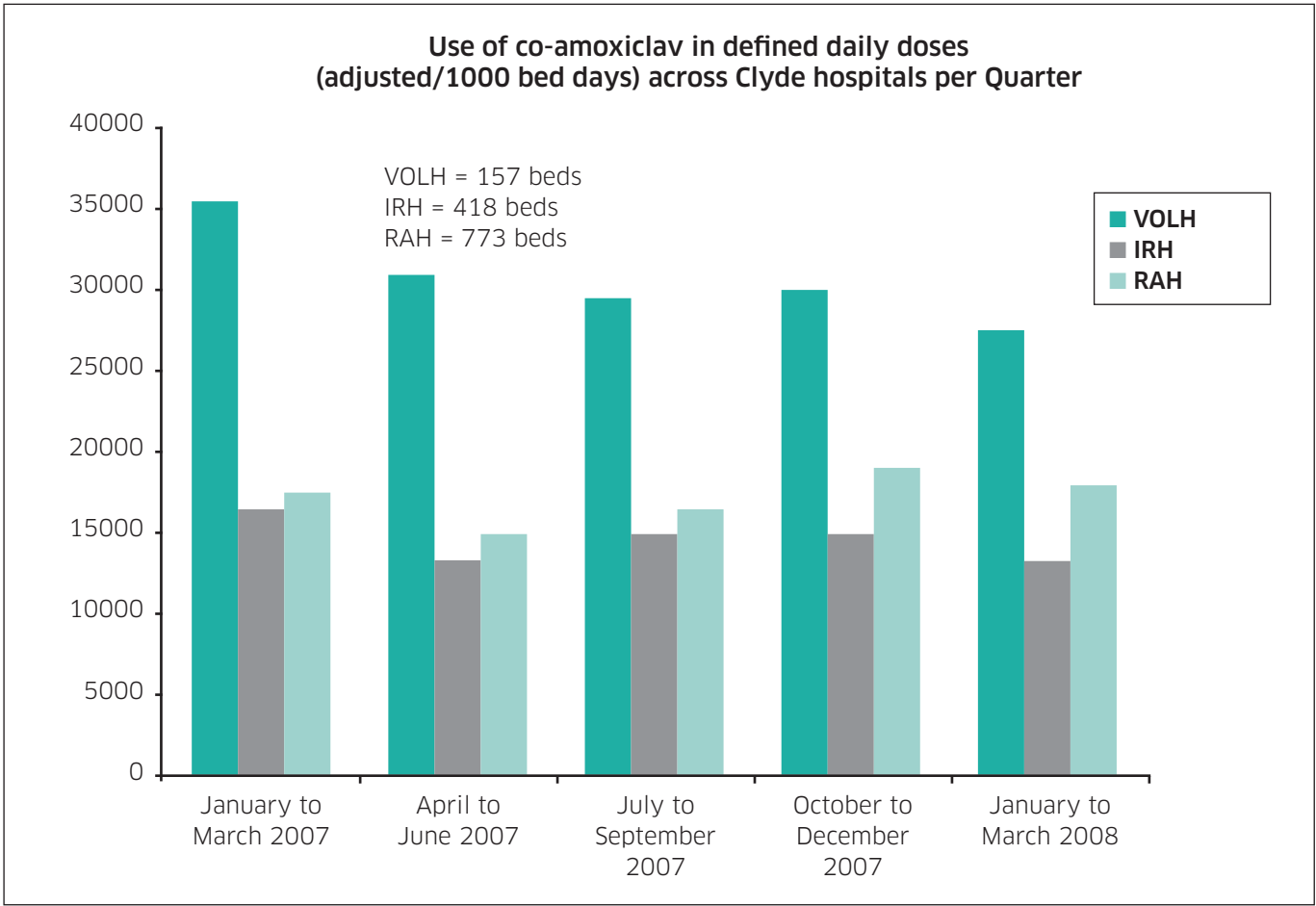
312 [GGC11060001](#)

313 [GGC11060003-04](#)

314 [GGC11060003-04](#)

315 [GGC11060006](#)

Figure 14.1 Co-amoxiclav use in Clyde hospitals



The VOLH has many fewer beds than either the IRH or the RAH. Figures have been adjusted for all three to represent an assumed figure of 1000 beds in each hospital and thus give an accurate basis for comparison. Figure 14.1 illustrates that throughout 2007 and into 2008 the rate of co-amoxiclav use at the VOLH was typically around double that of either of the other Clyde hospitals.

This analysis supports the conclusion arrived at by the Inquiry experts that there was inappropriate use of antibiotics at the VOLH for conditions other than CDI. After stricter controls were introduced in June 2008 there was a “precipitous reduction”³¹⁶ in the use of co-amoxiclav in hospitals in NHSGGC, including the VOLH.³¹⁷

Antibiotic treatment of *C. difficile* infection

The general consensus of the expert medical witnesses was that in most cases, once the treatment was started, appropriate antibiotic treatment by the prescription of metronidazole or vancomycin was given. The regularity of medical review and of assessment of symptoms has already been discussed. There were instances where ongoing monitoring should have led to a re-assessment of treatment with greater input from a microbiologist,³¹⁸ but there were also examples documented where the medical staff (generally the junior staff) did consult with a microbiologist and where advice on treatment was given and followed.³¹⁹

316 [TRA01150125](#)
317 [TRA01150125-126](#)

318 [TRA00640111](#); [TRA00630053](#)
319 [TRA00690026](#)

Some aspects of practice

There were instances where doses of the antibiotic prescribed for CDI were missed or at least not recorded on the drug kardex or the appropriate dosages were not given.³²⁰ This meant that the patient was receiving a sub-therapeutic dose.

In one case a patient only received half the recommended dose of vancomycin although a microbiologist had advised a more appropriate dose. This patient was inclined to wander, thereby increasing the risk of her infecting other patients. The expert microbiologist who looked at this case was not surprised that her CDI did not respond to the treatment.³²¹ A subsequent treatment plan devised by a microbiologist was not followed. The patient ended up suffering from a prolonged episode of CDI until eventually the correct dose was given to which she responded.³²² The doctor involved with this patient had a poor recollection of the reason for failure to follow the plan devised by the microbiologist.³²³

Consultation with consultant microbiologists

Because there was no microbiologist based at the VOLH in the period 1 January 2007 to 1 June 2008, it was necessary for medical staff at the VOLH seeking advice on antibiotic prescribing to telephone either the IRH or the RAH. The general impression gained by the experts who looked at the patient records of the patients in the focus group was that more use could have been made of the services of the medical microbiologists.

14.7 The process for testing for *C. difficile* toxin

Laboratory management

Certain aspects of the management and operation of the laboratory are considered in Chapter 15.

From 1 January 2007 to 1 June 2008 Mr Charles Kinloch³²⁴ was the Technical Head of

the Laboratory Support Services department at the VOLH.³²⁵ He had held that post since May 2005,³²⁶ and was responsible for all non-clinical aspects of the laboratory.³²⁷ Ms Marie Martin, General Manager, Diagnostics for Clyde, was his line manager.³²⁸

Laboratory hours

Mr Kinloch said that the VOLH laboratory was open from 08:40 to 17:00 Monday to Friday and 09:00 to 12:30 on Saturdays,³²⁹ although the VOLH Laboratory Manual provides slightly different times.³³⁰ There was also a 24 hour seven day service for the processing of emergency samples.³³¹ What constituted an emergency was a decision for medical staff. There were two collections of specimens on week days. One batch arrived at the laboratory at lunch time and the second batch arrived at around 15:00 hours,³³² and according to Mr Kinloch the general practice was that all specimens would be tested together just after the second batch arrived.³³³ If a Biomedical Scientist was available earlier, however, the testing of earlier samples could take place before 15:00 hours.³³⁴

Specimen collection process

Each ward had a collection point³³⁵ where stool specimens were kept pending collection by porters. For example, ward 6 had wall compartments located within the ward close to the entrance. Some wards had trays.³³⁶

If a specimen was taken from a patient on Saturday afternoon or Sunday, that specimen would not be received by the laboratory until Monday morning unless identified as an emergency specimen.³³⁷ There was evidence from one nurse that samples taken at night or at the weekend after Saturday morning

320 GGC21070188; TRA00530028; TRA00600129

321 TRA00600129

322 TRA00600131

323 TRA00760108

324 TRA00860096

325 TRA00860095-96

326 TRA00860097

327 TRA00860098-99

328 TRA00860099

329 TRA00860110

330 GGC24480007

331 TRA00860110-111

332 TRA00860119

333 TRA00860139-140

334 TRA00860139

335 TRA00310007

336 TRA00380143; TRA00450074; TRA00410134

337 TRA00860135

could remain on the ward for some time.³³⁸ There was no facility for refrigeration or storage of specimens pending collection.³³⁹ There was some inconclusive evidence of a fast track procedure, particularly in ward F, which involved contacting the porter after the specimen had been collected³⁴⁰ from the patient, and such a system might have been in place for a period after the problem with *C. difficile* in the VOLH had been identified,³⁴¹ but Mr Kinloch did not know what was meant by the fast track procedure.³⁴²

Receipt by the laboratory

The laboratory operated a computerised Laboratory Information Management System (LIMS) system for recording the information which ultimately was entered onto the hard copy Laboratory Report Form. When a stool specimen was taken from the ward to the laboratory it was accompanied by a two part Request Form comprising a front copy and a carbon back copy.³⁴³ The front copy was retained at the laboratory reception area for entry on the LIMS system, and the back carbon copy went with the specimen into the laboratory itself.³⁴⁴ The date on which the specimen was taken was written on the Request Form by ward staff. That date was entered into the LIMS system. It was that date which generally thereafter appeared on the Laboratory Report Form.

The date of receipt by the laboratory was also entered on the LIMS system. According to Mr Kinloch, that date would nearly always reflect the date of actual receipt.

There were, however, occasions when the information was not entered into the LIMS system until the day after actual receipt.³⁴⁵ Dr Clarke thought that this was “often” the case,³⁴⁶ and in that event the date of receipt entered into the LIMS system was the default date generated by the computer, which was

the current date.³⁴⁷ This would explain why, for example, in one case the laboratory appeared to have made the ward aware of the positive result for *C. difficile* toxin before they had even received the sample.³⁴⁸

Testing methodology

The *C. difficile* toxin test used by the laboratory in 2007 to 2008 was known as the Techlab TOX A/B QUIK CHEK³⁴⁹ test. This type of test was in common use at that time,³⁵⁰ and its sensitivity, by which is meant the ability to detect a positive, was around 80%.³⁵¹ The Standard Operating Procedure for the *C. difficile* toxin test³⁵² envisaged that toxin positive results would be phoned to the ward and to the Infection Control Team, but in practice the Infection Control Nurse was the first port of call and the ward was contacted only if she was not available.³⁵³ The test itself (usually done in a batch)³⁵⁴ took approximately 45 minutes.³⁵⁵ According to Mr Kinloch, the general expectation was that all specimens received by the laboratory by 12:30 and 15:00 hours would be tested the same day and reported either to the Infection Control Team or the ward.³⁵⁶

Impact of a delay in treatment of CDI

When there is a suspicion of CDI it is important that a specimen taken is tested without undue delay and treatment started as soon as CDI is confirmed. Delay in the prescription and administration of appropriate antibiotic therapy for CDI can have a significant impact on the management of the condition. A delay in treatment tends to make the outcome worse, particularly if the patient continues to receive broad spectrum antibiotics.³⁵⁷ With few exceptions, the general practice adopted in the VOLH was that treatment for CDI was not started until a positive result was communicated by the laboratory. That represents normal practice,

338 [TRA00310010](#)
 339 [TRA00310010](#); [TRA00380146](#)
 340 [TRA00410134-135](#)
 341 [TRA00370072-73](#)
 342 [TRA00870118](#)
 343 [TRA00870001-02](#)
 344 [TRA00870002](#)
 345 [TRA00870003](#)
 346 [TRA00500089](#)

347 [TRA00870003](#)
 348 GGC00090080-81; GGC00090202
 349 [GGC28100004](#)
 350 [TRA01050095](#)
 351 [TRA00600102](#)
 352 [GGC28100006](#)
 353 [TRA00860143](#)
 354 [TRA00860146](#)
 355 [TRA00860146](#)
 356 [TRA00860146-147](#)
 357 [TRA00860150](#) [TRA00530068](#)

but it means that the time between taking a specimen and the result of that specimen being communicated to the ward and acted upon is of extreme importance to the appropriate management of a CDI patient.

Specimens in the focus period

The Inquiry has identified from patient records and from data from the LIMS system³⁵⁸ that in the period from 1 December 2007 to 1 June 2008 90 specimens tested positive for *C. difficile* toxin. For three of these results there is inadequate information available to allow an analysis of whether there was any delay between the taking of the specimen and the treatment commencing, but there was sufficient information available for the other 87.

Patient records had to be relied upon in analysing whether there were any significant delays between the taking of specimens and starting treatment, and the deficiencies identified in many of the patient records must be acknowledged. Nonetheless, assuming that those entries that are in the records are reasonably accurate, some trends can be observed.

Types of delay

The analysis carried out by the Inquiry revealed that there were delays in 32 out of the 87 positive results. That number included 15 specimens taken at weekends, when the laboratory did not process the specimens. In only six of those weekend cases, however, could the delay be attributed to the reduced weekend service. The other nine cases

included a day or more on either side of the weekend in addition to the weekend delay. It follows that, although in the majority of cases there were fewer than 24 hours between collecting specimens and commencing treatment, there was a significant number of cases in which a delay of some sort occurred.

There are potentially three types of delay:

1. A process delay: Such a delay could be caused while either transporting or processing the specimen. Here the approach taken was that a delay occurred where there was more than 24 hours between the specimen being taken from the patient and the ward becoming aware of the CDI result.
2. A delay in treatment: The task here was one of examining the patient records to see if there was any significant delay between the ward becoming aware of a positive CDI result and the patient commencing treatment.
3. A combined process and treatment delay: A delay in the transport or processing of specimens and a further delay in commencing treatment.

Delays in process

The Inquiry's analysis revealed 22 individual process delays where there were more than 24 hours between the specimen being collected from the patient and the ward becoming aware of the CDI result. That includes five instances of a process delay of four days. Table 14.6 sets out the delays in processing samples.

358 INQ01740001; INQ01750001

Table 14.6 Delays in process

Patient	Date specimen collected	Date ward aware of CDI result	Total delay
Isobel Cameron	03/12/07	05/12/07	2 days
Patient B	15/12/07 (Saturday)	17/12/07	2 days
Agnes Burgess	22/12/07	24/12/07	2 days
Isobel Cameron	02/01/08	04/01/08	2 days
Mary Broadley	12/01/08	14/01/08	2 days
Rosa Rainey	19/01/08 (Saturday)	21/01/08	2 days
David Somerville	07/02/08	11/02/08	4 days
Jean Beattie	09/02/08 (Saturday)	11/02/08	2 days
Mary Hamilton	11/02/08	13/02/08	2 days
Margaret Gaughan	14/02/08	18/02/08	4 days
Jessie Jones	16/02/08 (Saturday)	18/02/08	2 days
Elizabeth Valentine	21/02/08	25/02/08	4 days
David Somerville	29/02/08	04/03/08	4 days
Allan Lynch	07/03/08 (Friday pm)	10/03/08	3 days
David Somerville	16/03/08	18/03/08	2 days
Mary McDougall	10/04/08	14/04/08	4 days
David Somerville	04/05/08	07/05/08	3 days
Moir McWilliams	06/05/08	09/05/08	3 days
Charles Cook	07/05/08	09/05/08	2 days
Charles Cook	07/05/08	09/05/08	2 days
Muriel Waddell	14/05/08	16/05/08	2 days
George Drummond	17/05/08 (Saturday)	19/05/08	2 days

Delays in treatment after ward aware of CDI result

So far as the Inquiry could ascertain from the patient records, there were 18 instances

where there was a delay in treatment after the ward became aware of the positive CDI result. Table 14.7 sets out when these delays occurred, and the nature of the delays.

Table 14.7 Delays in treatment

Patient	Date ward aware of positive CDI result	Date treatment started	Total delay
Isobel Cameron	05/12/07	06/12/07	1 day
Agnes Burgess	24/12/07	25/12/07	1 day
Isobel Cameron	04/01/08	09/01/08	5 days
Isobel Cameron (x 2 samples)	08/01/08	09/01/08	1 day
Mary Broadley	14/01/08	15/01/08	1 day
Margaret Thompson	17/01/08	18/01/08	1 day
Mary Hamilton	22/01/08	23/01/08	1 day
Matthew Macfarlane	12/02/08	13/02/08	1 day
Mary Hamilton	13/02/08	14/02/08	1 day
Margaret Gaughan	18/02/08	21/02/08	3 days
Anne Gray	26/02/08	28/02/08	2 days
Coleman Conroy	10/03/08	11/03/08	1 day
David Somerville	18/03/08	19/03/08	1 day
Coleman Conroy	24/03/08	25/03/08	1 day
Margaret Kelly	15/04/08	17/04/08	2 days
David Somerville	07/05/08	08/05/08	1 day
Margaret Stevenson	15/05/08	16/05/08	1 day

Combined delays in process and treatment

There were a number of cases where there were combined delays in processing samples and in commencing treatment after the ward

became aware of the positive CDI result. Table 14.8 sets out eight instances of such delays including some delays of three to seven days.

Table 14.8 Combined process and treatment delays

Patient	Date specimen Collected	Date ward aware	Process delay	Date treatment started	Treatment delay	Total combined delay
Isobel Cameron	03/12/07	05/12/07	2 days	06/12/07	1 day	3 days
Agnes Burgess	22/12/07 (Saturday)	24/12/07	2 days	25/12/07	1 day	3 days
Isobel Cameron	02/01/08	04/01/08	2 days	09/01/08	5 days	7 days
Mary Broadley	12/01/08 (Saturday)	14/01/08	2 days	15/01/08	1 day	3 days
Mary Hamilton	11/02/08	13/02/08	2 days	14/02/08	1 day	3 days
Margaret Gaughan	14/02/08	18/02/08	4 days	21/02/08	3 days	7 days
David Somerville	16/03/08 (Sunday)	18/03/08	2 days	19/03/08	1 day	3 days
David Somerville	04/05/08 (Sunday)	07/05/08	3 days	08/05/08	1 day	4 days

Negative results

Between 1 January 2007 and 30 November 2007 (the early period) there were 432 negative results for *C. difficile* toxin. Ninety-five of those negative results were for patients who did test positive for *C. difficile* toxin at some point, either earlier or later.

Between 1 December 2007 and 1 June 2008 (the focus period) there were 298 negative results. Of those, 80 were results for patients who did test *C. difficile* toxin positive at some point.

The practice adopted for negative results was that the laboratory did not telephone the Infection Control Nurse or the ward to notify them of the result. Instead the negative result was entered into the computer system where it could be accessed. Once available and printed off, the report was placed in the patient records.

Generally, nursing and medical staff were unaware of a negative result until the hard copy Laboratory Report was received on

the ward. It should have been the general practice for nurses and doctors to contact the laboratory or access the computer system to check on a result. Reliance on receipt of the formal Laboratory Report increased the delay in the ward becoming aware of the negative result, which meant that any decision to re-test was delayed as was any consideration of an alternative diagnosis.

Process delays with negative specimens

It was possible to make some assessment of process delays in 68 of the 80 negative results for the focus group patients. Here the picture was very similar to that of the positive CDI results. There appeared to be frequent delays in transport, for in 41 of the 68 negative results the specimen did not reach the laboratory the same day as it was collected. This exercise has been carried out by reference to laboratory records only, and is subject to the reservation that those records were not always accurate, but on the information available there were apparent transport delays of two to six days in 19 out of 68 negative results.

Handling of samples – false negatives

As already mentioned, the test in use in the VOLH laboratory normally had the ability to detect toxin positive results in about 80% of cases. This would indicate therefore, that there were false negative results produced in at least 20% of cases.³⁵⁹ But in addition to that, delays in transporting stool specimens from the ward to the laboratory could cause specimens to degrade and produce a higher rate of false negative results.³⁶⁰ Although there were refrigerated storage facilities in the laboratory, there was no evidence that specimens were ever refrigerated when on the ward. Indeed, the contrary seems to have been the case.³⁶¹ Yet according to the Standard Operation Procedure for the *C. difficile* toxin test:

“Optimal results are obtained with samples which are < 24 hours old. Most specimens may be stored at 2-8°C for up to 72 hours before significant degradation of toxin is noted”.³⁶²

It is therefore highly probable that the lack of refrigeration, in conjunction with the delays in specimens reaching the laboratory, contributed to the number of false negative results produced. In examining the records of CDI patients during the focus period, the Inquiry’s microbiology experts were able to identify 16 separate instances where in their view a false negative result was produced³⁶³ but because of the way specimens were managed, especially on the wards, there were more false negative results than identified by the experts.

Conclusion on antibiotic prescribing

Chapter 13 explores the mismatch between the regular issuing of policy and guidance on prudent antibiotic prescribing in the years prior to the emergence of the CDI problem at the VOLH and the implementation of policy and guidance. In this Inquiry the scrutiny of antibiotic prescribing for conditions other

than CDI has disclosed that the message on prudent prescribing had not reached the VOLH. Subject to the specific exceptions set out in this Chapter, in general the prescribing practice for CDI in the VOLH was appropriate.

There should have been a more effective system in place for the prompt reporting of *C. difficile* toxin positive results. The weekend should not have meant that the system of collection, testing and reporting was in any way compromised. Patients are as liable to become symptomatic on weekend days as on any other days. The treatment and care of patients suffering from CDI demand a seven-days-a-week programme of care. The existence of a system of reduced weekend sampling, combined with the practice in the VOLH of not isolating patients prior to the production of a positive *C. difficile* toxin result, only served to increase the risk of cross infection.

The delays identified in commencing treatment after positive results were known by the ward are inexcusable. These were patients who were suffering from a serious and potentially life threatening infection. Furthermore, a delay in treatment for CDI means that no assessment is made of the existing antibiotic treatment the patients might be receiving. This Chapter has also identified delays in the processing of specimens that produced false negative results.

The 32 separate delays between obtaining a specimen and commencing treatment occurred for 23 patients. Fifteen of those patients died and according to Professor George Griffin, the Inquiry’s infectious diseases expert, for 13 of those patients *C. difficile* was the cause or a contributory factor in their deaths. These were patients with co-morbidities and it is likely that their survival would not have been greatly extended had they not contracted CDI. Nonetheless, the delay in treatment of such patients reflected an extremely poor standard of nursing and medical care.

359 [TRA00600101-102](#)

360 [TRA00640028-29](#); [TRA00600101](#)

361 [TRA00310010](#); [TRA00380146](#)

362 [GGC28100006](#)

363 EXP01460010; EXP01470010; EXP01490011; EXP01530012; EXP01570010; EXP01620012; EXP01640011-12; EXP01750010; EXP01760009; EXP01780013; EXP01820010; EXP01980014; EXP01990034; EXP02100006

14.8 Overall conclusion

The overall quality of record keeping by junior doctors was poor. Problems with the recruitment of medical staff and a lack of middle grade medical staff meant that the consultants at the VOLH were overstretched. Junior doctors had the greater involvement with patients. There was a clear trend that assessments of the condition of many patients suffering from CDI were not being recorded which suggests that no assessments were being made. The frequency of the medical review of patients suffering from CDI was inadequate. Because consultants were overstretched, junior doctors at the VOLH were not being properly supervised. Although there were examples of appropriate prescribing of antibiotics for conditions other than CDI there were also many examples of inappropriate prescribing. The delays identified between the obtaining of a stool specimen and the commencement of antibiotic treatment after a positive test, particularly after the results were known, were inexcusable.

The failures identified in this Chapter will have compromised patient care. No doubt there were failures by individuals but the ultimate responsibility for standards having become unacceptable must rest with NHSGGC.

14.9 Recommendations

Recommendation 36: Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high quality care.

Recommendation 37: Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis.

Recommendation 38: Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff.

Recommendation 39: Health Boards should ensure that medical and nursing staff are aware that a DNAR decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy.

Recommendation 40: Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management.

Recommendation 41: Health Boards should ensure that there is no unnecessary delay in processing laboratory specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed.

Chapter 15

Infection prevention and control

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Introduction

Mr Thomas Divers, the NHSGGC Chief Executive, did not become aware of the longstanding *C. difficile* infection (CDI) problem at the VOLH until June 2008.¹ At the first meeting of the Outbreak Control Team on 10 June 2008 the results of the retrospective investigation into the period from 1 December 2007 to 31 May 2008 (the focus period) were available.² The extent of the current CDI problem was by then apparent and the risk matrix classification already referred to in Chapter 7 was now red.³ The Inquiry's remit, however, also includes the period from 1 January 2007 to 30 November 2007 (the early period). It is clear that the CDI problem also existed during that period, and as set out in Chapter 5 it is highly likely that there were outbreaks of CDI during the early period.

Management at all levels should have become aware of the problem in 2007. In particular the Chief Executive of the Health Board, as the person with ultimate responsibility for infection prevention and control, should have been made aware of the problem. When Mr Divers did become aware of the extent of the problem in June 2008, he did not know in detail what had "brought about such a protracted series of events".⁴ He did, however, realise that:

"things had gone far wrong and that, at a number of levels, there were likely to have been failures in the control and management arrangements".⁵

As set out in this Report, the Inquiry endorses that conclusion.

The intention in this Chapter is to discuss the infection prevention and control arrangements for the VOLH during the period 1 January 2007 to 1 June 2008. The Chapter also explores why the extent of the CDI problem was not identified by senior management until June 2008. The main changes made to the infection prevention

and control arrangements in response to the discovery of the problem are considered. What this Chapter discloses is a catalogue of serious individual and systemic failures that combined to place patients at risk and caused unnecessary suffering and deaths.

15.1 The constitution of an Infection Control Team

Guidance

Clear guidance has been in place on the constitution of an Infection Control Team since at least the publication of the Healthcare Associated Infection Control Standards⁶ by the Clinical Standards Board for Scotland (CSBS) (the CSBS Standards) in December 2001. The overarching Standard statement sets out the need for the creation of a "managed environment which minimises the risk of infection to patients, staff and visitors".⁷

The function of the Infection Control Team

The CSBS Standards required an appropriately constituted and functioning Infection Control Team.⁸ The rationale behind that provision was the importance of having in place a team responsible for the "day-to-day implementation of the Infection Control Programme"⁹ that can provide advice on infection control and manage patients with infection.

The membership of the Infection Control Team

The CSBS Standards stipulated that the Infection Control Team should include an Infection Control Doctor (ICD) and Infection Control Nurses (ICNs). The team was to be supported by dedicated secretarial, IT and audit staff. Members of the team had to be trained in infection control.¹⁰

The Infection Control Doctor as leader of the team

The Watt Group Report of 2002¹¹ also highlighted the importance of the role of the

1 [TRA01250057](#)
2 [GGC11140003](#)
3 [GGC11140004](#)
4 [TRA01250057](#)
5 [TRA01250057](#)

6 [GOV00160001](#)
7 [GOV00160017](#)
8 [GOV00160032](#)
9 [GOV00160032](#)
10 [GOV00160033](#)
11 [GOV00130001](#)

Infection Control Team in the management of healthcare associated infection (HAI), and recommended that the ICD should be the leader of the Infection Control Team.¹² The recommendation on this issue also provided that the ICDs would have “designated sessions” and a clearly defined job description for this component of their work.¹³ The CSBS Standards provided that the “contracted sessions per week”¹⁴ for the ICD were to be defined and agreed.

NHSGGC Infection Control Teams

NHSGGC had Infection Control Teams in place for the sectors that made up the NHSGGC area. The VOLH was in the Clyde Sector as was the RAH and the IRH.

15.2 The Infection Control Team for the VOLH

Infection Control Nurses

From January 2007 to July 2007 Mrs Jean Murray and Mrs Helen O'Neill were respectively Senior Infection Control Nurse and Infection Control Nurse at the VOLH. From July 2007 until her retirement in April 2008 Mrs Murray took on the post of interim Lead Nurse for Infection Control for the Clyde Directorate, taking on responsibility for four ICNs at the Inverclyde Royal Hospital (IRH) and four at the RAH in addition to Mrs O'Neill at the VOLH. Mrs Murray remained based at the VOLH,¹⁵ but the post was a full-time one,¹⁶ and while Mrs Murray retained some hands-on involvement in infection prevention and control at the VOLH the major part of the workload there was borne by Mrs O'Neill.

Infection Control Doctor

The ICD was Dr Elizabeth Biggs. She was also the ICD for the RAH and for the IRH, where she was based. Dr Biggs' role as ICD was taken over by Dr Linda Bagnade in early February 2008.

Non-clinical support staff

In 2006 and up to December 2007 Mr Craig Nixon was attached to the Infection Control Team at the VOLH with the job title of “Quality and Effectiveness Facilitator”.¹⁷ He managed the infection control database¹⁸ and was responsible for producing the quarterly reports on infection rates¹⁹ referred to later in this Chapter. When he left in December 2007 his post was not filled.

Mrs Isobelle McIntyre was the secretary to the Infection Control Team at the VOLH. She had held this post since November 2006,²⁰ and still held it at the time she gave evidence to the Inquiry in March 2012. She shared an office with Mr Nixon prior to his departure in December 2007.²¹

The Infection Control Nurse

Mrs O'Neill qualified as a nurse in 1975²² and has spent her working life in the VOLH. She became an ICN in August 2002.²³ She completed the Cleanliness Champions Programme (CCP) in 2006²⁴ but did not obtain a qualification in infection prevention and control. Her job description²⁵ envisaged that she would hold or would be willing to work towards a post-registration degree or diploma in infection control nursing,²⁶ but despite that provision Mrs O'Neill was unsuccessful in obtaining such a qualification and stopped working towards it in 2006.²⁷ Gaining a qualification in infection prevention and control should have been an essential requirement of Mrs O'Neill remaining in the post of ICN.

Included in Mrs O'Neill's job description was the duty to:

“Interpret surveillance data and communicate findings via reports and meetings to the appropriate users”.²⁸

12 [GOV00130030](#)
13 [GOV00130030](#)
14 [GOV00160033](#)
15 [TRA01010010](#)
16 [TRA01010012](#)

17 [TRA00920005](#)
18 [TRA00920010](#)
19 [TRA00920007](#)
20 [TRA00920033](#)
21 [TRA00920034](#)
22 [TRA00950001](#)
23 [TRA00950002](#)
24 [TRA00950004](#)
25 [INQ00380001](#)
26 [INQ00380011](#)
27 [TRA00950017-18](#)
28 [INQ00380004](#)

In her evidence, however, Mrs O'Neill said that she did not carry out that function and left it to Mrs Murray.²⁹ Her job description also envisaged that she would communicate with the ICD in relation to day-to-day infection control issues, placement of patients and information on infection and communicable diseases.³⁰ In practice Mrs O'Neill did not have regular contact with Dr Biggs.³¹

Mrs O'Neill's hours of work were from Monday to Friday from 9am to 5pm. There was no ICN cover at the VOLH at the weekends.³²

The Lead Nurse for Infection Control

Mrs Murray qualified as a registered nurse in 1989. She first took up a post as ICN in 1999 with Liverpool Health Authority, and had infection prevention and control qualifications including the English National Board Qualification for Infection Control. She was appointed to the post of ICN at the VOLH in October 2001,³³ becoming interim Lead Nurse for Infection Control for the Clyde Directorate in July 2007. Her line manager was the Head Nurse for Infection Control, Mrs Annette Rankin. Mrs Murray saw her line manager once or twice a month.³⁴

Mrs Murray thought that there were not many days when she was not present at the VOLH at some point during the day.³⁵ She said it was one of her responsibilities to make herself aware of the number of cases of CDI in the VOLH and to see whether there was an increase in such cases,³⁶ as well as to investigate the possibility of an outbreak.³⁷ Mrs Murray's job description envisaged that she would "Work closely with the relevant Infection Control Doctors ...".³⁸ That did not happen in practice when Dr Biggs was the ICD.³⁹

Mrs Murray commenced a phased retirement process in January 2008, so that over the following three months her working days were reduced. In January she worked four days a week, in February three days a week and in March two days a week. She stopped working on 17 March 2008, although she did not formally retire until April 2008.⁴⁰

The next Lead Nurse for Infection Control

Ms Joan Higgins became interim Lead Nurse for the Clyde Sector on 9 April 2008⁴¹ as the successor to Mrs Murray. Ms Rankin became her line manager.⁴² When she took up her post, Ms Higgins was based at the RAH. Like Mrs Murray, Ms Higgins was responsible for the VOLH, the RAH and the IRH,⁴³ although she only retained responsibility for the VOLH until July 2008.⁴⁴ She had no handover from Mrs Murray, who had already left.⁴⁵

Ms Higgins first visited the VOLH on 11 April 2008 and met Mrs O'Neill and Mrs McIntyre. There was no indication, particularly from Mrs O'Neill, that there was any concern over CDI at that time.⁴⁶ After her first visit to the VOLH on 11 April 2008 Ms Higgins visited the VOLH on a weekly basis until the CDI problem became evident.⁴⁷ She participated in the investigation in May and June 2008.

Dr Biggs

Dr Biggs qualified in 1977 with an MBChB degree from Glasgow University. She became a member of the Royal College of Pathologists in 1984. She became a Consultant Microbiologist in 1986 and since then had worked mainly at the IRH.⁴⁸

As discussed later in this Chapter, Dr Biggs was the ICD for the VOLH in the period from 1 January 2007 to 1 February 2008. As already mentioned she was also the ICD for the RAH and the IRH. The evidence was that Dr Biggs rarely attended at the VOLH. Her line manager, although not her professional

29 [TRA00950011-12](#)
30 [INQ00380009](#)
31 [TRA00950015](#)
32 [TRA00950007](#)
33 [TRA01010001-03](#)
34 [TRA01010017](#)
35 [TRA01010017](#)
36 [TRA01010023](#)
37 [TRA01010024](#)
38 [GGC30480002](#)
39 [TRA01010019](#)

40 [TRA01010016](#)
41 [TRA00990003](#)
42 [TRA00990006](#)
43 [TRA00990007](#)
44 [TRA00990015](#)
45 [TRA00990016](#)
46 [TRA00990023-25](#)
47 [TRA00990026](#)
48 [SPF01460002](#)

line manager, was Ms Marie Martin, General Manager, Diagnostics for Clyde. Ms Martin's position is considered later in this Chapter, as is the position of Dr Biggs' professional line manager.

Dr Biggs' job description⁴⁹ placed her under a duty to take "a lead role in the effective functioning of the Infection Control Team ..." ⁵⁰ at the hospitals for which she was the ICD. The job description also provided that the ICD would "attend all meetings" and be "an active member of the Hospital Infection Control Committee".⁵¹ Her responsibilities included investigating outbreaks of hospital infections and supporting the ICNs in their "day-to-day activities".⁵²

As already mentioned, the ICD is the clinical leader of the Infection Control Team. As far as the VOLH was concerned Dr Biggs failed comprehensively to carry out her responsibilities as the ICD. As discussed later in this Chapter, her failure as ICD made a real contribution to the development and undetected continuation of the serious CDI problem at the VOLH.

Dr Bagraade

Dr Bagraade thought she took on the role of ICD for the VOLH on 4 February 2008.⁵³ She also became the ICD for the RAH.⁵⁴

Dr Bagraade qualified as a medical doctor in 1997 from the Medical Academy of Latvia. She acquired some further qualifications, including a professional qualification in medical microbiology, from the Latvian Medical Microbiology Association in 2004.⁵⁵ Dr Bagraade first worked in Scotland as a specialist registrar in medical microbiology in 2006, and took up the post of Consultant Microbiologist at the RAH on 21 January 2008.⁵⁶ The RAH was her base even when she became ICD for the VOLH in early February 2008. Her line manager was Ms Martin.⁵⁷

Dr Bagraade first visited the VOLH in the second half of February 2008,⁵⁸ when she met Mrs Murray, Mrs O'Neill, Mrs McIntyre⁵⁹ and Mr Charles Kinloch, Technical Head for Microbiology at the VOLH.⁶⁰ Dr Bagraade did ask Mrs Murray and Mrs O'Neill if there were any problems,⁶¹ but neither of them identified any during that visit.⁶² Dr Bagraade said that after that first visit she visited the VOLH up to the beginning of May "more or less once a week, sometimes it was even more frequent ...".⁶³

Dr Bagraade remained in ignorance of the numbers of CDI cases in the VOLH after her appointment as ICD in early February. Nevertheless her practice of regular visits to the VOLH was in stark contrast to the attitude previously adopted by Dr Biggs.

Appraisal of Infection Control Team members

Although a process should be in place to regularly discuss and review the work of an employee in the course of a year, formal appraisals are important for a number of reasons. Firstly, the appraisal process presents individual employees with the opportunity to inform their appraiser of how they are finding their work. They can advise whether they are receiving appropriate support in that work and whether they consider that some additional training is necessary. Secondly, appraisals provide more senior staff with the opportunity to review an employee's performance against the agreed job plan and provide feedback on performance. They can identify whether further training may be required and ensure that the employee is fully aware of what is expected in the job.⁶⁴ Thirdly, appraisals provide an opportunity to agree the job plan and set clear priorities and objectives for the year ahead.

As line manager it should have been Mrs Murray's responsibility to carry out

49 [GGC32170001](#); [INQ05180001](#)

50 [GGC32170001](#)

51 [GGC32170001](#)

52 [GGC32170003](#)

53 [TRA01140001](#)

54 [TRA01140002](#)

55 [INQ03560001](#)

56 [TRA01020061](#)

57 [TRA01020084](#)

58 [TRA01020089](#)

59 [TRA01020090](#)

60 [TRA01020093](#)

61 [TRA01020100](#)

62 [TRA01020100-102](#)

63 [TRA01020104](#)

64 [TRA01040017](#)

appraisals of Mrs O'Neill.⁶⁵ Yet in the time she worked as an ICN at the VOLH, from 2002 to 2008,⁶⁶ Mrs O'Neill never had an appraisal carried out.⁶⁷ Mrs Murray said that there was no appraisal system in place during her time at the VOLH,⁶⁸ which was from October 2001⁶⁹ to March 2008.⁷⁰

The absence of a system of appraisals was not limited to the VOLH. Ms Rankin, as Mrs Murray's line manager from April 2007, would have been responsible for carrying out her appraisal, but Ms Rankin also said that there was no formal appraisal system in place.⁷¹ She did, however, assess Mrs Murray's performance through observation and feedback and discuss objectives with her. These were short-term objectives relating to integration with Greater Glasgow Health Board (GGHB) because Mrs Murray was due to retire in April 2008.⁷²

Although Dr Biggs suggested in one of her police statements and to the Internal Investigation that between May 2007 and July 2008 she did not have a line manager,⁷³ or that she did not know who her line manager was, that suggestion is not correct. As discussed in this Chapter, Ms Martin was her line manager and remained so up to June 2008. What Dr Biggs may, however, have been referring to is her professional line management during that period, and what she is noted as saying at her interview by the Internal Investigation panel is in the context of there being no Clinical Director.⁷⁴ This separation of line management roles is because appraisals for medical staff were carried out by another doctor.⁷⁵

Dr Geoffrey Douglas, who was Clinical Director, was Dr Biggs' professional line manager until 15 April 2006, but was then off work due to illness, and on his return

in September 2007 did not resume his professional line management duties.⁷⁶ There is no evidence that Dr Biggs had an appraisal carried out in the period 1 January 2007 to June 2008, and one of the issues identified during the VOLH Laboratory inspection on 18 and 19 September 2007⁷⁷ was that an appraisal for Dr Biggs was "not available".⁷⁸ In contrast, the inspectors were able to conclude that the appraisal for Dr François de Villiers, Consultant Microbiologist at the IRH, was over six months overdue.⁷⁹

The aim of a formal appraisal is at least in part to provide assurance about competence and fulfilment of the requirements of the job. An appraisal of Dr Biggs should have identified that she was not performing her ICD role for the VOLH.

The absence of a formal system of appraisals and the apparent absence of an appraisal of Dr Biggs during this period are just one aspect of the sub-standard management arrangements for the Infection Control Team at the VOLH.

Mrs O'Neill's lack of qualification

As mentioned earlier in this Section, Mrs O'Neill stopped working towards an infection prevention and control qualification in 2006. Her position should certainly have been reviewed by Mrs Murray as her line manager in the light of that, and the absence of a system of appraisals no doubt contributed to that failure to review. Dr Biggs was also aware of the position⁸⁰ and had a professional responsibility as the Infection Control Doctor prior to February 2008 to address this issue. The situation became particularly acute when Mrs Murray was on phased retirement from January 2008. This is discussed later in this Chapter.

65 [TRA00950022](#)

66 [TRA00950002](#)

67 [TRA00950022](#)

68 [WTS01170012](#)

69 [TRA01010001-03](#)

70 [TRA01010016](#)

71 [TRA01000004](#)

72 [TRA01000004](#)

73 [SPF01460003](#); [GOV00890099](#); [GOV00890101](#)

74 [GOV00890099](#)

75 [TRA01250011](#)

76 [TRA01250021-26](#)

77 [GGC30380001](#)

78 [GGC30380001](#)

79 [GGC30380001](#)

80 [SPF01460004](#)

15.3 The infection prevention and control management structure

Infection Control Team set-up

From 1 September 2007⁸¹ wards 14, 15 and F were fully integrated with the NHSGGC Rehabilitation and Assessment Directorate with Ms Anne Harkness as the Director, while the remaining wards, including wards 3, 5 and 6, remained within the Clyde Directorate where Mrs Deborah den Herder was the Director. That meant that in the VOLH two different Directors had parallel but separate responsibilities within the same hospital for different wards.⁸² The two Directorates were served by the same Infection Control Team, however, and had the same infection control line management structure. The Fruin and Christie wards in the VOLH were part of the community healthcare partnership and had a separate Infection Control Team from the rest of the hospital.

Line management – Mrs Murray and Mrs O'Neill

As discussed in the previous Section, Mrs Murray was line manager for Mrs O'Neill until her retirement in April 2008, when Ms Higgins took over that responsibility.

From about 23 April 2007 Ms Annette Rankin became the Infection Control Head Nurse for NHSGGC.⁸³ Prior to that date she had been acting Head Nurse for Infection Control for Glasgow acute services.⁸⁴ As the Head Nurse for Infection Control she became managerially and professionally responsible for all the Lead Nurses for Infection Control⁸⁵ in NHSGGC, which meant that when Mrs Murray became interim Lead Nurse for Infection Control for the Clyde Sector Ms Rankin became her line manager.⁸⁶ When Ms Higgins succeeded Mrs Murray on 9 April 2008⁸⁷ Ms Rankin also became her line manager.⁸⁸

Ms Rankin took up her first post as ICN in 1995.⁸⁹ Her qualifications included an MSc in infection control from the University of the Highlands and Islands.⁹⁰ Ms Rankin's job description provided that she was to "lead and manage both the infection control nursing service and function".⁹¹ Thomas Walsh, Infection Control Manager for NHSGGC, was her professional line manager, at least from the time he took up post in June 2007.

Line management – Ms Martin

Subject to the question of her secondment, which is examined later in this Chapter, Ms Martin had been the General Manager of Diagnostic Services for the Clyde Sector since April 2006.⁹² In addition to having responsibilities for radiology, Ms Martin's remit included infection prevention and control,⁹³ with responsibility to ensure that there was adequate staff in place and that the staff had the resources and the systems in place to allow them to do their job.⁹⁴ Ms Martin reported to Mrs den Herder, who was her line manager. Within the infection control structure for the Clyde Sector Ms Martin was the designated line manager for Dr Biggs and Ms Rankin,⁹⁵ and also became Dr Bagrade's line manager following her appointment in February 2008.⁹⁶

Line management and phased retirement/absence

No additional resources were made available during the time of Mrs Murray's phased retirement and there was no evidence that priorities were agreed during this period. Mrs O'Neill was on annual leave from 7 February to 18 February 2008, and there was no direct cover for her. Mrs Murray herself had duties as interim Lead Nurse as well as being in the midst of her phased retirement programme, with reduced working hours. It was at this point that a particular problem with CDI developed in ward F at the VOLH, and this is described in Section 15.4.

81 [TRA01180096](#)

82 [TRA01180099](#)

83 [TRA00990129](#)

84 [TRA00990129](#)

85 [TRA00990130](#)

86 [TRA00990130](#)

87 [TRA00990003](#)

88 [WTS01090001](#)

89 [TRA00990128](#)

90 [TRA00990146](#)

91 [GGC30200001](#); [TRA00990129](#)

92 [TRA01160001](#)

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94 [TRA01160010](#)

95 [TRA01160005](#)

96 [TRA01020084](#)

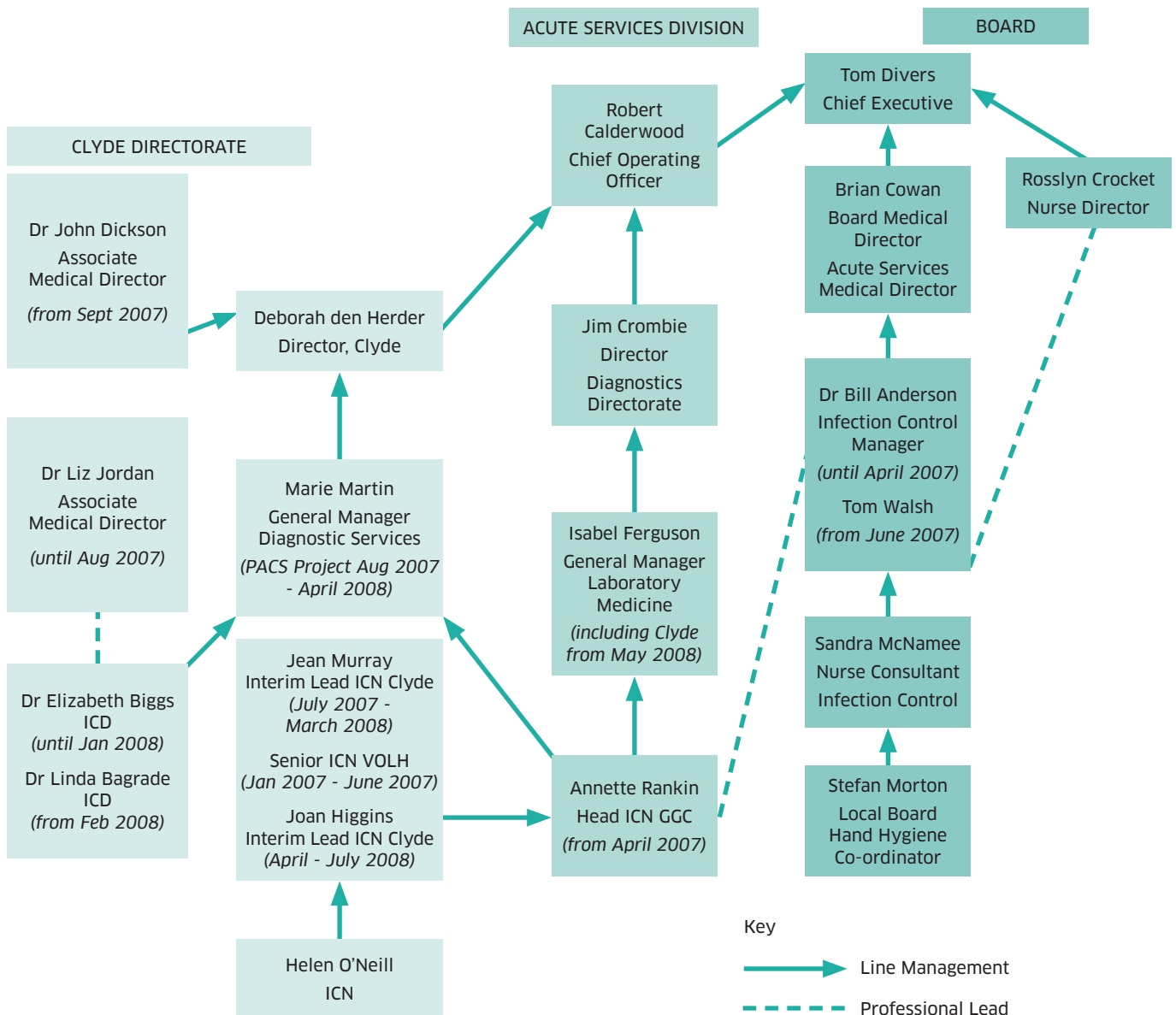
Ms Martin was fully aware of the arrangements for Mrs Murray's phased retirement.⁹⁷ Given Ms Martin's responsibility for ensuring that there was an adequate number of staff in place,⁹⁸ she should have addressed the obvious gap created by Mrs Murray's phased retirement, particularly when Mrs O'Neill did not have an infection control qualification and required supervision. It was only after Mrs Murray

fully retired that cover was provided from the RAH.⁹⁹ The combined impact of Mrs O'Neill's annual leave and Mrs Murray's phased retirement created an obvious gap. This gap was a significant one.

Line management – senior management

Figure 15.1 sets out the infection control management structure at the VOLH in the period January 2007 to June 2008.

Figure 15.1 The infection control management structure at the VOLH in the period January 2007 to June 2008



97 [GGC32980001; GGC33010001](#)
98 [TRA01160009-10](#)

99 [TRA01020030](#)

As Chief Executive Mr Divers had ultimate responsibility for infection prevention and control in the VOLH in the period from 1 January 2007 to 1 June 2008.¹⁰⁰ Within the Clyde Directorate Mrs den Herder as Director had line management responsibility for infection prevention and control with a reporting line to Mr Robert Calderwood, then Chief Operating Officer, Acute Services.

15.4 Implementation of policies and training

Infection Control Manual

The NHSGGC Infection Control Manual¹⁰¹ contained policies relevant to infection prevention and control. In the opinion of Professor Duerden, an infection control expert commissioned by the Inquiry, the policies in place were entirely appropriate.¹⁰² The manual was available in the wards¹⁰³ and was also accessible online on the VOLH intranet.¹⁰⁴ Professor Duerden did say that the manual as a whole was not user friendly, and that in addition laminated documents or posters available in appropriate places would have been more accessible to staff.¹⁰⁵ There is a limit on how many laminated signs can be in use at a given time, but a selection reinforcing important messages would have been appropriate.

Loose Stools Policy

In the two successive versions of the Loose Stools Policy¹⁰⁶ in force from 1 January 2007 to 1 June 2008 the important guidance for present purposes is identical. Loose stools were identified as “potentially infectious diarrhoea”. The precautions to be taken for patients with loose stools included placing such a patient in a single room or, if the patient was clinically unsuitable for isolation, a risk assessment was to be undertaken by the clinical team in conjunction with a member of the Infection Control Team.¹⁰⁷ A care plan was to be prepared for each

patient. All episodes of loose stools and actions taken were to be documented on a stool or fluid balance chart and in the medical or nursing records. A notice was to be put on the door of the patient’s isolation room. Information on loose stools and the prevention of cross-infection was to be provided to the patient and also to the next of kin.¹⁰⁸ The policy also contained a specific instruction to consider the possibility of CDI, especially if the patient was over 65. Importantly, the policy warned that if the precautions set out were not taken then an outbreak could easily occur.

C. difficile Policy

The *C. difficile* Policy¹⁰⁹ provided detailed information on the nature of the infection and the precautions to be taken with patients suffering from the infection. It highlighted the fact that the hands of healthcare workers and patients were the most common means of spread of infection. There could also be indirect spread of environmental contamination through equipment and instruments, such as commodes and bedpans.¹¹⁰ The people identified as most at risk from the infection were patients who were currently on antibiotics or who had had antibiotic therapy within the last eight weeks.¹¹¹ Wards where antibiotic use was high were identified as being a high risk environment.

The policy also provided that a care plan was to be put in place and that healthcare workers had to avoid exposure by wearing personal protective equipment. The importance of hand hygiene was emphasised, and in particular the fact that soap and water had to be used in conjunction with alcohol hand rub. Hands were to be decontaminated before and after each direct patient contact regardless of whether protective equipment was worn. The movement of patients between wards without prior consultation with the Infection Control Team was not advisable, except in cases of clinical emergencies. As was the case with the Loose Stools Policy, the *C. difficile* Policy warned

100 [TRA01250050-51](#); [GOV00380001](#)

101 [GGC00780001](#)

102 [TRA01050118](#)

103 [TRA00290113](#)

104 [WTS006800006](#); [TRA00810088](#); [TRA00800053-54](#)

105 [TRA01050120-121](#)

106 [GGC00780258](#); [GGC27590001](#)

107 [GGC00780259](#)

108 [GGC00780260](#)

109 [GGC00780252](#)

110 [GGC00780253](#)

111 [GGC00780253](#)

that an outbreak was likely if the infection control precautions stipulated in the policy were not followed.¹¹²

The guidance given on treatment was that if possible all current antibiotics should be discontinued and in the first instance metronidazole should be given. The policy also stipulated that loperamide (Imodium), an opiate anti-diarrhoeal agent, was not to be given to control diarrhoea.¹¹³

Outbreak Policies

Some of the provisions of the Outbreak Policies in place have already been discussed in Chapter 12. Of particular note are the definition of an outbreak as two or more linked cases of the same illness associated in person, place or time¹¹⁴ and the steps to be followed if an outbreak was suspected or confirmed, which included communication by the Infection Control Team with Management.¹¹⁵

Medical training and implementation of policies

None of the ward-based doctors who gave evidence had received any training in infection prevention and control prior to June 2008 other than as part of their undergraduate training,¹¹⁶ although some may have attended a presentation in January 2007 by Mrs Murray and Dr Barbara Weinhardt, Consultant Microbiologist, on CDI outbreaks at Stoke Mandeville Hospital and in Quebec.¹¹⁷ All ward-based doctors received training after June 2008.

Only one doctor had some understanding of what would constitute an outbreak.¹¹⁸ Some were aware of the existence of the Infection Control Manual,¹¹⁹ but with one exception¹²⁰ those doctors had not seen the Loose Stools Policy, the *C. difficile* Policy or the Outbreak

Policy.¹²¹ One doctor thought he might have been aware of the Infection Control Manual prior to June 2008, but on reflection his final position seemed to be that it was probably after June 2008.¹²² Two doctors appeared to be unaware of the existence of the Infection Control Manual.¹²³

Nursing staff training and implementation of policies

Nurses who had undertaken the CCP would have gained some insight into aspects of infection prevention and control. This is discussed in Chapter 12. Sister Lesley Fox, SCN on ward 6, had training in infection prevention and control elsewhere before she moved to work at the VOLH in 1997. This was part of her training in tissue viability because of the connection between continence and tissue damage.¹²⁴ Mrs Murray and Dr Weinhardt repeated the presentation on the Stoke Mandeville and Quebec hospitals for the benefit of the nursing staff in May 2007.¹²⁵ Of the 15 staff members who attended, nine were student nurses, three were staff nurses and one was a nursing assistant.¹²⁶ Those two presentations to doctors and nursing staff were the only education sessions on CDI provided by Mrs Murray in the period from January 2007 to June 2008.¹²⁷

The thrust of the evidence from nurses was that prior to June 2008 the nursing staff had received no formal training in CDI.¹²⁸ One nurse thought CDI was included in the CCP.¹²⁹ One nurse suggested in her witness statement that she had CDI training as part of her initial training¹³⁰ but clarified this in evidence as training more generally in infection prevention and control.¹³¹ A number of nurses pointed to the “bug of the month”

112 [GGC00780255](#)
113 [GGC00780256](#)
114 [GGC00780148](#)
115 [GGC27390008](#); [GGC00780153](#)
116 [TRA00730100-101](#); [TRA00710054-56](#); [TRA00830035](#); [TRA00820021](#); [TRA00770049-50](#); [TRA00760027-28](#); [WTS00840008-09](#)
117 [TRA01010042-43](#)
118 [WTS01910009](#)
119 [TRA00730097-98](#); [TRA00830032](#); [TRA00820020](#)
120 [TRA00830032-33](#)

121 [TRA00730098](#); [TRA00820020-21](#); [TRA00770045-47](#); [TRA00760034-36](#); [TRA00790108-109](#); [TRA00800054-56](#)
122 [TRA00710050-54](#)
123 [TRA00760034](#); [TRA00770044](#)
124 [TRA00300041-43](#)
125 [INQ03010001](#); [GGC17790002](#); [TRA01010041-44](#)
126 [GGC17790002](#)
127 [TRA01010043-44](#)
128 [TRA00370005](#); [TRA00390019](#); [TRA00450085-86](#)
129 [TRA00410027](#)
130 [WTS00680006](#)
131 [TRA00370117-118](#)

circular¹³² issued by the Infection Control Team as a source of information on infection control and on CDI in particular.¹³³ There was evidence that a “bug of the month” circular providing information specifically on CDI was issued to the nursing staff for the second time in April 2007.¹³⁴ Mandatory training in CDI was introduced in the VOLH after June 2008 for all staff.¹³⁵

The senior ward nurses who gave evidence said that they were aware of the existence of the Infection Control Manual and policies such as the Loose Stools Policy, the *C. difficile* Policy and the Outbreak Policy.¹³⁶ Most of those nurses knew what would constitute a CDI outbreak, although the Outbreak Policy

was never activated for *C. difficile* infection prior to May 2008.¹³⁷ The use of stool charts and care plans is discussed in Chapter 12.

Isolation

Despite the terms of the Loose Stools Policy, the general practice adopted at the VOLH across different wards (with some exceptions) was **not** to isolate patients with loose stools until the diagnosis of CDI was confirmed, either directly from the Laboratory or by the ICN. There was a general shortage of single rooms, and that was certainly the case in ward 3 where only one single room was available. Table 15.1 sets out the number of single rooms available in each ward.

Table 15.1 Number of beds and number of single rooms in each ward

Ward	Number of beds in each ward	Number of single rooms in each ward
3	20	1
5	20	1
6	21/22	3
F	16/17	3
14	24	4
15	24	4
Fruin	24	2
MAU	0	0

It does appear that in most cases patients were placed in a single room once a positive result was known. What is clear, however, is that symptomatic patients who could have been isolated were not isolated timeously in accordance with the terms of the Loose Stools Policy. Furthermore, in a significant number of cases the risk of cross infection caused by the practice of not isolating until a positive result was available was compounded by delays in isolation even after the results were

known. Delays in treatment after results were known are discussed in Chapter 14.

Delays in isolation after the result was known

Four patients had a further one day delay before being isolated after the *C. difficile* positive toxin result was known. There were six patients with three or more days' delay in isolating after CDI was confirmed. Table 15.2 provides information on these patients.

132 [GGC17790003](#)

133 [TRA00460084-85](#); [TRA00370116-117](#); [TRA00370005](#)

134 [TRA00950130-131](#); [GGC17790003](#)

135 [TRA00910132](#)

136 [TRA00290113](#); [TRA00300110-112](#); [TRA00360050](#); [TRA00380108-109](#); [TRA00410011-12](#); [TRA00410097-98](#); [TRA00450056-57](#)

137 [TRA01010082](#); [TRA01010089](#); [TRA01010092](#); [TRA01010102](#)

Table 15.2 Isolation delays after positive result known

Patient name	Ward	Confirmed CDI	Date moved into isolation	No. of days delay
Alister Brand	F	12 February 2008	22 February 2008 (isolated after a further CDI result)	More than 5
Isobel Cameron	14	4 January 2008	8 January 2008	4
Margaret Dalton	6	17 December 2007	18 December 2007	1
Janet Fitzsimmons	14	24 April 2008	25 April 2008	1
Matthew Macfarlane	3	12 February 2008	15 February 2008	3
William McKenzie	5	14 January 2008 (CDI on admission)	15 January 2008	1
Jacqueline Patrick	5	7 May 2008	8 May 2008	1
Patient C	F	24 December 2007	27 December 2007	3
Elizabeth Rainey	15	4 January 2008	7 January 2008	3
Margaret Thompson	6	18 January 2008	21 January 2008	3
David Somerville	6, 14	11 February 2008	21 February 2008	10
David Somerville	15	7 May 2008	12 May 2008	5

In the case of Margaret Thompson there is a note on the Infection Control Card that the patient was to be moved into isolation when a side room became available.¹³⁸

Matthew Macfarlane was symptomatic in the company of other patients for a period of three days while in ward 3. The Infection Control Card does note “unable to isolate”.¹³⁹ On 14 February 2008 he was moved to the Medical Bed Day Unit before being returned to ward 3 later the same day, which posed a further risk of cross infection to other patients.¹⁴⁰

A significant example of poor isolation practice was the case of Alister Brand. CDI was formally confirmed by the Laboratory on 12 February 2008 after a five day delay.¹⁴¹ There is no note in the patient records of

when the positive result was communicated to the ward, and in fact there is a nursing note dated 12 February 2008 that at that time he was *C. difficile* toxin negative,¹⁴² although that is likely to be an error, since the clinical note for the same day says “still symptomatic of C.diff”.¹⁴³ This was Mr Brand’s second episode of CDI, as he had tested positive and been isolated in January 2008.¹⁴⁴ He was tested again on 22 February 2008¹⁴⁵ and was moved into isolation when the positive result was communicated that day.¹⁴⁶ It is noted in the Infection Control card that at that time he was in a six-bedded room.¹⁴⁷ It is not clear to what extent he continued to suffer from loose stools over that period.

138 SPF00760001; GGC29010005

139 SPF00630001

140 INQ01710007

141 GGC21070096; GGC21070021

142 GGC21070132

143 GGC21070021

144 SPF01210001; [WTS01900010](#)

145 GGC21070024; GGC21070094

146 GGC21070128

147 SPF01210001

The other significant example of a risk of cross-contamination is the case of David Somerville. Not only did he test positive on ward 3 on 11 February 2008 after a four day delay from his sample being collected,¹⁴⁸ but he was then moved to ward 6 the following day while still symptomatic, rather than to isolation.¹⁴⁹ This was despite a note in the patient records that he should be isolated when a room became available.¹⁵⁰ He was then moved again on 19 February 2008 to ward 14¹⁵¹ while he remained symptomatic, but was still not moved into isolation. He remained symptomatic on ward 14 until 21 February 2008.¹⁵² Matters may have been confused by a negative *C. difficile* result which came in the same day as the positive result on 11 February,¹⁵³ but the patient records do record the positive result¹⁵⁴ and metronidazole was administered.¹⁵⁵ He remained symptomatic throughout.

On a later occasion David Somerville also experienced another inexplicable delay of five days throughout which he was symptomatic. He tested positive on 7 May 2008,¹⁵⁶ experienced a one day delay in commencing vancomycin¹⁵⁷ and then was not isolated until 12 May 2008.¹⁵⁸

Isobel Cameron experienced a delay of six days overall in being isolated. There was a delay at every stage of her treatment, for as well as the four day delay in isolating after CDI was confirmed¹⁵⁹ there had been an earlier two day delay in the Laboratory reporting.¹⁶⁰ Review of the patient records shows that there was a further one day delay in commencing treatment, which did not start until 9 January 2008.¹⁶¹

Cohorting

“Cohorting” of patients suffering from CDI “classically”¹⁶² means the separation of those patients and their nursing staff from other patients because isolation facilities are not available. It is a measure of last resort because it is inefficient in preventing cross-contamination.

The Inquiry has been able to identify at least two occasions in the period from December 2007 to June 2008, once in ward 6 and once in ward F, when a number of patients were placed under a form of cohorting.¹⁶³ Sister Fox thought that that might have happened in ward 6 on more than one occasion.¹⁶⁴ There was no evidence of that from the documentation provided to the Inquiry, but it may be the case that cohorting of CDI patients occurred in ward 6 on another occasion prior to December 2007. There are references on the infection prevention and control Access database to CDI patients being cared for in “shared”¹⁶⁵ accommodation and “multi bed all +ve” accommodation,¹⁶⁶ so that it is likely that some form of cohorting was taking place in the VOLH prior to December 2007.¹⁶⁷

Ward 6

In ward 6 two CDI patients shared room 13, a two-bedded bay, between 21 and 29 December 2007. One of the patients was in room 13 from 17 December 2007¹⁶⁸ after testing positive for CDI that day.¹⁶⁹ The stool sample had been collected from the patient early on 15 December 2007.¹⁷⁰ This patient was moved out of room 13 on 22 December 2007 at her own request for a period of approximately 32 hours and placed into a four-bedded area,¹⁷¹ and while there she continued to have loose stools.¹⁷² This kind

148 GGC00520034; GGC28050009; GGC00520294

149 GGC00520417

150 GGC00520035

151 GGC00520294

152 GGC00520295

153 GGC28050010

154 GGC00520034

155 GGC00520034; GGC00520379

156 GGC00520318

157 GGC00520318

158 [GGC23180007](#)

159 SPF00450001

160 GGC00070191

161 GGC00070233

162 [TRA00690150-151](#)

163 [TRA00300067](#); [TRA00420041](#); [TRA00410123](#)

164 [TRA00310034](#); [TRA00310100](#)

165 INQ02970123

166 INQ02970124

167 [TRA01010088](#)

168 SPF01430001

169 GGC26380045

170 GGC26380058

171 GGC26380053-54

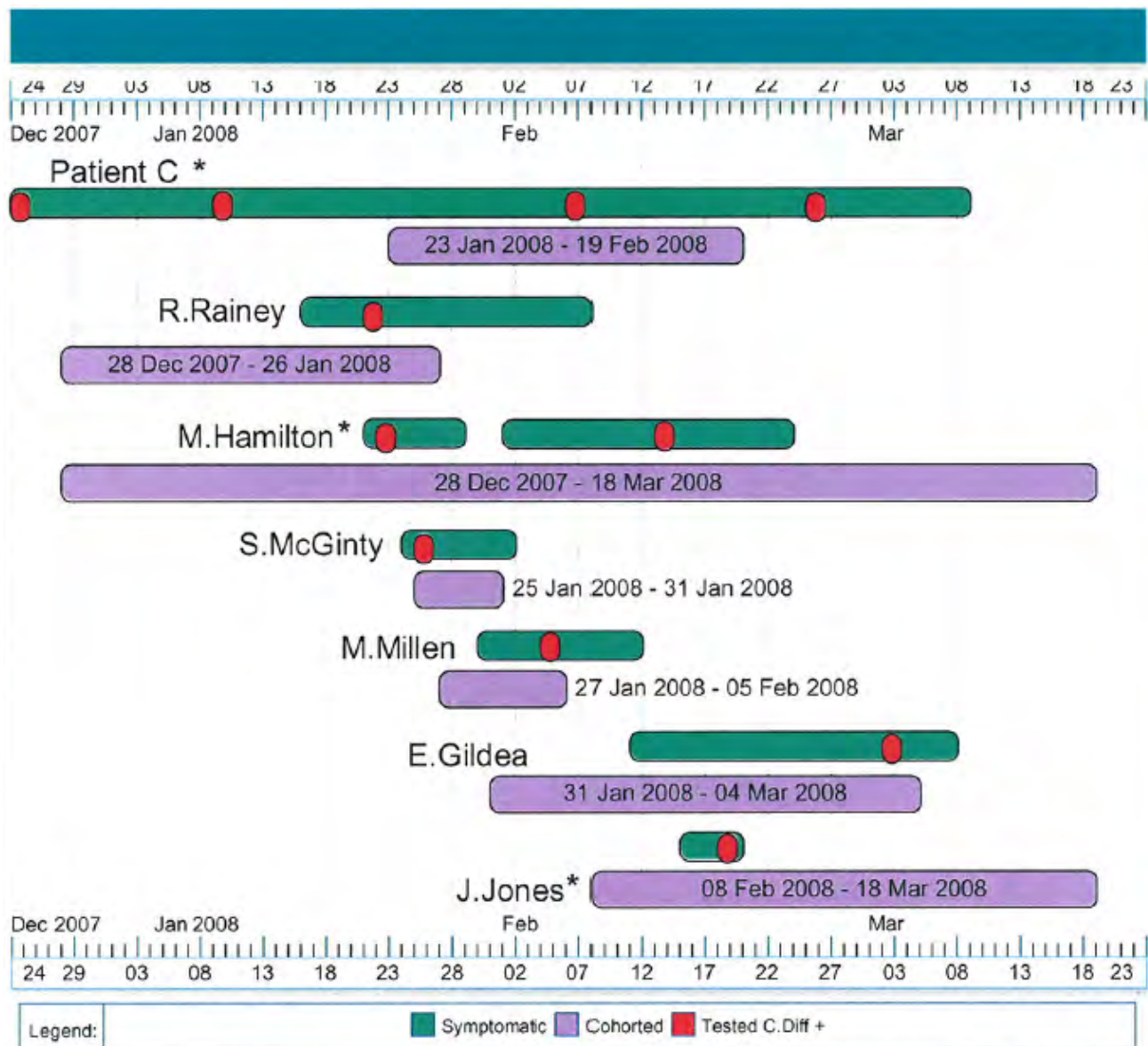
172 GGC26380054

of patient movement simply should not have happened, and served to increase the risk of spread of infection. It is not clear when the other patient was admitted to room 13, but it does appear from the Infection Control Card that she was there at least from 24 December 2007.¹⁷³

Ward F

The other clear instance of a form of cohorting occurred in January and February 2008 in ward F. Figure 15.2 displays the connections between patients in room 16 during January to March 2008 at times when patients were symptomatic or asymptomatic.

Figure 15.2 Patients cohorted in room 16 on ward F



*cohorted dates are best estimates derived from the patient records.

There are two coloured entries for each named patient on the chart.

The top entry shows when the patient was symptomatic for *C. difficile* (green) and the date the ward was aware of the CDI result (red).

The second line (purple) shows the period the patient was in room 16.

Over a period beginning on 21 January 2008¹⁷⁴ a total of seven patients were nursed together at different times in room 16. This was normally a three-bedded bay, but a contingency bed could be added to convert the room into a four-bedded bay. Four patients suffering from CDI were located there between 21 January and 25 January 2008.¹⁷⁵

Patient C first tested positive for CDI on 24 December 2007.¹⁷⁶ It is likely that she was in room 16 at that time. Although isolated elsewhere in ward F for a period, by 23 January 2008 she was certainly back in room 16.¹⁷⁷ She tested positive again for CDI on 9 January 2008¹⁷⁸ and again on 6 and 25 February.¹⁷⁹ She was the first patient to test positive for CDI in ward F in 2008, and because of a tendency to wander she was a difficult patient to place in isolation.¹⁸⁰ Patient C suffered from CDI for the whole period she was in room 16.

Another patient, Mary Millen, was admitted to ward F on 3 January 2008.¹⁸¹ She was asymptomatic with loose stools at the time. The patient records do not clearly specify her location, but it is likely she was moved into room 16 some time between 27 and 30 January as all four beds in the bay were occupied up until then. She was suffering from loose stools by 30 January 2008, when a sample was taken for *C. difficile* toxin analysis. Despite the suspicion of CDI and the fact that the test result was still awaited, on 31 January Mrs Millen was removed to the day space for a period of time because of her anxiety over another patient's behaviour.¹⁸² The Laboratory reported her sample as positive for CDI on 4 February 2008.¹⁸³ The Infection Control Card records that prior to isolation she had been in a shared bay with "previously positive patients".¹⁸⁴

By 31 January 2008 two other patients in room 16 had been moved into single rooms.¹⁸⁵ Quite inexplicably, Ellen Gildea, who was admitted to the VOLH on 29 January 2008 and who was not suffering from CDI, was moved into room 16 on 31 January 2008, at which point, as Figure 15.2 discloses, there were at least two patients in the room suffering from CDI.¹⁸⁶ Another patient in room 16 at that time, Mary Hamilton, had become asymptomatic by 29 January 2008,¹⁸⁷ but she became symptomatic again with loose stools, probably on 1 February 2008.¹⁸⁸

The placement of an asymptomatic patient in a bay where patients were suffering from CDI was extremely poor care for which the ICNs must bear responsibility. As the nurse in charge of ward F, Sister Laura Gargaro must also bear responsibility for this poor level of care. She was incorrect in her evidence in suggesting that the patients in room 16 were asymptomatic.¹⁸⁹ Furthermore, as Figure 15.2 discloses, Mrs Gildea was in room 16 for approximately four weeks along with symptomatic patients before she tested positive for CDI.¹⁹⁰ Having been moved to room 16 on 31 January, Mrs Gildea went on to develop loose stools on 11 February 2008. After stool samples collected on 12 February, 22 February and 25 February had tested negative for CDI, a positive sample was collected on 2 March 2008.¹⁹¹ She died on 7 March 2008,¹⁹² and CDI contributed to her death.¹⁹³

The admission of Mrs Jones

Mrs Jessie Jones was admitted to room 16 on ward F on 8 February 2008¹⁹⁴ when at least two patients were symptomatic with CDI. Mrs Murray was the ICN involved in that admission, since Mrs O'Neill was on leave.¹⁹⁵

174 SPF00710001; GGC00490013; GGC00490230
175 SPF00710001; GGC00490013-16; GGC00490231; GGC28650006; SPF00660001; SPF01390002
176 GGC26340172
177 GGC26340178; SPF01390001-02
178 GGC26340175
179 GGC26340185; SPF01390002
180 SPF01390001-02
181 GGC20980132-133; GGC20980109
182 GGC20980142
183 GGC20980143
184 SPF01260001

185 GGC00490229; [TRA00020072](#); [TRA00430001-02](#)
186 [TRA00020072](#); [TRA00430161-162](#)
187 SPF00560001
188 SPF00560001
189 [TRA00420164-165](#)
190 GGC00230060
191 INQ01750008
192 SPF00160001
193 SPF00160001; EXP02500006
194 GGC21010117
195 [TRA00950152](#)

Mrs Murray said she had no recollection of the admission itself, but subsequently, when the circumstances of the admission were raised by Mrs Jones' family, Mrs Murray told Mrs Jones' daughter that she had been under pressure to admit her and "had nowhere else to put her".¹⁹⁶

In her evidence Mrs Murray accepted that Mrs Jones should not have been admitted to a bay where there were symptomatic patients.¹⁹⁷ Mrs Murray's sanctioning of the admission of Mrs Jones to a bay where there were symptomatic patients was a serious failure. Mrs Jones' daughter was correct in describing that decision as exposing her mother to a "life threatening situation."¹⁹⁸ Mrs Jones did in fact contract CDI,¹⁹⁹ but fortunately survived. This has been explored further in Chapter 12, where Sister Gargaro's role in this admission is more fully considered. Once again the admission of an asymptomatic patient to a bay where it was evident that CDI was present is indicative of poor care and a lack of real understanding of the seriousness of CDI.

Infection control – everyone's business

As discussed in Chapters 6 and 7, and with the establishment of the HAI Taskforce in 2003, there were numerous items of guidance produced by the Scottish Executive and later the Scottish Government on HAIs. For example, the NHS Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection²⁰⁰ was circulated to a number of groups including Chief Executives of Health Boards by letter dated 12 May 2004.²⁰¹ The key message to be promoted was that infection control was not the sole domain of infection control experts because "infection control is everyone's business".²⁰² This was a message that was repeated, and Mr Divers, the Chief Executive of NHS GGC in 2007 and 2008, said that it was directed at

"everyone"²⁰³ including nurses, doctors, domestic staff working on the wards and catering staff interacting with patients.²⁰⁴

It is apparent that this message had not reached the medical staff at the VOLH who gave evidence. In the main they were not aware of policies such as the Loose Stools Policy, the *C. difficile* Policy and the Outbreak Policy, although the senior ward nurses who gave evidence were aware of those policies. Some nurses had had some training in infection prevention and control, but nevertheless the Loose Stools Policy was generally not followed in a number of respects such as isolation, stool charts and care planning. Similarly, the *C. difficile* Policy was not followed on important matters such as care planning.

The cohorting that did take place, particularly in ward F, was a poor attempt at managing the number of patients who contracted CDI. The placing of a non-infected patient on at least two, and more likely three, known occasions into a bay where there was already at least one patient with CDI was unacceptable practice.

The response of the ICNs to the presence of a number of patients suffering from CDI in ward F who were closely associated in time and place is considered in Section 15.11 of this Chapter. The inability to realise that the patients who only developed CDI after being placed into room 16 were likely to have contracted CDI by cross-infection is difficult to comprehend.

As discussed later, senior nursing staff did raise the number of CDI patients in their individual wards with the Infection Control Nurses, but they were prepared to accept at face value the ICNs' explanation that all the cases could be explained by the antibiotic treatment being administered to patients.

196 [TRA00070060](#); [TRA00070082](#); [GGC14490001](#)

197 [TRA01010142](#)

198 [TRA00070060](#)

199 [GGC21010087](#)

200 [GOV00090001](#)

201 [GOV00980001](#)

202 [GOV00380005](#)

203 [TRA01250055](#)

204 [TRA01250055-56](#)

15.5 The Infection Control Manager

The appointment of Mr Walsh

Mr Thomas Walsh was the Infection Control Manager for NHSGGC from 25 June 2007.²⁰⁵ His predecessor, Dr Bill Anderson, left on 26 March 2007.²⁰⁶ Mr Walsh was told on 28 March 2007 that he had been appointed to the position but because he was required to provide 12 weeks' notice there was a delay of some three months before he could take up his new role.²⁰⁷

Mr Walsh's post immediately prior to becoming the Infection Control Manager was that of Planning Manager with Regional Services of NHSGGC, but from December 2002 to April 2006 he had held the post of Assistant Director of Nursing in NHS Argyll and Clyde, in which he had some responsibility for infection prevention and control.²⁰⁸ In that post his responsibilities also covered the VOLH.²⁰⁹ Mr Walsh was not qualified in infection control²¹⁰ but Professor Duerden considered his background "entirely appropriate" for the position of Infection Control Manager.²¹¹

The role of the Infection Control Manager

Guidance on the role of the Infection Control Manager was first provided by the then Scottish Executive Health Department (SEHD) in a letter dated 9 February 2001 to Boards and Trusts,²¹² which provided that Chief Executives of NHS Trusts had to ensure that:

"A senior manager (i.e. either a member of the Trust/Board or directly accountable to a member of the Trust/Board) is designated as having overall responsibility for risk assessment and management processes relating to ... infection control ..."

Subsequently, by letter dated 18 March 2005 from the SEHD to Chief Executives of NHS Boards, additional information was given on

the role of the Infection Control Manager.²¹³ It was expected that the Infection Control Manager would report directly to the Chief Executive and the Board,²¹⁴ and his or her responsibilities were to include the following:

- The co-ordination of prevention and control of infection.
- Delivery of the Board's Infection Control Programme²¹⁵ in conjunction with the Infection Control Committee and Infection Control Team.
- Provision of clear mechanisms for access to specialist infection control advice and support.
- Assessing the impact of all existing and new policies and plans on healthcare acquired infection, and making recommendations for change.
- Challenging non-compliance with local and national protocols and guidance relating to prevention and control of infection.
- The production of an annual report on the state of healthcare acquired infection.

Job description

Mr Walsh's job description repeated the description of the role set out in the SEHD letters of 9 February 2001 and 18 March 2005. It was his function to ensure that there were:

"clear and effective structures and processes designed for co-ordinated decisions that achieve system wide infection control decontamination, surveillance and cleaning services standards".²¹⁶

Part of his role was to ensure the:

"development of robust systems, policies, procedures...in line with current evidence base and national policy".²¹⁷

In the job description the post was described as "a management post with an emphasis on leadership and management".²¹⁸ It specified

205 [TRA01200003](#)
 206 [TRA01200082](#)
 207 [TRA01200082](#)
 208 [INQ04130001](#); [TRA01200002](#)
 209 [TRA01200002-03](#)
 210 [TRA01200085](#)
 211 [TRA01050092](#)
 212 [GOV00440006](#)

213 [GOV00440003](#)
 214 [GOV00440004](#)
 215 [GOV00440004](#)
 216 [GGC01860001](#)
 217 [GGC01860001](#)
 218 [GGC01860001](#)

that the Infection Control Manager was to report directly to the Chief Executive and Medical Director of the Board. Mr Walsh himself said that he reported through the Medical Director, Dr Brian Cowan, who was his line manager, but that he would also report issues directly to Mr Divers, the Chief Executive.²¹⁹

The nature of the role

Terms such as “manager”, “leadership”, “management” and descriptions such as “overall responsibility for management processes” and “co-ordination of prevention and control of infection throughout the Board area” tend to suggest that the Infection Control Manager was to play a key operational and management role in the area of infection prevention and control. In reality, however, that was not the case, for Mr Walsh did not have any operational or line management responsibilities for infection prevention and control, and indeed that was the established practice when he took up the post in June 2007.²²⁰ Mr Walsh explained that the management reference in the job description related to “management of the processes rather than management of the human resources involved in this”.²²¹

In explaining the terms of the SEHD letter of 18 March 2005 that set out the role of the Infection Control Manager, Dr Kevin Woods, then Director General for Health for the Scottish Executive, accepted that the letter could be read in a way that suggested that the Infection Control Manager was not to have operational management responsibility.²²² Dr Syed Ahmed, Consultant in Public Health Medicine and Clinical Consultant in NHS GGC’s Public Health Protection Unit, explained that in Scotland there is a significant difference in size between Health Boards, with NHS GGC serving a population of about 1.2 million and managing around 20 hospitals.²²³ Because of this variation the SEHD did not prescribe a particular model job description for the Infection Control Manager. This explanation

did fit with Dr Woods’ evidence that the guidance for the role of Infection Control Manager reflected the diverse nature of Boards in Scotland and that the arrangements may have to be implemented in different ways.²²⁴ For an organisation the size of NHS GGC some latitude had to be given as to how the role of Infection Control Manager would work in practice.²²⁵

Dr Woods explained that what was

“non negotiable was that it needed to be somebody of standing, somebody with authority, somebody with access to highest level of the Board, and that there was clarity about how it was going to function in practice”.²²⁶

He went on to say that the Infection Control Manager had to have an overview across the whole of the Health Board and be able to “intervene at the highest levels”²²⁷ to ensure that appropriate action could be taken. Professor Paul Martin, former Chief Nursing Officer, drew an analogy in his evidence between the role of the Infection Control Manager as envisaged by the SEHD and the role that a quality assurance manager might play. The Infection Control Manager was someone who would be able to check that the systems and processes were working, but did not manage the system.²²⁸ This meant that the role would involve ensuring that there were clear infection control structures in place, and advising on those structures and on whether they were working appropriately and delivering what they were designed to deliver,²²⁹ but it was for line management to put the structures in place.

Mr Walsh’s position

In his evidence Mr Walsh agreed that he, together with the Nurse Consultant, could be thought of as a form of infection control policy unit.²³⁰ Nonetheless it was clear from other aspects of Mr Walsh’s own evidence that his responsibilities went beyond policy

219 [TRA01200079-80](#)
 220 [TRA01200007](#)
 221 [TRA01200007](#)
 222 [TRA00970045-46](#)
 223 [TRA01130145](#)

224 [TRA00970046](#)
 225 [TRA00970047](#)
 226 [TRA00970047](#)
 227 [TRA00970048](#)
 228 [TRA01080071-72](#)
 229 [TRA01080073](#)
 230 [TRA01200130](#)

and included strategic development of the annual infection control programme and education strategy.²³¹ The description of his role as a policy unit is more limited than that envisaged by Professor Martin, and Mr Divers was also of the view that the term “policy unit” was too narrow to describe the role of the Infection Control Manager.²³²

Mr Divers' and Dr Cowan's understanding of the role

According to Mr Divers, part of the Infection Control Manager's responsibility was to ensure that guidance was implemented within the organisation.²³³ So far as Mr Divers was concerned the Infection Control Manager did have a management role, in the sense that he had to ensure the:

“introduction of the appropriate procedures and that those were acted on and were followed through, as opposed to a more hands-off role”.²³⁴

Dr Cowan also described the Infection Control Manager's role to be a “very much policy”²³⁵ role, but he did elaborate on that to say that the Infection Control Manager had overall responsibility for the management processes, namely the committee structure, which could inform the Board as to what was happening with Infection Control. The Infection Control Manager had responsibility for overseeing those processes so that he could assure himself, and indeed Dr Cowan as his line manager, that those processes were working. The Infection Control Manager had to satisfy himself that the structure was intact and operating.²³⁶ That description was consistent with the one provided by Professor Martin.

An active role

After the CDI problem emerged in May 2008 Mr Walsh did appear to take an active role, chairing meetings at the RAH about cases of CDI on 21 and 28 May 2008²³⁷ and either

chairing the Outbreak Control Team meetings or attending as a member.²³⁸

Operational responsibility

What was clear from the evidence was that Mr Walsh did not have line management responsibility for infection prevention and control prior to June 2008.²³⁹ It is also the case that the manner in which the post of Infection Control Manager was structured in NHSGCC was based upon the SEHD letters of 9 February 2001 and 18 March 2005.²⁴⁰ After June 2008, and following upon the events at the VOLH, the role of the Infection Control Manager was changed in January 2009 to incorporate operational and line management responsibilities, and the job description now provides that the Infection Control Manager shall “Directly manage NHSGCC Infection Control Medical and Nursing Services”.²⁴¹ Mr Walsh described that as a significant change to the role.²⁴² He also said that, having had an opportunity of looking at the post of Infection Control Manager from both perspectives, there was a clearer line of accountability “up and down from board to ward”.²⁴³

The Inquiry experts' approach

Both the infection control experts commissioned by the Inquiry, Mrs Christine Perry and Professor Duerden, were critical of the fact that the Infection Control Manager did not perform an operational role within the infection prevention and control structure prior to January 2009.

Mrs Perry saw the lack of operational responsibility as a gap. Her view was that if the Infection Control Manager was ultimately to be accountable to the Board for having the correct structures in place for the infection prevention and control service, then he had to have operational responsibility for the service.²⁴⁴ At the time of giving evidence Mrs Perry was the Director of Infection Prevention and Control at the NHS Trust by which she was employed, a position

231 [TRA01200005-06](#)

232 [TRA01250071](#)

233 [TRA01250074-75](#)

234 [TRA01250074](#)

235 [TRA01220084](#)

236 [TRA01220085-86](#)

237 [GOV00650009](#); [GOV00650012](#)

238 [GOV00650077](#); [GOV00650072](#)

239 [TRA01200007](#)

240 [GOV00440006](#); [GOV00380001](#)

241 [INQ04220001](#)

242 [TRA01200112](#)

243 [TRA01200105](#)

244 [TRA01040091-92](#)

broadly equivalent to that of an Infection Control Manager in Scotland. The guidance issued to NHS Trusts in England in May 2004 included among the responsibilities of Directors of Infection Prevention and Control that they would “be responsible for the Infection Control Team within the healthcare organisation”,²⁴⁵ and it was the absence of that degree of responsibility that Mrs Perry saw as a gap in the Infection Control Manager’s role. She saw the change introduced in January 2009 as producing a strong structure that could enable the delivery of good infection prevention and control across the Board area.²⁴⁶ Mrs Perry noted that the Infection Control Manager’s job description included among his responsibilities:

“ensuring there (were) clear and effective structures and processes designed for co-ordinated decisions that achieve system wide infection control ...”.²⁴⁷

Her view was that if the Infection Control Manager had been operationally responsible for the service, he would have been better placed to address the structural failures that did occur, namely the failure of committees to meet.²⁴⁸

The essence of Professor Duerden’s position was that he could not see how the Infection Control Manager could be non-operational and yet be responsible for the co-ordination of prevention and control of infection in a healthcare setting, as envisaged in the job description.²⁴⁹ Professor Duerden made particular reference to the NHS Scotland Code of Practice²⁵⁰ and the emphasis there on the Infection Control Manager having “overall responsibility for risk assessment and management processes”.²⁵¹ This is a description repeated in the letters of 9 February 2001 and 18 March 2005. Professor Duerden’s opinion was that the Infection Control Manager could not properly carry out his function as envisaged

by the Code of Practice if he did not have operational responsibility for the Infection Control Service.²⁵²

So far as Professor Duerden was concerned, if the Infection Control Manager did not have operational responsibility for the Infection Control Service, then that would be a

“serious gap in the system, and it would mean that there was not a coherent system ... from Board to ward or ward to Board, which should be a continuous line”.²⁵³

The Code of Practice and the guidance contained in the letter of 18 March 2005 envisaged that the Infection Control Manager would be a senior manager who would report directly to the Chief Executive and the Board,²⁵⁴ and as Professor Duerden explained, such reports should include matters such as the scale, numbers and rates of HAIs, trends, audits and the distribution and implementation of the Board’s policies.²⁵⁵ To carry out that level of reporting the Infection Control Manager would have to have operational responsibility for the service.

Mr Divers’ disagreement

Mr Divers disagreed with Professor Duerden’s view that there was a lack of coherence in the system with the Infection Control Manager having no operational responsibility. He explained his view that the necessary connection from Board to ward and ward to Board could be made in the following way:

“There is no reason why those connections could not be made, and I believe they were being made in Greater Glasgow as we moved through the arrangements with the merger with Clyde, that in having ... Bill Anderson/Sandra McNamee ... working very closely with the Infection Control Teams and the sector lead ICDs, we had a coherent system”.²⁵⁶

245 [INQ03630002](#)

246 [TRA01040093](#)

247 [GGC16000007](#)

248 [TRA01050171](#)

249 [TRA01050082](#)

250 [GOV00090001](#)

251 [GOV00090007](#)

252 [TRA01050084](#)

253 [TRA01050085](#)

254 [GOV00440004](#)

255 [TRA01050086](#)

256 [TRA01250077](#)

The reference to Bill Anderson is a reference to Mr Walsh's predecessor, and Mr Divers' point was that the Infection Control Manager and the Nurse Consultant would be working very closely with Infection Control Teams, including the ICDs. Mr Walsh, when asked about the working relationship with the Infection Control Team in the Clyde Sector, described it as a "reasonable working relationship"²⁵⁷ that was "delivered through the committee structures".²⁵⁸

The flaw in Mr Divers' argument is this. Mr Walsh and the Nurse Consultant, Ms Sandra McNamee, were members of the Acute Control of Infection Committee (ACIC) and the Board Infection Control Committee (BICC). So too was Dr Biggs, but as discussed later in this Chapter Dr Biggs did not attend the meetings of either of those committees in the period from January 2007 to June 2008. There was therefore no effective platform for the kind of working relationship envisaged by Mr Walsh. The Nurse Consultant did attend a meeting of the Clyde Acute Infection Control Support Group (the Support Group) on 13 February 2007. That may have been the first time she met Dr Biggs,²⁵⁹ and it would appear that the only other contact the Nurse Consultant had with Dr Biggs was when they both attended two Outbreak Control Team meetings, one at the RAH and the other at the IRH.²⁶⁰ Contrary to Mr Divers' belief, there was no effective close working relationship between the Infection Control Manager, the Nurse Consultant and the leader of the VOLH Infection Control Team to promote the coherent system he assumed was in place.

Lack of effective leadership

The Inquiry is satisfied that the role created by the Board for the Infection Control Manager, as understood by Mr Walsh, did not provide effective leadership of infection prevention and control. Despite the reference in the job description to the Infection Control Manager's post being a "management post with emphasis on leadership and management", there was no leadership role in the way the job was in fact carried out. The

Chief Executive was ultimately responsible for the system, but the Infection Control Manager, as the Chief Executive's most direct link to the system, should have had a clear leadership role in keeping an oversight over what was happening. That role should have included the Infection Control Manager reviewing data, including rates of infection.

None of that happened. Mr Walsh was not aware of the failure of the committee structure, nor was he aware of Dr Biggs' failure to carry out her responsibilities as ICD, issues that are discussed later in this Chapter. Had his role been a more proactive one it is likely that he would have become aware of those failures in the infection prevention and control system. The Inquiry therefore welcomes the Board's change of approach to the role of the Infection Control Manager in January 2009. It is a change that, as Mr Walsh recognised, provided for clearer accountability from Board to ward.²⁶¹

15.6 The Nurse Consultant

The appointment of Ms McNamee

Sandra McNamee was the Nurse Consultant for Infection Control for NHS GGC in the period from 1 January 2007 to June 2008, having taken up this post in November 2006.²⁶² Her qualifications include a diploma in Infection Control Nursing from Glasgow University,²⁶³ and since she first took up a post in infection prevention and control in 1994 she had gained a significant amount of experience in the field. General guidance had been issued on the role of Nurse Consultant by the SEHD in 2001, and although it did not have a particular focus on HAI²⁶⁴ it did envisage direct involvement with patients "for a significant proportion of the time".²⁶⁵

Job description

The job description for the post required the Nurse Consultant to provide "strong, strategic and clinical leadership across NHS GGC".²⁶⁶ It

257 [TRA01200050](#)
 258 [TRA01200050](#)
 259 [TRA01210030-31](#)
 260 [TRA01210065-66](#)

261 [TRA01200105](#)
 262 [TRA01210003](#)
 263 [TRA01210002](#)
 264 [GOV01250001](#); [TRA01090053](#)
 265 [GOV01260002](#)
 266 [GGC30330004](#)

went on to specify that the Nurse Consultant will ensure the development of:

“robust systems, policies, procedures, professional guidance, consistent standards and training strategies in line with current national policy”.²⁶⁷

So far as that aspect of her remit was concerned, Ms McNamee explained that one of her priorities was to establish the use of Statistical Process Control Charts (SPC Charts) across the Board area.²⁶⁸ She did not know what surveillance systems were in place in the VOLH prior to June 2008, which is particularly surprising since her job description provided that her responsibilities included the review and development of “audit and surveillance programmes to reduce risks”.²⁶⁹ So far as she was concerned, since there were outbreaks declared in the RAH and norovirus outbreaks declared in the VOLH, there appeared to be evidence that the existing surveillance systems were working, and she therefore did not have any reason to evaluate the systems at that stage.²⁷⁰

Ms McNamee’s job description envisaged that she would continue to perform a clinical role as a practising ICN. This was an element that was not to exceed two days a week,²⁷¹ but was to allow her to use her:

“highly specialised knowledge” to provide expert nursing practice in relation to direct and indirect patient care through direct involvement with patient care activities”.²⁷²

Ms McNamee said this did not happen in practice because when she took up the post there were a number of key priority areas that required attention, such as the introduction of the Infection Control Manual to the Clyde Sector. Prior to Ms McNamee taking up her post in November 2006 there had not been a Nurse Consultant in post, and although a Lead Nurse had been responsible for the co-ordination of the Infection Control

Manual this person had left some six months before Ms McNamee’s appointment. The result was that “there were things that had slipped that were national priorities”²⁷³ and that had to be put in place as soon as possible.

Line management

Ms McNamee’s line manager was Mr Walsh. Like him, she did not have line management or operational responsibility for the Infection Control Teams, although her job description did provide that:

“crucial to the success of the post will be the provision of professional leadership for all the Infection Control Nurses in NHSGGC”.²⁷⁴

Ms McNamee said that she achieved that level of professional leadership by meeting with ICNs at two subgroups of the BICC. She chaired the Infection Control Policy Subgroup, which was composed of the ICNs and in which relevant literature was reviewed and policies were drafted. She also chaired the Infection Control Education Subgroup, which was then involved in reviewing relevant literature and providing appropriate educational materials.²⁷⁵

As with Mr Walsh, Ms McNamee took over managerial and operational responsibility for the ICNs of NHSGGC from 2009²⁷⁶ when she became Assistant Director of Nursing (Infection Control),²⁷⁷ a newly created post but one in which she retained her nurse consultant responsibilities.²⁷⁸

VOLH visits

Ms McNamee thought she had visited the VOLH on two occasions between 1 January and 1 April 2007²⁷⁹ when she was engaged in ensuring the Infection Control Manual had been “fully rolled-out to Clyde”.²⁸⁰ Her purpose was to go through the policies with the ICNs to make sure that they were fit for

267 [GGC30330004](#)
268 [TRA01210005](#)
269 [GGC30330006](#)
270 [TRA01210006-07](#)
271 [GGC30330005](#)
272 [GGC30330007](#)

273 [TRA01210062-64](#)
274 [GGC30330005](#)
275 [TRA01210014](#)
276 [TRA01210025](#)
277 [TRA01210001](#)
278 [TRA01210026](#)
279 [TRA01210020](#)
280 [TRA01210019](#)

purpose for the Clyde area.²⁸¹ Only senior nurses were involved in that process, which meant that Mrs O'Neill was not included.²⁸²

Lack of knowledge

Ms McNamee was a member of the ACIC and the BICC. She was not aware that Dr Biggs had stopped attending meetings of these committees. In fact, so far as Ms McNamee was concerned Dr Biggs was fulfilling her role as the ICD for the hospitals for which she was responsible.²⁸³ This view was reinforced by the fact that she had met Dr Biggs at the RAH for meetings into an investigation of an outbreak of MRSA in the intensive care unit.²⁸⁴

Had the Nurse Consultant been more operationally responsible for the infection prevention and control structures, she would have been in a better position to identify deficiencies in those structures. This includes, for example, the failure of the committee structures at the Clyde Sector level discussed

later in this Chapter. The Inquiry welcomes the change of remit for the Assistant Director of Nursing. As with the change in the responsibilities of the Infection Control Manager it is a change that can only serve to strengthen the infection prevention and control system.

15.7 The infection control committee structure

Overview of committee structure

The intention in this Section is to identify the infection control committee structure in place in the period from January 2007 to June 2008 and to comment on how the different committees within that structure functioned. Figure 15.3 sets out the committee structure then in place. The Clyde Sector groups are those below the dotted horizontal line, and the black arrows indicate where minutes were intended to be passed on in accordance with each group's or committee's terms of reference.

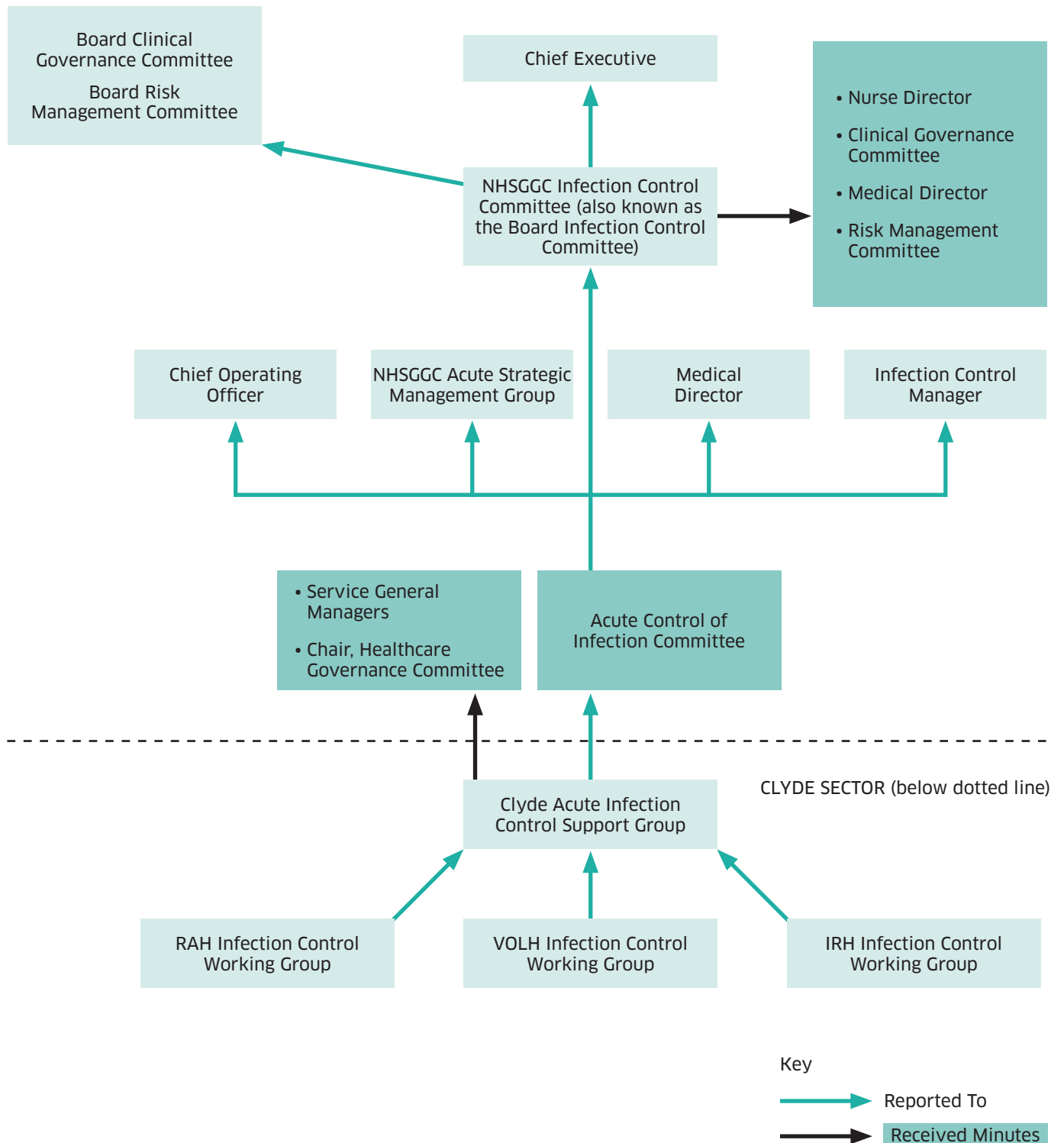
281 [TRA01210022](#)

282 [TRA01210021](#)

283 [TRA01210034-36](#)

284 [TRA01210037](#)

Figure 15.3 NHSGGC infection control reporting structures



Infection Control Link Nurses at the VOLH

The VOLH had an Infection Control Link Nurse system in place. The rationale underlying the system was well intentioned, and it represented an attempt to increase awareness of infection prevention and control issues at ward level in the VOLH, although the meetings of the Infection Control Link Nurses were not strictly within the infection control committee structure and there was no reporting line to a committee higher up the chain.

In the VOLH the intention was that the Infection Control Link Nurses would meet every two months.²⁸⁵ The meetings were chaired by Mrs O'Neill, and Link Nurses were supposed to attend as representatives of each ward. Mrs O'Neill would update those nurses on infection prevention and control issues, and they were then to report back to their respective wards.²⁸⁶ The group ceased to meet on 5 February 2008, and while Mrs O'Neill could not remember why²⁸⁷ she did recall that attendance was one of the problems.²⁸⁸

Overall, the attendance was extremely poor. An examination of the minutes of that group from 7 February 2007 to its final meeting on 5 February 2008²⁸⁹ discloses that there were at least two Link Nurses who never attended any of the meetings. Another two Link Nurses only attended on one occasion.

One Link Nurse gave oral evidence to the Inquiry. She qualified as a nurse in 2006, but could not recall receiving any training in infection prevention and control,²⁹⁰ and she only became the Link Nurse for her ward because the Link Nurse in place was leaving and she was asked to step into the position.²⁹¹ She only attended one meeting.

In the minute of the meeting of 4 April 2007 the following entry has been made:

285 [TRA00500115](#)
 286 [TRA00950120](#)
 287 [TRA00950121](#)
 288 [TRA00950121-123](#)
 289 [GGC17790010](#); [GGC17790004](#); [GGC17790007](#);
[GGC17790012](#); [GGC17790015](#); [GGC28080001](#)
 290 [TRA00500096](#)
 291 [TRA00500113](#)

“just to make staff aware of the increase in patients who are positive for C.diff. Could staff pay particular attention to:

- keeping stool charts so that staff are aware of when symptoms develop and cease”.²⁹²

It is clear from the evidence given to the Inquiry that this advice was often not followed. This is elaborated on in Chapter 12.

In the minute of the meeting of 5 February 2008 it was recorded that the meeting had to end prematurely as staff needed to go back to their areas of work. It was also minuted that the next meeting was to take place on 8 April 2008 but, as already noted, that did not happen.²⁹³

According to Mrs O'Neill one of the problems over attendance was that it was difficult for staff to get time off from their ward duties to attend. Whatever the cause, however, the key point is that the system was not working. Such poor attendance when the group did meet meant that the reporting back to the wards was inadequate.

There was no evidence before the Inquiry that this group made any effective contribution to infection prevention and control in the VOLH during the period from 1 January 2007 to 1 June 2008. The concept of having a local group at that level with the purpose of disseminating information on infection prevention and control to individual wards was a good one but it failed in practice.

VOLH Infection Control Working Group

The background to the establishment of the VOLH Infection Control Working Group (the Working Group) was the disbandment of the Argyll and Clyde Infection Control subgroups and their replacement by the Support Group. The Support Group wanted to have local working groups with a remit that included assisting the Infection Control Team in supporting NHSGGC's infection control programme and reporting to the Support Group.²⁹⁴ The terms of reference

292 [GGC17790005](#)
 293 [GGC28080002](#)
 294 [GGC11710001](#)

of the Support Group, drafted by Dr Biggs, stipulated that the Support Group was to “receive reports from the three acute hospital control teams”,²⁹⁵ but at the meeting of the Support Group held on 13 February 2007 it was minuted that it had been agreed at the previous meeting of 12 December 2006 that the papers and minutes from the three working groups would simply be available for the meeting. Any issues arising would be addressed by the Senior ICNs.²⁹⁶

Although terms of reference for the Working Group are mentioned in the minutes of the meeting held on 27 June 2007²⁹⁷ and of the meeting held on 26 September 2007,²⁹⁸ the Board was not able to supply the Inquiry with those terms of reference. The Working Group was due to meet on a quarterly basis, and the meetings that took place were chaired by Mrs Murray.

The first meeting of the Working Group was held on 5 April 2007, when Mrs Murray explained that it was important to have a local working group that could report to the next level in the structure, namely the Support Group and “thus to the Health Board”.²⁹⁹ The minute of that meeting discloses that those in attendance included Mrs Susan Wilson, Lead Nurse for Emergency Care and Medical Specialities, Mrs Elizabeth Rawle, Lead Nurse for the Rehabilitation and Assessment Directorate and Ms Judy Taylor, Senior Nurse Professional Practice. It was noted that apologies had been received from a number of people, including Dr Douglas McCrudden, Consultant Physician.

Meetings of the Working Group were poorly attended. Dr McCrudden was not able to attend any of the meetings. The Working Group last met on 28 September 2007, for although an agenda for a proposed meeting on 19 December 2007 was drawn up that did not take place. There were no further meetings after September 2007.

In the minute of the meeting held on 5 April 2007 it was noted that the numbers of *C. difficile* toxin positive patients were up on previous years; “a 40% increase on last year”.³⁰⁰ It was also minuted that Mrs Murray said that there appeared to be a significant increase in CDI since the start of enhanced surveillance. According to the minutes, Mrs Murray went on to say that because of this increase patients with *C. difficile* diarrhoea were to be nursed in isolation and that priority should be given to isolating patients who were *C. difficile* toxin positive over MRSA patients.

Mrs Murray said in evidence that the meeting of the Working Group proposed for December 2007 did not take place because so many apologies for non-attendance were received.³⁰¹ The next meeting would have been in March 2008, but no date for a further meeting was fixed.

Following her appointment as Consultant Microbiologist with designated responsibilities for Infection Control at the RAH and VOLH, Dr Bagrade proposed that the VOLH and RAH Infection Prevention and Control Working Groups be combined, having become aware that the Working Group at the VOLH had “experienced some difficulties in establishing the group”.³⁰² That combined group was duly constituted and held its first meeting on 14 May 2008.³⁰³

Clyde Acute Infection Control Support Group

The remit of the Support Group was set out as an appendix to the document “Proposed Infection Control Structure in NHS Greater Glasgow and Clyde”,³⁰⁴ and included a provision that the Support Group was to report to the ACIC any identified infection control incidents or outbreaks.³⁰⁵ In addition, Dr Biggs drafted what were styled “terms of reference” for the Support Group that reflected her intentions for the scope of its work. Those terms of reference provided that the Support Group was:

295 [GGC29140001](#)
296 [GGC29240001](#)
297 [GGC14760001](#)
298 [GGC14770001](#)
299 [GGC14750001](#)

300 [GGC14750004](#)
301 [TRA01010148](#)
302 [GGC13390015](#)
303 [GGC13390002](#)
304 [GGC29210001](#)
305 [GGC29210009-10](#)

“to disseminate good practice in the prevention and control (of) infection in the Acute Sector for the population of Clyde division”.³⁰⁶

It was to report to the ACIC, as set out in its remit.³⁰⁷ The terms of reference also envisaged that the Support Group would receive reports on outbreaks. It was to meet quarterly.³⁰⁸ Dr Biggs was named as the Chair, and was specifically designated in the document as “Infection Control Doctor”.³⁰⁹

Support Group meeting on 9 May 2007

A meeting of the Support Group was held on 9 May 2007, chaired by Dr Biggs. Mrs Murray, who was a member both before and after she became interim Lead Nurse, was not present, but Ms Rankin was present as the Head ICN. Mr Walsh was also present and is described in the minutes as “Infection Control Manager”,³¹⁰ although he was not yet in post. Ms McNamee had been present at the meeting of the Support Group on 13 February³¹¹ but was not present at the meeting of 9 May 2007. Ms Martin was also a member of the Support Group and was present on 9 May 2007. At the meeting Dr Biggs tabled a report for the VOLH for the period February to April 2007 in the absence of Mrs Murray,³¹² in which the following comments were made:

“numbers of *C. difficile* had increased in March and April causing some concern. The ICT are continuing to monitor this”.³¹³

The report concluded by noting that:

“April: There was an increase in the numbers of patients testing positive for *C. difficile* (see previous figures) particularly on one ward”.³¹⁴

This is discussed later, but it was apparent from the evidence given to the Inquiry that

the information disclosed in this report at this meeting did not prompt any action or investigation.

Support Group meeting on 10 July 2007

The next Support Group meeting on 10 July 2007 was chaired by Dr Biggs. Ms Martin and Mrs Murray were present, but the minutes record apologies from Ms Rankin and Mr Walsh. They also record that Dr Biggs felt that the ICD should not be the person to chair the Support Group as the ICD “has no actual link to feed the reports to”.³¹⁵ What was meant by that comment is not entirely clear, but it is certainly not correct that the Support Group had no reporting link, because the terms of reference drafted by Dr Biggs clearly provided that it was “to link into the Acute Control of Infection Committee”,³¹⁶ a committee of which Dr Biggs herself was a member.

It was also noted at the meeting of 10 July 2007 that Mrs Murray had nothing to report to the Support Group.³¹⁷ She tabled the surveillance report advising that there were “no major concerns”.³¹⁸ That surveillance report covered the period April to June 2007³¹⁹ and disclosed a significant increase in numbers of *C. difficile* toxin positive cases in comparison to the previous quarter (January to March 2007).

Failures to meet

The next meeting was due on 9 October 2007,³²⁰ but the Support Group did not meet again after 10 July 2007. Mrs Murray could provide no real explanation of why the Support Group stopped meeting except to surmise that Dr Biggs did not want to chair it.³²¹ She thought that Ms Martin was considering ways in which it could be resurrected.³²² When questioned by the Internal Investigation on this particular topic Dr Biggs is noted to have suggested that “nobody was coming to meetings ... managers

306 [GGC29140001](#)

307 [GGC29140001](#)

308 [GGC29140002](#)

309 [GGC29140002](#)

310 [GGC13260006](#)

311 [GGC29240001](#)

312 [GGC13260008](#)

313 [GGC13260013](#)

314 [GGC13260020](#)

315 [GGC20940002](#)

316 [GGC29140001](#)

317 [GGC20940002](#)

318 [GGC20940004](#)

319 [GGC20060001](#)

320 [GGC20940006](#)

321 [TRA01010085](#)

322 [TRA01010085](#)

saying too busy to come to IRH”.³²³ That was an obvious overstatement although certainly the meetings of 9 May 2007 and 10 July 2007 were quite poorly attended. Dr Biggs also claimed at that interview that Ms Martin would address the failure of the Support Group to meet but “nothing happened”.³²⁴

Ms Martin said in evidence that she was aware that the October meeting of the Support Group did not take place. She said initially in her evidence that because she was on secondment, what she could do about the issue was very limited as it was not her responsibility at that stage.³²⁵ Subsequently, when asked if she did anything about it she replied by saying that she was “limited” in what she could do, but that she:

“did flag it up with ... I’m sure I flagged it up with Robin Reid (Associate Medical Director, Diagnostics Directorate) but I definitely spoke to Isabel Ferguson (General Manager for Laboratory Medicine NHSGCC) and Tom Walsh about it”.³²⁶

Mr Walsh had no recollection of Ms Martin speaking to him about this matter. As far as he was concerned he only became aware that the Support Group was not meeting after May 2008.³²⁷ Dr Reid had no recollection of such a conversation. If he had been told that the Support Group was not meeting his response would have been to ask Ms Martin what she was doing about reinstating it.³²⁸ The issue of knowledge of the Support Group’s failure is discussed in Section 15.9.

Attendance by Mr Walsh and Ms McNamee

As noted previously, Mr Walsh attended the meeting of the Support Group held on 9 May 2007, although Ms McNamee did not. Neither Mr Walsh nor Ms McNamee attended the last meeting of the Support Group held on 10 July 2007. The minutes record Mr Walsh’s apologies for non-attendance, but Mr Walsh explained in evidence that in fact he had told Dr Biggs that it was not appropriate for him and the Nurse Consultant to attend

sector group meetings such as the meeting of the Support Group, as they did not belong to any other sector group.³²⁹ His attendance on 9 May 2007 was simply part of an orientation process prior to taking up post. Although Dr Biggs in drafting the terms of reference for the Support Group had included in its membership the Infection Control Manager and Consultant in Public Health,³³⁰ these were people who did not sit in on the sector group meetings.³³¹ The Inquiry accepts that Mr Walsh was not a member of the Support Group. The Nurse Consultant was not on the membership list in the terms of reference, and although she was present on 13 February 2007 Ms McNamee did not become a member of the Support Group.

Impact of committee failures

With the failure of the Support Group in July 2007 and the subsequent failure of the Working Group in September 2007, as Dr Ahmed, Consultant in Public Health Medicine and Clinical Consultant in the Public Health Protection Unit, said, there was a significant gap in the chain from the VOLH to the Board level.³³² So far as Dr Ahmed was concerned, there was a:

“significant risk to the whole organisation that information from the site may not be reaching to the top level of the organisation”.³³³

The reason nothing was done to remedy the situation that developed is addressed later in this Chapter.

The Acute Control of Infection Committee

The reporting line for the Support Group was to the ACIC. The ACIC’s primary objective was that of reducing the risks of HAIs to patients, relatives and healthcare workers in a number of ways, which included advising Mr Calderwood on infection control risks and significant unresolved issues.³³⁴ Its terms of reference included advising and supporting site Infection Control Teams and considering

323 [GOV00890101](#)
 324 [GOV00890101](#)
 325 [TRA01160019](#)
 326 [TRA01160068](#)
 327 [TRA01200039](#)
 328 [TRA01180041-42](#)

329 [TRA01200034-36](#)
 330 [GGC29140002](#)
 331 [TRA01200034-35](#); [TRA01130087](#)
 332 [TRA01130087](#)
 333 [TRA01130088](#)
 334 [GGC29210009](#)

reports on infections and infection-related problems from the site Infection Control Support Groups. These could come either from the Lead Nurse for Infection Control or the ICD. The attention of the Chief Operating Officer was to be drawn to any serious potential or actual risks in relation to infection control.³³⁵ It was also the function of the ACIC to develop and agree actions in response to specific outbreak situations.³³⁶

According to its terms of reference the ACIC was supposed to meet on a quarterly basis, but Dr Reid explained that this was changed because the importance of the committee's work demanded a shorter interval between meetings, and for that reason the ACIC met every second month.³³⁷ The terms of reference provided that it was to report to the Chief Operating Officer, the BICC, the Medical Director and the Infection Control Manager.³³⁸ Dr Reid agreed that the ACIC did report to the BICC but explained that the main line of reporting was to the Acute Strategic Management Group chaired by the Chief Operating Officer.³³⁹ The Infection Control Manager was in fact a member of the ACIC and reported to the Medical Director,³⁴⁰ who in turn reported to the Chief Executive.³⁴¹ It seems, therefore, that the reporting lines envisaged by the terms of reference were in place, albeit in a roundabout fashion.

Membership and attendance

The ACIC was chaired by Dr Robin Reid, and included in the membership of that committee were the Infection Control Doctors for each of the four sectors which made up NHSGCC, including Dr Biggs. Mr Walsh was a member of the ACIC, as Infection Control Manager, as were Ms McNamee and Ms Rankin. Mrs Murray became a member of the ACIC after she became the interim Lead Nurse for Infection Control for the Clyde Sector, and the first meeting that she attended was on 24 July 2007.³⁴²

Dr Biggs' attendance at ACIC

Dr Biggs did not attend any of the meetings of the ACIC in the period from January 2007 to June 2008. The minutes of the meeting of 23 January 2007 record apologies on behalf of Dr Biggs,³⁴³ but there is no such note in any of the other minutes covering the period up to June 2008. She did attend one meeting of the ACIC in the second half of 2006, but before that she had not been a member of the group.³⁴⁴ This means that from the time Dr Biggs became a member of the ACIC in 2006 up to June 2008 she only ever attended one meeting.

Dr Biggs' continued absence from the ACIC meetings was a matter that Dr Ahmed found "very concerning".³⁴⁵ In his evidence he said that he would have expected Dr Reid, as chairman, to investigate the reason for her absence over that period.³⁴⁶ Dr Reid explained, however, that any concerns he had were mitigated by the presence of other members of the Clyde team on the ACIC. He considered that their presence ensured that the flow in information was not being compromised by the absence of Dr Biggs.³⁴⁷ Furthermore, Dr Reid and others had a meeting with Dr Biggs at the IRH in September 2007 at which Dr Biggs indicated that her lack of mobility compromised her ability to attend meetings.³⁴⁸ According to Dr Reid, because Dr Biggs' line manager, Ms Martin, was present at the meeting and appeared to accept that explanation, he felt that it was a reasonable decision on the part of Dr Biggs³⁴⁹ not to attend the ACIC meetings. While Dr Reid's explanation is understandable, nevertheless regular attendance at meetings by the ICD was part of that job, and Dr Bagnard first attended the ACIC on 29 January 2008.³⁵⁰

As Dr Ahmed explained, it was particularly crucial at the level of the ACIC that the Sector ICD attended the committee meetings.³⁵¹

335 [GGC29210009-10](#)

336 [GGC29210010](#)

337 [TRA01180006](#)

338 [GGC29210009](#)

339 [TRA01180004](#)

340 [TRA01220083](#)

341 [TRA01220088](#)

342 [GGC02330001](#)

343 [GGC02320001](#)

344 [TRA01180006](#)

345 [TRA01130071](#)

346 [TRA01130071](#)

347 [TRA01180017](#)

348 [TRA01180017](#)

349 [TRA01180017](#)

350 [GGC02350001](#)

351 [TRA01130072-73](#)

This was not so important at the level of the BICC because a number of other people from Acute Services did attend and therefore Dr Ahmed could still communicate or pass down information.

The Board Infection Control Committee

Like the ACIC, the BICC, also known as the NHSGGC Control of Infection Committee, included among its objectives the reduction of the risks of infection to members of the public and patients.³⁵² Those objectives were to be achieved in a number of ways including advising the Chief Executive on all matters relating to infectious diseases throughout NHSGGC.

The BICC was also to liaise with other appropriate committees in NHSGGC and monitor their performance. It carried out a number of review functions including the reviewing of infection control policies. The BICC reported to the Chief Executive and to the Board Clinical Governance Committee, and the proposed infection control structure³⁵³ envisaged that the BICC would also report to the Risk Management Committee, but according to Dr Ahmed the reporting lines were only to the Chief Executive and the Board Clinical Governance Committee.³⁵⁴ The BICC was to meet quarterly.³⁵⁵

Membership

The BICC was chaired by Dr Ahmed, who at the time was a Consultant in Public Health Medicine in NHSGGC and also the Clinical Director of the Public Health Protection Unit.³⁵⁶ Dr Ahmed explained in evidence that the BICC had a broad remit, with HAI being only part of that remit. Its membership included representatives from Public Health and also representatives from Acute Services and Partnership Services. Dr Reid was a member as were Mr Walsh, Ms McNamee, Ms Rankin and Dr Biggs.

Dr Biggs' attendance at BICC

Dr Biggs first attended a BICC meeting on 20 March 2006 shortly before the dissolution of NHS Argyll and Clyde.³⁵⁷ She attended another two meetings in 2006,³⁵⁸ but none after that. Dr Bagnall first attended on 17 March 2008,³⁵⁹ when Dr Biggs' apologies for non-attendance are recorded. There is no record of apologies on Dr Biggs' behalf for non-attendance at any other meeting of the BICC. In short, Dr Biggs did not attend any meetings of the BICC from 1 January 2007 to 1 June 2008. Dr Ahmed said that her absence was a matter he did not pursue,³⁶⁰ and he could not remember whether her absence was noticed. He expected her to attend because that meeting was a forum for her to raise any issues at a very senior level.³⁶¹

NHSGGC Acute Strategic Management Group

According to its terms of reference the main purpose of the Acute Strategic Management Group (Acute SMG) was the development of overall strategy and policy for the Acute Services Division within the overall strategies and policies set by NHSGGC.³⁶² The Acute SMG was chaired by Mr Calderwood, and its membership included Mrs den Herder, Ms Harkness, Dr Cowan and Dr Reid. The terms of reference envisaged that the Acute SMG would set its own cycle of meetings but in the main would meet on a monthly basis. According to the ACIC Chair, Dr Reid, the ACIC reported to the Acute SMG, although this is not mentioned in the Acute SMG's terms of reference.³⁶³

In the period from 1 January 2007 to 27 September 2007 seven meetings of the Acute SMG took place without any reference in the minutes to infection prevention and control.³⁶⁴ At the meeting of 27 September 2007 it was noted in the minutes that Dr Reid introduced the Infection Control Report, which summarised the issues discussed in the

352 [GGC29210007](#)
353 [GGC29210007](#)
354 [TRA01130013](#)
355 [GGC29210008](#)
356 [TRA01130001](#)

357 [SPF01150002](#)
358 [TRA01130022](#)
359 [GGC02250001](#)
360 [TRA01130028-29](#)
361 [TRA01130023](#)
362 [QIS01280001](#)
363 [TRA01180004](#)
364 [GGC01390001](#); [GGC01340001](#); [GGC01350001](#);
[GGC01410001](#); [GGC01380001](#); [GGC01150001](#);
[GGC01370001](#)

past year by the ACIC.³⁶⁵ It was also minuted that:

“work towards providing a unified control of infection service across the single system was nearing completion”.³⁶⁶

Dr Reid was also noted as stating that one particular issue was the need to gather:

“consistent data across the whole of the organisation and then provide it in a meaningful manner”.³⁶⁷

In his evidence Dr Reid said that the process had developed to a point at which a more complete data set was in fact available by early 2008.³⁶⁸ By that time infection control teams had started to produce much more information, and SPC Charts, discussed later in this Chapter, were in place for a number of areas of the Health Board. SPC Charts were not in place for the VOLH prior to May 2008, an issue that is considered in Section 15.7.

There was no mention of infection prevention and control in the minutes of the five meetings of the Acute SMG that took place between September 2007 and April 2008.³⁶⁹ At the meeting of the Acute SMG held on 24 April 2008 the minutes disclose that the Infection Control Quarterly Report was introduced by Dr Reid,³⁷⁰ who reported that significant work had been undertaken to harmonise the infection control teams across the Board area, although there remained work still to be done. He also said that SPC Charts were being circulated to wards. There was some reference made to the HAI Task Force’s new Delivery Plan for 2008-11, and it was agreed that detailed progress of the targets contained in the plan would be monitored by the ACIC and that Dr Reid would report on progress in his routine reports to the Acute SMG.³⁷¹

15.8 Reporting within the infection control committee structure

Summary of the reporting structure

As set out earlier, in ascending order: the Support Group reported to the ACIC; the ACIC in turn reported to BICC; the BICC was the link to the Chief Executive and the Board Clinical Governance Committee. This Section is not concerned with the issues of clinical governance identified in Chapter 10, but with reporting within the infection control structure itself.

Exception reporting

From 1 January 2007 to June 2008 the reporting of issues relating to infection prevention and control was carried out within an established system of exception reporting. This meant that at the levels of the BICC and the ACIC an issue would only be reported to them if there was a concern that it was outwith normal parameters.³⁷² An outbreak of CDI would qualify for exception reporting.³⁷³ In addition, however, Dr Ahmed as the Chair of the BICC expected to have been told long before any meeting of that committee if there was an outbreak of CDI in any of the Health Board’s hospitals.³⁷⁴

The exception reporting system was designed to control the flow of information through the hierarchy of committees so that issues that could be resolved at a more local level did not need to be considered at a higher level.³⁷⁵ With an organisation as large as NHS GGC it was important that senior management was not inundated with matters that could be managed adequately at levels further down the chain.³⁷⁶ The focus of the Inquiry has been on the VOLH and on the Clyde Sector, but it is necessary to bear in mind that the VOLH is just one hospital in an organisation covering some 20 hospitals³⁷⁷ of which ten were acute hospitals. Some of these are a significant size, and at the time Clyde Sector was only one of five sectors in NHS GGC.

The system of exception reporting depends upon individuals recognising and reporting

365 [GGC01430005](#)

366 [GGC01430005](#)

367 [GGC01430005](#)

368 [TRA01180012](#)

369 [GGC01400001](#); [GGC01360001](#); [GGC01980001](#);
[GGC02410001](#); [GGC02400001](#)

370 [GGC02380005](#)

371 [GGC02380005](#)

372 [TRA01130032-33](#); [TRA01200087](#)

373 [TRA01130034-35](#)

374 [TRA01130034](#)

375 [TRA01180073-75](#)

376 [TRA01200132](#)

377 [TRA01130145](#)

exceptional events. Under this system, therefore, if staff at a lower level do not recognise or report an exceptional event, senior management do not become aware of it unless there are other systems to inform them of the event and of the earlier failure to report. It becomes critical, therefore, that at senior level there is assurance that the system is working and that patients are not being exposed to unnecessary risk.

The exception reporting system failed in relation to the CDI problem that existed in the VOLH throughout most of 2007 and in 2008 until its discovery in May 2008. As discussed later in this Chapter, there should have been a system in place for reporting the rates of CDI through the committee structure that could provide senior management and ultimately the Chief Executive with the necessary assurance that HAI was being managed successfully.

Sector level reporting – the Support Group

Dr Ahmed's expectation was that the CDI rates in hospitals within the jurisdiction of each of the sector committees would be reported to the relevant sector committee.³⁷⁸ At the level of the sector committees the membership included the ICDs and Lead ICNs. At least on the face of it, therefore, these committees possessed appropriate levels of expertise in infection prevention and control.

As discussed in Section 15.7, the Support Group for the Clyde Sector defined its terms of reference to include receiving reports from three hospital Infection Control Working Groups, including the VOLH Infection Control Working Group. In any event, the Support Group was to receive reports from the Infection Control Teams at the IRH, the RAH and the VOLH. Mention has already been made of the fact that at the meeting of the Support Group of 9 May 2007 Dr Biggs tabled the VOLH Infection Prevention and Control Report in the absence of the Lead Infection Control Nurse, Mrs Murray.³⁷⁹ That report is an 11 page document which provides important and detailed information about the prevalence of CDI rates at the VOLH. The heading of the report indicates that it was

for the period "February – April 2007",³⁸⁰ but particular attention is drawn in it to the figures for the month of April, in the course of which there were ten patients suffering from CDI in the hospital. Despite that, and in contrast to the report for the IRH, where the minutes disclose that certain aspects of the contents of that report were discussed,³⁸¹ there is no record of any discussion of the contents of the VOLH report at the Support Group meeting.

The Acute Control of Infection Committee meetings

In the period from 1 January 2007 to 1 June 2008 eight meetings of the ACIC took place. A meeting originally planned for 27 May 2008 did not take place until 3 June 2008. A meeting was also planned for 27 March 2007³⁸² but does not seem to have taken place.³⁸³ The ACIC minutes disclose that infection control reports were provided on an exception reporting basis on behalf of infection control sector groups.

The first meeting of the ACIC after the Support Group meeting of 9 May 2007 was on 15 May 2007. As previously discussed, Dr Biggs, although a member of the ACIC, did not attend any of the meetings in 2007. ICDs for other sectors were in attendance at that meeting,³⁸⁴ as were Ms Martin, Ms McNamee and Ms Rankin, all of whom had been in attendance at the Support Group meeting of 9 May 2007. The minutes record that the exception report of the Clyde Sector indicated that:

"There had been a few outbreaks of suspected norovirus at the Royal Alexandra Hospital and an outbreak of MRSA and C-Diff in a Care of the Elderly Ward".³⁸⁵

The reference to an outbreak of CDI here is to the RAH.³⁸⁶

The Chair, Dr Reid, would have expected the ACIC to be provided with an indication of the

³⁷⁸ [TRA01130150](#)
³⁷⁹ [GGC13260008](#)

³⁸⁰ [GGC13260011](#)
³⁸¹ [GGC13260008](#)
³⁸² [GGC02320006](#)
³⁸³ [GGC29230001](#)
³⁸⁴ [GGC02310001](#)
³⁸⁵ [GGC02310005](#)
³⁸⁶ [TRA01180009](#)

number of patients involved, the severity of the outbreak and a description of the actions taken, but these details are not minuted.³⁸⁷ It is, however, apparent from the minutes of the meeting of the Support Group on 9 May 2007 that an outbreak report was being prepared in relation to those outbreaks of MRSA and CDI raised in the exception report for the RAH,³⁸⁸ so that there appears to have been a response to those outbreaks.

The ACIC meeting of 24 July 2007 was the first Mrs Murray attended on becoming the interim Lead Nurse for Infection Control on 1 July 2007.³⁸⁹ The minutes record that in the Clyde Sector “the C.diff trend was downwards”.³⁹⁰ Nonetheless, in June 2007 there were four CDI patients closely associated in time in ward 3 of the VOLH. Moreover, about the time of the ACIC meeting of 24 July 2007 three patients were positive for *C. difficile* toxin in ward 14 of the VOLH. These numbers are examined later in this Chapter in Section 15.11.

The ACIC meeting of 24 July 2007 had been preceded by what was the final meeting of the Support Group on 10 July 2007³⁹¹ at which Mrs Murray had “reported that there were no major concerns”,³⁹² despite tabling a surveillance report which disclosed that in the period April 2007 to June 2007 there were 24 patients suffering from CDI in the VOLH. Of that number 21 were classified in the report as hospital acquired infection, with the remaining three said to have been community acquired. None of this information reached the ACIC. The simple fact is that important information available to Support Group meetings of 9 May and 10 July 2007 on figures and rates of CDI was never placed before the ACIC, even although the ACIC received reports from the Clyde Sector. The Support Group’s terms of reference, as drafted by Dr Biggs, envisaged that its minutes would be submitted to the ACIC,³⁹³ but according to Dr Reid that did

not happen.³⁹⁴ A number of reports were submitted by Mrs Murray to the ACIC, on 24 July, 12 October, 27 November 2007 and 29 January 2008,³⁹⁵ but not one of these alerted the ACIC to the CDI problem which existed in the VOLH.

Dr Reid confirmed that there was no discussion at the ACIC about the prevalence of CDI in the VOLH in the period from January 2007 to May 2008. No discussion was prompted by the system of exception reporting.³⁹⁶ Dr Reid’s evidence was that when he first became aware of the situation at the VOLH between January 2007 and May 2008 he “was completely taken by surprise”.³⁹⁷ He would have expected to be told of the situation at the time.³⁹⁸ Dr Reid said he should, for example, have been made aware of the report presented to the Support Group meeting of 9 May 2007 which makes reference to increases in the numbers of the *C. difficile* toxin positive patients. If he had been made aware, he would have asked what significance was attributed to the increases and what actions the operational team had put in place.³⁹⁹

Dr Reid went on to say that, had the information been made available, he would have wanted the Infection Control Team to monitor the position “in real time”.⁴⁰⁰ He could see in retrospect that there had been a serious problem, and had it been apparent at the time it would “unequivocally have been escalated to the Board committee”.⁴⁰¹ It would have been referred to the operational team without waiting for any further meetings.⁴⁰²

Reporting to the Board Infection Control Committee

There were a number of potential routes by which the information available to the Support Group on 9 May and 10 July 2007 could have been made known to the BICC at its meetings on 18 June and 17 September

387 [TRA01180009-11](#)

388 [GGC13260008](#)

389 [TRA01010004](#)

390 [GGC02330004](#)

391 [GGC20940001](#)

392 [GGC20940004](#)

393 [GGC29140002](#)

394 [TRA01180039](#)

395 [TRA01180043](#)

396 [TRA01180045](#)

397 [TRA01180049](#)

398 [TRA01180049](#)

399 [TRA01180052](#)

400 [TRA01180053](#)

401 [TRA01180053](#)

402 [TRA01180053](#)

2007. The information could have been reported by the ACIC, had that committee become aware of it. Dr Biggs would in theory have been in a position to raise the issue, but even if she had identified the problem, and there is no indication that she did, she did not attend any meetings of the BICC in 2007.

Ms Rankin was another potential source since she was a member of both the Support Group and the BICC, and presented the ACIC reports to the BICC. Ms Rankin did not cause any additional investigations to take place because, as explained later in this Chapter, it was Dr Biggs who tendered the VOLH report on 9 May 2007 and Ms Rankin assumed that Dr Biggs would have carried out an investigation since she was the ICD. No doubt Mrs Murray's assertion at the meeting of 10 July 2007 that there were "no major concerns"⁴⁰³ would also have provided her with some comfort about the situation in the VOLH.

In short, the BICC was not made aware of the persisting problem with CDI at the VOLH during this period. The trail that might have led to the discovery of the prevalence of CDI at the VOLH ran cold at the level of the Support Group.

The Inquiry expert's critique

Professor Duerden was critical of the fact that reports on the number of cases and rates of CDI for a sector such as the Clyde Sector were not provided to the ACIC as standing items on its agenda.⁴⁰⁴ His position was that the surveillance data from each sector should have been made available to the ACIC as a matter of course.⁴⁰⁵ If the data disclosed any outbreaks then so far as Professor Duerden was concerned that information needed to "go to the top",⁴⁰⁶ by which he meant the BICC. In any event, it is clear that if data disclosed that there was or had been an outbreak the Chief Executive would be informed. Making the surveillance data available to the ACIC would have provided the opportunity for some re-assessment, particularly in relation to the VOLH, of

whether there had been any outbreaks and whether there had been an appropriate response.⁴⁰⁷ He explained that although there would have to be a degree of summarising as the information passed through the hierarchy of committees, that process should not obscure what was happening within hospitals. Senior management had to be assured by the data that infection prevention and control was being properly managed.

Dr Ahmed said "not everything" that happens at hospital level can be discussed in detail at the other end of the committee structure.⁴⁰⁸ His view was that the sector level was the appropriate level at which the detailed data should be assessed, and that thereafter it should only be reported on an exception basis.⁴⁰⁹ At the sector level, with people such as ICDs and Head Nurse of the Infection Control Service being members of the committee, there was a level of expertise available to consider properly the material presented on the numbers of cases and rates. His view was that if the structure worked in the way it was intended to work there was a control system in place that was designed to pick up problems.

Dr Cowan said that in a Board as large as NHS GGC there had to be "robust systems"⁴¹⁰ of reporting in place. He also saw the "key"⁴¹¹ to such a system at the time to be the sector Support Groups.

The Inquiry agrees that the Clyde Sector Support Group had a key role to play in examining the numbers and rates of cases of CDI in hospitals in its jurisdiction. Furthermore, it is undoubtedly the case that if the infection control structure at that level had worked in the way it was intended to work the problem with CDI at the VOLH would have been discovered and responded to. At the very least the ACIC should have been told of the prevalence of CDI at the VOLH at its meetings on 15 May and 24 July 2007. The Inquiry accepts that as a committee the ACIC was ignorant of the

403 [GGC20940004](#)
 404 [TRA01050109-110](#)
 405 [TRA01050110](#)
 406 [TRA01050111](#)

407 [TRA01050133](#)
 408 [TRA01130143](#)
 409 [TRA01130143](#)
 410 [TRA01220123](#)
 411 [TRA01220123](#)

position due to individual failures and to the system of exception reporting adopted at that level in the committee structure.

The CSBS Standards provided that the results of surveillance should be “routinely reported”⁴¹² to the Infection Control Committees of the Board. That would certainly include reporting the results to committees such as the ACIC and the BICC, and indeed Dr Reid had recognised the need for his committee to see HAI statistics. This need was beginning to be satisfied from March 2008 by the production of data in the form of the SPC Charts and reports.⁴¹³

In fact those data were already available at the VOLH, at least for the VOLH, because of the existence of the Infection Control database, as the report prepared for the Support Group meeting of 9 May 2007 discloses.⁴¹⁴ It is apparent from the material contained in that report that information on the total number of cases, the number of cases in individual wards, and the assessment of trends could be presented in an intelligible way.

Infection prevention and control is a “core part”⁴¹⁵ of patient safety. It is essential that senior management is aware of the rates and trends of a HAI such as CDI. Indeed this was accepted by NHSGGC at the time. The principle of Board to ward, and ward to Board, means that there must be an unbroken line of reporting, accountability and assurance.

The failure to have a system in place which ensured that rates and trends of CDI in hospitals such as the VOLH were available at least to meetings of the ACIC, and subsequently reported to the Board, was a system failure that contributed to the CDI problem persisting up to June 2008. This is a failure for which the Board has to bear ultimate responsibility.

15.9 The failure of the committee structure

Committee structure gap

In principle there was a hierarchy of committees for reporting infection control issues from the VOLH to the Board, but there were malfunctions at the level of the Support Group and the Working Group which resulted in a significant gap⁴¹⁶ in the chain of information from the VOLH to Board level in the latter part of 2007. The intention in this Section is to examine who was responsible for or aware of the failure of those committees.

The failure of the VOLH Infection Control Working Group

As the Chair of the Working Group, Mrs Murray was directly responsible for its failure to meet after 28 September 2007. If the meeting fixed for 19 December 2007 could not take place because of lack of numbers, a meeting of the group should have been fixed for another date. That did not happen. This issue was addressed by Dr Bagnade after she became ICD for the VOLH in early February 2008.

The failure of the Clyde Acute Infection Control Support Group

As the Chair of the Support Group, Dr Biggs was directly responsible for its failure to meet after 10 July 2007. Even though she was dissatisfied with her particular role, Dr Biggs should have ensured that the Support Group continued to meet until alternative arrangements were made.

Ms Martin maintained that she was on full-time secondment from August 2007 to April 2008, and this is considered in detail later in this Chapter, but the Inquiry is satisfied that Ms Martin continued to retain her responsibilities for infection prevention and control in the Clyde Sector during that period. Ms Martin’s evidence that because she was on secondment she was “limited in what (she) could do”⁴¹⁷ is not accepted. She knew the Support Group had ceased to meet.⁴¹⁸ Indeed

412 [GOV00160045](#)

413 [GGC01890001-02](#); [TRA01180076-79](#)

414 [GGC13260017](#)

415 [GOV00380002](#)

416 [TRA01130087](#)

417 [TRA01160019](#)

418 [TRA01160019](#)

Dr Biggs made it clear to her by e-mail dated 5 September 2007 that she would not “attend or chair any meetings”⁴¹⁹ in connection with infection control until she had her role clarified. Ms Martin had direct responsibility to tackle the problem created by Dr Biggs’ failure to convene the Support Group. Her failure to do so was a serious failure.

Dr Ahmed was not aware of the failure of the Support Group. As chair of the BICC he should have been made aware of the Support Group’s malfunction,⁴²⁰ and if Dr Biggs had attended BICC meetings she would have had the opportunity to raise the issue. Ms Rankin attended a meeting of the BICC on 17 December 2007 and did not mention the problem.⁴²¹

Another possible source of information for Dr Ahmed was Dr Reid, the Chair of the ACIC, but the Inquiry is satisfied that Dr Reid did not become aware of the situation with the Support Group prior to June 2008. Ms Martin was incorrect in suggesting that she had “flagged”⁴²² the problem to him. Dr Reid’s view was that if Ms Martin had raised the problem with him, his response would have been “what are you doing about it to reinstate the committee?”⁴²³ That was perfectly understandable because, so far as he was concerned, Ms Martin was the manager responsible for infection prevention and control for the Clyde Sector.

Ms Martin also said she had spoken to Mr Walsh about the Support Group’s failure. Mr Walsh said he only became aware of the position after May 2008,⁴²⁴ and that if he had been told by Ms Martin that the Support Group had ceased to function that was not something he “would either forget or neglect”.⁴²⁵ He would regard such a failure as an important matter⁴²⁶ and would have done something about it.⁴²⁷

The Inquiry considers that Mr Walsh would have raised the failure of the Support Group with Ms den Herder or Mr Calderwood if he had known about it and if it had not been resolved, and is satisfied that Mr Walsh did not know before May 2008 that the Support Group had ceased to meet. Nonetheless, although Mr Walsh did not have operational responsibility for infection prevention and control at that time, he did have an oversight role to ensure that the committee structure was intact and functioning.⁴²⁸ He should have been made aware of the Support Group’s failure to meet.

Ms Martin suggested she raised the issue with Ms Isabel Ferguson, General Manager for Greater Glasgow Laboratory Medicine and Infection Control, but there would be no reason for her to do so, since the Clyde infection prevention and control management system was being operated separately from the rest of Greater Glasgow. Ms Ferguson was not even aware that Dr Biggs chaired the Support Group,⁴²⁹ and did not become aware of the suggestion that Ms Martin might have taken up a secondment position in August 2007 until she read the transcript of the evidence given by Ms Martin to the Inquiry.⁴³⁰ Furthermore, the problem was ultimately one for Mrs den Herder to deal with. Ms Ferguson was working on the basis that Dr Biggs was fulfilling her role as the ICD for the VOLH.⁴³¹ She had no reason to think otherwise.

Ms Rankin was aware that the Support Group had ceased to meet.⁴³² In her evidence she said she raised this at a meeting of the ACIC, of which she was a member, in November 2007. She went on to say in evidence that:

“there was some need to bring consistency and composition and meeting arrangements around the sector Infection Control Committees”.⁴³³

That response was almost identical to what had been recorded in the minutes of the

419 [SPF01130003](#)

420 [TRA01130090](#)

421 [GGC02270001](#)

422 [TRA01160068](#)

423 [TRA01180042](#)

424 [TRA01200039](#)

425 [TRA01200066](#)

426 [TRA01200066](#)

427 [TRA01200067](#)

428 [GGC30350001-02](#)

429 [TRA01210095](#)

430 [TRA01210091](#)

431 [TRA01210101](#)

432 [TRA01000025](#)

433 [TRA01000026](#)

ACIC held on 27 November 2007.⁴³⁴ What is clear, as Ms Rankin said in her evidence, is that what she mentioned at that meeting “wasn’t just particularly in relation to the Clyde Sector”.⁴³⁵ Ms Rankin had a further opportunity to raise this issue with the ACIC at its meeting of 29 January 2008 and did not do so. By then the Support Group had also failed to hold its January quarterly meeting. As already mentioned, Ms Rankin did not raise this issue at the BICC meeting of 17 December 2007. When recalled to give evidence she accepted that the failure of the Support Group was something not raised by her because her

“focus was on single-system working and integration, but I can’t give a rationale as to why this didn’t concern me, why I didn’t raise it”.⁴³⁶

Mrs Catherine MacGillivray, Head of Nursing for Clyde Acute, was a member of the Support Group and knew that it had ceased to meet.⁴³⁷ For that reason she had monthly meetings with Mrs Murray from autumn 2007 in order to be aware of “issues that would have been of importance”.⁴³⁸ These meetings usually took place in the VOLH.⁴³⁹ Mrs MacGillivray had no recollection of CDI being discussed at these meetings,⁴⁴⁰ but said that, with the knowledge she now had, she should have been told about the incidence of CDI in the VOLH.⁴⁴¹

Mrs MacGillivray could not remember if she discussed the failure of the Support Group with Mrs den Herder. Mrs MacGillivray would certainly have had the opportunity to do so as she was a member of the Clyde Acute Management Team and Mrs den Herder chaired⁴⁴² their monthly meetings.⁴⁴³ There was no reason why she would not tell Mrs den Herder, particularly as she was meeting Mrs Murray on a regular basis because of the Support Group’s failure. Mrs MacGillivray’s

view was that Mrs den Herder “must have known”⁴⁴⁴ that the Support Group had ceased to meet.

Mrs den Herder maintains in her letter dated 13 September 2012 that she did not know the Support Group had ceased to meet.⁴⁴⁵ That was also her position when she gave evidence to the Internal Investigation.⁴⁴⁶ As Mrs MacGillivray pointed out, however, Mrs den Herder did receive the minutes of the Support Group,⁴⁴⁷ and it should therefore have become apparent to her that the Support Group had stopped functioning.

As a member of the Support Group, Mrs Murray was aware that it had stopped meeting. Mrs Murray was also present at the ACIC meeting of 27 November 2007,⁴⁴⁸ and under the heading “Committee Reports” Mrs Murray is noted as having delivered the exception report for the Clyde Sector. There is no indication there that the Support Group had failed to hold its October meeting, nor did Mrs Murray mention the failure of the Support Group to hold its quarterly January 2008 meeting in the report she made to the ACIC meeting of 29 January 2008. Mrs Murray said that she did not do anything to see if the Support Group could be reinstated. She thought that Ms Martin was considering ways in which it could be resurrected.⁴⁴⁹

It therefore appears that those who could have informed the ACIC directly of the failure of the Support Group, Ms Rankin and Mrs Murray, did not do so. The ACIC was accordingly unaware that the Support Group had ceased to function. By autumn 2007 Ms Martin had stopped attending meetings of the ACIC on the unfounded basis that she no longer had managerial responsibility for infection prevention and control. Furthermore, members of the BICC were also unaware of the position, with the exception of Ms Rankin, who although a member did not mention the failure to the committee.

434 [GGC02340006](#)

435 [TRA01000026](#)

436 [TRA01260025](#)

437 [TRA00900090](#); [TRA00900096](#)

438 [TRA00900090](#)

439 [TRA00900093](#)

440 [TRA00900094](#)

441 [TRA00900096](#)

442 [GGC04550001](#)

443 [TRA00900145](#); [TRA00900147](#)

444 [TRA00900103](#)

445 [INQ04960006](#)

446 [GOV00890121](#)

447 [TRA00900103](#)

448 [GGC02340001](#)

449 [TRA01010085](#)

The failures by Ms Martin, Ms Rankin and Mrs Murray to raise this issue were serious failures. Mrs den Herder too should at least have realised that the Support Group was not meeting.

15.10 Surveillance systems

Clinical Standards Board for Scotland

It was evident from the CSBS Standards⁴⁵⁰ and other guidance produced by the SEHD that the prevention and control of HAIs was to be a “high-profile priority issue”⁴⁵¹ for NHSScotland. The duty on Chief Executives was that of designating the prevention and control of infection as a “core part”⁴⁵² of clinical governance and patient safety.

The CSBS Standards required Boards to have in place surveillance systems so that they could respond rapidly to outbreaks and minimise the risk of infections.⁴⁵³ The “Proposed Infection Control Structure in NHSGGC”⁴⁵⁴ produced in December 2005 and revised in March and June 2006⁴⁵⁵ referred to the CSBS Standards and acknowledged the Chief Executive’s accountability for “successful prevention and control of infection”.⁴⁵⁶ It set out that the Chief Executive had designated the prevention and control of infection as a “core part”⁴⁵⁷ of the Board’s clinical governance and patient safety. The SEHD’s letter of 10 July 2006⁴⁵⁸ included instructions to Boards on the mandatory reporting of *C. difficile* toxin positive cases from 1 September 2006, and

the vital importance of an “integrated and validated system of surveillance”⁴⁵⁹ was re-emphasised.

Effective surveillance is a necessary prerequisite of a properly functioning infection prevention and control system. As Professor Duerden suggested, “If you can’t measure it you can’t manage it”.⁴⁶⁰ In setting out the criteria relevant to surveillance of infection the CSBS Standards provided as follows:

“Results of surveillance with interpretation and recommendations are routinely reported to the ICC, clinicians, nurses, managers at all levels”.⁴⁶¹

Here the reference to the ICC is a reference to an Infection Control Committee with an equivalent status to that of the BICC.⁴⁶²

The T-card system

The ICNs at the VOLH operated a T-card monitoring system. This system used a wall mounted rack where coloured cards were placed to provide a real-time picture for each ward of patients suffering from different HAIs. The cards for *C. difficile* toxin positive cases were yellow. When a patient tested positive for *C. difficile* toxin the patient’s details were written on a card, and further information such as the patient’s location, treatment and dates of positive results was generally added. Figure 15.4 is an example of a T-card for a patient who has tested positive for *C. difficile* toxin.

450 [GOV00160001](#)

451 [GOV00090031](#)

452 [GOV00380002](#)

453 [GOV00160044](#)

454 [GGC29210001](#)

455 [GGC29210005](#)

456 [GGC29210001](#)

457 [GGC29210001](#)

458 [GOV00430001](#)

459 [GOV00430003](#)

460 [TRA01050121](#)

461 [GOV00160045](#)

462 [GOV00160030-31](#)

Figure 15.4 A T-card

Patient name	(230)	Ward 3
Patient date of birth	11/11/11	
CHI number	CRN 030603	Admitted 4/2/08.
		antibiotics ✓
	Data positive 12/2/08	No PPI
	13/2/08. Unable to isolate, remains symptomatic. Reinforce SCIPs + enhanced cleaning. Asked JHO to prescribe Flagyl.	
	18/2/08. Asymptomatic overweekend Day 4 of Flagyl	
	21/2/08 Discharged home today.	

Mrs Perry said that she would have expected sufficient detail of the contact the ICNs had made with the clinical team to be recorded on the T-card. This would include any telephone call or ward visit. The card should also detail the patient's condition and what advice had been given to the ward by the ICN.

Having reviewed the T-cards available, Mrs Perry concluded that the ICNs failed to maintain records of *C. difficile* positive

patients to an appropriate standard.⁴⁶³ There were instances where information about the antibiotic treatment being given for CDI was not recorded. There were cases where it was apparent there was a delay in recording the reporting of a positive result for *C. difficile* toxin. On occasions this delay was in excess of three days. Gaps between entries (in one instance a gap of 20 days)⁴⁶⁴ revealed failures to record what reviews of patients, if any,

463 [TRA01040069](#)

464 [TRA00950076](#)

were being conducted by the ICNs. Reviews appeared infrequent even though there were patients who may have suffered relapses of the infection.⁴⁶⁵

The *C. difficile* Policy set out that a risk assessment of “a patient and environment”⁴⁶⁶ was to be undertaken by the Infection Control Team. Mrs Murray’s job description included responsibility for carrying out risk assessments for patients with CDI,⁴⁶⁷ and the job description for Mrs O’Neill included the following responsibility:

“Use risk assessment frameworks in order to assess situations and implement the most appropriate corrective action where required”.⁴⁶⁸

Mrs O’Neill said risk assessments were carried out that involved discussions with ward staff about the availability of isolation,⁴⁶⁹ but that no record was made of such risk assessments.⁴⁷⁰ Mrs Murray said that risk assessment would include looking at other risk factors such as a patient’s age, underlying medical conditions and antibiotic usage. She agreed that a record should have been kept but that that was not done.⁴⁷¹

Mrs O’Neill said that the failure to record ward visits or patient reviews did not mean that such visits or reviews had not taken place.⁴⁷² Her position was that the gaps were a sign of poor record keeping.⁴⁷³ Mrs Murray said that the documenting of a patient’s condition and progress was not as good as it should have been.⁴⁷⁴ When Ms Higgins took over as interim Lead Nurse for Control of Infection in April 2008 she considered that the information provided on the T-cards was “very sparse”.⁴⁷⁵ It was not what she expected to find, and she expressed her concerns to Mrs O’Neill at the time about the

lack of information provided.⁴⁷⁶ It is perfectly clear to the Inquiry that the record keeping by Mrs O’Neill and Mrs Murray was totally inadequate.

The T-cards as a surveillance system

Professor Duerden described the T-card system as a “rudimentary form of surveillance”.⁴⁷⁷ This was not to decry the importance of it as a system that could provide contemporary information on the number of *C. difficile* toxin positive cases. The system could provide the information to the ICNs that they had a number of cases at the same time in the same ward. It could also show information hospital-wide and reveal whether there was a similar problem in more than one ward.⁴⁷⁸ If there were two or three CDI cases in a particular ward at the same time there would be two or three yellow cards in a line to display that information. According to Professor Duerden, two, three or four yellow cards on the board at the same time for the same ward should have triggered a response from the ICNs.⁴⁷⁹ Dr Ahmed said that the T-card system was “more than adequate”⁴⁸⁰ to identify an outbreak, and Ms Higgins described the system as a “good visual aid”.⁴⁸¹ That was undoubtedly the case.

The Infection Control database

There has already been some reference to the Infection Control database (the database) in this Chapter as well as in Chapter 5. This was an Access database system used by the ICNs to record information on patients who tested positive for *C. difficile* toxin, including the patient’s name, where the patient was located in the hospital, the date of admission to the hospital, the date of the onset of symptoms and the date the patient tested positive for *C. difficile* toxin. There was also a record made of whether or not the CDI was hospital or community acquired. Figure 15.5 is an example of a patient card which has been extracted from the database.

465 [TRA01040066-67](#)
 466 [GGC00780255](#)
 467 [GGC00780254](#)
 468 [INQ00380008](#)
 469 [TRA00950014](#)
 470 [TRA00950014](#)
 471 [TRA01010048](#)
 472 [TRA00950076](#)
 473 [TRA00950076](#)
 474 [TRA01010055](#)
 475 [TRA00990017](#)

476 [TRA00990017-18](#)
 477 [TRA01050122-123](#)
 478 [TRA01050123](#)
 479 [TRA01050127-128](#)
 480 [TRA01130141](#)
 481 [TRA00990023](#)

Figure 15.5 A patient card

Patient Details			
ID:		CHI Number:	
Unit Number:		Surname:	
First Name:		Date of birth:	
Admission			
Hospital:	VOL	Ward:	15
Situated:	single room	Adm date:	23/11/2007
Hospital related or community acquired:	Hospital	State hospital:	VOL
Ward:	15	Onset symptoms:	04/12/2007
Date positive:	05/12/2007	Relapse/Reinfection/New:	
Risk Factors			
Any risk factors:	Yes	Age	☒
ITU	☐	Bowel history	☐
N.G. OR P.E.G.	☐	Bowel Surgery/procedure	☐
Immunosuppressed	☐	Enemas	☐
Recent antibiotics	☒	Constipation	☐
Medical Condition	☐	Laxatives	☐
Previous gastroenteritis	☐	Proton Pump Inhibitor	☐
Patients in Same Bedded Area	☐	Patients in Other Bedded Area	☐
Outcome			
Antibiotic treatment:	yes metronidazole	Deceased:	☐
Outcome:		Date of death:	

Mr Nixon's role from 2006 to December 2007 has been referred to in Section 15.2, and was described as one of "general administration"⁴⁸² in which he was based at the VOLH for three days a week. He could obtain information from the database that could be used by the ICNs, and in particular produced spreadsheets and quarterly reports providing data on patients with HAIs such as *C. difficile*. Mrs Murray was Mr Nixon's line manager.⁴⁸³ Mr Nixon did not input data to the database himself. All information was entered onto the database by Mrs Murray or Mrs O'Neill.⁴⁸⁴

Mr Nixon understood that the purpose of the quarterly reports was to identify historical trends,⁴⁸⁵ and was aware that the quarterly reports were taken to quarterly meetings.⁴⁸⁶ In addition to producing quarterly reports containing data on infection prevention and

control, Mr Nixon said that he produced graphs to show the nature of the trends. The material attached to the minute of a meeting of the Clyde Infection Control Support Group on 9 May 2007, for example, was produced by Mr Nixon for Mrs Murray.⁴⁸⁷ He would not seek to interpret trends, but simply produced data that were available on the database.⁴⁸⁸ Mr Nixon said he could have also used the material in the database to produce reports on a much more regular basis showing the number of patients who had tested positive for CDI in each ward.⁴⁸⁹ An alert system that would warn if a particular number of patients tested positive was not in place,⁴⁹⁰ but such a system could have been in place and Mr Nixon would have been able to do that if asked.⁴⁹¹

Knowledge of the database system

In addition to the local members of the

482 [TRA00920005-07](#)

483 [TRA00920009](#)

484 [TRA00920010](#)

485 [TRA00920012](#)

486 [TRA00920012](#)

487 [TRA00920012-13](#)

488 [TRA00920013](#)

489 [TRA00920016](#)

490 [TRA00920018](#)

491 [TRA00920018-19](#)

Infection Control Team, a number of others were also aware of the existence of the database. Dr Bagrade knew the database existed but thought wrongly that it was not in active use.⁴⁹² She was unaware that the ICNs continued to input data into the database.⁴⁹³ Mrs Murray had been told by Ms Rankin not to input data into the database because of the planned introduction of the SPC Charts system, but Mrs Murray continued to do so because she saw no “harm” in doing so.⁴⁹⁴

Ms Rankin was also aware of the existence of the database and knew that along with the T-cards it formed the local surveillance system.⁴⁹⁵ She could not understand why the ICNs continued to enter data into the database after Mr Nixon left in December 2007 as they could “get nothing back from”⁴⁹⁶ it, and indeed this appears to have been the position after Mr Nixon’s departure.

Ms Martin was aware of the existence of the database. In particular she knew that when Mr Nixon was in post he could provide statistical information on the wards at the VOLH.

Dr de Villiers was aware of the T-card system but did not appear particularly certain whether or not there was a database system in place.⁴⁹⁷ Dr Alison Claxton, Consultant Microbiologist at the RAH, had no knowledge of the database,⁴⁹⁸ and neither did Mr Kinloch.⁴⁹⁹

In her second police statement Dr Biggs said she was aware that the VOLH had a “form of surveillance” but that she was “not sure which method they were working”.⁵⁰⁰ This issue was not raised with Dr Biggs in the course of her interview with the Internal Investigation panel.⁵⁰¹ Dr Biggs’ apparent ignorance of the surveillance arrangements is illustrative of the lack of interest she had in infection prevention and control at the VOLH.

Neither Mr Walsh nor Ms McNamee was aware of the database. Although they could have been made aware of its existence during the investigation carried out by the Outbreak Control Team, it appears they were not told.⁵⁰² In fact, the Outbreak Control Team Report does not mention the database system.

Ms Higgins’ perspective

After she took on the post of interim Lead Nurse in April 2008, Ms Higgins did discover the existence of the database as part of her fact finding exercise to see whether there was anything she should be concerned about.⁵⁰³ She was surprised to find that the Infection Control Team at the VOLH appeared to have “a database full of information” but that there were no reports available that she could look at to see if there were any issues of concern.⁵⁰⁴

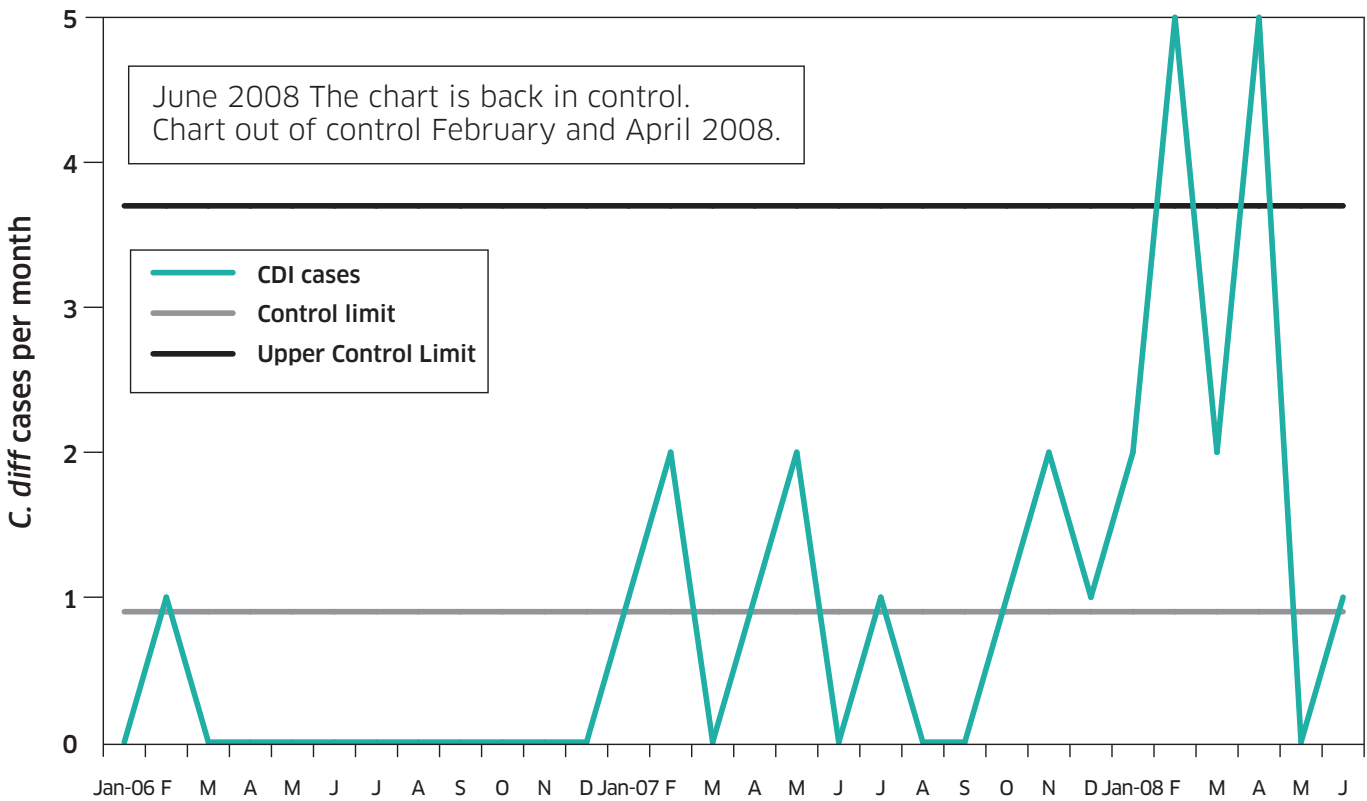
Ms Higgins was surprised that Mrs McIntyre was unable to produce simple reports from the database because she did not have the expertise to do so at the time.⁵⁰⁵ Her view was that SPC Charts could have been produced from the database prior to May 2008.⁵⁰⁶ What Ms Higgins meant by that was that charts providing information on historical trends could have been constructed from the information contained on the database, and those charts would have contained similar information to that provided on SPC Charts.⁵⁰⁷

Ms Higgins was able to construct a chart from the information on the database in May 2008 that revealed that there was a problem with CDI in ward 6.⁵⁰⁸ That chart is not available to the Inquiry, but Ms Higgins also produced a chart for the period to June 2008,⁵⁰⁹ which is reproduced in Figure 15.6 and represents the position in ward 6 up to June 2008. The points on that chart representing the position in ward 6 in February and April 2008 would have been the same on the original chart produced by Mrs Higgins.

492 [TRA01020095-96](#)
493 [TRA01140024](#)
494 [TRA01010061](#)
495 [TRA00990170](#)
496 [TRA01260033](#)
497 [TRA00840092-95](#)
498 [TRA01220071](#)
499 [WTS02170012](#)
500 [SPF01470003](#)
501 [GOV00890099-101](#)

502 [TRA01200097](#); [TRA012000102-103](#); [TRA01210054-55](#)
503 [TRA00990018-19](#)
504 [TRA00990019](#)
505 [TRA00990019](#)
506 [TRA00990093-95](#)
507 [TRA00990094-96](#)
508 [TRA00990072-73](#)
509 [TRA00990072-73](#); [GGC16630014](#)

Figure 15.6 New cases of CDI from 2006 to 2008 on ward 6



It is important to note that an SPC Chart is retrospective. It cannot be used to detect an outbreak in real time.

Adequacy of the T-card and the database

The systems available at the VOLH were perfectly adequate for the ICNs to discover the existence of potential outbreaks of CDI.⁵¹⁰ There was a combination of systems which ought to have alerted them to the existence of CDI patients in the VOLH who appeared to be linked closely in time and in place, and which should have initiated outbreak procedures.

15.11 Failure to identify outbreaks

Local failures

The failures at local level to appreciate the existence of a persisting CDI problem at the VOLH were serious and had a profound effect on patient care. In Chapter 5 points in time have been identified at which it was apparent in different wards that there were patients suffering from CDI who were linked in time and place. According to Dr Ahmed:

“Two cases of *C. difficile* linked in time and place is an outbreak, regardless whether you are waiting for the typing”.⁵¹¹

Opportunity after opportunity was missed to carry out a proper investigation. There clearly were outbreaks. And if an outbreak had been declared the appropriate reporting steps and procedures envisaged by the Outbreak Policies could have been taken.

510 [TRA01050124](#); [TRA01060017-18](#); [TRA01040053-54](#)

511 [TRA01130061](#)

The policy of infection control being everyone's business was not practised in the VOLH. The medical staff seemed oblivious to the persisting CDI problem. The attention paid to *C. difficile* toxin positive cases by nursing staff was influenced by the ICNs. The attitude adopted by the ICNs, and Mrs Murray in particular, is one that the Inquiry has difficulty in understanding. Professor Duerden described Mrs Murray's failure to respond to the *C. difficile* toxin positive cases as an "error of judgement".⁵¹² Mr Divers quite rightly could not understand how despite:

"the evidence in front of their eyes (they) somehow managed to conclude that there wasn't an outbreak".⁵¹³

In addition to the local failures discussed in this Section, there was a missed opportunity by others to recognise that there was a CDI problem at the VOLH.

An early missed opportunity

As mentioned earlier in this Chapter, information on the increased rates of CDI in the VOLH in April 2007, "particularly on one ward"⁵¹⁴ was available to the Support Group at its meeting of 9 May 2007 when Dr Biggs presented the report in the absence of Mrs Murray. Two extracts from that report are set out in Table 15.3⁵¹⁵ and Figure 15.7.⁵¹⁶

Table 15.3 discloses that in April 2007 there were 22 positive results for CDI in the VOLH, nearly half the total amount of infections recorded. Another source of evidence indicates that four of those CDI patients tested positive in ward 14 in the week beginning 13 April 2007.⁵¹⁷

Table 15.3 NHSGGC Infection Control report – number of infections at the VOLH

Lab Findings	Week ending				Grand Total
	06/04/07	13/04/07	20/04/07	27/04/07	
<i>Chlamydia trachomatis</i>	-	-	1	2	3
<i>Clostridium difficile</i> Toxin AB	6	6	8	2	22
<i>E.coli</i>	-	-	-	1	1
Group A Streptococcus	-	1	-	1	2
Group C Streptococcus	-	-	1	-	1
Group G Streptococcus	-	-	-	2	2
<i>Haemophilus influenzae</i>	-	-	-	1	1
MRSA	3	3	-	5	11
<i>Staphylococcus aureus</i>	1	-	-	1	2
Total	10	10	10	15	45

512 [TRA01050128](#)
513 [TRA01250078](#)

514 [GGC13260020](#)
515 [GGC13260019](#)
516 [GGC13260018](#)
517 [INQ02580001](#)

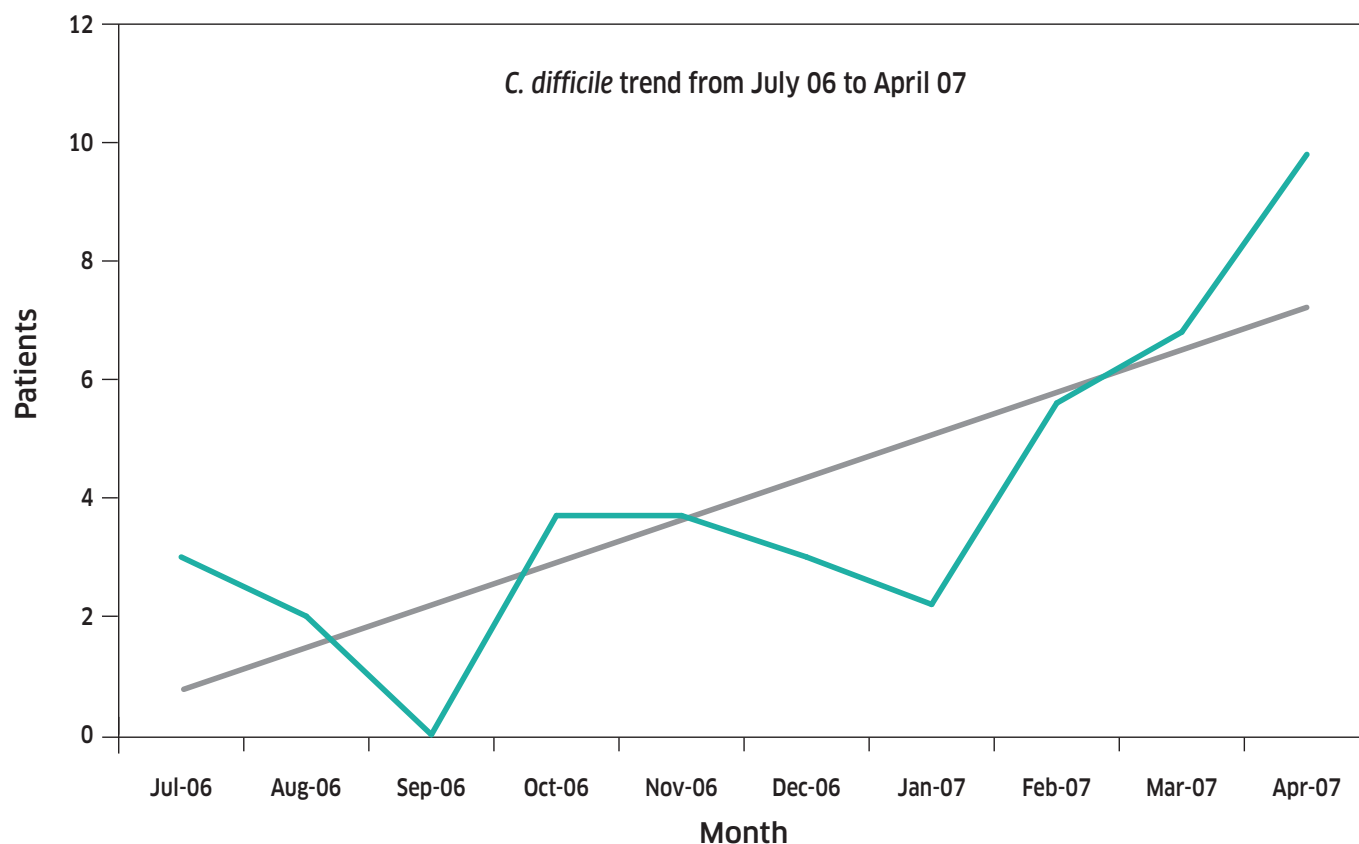
Figure 15.7 NHSGGC Infection Control report – *C. difficile* trend at the VOLH

Figure 15.7 shows the rising trend of CDI in the VOLH. This material was produced by Mr Nixon from information on the database,⁵¹⁸ and again this information was contained in the report presented by Dr Biggs at the Support Group meeting of 9 May 2007. That meeting was attended by Ms Martin, Ms Rankin, Mr Walsh, Mrs MacGillivray and of course the Chair, Dr Biggs.⁵¹⁹

Mr Divers was of the view that because Mr Walsh had not yet taken up his post of Infection Control Manager he did not have a direct responsibility to react to the CDI rates reported.⁵²⁰ That seems a valid point. Mr Walsh did seem to recall some discussion in relation to the VOLH report on increases in *C. difficile* toxin positive rates, but his expectation was that the issue would be investigated by the local Infection Control Team.⁵²¹

Mr Divers said that Ms Martin, Ms Rankin and Mrs MacGillivray had greater responsibility than Mr Walsh to act upon the concerns raised by the *C. difficile* toxin positive rates reported.⁵²² Dr Ahmed was of the view that there should have been a discussion and efforts made to find an explanation for the increase in *C. difficile* toxin positive cases.⁵²³ If there was no proper explanation and it was thought that there might be an outbreak he would expect “them to escalate further up”.⁵²⁴ As Dr Ahmed explained, the reason the Support Group was established was to monitor what was going on in that sector, if necessary by investigation and taking appropriate action.⁵²⁵

Had the Support Group responded to the VOLH report presented at the meeting on 9 May 2007, an investigation would have

518 [TRA00920012-14](#)

519 [GGC13260006](#)

520 [TRA01250113-115](#)

521 [TRA01200122-123](#)

522 [TRA01250113](#)

523 [TRA01130049-50](#)

524 [TRA01130050](#)

525 [TRA01130052](#)

disclosed the existence of potential outbreaks and the failure to report in terms of the Outbreak Policy.

Chapter 5 sets out the information the Inquiry has extracted from a number of sources on patients who tested positive for *C. difficile* toxin in the VOLH. This includes April 2007, the period covered by the report to the Support Group on 9 May 2007. Table 5.4 in Chapter 5 identifies four patients who tested positive for *C. difficile* toxin in ward 14 between 13 and 17 April 2007. Table 5.8 sets out CDI patients on ward 6 from February to April 2007. It identifies three patients who tested positive for *C. difficile* toxin between 5 and 13 April 2007. Earlier in March 2007 three patients tested positive for *C. difficile* toxin in ward F within a period of about three days. This is set out in Table 5.6. These are all instances of two or more CDI patients who were closely connected in place and time, and should have initiated outbreak procedures.

Ms Rankin said in evidence that “with hindsight”⁵²⁶ she should have enquired about the information provided to the Support Group meeting. Despite her responsibility for infection control, Ms Rankin did not consider any further investigation because from her perspective it was Dr Biggs, as the ICD and the person who had tendered the VOLH report, who had a direct responsibility for infection control at the VOLH. As Ms Rankin explained in evidence, the CDI rates at the VOLH were not raised as a particular concern with her, either by Mrs Murray or Dr Biggs.⁵²⁷ Moreover, Ms Rankin proceeded on the basis that there would have been an investigation into each case to see if there was a link.⁵²⁸ It was unfortunate that Ms Rankin did not respond in a more proactive way at that time, but it is at least understandable why she did not cause further enquiries to be made in such circumstances.

Mr Divers also mentioned Mrs MacGillivray and Ms Martin as having some responsibility to respond to concerns raised by the CDI rates reported. Mrs MacGillivray had held the post of Head of Nursing for the Clyde

Acute Directorate since 2006,⁵²⁹ and her line manager was Mrs den Herder. She had no recollection of the response to the CDI rates at the meeting of 9 May 2007⁵³⁰ but she would have expected the situation to be monitored. It would be unreasonable to be critical of Mrs MacGillivray for failing to respond more actively to the VOLH report. Ms Martin could be said to have had more direct responsibility than Mrs MacGillivray as Dr Biggs’ line manager, but as the Report had been tendered by Dr Biggs in her capacity as the ICD the Inquiry is not inclined to criticise Ms Martin for failing to take a more proactive stance in response to the contents of the report.

Dr Biggs should have conducted an investigation into the CDI information she presented in the report to the Support Group meeting on 9 May 2007. That would have disclosed the real likelihood of outbreaks at the VOLH that the local Infection Control Nurses had not properly investigated. Her failure to respond to the information available to her at that time was a significant one and professionally unacceptable.

Reasons for local failures

In Chapter 5 a number of occasions have been identified in the period from 1 January 2007 to 1 June 2008 when it was likely that there were CDI outbreaks in different wards at the VOLH. The intention now is to consider some aspects of practice in the VOLH and examine why the local ICNs did not respond appropriately by invoking the provisions of the NHSGGC Outbreak Policy.

Knowledge of outbreaks – nursing staff

The evidence from the senior nurses on the presence of CDI on the wards was somewhat mixed. Sister Lesley Fox, SCN for ward 6, said that it did not occur to her at any time that there could have been an outbreak in ward 6 because the cases could be explained.⁵³¹ Her evidence was that she had been told by Mrs O’Neill that the explanation lay in the fact that the patients had been given antibiotics.⁵³² Ms Isobel Law, the VOLH Bed

526 [TRA01260027](#)

527 [TRA01000014](#)

528 [TRA01000018](#)

529 [TRA00900074](#)

530 [TRA00900113-114](#)

531 [TRA00310094](#)

532 [TRA00340110-111](#)

Manager, raised the number of cases with Mrs Murray in 2007 and was reassured that there was not a problem with cross infection.⁵³³ Over the period from December 2007 to June 2008 Sister Anne Madden, SCN for ward 15, said that she did not think that she had given the presence of CDI in ward 15 a great deal of consideration.⁵³⁴

Mrs Margaret Kelso, a staff nurse in ward F, was concerned in January or February 2008 about the number of patients suffering from CDI, and was prompted to consult the infection control manual to check the definition of an outbreak. She thought the ward should be closed, and spoke to Sister Laura Gargaro, SCN for ward F, about her concerns. She assumed that the matter would be addressed at the bed meetings. Her evidence was that there was general concern among members of the nursing staff, and that there was also a feeling that patients were being moved into the ward when there were patients in the ward suffering from CDI.⁵³⁵

Sister Gargaro said that she did recognise, particularly in January 2008, that there was a level of CDI cases on ward F which exceeded the gastro-intestinal definition of an outbreak.⁵³⁶ She discussed the position with Mrs O'Neill when there were already three symptomatic patients in the ward and a fourth patient became symptomatic. Mrs O'Neill offered advice on cohorting patients. Sister Gargaro said in evidence that she asked Mrs O'Neill "should we not be closing?"⁵³⁷ but according to Sister Gargaro Mrs O'Neill's response was that the cases could be explained.⁵³⁸ Again the explanation given was that the patients had been on antibiotics "particularly ones that are C.diffogenic".⁵³⁹ Mrs O'Neill's final position in evidence was that she did not provide this explanation,⁵⁴⁰ but the antibiotic explanation was one advanced by Mrs Murray in evidence, and that does lend some credence to Sister Gargaro's evidence on this issue.

Knowledge of outbreaks – medical staff

The infection prevention and control policies covered in Section 15.4 apply to all healthcare workers. The Outbreak Policy states that "This policy applies to all staff employed by NHS Greater Glasgow and Clyde".⁵⁴¹ It goes on to specify that healthcare workers must follow the policy and must also report to the Infection Control Team when they suspect there may be an outbreak.⁵⁴² As noted in Section 15.4, only one doctor had some understanding of what would constitute an outbreak. None of the doctors who gave evidence considered there to be a particular problem with CDI at the time, and since they lacked knowledge of what constituted an outbreak it is hardly surprising that none of them gave much consideration to the prevalence of CDI.

Knowledge of outbreaks – Infection Control Nurses

The Inquiry has great difficulty in understanding why the ICNs did not appreciate the nature and extent of the CDI problem at the VOLH. From June 2007 Mrs O'Neill was the main presence at the VOLH, a factor that has already been commented upon in Section 15.2, but the CDI problem had developed before June 2007 at a time when Mrs Murray was the Senior ICN.

Mrs O'Neill's evidence – loose stools

Mrs O'Neill's evidence was that there was no regular practice prior to June 2008 of the ICNs being informed of patients who developed loose stools or who had samples taken for analysis.⁵⁴³ This contradicted the evidence of some nurses that the ICN would be informed of every case.⁵⁴⁴ The Inquiry sees no reason not to accept Mrs O'Neill's evidence on this issue. She did explain that the practice changed after June 2008.

533 [TRA00890024](#)
 534 [TRA00390005-06](#)
 535 [WTS02190004-07](#)
 536 [TRA00410100](#)
 537 [TRA00410102](#)
 538 [TRA00410102-104](#)
 539 [TRA00410104-105](#)
 540 [TRA00950178-179](#)

541 [GGC00780145](#)
 542 [GGC00780147](#)
 543 [TRA00950050-51](#)
 544 [TRA00950056](#)

Mrs O'Neill's position on outbreak definition

Mrs O'Neill was aware of an increase in *C. difficile* toxin positive patients in the period up to April 2007, but she did not consider at the time that there was a particular problem.⁵⁴⁵ Mrs O'Neill was aware that two or more linked cases of CDI could constitute an outbreak.⁵⁴⁶

Mrs O'Neill's position on CDI on the wards

The position in ward 14 as set out in Table 15.4 suggests that in April 2007 four patients were positive for *C. difficile* toxin in that ward and closely linked in time. This was considered by Mrs O'Neill in oral evidence.⁵⁴⁷

Table 15.4 *C. difficile* toxin positive cases in ward 14 in April 2007

	Admission to VOLH	Admission to ward 14	Patient records		Lab report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 1	19/03/07 to ward 3	28/03/07	unknown	13/04/07	13/04/07	17/04/07
Patient 2	12/01/07 from RAH to ward 5	15/01/07	unknown	13/04/07	13/04/07	17/04/07
Patient 3	10/04/07 from Western Infirmary to ward 14	10/04/07	unknown	16/04/07	14/04/07	17/04/07
Patient 4	21/03/07 to ward 6	13/04/07	16/04/07	17/04/07	16/04/07	19/04/07

Mrs O'Neill said that in this situation there would be a row of yellow T-cards representing the positive patients visible on the infection control board.⁵⁴⁸ She said that this picture could represent an outbreak, but was not able to explain why that possibility was not recognised at the time.⁵⁴⁹ She was

not aware of there being a reluctance to declare an outbreak.⁵⁵⁰

The position in ward F in March 2007 as set out in Table 15.5 was also explored in evidence with Mrs O'Neill.

545 [TRA00950124](#)

546 [TRA00950033](#)

548 [TRA00950124-125](#)

549 [TRA00950124](#)

547 [TRA00950123](#)

550 [TRA00950125-126](#)

Table 15.5 Patients who tested *C. difficile* toxin positive on ward F in March 2007

	Admission to VOLH	Admission to ward F	Patient records		Lab report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 7	20/02/07 to ward 3	02/03/07	unknown	18/03/07	18/03/07	21/03/07
Patient 8	09/02/07 to ward 6	20/02/07	26/03/07	27/03/07	26/03/07	28/03/07
Patient 9	19/01/07 from RAH to ward 6	26/01/07	29/03/07	29/03/07	29/03/07	02/04/07
Patient 10	unknown	21/02/07	29/03/07	29/03/07	29/03/07	02/04/07

Again she accepted that there would be four yellow T-cards in a row for ward F on the infection control board.⁵⁵¹ When asked why this presentation on the board did not provoke a response, Mrs O'Neill said she did raise her concerns about the general increase in CDI with Mrs Murray.⁵⁵² It was this concern that prompted the re-issue of the "Bug of the Month" circular.⁵⁵³ What Mrs O'Neill could not explain was why an outbreak of CDI was not considered at the time.⁵⁵⁴ This presentation for ward F was at a time when there was a similar presentation for ward 14.⁵⁵⁵

Mrs O'Neill's discussion with Mrs Murray

Mrs O'Neill acknowledged that it was a failure on her part not to appreciate at the time that there might have been an outbreak of CDI. Her evidence was that she had raised the issue with Mrs Murray, her line manager, and that "it was for her to deal with that".⁵⁵⁶ Mrs O'Neill expected Mrs Murray to contact the Infection Control Doctor but she did not suggest that to her.⁵⁵⁷ Even though it seems that Mrs O'Neill did think that there may have been an outbreak, she did not use the

term "outbreak"⁵⁵⁸ in her discussion with Mrs Murray.

When asked to consider the prevalence of *C. difficile* toxin positive patients in December 2007, Mrs O'Neill could offer no explanation of why an outbreak was not considered, despite it being apparent that there were infected patients closely connected in time and place.⁵⁵⁹

Mrs O'Neill again raised her "concerns" with Mrs Murray in January 2008,⁵⁶⁰ at a time when there were a number of *C. difficile* toxin positive patients in ward F and there would have been four yellow T-cards in a row allocated to that ward.⁵⁶¹ Mrs Murray told Mrs O'Neill that she would contact Dr Biggs. According to Mrs O'Neill she "just raised (her) concerns again that we had an increased number of C.diff in the hospital",⁵⁶² and said that she "probably pointed to the board",⁵⁶³ by which she meant the infection control board that displayed the yellow T-cards. Mrs O'Neill's understanding was that Mrs Murray was going to inform Dr Biggs of the increase in numbers of *C. difficile* toxin positive

551 [TRA00950130](#)
 552 [TRA00950130-131](#)
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 557 [TRA00950133](#)

558 [TRA00950130-131](#)
 559 [TRA00950142-144](#)
 560 [TRA00950148-149](#)
 561 [TRA00950149](#)
 562 [TRA00950149](#)
 563 [TRA00950150](#)

patients.⁵⁶⁴ Although Mrs O'Neill did consider that there was an outbreak of CDI, again, somewhat surprisingly, the term "outbreak" was not used in her discussions with Mrs Murray.⁵⁶⁵ She expected the situation to be investigated by the "senior members of the team".⁵⁶⁶ She was expecting an "answer"⁵⁶⁷ but none was forthcoming.⁵⁶⁸ Mrs O'Neill did not raise the issue again, but could not explain why she did not do so.⁵⁶⁹ The following exchange occurred in the course of her evidence:

"Q. Do you, yourself, see, at that time, you had a duty to make the point that there was an outbreak here?

A. No, because I felt I had dealt with it by informing my senior".⁵⁷⁰

In a similar way, Mrs O'Neill was shown a timeline covering in particular the period January to February 2008.⁵⁷¹ This had been prepared by Mrs Murray in response to a complaint that a patient had been admitted to a bay in ward F when there may have been a patient or patients suffering from CDI present. Mrs O'Neill did consider that this was evidence of an outbreak, but she did not raise that with Mrs Murray because she felt she "had raised it with her before".⁵⁷² Nor did she raise the possibility of an outbreak with anyone else.⁵⁷³

Mrs O'Neill's relationship with Dr Bagrade

When Dr Bagrade visited the VOLH as the new ICD in February 2008 Mrs O'Neill did not mention her concerns about the numbers of CDI patients because she assumed "Mrs Murray would have that discussion with her".⁵⁷⁴ After Mrs Murray retired in March 2008 there were further instances of patients suffering from CDI closely associated in time and place, particularly in ward 6, and Mrs O'Neill agreed that it would have been

incumbent on her to consider whether there was an outbreak. She said initially that she did not know why she did not declare an outbreak at that time,⁵⁷⁵ but then went on to say that the situation was the same as previously and she assumed that the ICD "was aware of that situation and nothing happened, and I felt this was the same situation".⁵⁷⁶

Mrs O'Neill's relationship with ward sisters

Mrs O'Neill had no recollection of discussions with ward sisters in which she suggested that CDI patient numbers could be explained by antibiotics.⁵⁷⁷ Indeed her position was ultimately that she did not provide such an explanation.⁵⁷⁸ Nevertheless, Mrs Murray's concentration on the effect of antibiotics on patients whom she regarded as carriers does lend support to the ward sisters' recollections.

Mrs O'Neill's position

The Inquiry has given serious consideration to whether Mrs O'Neill should be criticised for failing to recognise the likelihood of outbreaks of CDI. No doubt a competent infection control nurse would have realised the real nature of the CDI problem and acted so as to ensure that the problem was recognised and addressed. Mrs O'Neill, however, was in a rather unusual position. She had no qualification in infection prevention and control and there was no prospect of her obtaining such a qualification. There are mitigating circumstances to be found in the lack of ICD leadership and lack of adequate supervision. The Inquiry accepts too that at least she did raise the issue of CDI numbers with Mrs Murray. The Inquiry also recognises Mrs Murray's inability to recognise cross infection, as discussed below. In the circumstances the Inquiry does not criticise Mrs O'Neill.

Awareness of CDI cases in ward 6

A number of people had been made aware that there were patients who tested positive for *C. difficile* toxin in ward 6 in December

564 [TRA00950150](#)
 565 [TRA00950150](#)
 566 [TRA00950150-151](#)
 567 [TRA00950151](#)
 568 [TRA00950151](#)
 569 [TRA00950151](#)
 570 [TRA00950152](#)
 571 [SPF00990002-03](#)
 572 [TRA00960047-48](#)
 573 [TRA00960048](#)
 574 [TRA00950156](#)

575 [TRA00950167](#)
 576 [TRA00950170](#)
 577 [TRA00950177-178](#)
 578 [TRA00950178-180](#)

2007. By email dated 17 December 2007 Mrs Murray notified Mrs McNamee, Ms Martin and Ms Rankin that there were then three CDI patients on ward 6. In her evidence to the Inquiry Ms Rankin could not recall if she responded to that email, but her normal

practice would have been to investigate and call Mrs Murray to discuss individual cases.⁵⁷⁹ Table 15.6 sets out those three patients along with their CDI testing data as established by the Inquiry.

Table 15.6 CDI patients on ward 6 in December 2007

	Admission to VOLH	Admission to ward 6	Patient records		Lab report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Mary Burns	05/12/07 from RAH	05/12/07	05/12/07	06/12/07	05/12/07	07/12/07
Margaret Dalton	18/11/07 to ward 4 (Moved to HDU 19/11/07)	03/12/07	17/12/07	17/12/07	17/12/07	19/12/07
Patient B	07/12/07 to ward 6	07/12/07	15/12/07	17/12/07	15/12/07	17/12/07

In preparation for giving her evidence at the Inquiry's public hearing⁵⁸⁰ Ms Rankin had reviewed the three cases; Mary Burns, Margaret Dalton and Patient B. From the information she took from both the Infection Control Cards and the database, she did not consider the patients to be linked in time and place.⁵⁸¹ Her explanation was that one patient had tested positive prior to admission and another had tested positive the day after admission, so that neither result could be attributed to ward 6. In coming to that conclusion she applied the 48 hour conventional test discussed in Chapter 3 to define a hospital acquired infection.

An analysis of the records discloses, however, that Margaret Dalton and Patient B had been admitted to ward 6 more than 48 hours before they became symptomatic for *C. difficile*. The correct admission date has been omitted from the Infection Control

Card for Margaret Dalton, and incorrectly entered in the Infection Control database as 17 December 2007.⁵⁸² The correct admission date to the VOLH was 18 November 2007, with movement to ward 6 on 3 December 2007. On the basis of that information the criteria for an outbreak were indeed met. Ms Rankin did accept that in any event, having regard to the "increased burden"⁵⁸³ of CDI on the ward, some epidemiological investigation should have been carried out to see where patients had been previously in order to ascertain the source of the infection.⁵⁸⁴

Ms McNamee could not remember seeing the email of 17 December 2007. Her evidence was that she would have expected Ms Rankin to deal with it and that she would only have become involved if an Outbreak Control

580 [TRA01000029](#)
581 [TRA01000029-30](#)

579 [TRA01000029](#)
582 [INQ02970062](#)
583 [TRA01000032](#)
584 [TRA01000032-33](#)

Team was to be convened.⁵⁸⁵ Ms Martin had no recollection of receiving the email of 17 December 2007, although she did say it was the kind of email she would receive as General Manager.⁵⁸⁶

Mrs Murray's rationale

Mrs Murray knew that in terms of the Outbreak Policy an outbreak could include two or more linked cases of the same illness associated in place and time.⁵⁸⁷ She knew that if she did think there might be an outbreak certain procedures had to be followed.⁵⁸⁸ In the period from 1 January 2007 through to her retirement in March 2008, Mrs Murray was also aware that there were *C. difficile* toxin positive patients in different wards at the VOLH. In evidence she was asked to consider a number of occasions when, as discussed in Chapter 5, it was evident that there were patients suffering from CDI in different wards in the VOLH closely connected in time. Her position was that at the time she concluded that even if there were a number of CDI patients in the same ward at about the same time they were not linked.⁵⁸⁹

Mrs Murray's position on CDI on certain wards

The position in ward 14 in April 2007 set out earlier in Table 15.4 was put to Mrs Murray. As already mentioned, the Table shows four

patients tested positive for *C. difficile* toxin in that ward closely linked in time. In the database the CDI was described as "hospital related" for each of these four patients.⁵⁹⁰

Mrs Murray said that she thought that she was aware at that time of this number of patients testing positive for *C. difficile* toxin in ward 14.⁵⁹¹ Her evidence was that she excluded cross-infection because there were other risk factors that could lead to patients developing *C. difficile* diarrhoea. She summarised her position in the following way:

"That was our assumption at the time, yes, that there wasn't cross infection; that people were doing what they should have been doing and there were perhaps other reasons for the patients developing *C.diff*".⁵⁹²

That such an assumption should be made in the face of the evidence is difficult to understand. What is more, Mrs Murray had no recollection of discussing these particular patients with Dr Biggs at this particular time.⁵⁹³

Under reference to the timeline⁵⁹⁴ prepared by the Inquiry, Mrs Murray was also asked about the position in ward 3 in June 2007. Table 15.7 sets out the position in ward 3 at that time.

585 [TRA01210040](#)
586 [TRA01160089-90](#)
587 [TRA01010039-40](#)
588 [TRA01010040](#)
589 [TRA01010092](#)

590 [INQ02970123](#); [INQ02970022](#); [INQ02970124](#);
[INQ02970024](#)
591 [TRA01010091](#)
592 [TRA01010095](#)
593 [TRA01010096-97](#)
594 [INQ02910001](#)

Table 15.7 CDI patients on ward 3 in June 2007

	Admission to VOLH	Admission to ward 3	Patient records		Lab report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 14	01/06/07 to ward 3 (Previously discharged 15/05/07)	01/06/07	unknown	unknown	02/06/07	06/06/07
Patient 15	17/05/07 to ward 4	19/05/07	unknown	08/06/07	07/06/07	12/06/07
Patient 16	21/05/07 to ward 3	21/05/07	unknown	14/06/07	13/06/07	15/06/07
Patient 17	11/06/07 to ward 3 (Previously discharged 08/06/07)	11/06/07	unknown	unknown	12/06/07	15/06/07

Mrs Murray accepted that there were probably three patients testing positive for *C. difficile* toxin at about the same time but “for the same reasons” did not think that there was a link.⁵⁹⁵

Similarly, Mrs Murray was asked to consider the position in ward 6.⁵⁹⁶ Table 15.8 sets out the position from February to April 2007.

595 [TRA01010103](#)

596 [TRA01010104-108](#)

Table 15.8 Patients who tested *C. difficile* toxin positive on ward 6 from February to April 2007

	Admission to VOLH	Admission to ward 6	Patient records		Lab report sheets	
			Date specimen collected	Ward aware	Date specimen collected	Report date
Patient 18	08/02/07 to ward 6 (Previously discharged 01/02/07)	08/02/07	unknown	15/02/07	14/02/07	17/02/07
Patient 19	05/02/07 from RAH to ward 6	05/02/07	unknown	16/02/07	15/02/07	19/02/07
Patient 20	07/02/07 from RAH to ward 6	07/02/07	unknown	unknown	21/02/07	27/02/07
Patient 21	26/02/07 from RAH to ward 6	26/02/07	unknown	01/03/07	28/02/07	05/03/07
Patient 22	17/02/07 to ward 4	21/02/07	unknown	unknown	28/02/07	02/03/07 (Transferred to RAH 01/03/07)
Patient 18	08/02/07 to ward 6 (Previously discharged 01/02/07)	08/02/07	12/03/07	13/03/07	12/03/07	16/03/07
Patient 18	08/02/07 to ward 6. (Moved to ward 15 13/03/07)	28/03/07	29/03/07	unknown	29/03/07	03/04/07
Patient 23	03/04/07 from RAH to ward 6	03/04/07	04/04/07	05/04/07	04/04/07	09/04/07
Patient 24	08/04/07 to ward 6	08/04/07	unknown	10/04/07	08/04/07	11/04/07
Patient 25	21/03/07 to HDU	24/03/07	13/04/07	13/04/07	13/04/07	17/04/07

Mrs Murray conceded that there were probably more than two patients positive in that ward at the same time, and said that she would have considered an outbreak at this point.⁵⁹⁷ Mrs Murray's evidence on that period, and indeed on other periods, was that she would always consider the possibility of an outbreak but that the possibility of outbreaks was discounted. Although throughout 2007 and into 2008 there were what appeared to be clusters of CDI patients in different wards, at no stage did she conclude that there was an outbreak.⁵⁹⁸ Again, this approach is simply incomprehensible.

Mrs Murray's contact with Dr Biggs

Mrs McIntyre did recall an occasion when she mentioned to Mrs Murray that there were "an awful lot of yellow cards coming in to be filed".⁵⁹⁹ This conversation took place around January or February 2008.⁶⁰⁰ According to Mrs McIntyre, Mrs Murray responded by saying that there was a "little problem"⁶⁰¹ and that she had contacted the ICD. Mrs McIntyre did not know who the ICD was,⁶⁰² and had never seen Dr Biggs at the VOLH.

Mention has already been made of Mrs O'Neill's expressions of concern to Mrs Murray about increases in *C. difficile* toxin positive cases in January 2008,⁶⁰³ and of Mrs Murray's response that she would contact Dr Biggs.⁶⁰⁴ This may have been at around the same time Mrs McIntyre raised the number of yellow cards discussed in the previous paragraph, when the focus was on ward F. The evidence of Mrs O'Neill and Mrs McIntyre on this broadly reflects Mrs Murray's evidence that she did contact Dr Biggs about the number of cases in ward F.⁶⁰⁵ The context, however, according to Mrs Murray, was not that of suspecting an outbreak but rather of concern over antibiotic prescribing. In the course of that conversation Mrs Murray told Dr Biggs that there were a number of *C. difficile* toxin positive patients in the same ward, and she

may have told Dr Biggs there were four cases.⁶⁰⁶ Mrs Murray explained that Dr Biggs' response was "Well, what do you want me to do about it?"⁶⁰⁷ It is to be noted that Dr Biggs told the Internal Investigation carried out by NHSGGC after the emergence of the *C. difficile* problem that she had not been aware of *C. difficile* issues at the VOLH. She did say that she had some contact with Mrs Murray in March 2007 and told that there was a "slight increase".⁶⁰⁸ That appears to have been a different occasion to the one described by Mrs Murray in early 2008. The Inquiry accepts that Mrs Murray did contact Dr Biggs in early 2008 and that Dr Biggs responded in the manner described by Mrs Murray.

Dr Biggs' response was one that sums up her attitude to her responsibilities as ICD for the VOLH. An ICD acting appropriately would have investigated the situation. Mrs Murray had no recollection of contacting Dr Biggs about the numbers of *C. difficile* toxin positive patients on any other occasion.

Mrs Murray's email of 7 February 2008

On 7 February 2008 Mrs Murray sent an email⁶⁰⁹ to Mrs Ann Lang, Ms Rankin's secretary, with information on the number of *C. difficile* toxin positive patients at the VOLH in the period January 2006 to December 2007,⁶¹⁰ revealing a significant increase in the numbers in 2007 as compared to 2006. The information was being submitted for the purpose of collecting data for the SPC Charts, and Ms Rankin's secretary was not expected to make any clinical assessment of the data.⁶¹¹ Ms Rankin said that she did not see that information at the time, and that if she had been told about this she would have been concerned and would have contacted the Infection Control Team to clarify the position.⁶¹² That is not the point; what is significant about this evidence is that Mrs Murray was supplying this information to Ms Rankin's secretary on the basis that all the cases were cases of hospital associated CDI.

597 [TRA01010107](#)
598 [TRA01010116-117](#)

599 [TRA00920041](#)

600 [TRA00920043](#)

601 [TRA00920042](#)

602 [TRA00920042](#)

603 [TRA00950149](#)

604 [TRA00950150](#)

605 [TRA01010112-113](#); [TRA01010118-119](#)

606 [TRA01010119](#)

607 [TRA01010118](#)

608 [GOV00890100](#)

609 [GGC17250001](#)

610 [GGC17250016](#)

611 [TRA01000084-85](#)

612 [TRA01000085](#)

An illogical position

Mrs Murray's approach to the evidence of the CDI in the VOLH in the period from 1 January 2007 to March 2008 simply does not make sense. That is particularly so when the great majority of the cases were described in the database as hospital related. Nor can it be said that Mrs Murray was not aware of the risks of cross infection. As previously discussed, in April 2007 Mrs Murray and Mrs O'Neill re-issued the "Bug of the Month"⁶¹³ newsletter, prompted by an awareness of an increasing incidence of CDI, not only in the VOLH but also nationally, about which they themselves wanted to raise awareness in the VOLH.⁶¹⁴ Under the heading "TRANSMISSION" the following advice is given:

"Although some people can be healthy carriers of *C. difficile*, in most cases it develops after cross infection from another patient, either through direct patient contact, via healthcare staff, or via a contaminated environment".⁶¹⁵

Although the primary focus of the newsletter on transmission was on cross-infection, when faced with evidence of clusters of CDI, Mrs Murray unfortunately adopted a mindset that excluded cross infection.

Mrs Murray's position also flies in the face of her participation in the delivery of presentations on CDI, drawing upon the outbreaks of CDI at hospitals in Montreal and Quebec in Canada and Buckinghamshire in England,⁶¹⁶ to highlight infection control issues.⁶¹⁷ The first presentation was in January 2007, and subsequently in May 2007 Mrs Murray delivered the same presentation.⁶¹⁸ In light of that level of knowledge and expertise, her repeated rejection of the possibility that cross infection may have been responsible for the clusters of CDI that occurred on the VOLH from 1 January 2007 until her retirement in March 2008 is incomprehensible.

A memorandum dated 15 March 2007 was circulated by Mrs O'Neill to all Senior Charge Nurses.⁶¹⁹ The terms of this memorandum had been discussed with Mrs Murray,⁶²⁰ and the second paragraph was in the following terms:

"Where possible, patients who have developed diarrhoeal symptoms should be nursed in isolation as soon as they become symptomatic, to reduce the risk to other patients in the ward and to prevent an outbreak situation".

Clearly the concern here was the risk of cross infection. Yet although this was a risk that was apparently recognised, in practice Mrs Murray considered that, despite the number of clusters of CDI in different wards in the VOLH, there had been no ingestion of spores in the hospital and all these cases were patients who were already carriers of *C. difficile*.

Mrs Murray's conclusion that there was no cross infection is even more difficult to understand in light of a complaint made by the family of one patient who contracted CDI. Mrs Murray had a telephone conversation with that family member on 24 January 2008 and noted the nature of the complaint on the patient's Infection Control Card (T-card).⁶²¹ The thrust of the complaint was that the patient had had contact with a patient suffering from CDI who was wandering in the ward.⁶²² Mrs Murray's inability to see that cross infection was the likely cause of the patient contracting CDI once more simply does not make any sense, particularly as there were a number of other patients suffering from CDI in that ward.

Ms Law had discussions in 2007 with Mrs Murray about the fact that there seemed to be an increase in the number of *C. difficile* toxin positive patients.⁶²³ According to Mrs Law, Mrs Murray told her that all the cases could be explained and there was no evidence of cross infection.⁶²⁴ This response

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614 [TRA00950130](#)

615 [GGC17790003](#)

616 [INQ03010001](#)

617 [TRA01010042](#)

618 [TRA01010042](#)

619 [GGC17360002](#)

620 [TRA01010123](#)

621 [TRA01010124-125](#); SPF00710001

622 [TRA01010125-126](#)

623 [TRA00890024-25](#)

624 [TRA00890024](#)

was consistent with the line taken by Mrs Murray in her evidence.

In Chapter 12 the evidence surrounding the admission of a patient in February 2008 to ward F to a bay where there were symptomatic patients has already been considered. A family member, having carried out some research, put to Mrs Murray that there was an outbreak of CDI,⁶²⁵ and Mrs Murray responded by saying she would close the ward.⁶²⁶ There is no evidence that she did that.

Mrs Murray repeatedly failed to recognise that the most likely explanation for the presence of two or more patients suffering from CDI in the same ward and closely linked in time was cross infection. These were serious failures. Her failures meant that the outbreak procedures that would have alerted other levels of management were never invoked. Mrs Murray's failures contributed in a significant way to the persisting CDI problem in the VOLH. Her failures contributed to undetected outbreaks of CDI. She failed in a significant way in her duty of care to patients in the VOLH.

15.12 Role of the Microbiologists

Positions held

Dr Stephanie Dancer was the resident Consultant Microbiologist at the VOLH from January 1996 to February 2002,⁶²⁷ and was also the ICD. She resigned in February 2002 but continued to work at the VOLH as a locum until June 2002. Although her post at the VOLH had been advertised on a number of occasions over the years, Dr Dancer was not replaced.⁶²⁸ It was not an attractive post, particularly as the uncertainty over the future of the VOLH increased. Moreover, a single post with no colleagues can be unattractive to potential applicants.⁶²⁹

From 1 January 2007 to 1 January 2008 Dr Barbara Weinhardt was the Consultant Microbiologist at the RAH. In January 2008

Dr Linda Bagrade and Dr Alison Claxton also took up posts as Consultant Microbiologists at the RAH. Between 1 January 2007 and June 2008 Dr François de Villiers and Dr Biggs were Consultant Microbiologists based at the IRH. The role of Dr Biggs as Infection Control Doctor has already been discussed and is discussed further below.

The stopgap arrangements

Dr Geoffrey Douglas was a Consultant Anaesthetist until his retirement in April 2008. From November 2005 to April 2006 he was also the Clinical Director of Laboratory Specialities for Argyll and Clyde, and had clinical line management responsibility for Dr Biggs and Dr de Villiers.⁶³⁰ By 2005 there was a real concern about the number of vacant microbiology posts, with two out of the five posts being vacant,⁶³¹ and as a “stop gap”⁶³² position he arranged for Dr de Villiers to attend the VOLH for one session a week to provide microbiology input. A session was normally considered to be four hours,⁶³³ and travelling time was considered part of the session.⁶³⁴

Dr de Villiers

Dr de Villiers confirmed that from 1 January 2007 to January 2008 he did have a clinical responsibility for the VOLH. Although the plan had been that he would attend the VOLH on a weekly basis, in reality that was not possible, for his availability at the VOLH was dependent on Dr Biggs being present at the IRH. If Dr Biggs was on leave, at a meeting, or off work for some other reason, then he would not go to the VOLH.⁶³⁵ When he was on leave himself the VOLH would not be covered.⁶³⁶ Leave was normally a period of six weeks per year.⁶³⁷ Nor was there cover when Dr de Villiers or Dr Biggs was on study leave, a further period of some four weeks per year.⁶³⁸ Finally, because travelling time was included in his session, his attendance at the VOLH would normally be just a little

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626 [TRA00070062](#)

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632 [TRA01250028](#)

633 [TRA01250027](#)

634 [TRA01250027](#)

635 [TRA00840006-07](#); [TRA00840010](#)

636 [TRA00840008](#)

637 [TRA00840010](#)

638 [TRA01250004](#)

over two hours.⁶³⁹ It follows that there was not a great deal of direct microbiology cover in the VOLH, and as Dr de Villiers explained, he was really only maintaining some microbiology “visibility” at the VOLH.⁶⁴⁰ When he did attend he had an office based in the Laboratory and he would normally visit the High Dependency Unit. He would only visit a ward if he was called to do so for a particular reason.

As discussed in Section 15.2, Dr de Villiers did not have any responsibility for infection prevention and control as ICD at the VOLH.

Dr Weinhardt

After Dr Dancer’s departure Dr Biggs had taken on responsibility for the VOLH Laboratory, but she asked to be relieved of that responsibility because of her workload,⁶⁴¹ and in April 2006 Dr Douglas asked Dr Weinhardt to take on the responsibility as the head of department for the VOLH Laboratory.⁶⁴² At the time Dr Weinhardt was reluctant to take on that responsibility because a fellow Consultant Microbiologist had left the RAH in December 2005 and had not been replaced by April 2006,⁶⁴³ but she agreed to take on the responsibility because her understanding at the time was that all the microbiology services were going to be centralised at the RAH and that two new colleagues would be “swiftly” appointed.⁶⁴⁴

Dr Weinhardt had anticipated that the vacancies would be filled within a number of months, but that did not happen as Dr Bagnade and Dr Claxton did not take up their posts until January 2008. Because of her workload there were times when Dr Weinhardt felt under stress.⁶⁴⁵ She endeavoured to visit the Laboratory on a weekly basis for about two hours, but that obviously did not happen when she was on annual leave. Nor was she able to visit when she was otherwise too busy at the RAH. Dr

Weinhardt did not consider the position to be at all satisfactory, although on a day-to-day basis with locum support she did believe the clinical service was safe.⁶⁴⁶

Dr Douglas said he was at the time extremely concerned about Dr Weinhardt’s position as she was the only microbiologist left at the RAH, which was the largest and busiest hospital of the three main hospitals in Argyll and Clyde.⁶⁴⁷ From April 2006 Dr Douglas was absent from work for a considerable time due to illness,⁶⁴⁸ and his line management responsibility ceased at that point.⁶⁴⁹

Except at weekends and bank holidays, Dr Weinhardt did not have any clinical responsibility for the VOLH until February 2008.⁶⁵⁰ Her evidence was that she only had any responsibility for infection control issues at the VOLH on an out-of-hours basis and at weekends.⁶⁵¹

Authorisation of *C. difficile* toxin positive results

Although *C. difficile* toxin positive results required to be authorised by a Consultant Microbiologist, on occasion that did not happen. The reports prepared at the VOLH recording that a test for *C. difficile* toxin was positive could be accessed by computer at the IRH and the RAH, and prior to February 2008 the authorisation of those positive results was carried out at the IRH, primarily by Dr de Villiers and Dr Biggs. After January 2008 this exercise was carried out from the RAH by Dr Weinhardt, Dr Bagnade and Dr Claxton. The authorisation of such results was carried out on the computer screen, and the Consultant Microbiologists did not receive a hard copy of the report.⁶⁵²

There were discrete lists of reports to be authorised for each hospital laboratory, which meant that the person authorising the report could see a separate list for the VOLH.⁶⁵³ There was not, however, a separate

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652 [TRA00840026](#)
653 [TRA00840026-27](#)

list for *C. difficile* toxin positive results, which could be in a list mixed with other results such as blood culture results. Nor was there a separate list for hospital patients: the list contained all results for the VOLH Laboratory, which also served the community, and along with the results for the hospital there would also be results for patients of General Practitioners (GPs).⁶⁵⁴ These comprised around 60% of the work done in the VOLH.⁶⁵⁵ There could be as many as 80 reports to be authorised in one day,⁶⁵⁶ and authorisation of reports was carried out at different times in the course of the day rather than as a complete batch at a particular time.⁶⁵⁷

The number of positive results authorised by Dr Weinhardt

It would appear from the data recovered from the VOLH computer system that there were times from December 2007 to June 2008 when positive results for *C. difficile* toxin closely associated in time were authorised by the same Consultant Microbiologist. Table 15.9 has been prepared by the Inquiry based on the data obtained from the VOLH Laboratory computer system.

654 [TRA00840027-28](#)

655 [TRA00840030](#)

656 [TRA01020117](#)

657 [TRA01020117-118](#)

Table 15.9 *C. difficile* toxin positive results authorised by Microbiologists

Microbiologist	Ward	Report date	Patient
Dr de Villiers	14	05/12/07	Isobel Cameron
	15	06/12/07	Mary Broadley
	HDU	14/12/07	Alexander McDonald
	6	17/12/07	Patient B
	6	19/12/07	Margaret Dalton
	15	20/12/07	Mary Broadley
	14	20/12/07	Isabella Lettis
	6	24/12/07	Agnes Burgess
	6	24/12/07	Julia Monhan
	F	26/12/07	Patient C
Dr Weinhardt	F	25/02/08	Alister Brand
	6	25/02/08	Martha McGregor
	6	25/02/08	Elizabeth Valentine
	14	28/02/08	Anne Gray
	F	28/02/08	Patient C
	6	28/02/08	Moir McWilliams
Dr Bagrade	F	06/02/08	Mary Millen
	14	06/02/08	James Thomson
	3	08/02/08	David Somerville
	F	11/02/08	Patient C
	F	12/02/08	Alister Brand
	15	18/02/08	Margaret Gaughan
Dr Claxton	F	20/02/08	Jessie Jones
	F	20/02/08	Jessie Jones
	6	20/02/08	Annie Shaw
	3	21/02/08	William Hunter

It is evident from Table 15.9 that Dr Weinhardt authorised six positive results for *C. difficile* toxin in the period 25 February 2008 to 28 February 2008. It did occur to Dr Weinhardt at the time that there were a number of *C. difficile* toxin positive results emanating from the VOLH, and she said that she had a conversation with Dr Bagnade at about that time in connection with the increased rates of CDI. Dr Weinhardt's evidence was that Dr Bagnade had indicated to her that there could be a problem at the VOLH, which Dr Weinhardt understood related to the increase in CDI cases. Later, and Dr Weinhardt thought this was in April 2008, Dr Bagnade confirmed to her that there was a genuine problem with CDI at the VOLH.⁶⁵⁸

The increase identified by Dr de Villiers

Table 15.9 discloses that in the month of December 2007 Dr de Villiers authorised ten positive reports for *C. difficile* toxin. He said in evidence that this may have been one of the reasons that he had an impression that there was an increased incidence of CDI,⁶⁵⁹ although the main reason for the impression seems to have been an increase in calls for clinical advice,⁶⁶⁰ which he thought happened in January 2008.⁶⁶¹ At the time Dr de Villiers believed that the increase was in the IRH, and raised the issue with an ICN in the IRH, asking her to investigate. Dr Biggs was present when he made this request.⁶⁶² The ICN reported back to him the same day that there was no increase in the IRH.⁶⁶³ Again Dr Biggs was present, and at that stage Dr de Villiers suggested to Dr Biggs that she should have a look at the other hospitals for which she was the ICD.⁶⁶⁴

Dr de Villiers could not remember if Dr Biggs reported back to him⁶⁶⁵ and he did not pursue the matter any further.⁶⁶⁶ There is no evidence that Dr Biggs carried out any such investigation into the prevalence of CDI at the VOLH. In December 2007 there were patients

suffering from CDI, particularly in ward 6. In January 2008 there were patients suffering from CDI in a number of wards in the VOLH with five patients suffering from the infection in ward F alone. An investigation at that time would have disclosed the likelihood of an outbreak.

Authorisation by Dr Bagnade

Table 15.9 shows Dr Bagnade also authorised a number of *C. difficile* toxin positive results in February 2008. Her evidence was that, because of the way in which the authorisation system worked, that alone would not have suggested to her that there was a problem. A significant number of different types of results would be authorised in the course of a working day, and, as mentioned earlier, many results were for specimens submitted by GPs.

Dr Bagnade said that she did not have a conversation with Dr Weinhardt about a problem in the VOLH with CDI. She thought that she may have discussed the situation in relation to wash-hand basins at the VOLH with Dr Weinhardt.⁶⁶⁷

Authorisation by Dr Claxton

Dr Claxton was also involved in authorising *C. difficile* toxin positive results.⁶⁶⁸ Table 15.9 discloses that Dr Claxton authorised four positive reports for three patients on 20 and 21 February 2008. Although her evidence on this was not entirely clear, Dr Claxton did not have a specific recollection of what she did at the time.⁶⁶⁹ Her evidence was that in such circumstances she would expect the Infection Control Team to investigate.

Dr Bagnade's knowledge of CDI rates at the VOLH

Like Dr Weinhardt, Dr Claxton also gave evidence that Dr Bagnade had said there might be a problem at the VOLH in relation to CDI. She thought this was some time in March 2008. That date was the "nearest"⁶⁷⁰ she could estimate, and Dr Weinhardt was

658 [TRA00850130-33](#)

659 [TRA00840074-76](#)

660 [TRA00840074](#)

661 [TRA00840075](#)

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664 [TRA00840076](#)

665 [TRA00840077-79](#)

666 [TRA00840079](#)

667 [TRA01020120](#)

668 [TRA01220056](#)

669 [TRA01220062-63](#)

670 [TRA01220068](#)

present at the time.⁶⁷¹ Dr Claxton did not know if Dr Bagraade was talking about CDI numbers or some other aspect of CDI.⁶⁷² Dr Claxton's recollection of the event was poor, and having regard to her uncertainty over the date any conversation that did take place could very well have been after the problem emerged.

The Inquiry is not able to come to a conclusion on this divergence in the evidence. It is certainly the case that when the CDI problem emerged in May 2008 Dr Bagraade did respond promptly.

Other Consultant Microbiologists' knowledge of CDI rates at the VOLH

Although there seems to have been an awareness of an increased incidence of CDI at the VOLH, particularly by Dr Weinhardt and Dr de Villiers, that awareness did not result in any action at the time. The Inquiry accepts that Dr de Villiers did raise this issue with Dr Biggs in January 2008 and that Dr Biggs did not respond to his concerns.

Consultant Microbiologist staffing from January 2007 to January 2008

The staffing arrangements for Consultant Microbiologists were totally unsatisfactory in the period from January 2007 to January 2008 and had been for some time before that period. Dr Douglas's temporary reorganisation of the microbiology service in around April 2006 was well intentioned, but it was a temporary solution that remained unresolved for a significant period of time.

Dr Weinhardt's concerns over the microbiology service, and the stress that she was under, caused her to press for the vacant posts to be filled, and on 22 September 2006 she wrote to a member of the Board setting out the nature of the problem and asking for the two vacant posts to be re-advertised.⁶⁷³ The posts had not been advertised since January 2006,⁶⁷⁴ and because there had previously been difficulties in filling the vacant post at the VOLH Dr Weinhardt

pressed for the three Consultant Microbiologists to be based at the RAH.⁶⁷⁵

Dr Weinhardt secured a meeting with Mrs den Herder in December 2006 and authority was given for the vacant RAH post to be advertised,⁶⁷⁶ but it appears that neither of the two posts was advertised until summer 2007. Shortly before that Mrs den Herder discussed her intentions with Dr Cowan, seeking his view on her proposal to advertise one of the posts as a Microbiologist with ICD responsibilities.⁶⁷⁷ The posts were not filled until the appointment of Dr Bagraade and Dr Claxton in January 2008.

The division of responsibility

Professor Duerden explained that a system where different microbiologists were intended to undertake separate duties for the VOLH was:

"unlikely to provide a robust, secure and reliable situation for the Laboratory, the hospital clinicians or the infection control staff".⁶⁷⁸

Dr de Villiers' intended role was in reality even more limited than that envisaged by Dr Douglas. Dr Weinhardt was under pressure because of the staffing problems and her role as head of the Laboratory service was a limited one. Critically, Dr Biggs' performance as Infection Control Doctor was inadequate. The Inquiry agrees with Professor Duerden that a co-ordinated, integrated service was not being provided to the VOLH.⁶⁷⁹ The inadequate nature of Dr Biggs' role is further explored in Section 15.13, and her failure as ICD was clearly highly relevant to the nature of the microbiology service provided at the VOLH. The difficulties in recruiting staff were also an important factor.

671 [TRA01220068](#)

672 [TRA01220070](#)

673 [TRA00860015-16](#); [INQ03500001](#)

674 [TRA00860022-23](#)

675 [TRA00850105-106](#)

676 [TRA00860019](#)

677 [TRA01220110-111](#)

678 [TRA01050066](#)

679 [TRA01050067](#)

15.13 The Infection Control Doctor

Dr Biggs

Unfortunately, as explained in Chapter 2, Dr Biggs was unable on health grounds to provide a written statement or give oral evidence to the Inquiry. Two police statements made by Dr Biggs in the course of the earlier police investigation were available to the Inquiry, dated 16 March 2009⁶⁸⁰ and 7 May 2009 respectively.⁶⁸¹ In addition, Dr Biggs had been interviewed by the Internal Investigation panel on 18 June 2008, and notes of that interview were available to the Inquiry.⁶⁸² The Internal Investigation is considered further in Chapter 17.

As already mentioned, Dr Biggs was the designated ICD for the Clyde Sector, which included the VOLH. Her responsibility as ICD for the VOLH certainly spanned the period from 1 January 2007 to early February 2008, when Dr Bagnade took over that particular responsibility. Although as discussed in this Section Dr Biggs claimed that her role was a “firefighting”⁶⁸³ one the Inquiry finds that there was no excuse for her not being fully aware that she was the designated ICD for the VOLH. She did not in fact carry out her responsibilities as ICD.

Professional line management

Dr Douglas was Dr Biggs’ professional line manager until he went on leave due to illness in April 2006.

It has to be stressed that a professional line manager has an important role to play in providing advice and support, but there is some confusion over who took on the role of Dr Biggs’ professional line manager after Dr Douglas’s departure. There was no Clinical Director replacing Dr Douglas, and the next person in the professional line management chain was Dr Elizabeth Jordan, the Associate Medical Director. She should have taken over professional line management for Dr Biggs to fill the gap left by Dr Douglas, and at her interview with the Internal Investigation Dr Biggs is noted to have said that in the

absence of a Clinical Director she would contact Dr Jordan.⁶⁸⁴ According to the police statement she provided on 16 September 2009, however, Dr Biggs said that Dr Jordan was only her line manager up to May 2007 and that Dr Jordan had “resigned”.⁶⁸⁵ Dr Jordan did not in fact leave her post until 12 August 2007,⁶⁸⁶ so Dr Biggs may have been confused about the date, and in the email exchanges discussed below between Dr Biggs and Mr Walsh in June 2007 Dr Biggs was directed by Mr Walsh to contact Ms Martin and Dr Jordan, a response that suggests that Dr Jordan was Dr Biggs’ professional line manager at that time.

As set out in Chapter 2, Dr Jordan, who is in Australia, has declined to co-operate with the Inquiry, but there is no evidence before the Inquiry that she provided any real support to Dr Biggs. After Dr Jordan left, her position as Associate Medical Director was taken over in September 2007 by Dr John Dickson,⁶⁸⁷ although it appears he did not step into the role of professional line manager for Dr Biggs.⁶⁸⁸ Dr Douglas did return to work in September 2007, but he did not resume his professional line management responsibilities.⁶⁸⁹

Inadequate professional line management

So far as the Inquiry can ascertain the professional line management for Dr Biggs was inadequate, and this is a factor that must be taken into account when considering Dr Biggs’ position. It is not at all clear why Dr Biggs was not given greater professional support. This may be an issue on which Dr Jordan could have provided the Inquiry with some assistance. It is apparent, as discussed later, that Dr Biggs was unhappy with her role, and a higher level of professional support should have been available to her.

Dr Biggs’ job description

Dr Biggs did not receive a job description providing details of her role until it was sent to her by her line manager Ms Martin on

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 681 [SPF01470001](#)
 682 [GOV00890099-101](#)
 683 [GOV00890100](#)

684 [GOV00890101](#)
 685 [SPF01460003](#)
 686 [GGC33120001](#)
 687 [WTS00820001](#)
 688 [WTS02290001-02](#)
 689 [WTS02350004](#)

19 September 2007.⁶⁹⁰ This was in response to a series of emails from Dr Biggs to Ms Martin from at least 20 August 2007⁶⁹¹ seeking “absolute clarification”⁶⁹² on her role as ICD. Ms Martin said that until then she was not aware that Dr Biggs did not have a job description, because she took over as her line manager in April 2006 when Dr Biggs was already in her post as ICD. Ms Martin should have clarified the position much earlier with Dr Biggs, but Dr Biggs could have been in no doubt what her duties were and she did not question the terms of the job description⁶⁹³ sent to her in September 2007.⁶⁹⁴

Ms Martin’s position

Ms Martin was clear that Dr Biggs was the ICD for the VOLH and “the leader of the Infection Control Team”,⁶⁹⁵ but she also maintained that Dr Biggs could delegate her VOLH ICD responsibilities to Dr de Villiers, and knew that Dr de Villiers was due to attend the VOLH one day a week.⁶⁹⁶ Ms Martin suggested that this arrangement had been set up in 2006 by Dr Douglas because of the problems Dr Biggs had with her mobility and also because of the shortage of consultant microbiologists.⁶⁹⁷

The Inquiry does not accept Ms Martin’s evidence that the arrangement she described had been put into place. Ms Martin’s position is not supported by Dr Douglas and it is contradicted by Dr de Villiers. Dr Douglas met Dr Biggs and Dr de Villiers together in the latter part of 2005. Thereafter, Dr Douglas had separate meetings with Dr Biggs (7 December 2005) and Dr de Villiers (14 February 2006).⁶⁹⁸ However, Dr Douglas did not set up an arrangement whereby Dr de Villiers had responsibilities as ICD for the VOLH beyond what was expected of any microbiologist on a day-to-day basis.⁶⁹⁹ So far as Dr Douglas was concerned it was Dr Biggs who was to perform the duty of ICD for

the VOLH.⁷⁰⁰ Dr de Villiers also contradicted Ms Martin’s understanding of his role.⁷⁰¹ In fact, for a significant percentage of the year, for reasons already mentioned, Dr de Villiers did not go to the VOLH.⁷⁰² Ms Martin said she understood that Dr de Villiers attended the VOLH on a weekly basis other than when he was on annual leave.⁷⁰³

Nor indeed can any support for Ms Martin’s evidence be gleaned from statements made by Dr Biggs. There is no suggestion in the police statements provided by Dr Biggs, or from the notes taken in the interview to the Internal Investigation panel, that she delegated her ICD responsibilities for the VOLH to Dr de Villiers. According to the police statement dated 7 May 2009 Dr Biggs said that Dr de Villiers would cover as ICD when she was on annual leave,⁷⁰⁴ but there is no suggestion that Dr de Villiers had the role ascribed to him by Ms Martin. Furthermore, as discussed later in this Chapter, in the emails written by Dr Biggs in 2007 about what she perceived to be her role as ICD for the VOLH there is no suggestion that Dr de Villiers was to cover for her in that role on his visits to the VOLH.

When she was recalled to give further evidence, the evidence of Dr de Villiers and Dr Douglas was put to Ms Martin.⁷⁰⁵ She provided some equivocal responses to questions but seemed to accept she could have misunderstood the position.⁷⁰⁶ At one point she gave the following explanation:

“I honestly did think that Dr de Villiers was covering infection control issues on behalf of Dr Biggs while he was at Vale of Leven”.⁷⁰⁷

The Inquiry can sympathise with the view that if a microbiology colleague attends a hospital in the capacity of Consultant Microbiologist it would be reasonable to assume there would be a degree of cross-

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 691 [GGC08690001](#); [GGC08700001](#); [GGC08710001](#)
 692 [GGC08690001](#)
 693 [GGC32170001](#)
 694 [TRA01160033-34](#); [SPF00970002](#)
 695 [TRA01160011](#)
 696 [TRA01160013](#)
 697 [TRA01160013-14](#)
 698 [WTS02350001](#)
 699 [TRA01250024](#); [WTS02350003](#)

700 [TRA01250030](#)
 701 [TRA01250001-05](#)
 702 [TRA01250004-05](#)
 703 [TRA01160061](#)
 704 [SPF01470006](#)
 705 [TRA01260072](#)
 706 [TRA01260073](#)
 707 [TRA01260073](#)

cover on infection prevention and control matters. That was not, however, the position. Ms Martin said that if she had appreciated the true position, and understood that Dr de Villiers was not covering for Dr Biggs, she would have been concerned and would have made other arrangements.⁷⁰⁸

The fact that Ms Martin may have thought that Dr de Villiers was covering for Dr Biggs as ICD at the VOLH on his visits there itself highlights the dysfunctional nature of the arrangements for infection prevention and control at the VOLH. There was no coherent strategy for ICD cover there.

Dr Biggs' concerns

In a series of emails in 2007 Dr Biggs raised a number of issues in relation to her position as ICD. The issue of her job description has already been covered, but by email dated 1 June 2007 from Dr Biggs to Mr Walsh, who was about to take up post as Infection Control Manager, and copied to a number of other people including Ms Martin, Dr Biggs began by saying that she was finding her position as ICD for Clyde was “becoming untenable”.⁷⁰⁹ She ends the email by intimating that she would need to “carefully decide whether I can continue in this role”.⁷¹⁰

By email dated 5 June 2007 Mr Walsh responded that Dr Biggs would need to raise the issues relating to her role as ICD with Dr Jordan and Ms Martin.⁷¹¹ The response directing Dr Biggs to Ms Martin, her line manager, was a reasonable one on the part of Mr Walsh at that time. The reference to Dr Jordan was made because Mr Walsh understood that, as Dr Jordan was Associate Medical Director, she was Dr Biggs' professional manager⁷¹² in the absence of Dr Douglas.

By email dated 16 August 2007 Dr Biggs complained to Ms Martin of “great stress” and concluded the email in the following way:

“I can take no responsibility for outbreaks or any infection control issues as I have no say in any matter of management of infection control services. I feel my position is becoming untenable”.⁷¹³

Ms Martin responded to that email the same day, but did not address the infection control issues raised by Dr Biggs. This is a point made by Dr Biggs in a subsequent email that day.⁷¹⁴

Ms Martin said in evidence that although she was responding to Dr Biggs it was not her responsibility to do so as she was on full-time secondment.⁷¹⁵ She said that even though it was not her responsibility she would “never ignore Dr Biggs”.⁷¹⁶ So far as Ms Martin was concerned Dr Biggs was “being dramatic and just expressing herself very strongly”.⁷¹⁷

On 20 August 2007 Dr Biggs sent another email to Ms Martin stipulating that she needed “absolute clarification of my role as Infection Control Doctor...”.⁷¹⁸ On 27 August 2007 she sent a further email to Ms Martin headed “high priority”,⁷¹⁹ in which she indicated that she had still had “no response to my email about roles responsibilities and professional line management”.⁷²⁰ Ms Martin was able in evidence to give some background to what was troubling Dr Biggs at this stage. She explained that Dr Biggs was “disgruntled”⁷²¹ about the fact that by this time the other sectors in NHS GGC had been provided with a particular structure for the role of ICD, whereas a similar structure had not been put in place for the Clyde Sector. Ms Martin did respond to Dr Biggs by email dated 31 August 2007 reassuring her that there was to be a paper issued “shortly from Glasgow which will answer your questions in relation to Acute”.⁷²²

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714 [SPF01130002](#)
715 [TRA01160045-46](#)
716 [TRA01160042](#)
717 [TRA01160042](#)
718 [GGC08690001](#)
719 [GGC08700001](#)
720 [GGC08700001](#)
721 [TRA01160047-49](#)
722 [SPF00900002](#)

Dr Biggs' response to Ms Martin is contained in an email dated 5 September 2007 in which she said that she would not "attend or chair any meetings as far as infection control is concerned until I have the role clarified".⁷²³ Ms Martin agreed that Dr Biggs was providing a very clear message about how she saw her responsibilities for infection control, but she also made the point that despite the tone of Dr Biggs' email Dr Biggs did not resign from her position as ICD.⁷²⁴ That is correct, but Dr Biggs was also making it clear that she had no intention of carrying out her responsibilities as ICD. Her attitude demanded a prompt and effective response.

At her interview with the Internal Investigation panel on 18 June 2008,⁷²⁵ when it was put to Dr Biggs that she was ICD for the VOLH in the period December 2007 to the beginning of February 2008 Dr Biggs is noted as responding in the following way: "Firefighting. Purely emergency cover. Not aware of C.diff issues at VOL".⁷²⁶ Ms Martin did not accept that that was the way in which Dr Biggs understood the role, and thought that that Dr Biggs was "trying to put herself at arm's length from the situation".⁷²⁷

According to her first police statement of 16 March 2009, Dr Biggs again made reference to her performing "a firefighting role only...",⁷²⁸ saying:

"When I said 'firefighting' earlier in relation to my role as Infection Control Doctor I meant that I would only become involved if there was an outbreak. My belief is an outbreak is 2 or more linked infections which can be related in the same area. ... I was never informed of any issues at the VOLH".⁷²⁹

According to her second statement given on 7 May 2009, Dr Biggs explained her position thus:

"In terms of clinical advice or dealing with outbreaks relied upon me being informed and I would react to it. There was nothing pro-active ... I did not fit into the Infection Control structure as the Infection Control Doctor as it had not been clearly defined. That is where the problem was. They did however look at me as the Infection Control Doctor for the IRH, RAH, VOL and Oban".⁷³⁰

Dr Biggs' attitude to her role as ICD for the VOLH was inappropriate and professionally unacceptable. It is contradicted by the job description applicable to her position, which provided that she was to act as leader of the Infection Control Team.⁷³¹ Furthermore in her application for consultant discretionary points Dr Biggs claimed that she was the "area Infection Control Doctor to cover two consultancy vacancies..." in the period 2006 to 2008.⁷³² The purpose of this application was to receive recognition for additional work in the form of additional points, which could have an impact on salary, and what Dr Biggs held out in that application can be read as an acknowledgement that she did have ICD duties for the VOLH.⁷³³ In reality Dr Biggs was not fulfilling her duties as the ICD for the VOLH, certainly in the period from 1 January 2007 to early February 2008, and any suggestion in this application to the contrary was incorrect.

Dr Biggs' relationship with the Infection Control Nurses

Mrs Murray did not see Dr Biggs very often. She said that usually it would be at an infection control meeting,⁷³⁴ but as the Support Group last met in June 2007 and Dr Biggs ceased to attend meetings of the ACIC there was very little personal contact. Mrs Murray summed up Dr Biggs' relationship with the VOLH as "quite remote",⁷³⁵ adding that even when contact was made with Dr Biggs "you didn't always get a very satisfactory answer".⁷³⁶ In contrast, Mrs

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 726 [GOV00890100](#)
 727 [TRA01160067](#)
 728 [SPF01460003](#)
 729 [SPF01460004-05](#)

730 [SPF01470006](#)
 731 [GGC32170003](#)
 732 [GGC31980001](#)
 733 [TRA01150059-62](#)
 734 [TRA01010019](#)
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 736 [TRA01010019](#)

Murray had had a “very good...working relationship” with Dr Dancer, the previous ICD at the VOLH.⁷³⁷

According to Mrs Murray, Dr Biggs had not visited the VOLH for a “few years”, a situation she found “difficult”.⁷³⁸ Dr Biggs’ lack of contribution as ICD meant that “more responsibility”⁷³⁹ was placed on Mrs Murray and on Mrs O’Neill. Mrs Murray said that when there was some contact Dr Biggs could be “abrasive”⁷⁴⁰ and could adopt a “belittling”⁷⁴¹ attitude. Mrs Murray acknowledged that Dr Biggs’ attitude meant that there was a significant problem with the leadership of the VOLH Infection Control Team which had continued for a number of years⁷⁴² and became worse following integration with GGHB.⁷⁴³

Mrs O’Neill confirmed that Dr Biggs was seldom at the VOLH and said that most contact she had with her was by telephone.⁷⁴⁴ She thought her contact with Dr Biggs would be “probably about once a month, maybe less”⁷⁴⁵ Mrs O’Neill did think that Dr Biggs might have attended the VOLH “about twice”⁷⁴⁶ during 2007 and 2008. There was not a close and effective working relationship with Dr Biggs,⁷⁴⁷ and so far as Mrs O’Neill was concerned the Infection Control Team did not function well as a team because of Dr Biggs’ lack of involvement.⁷⁴⁸

Dr Biggs’ relationship with Annette Rankin

As the Head ICN responsible for the VOLH and the line manager for Mrs Murray, Ms Rankin was aware that there were “challenges”⁷⁴⁹ with Dr Biggs. These challenges included Dr Biggs’ antagonism towards the integration of Glasgow and Clyde and the prospect of single-system

working.⁷⁵⁰ Ms Rankin knew that there was an unsatisfactory working relationship between Mrs Murray and Dr Biggs,⁷⁵¹ but was not aware that Dr Biggs did not attend the VOLH,⁷⁵² and Mrs Murray certainly did not suggest that she told Ms Rankin that.

Ms Rankin’s evidence was that, in contrast to the ICDs in the other sectors of NHS GGC, Dr Biggs “was working against”⁷⁵³ her. From Ms Rankin’s perspective there existed an “underlying unpleasantness”⁷⁵⁴ towards her on the part of Dr Biggs. Ms Rankin was aware that Dr Biggs did not attend meetings of committees of which she was a member, and sought to put that non-attendance into context in the following way:

“Dr Biggs didn’t appear to attend anything, and it was accepted behaviour, so it wasn’t unusual to go to a meeting and Dr Biggs wasn’t present”.⁷⁵⁵

Although Ms Rankin said that she did not raise Dr Biggs’ non-attendance at committees with Mr Walsh,⁷⁵⁶ she did raise the difficulties she had with Dr Biggs with both Mr Walsh, her professional line manager, and Ms Martin, her line manager.⁷⁵⁷ When asked what Mr Walsh did about this issue Ms Rankin provided the following response:

“I think there was an acceptance that ... this behaviour wasn’t new. This wasn’t a behaviour that had manifested itself towards me or towards the infection control team. I think ... my understanding of it is this was the behaviour that had been displayed through time. So this wasn’t new behaviour that I was experiencing. Perhaps wrongly, but I accepted that, if it hadn’t been dealt with before, I don’t know what hope I had trying to address it. But I kept ... in terms of trying to provide a service, I raised my concerns”.⁷⁵⁸

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738 [TRA01010065](#)

739 [TRA01010064-65](#)

740 [TRA01010067](#)

741 [TRA01010067](#)

742 [TRA01010069](#)

743 [TRA01010071](#)

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746 [TRA00950016](#)

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749 [TRA01260017](#); [TRA01260037](#)

750 [TRA01260013](#)

751 [TRA01260020](#)

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753 [TRA01260037](#)

754 [TRA01260021](#)

755 [TRA01260022](#)

756 [TRA01260022](#)

757 [TRA01260017](#); [TRA01260022](#)

758 [TRA01260018-19](#)

Dr Biggs' failures

Dr Biggs was not performing her duties as ICD for the VOLH. She had minimal contact with the ICNs and provided little support and leadership. Her attitude towards Ms Rankin was counter-productive to an appropriate working relationship and unprofessional.

Dr Biggs' self-imposed restriction on her role as ICD for the VOLH as having "no responsibility for outbreaks or any infection control issues",⁷⁵⁹ or that the role was simply a "fire fighting"⁷⁶⁰ one, was without justification, whatever reservations she may have had over proposed changes to the infection control structures. Her failure to carry out her ICD duties for the VOLH in an appropriate manner was a serious failure on her part. It is almost certainly a failure that contributed significantly to the ongoing CDI problem at the VOLH and unnecessary suffering to patients.

It is worthy of note that in the course of giving her police statement of 7 May 2009 Dr Biggs was shown CDI data for a period that included 1 January 2007 to June 2008 and said that if she had been made aware of the data she "would have done something about it, an investigation would have been necessary".⁷⁶¹ She went on to say that she would have expected the ICNs to identify the issue and contact her to discuss it. As mentioned earlier, Mrs Murray did raise the number of CDI patients with her on at least one occasion. There is no doubt that the problem should have been identified locally, but neither is there any doubt that had Dr Biggs been fulfilling her duties as the designated ICD for the VOLH the problem would have been discovered. Dr Biggs had direct responsibility for infection prevention and control at the VOLH, and it was no excuse for her to suggest that she was not aware of the problem with CDI.

15.14 Knowledge of Dr Biggs' failure as Infection Control Doctor**Knowledge of Dr Biggs' behaviour**

An important issue that the Inquiry has had to determine is who knew that Dr Biggs was not carrying out her responsibilities as ICD for the VOLH. A related issue is who ought to have known. A number of people knew that Dr Biggs was antagonistic towards the changes in the infection control structures, but it does not follow from that attitude in itself that she was not performing her role as ICD in an appropriate fashion. Nonetheless, there were aspects of Dr Biggs' behaviour that were well known.

Attendance at meetings

A striking example of the attitude taken by Dr Biggs is seen in a meeting that was ultimately arranged to take place at the IRH. Originally that meeting was to take place on 20 September 2007 in the infection control office in the Victoria Infirmary in Glasgow,⁷⁶² but by email dated 29 August 2007 addressed to Ms Rankin's secretary Dr Biggs intimated that she would be unable to attend because she "would not be available to travel to the Victoria".⁷⁶³ After an unsuccessful attempt to persuade Dr Biggs to travel to the Southern General Hospital instead, Ms Rankin offered to collect Dr Biggs from the car park area of the Victoria Infirmary and take her to the office where the meeting was to be held.⁷⁶⁴ Despite this, on 17 September 2007 Dr Biggs sent an email to Ms Ferguson in which she now announced that she would not be attending the meeting until she had her role clarified, as she no longer had "any control over the team that I am supposed to be leading".⁷⁶⁵ Thereafter the meeting was rearranged to take place at the IRH where Dr Biggs was based. This entailed nine people who were to attend the meeting travelling from Glasgow to Greenock. Members of the ACIC attended the meeting including Dr Reid, Ms Martin and Ms Rankin. It is unclear if Mr Walsh attended that meeting, although he did have some recollection of attending a

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meeting in September 2007 with Dr Biggs in connection with the same subject matter.⁷⁶⁶

It was clear to a number of people that Dr Biggs' dissatisfaction with the infection control system meant that she was generally unenthusiastic about attending meetings in connection with her role as ICD. Dr Biggs' attitude in refusing to attend the meeting planned for the Victoria Infirmary was equivocal. She appears to have at least implied that her inability to attend was because of difficulties in travelling. Ms Rankin also thought the problem was a mobility issue, and it was for that reason that she offered to assist her.⁷⁶⁷ There was evidence that Dr Biggs did have some mobility problems,⁷⁶⁸ but it is apparent that in this instance Dr Biggs' refusal to travel arose from her dissatisfaction over her role as ICD. Dr de Villiers said that at times Dr Biggs used a walking stick and that she often complained about her mobility problems, but added that her attitude to her mobility problems could be selective, as Dr Biggs was perfectly capable of attending to her private practice commitments at Ross Hall Hospital, and although she lived close to the Southern General Hospital in Glasgow she was able to travel to the IRH daily, a distance of some 27 miles.⁷⁶⁹

Dr Biggs' involvement in outbreak meetings

Dr Biggs was based at the IRH, but as the ICD for the VOLH, the RAH and the IRH she had responsibility for each of these hospitals. There was evidence that she did on occasion attend the RAH for some outbreak control meetings in connection with norovirus outbreaks,⁷⁷⁰ for there are nine sets of minutes of RAH outbreak meetings available for December 2007,⁷⁷¹ of which Dr Biggs attended two. There are 17 sets of minutes of outbreak meetings held at the RAH available

for January 2008.⁷⁷² Dr Biggs attended none. Dr Bagraade began to attend on 21 January 2008 having just taken up her post as Consultant Microbiologist.

Nor did Dr Biggs visit the RAH on other occasions.⁷⁷³ Ms Rankin said of Dr Biggs' day-to-day visibility that she had:

“visibility as an Infection Control Doctor that would appear to be within the laboratory building of Inverclyde Royal”.⁷⁷⁴

In making that statement Ms Rankin was speaking with the benefit of information subsequently obtained.⁷⁷⁵

The Infection Control Nurses and the Head Infection Control Nurse

Clearly, Mrs Murray and Mrs O'Neill were aware that Dr Biggs was not carrying out her ICD responsibilities for the VOLH. Ms Rankin, as Mrs Murray's line manager, was aware of the poor working relationship between ICNs and Dr Biggs. She was also aware that Dr Biggs did not attend meetings.⁷⁷⁶

Mrs Murray had discussions with Ms Rankin about Dr Biggs' failure to carry out her ICD duties.⁷⁷⁷ Mrs Murray told Ms Rankin that Dr Biggs was “actually not attending anywhere that happened to be outwith Inverclyde hospital”.⁷⁷⁸ Ms Rankin herself echoed Mrs Murray's view when she said in evidence that “Dr Biggs didn't appear to be involved in anything other than Inverclyde”.⁷⁷⁹ At one stage in her evidence Ms Rankin said that she did not know that Dr Biggs did not attend the VOLH. Nonetheless it is clear that Ms Rankin knew in the course of 2007 and after she became the Head ICN in April 2007 that Dr Biggs was not carrying out her ICD responsibilities for the VOLH. Ms Rankin did, however, regularly pass on her concerns to

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771 [GGC09680001](#); [GGC09690001](#); [GGC09700001](#); [GGC09710001](#); [GGC09720001](#); [GGC09730001](#); [GGC09740001](#); [GGC09750001](#); [GGC09760001](#)

772 [GGC09770001](#); [GGC09780001](#); [GGC09800001](#); [GGC09790001](#); [GGC09820001](#); [GGC09850001](#); [GGC09870001](#); [GGC09910001](#); [GGC09970001](#); [GGC09990001](#); [GGC10010001](#); [GGC10030001](#); [GGC10040001](#); [GGC10050001](#); [GGC10070001](#); [GGC10090001](#); [GGC10110001](#)

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Ms Martin and Mr Walsh in the course of 2007.⁷⁸⁰ From Ms Rankin's perspective, as set out in Section 15.13, Dr Biggs' behaviour had become "accepted behaviour".⁷⁸¹

The Infection Control Manager's knowledge

As previously mentioned, Dr Biggs expressed her dissatisfaction with her role as ICD to Mr Walsh in an email dated 1 June 2007.⁷⁸² Mr Walsh suspected that Dr Biggs might have selected him either because of his past role as Assistant Director of Nursing for NHS Argyll and Clyde, a position that included a remit for infection control, or possibly because he had been appointed to the post of Infection Control Manager.⁷⁸³ Mr Walsh's response of 5 June 2007 advised Dr Biggs to raise the issue with Ms Martin as her line manager and with Dr Jordan.

Before responding as he did, Mr Walsh discussed Dr Biggs' e-mail with Ms Martin. He was advised by Ms Martin that she would take responsibility for the immediate issue with Dr Biggs and that there was a "medium term plan"⁷⁸⁴ to replace Dr Biggs when one of two new microbiologists was appointed. Mr Walsh was not copied into the subsequent email exchanges involving Dr Biggs in which she continued to question her role and disclaimed any responsibility for the infection control service,⁷⁸⁵ and it appears that after June 2007 Mr Walsh had very little contact with Dr Biggs, who did not attend meetings of the ACIC or the BICC, of which Dr Biggs and Mr Walsh were members. His contact with Dr Biggs was limited to the meeting with her in September 2007 and "two or three other outbreak meetings".⁷⁸⁶ He was not present at the two outbreak control meetings attended by Dr Biggs in December 2007.⁷⁸⁷ He did attend outbreak control meetings in December 2007 and January 2008, but Dr Biggs was not present at those meetings.⁷⁸⁸ These outbreak meetings were not in connection with CDI.

The Inquiry accepts that Ms Rankin did pass on her concerns about Dr Biggs to Mr Walsh.⁷⁸⁹ As Mr Walsh said in evidence, he may not have been aware of the extent of the problem,⁷⁹⁰ but he could not avoid being aware that there was a problem, and he ought to have made himself aware of the extent of the problem, and to have carried out any inquiries to see if the issues raised by Dr Biggs had been resolved.⁷⁹¹

When contacted by Dr Biggs on 1 June 2007, Mr Walsh had of course still to take up post, and his response of 5 June 2007 may have been reasonable at the time,⁷⁹² but the question remains whether he should have done more thereafter to satisfy himself that any problems had been resolved.

Mr Walsh was correct in his expectation that the problem of Dr Biggs was an issue to be managed by Ms Martin.⁷⁹³ Nonetheless he had overarching responsibility for the effectiveness of the infection prevention and control system. Having become aware of the problem, and been reminded of it by Ms Rankin, it is disappointing that he did not do more to satisfy himself that the provision of the infection prevention and control service was not being placed at risk by Dr Biggs' attitude. Because Dr Biggs' responsibilities as ICD included the VOLH, the IRH and the RAH, she was a key part of the structure in so far as those hospitals were concerned. In his evidence Mr Walsh agreed that "in hindsight" he should have conducted some further inquiries to see if the problem had been resolved.⁷⁹⁴

Ms Martin's knowledge

The email exchanges between Dr Biggs and Ms Martin have already been commented upon in Section 15.13. The conclusion the Inquiry has arrived at, as discussed in Section 15.15, is that Ms Martin was not on full-time secondment in the latter part of 2007 and remained Dr Biggs' line manager. Ms Martin knew that Dr Biggs did not

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786 [TRA01200054-55](#)

787 [GGC09710001](#); [GGC09720001](#)

788 [GGC09820001](#); [GGC09850001](#); [GGC09870001](#)

789 [TRA01000070-71](#)

790 [TRA01200073-74](#)

791 [TRA01200051](#)

792 [GGC08660001](#)

793 [TRA01200028-29](#); [TRA01200051](#)

794 [TRA01200051](#)

attend the VOLH.⁷⁹⁵ As already discussed in Section 15.13 she had no proper basis in fact to believe that Dr de Villiers was covering as Infection Control Doctor for Dr Biggs when he made his visits to the VOLH. It is possible to sympathise with the view that as a Consultant Microbiologist Dr de Villiers should have been alert to infection prevention and control issues during those visits, but Ms Martin should nevertheless have satisfied herself that the ICD role was being properly fulfilled in the VOLH.

Mrs den Herder's knowledge

Mrs den Herder was not copied into the email in which Dr Biggs expressed her attitude to the role of ICD, and in her evidence to the Internal Investigation on 19 June 2008 she said she did not know that Dr Biggs was not fulfilling her role as ICD.⁷⁹⁶ There is independent support for that position, in that Mrs den Herder was involved in considering Dr Biggs' application for consultant discretionary points in which Dr Biggs held out that her professional leadership included acting as "Area Infection Control Doctor to cover 2 Consultant vacancies 2006-2008".⁷⁹⁷ Furthermore, the conversation Dr Cowan had with Mrs den Herder, probably in the summer of 2007, about advertising for two microbiology posts lends some additional support to that conclusion. Dr Cowan said that Mrs den Herder told him that the ICD wanted to give up the role, which could only have been a reference to Dr Biggs. Importantly, Dr Cowan said that Mrs den Herder did not say there was any problem with the existing ICD, for if that had been the position "it would have been a different conversation with a totally different result".⁷⁹⁸ There was no reason for Mrs den Herder to refrain from discussing with Dr Cowan Dr Biggs' failure to carry out her responsibilities for infection prevention and control at the VOLH if she was aware of that failure.

What is clear is that Mrs den Herder ought to have been made aware of that failure. Ms Martin in particular ought to have made her aware of the problems with Dr Biggs.

Furthermore, as discussed in Chapter 9, Mrs den Herder herself should have paid closer attention to infection prevention and control, and in particular should have considered whether Ms Martin was an effective link to the infection prevention and control system during her secondment, even although that secondment was only part-time.

Summary of failures over Dr Biggs

The ICD has a pivotal role to play in the management of infection prevention and control. Mr Divers observed that:

"there was a key point in time when it was clear that that sector arrangement for Clyde with Dr Biggs as the Infection Control Doctor, that that was about to come apart, nothing was done to deal with it".⁷⁹⁹

He was in no doubt that if Ms Martin had had difficulty resolving the issue "she should have elevated it",⁸⁰⁰ by which he meant raising the issue with Mrs den Herder or Mr Calderwood, and if necessary with Dr Cowan and Mr Divers himself.

Ms Martin has to accept responsibility for failing to deal with the problems created by Dr Biggs in her attitude to her role as ICD. Whatever may have been Ms Martin's understanding of whether or not there was any infection control presence at any time at the VOLH, it was perfectly clear from the messages she was receiving from Dr Biggs that Dr Biggs was not fulfilling her duties as ICD. Ms Martin's failure to address the problems created by Dr Biggs was a serious failure.

The reality is that in the latter part of 2007 no-one was prepared to tackle the issues associated with Dr Biggs. By then there was a plan to replace Dr Biggs after the appointment of the two new Consultant Microbiologists, but that does not excuse the failure at the time to deal with an ICD who was not carrying out her responsibilities for the VOLH. Ms Rankin did make Ms Martin aware of her concerns, and although Ms

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798 [TRA01220111-112](#)

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Rankin could have done more, she was faced with a situation in which Dr Biggs' behaviour had become "accepted behaviour".⁸⁰¹ Mr Walsh quite fairly accepted that with the benefit of hindsight he should have done more to see if the problems over Dr Biggs' role had been resolved. It was unfortunate that he did not do so at the time, but it is right to point out that he did direct Dr Biggs to her professional and line managers in the expectation that Dr Biggs' issues would be addressed. It also has to be acknowledged that Dr Biggs seemed to lack adequate professional line management support during the relevant period.

15.15 The secondment issue

The Picture Archiving Communication Systems

Ms Martin's role as General Manager of Diagnostic Services for Clyde has already been discussed at Section 15.3. In her evidence Ms Martin said that she was on full-time secondment to the Picture Archiving Communication Systems (PACS) project from August 2007 to April 2008.⁸⁰² Her evidence was that when on secondment she had no responsibilities for infection prevention and control.⁸⁰³ The assertion that Ms Martin was seconded full time to the PACS project was supported by Dr Alan Wallace the Lead Radiologist for the PACS project.⁸⁰⁴

No formal agreement

There does not appear to have been any formal written agreement setting out the terms of the secondment that Ms Martin was to take up. The action notes from a meeting of the Clyde Acute Senior Management Team of 22 September 2007 simply contain the following entry:

"PACs Update: Deborah advised that Marie had been seconded from GM role to lead on this for Clyde".⁸⁰⁵

The reference to "Deborah" is to Mrs den Herder.

Ms Martin's witness statement

In her witness statement to the Inquiry Ms Martin does not mention that she was on full-time secondment. She did say that "For the few months preceding my retirement I was not actively involved in any IC function".⁸⁰⁶ Ms Martin retired in August 2008.⁸⁰⁷

The Internal Investigation

At her interview by the Internal Investigation panel on 16 June 2008 it was noted that when asked about her role Ms Martin replied by saying that she was the General Manager for Diagnostics in Clyde "including responsibility for Infection Control".⁸⁰⁸ It was also noted that when asked who reported to her in connection with infection prevention and control she first named Ms Rankin, then apparently in response to a question about medical staff said "Dr Biggs, Infection Control Doctor to end January 2008, and then Dr Bagraade came into post also".⁸⁰⁹

Ms Martin did mention her secondment in explaining why she did not attend meetings of the ACIC, and was noted as saying:

"From September last year, I couldn't go to Acute IC meetings as I was on secondment. Dr Biggs plus Jean Murray attended".⁸¹⁰

It was also noted that when asked about the secondment she said:

"Secondment was supposed to be full time but GM post was not backfilled. Nobody deputised".⁸¹¹

Finally, it was noted that she said the secondment was to the end of January.⁸¹²

Ms Martin's position

Ms Martin's evidence was that having taken up her full-time secondment post she no longer had any responsibility for infection prevention and control or indeed her other duties as General Manager of Diagnostics.

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804 [GGC32120001](#); [TRA01260047](#)
805 [GGC04550003](#)

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808 [GOV00890024](#)
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Her position was that there was “a gap”⁸¹³ because her responsibilities for infection prevention and control were not taken over by somebody else. Ms Martin’s initial understanding was that Isabel Ferguson, who held a similar post to her in Greater Glasgow, would cover for her,⁸¹⁴ particularly as at that time NHSGGC was working towards full integration. She went on to say that in October 2007 she was told by Mrs den Herder that Mr Calderwood had not allowed Ms Ferguson to cover for her in that role.⁸¹⁵

Ms Ferguson’s position

As the General Manager for Greater Glasgow Laboratory Medicine and Infection Control from April 2006 to May 2008, Ms Ferguson⁸¹⁶ was the line manager for the Infection Control Doctors in the Greater Glasgow sectors. In May 2008 she also took over line management for infection control in Clyde.⁸¹⁷

Ms Ferguson, as already mentioned, was not aware of Ms Martin’s secondment at the time, nor was she aware of the proposal that she should cover for Ms Martin during that secondment.⁸¹⁸ Ms Ferguson’s understanding was that in September 2007 there was some discussion about the possibility of early integration, through which she would assume managerial responsibility for infection prevention and control for the Clyde Sector, but because the decision had already been taken that the Clyde Sector would run as a separate directorate until 2008 this was not pursued.⁸¹⁹ The issue of early integration had nothing to do with Ms Martin’s secondment.⁸²⁰ For her part, Ms Martin appeared to accept that the issue of concern to Ms Ferguson may have been early integration rather than the need to cover Ms Martin’s responsibilities for infection prevention and control because of her secondment to the PACS project.⁸²¹

Evidence adverse to Ms Martin’s position

The Inquiry is satisfied that Ms Martin participated in the PACS project. That in itself does not mean that she no longer had any responsibility for infection prevention and control. In fact when the evidence is fully considered it appears that Ms Martin continued to be involved in the management of infection prevention and control, at least to some extent.

When recalled to give further evidence Ms Martin was asked if it was still her position that a critical post such as her own was not being covered and whether she had raised that issue with anybody. She responded in the following way:

“Yes, I did complain. I did complain to Deb den Herder. I was not happy that I was really basically on a full time secondment and I still had to try to fulfil the role of the Infection Control Manager because nobody had been seconded into that. It just resulted in me working many long hours to try to fulfil that role, but I was not happy and I did complain about it”.⁸²²

In that answer Ms Martin appears to accept that she did continue to carry out infection control management responsibilities. As noted hereafter there is other evidence to support that conclusion.

Dr Bagrade’s position

When Dr Bagrade took up her post as ICD in early February 2008 she had a meeting with Ms Rankin and Ms Martin, in the course of which her role as ICD in the Clyde Sector was discussed.⁸²³ Although Dr Bagrade did not have a formal handover from Dr Biggs, she did have a meeting with Dr Biggs, attended by Ms Martin.⁸²⁴ Dr Bagrade was taking over responsibility as ICD for the VOLH and the RAH, while Dr Biggs retained responsibility as ICD for the IRH. Dr Bagrade’s line manager was Ms Martin.⁸²⁵

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821 [TRA01260065](#)

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823 [TRA01020066-80](#)

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Dr Bagraade first visited the VOLH in the second half of February⁸²⁶ and became aware of the lack of hand washing facilities. She was told by Mrs Murray that the lack of such facilities had been a longstanding problem and that new wash-hand basins had been purchased for the wards, but that due to budget restrictions they had not been installed.⁸²⁷ Dr Bagraade said she raised this issue with Ms Martin, who, according to Dr Bagraade, expressed surprise and said that she would “look into it”.⁸²⁸

Ms Martin herself said in evidence that she became Dr Bagraade’s line manager when Dr Bagraade took over from Dr Biggs.⁸²⁹ That in itself suggests that, despite Ms Martin’s protestations, she continued to be Dr Biggs’ line manager up to that point. Some aspects of the notes made by the Internal Investigation panel have already been referred to. The crux of what Ms Martin was noted as having said is that she retained her line management responsibilities.

Continuing role as General Manager

There was also a clear suggestion in documents made available to the Inquiry that Ms Martin continued to carry out certain duties in her role as General Manager of Diagnostics. At a meeting for the Clyde Acute Clinical Governance Forum on 18 September 2007 it was noted that Ms Martin gave a report on behalf of the Diagnostics Clinical Directorate⁸³⁰ intimating that the Infection Control and Blood Transfusion Committees had been integrated with Greater Glasgow.

The minutes of the following meeting of the same group on 11 December 2007 record that Ms Martin again provided a report on behalf of the Diagnostics and Clinical Directorate. That report intimated that two new consultant microbiologists were due to start and would be in post by the end of January.⁸³¹ Ms Martin’s explanation for that entry was that because she was attending anyway she was simply presenting reports

prepared by her Assistant General Managers in order to save them having to attend.⁸³²

The next meeting of that group took place on 11 March 2008 and once again Ms Martin attended. It was noted in the minutes that she provided a report on behalf of the Diagnostic Clinical Directorate, and once again that report contained matters that were not PACS issues, including intimation that the two new Consultant Microbiologists had started work at the end of January.⁸³³ Again Ms Martin explained in evidence that she was simply presenting reports from her Assistant General Managers to save them also having to attend the meeting.⁸³⁴

The email exchanges

There was also other evidence suggesting that Ms Martin continued to perform a management role in infection prevention and control. Some of the emails that she sent to Dr Biggs have already been mentioned, but in addition Dr Biggs had apparently been led to believe that Ms Martin was to hand over to Ms Ferguson, and in an email to Ms Martin dated 4 October 2007 Dr Biggs wrote as follows:

“When you meet Isobel for handover, could you make sure she knows that I am only responsible for control of Infection acute at IRH and had been doing the rest of Clyde as a voluntary help for Barbara (Weinhardt) till the new consultants start”.⁸³⁵

Ms Martin responded to that by email dated 9 October 2007 in the following way:

“as you probably gather from the letter from Deb yesterday I will not be handing over to Isobel”.⁸³⁶

In her reply on 10 October 2007 Dr Biggs commented: “I just wanted to know I am glad (glad) you are still with us”.⁸³⁷ This message appears at odds with what was said by Dr Biggs at her interview by the Internal Investigation panel on 18 June 2008, since

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827 [TRA01020092](#)
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829 [TRA01160006](#)
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831 [GGC15400003](#)

832 [TRA01260053](#)
833 [GGC03760003](#)
834 [TRA01260055-56](#)
835 [SPF01130004](#)
836 [INQ03990001](#)
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when asked about her relationship with Ms Martin she was noted as saying, “Good, but IC taken from Marie a year ago”.⁸³⁸

Ms Martin also received emails in connection with Mrs Murray’s phased retirement. By email dated 4 January 2008 addressed to Ms Martin, Mrs Murray set out her intentions during the phased retirement period of three months.⁸³⁹ By an email of the same date Ms Rankin provided Ms Martin with details of Mrs Murray’s infection prevention and control commitments during her phased retirement.⁸⁴⁰

The letter of 8 October 2007

Ms Martin’s email to Dr Biggs of 9 October 2007 refers to a letter from Mrs den Herder “yesterday”.⁸⁴¹ This letter, dated 8 October 2007, is addressed to “all staff, Clyde Laboratory Services”⁸⁴² and begins by intimating that Ms Martin has agreed to lead the implementation of PACS within Clyde, going on to say:

“I recognise that Marie will be required to be supported in various aspects of her management role to provide sufficient time to enable her to undertake the PACS work”.

Mrs den Herder also sets out in the letter that “Marie will retain her overall responsibility for laboratory management”,⁸⁴³ directly contradicting Ms Martin’s evidence that she was on full-time secondment to the PACS project in 2007 and 2008.

Mrs den Herder’s evidence to the Internal Investigation on 19 June 2008 was consistent with her letter of 8 October 2007. The following exchange has been noted:

“Q. Marie was seconded was that full time?
A. Initially she would be seconded out and we would back fill however this changed and she was told she could have some support but would still be GM (General Manager)”.⁸⁴⁴

Ms Martin and line management

Ms Martin’s position was that her post as line manager for infection control in the Clyde Sector was not filled. When she was asked in oral evidence who was managing infection control in that sector she responded in the following way:

“Well, really, then it fell to Deb den Herder herself. Because she had allowed me to take up the secondment, so she, as my manager, it was really up to her to put someone else to fill that job, but she didn’t”.⁸⁴⁵

Ms Martin’s contact with Dr Biggs ostensibly in a line management capacity has already been discussed. Furthermore, so far as Dr Bagnade was concerned Ms Martin was her line manager when she took over as ICD for the VOLH and the RAH in early February 2008. Similarly, when Ms Rankin took up her post as Infection Control Head Nurse in April 2007, Ms Martin was her line manager.⁸⁴⁶

The Infection Control Manager’s request

When Dr Bagnade took over as Infection Control Doctor in February 2008, Mr Walsh wrote to Ms Martin by email dated 6 February 2008 asking whether there had been:

“any discussion/agreement on which of the ICDs in Clyde will represent Clyde on the Acute Board Infection Control Committees?”⁸⁴⁷

Ms Martin responded by sending an email to Dr Biggs and Dr Bagnade suggesting that Dr Bagnade could represent Clyde on the ACIC and Dr Biggs represent Clyde on the BICC. She ended the email by asking them to let her know if they were in agreement with that proposal.⁸⁴⁸ When asked about this in evidence Ms Martin provided the following explanation:

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840 [GGC33010001](#)

841 [INQ03990001](#)

842 [GGC32630001](#)

843 [GGC32630001](#)

844 [GOV00890122](#)

845 [TRA01160022](#)

846 [TRA00990131](#)

847 [GGC08730001](#)

848 [GGC08730001](#); [TRA01260058-59](#)

“I was trying to plug a gap there. I had obviously been approached. Nobody backfilled for me. I mean, I could see there was nobody in that role. What actually happened was people did tend to still come to me for advice because no one else backfilled the role”.⁸⁴⁹

What this shows is firstly that Ms Martin was trying to fulfil the role of manager with responsibility for infection control, as indeed she did say at one point in evidence, and secondly that Mr Walsh was proceeding on the basis that Ms Martin was the line manager.

Letter to Dr de Villiers

Another example of Ms Martin purporting to carry out line management responsibility for a third Consultant Microbiologist is a letter dated 20 December 2007 from Ms Martin to Dr de Villiers,⁸⁵⁰ in which she wrote:

“I write to confirm that from 1 February 2008 you will no longer receive the 2 EPAs vacancy recognition payment due to the successful recruitment to the Consultant vacancies”.

When asked about this in evidence Ms Martin explained that this was a matter that her Assistant General Manager Mr Bruce Barnett was dealing with, but that because it was a matter that was dealing with payment Mr Barnett thought that it would be better if the letter was signed by her.⁸⁵¹

The Assistant General Manager's position

Mr Barnett was the Assistant General Manager for Laboratories for Clyde, a position which he held from April 2006. He had no responsibility for infection prevention and control,⁸⁵² although his line manager was Ms Martin.⁸⁵³ Mr Barnett's reaction to the letter of 20 December 2007 to Dr de Villiers was that he would not have been able to authorise such payments or negotiate their reduction with Dr de Villiers.⁸⁵⁴ He

also pointed out that the initials LS in the reference were the initials of Ms Martin's secretary.⁸⁵⁵

Ms Martin accepted that at least prior to August 2007 she was the line manager for Ms Rankin, Dr Biggs, Dr de Villiers and Dr Weinhardt. She also seemed to suggest, however, that so far as Dr Weinhardt and Dr de Villiers were concerned Mr Barnett was “their direct line manager and then I was above that”.⁸⁵⁶ That suggestion was also rejected by Mr Barnett,⁸⁵⁷ and it would certainly make little sense for Ms Martin to be line manager for Dr Biggs and not for the other Microbiologists.

Mr Barnett did not think that Ms Martin was on full-time secondment to the PACS project. She did not move her office or change her job title. He pointed to the letter from Mrs den Herder to all staff of 8 October 2007,⁸⁵⁸ which he understood to mean that Ms Martin's participation in the PACS project did not mean that she relinquished her other responsibilities.⁸⁵⁹ Furthermore, according to Mr Barnett the reports that Ms Martin made to the Clyde Acute Clinical Governance Forum were not being made on behalf of her Assistant General Managers, but were made in the normal course of her being General Manager of Diagnostics and retaining managerial responsibilities for that area. The PACS update would simply have been a part of that responsibility.⁸⁶⁰

The Director's position

The position adopted by Mrs den Herder towards the Inquiry has already been commented upon in Chapter 2. Only if Mrs den Herder's written evidence is not disputed or can be supported by other evidence, can any reliance be placed upon it by the Inquiry.

In her letter of 22 June 2012 to the Inquiry Mrs den Herder responded to the issue of Ms Martin's secondment in the following way:

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855 [WTS02340011](#)
856 [TRA01260045](#)
857 [WTS02340006](#)
858 [GGC32630001](#)
859 [WTS02340008](#)
860 [WTS02340010](#)

“I understand that there is some confusion about Mrs Martin’s secondment to a role of project manager for the imaging archiving system. I can confirm that it was the initial intention to second her full time, and to transfer the control of infection control responsibilities to Ms Ferguson. This was vetoed, however, on the grounds that it would appear to pre-empt a measured process towards integration and would further negative perceptions of a Glasgow takeover. Because this was vetoed, and because other options (separate recruitment to the project management post or backfill from the redeployment pool, both of which were investigated) were not possible, it was agreed that Mrs Martin would retain responsibilities for those elements of the service that could not be delegated. This latter included the control of infection service (the remaining elements were transferred to her assistants)”.⁸⁶¹

The position set out in Mrs den Herder’s letter was put to Ms Martin,⁸⁶² who rejected the proposition that she retained responsibility for infection prevention and control,⁸⁶³ but the evidence already examined in this Section contradicts Ms Martin and supports Mrs den Herder’s evidence.

The Associate Medical Director’s position

Dr Dickson succeeded Dr Jordan as Associate Medical Director in September 2007.⁸⁶⁴ On management issues he reported to Mrs den Herder.⁸⁶⁵ Dr Dickson was not made aware of the difficulties with Dr Biggs or of the email exchanges which included Dr Jordan.⁸⁶⁶ He was aware that Ms Martin had been asked to undertake a secondment, but his understanding was that she was continuing her role as General Manager with support.⁸⁶⁷

Conclusion on secondment

The Inquiry is satisfied that Ms Martin did not take up a full-time secondment position in August 2007 at the expense of her infection prevention and control management duties. She contradicted herself in evidence, maintaining on the one hand that because of her secondment there was a gap in the management structure, while on the other hand claiming that she was “working many long hours” to fulfil the management role.⁸⁶⁸

It has to be acknowledged that Ms Martin was placed in a difficult position because of the extent of her role after she took up her secondment duties. She continued to deal with a number of general management duties and infection prevention and control matters. She was considered by Mrs den Herder and others to be the responsible manager. Ms Martin said in evidence that the consequence of her secondment without cover was that there was a gap and that it was for Mrs den Herder to fill that gap.⁸⁶⁹ That assertion was incorrect for the simple reason that Ms Martin’s involvement with the PACS project was not at the expense of other duties. The intention set out in Mrs den Herder’s letter of 8 October 2007 was that Ms Martin would be able to obtain support from her assistant managers. The secondment issue does undoubtedly highlight the fact that there was a major flaw in the infection prevention and control management arrangements, but it was not the one identified by Ms Martin.

Mrs den Herder does not escape criticism for placing Ms Martin in such a difficult position, and this is also examined in Chapter 9. It is clear that Ms Martin did complain to Mrs den Herder about the pressure she was under⁸⁷⁰ because of the extent of her responsibilities. Mrs den Herder should have responded positively to those complaints, but she failed to do so. Furthermore, Ms Martin’s complaints of overwork should have alerted Mrs den Herder to the real possibility that the management of infection prevention and control was at risk of being neglected.

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867 [WTS02290002-03](#)

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15.16 The reporting of *C. difficile* data to Health Protection Scotland and the Public Health Protection Unit

Mandatory reporting

As discussed in Chapter 6, mandatory reporting of *C. difficile* toxin positive cases was required from 1 September 2006 as part of the national surveillance system. Reporting from the Clyde Sector was carried out on a weekly basis with separate reports for each of the hospitals. For the VOLH the first stage of the reporting process was managed from the RAH.

Mr Mallon's role

In the period from 1 January 2007 to 1 June 2008 Mr John Mallon held the post of Chief Biomedical Scientist in the RAH Laboratory.⁸⁷¹ He had been directly involved in setting up the Laboratory Information Management System (LIMS) that was installed in the VOLH, the IRH and the RAH Laboratories.⁸⁷² The system in each of the laboratories was the same and as a result it was possible to recover at the IRH Laboratory data put on the system at the VOLH Laboratory.

Reporting methods – Health Protection Scotland

From 1 January 2007 to 5 February 2008 reports were sent in paper form from the laboratories to Health Protection Scotland (HPS) providing details of *C. difficile* toxin positive cases. After the installation of an electronic system known as the Electronic Communication of Surveillance in Scotland System (ECOSS) in November 2007, reports were sent to HPS both in paper form and electronically⁸⁷³ while HPS carried out a validation exercise⁸⁷⁴ to check the accuracy of the paper and electronic results. From 5 February 2008 reports were sent electronically only.

Content of the reports

The reports identified the patient's name, gender, and date of birth, as well as the ward in which the patient was being accommodated

at the time. By way of example the report for the week ending 25 January 2008 disclosed that there were three patients who were *C. difficile* toxin positive in ward F in the course of that week.⁸⁷⁵ The report was designed by Mr Mallon to be signed by a Consultant Microbiologist.

Submission of reports to Microbiologists

RAH reports were sent direct to HPS, whereas VOLH reports were sent to the VOLH Laboratory for checking and onward transmission to HPS. Before this stage, however, it was Mr Mallon's practice to have the printed reports, including the VOLH reports, sent to the Microbiologists' office in the RAH.⁸⁷⁶ So far as Mr Mallon was concerned the purpose of this part of the exercise was that a Consultant Microbiologist would have sight of not just what was happening at the RAH but also what was happening in the VOLH.⁸⁷⁷ Even after the ECOSS system was in operation the printed reports from the VOLH were sent to a Consultant Microbiologist and thereafter filed.⁸⁷⁸ That remained the position until the middle part of 2008.⁸⁷⁹

The position at the VOLH Laboratory

When the VOLH reports were received by the VOLH Laboratory they were checked by Mr Kinloch. Prior to the change to the electronic system in February 2008, if he was satisfied with the accuracy of the reports he would sign each of them on behalf of a Consultant Microbiologist, having been instructed to do so by Dr Weinhardt,⁸⁸⁰ and post them to HPS. Although Dr Weinhardt could not remember delegating that duty to Mr Kinloch, she thought it was very likely that she did so because it was important that the information contained in the reports was sent to HPS on a timely and accurate basis⁸⁸¹ and she was not on site at the VOLH.

The role of the Microbiologists

Although Dr Bagnade did not take over the responsibilities of the ICD for the VOLH

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878 [TRA01100084](#)
879 [TRA01100085](#)
880 [TRA00870034-35](#)
881 [TRA00880002-03](#)

until 4 February 2008, she did take up the post of Consultant Microbiologist on about 21 January 2008.⁸⁸² Dr Bagnade had a clear recollection of signing the reports for the RAH,⁸⁸³ and explained that in doing so she was confirming that they provided an accurate reflection of the results.⁸⁸⁴ By contrast, Dr Bagnade had no recollection of seeing the VOLH reports. Her recollection was that when all the reports were taken to the Microbiologists' office a secretary separated those requiring to be signed at the RAH, and it was only those reports that were signed by a Microbiologist in the RAH. The VOLH reports were sent to the VOLH Laboratory for signing.⁸⁸⁵

Dr Bagnade emphasised that this part of the reporting system was never designed to be a surveillance tool. It was simply a method of identifying how many patients had been diagnosed with CDI in a particular week to be submitted to HPS as part of the national surveillance programme.⁸⁸⁶ Nonetheless Dr Bagnade did say that, after she became ICD for the VOLH, if she had seen that there were three or possibly more patients who were *C. difficile* toxin positive in a particular ward in a week she would have investigated to see what was going on.⁸⁸⁷

Dr Weinhardt confirmed that she definitely had sight of the reports for the RAH,⁸⁸⁸ but the thrust of her evidence was that she had no recollection of the VOLH reports.⁸⁸⁹ She also said that as far as the VOLH reports were concerned Mr Kinloch's function was simply to check the accuracy of the data, and that he had no responsibility for monitoring the position because, according to Dr Weinhardt, that was already in place with the presence of the Infection Control Team.⁸⁹⁰ Dr Weinhardt's initial position was that if she had seen a report that indicated that there were a number of positive patients in a ward at about the same time that would

have been a matter of concern which she would probably have raised in a general way with the ICNs.⁸⁹¹ Later she said that she might have raised it in passing, but that in any event the ICNs would already know about the position from their own records.⁸⁹² Her final position was that at that time she would not necessarily have raised the issue,⁸⁹³ but that the position was different now and if she were to be in that situation today she would raise it.⁸⁹⁴

Dr Claxton took up the post of Consultant Microbiologist at the RAH on 28 January 2008.⁸⁹⁵ She also said that she looked at the reports for the RAH, but did not pay particular attention to the CDI numbers because she knew they would already have been considered by the Infection Control Team.⁸⁹⁶ She had no recollection of seeing the VOLH reports.⁸⁹⁷

Having regard to that evidence, it appears to have been the case that the microbiologists at the RAH did not see the VOLH reports before they were sent to the VOLH Laboratory.

Receipt of data by HPS

Professor Jacqui Reilly, Head of Group for Healthcare Associated Infection, HPS, provided some insight into how the reports containing the information on *C. difficile* toxin positive cases were managed once received by HPS prior to the time when the ECOS system was fully functional. Hundreds of weekly reports would be received from the laboratories, but there was no standard form of report. Although ward level information was being provided, that information was not relevant for national surveillance, and some laboratories did not send ward based information. Neither was the weekly information contained in reports of interest to HPS, because quarterly rather than weekly data were used for CDI analysis. Furthermore, paper records were destroyed once

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information had been entered into the HPS database in accordance with a policy devised under requirements of data protection.⁸⁹⁸ In short, the whole purpose of the reporting to HPS was that of national surveillance so that the trends at Board, regional or national levels could be examined.⁸⁹⁹ HPS was not responsible for local surveillance, which was entirely the responsibility of Boards. This was clear from the guidance that had been provided over the years, including the CSBS Standards.⁹⁰⁰

The essence of the HPS position was that the system of national surveillance that followed the introduction of mandatory reporting was not intended in any shape or form to replace effective systems of local surveillance and reporting.

Reporting to the Public Health Protection Unit

Copies of the reports sent to HPS were also sent to the NHSGGC Public Health Protection Unit (PHPU) on a weekly basis in terms of a policy that required microbiologists to report to the PHPU *C. difficile* toxin positive cases that were reported to HPS.⁹⁰¹ Dr Ahmed, Consultant in Public Health Medicine and Clinical Consultant in the Public Health Protection Unit, explained that the PHPU performed a surveillance function, particularly in relation to community acquired notifiable diseases such as tuberculosis and hepatitis. The role of the PHPU was to ensure that such cases were followed up in the community, since most cases were acquired in the community.⁹⁰²

The weekly reports submitted by laboratories such as the VOLH Laboratory were a form of safety net, for although laboratories were supposed to inform the PHPU of notifiable diseases, on occasion they would forget to do so.⁹⁰³ Laboratories were therefore instructed to submit copies of the forms submitted to HPS to allow the PHPU to check they had received the relevant information on the

cases in which the unit might be interested.⁹⁰⁴ Accordingly, although CDI was included in the information submitted, it was not among the diseases on which the PHPU carried out surveillance in the community.⁹⁰⁵ Dr Ahmed went on to explain, however, that the PHPU would take action if a case of CDI was identified in the community. The identification of community acquired CDI was carried out by a clerk, and if the patient was based in a nursing home or a residential home for which the unit had responsibility then that would be followed up. On the other hand, if the case of CDI was from a hospital, the clerk would simply not do anything with it⁹⁰⁶ and the report would then be filed away.⁹⁰⁷ PHPU was not performing a surveillance function in relation to CDI that was hospital acquired: it was the role of the hospital Infection Control Team to perform that function.

No failures by HPS or PHPU

The Inquiry is satisfied that the system of reporting weekly results to HPS and the PHPU was not designed to provide those bodies with information that could have alerted them to the CDI problem in the VOLH. The reporting to HPS was part of the national surveillance programme and was not a local surveillance system. The reporting of CDI cases to the PHPU was incidental to its surveillance of community acquired notifiable diseases.

15.17 Statistical Process Control Charts

A surveillance tool

The Statistical Process Control (SPC) chart was a surveillance tool that could provide retrospective information on a monthly basis on the number of *C. difficile* toxin positive patients and trends.⁹⁰⁸ Although available in 2007 in some Board areas, SPC Charts were not introduced to the VOLH until April or May 2008.⁹⁰⁹

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 907 [TRA01130157-158](#)
 908 [TRA01200135](#)
 909 [TRA00990095](#)

The creation of SPC Charts

The SPC Charts are the application of statistical theory to quality control.⁹¹⁰ Calculations from the data acquired on cases of CDI are used to produce an upper control limit, a centre line and a lower control line. To introduce the system it is necessary to have a minimum of two years of data⁹¹¹ in order to set the upper and lower control limits. The most recent point on an SPC Chart will be the most recent four weeks or calendar month.⁹¹² In addition to providing information on rates and trends, SPC Charts also act as a quality improvement tool, since if results below the lower control limit are achieved, both the upper and lower control limits will drop. Fewer cases will then be required to meet the new, and more demanding, upper control limit.⁹¹³

Delayed introduction to Clyde

When in use SPC Charts are made available on wards so that staff can see rates of infection. The system was seen as a “robust system”⁹¹⁴ and valuable in the management of infection prevention and control. There is, however, a time delay between occurrence of infection and the presentation of the data on the SPC Chart, and the earliest detection of outbreaks remains at ward level by the Infection Control Team.⁹¹⁵

First introduction of the SPC Chart

The SPC Chart system was first set up in Glasgow Royal Infirmary in response to an “uncontrollable level of MRSA”⁹¹⁶ in 2000, although Professor John Coia, Director of Scottish Microbiology Reference Laboratories, thought that charts might have been introduced in November 1999.⁹¹⁷ Their use contributed to a 50% reduction in new cases of MRSA in the course of 2000, and they were also being successfully used in the control of CDI.⁹¹⁸ Therefore, although in evidence Ms Rankin described the SPC Chart

system as a “relatively new concept”,⁹¹⁹ it had in fact been in existence in at least in one hospital in the former Greater Glasgow area since 2000.

Availability of SPC Charts

SPC Charts had apparently been available in certain areas of NHSGGC in 2006.⁹²⁰ Originally the plan under the annual infection control programme was to have SPC Charts in place across the whole Health Board area, including Clyde, by September 2007.⁹²¹ As already mentioned, the SPC Charts were not introduced to the VOLH until April or May 2008,⁹²² but the introduction of the system to areas other than the Clyde Sector was successfully completed within the proposed timescale.⁹²³

There appear to have been two reasons for the delay in introducing the charts to the Clyde Sector. Firstly, the definition used for HAI in the Clyde Sector differed from that in Greater Glasgow, which used the national prevalence definition. This defined HAI as an infection which occurred 48 hours after admission to hospital, whereas in the Clyde Sector the timescale used was 72 hours. Consequently all the cases of CDI in Clyde had to be reviewed in order to match the national and Greater Glasgow definition.⁹²⁴ The second reason for the delay was that the RAH did not have an electronic surveillance system⁹²⁵ for MRSA. The RAH used a T-card system, and all the relevant data were on the T-cards, so that it was necessary to examine hundreds of T-cards.

Somewhat surprisingly, Ms Rankin thought that SPC Charts had been available in the VOLH in December 2007 and included data relevant to November 2007.⁹²⁶ She said she was not aware that they had only been introduced to the VOLH after Ms Higgins took up her post as interim Lead Nurse in Infection Control in April 2008.⁹²⁷

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 917 [TRA01220032-33](#)
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 920 [TRA01130139-140](#)
 921 [GGC19420006](#)
 922 [TRA00990095](#)
 923 [GGC32180011](#)
 924 [TRA01020080-83](#); [GGC32180011](#)
 925 [TRA01020081](#)
 926 [TRA01000093](#)
 927 [TRA01000092](#)

Mr Divers' position on SPC Charts

By coincidence the SPC Chart system was introduced in the VOLH at about the time the CDI problem was becoming evident. Mr Divers regretted that the system had not been implemented more quickly in the VOLH, as he considered that the SPC Chart system offered "a level of fail-safe and cover, even if there was a series of earlier failures".⁹²⁸ He did agree that a policy decision in 2007 to introduce the system across the Health Board area seemed to represent a long delay since the work that had been done on SPC Charts in 2000.⁹²⁹

SPC Charts – a difference?

The Inquiry considers that Mr Divers was correct in believing that, had SPC Charts been in place in 2007, an increased level of awareness would have been generated in relation to rates of CDI at the VOLH and it is likely that the CDI problem would have been discovered sooner. That having been said, the dissolution of NHS Argyll and Clyde and the integration with GGHB only took place in April 2006 and it is clear that the preparations for the introduction of the SPC Chart system in the VOLH were going to take some time. In the circumstances set out in this Section it was not unreasonable that the introduction of the SPC Chart system to the Clyde Sector, and the VOLH in particular, suffered some delay in comparison to other areas of NHSGGC. It must also be stressed that SPC Charts are not a substitute for acute observation in real-time. The yellow T-cards should have alerted the Infection Control Nurses to the extent of the problem with CDI at the VOLH. The Access database was also a source that should have been used to identify rates and trends of CDI.

15.18 The VOLH Laboratory accreditation

The responsible body

Clinical Pathology Accreditation (UK) Limited (CPA) is the body responsible for the accreditation of laboratories in Scotland. Accreditation is granted if after assessment the Laboratory is in full compliance with internationally laid down standards for quality and competence.⁹³⁰ A Laboratory can also be granted conditional approval if there are non-compliances with the standards. Non-compliances can be graded as critical or non-critical. All issues of non-compliance must be addressed for accreditation to be obtained, although critical non-compliance has to be responded to more urgently.⁹³¹ New and more exacting standards were published in 2004.⁹³²

Non-compliances

The VOLH Laboratory was inspected by CPA on 29 January 2003 and granted conditional approval.⁹³³ That remained the position until further inspection by CPA on 18 and 19 September 2007,⁹³⁴ when the VOLH Laboratory was again granted conditional approval. Mr Kinloch said that after the 2003 inspection the technical non-compliances were corrected.⁹³⁵ He thought that accreditation had not been granted thereafter because of problems over consultant microbiologist cover, although such cover was provided from April 2006 when Dr Weinhardt became Head of Department for the VOLH Laboratory.⁹³⁶

The September 2007 inspection produced a list of 43 non-compliances.⁹³⁷ These included the failure for some years to conduct staff annual joint reviews. There was, however, a timetable available for such reviews to take place in late 2007 and early 2008.⁹³⁸ Mr Kinloch explained that joint reviews had not taken place because he thought the Laboratory would have been closed prior to

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933 [GGC30370001](#)
934 [TRA00870056-57](#); [TRA00870125](#)
935 [TRA00870056-62](#)
936 [TRA00850100](#); [TRA00870071-72](#)
937 [GGC30380001](#); [GGC30360001](#)
938 [GGC30380001](#)

the notice of the pending CPA visit,⁹³⁹ and having had notice of the CPA visit in advance he had prepared a timetable showing planned staff reviews.⁹⁴⁰ The inspection report also included criticisms of document control and of a lack of auditing of the time taken between receipt of a specimen and entry into the LIMS system. The inspection identified the fact that the date of the entry into the LIMS system could in fact be the day after receipt by the Laboratory,⁹⁴¹ as discussed in Chapter 14. There was no audit system in place at that time,⁹⁴² but an audit was carried out after the inspection.⁹⁴³ The Laboratory did not obtain accreditation until January 2009,⁹⁴⁴ by which time all the non-compliances identified at the 2007 inspection had been rectified.⁹⁴⁵ The Laboratory closed in January 2010.⁹⁴⁶

The Inspectors' overview report

Although the list of non-compliances might suggest management and organisational problems, the CPA inspectors' overview report described the Laboratory as well managed and well led.⁹⁴⁷ The numerous document control issues disclosed by the inspection were explained by the fact that the Laboratory was in a transitional phase of migrating to an electronic system. The inspectors concluded that despite the number of non-compliances the quality of the service provided was not being compromised.⁹⁴⁸

Despite the tenor of the overview report, the extent of the non-compliances shows that the general management of the microbiology service did need to be improved. This is not a criticism of Dr Weinhardt, who had been placed in a difficult position as a result of the manner in which the microbiology service was being run in 2007. The Laboratory management of faecal samples sent for *C. difficile* toxin testing is considered in Chapter 14.

15.19 Risk registers

Risk management

As discussed in Chapter 7, the importance of managing the risk of HAI in Scotland has been recognised since at least April 2001, the date of publication of the report of the Joint Scottish Executive Health Department Working Group chaired by Mr Richard Carey. Reference has also already been made to the consultation document produced in 2004, "The Risk Management of HAI: A Proposed Methodology for NHS Scotland consultation document".⁹⁴⁹ The Scottish Government proposals following that consultation process were not published until November 2008,⁹⁵⁰ but prior to that, in October 2005, NHS Quality Improvement Scotland (NHSQIS) published national standards in clinical governance and risk management⁹⁵¹ which acknowledged that "Organisations that manage risk effectively and efficiently are more likely to achieve safe and effective care".⁹⁵² It was a mandatory requirement that NHS Boards had systems in place to manage risk.⁹⁵³

An important strategy for the management of risk is the use of risk registers. The creation and maintenance of a risk register ensures that risks relevant to a particular area of health care have been identified. Where possible, risks are removed, but otherwise the risk register ensures that appropriate controls and precautions are in place to prevent those risks materialising.⁹⁵⁴

The key to the creation of a risk register is risk assessment. That involves assessing the nature of the risk and the likelihood of the risk occurring. The assessment reviews the controls already in place and evaluates what additional controls may be necessary. Within an organisation such as NHS GGC, risk registers should be maintained at different levels including hospital level.⁹⁵⁵

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 953 [INQ04970009](#)
 954 [TRA01040047](#); [QIS02200005](#)
 955 [EXP02820027-30](#); [TRA01040047-50](#)

NHSGGC Risk Register Policy

NHSGGC implemented a Risk Register Policy on 1 April 2006,⁹⁵⁶ acknowledging in that document that:

“The continuing development of a comprehensive risk register is a core part of risk management activity”.⁹⁵⁷

The objectives of the risk register included achieving proactive rather than reactive management in order to reduce the likelihood that risks will occur, and ensuring that all significant risk register management concerns were properly considered and communicated to the Board.⁹⁵⁸ The Chief Executive had overall responsibility for having an effective risk register management system in place by ensuring that appropriate structures were in place and adequate resources were available to provide effective risk management throughout the Health Board area.⁹⁵⁹ Under the policy Directors had to ensure that a comprehensive risk register was established and maintained for their areas so as:

“to provide an accurate account of the risks preventing the achievement of objectives for their area of responsibility”.⁹⁶⁰

The risk register system was intended to operate on three main levels; at the corporate level, the directorate level, and the clinical services and operational service level. The policy set out who was to be responsible for these levels of risk registers and who should monitor them. It also set out what was to be involved in the risk register process, how risk was to be assessed and the sources of information for the risk registers.⁹⁶¹ The Risk Register Policy was updated in April 2007 without any significant revision.⁹⁶²

Operational risk registers in the VOLH

There were generic operational risk registers available for the wards in the VOLH with some reference to infection prevention

and control issues. The risk register for the Cardiac Care Unit for 2006 to 2007 identified “isolation procedure” as a high risk and described the existing controls as “inadequate”.⁹⁶³ The risk register for ward 6 for the period from 20 September 2006 to a review date of 31 March 2007⁹⁶⁴ identified isolation procedures as a low risk and the controls in place as adequate.⁹⁶⁵ The ward F risk register dated 2 February 2008 identified isolation procedures as a medium risk and also described the controls in place as adequate.⁹⁶⁶

The operational risk registers in the VOLH generally tended to identify contamination of equipment and needle-stick injuries as risks.⁹⁶⁷ Risks relating to the condition of the hospital environment were also identified. The risk register for ward 3 for 2006 to 2007 identified the high risk of slipping on the “wet bathroom and ward floor due to water spillage from shower”,⁹⁶⁸ and recorded that the existing controls were inadequate. A similar entry on shower spillage into the ward is made in the risk register for the Cardiac Care Unit for the same period.⁹⁶⁹

At least two ward risk registers identified the fact that windows were dangerous to use.⁹⁷⁰ The problem with a wandering patient in ward F has already been identified in Chapter 12, and the risk register dated 2 February 2008 does identify as a medium risk a confused patient entering the “wrong room”,⁹⁷¹ describing the controls in place as adequate. Only the risk register for the Renal Unit for the period 21 March 2006 to March 2007 refers to HAIs as a high risk requiring action,⁹⁷² including adherence to infection control policies and procedures.⁹⁷³

956 [QIS02200001](#)
 957 [QIS02200003](#)
 958 [QIS02200003](#)
 959 [QIS02200003](#)
 960 [QIS02200004](#)
 961 [QIS02200004-10](#)
 962 [GGC04850001-02](#)

963 [GGC04880004](#)
 964 [GGC04910001](#)
 965 [GGC04910005](#)
 966 [GGC04950002](#)
 967 [GGC04880002](#); [GGC04880010](#); [GGC04880012](#);
[GGC04880013](#); [GGC04880016](#); [GGC04890002](#);
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The corporate risk register

The risk register maintained at corporate level was intended to identify those risks that had been assessed as being high or very high. The corporate risk register dated January 2008⁹⁷⁴ does not identify HAI as a risk. The updated risk register of December 2008⁹⁷⁵ does, and describes the further action required to reduce the risk.⁹⁷⁶

Risk register for healthcare associated infections (HAIs)

A risk register specifically for infection prevention and control for the Acute Services Division was first discussed at a meeting of the ACIC on 26 November 2006. There was some further discussion on the topic at the following meeting on 23 January 2007.⁹⁷⁷ Thereafter at the meeting of 15 May 2007 it was reported that the ICNs had met and had identified a number of risks for incorporation in the risk register.⁹⁷⁸

By the time of the ACIC meeting of 24 July 2007⁹⁷⁹ Ms Rankin had taken on responsibility for the work necessary for the proposed risk register.⁹⁸⁰ At the meeting itself Ms Rankin advised that she expected that a draft would be ready to be submitted to the next meeting,⁹⁸¹ and at the following meeting Ms Rankin intimated that she had submitted a draft to Dr Reid.⁹⁸² Ms Rankin explained in evidence that the risk register was in draft form as there were areas such as antimicrobial prescribing which were outside her remit and needed to be completed by others, although at that stage she and the Lead Nurses in Infection Control had identified relevant risks for infection prevention and control and she had included those risks in the draft.⁹⁸³ The draft risk register required to be reviewed and approved by the ACIC itself.⁹⁸⁴

Ms Rankin's draft risk register

The draft infection prevention and control risk register did not make specific mention of CDI, but it did mention MRSA.⁹⁸⁵ It identified non-compliance with infection control policies resulting from cross infection as a risk,⁹⁸⁶ and the actions to be taken included education of staff about infection prevention and control policies and monitoring of monthly HAI rates.⁹⁸⁷ In the section headed "outbreaks" a generic outbreak is defined as "Two or more linked cases (or isolates) within a healthcare premises".⁹⁸⁸ Closure of a ward to admissions and curtailment of transfers to other healthcare establishments are included in the controls required to deal with an increased incidence of cases in a ward.

Completion of the risk register

There was some further discussion of the risk register for infection prevention and control at meetings of the ACIC in 2008. At the meeting of 25 March 2008 it was noted that the infection prevention and control risk register was not completed and still required some work.⁹⁸⁹ That risk register is mentioned again at the next meeting on 3 June 2008, with a note that Ms Rankin was to report back to the next meeting.⁹⁹⁰ No update was provided at the meeting of 30 September 2008, but at the meeting of 3 December 2008 there was some discussion and some amendments to the draft were considered. It was at that meeting that the decision was taken that the infection prevention and control risk register could be made "live".⁹⁹¹

The delay in completion

It seems that from the time the risk register for infection prevention and control was first considered by the ACIC in November 2006 it took just over two years for a final version to be approved. Mr Calderwood agreed that "looking back, it does seem rather a long time".⁹⁹² What is more, it appears that CDI did not feature in earlier drafts, and that it

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 983 [TRA01000047](#)
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 987 [GGC31250003](#)
 988 [GGC31250009](#)
 989 [GGC01890003](#)
 990 [GGC01870003](#)
 991 [GGC01880004](#)
 992 [TRA01240015](#)

was only at the meeting of 3 December 2008 that the decision was taken for CDI to be included.⁹⁹³

Although the methodology for the risk registers for HAI was not published by the Scottish Government until November 2008, the consultation process had begun in 2004. The need for the management of risk generally had been emphasised by NHS QIS in October 2005.⁹⁹⁴ The NHSGGC Board's response in putting in process the preparation of the risk registers in November 2006 was a perfectly adequate one, and an example of a Board applying the best practice at the time based on the guidance available. Thereafter, however, there was undue delay in putting in place a risk register dealing with infection prevention and control.

Whether having such a risk register more quickly would have made any difference to the CDI problem that developed at the VOLH is difficult to say. The opinion of Mrs Perry was that the risk had to be adequately described and the appropriate controls put in place. Further, she considered that a failure to do so could impair the work necessary to prevent a HAI like CDI.⁹⁹⁵ The identification of HAI and CDI in particular as a risk on the risk register would have raised awareness of such a risk, and that is undoubtedly what the Board set out to do in November 2006. It has to be recognised that when that process began it was one of the many issues facing the Board at a time of significant change, and that the emergence of the VOLH CDI problem did increase the level of attention paid to infection prevention and control after June 2008.⁹⁹⁶

15.20 Hygiene, environment and audits

Importance of cleanliness

The national *C. difficile* guidance published in 1994,⁹⁹⁷ and still relevant to Scotland in 2007 and 2008, emphasised the importance of personal and environmental cleanliness

to the prevention and control of CDI.⁹⁹⁸ The intention in this Section is to consider a number of issues relating to hygiene and environment at the VOLH in the period prior to June 2008. It examines how well the Cleanliness Champions Programme (CCP) was implemented, and also reviews how conducive certain environmental factors were to the spread of an infection such as CDI.

As explained in Chapter 3, CDI produces spores that enable it to survive in the environment for significant periods of time. Healthcare staff or patients can have frequent contact with contaminated areas such as toilets and surfaces, with the result that an infection can be spread easily by hand transfer. Hand hygiene in particular is of extreme importance in the prevention of the spread of an infection like CDI, but so too are environmental factors. It is obvious, for example, that damaged surfaces make cleaning more difficult, for the removal of micro-organisms is harder from damaged or irregular surfaces than smooth surfaces.⁹⁹⁹ The NHSScotland Code of Practice for the Local Management of Hygiene and Healthcare Associated Infection (2004)¹⁰⁰⁰ provides that patients, staff and visitors have "a right to, and expect, a safe physical healthcare environment".¹⁰⁰¹ The Code recognises that cleanliness is essential to this right and expectation.

The Cleanliness Champions Programme

The background to the creation of the Cleanliness Champions Programme has been discussed in Chapter 7. When launched in September 2003 as part of the first HAI Task Force Plan the CCP was viewed as an important aspect of infection prevention and control.

As explained in Chapter 7, in a letter dated 18 March 2005 addressed to Chief Executives, NHS Boards and Nursing Directors, the Chief Nursing Officer sought to reinforce the importance of the nursing contribution to the "culture" of "infection

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 995 [TRA01050168](#)
 996 [TRA01220144-145](#)
 997 [INQ01700001](#)

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 999 [EXP02820075-76](#)
 1000 [GOV00090001](#)
 1001 [GOV00090019](#)

control is everyone's responsibility".¹⁰⁰² The Chief Nursing Officer required all grade G Sisters/SCNs to "undertake the Cleanliness Champions educational programme forthwith",¹⁰⁰³ and went on to say that local implementation should take account of workload and available access to the required IT resources.¹⁰⁰⁴

Initial G grade completion target – July 2007

At the request of the Inquiry NHSGGC provided details of the healthcare staff at the VOLH who had completed the programme since the time of its launch in September 2003 including the period 1 January 2007 to 1 June 2008.¹⁰⁰⁵

The Inquiry has examined the rates of CDI at the VOLH in a number of different wards. Wards 3, 5, 6, 14, 15 and F have come under particular scrutiny. Despite the terms of the Chief Nursing Officer's letter of 18 March 2005, and so far as the Inquiry can determine from the documents submitted by NHSGGC, prior to January 2007 possibly only five members of the nursing staff from these particular wards had completed the programme.

The need for improvement

It is apparent that in the course of 2007 some consideration was given to the need to increase the number of nurses who had completed the CCP. At the meeting of the Professional Nursing Forum of 27 February 2007, which covered the three Clyde hospitals, it was agreed that the priority would be nursing staff at grades G and F completing the CCP.¹⁰⁰⁶ This equates generally to Sisters (SCNs) and Deputy Sisters. At the next meeting of that group on 27 March 2007 it was noted that the majority of Ward Managers had commenced the CCP but were finding it very difficult to find time to complete the programme.¹⁰⁰⁷

At the meeting of the Professional Nursing Forum of 26 April 2007 a target was set

that all G grade nurses in Clyde were to have completed the CCP by 31 July 2007.¹⁰⁰⁸ Any G grade nurse who had not registered had to do so and would have up to 30 September 2007 to complete it. F grade nurses were also given a deadline of 30 September 2007 to complete the programme.¹⁰⁰⁹ Clearly there was a desire that nursing staff at those grades proceed expeditiously towards completion of the programme. So far as the Inquiry can ascertain, it seems that in the VOLH only one additional G grade nurse from the wards of particular interest to the Inquiry completed the programme by the 31 July 2007 deadline. Two grade F nurses and a grade D nurse also completed the programme prior to that date.

It appears to have been the case that in 2007 NHSGGC was underperforming generally in relation to healthcare staff completing the CCP. At the ACIC meeting of 15 May 2007 Ms Rankin reported that "the board was significantly off target".¹⁰¹⁰ She also reported that a one year post of Practice Development Nurse – Infection Control Champion was being advertised in order to lead the programme.

The VOLH perception

In the VOLH there was a perception that progress was being made. At the Sisters' meeting on 28 June 2007 Mrs Rawle, Lead Nurse for the Rehabilitation and Assessment Directorate, is noted as having advised the meeting that:

"it was now alright to roll out the training to E grades, provided all G and F grades had been done".¹⁰¹¹

The training records, however, do not bear out that degree of progress.¹⁰¹² Furthermore, in the period of 31 July 2007 to the end of December 2007 only three nurses in the wards of particular interest to the Inquiry completed the programme. Two were at grade G level and one at grade F.

¹⁰⁰² [GOV00440010](#)

¹⁰⁰³ [GOV00440011](#)

¹⁰⁰⁴ [GOV00080002](#)

¹⁰⁰⁵ [INQ05250001](#); [GGC26620001-03](#)

¹⁰⁰⁶ [GGC15090002](#)

¹⁰⁰⁷ [GGC15100002](#)

¹⁰⁰⁸ [GGC15110002](#)

¹⁰⁰⁹ [GGC15110002](#)

¹⁰¹⁰ [GGC02310004](#)

¹⁰¹¹ [GGC03980002](#)

¹⁰¹² [GGC26620001](#)

An overview of the position at the VOLH

Table 15.10 has been compiled from the information supplied to the Inquiry by NHSGGC on the nursing staff levels in wards at the VOLH¹⁰¹³ and from the training records.¹⁰¹⁴ The ward staffing levels have been taken from the figures available for January 2008.¹⁰¹⁵ The Table provides a

breakdown of the nurses who completed the CCP in the wards of particular interest to the Inquiry. This is divided into the pre-1 January 2007 period, the early period (1 January 2007 to 30 November 2007) and the focus period (1 December 2007 to 1 June 2008).

Table 15.10 Nurses who completed CCP by ward prior to 1 June 2008

Ward	Number of nursing staff	Before 01/01/07	Early period 01/01/07 to 30/11/07	Focus period 01/12/07 to 01/06/08	Total
3	18	0	2	0	2 (11%)
5	23	1	2	0	3 (13%)
6	16	0	2	0	2 (13%)
14	12	1	1	0	2 (17%)
15	13	3	0	0	3 (23%)
F	14	0	0	0	0 (0%)
Total	96	5	7	0	12 (13%)

Table 15.11 shows during which period the G grades (Sisters/Ward Managers) and F grades (Deputy Sisters) for each ward completed the CCP.

Table 15.11 Period during which Sisters and Deputy Sisters completed CCPs

Ward	Before 01/01/07	Early period 01/01/07 to 30/11/07	Focus period 01/12/07 to 01/06/08	Post 01/06/08
3		Deputy		Sister
5	Deputy	Sister		
6		Deputy + Sister		
14	Deputy	Sister		
15	Deputy + Sister			
F				Sister
MAU				Sister + Deputy

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1015 [GGC21710001-22](#)

Ward F

According to the training records supplied to the Inquiry, Sister Gargaro, SCN on ward F, did not complete her CCP until 8 October 2008. In her statement she indicated that she had completed the programme in early 2007.¹⁰¹⁶ This was incorrect, and in fact no nurses in ward F had completed the CCP prior to 1 June 2008.

Time taken to complete the programme

As already explained, the CCP involved no more than 20 hours of online learning and was capable of being completed in 16 weeks. The SCNs at the VOLH took between nine and 31 months to complete the programme,¹⁰¹⁷ the average being around 23 months. Table 15.12 sets out the time taken to complete the CCP by SCNs associated with the wards of particular interest to the Inquiry.

Table 15.12 Time taken to complete CCP by Ward Managers

Ward	Date completed	Months to complete
15	8 August 2006	9
6	26 June 2007	15
14	27 August 2007	15
5	5 November 2007	25
3	24 September 2008	31
F	8 October 2008	29

Inaction

It seems that little was done when the set completion targets were not met. There is no evidence that failures to meet the targets were discussed at a senior level, and it is clear that the programme did not receive the priority it should have received. So far as the VOLH was concerned, the completion rate of the programme in the period prior to June 2008 was extremely slow. A more determined attitude to infection prevention and control would have provided more impetus to the implementation of the programme.

Terminal cleans

In the Scottish Executive Policy document, “The NHSScotland National Cleaning Services Specification”, published in May 2004, a terminal clean is defined as the procedure required:

“to ensure that an area has been cleaned/ decontaminated after a patient with an alert organism or communicable disease has been nursed in the area, in order to render it safe for the next patient”.¹⁰¹⁸

The Board’s Infection Control Manual contained policies providing guidance on terminal cleans¹⁰¹⁹ and the twice daily cleaning,¹⁰²⁰ of isolation rooms.

Based upon information made available to the Inquiry by NHSGGC,¹⁰²¹ Table 15.13 provides details of full ward terminal cleans that took place at the VOLH in the period from December 2007 to June 2008. Because outbreaks of CDI were not identified prior to May 2008, there were no ward terminal cleans or ward closures in response to CDI

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1021 [GGC15790001](#)

until then, although some of the ward terminal cleans which were carried out in response to norovirus outbreaks are likely to have coincided with CDI outbreaks. There

were in addition 283 terminal cleans of single rooms and patient bays in the VOLH in that same period¹⁰²² in response to suspected or confirmed infection.

Table 15.13 VOLH terminal cleans December 2007 to June 2008

DATE	WARD	REASON FOR TERMINAL CLEAN
21/12/07	6	Norovirus outbreak
28/12/07	F	Norovirus outbreak
07/01/08	15	Norovirus outbreak
10/01/08	14	Norovirus outbreak
16/01/08	14	Norovirus outbreak
24/01/08	15	Norovirus outbreak
11/02/08	14	Norovirus outbreak
25/02/08	F	Norovirus outbreak
25/04/08	F	Norovirus outbreak
14/05/08	6	Preventative measure as part of management of three linked 027 C.diff cases at VOLH and RAH
15/05/08	3	Preventative measure as part of management of three linked 027 C.diff cases at VOLH and RAH
26/05/08	15	Preventative measure as part of management of three linked 027 C.diff cases at VOLH and RAH
28/05/08	14	Preventative measure as part of management of three linked 027 C.diff cases at VOLH and RAH
16/06/08	5	Preventative measure as part of response to retrospective outbreak
17/06/08	3	Preventative measure as part of response to retrospective outbreak
20/06/08	F	Preventative measure as part of response to retrospective outbreak
24/06/08	14	Preventative measure as part of response to retrospective outbreak
25/06/08	15	Preventative measure as part of response to retrospective outbreak

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Some environmental issues

From April 2007 Mr John Menzies was the Site Estates Manager at the VOLH,¹⁰²³ responsible for the day-to-day maintenance of the buildings and engineering services.¹⁰²⁴ From 2004 to April 2007 he had been the Estates Project Manager for the VOLH.¹⁰²⁵ In essence his job involved ensuring that proper planned maintenance systems were in place.¹⁰²⁶

Mr Menzies explained that in the years leading up to June 2008 there was limited funding available for the effective maintenance of the VOLH.¹⁰²⁷ There was a belief that the future of the VOLH was in doubt, and the maintenance budget was used primarily in an attempt to keep the environment of the VOLH as safe as possible.¹⁰²⁸ He gave the example of how damage to floor coverings was addressed in the period up to June 2008. A high number of slips, trips and falls had been reported because of the state of the floor coverings,¹⁰²⁹ for which the obvious solution would have been to replace the flooring. Instead, because of budgetary constraints, minor repairs were carried out using tape to cover gaps in joints in the floor coverings.¹⁰³⁰ Mr Menzies said this made cleaning more difficult.¹⁰³¹ There were also serious problems with the internal fabric of the building because of lack of resources.¹⁰³² The evidence of patients and families on the condition of the VOLH is addressed in Chapter 11, and much of their evidence on the condition of the VOLH in the period 2007 to June 2008 was supported by Mr Menzies.

The walk rounds

On 23 and 27 May 2008 Ms Higgins led an inspection of areas in the VOLH. Having succeeded Mrs Murray on 9 April 2008,¹⁰³³ she asked for the environmental audit results for the VOLH,¹⁰³⁴ and was reassured by

what appeared to be satisfactory scores,¹⁰³⁵ but when she discovered in May 2008 that there was a problem with CDI in ward 6 she decided to organise the inspections.¹⁰³⁶ Ms Higgins thought Mrs O'Neill accompanied her on 23 May,¹⁰³⁷ and those involved on 27 May 2008 included Mr Menzies and Mrs O'Neill.¹⁰³⁸ Two reports of these inspections were prepared.¹⁰³⁹

The report of 23 May 2008 was solely on the inspection of the ward 6 area.¹⁰⁴⁰ A significant number of environmental issues were discovered in the course of that inspection, including the following:

- Many visitor chairs were non-intact
- Areas of the floor were non-intact and covered in adhesive tape
- There was a lack of wash-hand basins within the ward
- Linen was stored within patient bed areas
- Weighing scales in the toilet were very dusty
- There was no wash-hand basin in the treatment room
- Many bags of linen and waste and Book Club books were stored in the sluice area
- Pressure-relieving cushions were being shared by patients¹⁰⁴¹

Ms Higgins explained that matters such as the storage of linen in patient areas were not good practice, particularly if a patient has diarrhoea, and that linen should be stored separately to prevent possible contamination.¹⁰⁴² Pressure-relieving cushions should not be used by different patients without being cleaned in line with the decontamination policy.¹⁰⁴³ Ms Higgins was concerned that what she discovered in ward 6 did increase the risk of cross-contamination of an infection like CDI.¹⁰⁴⁴

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 1029 [TRA01120020-21](#)
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 1036 [TRA00990055-56](#)
 1037 [TRA00990055](#)
 1038 [GGC07560006](#)
 1039 [INQ04080001](#); [GGC07560006](#)
 1040 [INQ04080001](#)
 1041 [TRA00990049-54](#)
 1042 [TRA00990051](#)
 1043 [TRA00990052](#)
 1044 [TRA00990055-56](#)

Most of the remaining areas of the VOLH were inspected in the course of the inspection of 27 May 2008, including the medical assessment unit and wards 3, 5, 14, 15 and F.¹⁰⁴⁵ Of greatest concern to Ms Higgins was the lack of wash-hand basins in most of the areas visited, which she said created the greatest risk of cross infection. There were patient toilets that had no wash-hand basins,¹⁰⁴⁶ and patient bays in the medical assessment unit and ward 3 had no wash-hand basins, so that staff and patients were required to leave these areas and use wash-hand basins in the main ward areas when they wished to wash their hands.¹⁰⁴⁷

There were areas where surfaces and floors were non-intact.¹⁰⁴⁸ The floors in areas in ward 14 required immediate attention because of the poor state of repair.¹⁰⁴⁹

Dust was seen on items such as an emergency trolley,¹⁰⁵⁰ roof vents,¹⁰⁵¹ and a bath aid.¹⁰⁵² There was a soiled commode in ward 3,¹⁰⁵³ and many of the commodes were found not to be fit for use and required to be replaced urgently.¹⁰⁵⁴ A toilet seat in ward 5 was seen to be soiled. Clean linen was stored beside dirty linen.¹⁰⁵⁵ The cleaning issues identified by Ms Higgins were the responsibility of the nursing staff and not the domestic staff.¹⁰⁵⁶

Ms Higgins said that she was disappointed and surprised by what she discovered during the inspections. She thought she had assurances that the environment of the VOLH was satisfactory because of the environmental audit scores that had been reported.¹⁰⁵⁷

Following upon the inspection of 27 May 2008, a further assessment was carried out

on 11 June 2008 by a group including Mr Menzies. Areas that required immediate action included a review of bed spacing, which was “minimal”, throughout the hospital, the replacement of commodes and a review of the shortage of wash-hand basins.¹⁰⁵⁸

The inspection findings again fit well with some of the evidence provided by patients and families about the condition of the VOLH described in Chapter 11.

Purchase of wash-hand basins in 2006

The inspections of 23 and 27 May 2008 identified the lack of appropriate numbers of wash-hand basins as the most concerning issue. The shortage of wash-hand basins was well known and had been identified in environmental audits.¹⁰⁵⁹ Mr Menzies, however, said he was not aware of the shortage,¹⁰⁶⁰ although he was aware that there were no wash-hand basins in some of the toilets in the VOLH.¹⁰⁶¹

Ten new wash-hand basins and associated fittings were purchased for the VOLH in early 2006.¹⁰⁶² The Scottish Executive had provided a sum in the region of £25,000 to NHS Argyll and Clyde for the specific purpose of putting improvements in place in connection with HAI,¹⁰⁶³ and it appears that £4500 of that sum was provided to the estates department of the VOLH and used to purchase the wash-hand basins.¹⁰⁶⁴ The purpose was not to install wash-hand basins in new locations where there ought to have been wash-hand basins, for example in toilets, but to replace old wash-hand basins and fittings that were no longer fit for purpose.¹⁰⁶⁵

In anticipation of the work being carried out in early 2006¹⁰⁶⁶ Mrs Murray prepared a replacement plan with details of the locations as well as an explanation of why the replacements were required, which included the poor state of some wash-hand basins and

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 1062 [TRA01120031-32](#); [INQ05260003](#)
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 1066 [INQ00440001](#); [WTS01170024](#)

the widespread absence of elbow taps. There were cracked wash-hand basins in ward 15, some taps were not working properly, and in the sluice of the day hospital the wash-hand basin taps did not work at all.¹⁰⁶⁷ Mrs Murray's programme also set out the order of priority of items to be replaced.

The Estates Manager at the time of the purchase was Mr John Gilmore, who left that position on 27 March 2007.¹⁰⁶⁸ The wash-hand basins and fittings were not installed prior to his departure due to lack of funds in the building budget.¹⁰⁶⁹ All available plumbing funding was used during that period to target operational priorities.¹⁰⁷⁰

In her evidence Mrs Murray said that she was "pushing"¹⁰⁷¹ for the wash-hand basins to be installed, but that there was reluctance by anyone to accept responsibility for the cost of the installation.¹⁰⁷² Although the position is far from clear, it appears that some wash-hand basins had been installed in a piecemeal fashion as replacements¹⁰⁷³ by the time Mrs Murray left in March 2008.

Mr Menzies only became aware of the purchase of the wash-hand basins and fittings when he was interviewed by the Health and Safety Executive in March 2009.¹⁰⁷⁴ He carried out some inquiries at that time and ascertained that no money had been made available to allow the installation programme to go ahead.¹⁰⁷⁵ He also checked to see if there were wash-hand basins in storage and could not find any.¹⁰⁷⁶ Annual stocktaking had ceased a few years previously and so, according to Mr Menzies, he would not be aware of the existence of the wash-hand basins unless it was drawn to his attention.¹⁰⁷⁷

At the Infection Control Working Group Meeting held on 14 May 2008 it was noted

that wash-hand basins and taps had been purchased for the VOLH but no money had been made available to install them. The minutes record that the estimated cost of installation was £1000, and that Ms Martin was asked to identify a source of funding.¹⁰⁷⁸ It may therefore be that the absence of wash-hand basins in storage when Mr Menzies checked in 2009 can be explained by the fact that any wash-hand basins that had not been installed prior to May 2008 were installed after that meeting.

Reaction to the inspection findings

A number of witnesses in senior posts were asked about their reactions to the reports of the inspections of 23 and 27 May 2008. Ms McNamee said she was surprised to discover that there was a lack of wash-hand basins in the VOLH. She had practised as an ICN in all the hospitals in North Glasgow and had never come across a situation where there were no wash-hand basins in patient bathrooms or any bay area.

Ms Harkness had responsibility for RAD areas including wards 14, 15 and F from 1 September 2007, the date of integration. She was also surprised by some of the findings that were made. She had not been aware that the flooring or the showers were in the state that they were in. Nor was she aware that there was a lack of wash-hand basins.¹⁰⁷⁹ She would have expected such issues to be highlighted in the environmental audits. If not addressed at that point, she would have expected them to be "escalated" to her for priority funding.¹⁰⁸⁰ She understood that the environmental audits for these wards had scored at an acceptable level and she therefore did not intervene.¹⁰⁸¹ As discussed later in this Section, however, the lack of wash-hand basins and the non-compliance with appropriate standards were issues raised in audits.

Mr Calderwood was also surprised at the findings, particularly in relation to the wash-hand basins. He would have expected action to have been taken by NHS Argyll and

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 1080 [TRA01180134-35](#)
 1081 [TRA01180134](#)

Clyde.¹⁰⁸² Mr Divers could not comprehend how there could have been a difficulty in installing wash-hand basins that had been purchased,¹⁰⁸³ although he accepted that the uncertainty over the future of the VOLH had led to reluctance to commit major sums of money to its refurbishment. His conclusion was that there had developed a “mind set” that “well, things don’t get done around here”.¹⁰⁸⁴

The response to the Stoke Mandeville report on environmental issues

Following upon the report on the CDI outbreaks at Stoke Mandeville Hospital by the Healthcare Commission for England and Wales,¹⁰⁸⁵ all NHS GGC site managers were asked to review matters highlighted in the report that were relevant to their location.¹⁰⁸⁶ Such a review of facilities services was carried out in the VOLH on 14 February 2007 by Ms Catriona Sweeney, the Site and Facilities Manager, Mrs Lena Keeley, the Assistant Domestic Services Manager, and Mrs O’Neill,¹⁰⁸⁷ and identified cluttered environments and a lack of storage facilities.¹⁰⁸⁸ When the position was reviewed in February 2008 the problem of lack of storage space still existed, and this was confirmed by the inspections in May 2008.

The review in February 2007 also identified poor maintenance of the fabric of the VOLH and equipment as issues of concern.¹⁰⁸⁹ It noted that the Estates Department did not have a budget for painting and fabric repairs, and that all repairs were either of an emergency nature or when there was a breakdown.¹⁰⁹⁰ There was no change in the position at the review in February 2008 or at the time of the May 2008 inspections. The response to Stoke Mandeville and other outbreaks is considered more generally in Chapter 18.

Audits

Infection control audits, including audits of the hospital environment, hand hygiene and isolation precautions, were to be carried out on an annual basis in the VOLH.¹⁰⁹¹ Mrs Perry explained that the purpose of such audits is to assess compliance against set standards. An overall percentage score is calculated under reference to criteria set out in the audit tool, and an audit score below 70% should be considered one which requires immediate remedial action.¹⁰⁹² The audit tool used in the VOLH was based on an audit system that was widely used by Infection Control Teams across the United Kingdom at the time.¹⁰⁹³ Once the audit had been completed the ICN would send an action plan to the SCN and expect to receive feedback once the actions in the plan had been completed.¹⁰⁹⁴

Hand hygiene audits

Although the audit tool included a section dealing with hand hygiene, other specific hand hygiene audits were carried in the VOLH by Mr Stefan Morton, the Hand Hygiene Coordinator.¹⁰⁹⁵ This was a more thorough assessment.¹⁰⁹⁶ Table 15.14 has been compiled from the audits carried out by Mr Morton and displays the compliance scores of all staff at the VOLH.¹⁰⁹⁷ The groups which would have the most contact with patients are nursing and medical staff. The nursing staff generally performed better than the medical staff, and indeed in some instances the comparison is quite marked.

1082 [TRA01240088](#)
 1083 [TRA01250129](#)
 1084 [TRA01250131](#)
 1085 [INQ02890001](#)
 1086 [GGC07790001](#)
 1087 [GGC20710001](#)
 1088 [GGC20710001-02](#)
 1089 [GGC20710003](#)
 1090 [GGC20710003](#)

1091 [WTS00870020](#)
 1092 [TRA01040042](#); [EXP02800026](#)
 1093 [TRA01040042](#)
 1094 [TRA00960018](#)
 1095 [TRA00960006](#)
 1096 [TRA00960006](#)
 1097 [GGC02940003](#); [GGC02930003](#); [GGC03010003](#);
[GGC03020003](#); [GGC02950003](#); [GGC02960003](#);
[GGC02970003](#); [GGC02980003](#); [GGC03030003](#);
[GGC03050003](#); [GGC03040003](#); [GGC02890003](#);
[GGC02880003](#); [GGC02900003](#); [GGC02920003](#);
[GGC02910003](#)

Table 15.14 Hand Hygiene Audit – Compliance of staff

Ward	Date	Staff Group Compliance			
		Nurse (%)	Medical (%)	AHP* (%)	Others (%)
3	28/02/2007	78	25	67	50
	12/06/2008	92	33	0	100
4	08/04/2008	100	75	0	33
	17/06/2008	92	100	0	100
5	09/07/2007	82	0	83	67
	12/06/2008	100	67	0	25
6	10/07/2007	92	67	50	50
	12/06/2008	88	67	83	100
F	09/07/2007	89	100	100	20
	25/02/2008	64	0	100	100
	17/06/2008	100	75	100	25
14	28/02/2007	90	33	100	40
	16/06/2008	86	50	100	100
15	10/07/2007	88	100	63	0
	25/02/2008	100	80	80	50

*AHP – Allied Health Practitioners

Table 15.15 has been compiled from the overall compliance scores compiled separately by Mr Morton and by the ICNs. It is to be noted that the audit tools used to assess compliance are different, but in the majority of cases there are no significant differences between the two scores. Mrs

Perry explained that that spread of results is what she would expect from any audit programme.¹⁰⁹⁸ Scores in the region of 70% to about 85% would normally include an improvement plan, and 85% to 100% was often seen as acceptable practice.

Table 15.15 Overall compliance in hand hygiene audits

Ward	Year	Overall compliance (Stefan Morton) (%)	Overall compliance (Infection Control Audit) (%)
3	2007	60	71
	2008	85	95
4	2007	0	78
	2008	85	0
	2008	95	0
5	2007	80	78
	2008	80	0
6	2007	80	80
	2008	85	86
F	2007	75	87
	2008	70	0
	2008	80	0
14	2007	70	76
	2008	85	83
15	2007	65	84
	2008	75	0

0 = no information available

Environmental audits

Table 15.16 sets out the compliance scores for environmental audits assessed by ICNs. This includes items of equipment relevant to infection control, among them commodes. Of the ten audits carried out during that

particular period, in seven instances commodes did not comply with standards. The letter X denotes non-compliance, and the reasons for non-compliance have been set out in the third column of the table where available.

Table 15.16 Environmental audits

Ward	Year	Overall compliance (%)	Commodes non-compliant
3	01/10/2007	70	X
	09/05/2008	75	X (Stained underside and frame)
4	07/08/2007	83	X (Frames need thorough clean)
5	07/08/2007	81	X (Ingrained dirt and rusted)
6	29/04/2007	65	X (Dirty - faeces)
	08/05/2008	71	X (Faecal staining)
F	12/10/2007	88	
14	08/08/2007	78	X (Dirty)
	04/2008	83	
15	14/06/2007	90	

The environmental audits also highlighted the inadequate number of wash-hand basins and fittings. All of the wards listed in Table 15.16 were assessed as having either an inadequate number of wash-hand basins or wash-hand basins and fittings that did not conform to the required standards.

Auditing of infection control policies

The *C. difficile* Policy and the Loose Stools Policy contained audit tools¹⁰⁹⁹ detailing the criteria that had to be met. Table 15.17¹¹⁰⁰ sets out the audit tool in the *C. difficile* Policy. The policies provide that the audits were to be carried out by the Infection Control Team or by a member of the ward staff or healthcare worker.¹¹⁰¹

Table 15.17 Audit criteria

	Criteria	Score Yes, No, Not applicable
1.	Patients with CDAD are nursed in a single room with their own toilet facilities/commode.	
2.	Linen from isolated patients is disposed of as fouled/infected.	
3.	Patients with CDAD have been allocated their own equipment.	
4.	All commodes in use are visibly clean.	
5.	There are no extraneous items in isolation rooms.	
6.	There is no fabric furniture in use in clinical areas.	

When asked specifically about auditing the implementation of the *C. difficile* Policy Mrs O'Neill said she had not been aware of the existence of the audit tool and that no such audits were carried out.¹¹⁰² She only became aware of the tool after June 2008, and since then audits have been carried out in compliance with the policy. Because of the absence of appropriate auditing there was previously no formal assurance that policies like the *C. difficile* and Loose Stools Policies were being properly applied in practice.¹¹⁰³

Nursing feedback to audits

The system of audits involved the ward implementing an action plan and feeding back to the ICNs that appropriate remedial action had been taken. A lack of resources meant that action to resolve the wash-hand basin problem or even any problems

with commodes could not be taken.¹¹⁰⁴ The process of acting upon the audit findings was locally managed,¹¹⁰⁵ and there was no follow-up through the managerial structure when problems identified could not be remedied.¹¹⁰⁶

Summary

The picture that emerges from the evidence set out in this Section, and further developed in Chapter 8, is that of a hospital dogged by uncertainty before and after the dissolution of NHS Argyll and Clyde. NHS GGC inherited a hospital in which underinvestment in maintenance and infrastructure had existed for a number of years. The environmental deficiencies had existed in the years prior to

1102 [TRA00950025](#)

1103 [TRA01040038](#); [EXP02820026](#)

1099 [GGC0078025Z](#); [GGC00780262](#); [GGC27590006](#)

1100 [GGC01010006](#)

1101 [GGC0078025Z](#); [GGC00780262](#); [GGC27590006](#)

1104 [WTS01170020-21](#)

1105 [WTS01170020](#)

1106 [TRA01050004-05](#)

dissolution and persisted afterwards without resolution. Mrs Murray did say that defective commodes might eventually be replaced but it was a “drip, drip sort of situation”, and they were “always working with equipment that was in some measure of bad state of repair”.¹¹⁰⁷ There was an acceptance that because of the lack of investment the improvements were not going to happen.¹¹⁰⁸ Until a decision on the VOLH’s future could be made the problem of lack of investment could not be addressed. This is considered in Chapter 8.

The infection control audit process did identify key areas of persistent non-compliance, but there was no effective process of ensuring managerial awareness at a level where appropriate action could be taken. Environmental issues that had a clear impact on infection prevention and control were not addressed. Patients were put at risk. Staff morale was affected. Uncertainty led to the acceptance of the unacceptable from the perspective of patient safety.

15.21 Changes after June 2008

Significant changes

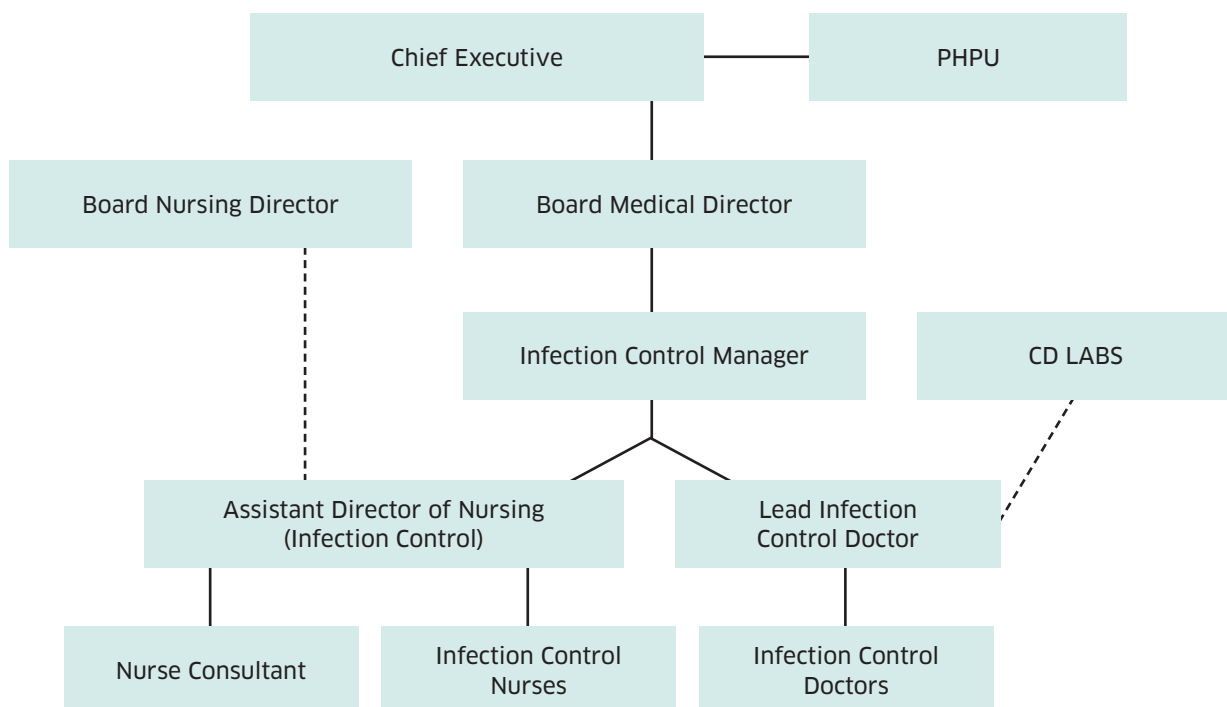
The NHSGGC Board responded promptly to the discovery of the failures that had occurred in the VOLH prior to June 2008 and made important changes to the infection control structures. The intention in this Section is to identify the more significant changes made after June 2008.

As discussed earlier, the Chief Executive is responsible for ensuring that there is successful infection prevention and control throughout the Health Board area. From January 2009 Dr Cowan had responsibility for the oversight of the infection prevention and control arrangements, although the Chief Executive maintained ultimate responsibility.¹¹⁰⁹

Infection prevention and control management structure

A revised management structure was approved in December 2008 and fully implemented by February 2009.¹¹¹⁰ Figure 15.8¹¹¹¹ sets out the revised structure.

Figure 15.8 Infection control management structure 2009 onwards



1107 [TRA01010029](#)

1108 [TRA01010027](#); [WTS01170021](#)

1109 [GGC04500001-02](#); [TRA01220137](#)

1110 [GGC32220166](#); [TRA01220138](#)

1111 [GGC32220170](#)

Board to ward accountability is provided by a single management structure with the Board Medical Director, as the accountable executive officer, reporting to the Chief Executive. The Board Medical Director is now required to bring infection control and HAI reports to every Board meeting. This is to be the first item on the agenda.¹¹¹² As already mentioned in Section 15.5 the Infection Control Manager’s role and job description were revised to include operational management responsibility for all ICNs and ICDs. The Infection Control Manager has to report directly to the Board Medical Director, and included among his duties is the provision of monthly reports to directors detailing agreed infection control data.¹¹¹³

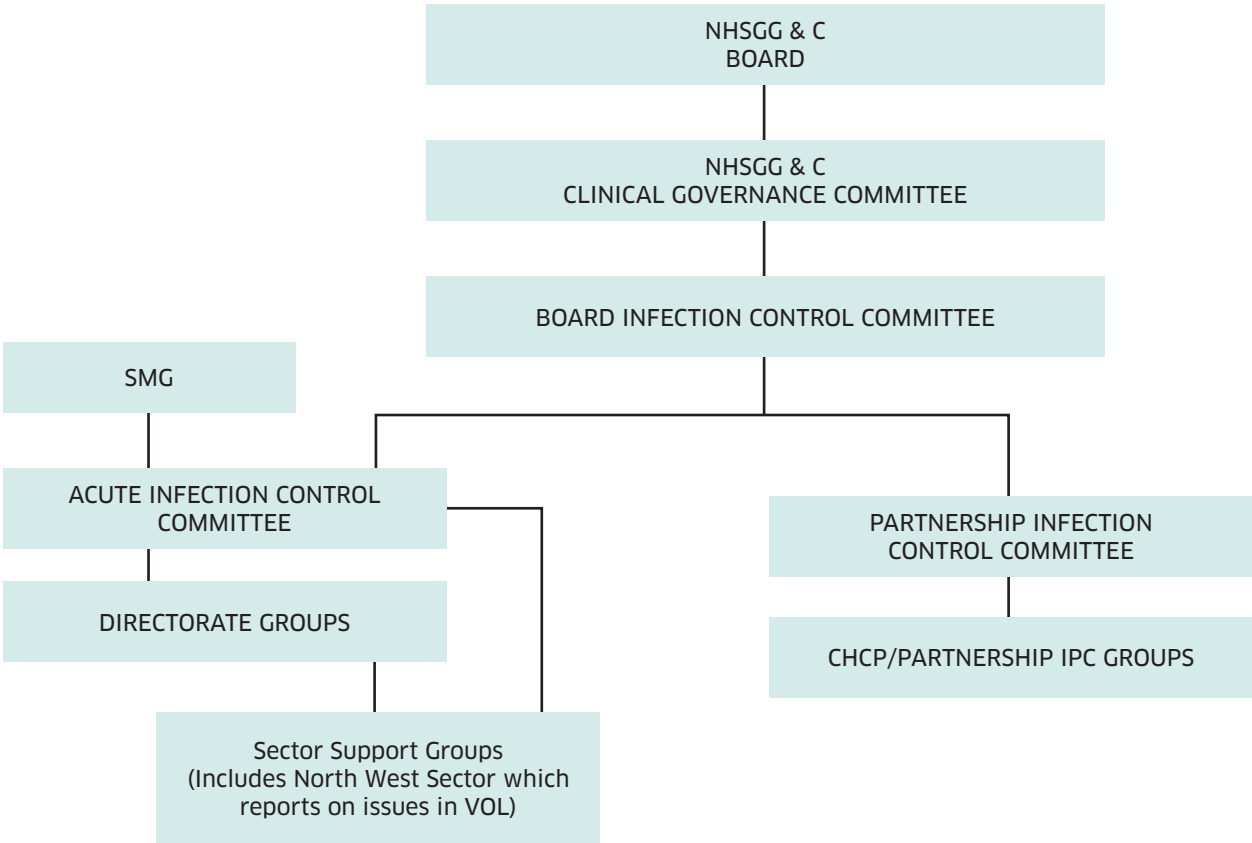
A new post of Assistant Director of Nursing (Infection Control) has been created to provide managerial and professional

leadership to all the ICNs in NHSGGC. Included in the post holder’s duties is the role of assisting the Infection Control Manager in discharging his responsibilities. A post of Lead Infection Control Doctor has also been created to provide professional and managerial leadership to the ICDs in NHSGGC. The job description provides that a specific proportion of time is to be devoted to that role, and included among the post holder’s duties is that of providing expert advice to the Infection Control Manager and Board Medical Director.¹¹¹⁴

The committee structure

There have also been changes to the infection prevention and control committee structure. Figure 15.9¹¹¹⁵ sets out the revised structure. The VOLH is now under the jurisdiction of the North West Sector.

Figure 15.9 Infection control committee structure 2009 onwards



1112 [GGC04500003](#)
1113 [GGC04500004](#)

1114 [GGC04500005](#)
1115 [GGC32220170](#)

Governance accountability and reporting arrangements

There have been significant changes made to the reporting arrangements and to the

monitoring and reporting system for HAI such as CDI. Table 15.18¹¹¹⁶ summarises some important aspects of these changes in the Acute Division.

Table 15.18 Infection control report – Timetable for CDI

Frequency	Report	Issued to
Twice weekly	Lead Nurses Report Verbal – Tuesday Written – Friday	Assistant Director of Nursing (Infection Control) On call Microbiologists and Clinical Coordinators
Weekly	Infection Control Weekly Update report – includes breaches in the UCL* in any ward. Any instances where two cases of HAI CDI have been identified in a two week period. Any deaths related to CDI. Any other significant clinical incidents.	Board Nurse and Medical Directors Chief Operating Officer and Chief Executive Officer Acute Directors Infection Control Manager Lead Infection Control Doctor
Monthly	Directorate Reports – includes results of Hand Hygiene Audits, Infection Control Audits, trajectories to meet HEAT targets, failure to isolate, Directorate SPC Charts, any wards that have breached their UCL.	Acute Directors
Monthly	Statistical Process Control Charts	Senior Charge Nurses and Lead Nurses
Monthly	Assistant Director of Nursing (Infection Control) – Infection Control Update	Heads of Nursing (Acute) Acute Nurse Director
Bi monthly	Healthcare Associated Infection Reporting template	NHS Board and Quality and Performance Committee ACIC Board Infection Control Committee Senior Management Team (Acute) Antimicrobial Utilisation Committee
Bi monthly	Sector Report from Lead Nurse, Infection Control	ACIC

*UCL – Upper Control Limit

Infection prevention and control education and training

The intention is that all Lead Nurses for Infection Control are to be educated to Master's level. As at 2012, of the five Lead Nurses, three had obtained a Master's degree. A fourth had completed the Master's degree course and the fifth Lead Nurse had 20 years' experience, a BSc degree in Health Studies and a diploma in Infection Control. All Senior ICNs are educated to diploma level and all other ICNs are required to complete a course of training within a year of commencement.¹¹¹⁷ Formal appraisals of each member of the Infection Control Team are carried out on an annual basis.¹¹¹⁸

The Cleanliness Champions Programme has already been discussed in Section 15.20. The uptake of the programme by members of staff at the VOLH increased significantly after June 2008.

The NHSGGC Infection Control Team now provides a programme of education and training in infection prevention and control.¹¹¹⁹ The Infection Control Team at the VOLH provides education on infection prevention and control to all grades of staff. Furthermore, a course of mandatory education update training was developed in 2010 to 2011 across the Acute Division. Infection prevention and control is a core part of this training.¹¹²⁰

In 2008 the Board launched an in-house education package known as Training Tracker. The programme contains 18 online education modules accessible to all staff in NHSGGC. The Infection Control Team supports the delivery of this education programme through continuous updating of the programme to reflect current policy and practice.¹¹²¹ Table 15.19¹¹²² sets out the training tracker modules taken at the VOLH in 2009 to 2011, and the number of staff members who undertook the modules.

1117 [GGC32220176](#)
1118 [GGC32220176](#)

1119 [GGC32220175](#)
1120 [GGC32220179](#)
1121 [GGC32220178](#)
1122 [GGC32220178](#)

Table 15.19 Training Tracker Modules taken at VOLH (2009-2011)

Year	2009	2010	2011
HAI Induction	20	124	170
Admission Assessment	6	76	59
Hand Hygiene	25	154	320
Influenza (including H1N1)	1	45	166
Standard Precautions	12	127	276
Transmission Based Precautions	5	89	152
Decontaminating Equipment and Environment	6	92	158
Outbreaks	5	75	132
Tuberculosis	7	66	126
MRSA	9	84	142
<i>C. difficile</i>	25	79	200
Measles	5	51	114
Rubella	5	44	110
Care Bundles	4	53	122
Policy Documents and SOPs	3	48	119
<i>Staphylococcus aureus</i> Bacteraemia	5	48	114
Understanding Statistical Process Control Charts	0	39	107
Blood borne Viruses	0	0	143
Totals	132	1294	2730

Infection prevention and control policies

The infection prevention and control policies have all been updated since 2009. The Outbreak Policy is updated on a yearly basis and all other policies are updated on a three year programme.¹¹²³

An audit programme to monitor compliance with the infection prevention and control policies is now in place in addition to the

Infection Control Safe Patient Environment Audit discussed below.¹¹²⁴

Infection Control Safe Patient Environment Audit

This audit is to be undertaken in every ward on at least an annual basis. The scoring system and the re-audit cycle are set out in Table 15.20.¹¹²⁵

1123 [GGC32220179](#)

1124 [GGC32220180](#)

1125 [GGC32220181](#)

Table 15.20 Scoring system and re-audit cycle

	Gold – 91% or above	Re audit in one year
	Green – 80-90%	Re audit in one year
	Amber – 66-79%	Re audit in six months
	Red – less than 66%	Re audit in three months

The audit is carried out by the Infection Control Team. After the audit has been completed the issues raised must be responded to by providing an action plan to the Infection Control Team within one month.¹¹²⁶ The Assistant Director of Nursing (Infection Control), the General Manager and

the Head of Nursing are to be informed of all red audit scores. Table 15.21¹¹²⁷ sets out the results obtained from the Infection Control Safe Patient Environment Audit in 2010 and 2011 before and after the refurbishment of the VOLH.

Table 15.21 Infection Control Safe Patient Environment Audits 2010-2011

Pre Refurbishment	Post Refurbishment	2010	2011
Ward 6	Ward 6 Surgical	84% Green	93% Gold
Ward 5 Surgical	Ward 5 Outpatient Oncology	97% Gold	Oncology OP 97% Gold Haematology OP 98% Gold
Ward 14 RAD	Ward 14 RAD	88% Green	85% Green
Ward 15 RAD	Ward 15 RAD	85% Green	90% Green
Ward F RAD	Closed	89% Green	Closed
Lomond Ward Medical	Lomond Ward Medical	96% Gold	97% Gold
Ward 4 (CCU) Medical	Outpatient B department	86% Green	96% Gold
Ward 3 Medical	Ward 3 AMRU	84% Green	93% Gold

1126 [GGC32220181](#)1127 [GGC32220181](#)

Risk management in infection prevention and control

In Section 15.19 it was pointed out that infection prevention and control was not specifically incorporated into the risk register process until December 2008. NHSGGC now has a risk management strategy that takes into account the Scottish Government proposals contained in “The Risk Management of HAI: A Methodology for NHSScotland” published in 2008.¹¹²⁸ Each clinical directorate in the Acute Division includes infection prevention and control risks in its individual directorate risk register. Furthermore, the Infection Control Manager has the responsibility for the overarching infection control risk register, which is monitored by the ACIC and reviewed annually.¹¹²⁹

Public focus patient involvement

NHSGGC pursues a policy that treats patient experience and involvement as an important element in the infection prevention and control programme. The Patient Experience Steering Group is a forum that is intended to facilitate effective involvement by members of the public in the work of the Health Board. A member of the Infection Control Team attends meetings of this group to ensure, for example, that members of the public participate in the development of the Infection Control Programme.¹¹³⁰ Members of the public are also entitled to participate fully at meetings of the BICC.¹¹³¹

Corporate inspection team

The NHSGGC Board has established an inspection regime in which multidisciplinary teams of four to six members inspect hospitals following the methodology adopted by the Healthcare Environment Inspectorate (HEI).¹¹³² The Board envisages that by undergoing such inspections frontline staff and the clinical environment will be appropriately prepared for both planned and unplanned visits from the HEI team. Issues raised from these site inspections are reported to the directorate head. An

inspection team could include the Assistant Director of Nursing (Infection Control), a Lead ICN and also a patient representative.¹¹³³

Environmental changes after June 2008

Between June 2008 and June 2012 the sum of £4,687,667 was invested in improving the healthcare and general environment at the VOLH.¹¹³⁴ All wards have been upgraded with the provision of additional wash-hand basins, new preparation areas, additional storage facilities, upgraded ward pantries and domestic service rooms.¹¹³⁵ New floors have been laid and redecoration has taken place. There has been a reduction in bed numbers in the wards and all beds in the hospital are at least 2.7m apart.¹¹³⁶ There are more single rooms available.¹¹³⁷ There can be no doubt that, after years of uncertainty and underinvestment, the VOLH has been transformed by the investment made by the Board.

15.22 Conclusion

The personal and system failures in infection prevention and control identified in this Chapter had a profound impact upon the care provided to patients at the VOLH. The suffering and the deaths in which CDI was either the cause or a contributory factor have been considered in other Chapters.

Local personal failures by Mrs Murray were compounded by Dr Biggs’ attitude to her ICD duties for the VOLH. Those personal failures were serious, but the individuals concerned should not be used as scapegoats for the extent and duration of the CDI problem. There were other significant failures.

The failure to tackle Dr Biggs in an effective way permitted her attitude towards her responsibilities to subsist. Tolerance of her behaviour as accepted behaviour¹¹³⁸ was a significant failure in management that made a real contribution to the ongoing CDI problem at the VOLH.

1128 [INQ03930001](#); [GGC32220181-182](#)

1129 [GGC32220182](#)

1130 [GGC32220183-184](#)

1131 [GGC32220183](#)

1132 [GGC32220186](#)

1133 [GGC32220186](#)

1134 [GGC32220385](#)

1135 [GGC30410003](#)

1136 [GGC32220388-389](#); [GGC30410003](#)

1137 [GGC30410003](#)

1138 [TRA01260022](#)

The infection control committee structure became unfit for purpose. The reporting system was inadequate and failed to ensure that there was ward to Board and Board to ward accountability. Had the committee structure functioned properly and adequate reporting systems been in place, the local failures would have been identified much sooner.

It is evident that the health professionals employed at the VOLH failed to identify the extent of the CDI problem over a period of about 18 months. A culture had developed at the VOLH where CDI was tolerated and infection prevention and control was not a priority. Dr Cowan said that what happened produced a “seismic change”¹¹³⁹ in the attitude to infection prevention and control, with it now at “the front of everybody’s mind”.¹¹⁴⁰ It is to be regretted that the creation of that cultural change had to be driven by failures that should not have happened.

NHSGGC did learn lessons from the failures that created the persistent CDI problem at the VOLH. The threat of closure of the VOLH has been removed by significant investment. The arrangements for the management of infection prevention and control have been replaced by what appears to be an effective system geared to ensuring that the Chief Executive and the Board are fully aware of numbers and rates of CDI.

15.23 Recommendations

Recommendation 42: Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention and control training that includes CDI on appointment and regularly thereafter. Staff records should be audited to ensure that such training has taken place.

Recommendation 43: Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control, of which a record should be kept.

Recommendation 44: Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles.

Recommendation 45: Health Boards should ensure that where a manager has responsibility for oversight of infection prevention and control, this is specified in the job description.

Recommendation 46: Health Boards should ensure that the Infection Control Manager has direct responsibility for the infection prevention and control service and its staff.

Recommendation 47: Health Boards should ensure that the Infection Control Manager reports direct to the Chief Executive, or at least to an executive board member.

Recommendation 48: Health Boards should ensure that the Infection Control Manager is responsible for reporting to the Board on the state of healthcare associated infection in the organisation.

Recommendation 49: Scottish Government should re-issue national guidance on the role of the Infection Control Manager, stipulating that the Infection Control Manager must be responsible for the management of the infection prevention and control service.

1139 [TRA01220147](#)

1140 [TRA01220147](#)

Recommendation 50: Health Boards should ensure that there is 24 hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place.

Recommendation 51: Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings.

Recommendation 52: Health Boards should ensure that adherence to infection prevention and control policies, for example the *C. difficile* and Loose Stool Policies, is audited at least annually, and that serious non-adherence is reported to the Board.

Recommendation 53: Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time.

Recommendation 54: Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available.

Recommendation 55: Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the level of the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level.

Recommendation 56: Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.

Recommendation 57: Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports, and training reports.

Recommendation 58: Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement.

Recommendation 59: Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable.

Recommendation 60: Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice, such as the Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes.

Recommendation 61: Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine infection prevention and control arrangements, including policy implementation and cleanliness.

Recommendation 62: Health Boards should ensure that senior managers accompanied by infection prevention and control staff visit clinical areas at least weekly to verify that proper attention is being paid to infection prevention and control.

Recommendation 63: Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI, and that failure to isolate is reported to senior management.

Recommendation 64: Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing, with infected patients nursed in cohort bays with en-suite facilities.

Recommendation 65: Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea.

Recommendation 66: Health Boards should ensure that the healthcare environment does not compromise effective infection prevention and control, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective infection prevention and control practice, are not tolerated.

Recommendation 67: Health Boards should ensure that, where a local Link Nurse system is in place as part of the infection prevention and control system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.

Chapter 16

Death certification

Introduction

When a person dies in Scotland a licensed medical practitioner normally issues a medical certificate with the cause of death (a death certificate). This Chapter examines how death certification was carried out in the VOLH. Dr Simon Mackenzie, an expert on death certification commissioned by the Inquiry, prepared a report for the Inquiry in which the process is set out.¹ Dr Mackenzie was a member of the working group of the HAI Task Force that produced the supplementary guidance on death certification in October 2011² referred to later in this Chapter, and death certification is an area in which he had a particular interest.³

16.1 Form of death certificate

Background

The death certificate is in a form prescribed by the Registration of Births, Still-births, Deaths and Marriages (Prescription of Forms) (Scotland) Regulations 1997, made under the Registration of Births, Deaths and Marriages (Scotland) Act 1965, and a sample can be found in training material provided to the Inquiry.⁴ It complies with the recommendations of the World Health Organization and is designed to allow comparison of Scottish data with data from other jurisdictions for epidemiological purposes.

Important details

Death certificates require the recording of the time and place of death as well as details of the cause of death. The section of the death certificate which is devoted to the cause of death is divided into two parts. Part I deals with the direct cause of death and any conditions giving rise to that. Part II deals with other conditions which have contributed to death but are not part of the main sequence of events leading to death.⁵

In Part I the direct or immediate cause of death is stated first. Thereafter information is provided about the disease or condition

which started the process. The last reference in Part I should be to the main disease that led to death.⁶ This is known as the underlying cause of death and is important for epidemiological purposes.

In Part II the doctor should state any significant condition or disease or accident which contributed to the death but which was not part of the sequence leading directly to death.

Professional judgement

Death certification, Dr Mackenzie emphasises, is a matter of professional judgement. A doctor issuing a certificate needs to make a judgement as to which of the illnesses suffered by a patient should be in Part II. Part II need not list every medical condition that the person had, since the judgement of the doctor may be that some of them were of no relevance to the death.⁷

Where a death occurs in hospital, the death certificate is normally completed by a doctor employed at the hospital. It is then handed over, usually to a relative or to the undertaker, and presented to the Registrar of Births, Deaths and Marriages, who records other personal information as well as the cause of death. The death certificate is retained by the Registrar, who will provide the person registering the death with an extract from the register showing the information recorded.

16.2 The 1999 guidance on death certification and VOLH practice

The purpose of the 1999 Guidance

Guidance on the completion of death certificates was issued by the Registrar General for Scotland in January 1999.⁸ Dr Mackenzie explained that the underlying purpose of this was to help doctors certify a death in a reliable, accurate and consistent manner to produce the most accurate medical certificate of the cause of death that can realistically be achieved.⁹

1 [EXP02730001](#)
2 [EXP02730008](#)
3 [TRA01070004](#)
4 [INQ00790010-11](#)
5 [INQ00790005](#)

6 [INQ00790003](#)
7 [TRA01070018](#)
8 [INQ00790001](#)
9 [TRA01070007](#)

According to the guidance:

“It is best if a consultant, general practitioner or other experienced clinician certifies the death. For a death in hospital, a doctor with provisional or limited registration should certify the death only if he or she is closely supervised and the experienced clinician is content that the causes of death are accurately recorded”.¹⁰

Scottish practice

According to Dr Mackenzie, however, consultants in Scotland were rarely involved in death certification in 2007 and 2008.¹¹ This observation is confirmed for the VOLH by an examination of extracts from the Register relating to cases investigated by the Inquiry. Thirty-three extracts¹² were reviewed in cases where death was certified at the VOLH, and that examination disclosed that none of the 33 death certificates was signed by a permanent Consultant. Eleven were signed by experienced clinicians, two by a Senior House Officer, and the remaining 20 were signed by junior doctors.

It is not to be inferred from this that the Consultants were never consulted before the certificate was completed. In three cases, entries in patient records suggest that junior doctors did contact the Consultants.¹³ Additionally, in the case of deaths at night, there is a pattern of junior on-call doctors and integrated care GPs leaving it to day-time medical staff to sign the certificate.¹⁴ This practice allows a more senior doctor to review what should be included in the certificate, and in some instances the certificate has been signed by a more senior doctor. In the majority of cases, however, the certificate was ultimately signed by another

junior doctor without any recorded consultation with more senior staff.

The Procurator Fiscal

Before issuing a death certificate, the doctor concerned is obliged to consider whether or not the death should be reported to the Procurator Fiscal. The Procurator Fiscal is a lawyer in public service whose best known role is that of local public prosecutor, but the Procurator Fiscal has a separate duty, similar to that of the coroner in England and Wales, to investigate all sudden, suspicious, accidental, unexpected and unexplained deaths, and any deaths occurring in circumstances causing serious public concern.

Guidance is issued by the Crown Office and Procurator Fiscal Service (COPFS) in a publication entitled “Death and the Procurator Fiscal”. This has been updated on a number of occasions and the edition applicable during 2007-2008 was issued in November 1998.¹⁵

That publication sets out certain categories of death to be reported to the Procurator Fiscal and includes:

“any death as a result of medical mishap, and any death where a complaint is received which suggests that medical treatment or the absence of treatment may have contributed to the death”.¹⁶

Section 3 provides further explanation of this category. No explicit reference to healthcare associated infection (HAI) is made, and neither does *C. difficile* infection (CDI) fall readily within the scope of Section 3.

The guidance also lists among the deaths to be reported “any death due to notifiable infectious disease”.¹⁷ These diseases are specified in Appendix 1 of the Guidance but CDI is not among them.

10 [INQ00790002](#)

11 [TRA01070009-10](#)

12 INQ00730001; INQ00960001; SPF00020001; SPF00030001; SPF00040001; SPF00050001; SPF00060001; SPF00070001; SPF00080001; SPF00090001; SPF00110001; SPF00120001; SPF00140001; SPF00150001; SPF00160001; SPF00170001; SPF00180001; SPF00190001; SPF00200001; SPF00210001; SPF00220001; SPF00230001; SPF00250001; SPF00260001; SPF00270001; SPF00290001; SPF00300001; SPF00330001; SPF00340001; SPF00350001; SPF00360001; SPF00370001; SPF00380001

13 GGC00580196; GGC00430035; GGC00450019

14 GGC00070025; GGC00560064; GGC00080088

15 [INQ01370001](#)

16 [INQ01370003](#)

17 [INQ01370003](#)

16.3 Accuracy in death certification in the VOLH

Role of death certification

In his evidence Dr Mackenzie stressed the importance of accuracy in death certification:

“One of the uses of death certification is to understand what the health needs of the population are. Therefore, it is extremely helpful to know what the patterns of illness leading to death are”.¹⁸

Professor George Griffin, an infectious diseases expert commissioned by the Inquiry, had this to say on the role of death certification:

“Death certification is an important role of the doctor. Accuracy is crucial in order to allow collation of data at population level to enable definition of trends and potential public health measures to prevent diseases. In the case of the Vale of Leven cohort described in this report, in seven of the 28 cases in the focus group judged to have *C. difficile* as a cause of or contributory factor to death, this organism was not stated. Such omission would potentially therefore reduce the ability to determine the importance of this infection as a cause or contributory factor to death. Thought needs to be given on advice to doctors completing death certificates. Such advice needs to be incorporated into medical education at undergraduate and postgraduate level”.¹⁹

Subsequently in his evidence he went on to say that it is also “very important for the family ... to know what their loved one has died of”.²⁰

Lack of accuracy

The lack of accuracy in practice was acknowledged at the time the VOLH outbreak came to light. Dr Bob Masterton, Medical Director, NHS Ayrshire and Arran, presented a paper on death certification issues to the emergency meeting of the HAI Task Force on

4 July 2008,²¹ called as a result of actions arising from the outbreak of CDI at the VOLH and the announcement of an Independent Review. In the paper he referred to a number of earlier studies casting doubt on the accuracy of a significant proportion of death certificates, although it is not clear from the citations in his paper where these studies were undertaken. He identified a number of problems:²²

1. Lack of experience/knowledge
2. Lack of knowledge of deceased
3. Quality assurance (or the lack of it)
4. Error rates
5. Lack of specificity
6. Omission of sensitive information
7. Multiple pathology (many possible causes of death)
8. Medical terminology (a marked variability in terms used to describe the same or similar conditions)

Dr Masterton highlighted the difficulty in assessing whether the increase in reference to CDI should be ascribed to increased laboratory testing and heightened clinical appreciation of the condition, as much as to a genuine increase in numbers. He also drew attention to the difficulty in interpreting the significance of laboratory findings of *C. difficile* prior to death.²³

Dr Masterton’s concern over the need for accuracy of death certificates and the lack of accuracy in practice is echoed by Professor Griffin.²⁴ His analysis of patients who contracted CDI and subsequently died has already been considered in Chapter 4.

Professor Griffin’s conclusion

In summary, Professor Griffin concluded that during the focus period 28 patients should have had CDI mentioned on their death certificates and seven of those patients did not. He also concluded that six patients who died outwith the focus period should have had CDI referred to in their death certificates and three of those patients did not.

¹⁸ [TRA01070013-14](#)

¹⁹ [EXP02780006-07](#)

²⁰ [TRA00730051](#)

²¹ [GOV00710091](#)

²² [GOV00710092-93](#)

²³ [GOV00710093](#)

²⁴ [EXP02780006-07](#); [TRA00730051-52](#)

Other experts

Medical experts commissioned by the Inquiry broadly supported the views of Professor Griffin. In particular, Dr Mary Harrington, in her evidence to the Inquiry expressed a number of concerns over death certification in cases examined by her. These included entries without a medical history to support the diagnosis, lack of adequate medical assessment to allow conclusions to be drawn as to the cause of death,²⁵ and failure to consider the potential consequences of a recent fall.²⁶ According to the COPFS guidance in force, a recent fall should have led to the death being reported to the Procurator Fiscal as potentially arising due to an accident or associated with a lack of medical care.

Other medical experts expressed similar concerns in a number of the cases they examined. These were with regard to the omission of *C. difficile* from the death certificate and more generally over incorrect causes of death listed.²⁷

Reference has been made previously to the absence of death certificates signed by permanent consultants and to the lack of recorded consultation between junior and senior doctors over the content of death certificates. Nevertheless, of those cases in which CDI does not appear on the certificate, but ought to in the view of Professor Griffin, analysis does not identify any greater degree of accuracy in those certificates completed by senior staff or discussed with them.

Finally, it is apparent from both Dr Mackenzie's evidence and Dr Masterton's paper that concern over the accuracy of death certification at the time was not restricted to the NHSGGC area. In view of this the Inquiry has not attempted any comparative exercise with other areas, and has confined its examination to the death certificates in cases within its remit.

16.4 Updated guidance

The 2008 guidance

Significant developments have taken place in the guidance available to doctors on death certification since the VOLH CDI problem emerged. In October 2008, COPFS issued an updated version of "Death and the Procurator Fiscal". Deaths to be reported now include:

"any death due to a disease, infectious disease or syndrome which poses an acute, serious public health risk including....any hospital acquired infection".²⁸

Section 9 of this edition, entitled "Deaths associated with medical or dental care", also specifies explicitly that deaths from HAIs must be reported.²⁹

The 2009 guidance

Further guidance was issued in September 2009 by the Chief Medical Officer of the Scottish Government in a document entitled Guidance on completion of medical certificates of the cause of death.³⁰ This reminds practitioners that they are required to report to the Procurator Fiscal any death where a HAI is recorded as the underlying or contributory cause of death, and explains:

"Reporting of an HAI related death will not necessarily lead to action on the part of the Procurator Fiscal, but will allow local Area Procurator Fiscal offices to identify any clusters of HAI related deaths that may imply an acute serious public health risk in addition to the monitoring undertaken by Health Boards, supported by Health Protection Scotland (HPS), General Register Office for Scotland (GROS) and Information Services Division (ISD)".³¹

The Chief Medical Officer also provides further guidance on who should certify deaths:

"In hospital, there may be several doctors in a team caring for the patient. The consultant in charge of the patient's care is ultimately responsible for ensuring the

25 [TRA00590035-36](#)

26 [TRA00580130](#)

27 EXP00900014; EXP00910011; EXP00980023-25; EXP01120023; EXP01230012

28 [GGC11640003](#)

29 [GGC11640005](#)

30 [INQ00540001](#)

31 [INQ00540022](#)

death is properly certified, as subsequent enquiries about the patient, such as results of post-mortem or ante-mortem investigations, will be addressed to the consultant".³²

The 2011 guidance

The 2008 guidance was further supplemented in October 2011 by a letter from the Chief Medical Officer entitled "Accurate recording of deaths from healthcare associated infection and action",³³ which required Health Boards to:

- Ensure that systems are in place whereby deaths where an HAI is recorded on the death certificate are reported to the Infection Control Manager
- Ensure consistent and reliable systems to identify *C. difficile* and MRSA associated deaths
- Conduct rapid event investigation for all deaths where *C. difficile* or *Staphylococcus aureus* bacteraemia (SAB) contributed to the death
- Develop and implement processes to convey timeously the weekly and quarterly death data for *C. difficile* and MRSA from National Records of Scotland to the Infection Control Manager
- Assure themselves that all doctors employed by Health Boards are appropriately trained in completion of death certificates³⁴

Boards are also encouraged to establish liaison with the local Procurator Fiscal for more co-ordinated action.

Additional guidance issued in the Chief Medical Officer's letter includes the following:

- "Death certificates for patients who have died in hospital should only be completed after discussion with a consultant. Ideally this will be the patient's named consultant"³⁵

- Wherever possible, medical staff should discuss the death certificate with the relatives of the deceased³⁶
- Boards should ensure they have reliable systems in place to identify, as a minimum, *C. difficile* and MRSA associated deaths"³⁷

16.5 Collation, analysis of data and future changes

The Procurator Fiscal's role

Despite the terms of the Chief Medical Officer's guidance of September 2009, the Crown Office and Procurator Fiscal Service (COPFS) does not in fact collate information on HAI related deaths. It considers that this is best done by other bodies.³⁸

National Records of Scotland

Certain information on the number of HAI related deaths is recorded by National Records of Scotland (NRS), previously known as the General Register Office for Scotland (GROS). Mr Frank Dixon, a Vital Events Statistician, at the then GROS, described to the Inquiry their system of coding of information on deaths:

"It is to produce internationally comparable statistics on causes of death, so that we can compare our deaths, from whatever cause, with those of England, Wales, Northern Ireland, other European countries, and other countries around the world. If we are all coding to the same standards, applying the same rules, using the same standard death certificate layouts, then our statistics should be comparable".³⁹

Registrars also have a statutory duty to provide information on deaths to Chief Medical Officers and to Health Boards.

Since September 2008, GROS has published on its website information on deaths where *C. difficile* is mentioned on the death certificate. This is done in order to assist organisations with an interest in the issue, but although it collates and publishes this

32 [INQ00540006](#)

33 [INQ02980001-02](#)

34 [INQ02980001-02](#)

35 [INQ02980003](#)

36 [INQ02980003](#)

37 [INQ02980005](#)

38 [INQ05090001-02](#)

39 [TRA01070060](#)

raw data, GROS does not itself operate any form of surveillance system.⁴⁰ Indeed, as explained by Professor Jacqui Reilly, Head of Group for Healthcare Associated Infection, HPS, there is no national surveillance of mortality rates *C. difficile* or any other infections in Scotland,⁴¹ nor is there any mandatory local surveillance beyond the requirement upon Boards to identify deaths associated with CDI.⁴²

A national survey

Only one, limited, national survey appears to have been carried out. Following identification of the VOLH outbreak, Health Boards in Scotland were required by the Scottish Government to collect data retrospectively on the numbers of cases and deaths due to *C. difficile* Associated Disease (CDAD) by hospital and month for the period 1 December 2007 to 31 May 2008. HPS was in turn asked to collate these data and comment on whether there were other unidentified outbreaks and excess deaths associated with CDAD in acute hospitals in NHSScotland.

The resulting HPS report, entitled “Report on Review of *Clostridium difficile* Associated Disease Cases and Mortality in all Acute Hospitals in Scotland from December 2007 – May 2008”,⁴³ was published in July 2008. By then the mandatory national surveillance programme of the incidence of CDAD in those aged 65 and over, introduced in 2006 and discussed earlier in Chapter 6, had been running for less than two years, and the introduction to the report stated:

“It has always been the intention to link CDAD case data held by HPS to mortality data, and this was already highlighted as a step in the development of the surveillance system once the monitoring of CDAD cases was fully established”.⁴⁴

The report identified a number of hospitals in which death rates warranted further investigation, and in particular found that

fatality rates at the VOLH were “significantly higher than expected”,⁴⁵ but it did not carry out an analysis of the reasons for those rates. The executive summary of the report notes:

“There are no routine systems for monitoring deaths associated with HAI in Scotland other than registration of death certificates by GROS. This is the same across the UK, and when mortality is investigated, special retrospective studies are required. No routine surveillance system in the UK would have identified this excess of mortality”.⁴⁶

Among the report’s recommendations was the following recommendation:

“Routine national monitoring of CDAD mortality is unlikely to be productive in informing action to reduce the incidence of CDAD. However, if there is a decision to collect mortality data in relation to CDAD this should be carefully designed and planned, and consideration given to data definitions and data collection criteria. Further discussion should take place on the most appropriate national agency to undertake these reviews”.⁴⁷

Such monitoring may not, as is remarked previously, reduce the incidence of CDI, but as Professor Griffin has observed, patients with CDI are often very vulnerable, and small changes in clinical state caused by *C. difficile* colitis may have profound effects.⁴⁸ A closer analysis of the incidence of mortality might well contribute to a reduction in the number of deaths. Given:

- the importance apparently ascribed by the Chief Medical Officer in his guidance of September 2009 to identification of clusters of deaths
- the intention of HPS to link case data to mortality
- the variation in death rates observed by HPS in the 2007 – 2008 study, and
- the availability of data

40 [TRA01070071-72](#)

41 [TRA01100126](#)

42 [TRA01100126](#)

43 [HPS01570001](#)

44 [HPS01570005](#)

45 [HPS01570024](#)

46 [HPS01570003](#)

47 [HPS01570045](#)

48 [EXP02780003](#)

there is a real need for a system of national monitoring to be in place. A proposal was made by the Medical and Dental Defence Union of Scotland (MDDUS) in its closing submission to the Inquiry⁴⁹ that the Scottish Government should identify a national body to take responsibility for analysing and warning Health Boards of trends in deaths from HAIs. Scottish Ministers in their response suggested that this is unnecessary,⁵⁰ citing the changes already put in place in recording of information. But in the absence of any analysis at national level, the existence of regional variation in case fatality rates (such as those identified by HPS in 2008), will not be apparent, nor can any attempt be made to identify the reasons for these variations.

Future changes

The Certification of Death (Scotland) Act 2011⁵¹ is designed to introduce a system of independent scrutiny of death certification to improve the quality and accuracy of the information on death certificates and to improve public health information. It introduces a system of review of death certificates by Medical Reviewers through random scrutiny. This Act received the Royal Assent on 20 April 2011 but is not yet fully in force.

The policy objectives and aims of this legislation are set out in the Policy Memorandum⁵² published at the time the Bill was introduced to the Scottish Parliament. They are:

- To introduce a single system of independent, effective scrutiny applicable to deaths that do not require a Procurator Fiscal investigation
- To improve the quality and accuracy of the medical certificate of cause of death (MCCD) form
- To provide improved public health information and strengthened clinical governance in relation to deaths

The proposed new system covers only those cases which are not examined by the Procurator Fiscal. Medical Reviewers and Senior Medical Reviewers will be appointed and will review death certificates both by random selection and at the request of interested persons. If the Medical Reviewer does not approve the certificate, he or she may ask the medical practitioner who signed it to issue a new certificate. If the medical practitioner does not issue a new certificate, then the matter will be referred to the Senior Medical Reviewer, who may in turn refer the certificate to the Procurator Fiscal for investigation into the cause of death. Medical Reviewers will also provide training, guidance and support to those required to complete death certificates.

16.6 Conclusion

The lack of significant consultant involvement in death certification at the VOLH in the 2007 to 2008 period reflected the general practice in Scotland at that time. This was despite guidance that envisaged consultant involvement. Furthermore, as discussed in Chapter 14, the opportunity for Consultant involvement at the VOLH was limited by the shortage of consultant cover. This practice at the VOLH is therefore not to be seen as a criticism of the VOLH Consultants. Nonetheless, the practice should never have developed.

The guidance in place at the time had been issued in January 1999 and by 2007-2008 it was inadequate and outdated. Death certification was viewed as a low priority despite the important role it plays, as already discussed in this Chapter.

The examination of the death certificates carried out by Professor Griffin and the other medical experts commissioned by the Inquiry, and in particular the inaccuracies identified by them, revealed a lack of understanding of the way in which death certificates should be completed, particularly in relation to when *C. difficile* should be recorded as a primary cause and as an underlying cause of death. For that reason, the Inquiry endorses the provision in the Chief Medical Officer's 2011 guidance that Boards should assure

49 [INQ04880117](#)

50 [INQ05050017](#)

51 Certification of Death (Scotland) Act 2011 (asp 11).

52 [INQ05130004](#)

themselves that all doctors employed by them are appropriately trained in the completion of death certificates.⁵³ The comprehensive guidance issued by the Chief Medical Officer and its particular focus on HAI was a welcome development.

The Chief Medical Officer's expectation in 2009 was that reporting HAI related deaths to the Procurator Fiscal would allow a Procurator Fiscal to identify "clusters of HAI related deaths".⁵⁴ The function of COPFS is, however, to investigate, and it does not have a surveillance function of the kind envisaged by the Chief Medical Officer. Nevertheless the Inquiry would agree with the principle underlying the Chief Medical Officer's expectation that monitoring HAI mortality rates, and *C. difficile* deaths in particular, at national level might contribute to a reduction in the number of deaths.

16.7 Recommendations

Recommendation 68: Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patient's care is involved in the completion of the death certificate wherever practicable, and that such involvement is clearly recorded in the patient records. Regular auditing of this process should take place.

Recommendation 69: Health Boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient's death.

Recommendation 70: Crown Office and the Procurator Fiscal Service (COPFS) should review its guidance on the reporting of deaths regularly and at least every two years.

Recommendation 71: Scottish Government should identify a national agency to undertake routine national monitoring of deaths related to CDI.

53 [INQ02980004](#)

54 [INQ00540022](#)

Chapter 17

Investigations from
May 2008

Introduction

This Chapter outlines and reviews the reports of two investigations by NHSGGC which took place as an early response to events at the Vale of Leven Hospital (VOLH). These are:

- Vale of Leven Internal Investigation report, 11 July 2008.¹
- The Report of the Outbreak Control Team (OCT), October 2008.²

17.1 The Independent Review

In addition to these two internal reports, on 18 June 2008 the Cabinet Secretary for Health and Wellbeing announced an Independent Review of the cases of *C. difficile* Infection (CDI) at the VOLH.³ Its remit was to review procedures in place at the VOLH over the period December 2007 to 1 June 2008, and it was led by Professor William Cairns Smith, OBE, Professor of Public Health at the University of Aberdeen.⁴

The report of the Independent Review was published in August 2008. It made a number of recommendations, including a recommendation that an independent audit be conducted of the implementation of its recommendations by the end of 2008.⁵ That audit was carried out by the Independent Review Team in December 2008.⁶ In a follow-up report published in January 2009⁷ the team concluded that “rapid and very significant progress”⁸ had been made in implementing its recommendations at the VOLH.

17.2 Vale of Leven Internal Investigation Report

Background

Mr Robert Calderwood, then the Chief Operating Officer of NHSGGC Acute Services, gave evidence that he became aware of the CDI cases and associated deaths on 9 June 2008.⁹ As a response to this knowledge he then commissioned an internal investigation.

1 [GGC00610001](#)
 2 [GGC00600001](#)
 3 [GOV00030004](#)
 4 [GOV00030009](#)
 5 [GOV00030022](#)
 6 [GOV00020010](#)
 7 [GOV00020001](#)
 8 [GOV00020019](#)
 9 [TRA01240093](#)

The Investigating Team

The Internal Investigation Team drew from senior staff in the Board and consisted of Ms Rosslyn Crocket, Board Nurse Director and Director of Women and Children’s Services; Mrs Jane Grant, Director of Surgery and Anaesthetics; and Mrs Anne MacPherson, Associate Director of Human Resources.

Professor Brian Duerden, an Infection Control expert commissioned by the Inquiry, noted that the team:

“did not include anyone with specific expertise, qualification or training in infection prevention and control or the public health aspects of outbreak investigation”.¹⁰

This was not intended as a criticism but rather as an observation that the team conducting the investigation would view it differently to someone with infection control expertise.

Mr Alex Smith, an NHS management expert commissioned by the Inquiry, thought that it might have been beneficial to include a non-executive Board member or a representative from internal audit as part of the team. His view was that this would have provided a degree of impartiality.¹¹

Scope of review

The team worked to the following remit:

“The purpose of this investigation is to review all correspondence from April 2006 with regards to the Vale of Leven *C Difficile* issue and, in particular, from December 2007 with regards to who knew about the *C Diff* cases, what action did they take and who did they report matters to”.¹²

In his evidence to the Inquiry, Mr Calderwood agreed that he was concerned to find out who knew what. In particular, he was keen to find out if management staff knew anything about the cases of CDI, and if so what action they took.¹³

10 [TRA01060021](#)
 11 [EXP02800018](#)
 12 [GGC00610002](#)
 13 [TRA01240072](#); [WTS00880019](#)

Clearly, the team had a very limited remit,¹⁴ but as a consequence of the information the team gathered during its investigation it did not in fact limit its conclusions to the terms of that remit.¹⁵

How the team approached the review

The team began its work around 12 or 13 June 2008,¹⁶ the investigation was conducted within one month, and the report was issued on 11 July 2008. At the meeting of the Acute Operational Management Group on 10 July 2008¹⁷ it had been agreed to circulate the report to directors and to reconvene the meeting on 11 July to comment on any matters of fact. The report would then be submitted to the Independent Review Team chaired by Professor Cairns Smith. The Acute Operational Management Group agreed that the report would be submitted to Dr Syed Ahmed, Chair of the OCT, as an individual and for onward transmission to the Independent Review Team, but was not for wider circulation at that stage.

Mrs Grant explained in her evidence how the group tackled its work.¹⁸ None of the team was familiar with the VOLH, so they established a working base there. According to Mrs Grant, this allowed them to establish who the individuals involved were and how the hospital worked¹⁹ and in addition to familiarise themselves with relevant paperwork and correspondence.

The team interviewed around 40 staff representing the relevant directorates at the VOLH. They spoke to the senior management teams of Clyde Acute Directorate and the Rehabilitation and Assessment Directorate (RAD) including Mrs Deborah den Herder, Director, Clyde Acute Services, NHSGCC and Ms Anne Harkness, Director of Rehabilitation and Assessment, as well as infection control staff, ward medical and nursing staff, and facilities and estates staff. The team did not speak to Mrs Jean Murray, the former

Lead Nurse for Infection Control, as she was unavailable, but Dr Elizabeth Biggs, the Infection Control Doctor, was interviewed by the team.²⁰ The team also reviewed contemporary documentation.

The Clyde Directorate

The team examined the minutes of meetings of the Clyde Management Team for the period 29 August 2006 to 1 May 2008²¹ and noted that healthcare associated infection (HAI) was mentioned on one occasion over that period. A similar exercise was carried out in relation to the minutes of the Clyde Clinical Governance Committee. Here, the team discovered that there was no mention of any specific infection control issues with regard to the VOLH.²² The performance of these committees in relation to infection prevention and control has already been considered in Chapter 15. The team did not explore why there was not greater reference to infection prevention and control at these committee meetings.

Rehabilitation and Assessment Directorate

The minutes of the meetings of the RAD Management Team and the RAD Clinical Governance Forum were also examined.²³ The team noted that in the period from 19 September 2007 to 28 May 2008 seven meetings of the RAD Management Team took place and that none of the Clyde hospitals was discussed.²⁴ The team noted too that within a similar period the RAD Clinical Governance Forum had five meetings, and that although there was evidence of infection prevention and control being discussed at the meetings of 13 February 2008 and 16 April 2008 there was no mention of any specific incidents of CDI at the VOLH.²⁵

Minutes of infection control meetings

Minutes of the Board, Acute and Clyde Infection Control Meetings were also reviewed by the team over the relevant period. The team concluded from these that attendance at the Board Infection Control Committee by

14 [TRA01060023](#)
15 [TRA01240072](#)
16 [TRA01140122](#)
17 [GGC02050001-02](#)
18 [TRA01140123](#)
19 [TRA01140123](#)

20 [GOV00890099-101](#)
21 [GGC00610006](#)
22 [GGC00610007](#)
23 [GGC00610008](#)
24 [GGC00610008](#)
25 [GGC00610008](#)

representatives from Clyde directorate was “sporadic”,²⁶ noting that at the September and December 2007 meetings no representatives from Clyde were present.²⁷ Professor Duerden agreed that the Clyde attendance at this Committee was inadequate.²⁸

The team did note that an outbreak of CDI in a care home was discussed at a meeting of the Acute Infection Control Committee on 24 July 2007 but that there was no mention of the VOLH.

The Clyde Infection Control Group minutes

The team reported that two separate groups met within Clyde: the Support Group, which operated as Clyde’s Infection Control Committee, and a Working Group, which operated at a level below. It was noted that these groups met infrequently and that the last meeting of the Support Group was in July 2007.²⁹ The failure of these two groups is discussed in Chapter 15. Professor Duerden observed that this reflected a “dangerous breakdown” in the local oversight of infection prevention and control.³⁰ The report does not explore why these groups ceased to meet or whether this was significant in the management structure.

Other meetings

The team also examined the minutes of meetings held monthly by ward Sisters and noted that infection control issues were discussed.³¹ A review of the minutes of the monthly Facilities Management Team disclosed that there had been very limited debate on infection prevention and control issues in the VOLH.³²

Minutes of the Clean Bill of Health Committee were also examined. The purpose of that committee included looking at the overall cleanliness of hospital sites.³³ Seven sets of minutes were looked at covering the period

from June 2006 to February 2008, and no major problems were identified at the VOLH in those minutes.³⁴

Internal Investigation conclusions from examination of minutes

In her evidence Mrs Grant said that the team concluded from its examination of the minutes of the meetings referred to previously, and other minutes of meetings, that there was no clear evidence that “people had been aware of what was going on”.³⁵ By this she meant the nature and extent of the CDI problem at the VOLH.

Surveillance data

The team examined how data on CDI were collected and noted in the report that the data were collected manually, expressing the view that this method of surveillance was “unusual” and in contrast to other areas, which had “electronic models”.³⁶ The team also noted that since May 2008 Statistical Process Control Charts (SPCs) had been introduced.³⁷ The report commented that staff seemed to have limited understanding of the implications of the charts produced, and recommended a more comprehensive awareness programme to ensure that all staff were aware of the charts and how to interpret them.³⁸

There is no mention in the report of the infection prevention and control database which was in existence at the VOLH and which could have been used to monitor the number and trends of *C. difficile* cases. Mrs Grant did say in evidence that Mrs Helen O’Neill, Infection Control Nurse at the VOLH, mentioned the database in the course of her interview,³⁹ but that the conclusion they arrived at was that the database was not being used to generate any information.⁴⁰ As discussed in Chapter 15, that was correct, but the database should have been used to generate information for circulation within the infection prevention and control structure.

26 [GGC00610014](#)

27 [GGC00610014](#)

28 [EXP02810004](#)

29 [GGC00610015](#)

30 [EXP02810004](#)

31 [GGC04020001](#); [GGC04010003](#); [GGC03980002](#); [GGC03970002](#); [GGC03950001](#); [GGC03920006](#); [GGC14820002](#); [GGC14810002](#); [GGC14800001](#)

32 [GGC00610010](#)

33 [GGC00610010](#)

34 [GGC00610010](#)

35 [TRA01150011](#)

36 [GGC00610013](#)

37 [GGC00610013](#)

38 [GGC00610013](#)

39 [TRA01150018](#)

40 [TRA01150019](#)

Outbreak Policy

Compliance with the NHSGGC Outbreak Policy was examined. The team found that the laboratory complied with the policy in that any increase in the number of specimens was reported to the Infection Control Team. The policy said that if single rooms were not available patients should be “cohorted”,⁴¹ but the team was told by Lead Nurses that cohorting was a “rare occurrence” and that most patients were nursed in single rooms.⁴² The Loose Stools Policy also stated that patients should be isolated at the onset of diarrhoea. Analysis undertaken by the Inquiry, however, shows that the general practice adopted at the VOLH was not to isolate patients with loose stools until the diagnosis of *C. difficile* was confirmed, either by the laboratory or by the Infection Control Nurse. Once a positive diagnosis was made most patients were placed in a single room. The isolation of patients is fully explored in Chapter 15.

Environmental audits

The team also undertook a review of environmental audits of wards at the VOLH, and its report identified failures in the audit system. The scoring system that was in use could indicate overall compliance while hiding important underlying failures. The information was only received by the ward manager, and neither the Lead Nurse nor the estates team automatically received the results of the audit. Action plans in response to the audit were inconsistent, and there was no evidence that progress was monitored by the Infection Control Team.⁴³

Staff governance

The report concluded that there was no problem with nurse staffing levels. This was based on evidence from interviews with all Senior Charge Nurses/Ward Managers and Lead Nurses/Clinical Service Managers, who confirmed that they did not have staffing problems. They said that they had a low turnover of staff, that sickness absence was well controlled, and that they had not

needed to raise staffing issues with General Managers.⁴⁴

This view contrasts with evidence the Inquiry heard to the effect that nurses were not able to complete certain documentation because of the “firefighting” in the wards.⁴⁵ This is explored further in Chapter 12.

Mrs Grant agreed in her evidence that the ward Senior Charge Nurses did describe some of the issues they had with staffing.

“I think they did describe – you know, within a ward you do have sometimes two people off sick and long term sick does cause you some issues”.⁴⁶

The team did not think, however, that there were sustained staffing difficulties at the VOLH or that there was a problem with accessing bank staff if required.

The report notes that the medical management structure had not been well developed and that clinical directors had only recently been appointed in some areas. Full integration of the medical management model was seen as important in the transition process.

Under the heading of “Leadership” the report comments on general management based on some observations made during interviews. In her evidence, Mrs Grant explained that:

“in certain areas, the concept of general management was not as well developed as might be anticipated after 2 years of the current structure and, with the proposed full integration on 1 July 2008, it will be important to re-emphasise the initial concepts agreed in April 2006”.⁴⁷

The team felt that it was useful to be clear about reporting arrangements as one or two staff had said that they were not clear who their line manager was or about their roles and responsibilities.⁴⁸

41 [GGC00610014](#)

42 [GGC00610014](#)

43 [GGC00610016](#)

44 [GGC00610017](#)

45 [TRA01150022](#)

46 [TRA01150022](#)

47 [TRA01150023](#)

48 [TRA01150024-25](#)

Effectiveness of the report

It can be seen from the previous discussion that the Internal Investigation Team's narrow remit did not prevent the team from considering issues outwith that remit. The scope of the investigation broadened and comments were made on other issues as a result of the information gathered during the investigation. As Mr Calderwood explained, however, the work of the Internal Investigation Team was overtaken by the establishment of the Independent Review chaired by Professor Smith.⁴⁹ NHSGGC was invited to assist with the Independent Review rather than to continue with its own Internal Investigation, and at that point the Internal Investigation stopped.⁵⁰

Mr Smith acknowledged that the "commissioning of the report was an important and appropriate action",⁵¹ and that it identified learning opportunities at an early stage. Given greater time he would have expected conclusions and more recommendations, but it was critical to have early identification of key issues and of actions which should be taken.

Professor Duerden was more critical of the Internal Investigation in a number of ways. The report did not, for example, identify errors or failures which must have been present to allow an outbreak to occur and to go unnoticed for a number of months.⁵² The team did not establish the scale, extent and timeframe of any outbreak and without that starting point Professor Duerden found it difficult to see how the team could fulfil even its limited remit of establishing who knew about the cases of CDI.

The fact, unknown to Professor Duerden, that the work of the Internal Investigation Team was ended prematurely is sufficient mitigation to allow this part of the Board's response to the VOLH CDI problem to escape specific criticism by the Inquiry. The Inquiry accepts that Mr Calderwood was anxious to discover who knew what about the CDI problem at the VOLH.

The Internal Investigation report did identify a number of learning opportunities in corporate, clinical and staff governance. Under the heading "Clinical Governance", for example, the report proposed that:

"Each Directorate's Clinical Governance Committee should have a standing item on Control of Infection".⁵³

That was entirely appropriate, and the need for data on infection prevention and control to be made available at meetings is discussed in other Chapters of this Report.

17.3 Outbreak Control Team Investigation

Background

The events leading to the setting up of the OCT investigation have been discussed in Chapter 4. The OCT was chaired by Dr Ahmed, and the team included other key Health Board staff such as Mr Thomas Walsh, Infection Control Manager and Dr Andrew Seaton, Lead Infectious Diseases Physician, as well as an epidemiologist and consultant microbiologist from HPS. Dr Linda Bagraade, who by this time was the Infection Control Doctor for the VOLH, was also a member. Professor Duerden felt it was an appropriately constituted group.⁵⁴

The OCT first met on 10 June 2008 and held six meetings. The report of the team's findings was published in October 2008.

Remit

The remit of the OCT was to:

- Co-ordinate the investigations of all aspects of this outbreak
- Ensure that all control measures were in place including treatment of cases
- Co-ordinate communication between the Board and external agencies including the media
- Make recommendations to the Board on its findings⁵⁵

49 [TRA01240116](#)

50 [TRA01240116](#)

51 [EXP02800018](#)

52 [TRA01060025](#)

53 [GGC00610003](#)

54 [TRA01060033-34](#)

55 [GGC00600012](#)

Outbreak period

The report identified the outbreak period as 1 December 2007 to 31 May 2008. That period had been focussed upon by the local Infection Control Team because of press enquiries about the number of deaths in the six months up to June 2008. Prior to the creation of the OCT, 55 cases of CDI had been identified by the Infection Control Team, and that was the number of cases adopted by the OCT in its report.⁵⁶ Isolates were available for ribotyping from 16 patients, and out of these 14 were identified as ribotype 027. This supported the view that the cases represented an outbreak, with mainly the same strain being transmitted across the patient population.

At the time of the OCT investigation, 28 patients were thought to have died, and CDI was thought to have caused or contributed to the death of 18 of those patients.⁵⁷ As explained in Chapter 4, the Inquiry has revised the number of patients who contracted CDI and who died with CDI causing or contributing to their death. Within the Inquiry's remit there were 43 patients who died having suffered from CDI, and for 34 of these patients CDI was a causative factor in their deaths, either as a cause of death or as a contributory cause of death.

Discussion of the number of cases

There was some discussion during Mr Calderwood's evidence to the Inquiry about email communication between him and Dr Ahmed on 5 November 2008⁵⁸ in which Mr Calderwood wrote:

"Syed, in essence, what I am trying to say is that any allegation of management inaction cannot be held to have affected the care of the 55 and 18. Indeed, my own view is I think we could suggest that at best, had management action been initiated in late January, the number of *C.diff* cases that may have been reduced is a number less than 30 and the deaths which might have been averted is not 18

but is a lesser number 18 less the four who died in December less the two who died in the community and less the one who died in June, i.e. 11 patients".⁵⁹

The email appeared to be putting forward arguments that might be seen to minimise the extent of the CDI problem, but Mr Calderwood disagreed with such an interpretation. He explained that he was trying to create a timeline of those patients who had contracted CDI which was considered to be community acquired as opposed to hospital acquired, and to establish the point at which the system should have caught up and identified an outbreak.⁶⁰

Mr Calderwood took late January as a starting point. Dr Ahmed did not agree with this approach. He could not say with any confidence that the outbreak occurred in late January, and was of the view that it might have started before that.⁶¹ As discussed in Chapter 15, Dr Ahmed was right to be cautious, because there was a significant CDI problem prior to January 2008.

Mr Thomas Divers, Chief Executive, did not think that Mr Calderwood's comments were an attempt to minimise the impact of the *C. difficile* infection problem:

"I think Robert was genuinely exercised about trying to understand, as best all of us could, what had happened here. The reality is there was a huge volume of cases that actually were involved in this, and my final take on this was: the Fiscal is starting work, he needs the OCT report. And, in essence, I shut the debate down and told Syed to send the OCT report off, and I told Robert I was doing that".⁶²

Identification of outbreaks

The OCT concluded that the number of cases of CDI "at the VOLH for the six-month period from 1 December 2007 to 31 May 2008 was more than expected for the hospital, based on the historical data".⁶³ The OCT looked at

56 [GGC00600005](#)

57 [GGC00600005](#)

58 [GGC16670002](#)

59 [GGC16670002](#)

60 [TRA01240089-92](#)

61 [TRA01240092-93](#)

62 [TRA01250137](#)

63 [GGC00600064](#)

overall numbers and did not identify clusters within that six month period,⁶⁴ but there was no real dispute that there had been outbreaks.

The OCT also concluded that the fatality rate among those patients affected by CDI appeared to be higher than reported from elsewhere, and noted from the patient records of deceased patients that they were vulnerable due to their age and other existing clinical conditions.⁶⁵

Surveillance systems

The OCT concluded that the surveillance system that was in place at the time of the outbreaks was inadequate to alert the local Infection Control Team to “trends over time”.⁶⁶

The surveillance system in use at the VOLH, which has already been described in Chapter 15, used a coloured card (T-Card) system which identified individual infections by colour. As discussed in Chapter 15, the T-card system could have provided a snapshot of what was happening, as there would have been a cluster of yellow cards showing the number of patients on each ward with CDI. The T-cards, however, could not show trends or patterns over time, and certainly in that sense the surveillance system was inadequate.⁶⁷

No mention is made in the OCT report of the infection prevention and control Access database, which could have provided regular surveillance reports.⁶⁸ Professor Duerden explained that he would have expected some members of the OCT to be aware of the database, including Mr Walsh, Dr Bagrade, and Ms Annette Rankin, the Head Infection Control Nurse.⁶⁹

The local surveillance arrangements for *C. difficile* at the VOLH were described by the OCT as being “in transit” during this period.⁷⁰

This was a reference to the introduction of the SPC Chart system. The relevance of the SPC Charts to acute *C. difficile* surveillance is discussed in Chapter 15.

Cleaning and hand hygiene

The OCT concluded that cleaning of the VOLH environment was regularly audited as part of the national monitoring mechanism, using the National Cleaning Services Specification. Monitoring data for the six months during the outbreak period did not identify any significant issues over cleanliness of the patient care environment.⁷¹ Nor did data for the VOLH provide any evidence that the hospital was underperforming on hand hygiene when compared to other acute hospitals in NHS GGC.⁷²

Antimicrobial prescribing

A policy of antimicrobial prescribing was in place at the VOLH during the period examined by the OCT. The OCT report acknowledges, however, that there were no formal arrangements in place to monitor antibiotic use or to audit compliance with the antimicrobial prescribing policies. The Antimicrobial Management Team carried out a subsequent audit on behalf of the OCT which showed that the use of some broad spectrum antibiotics at the VOLH was higher than in other hospitals in Clyde.⁷³ Antibiotic prescribing policies are discussed in detail in Chapter 13.

Clinical environment

The OCT reported that the clinical environment where some of the patients were managed did not have adequate facilities for the practice of good infection control procedures, but went on to conclude that there was:

“no evidence that this has in any way affected the clinical treatment of CDAD patients and/or their outcome”.⁷⁴

Environmental factors are considered in detail in Chapter 15. It suffices to say here that it should have been obvious to the OCT that, for example, a shortage of hand washing facilities could affect patient safety.

64 [TRA01060033](#)

65 [GGC00600007](#)

66 [GGC00600031](#)

67 [TRA01060036-37](#)

68 [EXP02810005](#)

69 [TRA01060039](#)

70 [GGC00600064](#)

71 [GGC00600007](#)

72 [GGC00600006](#)

73 [GGC00600040-41](#)

74 [GGC00600007](#)

Recommendations by the Outbreak Control Team

The OCT report made the following recommendations:

- “Based on the lessons learnt from this outbreak, the NHS Board should review and clarify roles, responsibilities and communication chain for HAI throughout the organisation
- The programme of work to improve the structural environment of the VOLH should continue and an assessment of more significant works should be completed to facilitate optimum infection control practice
- The Antimicrobial Management Policy and the *Clostridium difficile* treatment protocol should be implemented in areas covering both primary and secondary care prescribing activities in NHSGGC. The Antimicrobial Management Policy should be audited at regular intervals
- A system should be developed to monitor the number of deaths of patients with CDAD and these should be regularly reviewed by the local ICT
- The local surveillance system should be regularly monitored to ensure that it is fit for purpose and if necessary updated based on national guidance. Local surveillance data should continue to be fed back to the senior charge nurses and lead nurses of the wards. In addition, data should be held on the number of new cases of severe alert organisms (*Clostridium difficile* and MRSA) per ward, per directorate and per site
- Education with regard to infection control and HAI issues should be available for all staff and the uptake of training should be monitored
- NHS Board should continue to work closely with Public Focus Patient Involvement (PFPI) and Patient Public Focus (PPF) leads for Community Health Care Partnerships (CHCPs) to review communication methods and materials used to communicate with patients and relatives and also with the wider community on HAI issues
- Clinicians completing a DNAR order must ensure that the decision making process is

fully documented and this decision must be prominently displayed in the casenote”⁷⁵

Some criticism of the Outbreak Control Team report

Professor Duerden was critical of the OCT report. In particular he said that the OCT report had started to look at the outbreak but it had not come to clear conclusions about the real cause and pattern of the outbreak. This was in part due to the lack, even at this stage, of a detailed timeline demonstrating which patients had become infected, in which wards, and any relationship between the patients. A detailed timeline was critical to an understanding of the pattern of an outbreak.⁷⁶ He suggested that the report was very weak in describing the activities which occurred during the outbreak period, but acknowledged that it did recognise the gaps in the infection prevention and control arrangements.⁷⁷

It is worthy of note that, following the outbreak of salmonella at the Victoria Infirmary in 2005, the Watt Group report criticised an aspect of the OCT report into that outbreak on the basis that:

“the Report did not document the fundamental aspects of the likely spread of infection, nor give details of key infection control issues relevant to the outbreak”.⁷⁸

The Watt Group recommended:

“that all OCT reports should provide sufficient details of the key factors in the spread of infection to allow proper audit”.⁷⁹

For the reasons given by Professor Duerden, this recommendation was not fully reflected in the VOLH OCT report.

Neither were individual or corporate failures identified in the report. Professor Duerden would have expected some sort of comment on the reasons why the increased number of cases had not been brought to the attention

⁷⁵ [GGC00600066-67](#)

⁷⁶ [TRA01060032](#)

⁷⁷ [EXP02810005](#)

⁷⁸ [GOV00130025](#)

⁷⁹ [GOV00130025](#)

of the Infection Control Doctor and the infection control committee structure.⁸⁰ Counterbalancing these criticisms, however, is the explanation by Dr Ahmed that the OCT was not looking to see if there had been systemic failures because the team was aware of other investigations taking place, including those of the Health and Safety Executive and the Independent Review Team.⁸¹ The OCT did not wish to encroach upon these other investigations, and the decision was taken to conclude its investigations on 16 July 2008. It was for that reason that the OCT did not contact Dr Biggs,⁸² although it did conclude that there was a lack of Infection Control Doctor leadership at the VOLH.⁸³

Dr Ahmed said that the key purpose of the OCT was to “control the outbreaks”.⁸⁴ The purpose was not “to forensically examine ... case by case the detail of the outbreak”;⁸⁵ it was to identify the problem and to deal with it in order to protect public health.⁸⁶ There is no suggestion that this goal was not achieved.

Despite the reasons provided by Dr Ahmed for the OCT’s approach, it has to be emphasised that any outbreak investigation should be able to define an outbreak in terms of the number of patients affected and over what period. It should also define the timelines of cases and any evidence of links in time and place between cases. This information defines an outbreak and is central to any investigation into aspects of an outbreak.

17.4 Conclusion

This Chapter has examined only that part of the NHS GGC Board’s response to the occurrence of CDI at the VOLH that is reflected in the work of the Internal Investigation or of the OCT. Other aspects of the Board’s response, including the Board’s approach to the examination of patient records, the

substantial investment into the VOLH, and the changes in antimicrobial prescribing are discussed in other Chapters of this Report.

As set out in this Chapter, the Internal Investigation had a limited remit and had its deliberations curtailed by the appointment of the Independent Review. A similar fate befell the OCT’s investigation. Both investigations did produce lessons to be learned or recommendations that were entirely appropriate.

It is apparent that the message from nurses in their evidence to the Inquiry that shortage of staff meant that they were “firefighting” was not one conveyed to these investigations. Neither investigation examined nursing and medical care for the simple reason that that was not covered by their respective remits. In his witness statement to the Inquiry Mr Calderwood set out his understanding of the care given to patients who suffered from CDI at the VOLH in the following way:

“However, the findings of the outbreak control team and independent review team show that every patient with C.diff at the Vale of Leven during these six months was identified and given the appropriate nursing care”.⁸⁷

Mr Calderwood’s reference in these remarks to the Independent Review is misleading, but not deliberately so. Professor Smith has confirmed to the Inquiry that his review did not look at general nursing care. That was outwith the team’s remit, and a longer period would have been necessary to conduct such a review.⁸⁸

As explored in other Chapters of this Report, what Mr Calderwood said was not accurate. There were failures in care. Mr Calderwood agreed in evidence that evidence of lack of appropriate care planning or stool charts and a failure to isolate patients would cause him to “retract”⁸⁹ that statement. He said he would reflect on the facts emerging from the Inquiry.⁹⁰

80 [TRA01060035](#)

81 [TRA01140048](#)

82 [TRA01140053](#)

83 [CGC00600031](#)

84 [TRA01140055](#)

85 [TRA01140048](#)

86 [TRA01140048](#)

87 [WTS00880019](#)

88 [WTS02140005](#)

89 [TRA01240086](#)

90 [TRA01240086](#)

Both the Internal Investigation, despite its narrow remit, and the OCT did focus on issues of infection prevention and control. Surprisingly, however, neither explored what role, if any, was played by the infection prevention and control Access database. As already mentioned in this Chapter, Mrs Grant did say that the existence of the database had been mentioned by Mrs O'Neill. Had the OCT in particular focused on the existence of the database then that could have prompted some inquiry into what role it might have played in the past and why it was not in use in 2008. These are issues that are explored in Chapter 15.

As observed earlier, it should have been obvious to the OCT that environmental factors and lack of facilities could affect patient safety. The Inquiry is not otherwise inclined to criticise the manner in which the two investigations approached the specific tasks that they undertook, particularly because these investigations were overtaken by the setting up of the Independent Review.

17.5 Recommendations

Recommendation 72: Health Boards should ensure that a non-executive Board member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHSGGC.

Recommendation 73: Health Boards should ensure that OCT reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report.

Chapter 18

Experiences of *C. difficile* infection
within and beyond Scotland

Introduction

The aim of this Chapter is to examine reports of other outbreaks of *C. difficile* infection (CDI) in order to consider whether lessons could have been learned from them to prompt an examination of infection prevention and control practices at the VOLH and the care of patients suffering from CDI. There will be a particular focus on the reports published on outbreaks of CDI at Stoke Mandeville Hospital, Buckinghamshire Hospitals NHS Trust (Stoke Mandeville), and Maidstone and Tunbridge Wells NHS Trust (Maidstone and Tunbridge Wells).

The Inquiry is aware of outbreaks of CDI, and of the 027 strain that is discussed in this Chapter, in other parts of the world. Professor Poxton described in his evidence and his report the development of the 027 strain, firstly in Montreal and thereafter in other parts of North America and in Western Europe.¹ Information published by the Canadian Medical Association Journal in 2006,² drawing on data from 2003 onwards, disclosed that with the emergence of the 027 strain there was an increased severity of infection as well as a significantly increased mortality rate. Professor Poxton drew attention to the fact that surveillance systems in some parts of the world are in their infancy, so that the information available is limited.³ While statistical data on rates of infection are available from Canada, no reports of detailed investigation of the management of any particular outbreak appear to have been published.

Given these limitations, in contrast to the detailed investigations carried out into 027 outbreaks within the United Kingdom, the Inquiry has concluded that further examination of the management of CDI, and of the 027 strain in particular, in North America would not be a useful exercise.

18.1 The 027 strain

A hypervirulent strain

Chapter 3 explains the different strains of *C. difficile* and how strains can be identified. At the time of the Stoke Mandeville and Maidstone and Tunbridge Wells reports in 2006 and 2007, and in the aftermath of those outbreaks, the 027 strain was seen as a “hypervirulent” strain because it caused more severe disease and more deaths.⁴ Professor Ian Poxton, Professor of Microbial Infection and Immunity at the University of Edinburgh, emphasised in evidence, however, expressing a view echoed by Professor Duerden,⁵ “All *Clostridium difficile* toxin-producing strains are to be worried about.”⁶

Over the years it became more apparent that some of the outbreaks that involved the 027 strain were not particularly severe, although others were devastating and fatal.⁷ There is no doubt, however, that at the time of the outbreaks at Stoke Mandeville and Maidstone and Tunbridge Wells the 027 strain was seen as important because of the clinical severity associated with it.⁸

Recognition of the 027 strain in Scotland

The hypervirulent nature of the 027 strain was recognised in Scotland before the discovery of the CDI problem at the VOLH. The Health Protection Scotland (HPS) weekly report dated 19 September 2006 recognised that it was a virulent strain and that it had been the strain which caused most of the cases in the outbreak at Stoke Mandeville.⁹ The HPS weekly report dated 7 November 2007 intimated that there had been a case of CDI with the 027 strain in a hospital in the west of Scotland, and that this was the second reported case of the 027 strain in Scotland.¹⁰

The HAI Task Force Delivery Plan “Project Initiation Document” designed to develop a programme for reduction of *C. difficile* in July 2007 also described the 027 strain as hypervirulent.¹¹

1 [TRA00090037-38](#); [EXP00690021-24](#)

2 [INQ05290001](#)

3 [EXP00600005](#)

4 [TRA00090037-42](#)

5 [TRA01050053-54](#)

6 [TRA00090042](#)

7 [TRA01050053](#)

8 [TRA01050055](#)

9 [GOV01110001](#)

10 [INQ03650001](#)

11 [HPS00250001](#)

The point to be made here is that, whatever change there may have been in the state of knowledge about the virulence of the 027 strain since the discovery of the CDI problem at the VOLH, prior to and indeed up until then it was being viewed as a hypervirulent strain capable of causing very severe disease and death. That is the context in which any response in Scotland to its emergence must be considered.

18.2 The Stoke Mandeville, and Maidstone and Tunbridge Wells reports

Two important reports

The Stoke Mandeville, and Maidstone and Tunbridge Wells reports,¹² both of which arise from outbreaks in England that occurred within recent years, provide important lessons on infection prevention and control and on patient care.

Stoke Mandeville

In July 2006 the Healthcare Commission in England published the report into outbreaks of CDI at Stoke Mandeville.¹³ This examined two outbreaks, the first between October 2003 and June 2004 and the second between October 2004 and June 2005. In the first outbreak there were 174 CDI cases with 19 deaths definitely or probably due to CDI. In the second there were 160 CDI cases with 19 further deaths definitely or probably due to CDI.¹⁴

Any comparison of these figures with figures for the VOLH must of course take account of the fact that Stoke Mandeville was a much larger hospital with around 460 beds.¹⁵ As already mentioned in Chapter 8, by 2008 the bed complement in the VOLH was about 136. Yet, as set out in Chapter 4, in the period 1 January 2007 to 31 December 2008, 143 patients who were or had been patients in the VOLH tested positive for CDI. CDI was a causal factor in the deaths of at least 34 of those patients.

Some Stoke Mandeville issues

The following factors were among those identified in the Stoke Mandeville report as contributing to the outbreaks:¹⁶

- The poor state of repair of the buildings
- Failure to isolate patients with diarrhoea
- Difficulty in isolating patients due to lack of side rooms
- Excessive movement of patients
- Shortages of nurses
- Lack of facilities for hand washing
- Poor storage facilities
- Low priority afforded to infection control
- Failure to ensure that the governance structure identified issues of patient safety

The following aspects of the management of patients with CDI were identified:¹⁷

- Fluid balance was given little attention
- Poor care planning and nursing assessments

The Stoke Mandeville report found that by the time its investigations were carried out certain precautions had already been taken. As early as 2003 the policy on use of broad spectrum antibiotics at Stoke Mandeville had been changed in response to cases of CDI,¹⁸ although the report does not make clear who prompted that change. Guidelines for antibiotic use were thereafter regularly reviewed. The outbreak committee had also identified a need for new wash-hand basins and new partitions, which were in place by July 2004.¹⁹

In 2004 samples were sent to the Anaerobe Referencing Laboratory in Cardiff for typing, which led to the identification of many cases as due to the 027 strain. There was concern that the clinical picture was more severe than usually associated with CDI outbreaks, but the 027 strain was then thought to be rare in the United Kingdom and its significance was not generally recognised.

12 [INQ02890001](#); [INQ02870001](#)

13 [INQ02890001](#)

14 [INQ02890006](#)

15 [INQ02890021](#)

16 [INQ02890007-09](#)

17 [INQ02890033](#)

18 [INQ02890026](#)

19 [INQ02890027](#)

Stoke Mandeville recommendations

The Stoke Mandeville report included recommendations that were highly relevant to the problems identified by this Inquiry at the VOLH. In relation to standards of care, for example, the report stressed that in the clinical management of patients with *C. difficile* good records had to be kept of fluid management, and that the standard of documenting and implementing decisions about clinical management had to be improved. There were also important recommendations on issues such as adequate levels of staffing, management involvement in infection prevention and control, training, clinical governance, and the management of risk.²⁰

Maidstone and Tunbridge Wells

In October 2007 the Healthcare Commission published its report into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells.²¹ The report examined the period from April 2004 to September 2006,²² and identified two outbreaks occurring during that period. The first of these was in the autumn of 2005, but had not been identified by the Trust and consequently was not declared. The second was declared on 12 April 2006. During the two outbreaks more than 500 patients developed CDI.²³ The report estimated that there were approximately 90 deaths where *C. difficile* was definitely or probably the main cause of death.²⁴

Again any comparison with figures for VOLH must take account of the fact that at the time the Trust had 857 to 900 beds spread over three hospitals.²⁵

Some Maidstone and Tunbridge Wells issues

Among the issues identified in the report were:

- Ineffective local surveillance²⁶
- Limited use of stool charts²⁷
- Unnecessary administration of broad spectrum antibiotics²⁸
- Inadequate fluid management²⁹
- Dissatisfaction among patients and families over information provided³⁰
- Lack of hand basins, lack of sluice space, inadequate storage in wards³¹
- Limited availability of microbiologists, few visits to wards³²
- Microbiologists and infection control nurses not working closely together³³
- Link nurse scheme not well established³⁴
- Inadequate level of training on infection control³⁵
- Heavy reliance on bank and agency staff³⁶
- Complex governance structure did not ensure operational problems and risks to patients identified³⁷
- Little leadership to, or monitoring of, directorates by governance and risk committee³⁸
- Absence of information on *C. difficile* for Board³⁹
- Perception that priorities of leadership were finance, access targets, and reconfiguration of services⁴⁰

Maidstone and Tunbridge Wells recommendations

The Maidstone and Tunbridge Wells report's recommendations bore a significant degree of similarity to those of the Stoke Mandeville report. Once again clinical governance and the management of risk were identified as important issues, with emphasis on the point that control of infection needed to be seen as an integral part of clinical governance. Recommendations were also made on standards of care, including specific reference to the importance of treating *C. difficile* as a diagnosis in its own right that necessitated

20 [INQ02890093-95](#)

21 [INQ02870001](#)

22 [INQ02870005-06](#)

23 [INQ02870005](#)

24 [INQ02870006](#)

25 [INQ02870020-21](#)

26 [INQ02870026](#)

27 [INQ02870034](#)

28 [INQ02870035](#)

29 [INQ02870036](#)

30 [INQ02870042](#)

31 [INQ02870048](#)

32 [INQ02870056](#)

33 [INQ02870057](#)

34 [INQ02870057](#)

35 [INQ02870060](#)

36 [INQ02870069](#)

37 [INQ02870088](#)

38 [INQ02870088](#)

39 [INQ02870091-92](#)

40 [INQ02870097](#)

regular review. One recommendation emphasised the importance of basic aspects of nursing care that required nurses to administer medication appropriately and to take steps to prevent pressure damage. The importance of prudent prescribing of antibiotics, whereby the narrowest possible spectrum antibiotics were prescribed for the shortest period possible, was also highlighted.

18.3 The NHS Greater Glasgow and Clyde response to Stoke Mandeville, and Maidstone and Tunbridge Wells

A level of awareness

It is apparent that quite a number of NHSGGC staff were aware of the Stoke Mandeville report.⁴¹ The chair of the Acute Control of Infection Committee (ACIC), Dr Robin Reid, had read it, although not an infection control professional, and he was in little doubt that Infection Control Doctors and Infection Control Nurses would have been aware of it.⁴² Professor John Coia, Director of Scottish Microbiology Reference Laboratories, could not recollect any discussion of the Stoke Mandeville and Maidstone and Tunbridge Wells reports at the meetings of the ACIC, of which he was a member, but he was able to say that there was “a lot of discussion of both these reports within the infection control community within Greater Glasgow...”.⁴³

The Nurse Consultant for Infection Control, Ms Sandra McNamee, had read the Stoke Mandeville⁴⁴ and Maidstone and Tunbridge Wells reports⁴⁵ and used them to inform her own practice. She explained to the Inquiry that she had reviewed both reports and extracted those parts she felt ought to be in the infection control programme. She went on to say, however, that “unfortunately the reports in their entirety didn’t go to any of the committees that I’m aware of”.⁴⁶ She did not believe that any steps were taken to inform staff at hospital level of the lessons to be learned from the two incidents.⁴⁷

On the other hand, Dr Syed Ahmed, Consultant in Public Health, NHSGGC, said that although it is not recorded in the minutes of the Board Infection Control Committee these reports were discussed there and responded to by making changes to policies.⁴⁸

Some practical steps

According to Mr Thomas Walsh, the Infection Control Manager (ICM), he discussed the Maidstone and Tunbridge Wells report with Ms McNamee. They followed that up with two additional educational components for the online training modules and an improved patient and relative leaflet. He said that the Maidstone and Tunbridge Wells report was one of the reasons that CDI was considered for the statistical process control charts described in Chapter 15.⁴⁹ He also said that he carried out what he described as a “gap analysis”, with a particular focus on policies.⁵⁰

The VOLH response

Notably, there were actions taken at the VOLH that can be directly attributed to the Stoke Mandeville report.⁵¹ A meeting took place at the VOLH on 16 February 2007 to discuss facilities services at the hospital in the light of issues raised in the Stoke Mandeville report.⁵² This was attended by Mrs Catriona Sweeney, Site and Facilities Manager, Mrs Lena Keeley, Assistant Domestic Services Manager and Mrs Helen O'Neill, Infection Control Nurse. Although the original instruction to carry out this review has not been seen by the Inquiry, it is apparent from later correspondence that it was issued to all NHSGGC site managers.⁵³

The meeting identified several concerns related to areas highlighted in the report.⁵⁴ Storage issues and poor housekeeping practices were noted in some wards and departments. Poor maintenance of fabric and equipment was also identified. It was noted that estates had no budget for painting

41 [INQ02890001](#)

42 [TRA01180055](#)

43 [TRA01220034](#)

44 [INQ02890001](#)

45 [INQ02870001](#)

46 [TRA01210028](#)

47 [TRA01210029](#)

48 [TRA01130028-31](#)

49 [TRA01200103](#)

50 [TRA01200104](#)

51 [INQ02890001](#)

52 [GGC07790002](#); [INQ02890001](#)

53 [GGC07790001](#)

54 [GGC07790002-06](#); [GGC20710001-05](#)

or fabric repairs, and that all repairs were of an emergency nature. There was a need for supervisors to be vigilant in observing domestic staff to ensure compliance with infection control requirements.

The same team conducted a review in February 2008.⁵⁵ In a number of instances problems had not been resolved, which is of course a cause for concern. But what these meetings and reviews do demonstrate is that it was possible and relatively easy for local consideration to be given to the immediate relevance of issues identified in the Stoke Mandeville report⁵⁶ and to possible solutions.

Presentations to staff at the VOLH

As mentioned in Chapter 15, in early 2007 Mrs Jean Murray, Interim Lead Nurse for Infection Control, gave a presentation on CDI to doctors which was based to a large extent on the Stoke Mandeville report. She dealt with the infection control aspects, while Dr Barbara Weinhardt, Consultant Microbiologist, dealt with the pathology, biology and microbiology.⁵⁷ Mrs Murray gave a further presentation to nurses on 8 May 2007.⁵⁸

Mrs Murray explained that one of the principal reasons for focusing on the Stoke Mandeville report was her recognition of a number of similarities between the environment at the VOLH and that described in the report, in particular poor maintenance and lack of isolation facilities.⁵⁹ Taken as a whole that presentation covered many of the problems identified in the Stoke Mandeville report, including poor infection prevention and control practices and the importance of prudent antibiotic prescribing.⁶⁰

The practices of infection control staff at VOLH are examined in greater detail in Chapter 15. At this point the Inquiry simply notes this further example of local consideration being given to issues raised in the Stoke Mandeville report.

Failure to apply lessons

It can be seen, therefore, that NHSGGC did respond to the Stoke Mandeville and Maidstone and Tunbridge Wells reports. What is unfortunate, however, is that the NHSGGC Board did not consider the lessons learned from the Stoke Mandeville report or indeed the Maidstone and Tunbridge Wells report as a checklist against which to assess the operation of infection prevention and control at the VOLH.

18.4 NHS Quality Improvement Scotland response

Role of NHS Quality Improvement Scotland

The role of NHS Quality Improvement Scotland (NHS QIS) is set out in Chapter 6. It was to take the lead in improving the quality of care and treatment delivered by NHSScotland. Its declared key functions were:

- Providing clear advice and guidance on effective clinical practice
- Setting clear clinical and non-clinical standards of care
- Reviewing and monitoring the performance of NHS services
- Supporting NHS staff in improving services, and
- Promoting patient safety and implementation of clinical governance⁶¹

Reference to the Stoke Mandeville report by NHS Quality Improvement Scotland

The background to the publication of standards for HAI infection prevention and control is considered in Chapter 6. These standards were originally published in December 2001. The Stoke Mandeville report⁶² was one of a substantial number of documents referenced in the draft of the revised standards,⁶³ issued in August 2007, and revised standards were published by NHS QIS in March 2008.⁶⁴

55 [GGC20710001](#)

56 [INQ02890001](#)

57 [TRA01010042](#)

58 [GGC17790002](#)

59 [TRA01010044](#)

60 [INQ0301001-05](#); [INQ03010015](#)

61 [INQ00840027](#)

62 [INQ02890001](#)

63 [GGC17380002](#)

64 [INQ00840001](#)

These standards did not in themselves anticipate or entail review by Health Boards of their policies or practices. They were:

“written with the overall intention that meeting them should not require NHS boards to introduce new initiatives or create new pieces of evidence unless absolutely necessary, but rather should allow NHS boards to build upon work already being done”.⁶⁵

As the document explained:

“These standards are one part of the drive for a safer NHS Scotland, so should be seen as complementary to HAI and patient safety work undertaken by other bodies”.⁶⁶

No guidance appears to have been issued, or review conducted, by NHS QIS specifically in the light of the Stoke Mandeville or Maidstone and Tunbridge Wells reports.

The Inquiry notes that since the period under scrutiny the functions of NHS QIS have been taken over by Healthcare Improvement Scotland (HIS).

18.5 The response to the Stoke Mandeville, and Maidstone and Tunbridge Wells reports by Health Protection Scotland

Health Protection Scotland

The role of Health Protection Scotland (HPS) is discussed in Chapter 6. To summarise: HPS was formally established in 2005 as successor to the Scottish Centre for Infection and Environmental Health.⁶⁷ It has responsibility for implementing health protection programmes and policies, for providing expert advice on policy development, and for implementing a quality assurance framework for health protection at local, regional and national levels. It also has responsibility for public communication and advice on health protection issues in line with Scottish Government policy.⁶⁸

⁶⁵ [INQ00840004](#)

⁶⁶ [INQ00840005](#)

⁶⁷ [INQ04900005](#)

⁶⁸ [INQ04900007](#)

The Healthcare Associated Infection Task Force

The relationship between HPS and the Healthcare Associated Infection (HAI) Task Force is also considered in Chapter 6. The work of HPS in connection with HAI is overseen by the Task Force.⁶⁹ Led by the Chief Medical Officer, with members drawn from Health Boards, NHS QIS, HPS and elsewhere, the HAI Task Force was responsible for leading the programme of work detailed in the Scottish Executive Action Plan to reduce the risk to patients, staff and visitors from HAI (2002 to 2005),⁷⁰ and for its own subsequent Delivery Plans (2006 to 2008,⁷¹ 2008 to 2011⁷²).

Development of policies and guidance

The national policies and guidance in place in Scotland on HAI, and on *C. difficile* in particular, are considered in Chapter 7. Policies and guidance were being developed before the publication of the Stoke Mandeville report.⁷³ They continued to be developed between then and the publication of the Maidstone and Tunbridge Wells report,⁷⁴ and thereafter. The following list of guidance documents published prior to June 2008, with dates of issue, was provided to the Inquiry by HPS:⁷⁵

- Standard Infection Control Precautions (SICPs), published September 2006
- CDAD Reduction Programme established, February 2007
- Project initiation document on the ‘CDAD Reduction Programme’ submitted to HAI Task Force, July 2007
- Collaboration with National Education Scotland (NES) on developing on-line training material for junior doctors initiated May 2007, completed May 2009
- Electronic *C. difficile* network (‘shared space’ on NHS e-Library server), established August 2007

⁶⁹ [INQ04900010](#)

⁷⁰ [GOV00100001](#)

⁷¹ [GOV00150001](#)

⁷² [GOV00140001](#)

⁷³ [INQ02890001](#)

⁷⁴ [INQ02870001](#)

⁷⁵ [HPS00170003](#)

- CDAD care bundle initiated in October 2007, published/distributed, March 2008
- Transmission Based Precautions (policies), published April 2008

This demonstrates a continuing awareness of the need for additional and updated guidance on infection prevention and control.

Nevertheless, to measure the extent to which the lessons of the Stoke Mandeville and Maidstone and Tunbridge Wells reports were being learned in Scotland it is a useful exercise to identify the developments that took place in Scotland **expressly or even implicitly** in the light of these reports.

Some consideration of Stoke Mandeville and Maidstone and Tunbridge Wells reports

The Project Initiation Document produced by the HAI Task Force in July 2007 for the development of a programme for reduction of healthcare associated CDI in Scotland identified HPS as the lead organisation and explained by way of introduction that:⁷⁶

“The incidence of healthcare associated CDAD (*C. difficile* Associated Disease) in Scotland has steadily increased in the period 1994 to 2006. Recently a new emerging hypervirulent strain (PCR ribotype 027), which causes more severe disease, has caused large outbreaks in England, Europe and North America”.⁷⁷

Specific mention is also made of the Healthcare Commission’s recommendations contained in the Stoke Mandeville report,⁷⁸ in particular those relating to hospital management, risk management, clinical governance and links to external health organisations.

The tasks identified in that document were:

- Review existing local, national and international guidelines for prevention and control of CDAD to adapt appropriate guidance for Scotland

- Review existing interventions and quality improvement tools to produce and provide an agreed set of interventions
- Produce a model policy for prevention and control of CDAD
- Produce educational material for healthcare staff and the public
- Establish a communication network of key persons involved in infection control⁷⁹

At a later stage the HAI Task Force also considered the Maidstone and Tunbridge Wells report.⁸⁰ This was soon after its publication, the subject being raised at the HAI Task Force meeting of 30 October 2007 by the Chief Nursing Officer, Professor Paul Martin. He advised the meeting:

“that he proposed to issue a letter to Chief Executives (copied to Chairs) of NHS Boards, reminding them of their responsibilities to minimise and manage risk and to ensure that actions are in place to avoid any similar outbreaks”.⁸¹

Professor Martin’s letter

Professor Martin’s letter was issued on 8 November 2007.⁸² The principal subject matter was the need to maintain good communication channels between Boards and the Scottish Government in the event of an outbreak. There is no explicit reference to Maidstone and Tunbridge Wells in the letter, but he urges each Chief Executive to:

“ensure that your Board undertakes an immediate and thorough review of its local infection control policies to help minimise the risk of any outbreaks occurring”.⁸³

Asked in the course of his evidence what response he would have expected to the letter, Professor Martin explained:

“We would expect, and did expect, the Chief Executives and the Boards through the infection control committees and, indeed, through their clinical governance

⁷⁶ [HPS00250001](#)

⁷⁷ [HPS00250001](#)

⁷⁸ [INQ02890001](#)

⁷⁹ [HPS00250002](#)

⁸⁰ [INQ02870001](#)

⁸¹ [GOV01210007](#)

⁸² [GGC14420004](#)

⁸³ [GGC14420004](#)

machinery to do a review, to make sure that the systems and the processes were in place, that policies were in place, that staff in all of the settings knew how to respond if there were issues raised, education was happening, et cetera”.⁸⁴

That expectation was not spelled out in his letter, which referred only to a review of infection control policies.

Mr Walsh's response

On 12 November 2007 Mr Walsh circulated the Chief Nursing Officer's letter of 8 November to a number of health professionals including Ms McNamee, Ms Annette Rankin, Head Infection Control Nurse, and Dr Ahmed. In his covering email he explained:

“In practice as Board ICM and Nurse Consultant, Sandra and I already undertake this function. The letter merely requires inclusion of a couple of additional SGHD (Scottish Government Health Department) email addresses to the distribution of updates from NHSGGC”.⁸⁵

The “function” referred to was that of informing key contacts in the Scottish Government of major incidents and outbreaks of infection – an issue raised in Professor Martin's letter.

No mention is made by Mr Walsh of any review of policies. Mr Walsh explained in his evidence to the Inquiry that revision of infection control policies is an ongoing process, not one triggered by such reminders,⁸⁶ and it certainly does appear that, for example, the Loose Stools Policy was reviewed in December 2007.⁸⁷

In the absence of any specific reference to the Maidstone and Tunbridge Wells report,⁸⁸ it does not appear to the Inquiry that the Chief Nursing Officer's letter could have been expected to trigger a review of infection control policies specifically in the light of

that report. It is therefore no surprise to the Inquiry that Professor Martin's expectation of a more extensive review of systems and processes was not realised. This is not to be seen as a criticism of Professor Martin, whose purpose in sending out the letter was well intentioned, or of Mr Walsh, who provided a satisfactory reason for his response. Nevertheless, the lesson to be learned from this episode is that of the importance of absolute clarity in communication when dealing with important aspects of infection prevention and control. Had the letter been more specific then it is very likely that NHSGGC would have carried out the kind of review described by Professor Martin in his evidence. That kind of thorough review would have provided an opportunity to identify problems discussed in this Report in connection with infection prevention and control at the VOLH.

HPS retrospective summary

A retrospective summary of HPS developments up to March 2008 in the field of guidance and surveillance relating to CDI was provided to the Inquiry. This explains that the development of a national guidance document on prevention and control of CDI was scheduled in 2007, but was not commenced then as a joint European systematic review that was going to provide the evidence base for the Scottish document was still in production. Because of the severity of the VOLH CDI problem, however, the SGHD required in June 2008 that HPS deliver a draft of the guidance by August 2008, a period for production of guidance considerably shorter than recommended by medical guideline bodies. The first version of the national guidance on CDI was published in October 2008. A CDI checklist for NHSScotland was published by HPS in September 2008.⁸⁹

Further reference to national guidance and to the checklist will be made later. It suffices to note at this point that by September 2008 the Stoke Mandeville report⁹⁰ had been in the public domain for over two years.

84 [TRA01080100](#)

85 [GGC14420001](#)

86 [TRA01200019](#)

87 [GGC27590001](#)

88 [INQ02870001](#)

89 [HPS00170001-02](#)

90 [INQ02890001](#)

Professor Reilly's position

Professor Jacqui Reilly, Head of Group for Healthcare Associated Infection at HPS, was posed the following question:

"Can we take it that it was thought that nationally across Scotland, Health Boards needed the guidance of HPS to learn lessons from the Stoke Mandeville and other outbreak reports?"

She replied:

"No, the Stoke Mandeville report received a high profile in the national press and the report was in the public domain so all the NHS boards had access to it and could read it, as could HPS".⁹¹

From this reply it would appear that, despite acknowledgement by HPS of the similarity between its role in Scotland and that of the Health Protection Agency in England,⁹² HPS did not consider it appropriate to follow the recommendations of the Stoke Mandeville report that:

"16 The Health Protection Agency should ensure that the system for disseminating relevant information to the NHS about the emergence of new strains of micro organisms is robust. This will require collaboration with the reference laboratories and the NHS.

17. The Health Protection Agency should ensure that it provides regular, up-to-date advice to health professionals, in an electronic form, on the management of *C. difficile*".⁹³

HPS did not issue any form of guidance on CDI based upon the Stoke Mandeville report or the Maidstone and Tunbridge Wells report prior to the publication of the HPS checklist in September 2008. Instead, according to Professor Reilly, the task of reviewing a report like the Stoke Mandeville report was left to Health Boards, and it was for Boards to consider whether there were any implications for their own practice.⁹⁴

The checklist

In her evidence Professor Reilly explained the creation of the HPS checklist⁹⁵ in the following terms:

"The HPS CDI checklist was developed as a support tool to check control measures were in place in the light of the evidence arising from both of these high profile outbreaks of CDI. It was discussed in the HPS internal CDI programme in early 2008. HPS had initial discussions with Sandra McNamee from GG&C about this in the context of the VOL outbreak, we sent her a draft version on 18 June 2008 to use at VOL. A consultation version was sent out to all NHS boards on 19 June 2008 (and comments were received from boards and HFS) which were collated on 22 August 2008. It was published on HPS website on 29 August 2008. We were unaware of whether any other board needed it at that time".

As Professor Reilly acknowledges in that quotation, the creation of the checklist was prompted by the Stoke Mandeville and Maidstone and Tunbridge Wells outbreaks. This is confirmed by Dr Anne Eastaway, Consultant Microbiologist with HPS, who explained that:

"HPS had also been working on a checklist which had been drawn up based on the findings of the Stoke Mandeville and other outbreak reports. The checklist draws together actions that need to be taken across an NHS organisation such as an NHS board or hospital".⁹⁶

As Professor Reilly explained, the production of the checklist was "accelerated"⁹⁷ following the discovery of the CDI problem at the VOLH. The checklist was used in June 2008 to assist in remedial action being taken when addressing the CDI problem at the VOLH.

The checklist highlights 32 issues seen as important to preventing and controlling CDI, including:

91 [TRA01100103](#)

92 [INQ04900008](#)

93 [INQ02890094-95](#)

94 [TRA01090155-156](#)

95 [TRA01100103](#); [HPS01590002](#)

96 [WTS02030011](#)

97 [TRA01090149](#)

- Data collection at ward level and data review
- Specific CDI issues are reviewed at senior management meetings, for example, outbreak/increased incidence reports and non-adherence to best practice
- CDI is acknowledged on the NHS Board's risk register
- Senior management supports and facilitates provision of infection prevention and control education programmes
- Antibiotic policy is followed with drug kardexes being checked
- Patients with CDI are in a single, clutter-free room
- There is evidence of medical review
- Equipment in use is fit for purpose⁹⁸

The Inquiry concludes from this evidence that HPS *did* consider the Stoke Mandeville and Maidstone and Tunbridge Wells reports⁹⁹ and *did* eventually issue guidance in the form of the checklist in the light of these reports. As mentioned earlier in this Chapter, the Stoke Mandeville report was published in July 2006 and the Maidstone and Tunbridge Wells report was published in October 2007. If the publication of the Stoke Mandeville report is taken as a starting point, it took two years for the checklist to be produced.

Guidance provided by Health Protection Scotland in May 2008

HPS also provided guidance to Boards, and to Infection Control Managers in particular, by letter dated 14 May 2008.¹⁰⁰ That letter was prompted by the discovery of CDI patients in Clyde with the 027 strain when there was a developing awareness of the CDI problem at the VOLH. It contained some of the advice subsequently contained in the checklist, and describes the 027 strain as “hypervirulent”.¹⁰¹ Notably, the letter draws upon draft guidance issued by the Department of Health in England. And while it does concentrate on the 027 strain, it also emphasises that the management of CDI is important regardless of ribotype.

No guidance on the 027 strain

It remains unclear to the Inquiry why no guidance on the *C. difficile* 027 strain was issued to Boards until May 2008, when the CDI problem involving the 027 strain in the VOLH was beginning to emerge. Knowledge of the issue at national level, at least in the specialist community, is not in question. The HPS weekly newsletter issued on 19 September 2006 has already been mentioned. That weekly report does record that no case of the 027 strain had yet been detected in Scotland (although Professor Reilly confirmed that the first was identified in 2006,¹⁰² which appears to have been an isolated case). In addition, while the weekly report notes conflicting evidence on the virulence of that strain in comparison with others, the HAI Task Force Delivery Plan project initiation document of July 2007 harbours no doubts over that, referring to “a new emerging hypervirulent strain (PCR ribotype 027), which causes more severe disease...”¹⁰³

The time taken to produce national guidance

A certain delay is understandable as far as the issue of national guidance is concerned. The Inquiry recognises that producing documents such as the NHS QIS Standards, eventually published in March 2008, and the HPS Guidance of Prevention and Control of CDAD, published in October 2008, requires time.

The Inquiry sees no reason, however, why advice to Boards to review their own facilities, systems and practices in the light of the Stoke Mandeville report could not have been issued within weeks of its publication. The advice in the form of the checklist would not have been difficult to produce much sooner. The issue of such advice was the responsibility of Scottish Government, but as Dr Kevin Woods, Director General for Health, Scottish Government, pointed out, it had not been alerted to the issue.

As noted earlier in this Chapter, the HAI Task Force Project Initiation Document produced in July 2007 had identified the need for extensive review, drawing to an extent on the

98 [HPS01590002-08](#)

99 [INQ02890001](#); [INQ02870001](#)

100 [HPS00730001](#)

101 [HPS00730003](#)

102 [TRA01100018](#)

103 [HPS00250001](#)

Stoke Mandeville report.¹⁰⁴ HPS was named in this document as the lead organisation.

Loss of opportunity to reinforce infection control messages

One result of the approach adopted by HPS is the significant lapse of time before the issue of the checklist. A second result is the loss of opportunity to use the detailed findings and recommendations of the earlier reports to encourage a Board such as NHSGGC to conduct a detailed audit of its own policies, practices and facilities, particularly at local level, in the light of those detailed findings and recommendations. The vital question here appears to the Inquiry **not** to be whether there were already policies and guidance in place, but whether use could have been made of the Stoke Mandeville and Maidstone and Tunbridge Wells reports to encourage implementation of those policies and guidance and review of their application.

Earlier circulation of the kind of advice contained in the checklist would have been highly desirable for that reason. It is to be noted that in England, in response to the outbreaks at Stoke Mandeville and before the publication of the report itself, a joint letter dated 21 December 2005 from the Chief Medical Officer and the Chief Nursing Officer was sent to all NHS Trust Chief Executives. The purpose of the letter was to draw attention to the prevalence of the potentially hypervirulent strain type 027 and to remind NHS Trusts of the importance of the need to minimise the risk of infection caused by *C. difficile*.¹⁰⁵

Had such advice been issued and received appropriate attention, it could only have led to a more timely and comprehensive overhaul of practice, if not policy, across Scotland. It would also have alerted Health Boards to the dangers of the 027 strain and put them in a better position to manage an outbreak of that strain when it arose, as was virtually inevitable.

Had it only been a question of publicising the prevalence of the new strain and the

increased risks associated with it, it would perhaps be easier to understand why this was not done until the 027 strain became a live issue in Scotland. But even on that particular issue, the Inquiry notes the evidence of Dr Woods that in retrospect perhaps not enough was done to alert Health Boards to the 027 strain and its implications.¹⁰⁶ The Inquiry endorses that view. In any event, the issues highlighted in the Stoke Mandeville and Maidstone and Tunbridge Wells reports went far beyond the 027 strain and CDI itself, and covered broader issues of patient safety and infection prevention and control.

18.6 The Scottish Government response

No action

In his evidence Dr Woods stated that “the Scottish Government did not take any action to draw the Stoke Mandeville case to the attention of Health Boards”.¹⁰⁷ He pointed out that in mid 2006 there were no recorded cases of *C. difficile* strain 027 in Scotland. He expected that there would be a general awareness of it and that it would be of interest to the infection control community.¹⁰⁸

No advice on further action

When asked if enough was done at national level to alert Health Boards to the newly emerging 027 strain, Dr Woods said that “in retrospect maybe not enough was done..”.¹⁰⁹ Importantly, Dr Woods went on to observe that Scottish Government had not as at June 2008 received any advice that further action was required. HPS had not, so far as he was aware, circulated information on the 027 strain beyond the specialist community.¹¹⁰

18.7 The Northern Health and Social Care Trust, Northern Ireland

The Northern Health and Social Care Trust

The Northern Health and Social Care Trust was established in 2007 as one of five such trusts providing health and social care

¹⁰⁴ [HPS00250001](#)

¹⁰⁵ [INQ05580001](#)

¹⁰⁶ [TRA00980068](#)

¹⁰⁷ [TRA00970114](#)

¹⁰⁸ [TRA00970114-115](#)

¹⁰⁹ [TRA00980067-68](#)

¹¹⁰ [TRA00980068](#)

services to the public in Northern Ireland. It covered the largest geographical area of the five, and included County Antrim and parts of Counties Tyrone and Londonderry. It provided hospital and community services to a population of about 440,000 living in these areas, and contained nine hospitals and 13 homes for older people.¹¹¹

The Regulation and Quality Improvement Authority for Northern Ireland (RQIA), published a review in August 2008 of the circumstances contributing to the incidence of CDI in the Northern Health and Social Care Trust in 2007 and early 2008.¹¹² After the publication of the RQIA report a Public Inquiry into the outbreak of *C. difficile* in the Trust hospitals was established in March 2009 (the Northern Ireland Public Inquiry), and its report was published on 21 March 2011.¹¹³

Remit of the Regulation and Quality Improvement Authority for Northern Ireland and findings

The RQIA had a broad remit that included reviewing the circumstances contributing to the rates of CDI in the Northern Trust in 2007 and 2008.

The RQIA made the following findings:

- Lack of awareness of the possible impact of the introduction of a virulent strain of CDI¹¹⁴
- Structural reorganisation putting monitoring of infection prevention at risk¹¹⁵
- Transfer of patients facilitating spread of infection¹¹⁶
- Shortage of isolation beds¹¹⁷
- Inappropriate use of antibiotics¹¹⁸
- Lack of systems to monitor implementation of antibiotic policies¹¹⁹
- Absence of systems to monitor the distribution of information to patients and staff¹²⁰

- Delay in recognition that there was an outbreak¹²¹

The Northern Ireland Public Inquiry remit and findings

The Northern Ireland Public Inquiry's remit was a narrow one and it was not required to repeat the work of the RQIA. Its purpose was:

1. To establish how many deaths occurred in Northern Health and Social Care Trust hospitals during the outbreak, for which *C. difficile* was the underlying cause of death, or was a condition contributing to death.
2. To examine and report on the experiences of patients and others who were affected directly by the outbreak, and to make recommendations accordingly.¹²²

The report of the Northern Ireland Public Inquiry includes a considerable body of evidence from patients and families of:

- Failure of effective communication with patients and relatives about the diagnosis and nature of the disease.
- Inadequate communication over personal protective equipment.
- Lack of communication over laundry.
- Lack of communication with relatives over death certification.
- Poor quality of nursing notes.
- General lack of care plans and needs assessments.

This evidence, although not expressed in terms of specific findings, was clearly largely accepted by the Inquiry in view of its recommendations.¹²³

The Northern Trust reports

Clearly, due to the timing of the publication of their reports, the Northern Ireland Inquiries fall into a different category from the Stoke Mandeville and Maidstone and Tunbridge Wells Inquiries. The period under investigation, 16 June 2007 to 31 August 2008, to a large extent overlaps with the

111 [INQ04460021](#)
 112 [INQ05280001](#)
 113 [INQ04460001](#)
 114 [INQ05280111](#)
 115 [INQ05280067-68](#)
 116 [INQ05280112](#)
 117 [INQ05280117](#)
 118 [INQ05280120](#)
 119 [INQ05280120](#)
 120 [INQ05280128-129](#)

121 [INQ05280130](#)
 122 [INQ04460005](#)
 123 [INQ04460050-76](#)

period examined in this Inquiry. Furthermore, publication of the RQIA report took place after the period under examination by this Inquiry, and publication of the report of the Northern Ireland Public Inquiry took place when this Inquiry was in progress.

From the findings in the RQIA report in particular, as well as the report of the Northern Ireland Public Inquiry, it is apparent that the lessons available from Stoke Mandeville and from Maidstone and Tunbridge Wells had not been learned in the Northern Trust.

18.8 Ninewells Hospital, Dundee

The outbreak

Between 31 July and 6 November 2009 seven patients who had been in ward 31 of Ninewells Hospital, Dundee were found to be infected with the 027 strain of *C. difficile*. This infection caused the death of two patients, and contributed to the death of three further patients between 21 October and 6 November 2009.

At an early stage in its investigations this Inquiry intimated that it would explore what happened in the Ninewells outbreak. The Inquiry could not examine or comment upon individual cases of CDI. It was limited to considering the documentary evidence supplied by Tayside Health Board, in particular the report of the Outbreak Control Team and a number of contemporaneous records and minutes.

Outbreak report

The report of the Ninewells Outbreak Control Team¹²⁴ provides background information on the ward in question. Ward 31 was a 22-bedded medicine for the elderly ward, comprising three six-bedded bays and four side rooms. Patients were usually admitted from acute medical admissions for assessment and discharge either home or to other health or social care settings.¹²⁵ The report notes a general downward trend in CDI over the previous two years in Tayside.¹²⁶

The Outbreak Control Team report also provides a description of the outbreak itself. At the beginning of August a patient in ward 31, who was already known to be *C. difficile* toxin positive, experienced a relapse of symptoms of CDI. The patient was moved to a single room on 6 August and remained there. The strain of *C. difficile* was identified in September as 027.

No further case of CDI was detected in patients in the ward until 16 October. But on 14 October the Infection Control Nurse reported to the Infection Control Doctor that there had been three CDI patients, including the one previously identified in ward 31, in the preceding 30 days. Neither of the other two patients was by then still in ward 31, but testing indicated one of them had the 027 strain.

No other patient with diarrhoea was identified on the ward at that stage. The decision was taken to alert ward and clinical staff to the further 027 cases and to review the situation should another patient develop CDI. From 14 October infection control presence on the ward was increased and four additional infection control education sessions were delivered. Daily observations of infection control practice were carried out and records were kept.

Over the weekend of 17 and 18 October two further patients tested positive for *C. difficile*, and both cases were subsequently identified as 027 strain. They were managed according to the protocol in force and no further admissions were taken on the ward over the weekend. An outbreak was declared on 19 October and the ward was closed to further admissions from that afternoon.¹²⁷

An Outbreak Control Team was formed and met on the afternoon of 20 October, and it was agreed that the ward should remain closed. Full terminal cleaning of the ward took place on 24 and 25 October. A visit by HPS on 29 October did not highlight any omissions, and verbal feedback was provided to the Outbreak Control Team.¹²⁸ Arrangements were

124 [TAY00010001](#)

125 [TAY00010005](#)

126 [TAY00010003](#)

127 [TAY00010009](#)

128 [TAY00010012](#)

made to bring an additional side room back into use and to reduce the number of beds in each bay from six to four. Following the HPS visit, two mattresses failed an integrity test. Although there were no visible signs of damage, the *C. difficile* 027 strain was isolated from one of these mattresses.¹²⁹

The Outbreak Control Team report did not identify a single cause for the outbreak, but it listed potential contributory factors, including environmental issues, use of Proton Pump Inhibitors, and the characteristics of the 027 strain.¹³⁰

A number of actions for future practice emerged from the Outbreak Control Team report. Actions identified included the need to continue to press for compliance with restricted antibiotics, optimal compliance with hand hygiene and the importance of communication with staff, patients and the media.¹³¹

Following completion of the Outbreak Control Team report,¹³² a “lessons learnt” report was presented to the Executive Management Team of Tayside Health Board at its meeting on 22 February 2010.¹³³ The Outbreak Control Team report had been publicly released on 18 February.¹³⁴

The Ninewells Hospital outbreak – the different environment

The Ninewells outbreak occurred in an environment significantly altered by developments since, and in light of, the emergence of the VOLH outbreaks. This rules out direct comparisons between the outbreaks. Nevertheless, the documents examined by the Inquiry, in particular the Outbreak Control Team report, appear to present the following information:

- The outbreak trigger level was identified as soon as it was reached, and steps were therefore taken at an early stage to prevent further spread of infection, including requests for expert assistance from HPS

- The Outbreak Control Team was formed as soon as the outbreak was identified and met regularly, with almost daily updates circulated¹³⁵
- There was detailed monitoring of infection rates¹³⁶
- A close working relationship was in place between the Infection Control Nurse, the Infection Control Doctor and ward staff¹³⁷

18.9 Comparison between the VOLH, Stoke Mandeville, and Maidstone and Tunbridge Wells

The importance of learning lessons

In the foreword to the Stoke Mandeville report the Chairman made the following observations:

“I said in the immediate aftermath of the Bristol report (into children’s cardiac surgical services at Bristol Royal Infirmary) that it was not possible to say with confidence that events such as those which took place at Bristol would not happen again. What happened at Stoke Mandeville demonstrates that they are still happening. Patients died when their deaths could have been avoided. It is a matter of the greatest regret that the lessons of Bristol have not been learned and incorporated into every corner of the NHS”.¹³⁸

The same can be said in this Inquiry Report about the lessons of Stoke Mandeville, and later those of Maidstone and Tunbridge Wells.

List of VOLH issues

The Inquiry has identified at least 20 issues that have come under scrutiny in its own

129 [TAY00010015](#)

130 [TAY00010015](#)

131 [TAY00010017](#)

132 [TAY00010001](#)

133 [TAY00650004](#)

134 [TAY00650002](#)

135 [TAY00040001](#); [TAY00050001](#); [TAY00060001](#); [TAY00070001](#); [TAY00080001](#); [TAY00090001](#); [TAY00100001](#); [TAY00110001](#); [TAY00120001](#); [TAY00130001](#); [TAY00140001](#); [TAY00150001](#); [TAY00160001](#); [TAY00170001](#); [TAY00180001](#); [TAY00190001](#); [TAY00200001](#); [TAY00210001](#); [TAY00220001](#); [TAY00230001](#); [TAY00240001](#); [TAY00250001](#); [TAY00260001](#); [TAY00270001](#); [TAY00280001](#); [TAY00290001](#); [TAY00300001](#); [TAY00310001](#)

136 [TAY00010009](#); [TAY00010034](#)

137 [TAY00010007](#); [TAY00010009](#)

138 [INQ02890004](#)

investigations and are covered in this Report. On all of these there were lessons to be learned from the Stoke Mandeville and Tunbridge Wells reports.

- 1 State of repair of buildings and fabric
- 2 Hand washing facilities
- 3 Isolation of symptomatic patients
- 4 Communication with relatives
- 5 Laundry management
- 6 Provision of single rooms
- 7 Storage
- 8 Local surveillance
- 9 Fluid balance monitoring
- 10 Care planning
- 11 Stool charts
- 12 Training
- 13 Prescription of antibiotics
- 14 Recording of treatment and decisions
- 15 The impact of organisational change on patient safety
- 16 Clinical governance in infection control
- 17 Working relationships within the Infection Control Team
- 18 Management of a hitherto unknown and hypervirulent strain of infection
- 19 Staffing
- 20 Death certification

To a large extent these issues are reviewed in detail elsewhere in this Report, and to do so again here would be unnecessarily repetitive. Reference is made only to three selected examples.

Isolation of patients

Despite the “major lesson” of Stoke Mandeville – “that the immediate isolation of symptomatic patients was crucial to the control of outbreaks of *C. difficile*”¹³⁹ – there is clear evidence that this was not being applied in the VOLH. The Infection Control Manual,

issued in October 2004 and still in force in 2008, provided that for *C. difficile* patients “a risk assessment should be carried out by the ICT (Infection Control Team) to determine if the patient requires isolation nursing”.¹⁴⁰ Yet the practice at the VOLH was not to isolate patients until confirmation that they tested positive for *C. difficile* toxin. As discussed elsewhere in this Report, in a number of instances isolation did not take place even at that stage.

Prescription of antibiotics

The subject of antibiotic prescription is discussed in Chapter 13. It is clear that the general issue of inappropriate prescribing had long been recognised, although action to tackle it had been slow to materialise.

Dr Andrew Seaton, Consultant Physician in Infectious Diseases, NHSGGC, described the VOLH problem as a watershed moment and the point at which a much more strict approach towards antibiotic prescribing was adopted.¹⁴¹ That is no doubt correct. But clear evidence that broad spectrum antibiotics increased the risk of CDI had been in the public domain for a number of years. The Stoke Mandeville report states explicitly that “The restriction of the antibiotics to be prescribed is one of the established means of reducing the risk to patients of contracting *C. difficile*”, and a reduction in prescription of broad spectrum antibiotics had been put in place at Stoke Mandeville as early as 2003.¹⁴² The Maidstone and Tunbridge Wells report contains a recommendation that antibiotics “should be targeted, of the narrowest spectrum possible, and used for the shortest time possible”.¹⁴³ No one who had read those reports could be in doubt about the issue. It was only a “watershed moment” because action had not been taken sooner. Had the message been acted upon at the VOLH earlier, as it could have been, it is likely that the number of people contracting the infection would have been reduced.

¹⁴⁰ [GGC00780254](#)

¹⁴¹ [TRA01150116-117](#)

¹⁴² [INQ02890026](#)

¹⁴³ [INQ02870117](#)

¹³⁹ [INQ02890030](#)

Maintenance and repair

A feature of the outbreaks at both Stoke Mandeville and Maidstone and Tunbridge Wells was the poor state of repair of the buildings, with the increased risk of infection that that entailed. The lack of maintenance at the VOLH, and the consequences of this are considered in Chapter 15 and the consequences of indecision over the hospital's future are raised in Chapter 8. This issue was identified in the local assessment at VOLH¹⁴⁴ but was not the primary focus of that assessment, no doubt because it was the one those involved had least power to alter. Had greater attention been paid at more senior level to the experience set out in those reports, it is likely that the increased risk to patient safety would have been better recognised and more effective steps taken to reduce this.

Relevant findings and recommendations

The Inquiry considers that the findings in the Stoke Mandeville and Maidstone and Tunbridge Wells reports contained important lessons on how the management of CDI could go wrong and how it should be managed. The recommendations in both reports provided valuable guidance which was available in the one case from July 2006, and in the other from October 2007, to be adapted and used elsewhere.

18.10 Conclusion

There was a failure at national and NHSGGC level to utilise the Stoke Mandeville and Maidstone and Tunbridge Wells reports as a basis for timely guidance and for audit and review. This meant that the application of lessons learned from Stoke Mandeville in particular, but also from Maidstone and Tunbridge Wells, was patchy, and was long delayed. Opportunities were lost at national and at Board level to improve the prevention and control of healthcare associated infection by drawing upon particular findings in those reports.

As discussed in Chapter 7 there was a two-year programme of work involved in the production of the Scottish *C. difficile* guidance linked to European guidance that was due to be published in 2008. The HPS approach was entirely appropriate. The production of the checklist based upon lessons to be learned from Stoke Mandeville in particular and subsequently Maidstone and Tunbridge Wells is a different matter. There was undue delay on the part of HPS in producing the kind of advice set out in the checklist. Earlier publication would have served to alert Health Boards to the dangers of the 027 strain and reinforced the importance of effective infection prevention and control measures and prudent prescribing. There was an opportunity missed.

Had NHSGGC considered the findings and recommendations of the Stoke Mandeville report in a more thorough and systematic way, and reviewed practices and implementation of policies in the light of these, many of the factors contributing to the VOLH CDI problem would have been eliminated or at least reduced by 2007. This would have been the case whether NHSGGC had acted on its own initiative or in response to guidance from HPS, NHS QIS or another central body. To a lesser degree the same is true of the Maidstone and Tunbridge Wells report.

The Inquiry draws additional support for its findings and recommendations in the report of the Northern Ireland Public Inquiry. This includes a recommendation that:

“organisational change should be recognised by the (Department of Health, Social Services and Public Safety) DHSSPS as carrying high risk for patient safety and quality of care, including the potential for a sub-optimal response to an outbreak of a healthcare associated infection. At such times of change, this risk should be addressed specifically and reported in the risk register of all trusts”.¹⁴⁵

144 [GGC20710003](#)

145 [INQ04460099](#)

The importance of this issue is given recognition in the Inquiry's own recommendation of due diligence and review in any major structural reorganisation.

Leaving that specific point aside, the Northern Ireland experience does exemplify what can happen if attention is not paid to lessons learned elsewhere. For the future it is therefore important that an effective system should be put in place to enable lessons learned elsewhere to be applied in Scotland in a timely manner.

18.11 Recommendations

Recommendation 74: Scottish Government (whether through HPS, HIS, the HAI Task Force or otherwise) should as a matter of standard practice ensure that reports published in the United Kingdom and in other relevant jurisdictions on infection prevention and control and patient safety are reviewed as soon as possible, and that, as a minimum, any necessary interim guidance is issued within three months.

Recommendation 75: Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons.

Chapter 19

Conclusion and Recommendations

Conclusion

This was a lengthy and complicated Inquiry. It was necessary to examine a wide range of topics in order to comply with the terms of the remit. I was determined to carry out as comprehensive an investigation as possible so that a full account could be provided of why the CDI problem at the VOLH was so persistent and devastating. Patients and families had to relive painful experiences in providing statements and giving oral evidence and then had to wait for some considerable time for the publication of the Report. I consider that wait to be highly regrettable but I do firmly believe that the timescales identified throughout the Inquiry process were unrealistic. The extent of the work required to undertake a thorough examination of the many relevant issues cannot be overemphasised. In the event the Inquiry has unearthed serious personal and systemic failures. Patients who suffered from CDI at the VOLH were badly let down by people at different levels of NHS GGC who were supposed to care for them. The Scottish Ministers bear ultimate responsibility for NHS Scotland and even at the level of the Scottish Government the systems were simply not adequate to tackle effectively an HAI like CDI. The major single lesson to be learned is that what happened at the VOLH to cause such personal suffering should never be allowed to happen again.

The Report and the recommendations are informed by all the relevant documentation gathered by the Inquiry, the evidence contained in written statements, and the evidence at the oral hearings, including the evidence of the experts who were commissioned to assist the Inquiry. The lessons to be learned are contained within the narrative of the Report and reflected in the recommendations.

Some of the recommendations are directed to aspects of basic nursing care, for example fluid monitoring, care planning, and the

prevention and management of pressure damage. I note from the important inspection work being carried out by Healthcare Improvement Scotland that these aspects of care still feature as sources of criticism, and I make no apology for including recommendations on these issues to reinforce how critical they are to good quality care. Such basic care is integral to compassionate care. The recommendations are not directed against individuals although they will have an impact on individual behaviour. Nevertheless, it is important for individuals such as nurses and doctors to realise that they have a professional responsibility to comply with what is laid down as proper practice by their professional bodies.

There may be some recommendations that have been overtaken by events. For example, as set out in Chapter 15, NHS GGC did introduce more effective reporting systems for CDI after June 2008, but again the message should be reinforced that systems must ensure that important information is relayed from ward to Board

I am convinced that the adoption of the recommendations proposed will result in a significantly improved focus on patient care, and in particular on the care of patients who contract a hospital infection such as CDI. CDI has been the focus of the Inquiry, but I am in no doubt that, although it was the failures in how CDI was managed at the VOLH that governed the work of the Inquiry, the recommendations should have a more far-reaching impact. Indeed the express intention of the Cabinet Secretary when announcing the setting up of the Inquiry was that lessons should be learned across Scotland. The recommendations are designed to encapsulate a concept of patient care that includes skilled and considerate medical and nursing care, transparency, candour, effective systems of infection prevention and control, and strong and dedicated leadership.

Recommendations

Chapter 6 National structures and systems

Recommendation 1: Scottish Government should ensure that the Healthcare Environment Inspectorate (HEI) has the power to close a ward to new admissions if the HEI concludes that there is a real risk to the safety of patients. In the event of such closure, an urgent action plan should be devised with the Infection Prevention and Control Team and management.

Chapter 7 National policies and guidance

Recommendation 2: Scottish Government should ensure that policies and guidance on healthcare associated infection are accompanied by an implementation strategy and that implementation is monitored.

Recommendation 3: Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart.

Recommendation 4: Scottish Government should develop local Healthcare Associated Infection (HAI) Task Forces within each Health Board area.

Chapter 8 Changes in services at the Vale of Leven Hospital from 2002

Recommendation 5: Scottish Government should ensure that where any uncertainty over the future of any hospital or service exists, resolution of the uncertainty is not delayed any longer than is essential for planning and consultation to take place.

Recommendation 6: Scottish Government should ensure that where major changes in patient services are planned there should be clear and effective plans in place for continuity of safe patient care during the period of planning and change.

Chapter 9 The creation, leadership and management of the Clyde Directorate

Recommendation 7: In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment

should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.

Recommendation 8: In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.

Chapter 10 Clinical governance

Recommendation 9: Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level.

Chapter 11 The experiences of patients and relatives

Recommendation 10: Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where appropriate, relatives should also be involved.

Recommendation 11: Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.

Recommendation 12: Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and

clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.

Chapter 12 Nursing care

Recommendation 13: Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board.

Recommendation 14: Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records. Health Boards should ensure that there is an effective system of audit of patient records, and that there is effective scrutiny of audits by the Board.

Recommendation 15: Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure.

Recommendation 16: Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team.

Recommendation 17: Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient's status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously.

Recommendation 18: Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.

Recommendation 19: Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in the patient notes and are included in care planning for the patient.

Recommendation 20: Health Boards should ensure that where a patient has, or is suspected of having, *C. difficile* diarrhoea a proper record of the patient's stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance.

Recommendation 21: Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods.

Recommendation 22: Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.

Recommendation 23: Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN.

Recommendation 24: Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient.

Recommendation 25: Health Boards should ensure that every patient is assessed for risk of pressure damage on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit.

Recommendation 26: Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient's condition. Compliance should be monitored by a system of audit.

Recommendation 27: Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit.

Recommendation 28: Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support.

Recommendation 29: Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays.

Recommendation 30: Health Boards should ensure that where patients require fluid monitoring as part of their clinical care,

nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period.

Recommendation 31: Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes, (due to acuity and/or dependency) an agreed review framework and process should be in place to ensure that the appropriate skills base and resource requirements are easily provided.

Recommendation 32: Health Boards should ensure that there is a straightforward and timely escalation process for nurses to report concerns about the staffing numbers/skill mix.

Recommendation 33: Health Boards should ensure that where a complaint is made about nursing practice on a ward this complaint is investigated by an independent senior member of Nursing Management.

Chapter 13 Antibiotic prescribing

Recommendation 34: Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay.

Recommendation 35: Scottish Government should monitor the implementation of policies and/or guidance on antibiotic prescribing issued in connection with healthcare associated infection and seek assurance within specified time limits that implementation has taken place.

Chapter 14 Medical care

Recommendation 36: Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high quality care.

Recommendation 37: Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy

for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis.

Recommendation 38: Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff.

Recommendation 39: Health Boards should ensure that medical and nursing staff are aware that a DNAR decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy.

Recommendation 40: Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management.

Recommendation 41: Health Boards should ensure that there is no unnecessary delay in processing laboratory specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed.

Chapter 15 Infection prevention and control

Recommendation 42: Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention and control training that includes CDI on appointment and regularly thereafter. Staff records should be audited to ensure that such training has taken place.

Recommendation 43: Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control, of which a record should be kept.

Recommendation 44: Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles.

Recommendation 45: Health Boards should ensure that where a manager has responsibility for oversight of infection prevention and control, this is specified in the job description.

Recommendation 46: Health Boards should ensure that the Infection Control Manager has direct responsibility for the infection prevention and control service and its staff.

Recommendation 47: Health Boards should ensure that the Infection Control Manager reports direct to the Chief Executive, or at least to an executive board member.

Recommendation 48: Health Boards should ensure that the Infection Control Manager is responsible for reporting to the Board on the state of healthcare associated infection in the organisation.

Recommendation 49: Scottish Government should re-issue national guidance on the role of the Infection Control Manager, stipulating that the Infection Control Manager must be responsible for the management of the infection prevention and control service.

Recommendation 50: Health Boards should ensure that there is 24-hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place.

Recommendation 51: Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings.

Recommendation 52: Health Boards should ensure that adherence to infection prevention and control policies, for example the *C. difficile* and Loose Stool Policies, is audited at least annually, and that serious non-adherence is reported to the Board.

Recommendation 53: Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time.

Recommendation 54: Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available.

Recommendation 55: Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the level of the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level.

Recommendation 56: Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.

Recommendation 57: Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports, and training reports.

Recommendation 58: Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement.

Recommendation 59: Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable.

Recommendation 60: Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice, such as the Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes.

Recommendation 61: Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine infection prevention and control arrangements, including policy implementation and cleanliness.

Recommendation 62: Health Boards should ensure that senior managers accompanied by infection prevention and control staff visit clinical areas at least weekly to verify that proper attention is being paid to infection prevention and control.

Recommendation 63: Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI, and that failure to isolate is reported to senior management.

Recommendation 64: Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing, with infected patients nursed in cohort bays with en-suite facilities.

Recommendation 65: Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea.

Recommendation 66: Health Boards should ensure that the healthcare environment does not compromise effective infection prevention and control, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective infection prevention and control practice, are not tolerated.

Recommendation 67: Health Boards should ensure that, where a local Link Nurse system is in place as part of the infection prevention and control system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.

Chapter 16 Death certification

Recommendation 68: Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patient's care is involved in the completion of the death certificate wherever practicable, and that such involvement is clearly recorded in the patient records. Regular auditing of this process should take place.

Recommendation 69: Health Boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient's death.

Recommendation 70: Crown Office and the Procurator Fiscal Service (COPFS) should review its guidance on the reporting of deaths regularly and at least every two years.

Recommendation 71: Scottish Government should identify a national agency to undertake routine national monitoring of deaths related to CDI.

Chapter 17 Investigations from May 2008

Recommendation 72: Health Boards should ensure that a non-executive Board member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHS GGC.

Recommendation 73: Health Boards should ensure that OCT reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report.

Chapter 18 Experiences of *C. difficile* infection within and beyond Scotland

Recommendation 74: Scottish Government (whether through HPS, HIS, the HAI Task Force or otherwise) should as a matter of standard practice ensure that reports published in the United Kingdom and in other relevant jurisdictions on infection prevention and control and patient safety are reviewed as soon as possible, and that, as a minimum, any necessary interim guidance is issued within three months.

Recommendation 75: Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons.

Appendices

Appendix 1

Patients for whom individual expert reports were commissioned

Anne Agnew	Irene Harnett	Julia Monhan
Jean Beattie	Catherine Hitchinson	Patient A
John Boyle	William Hunter	Patient B
Alister Brand	Annie Johnson	Patient C
Mary Broadley	Alister Johnston	Patient D
Agnes Burgess	Jessie Jones	Jacqueline Patrick
Mary Burns	Margaret Kelly	Ellen Pirog
Rose Burns	Isabella Lettis	Elizabeth Rainey
Isobel Cameron	Allan Lynch	Rosa Rainey
Agnes Campbell	Agnes MacFarlane	Evelyn Scott-Adamson
Dureena Chandayly	Matthew Macfarlane	Walter Scullion
Coleman Conroy	Alexander McDonald	Annie Shaw
Charles Cook	Mary McDougall	Doris Smith
Margaret Dalton	Sarah McGinty	David Somerville
Edward Docherty	Thomas McGowan	Margaret Stevenson
Jeanie Dow	Martha McGregor	Catherine Stewart
George Drummond	Archibald McInally	Margaret Thompson
Janet Fitzsimmons	William McKenzie	James Thomson
Margaret Gaughan	Moir McWilliams	Elizabeth Valentine
Ellen Gildea	Mary Millen	Muriel Waddell
Anne Gray	Christina Miller	Catherine Wrethman
Mary Hamilton	John Miller	

Appendix 2

The Inquiry Team

Chairman of the Vale of Leven Hospital Inquiry – the Right Honourable Lord MacLean

Lord MacLean was admitted to the Faculty of Advocates in 1964 and became a Queen's Counsel (QC) in 1977. He was appointed a Senator of the College of Justice in 1990. In April 2001 he was appointed to the Inner House of the Court of Session and was also sworn as a member of Her Majesty's Privy Council. He retired as a judge in 2005.

His previous appointments and appearances relevant to the Chairmanship of this Inquiry include:

Membership of the Stewart Committee on Alternatives to Prosecution for Minor Offences (1977 – 1983);

Senior Counsel in the Piper Alpha Inquiry (1989 – 1990) where he represented those who survived the Disaster and the relatives of those who died in it;

Membership of the Parole Board for Scotland (1998 – 2000, 2003);

Chairman of the Committee on Serious Violent and Sexual Offenders (1999 – 2000);

One of the Judges who presided at the Lockerbie Trial at Camp Zeist (2000 – 2001);

Membership of the Judicial Appointments Board for Scotland (2002 – 2005);

Chairman of the Sentencing Commission for Scotland (2003 – 2005);

Chairman of the Billy Wright Inquiry in Northern Ireland (2004 – 2010).

Assessor to the Inquiry – Mrs Mary Waddell OBE

Mrs Mary Waddell is a Registered General Nurse and clinical teacher. Following completion of her general nurse training, Mrs Waddell held staff nurse posts in theatres and neurological nursing prior to completing midwifery training and two years in central Africa.

On return, a career in intensive care nursing followed with ten years being Sister in Charge of an intensive care unit in the Mater Hospital, Belfast. Mrs Waddell held a Nursing Officer post and then became Director of Nursing at the Mater.

In 1990, Mrs Waddell was appointed Director of Nursing at the Eastern Health and Social Services Board, a post she held until retirement. Mrs Waddell has wide clinical experience in key branches of nursing and commissioning at Trust, Board and Regional level. She has led a number of projects that significantly impacted on patient care at local and national level (wound management, continence, workforce planning, emergency planning and complaints).

Mrs Waddell was Nurse Advisor to the Regional Medical Services Committee, a group that had responsibility for commissioning all regional specialist services. She has provided advice, guidance and reports at Board level to allow them to meet their statutory responsibilities. Mrs Waddell had a key responsibility for standard setting and ensuring quality standards were met by Trusts. She chaired regional professional and educational groups.

Mary Waddell was awarded an OBE for services to Nursing in the 2002 New Year's Honours list.

Assessor to the Inquiry – Dr Geoff Ridgway OBE

Dr Geoff Ridgway was until recently a consultant to the Health Protection Branch and the Estates and Facilities Branch at the Department of Health, London. He was appointed OBE for services to Microbiology in the New Year's Honours list December 2008.

Dr Ridgway qualified BSc Special Zoology in 1966 and went on to study Medicine at the Royal Free Hospital School of Medicine, qualifying MB BS in 1971. He specialised in Medical Microbiology, obtaining MD by thesis in 1977, at which time he was appointed Consultant in Clinical Microbiology at

University College London Hospitals; a post held until retirement in March 2004. He is a Fellow of both the Royal College of Pathologists and the Royal College of Physicians. He holds an Honorary Diploma in Hospital Infection Control, and was an Honorary Senior Lecturer at University College and at the School of Hygiene and Tropical Medicine, University of London.

His career encompassed the diagnosis and management of infectious diseases, with a special interest in genito-urinary bacterial infections. Other research interests included Hospital Infection Control and sterilization and disinfection technology.

Senior Counsel	Colin MacAulay
Junior Counsel	Lauren Sutherland
Solicitor	Nigel Orr
Deputy Solicitor	Andrea Summers Felicity Cullen – until May 2011
Secretary	Julie-Anne Jamieson
Deputy Secretary	Mark Dorrian
Document Manager	Alan Owenson
Witness Liaison Manager/ Analysis & Evidence Manager	Lynne Allan
Legal Assistant	Leeon Fleming
Office Manager	Ann Pullar Nicola Scammell – until July 2012 Lorna Innes – until March 2011
Witness Statement Team Leader	Peter Ritchie
Witness Statement Taker	Andrew Gibson
Specialist Support Officer	Nicola Keys
Specialist Support Officer	Emma Filshie
Administrative Support Officer	Agata Myszka

Appendix 3

Core Participants and their legal representation

Core Participant	Recognised legal representative	Senior Counsel and Junior Counsel
Greater Glasgow Health Board (also known as NHS Greater Glasgow and Clyde)	Robbie Wightman, Solicitor, NHS Central Legal Office	Alastair Kinroy QC Brian Gill, Advocate
Health Facilities Scotland	Stefano Rinaldi, Solicitor, NHS Central Legal Office	Simon Bowie QC Alasdair Burnet, Advocate
Health Protection Scotland	Stefano Rinaldi, Solicitor, NHS Central Legal Office	Simon Bowie QC Alasdair Burnet, Advocate
Medical and Dental Defence Union of Scotland	Laura Donald, Solicitor Advocate, BTO, Edinburgh	Dame Elish Angiolini QC
Royal College of Nursing	Chris Dickson, Solicitor Advocate, Anderson Strathern, Edinburgh	N/A
Scottish Ministers	Murray Sinclair, Solicitor to the Scottish Government, Scottish Government Legal Directorate	Alan Dewar QC Kay Springham, Advocate
Tayside Health Board (until December 2010)	Lorna McPhail, Solicitor, NHS Central Legal Office	Alastair Kinroy QC Catherine Devaney, Advocate
Patients and Relatives Jean Beattie Gareth Bourhill Brenda Bowes Sheila Chandler Anne Chisholm Marion Copland Brian Gaughan George Hamilton Margaret Harnett Joanne Harvey David Logan Allan Lynch Agnes MacFarlane Alexander McDonald Anne McDonald Anne McGarrity Michelle McGinty Enid McMurdo Carol Moore Maria Shaw Anna Squires Linsey MacFarlane (replacing Agnes MacFarlane) Marjory Cambridge (replacing Brian Gaughan)	Patrick McGuire, Solicitor Advocate, Thompsons, Glasgow	Jim Peoples QC Gordon Lamont, Advocate

Appendix 4

Expert witnesses instructed by the Inquiry

Ms Elizabeth Colgan

Elizabeth Colgan, RGN, RMN, ANDIP is Head of Programme of the Infection Prevention/ Hygiene Team in the Regulation and Quality Improvement Authority, Northern Ireland. She was commissioned by the Inquiry to provide written reports on the nursing care of seven focus patients who had contracted *C. difficile*, and to provide a separate overview report of her findings. Ms Colgan has extensive nursing experience and is involved in the inspection of hospitals and community facilities in relation to infection control and environmental cleanliness. She is also involved in the development and review of policies and procedures in relation to infection control and environmental cleanliness. She has recently led a series of inspections which focus on the care provided for the older person in the acute hospital setting, and has been given the responsibility for leading the development of a new programme of hospital inspection across Northern Ireland.

Ms Elaine Connolly

Elaine Connolly RGN, BSc is a Senior Inspector for the Independent Health Care Team in the Regulation and Quality Improvement Authority, Northern Ireland. She was commissioned by the Inquiry to provide written reports on the nursing care of five focus patients who had contracted *C. difficile*, and to provide a separate overview report of her findings. Ms Connolly is a qualified nurse, has been a registered manager of Nursing Homes and has had extensive experience in the senior management of the inspection of independent healthcare settings.

Dr Martin Connor

Dr Martin Connor MSc, MBChB, FRCPath, FFFPH, DTM&H is a Consultant Microbiologist at Dumfries and Galloway Royal Infirmary. He was commissioned by the Inquiry to provide written microbiology reports on 18 focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. A Consultant Microbiologist since 1998, Dr Connor has extensive audit and management experience as well as experience of teaching medical students, junior doctors and nurses. Dr Connor to date has carried out a variety of research projects and produced a large number of publications.

Professor Brian Duerden

Professor Brian Duerden CBE, BSc (Hons, Med. Sci.), MD, FRCPath, FRCPEdin, was Inspector of Microbiology and Infection Control at the Department of Health until December 2010. He was responsible for clinical and public health microbiology services and was the clinical director for the HCAI programme. He is emeritus Professor of Medical Microbiology at Cardiff University and a Visiting Professor at Imperial College, London. Professor Duerden has provided the Vale of Leven Hospital Inquiry with expert microbiology advice with regard to the number of cases of *C. difficile* that occurred at the VOLH during 2007 and 2008. He has written a report reviewing the infection control arrangements at the VOLH during this period, and provided commentary on reports into the outbreak of *C. difficile* at the VOLH between December 2007 and June 2008 and a review of transcripts. Before moving to the Department of Health in 2004, Professor Duerden was Medical Director and Director of Service in the Public Health Laboratory Service and Director for Clinical Quality in the Health Protection Agency. His major interests are in anaerobic microbiology, healthcare associated infection and antibiotic resistance. He has published over 150 scientific papers, edited and contributed to several textbooks and served for 20 years as Editor in Chief of the Journal of Medical Microbiology. He was awarded CBE for services to medicine and charity in 2008.

Mr William Evans

William Evans RGN, PG Diploma, BSc is a Clinical Nurse Specialist in Infection Prevention and Control and Geographical Lead for the West Team based at St John's Hospital, Livingston. He was commissioned by the Inquiry to provide written reports on the nursing care of nine focus patients and one other patient who had contracted *C. difficile*, and to provide a separate overview report of his findings. Mr Evans is an experienced Registered Nurse with specialist experience in infection prevention and control. He also has previous operational management experience covering all aspects of care within elderly wards and day hospitals, with specific responsibility for the development of standards and audits.

Professor George Griffin

Professor George Griffin BSc, PhD, FRCP, FRCP(E), FRCPath, F.Med Sci, practises as a consultant physician in infectious diseases and general internal medicine at St George's, University of London. Working within the clinical infection unit he receives local, national and international referrals. He is also Professor of Infectious Diseases and Medicine and heads up the Academic Centre for Infection at St George's. Professor Griffin was commissioned by the Inquiry to carry out an analysis of the medical records of focus patients, as well as of a number of statistical patients, and to consider the role of *C. difficile* as a cause of death or a contributory factor to death. He provided a report on each of the 44 individual cases examined by him, and in addition produced an overview report of his findings in relation to death certification. Professor Griffin is the Chair of the Advisory Committee on Dangerous Pathogens (ACDP) and the special advisor to the government emergency committee called SAGE. He also chairs the committee for the Health and Safety Executive. Professor Griffin has extensive medical administration and teaching experience and has produced over 240 publications, given over 60 national and international guest lectures and held over 40 research grants.

Dr Mary Harrington

Dr Mary Harrington BA (Hons), MB, BS, MA (Oxon), MRCP, FRCP is a Consultant Geriatrician who has held consultant posts in London, Yorkshire and Manchester. She was commissioned by the Inquiry to provide written reports on the medical care of nine focus patients and one other patient who had contracted *C. difficile*, and to provide a separate overview report of her findings. Dr Harrington has extensive experience of acute and rehabilitation services for elderly patients, including orthogeriatrics, and as a community geriatrician. She served for over ten years on her hospital Mortality Review Committee, which scrutinises the care of all patients who die in the hospital. She was an expert panel member for Operation Jasmine, a police inquiry into care in nursing homes in South Wales, and is regularly instructed as an expert witness by coroners in England and Wales.

Ms Annette Jeanes

Ms Annette Jeanes RGN, SCM, ENB 100, 934, 998, Diploma in Nursing, Diploma in Infection Control, MSc is the Director of Infection Prevention and Control, University College London Hospitals Foundation Trust. She was commissioned by the Inquiry to provide written reports on the nursing care of ten focus patients who had contracted *C. difficile*, and to provide a separate overview report of her findings. Ms Jeanes has extensive experience as an expert witness and undertakes consultancy work. As well as being heavily involved in current infection control research, she has produced numerous publications and is a regular guest speaker at conferences and events with subjects ranging from cleaning to change management.

Dr Mike Jones

Dr Mike Jones BSc (Hons), MB, ChB, MD (Hons), FRCP (Edin), FRCP, FRCPS (G) is a Consultant in Acute Medicine at the University Hospital of North Durham. He is Director of Standards at the Royal College of Physicians of Edinburgh having previously been Vice President. He is National Clinical lead for ACUMEN e-learning project, and lead of the educational workstream of the national acute kidney injury project. He was commissioned by the Inquiry to provide written reports on the medical care of 13 focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. Dr Jones has specialised in Acute General Medicine since 1998 and has extensive medical administration and teaching experience. He has produced some 80 articles, chapters, reports and presentations. He is also an External Examiner for International MRCP examinations, and was previously Clinical Specialty Advisor in General Medicine to the Chief Medical Officer for Scotland.

Professor Kevin Kerr

Professor Kevin Kerr BSc, MB, ChB, MD, FRCPath, FRSPH is Consultant Microbiologist and Director of Infection Control at Harrogate and District NHS Foundation Trust, where he created the *C. difficile* Rapid Response Team. He was commissioned by the Inquiry to provide written microbiology reports on eight focus patients and one other patient who had contracted *C. difficile*, and to provide a separate overview report of his findings. He has published extensively and given a large number of presentations at national/international meetings in relation to infection control. He is Reviews Editor of the "Journal of Hospital Infection". He sits on the International Advisory Board of the Journal of Clinical Pathology and also the Association of Clinical Pathologists' Microbiology Committee. He is Honorary Clinical Professor of Microbiology at Hull York Medical School and an affiliate of the Centre for Immunology and Infection, University of York.

Dr Alan MacDonald

Dr Alan MacDonald BSc (Hons), MBChB, MSc MRCPPath, FRCPath, is an Infection Prevention and Control Doctor/Consultant Microbiologist for NHS Ayrshire and Arran. He was commissioned by the Inquiry to provide written microbiology reports on six focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. Dr MacDonald has extensive experience of microbiology in hospital settings, is a member of a number of professional bodies, and has produced several publications on infection control.

Dr Simon Mackenzie

Dr Simon Mackenzie is Divisional Medical Director, NHS Lothian, University Hospitals Division, and Consultant in Intensive Care in the Royal Infirmary, Edinburgh. He was commissioned by the Inquiry to provide a report on death certification where the patient has suffered from *C. difficile*. He was asked to provide details of policy, practice and guidance on death certification in 2007 to 2008 and to specific changes in policy, practice and guidance since then. Dr Mackenzie is Honorary Clinical Senior Lecturer at University of Edinburgh and an Examiner for the UK and European Diplomas in Intensive Care Medicine. He was also past-President of the Scottish Intensive Care Society and is a Specialist Adviser to the Scottish Medicines Consortium and the National Institute of Clinical Excellence.

Professor Anthony Palmer

Professor Anthony Palmer RGN, BSc, Diploma Nursing, PGCE, RNT was until recently Executive Director of Nursing and Deputy Chief Executive at Luton and Dunstable Hospital NHS Foundation Trust. He is currently an Independent Nursing Consultant and Expert Witness. Professor Palmer was commissioned by the Inquiry to provide written nursing reports on ten focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. Professor Palmer is on the approved NHSLA List as a Nursing Expert and a member of the Expert Witness Institute with expertise in nursing care of the elderly. He is accredited with the Royal College of Nursing as a Nursing Expert and also a Clinical Advisor/Associate for the Care Quality Commission.

Mrs Lynne Phair

Lynne Phair MA, BSc (Hons), RMN, RGN, DPNS, IP is an Independent Consultant Nurse for Older People. From January 2010 to October 2010 she was a member of the Expert Medical Advisory Group to the *C. difficile* Public Inquiry, Northern Health and Social Care Trust, Northern Ireland. Mrs Phair has acted as an Expert Witness since 1993, and has provided expert nursing reports for a number of institutions including coroners, Police, Crown Prosecution Service, Court of Protection and the High Court. She has published over 50 books, chapters and articles since 1989. The Inquiry commissioned Mrs Phair to provide written reports on 11 focus patients and one other patient. She also provided an overview report setting out the principles of nursing older people and fundamental care and an evaluation as well as summary report of the care of an additional 35 patients with CDI in the early period of the Inquiry's investigation.

Mrs Christine Perry

Christine Perry RGN, MSc Nursing, is Director of Nursing and Director of Infection Prevention and Control at Weston Area Health NHS Trust. Mrs Perry has extensive nursing experience and became an Infection Control Nurse in 1995, being promoted to Senior Infection Control Nurse in 1998 and to Nurse Consultant in Infection Control in 2002. In 2004 she was one of the first Infection Control Nurses to be appointed as Director of Infection Prevention and Control. She was commissioned by the Inquiry to write a report on nursing structures at the VOLH, and was asked specifically to focus on staffing and management structures, infection control, hygiene/cleanliness, and communication. Mrs Perry is a former Chair of the Infection Control Nurses' Association and has been a member of national committees and advisory groups. She also provided the infection control nurse expertise to the Health Care Commission for its investigations into *C. difficile* at Stoke Mandeville Hospital and at Maidstone and Tunbridge Wells NHS Trust.

Professor Ian Poxton

Professor Ian Poxton BSc, PhD, DSc was Professor of Microbial Infection and Immunity at the University of Edinburgh until his retirement in December 2012, and is now Professor Emeritus. He provided a report outlining what *C. difficile* is and how it is acquired, the experience of, and data on, *C. difficile* outwith the UK, and future developments in the treatment and prevention of *C. difficile* infection. His major research interests are in bacterial pathogens. Professor Poxton has taught extensively as a postgraduate supervisor and published extensively on infection control and specifically on *C. difficile*. He is a member of a number of national and regional societies and committees.

Dr James Reid

Dr James Reid BA, BM, BCh, MRCP holds a Postgraduate Certificate in Managing Health and Social Care, and is Consultant in Integrated Medicine at Leicester Royal Infirmary. He specialises in General Medicine and Geriatric Medicine with special interest in orthogeriatric liaison and rehabilitation and postural stability and falls in the elderly. He was commissioned by the Inquiry to provide written reports on the medical care of 11 focus patients and one other patient who had contracted *C. difficile*, and to provide a separate overview report of his findings. Dr Reid has extensive clinical management experience and has produced a number of publications. In 2007 he helped produce the operational policy for a 22 bed Isolation Ward in response to high levels of hospital acquired *C. difficile* infection at the University Hospitals Leicester NHS Trust. Since the ward was opened in-hospital mortality, stay duration following CDT diagnosis, and readmissions have all reduced.

Professor Chris Robertson

Professor Chris Robertson BSc, MSc, PhD is Professor of Public Health Epidemiology, Mathematics and Statistics at Strathclyde University, Glasgow. He was commissioned to provide a statistical analysis of data supplied by the Inquiry. The main aims of this analysis were to investigate the temporal and ward patterns of diagnoses and testing for *C. difficile*, and to investigate the temporal and ward patterns of deaths among *C. difficile* patients. Professor Robertson is an applied statistician with interests in the application of statistics over a wide variety of disciplines. His main current research interest is in statistical modelling of infectious diseases and in epidemiological studies.

Dr Ray Sheridan

Dr Ray Sheridan BSc (Hons), MRCP is a Consultant Physician in General Medicine and Medicine for the Elderly with special interests in falls and movement disorders. He also has teaching responsibilities for the Peninsula Medical School at the Royal Devon and Exeter Hospital. Dr Sheridan looks after a general and geriatric medicine ward where cases of infections such as *C. difficile* are cohorted. He is also responsible for weekly multidisciplinary *C. difficile* ward rounds jointly with Infection Control, Pharmacy and Microbiology. He was commissioned by the Inquiry to provide written reports on the medical care of 11 focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. Dr Sheridan worked on the Regulation and Quality Improvement Authority Independent Review of the *C. difficile* outbreak in Northern Ireland. He has published a paper on assessing *C. difficile* severity and mortality risk factors.

Mr Alex Smith

Alex Smith CPFA is a chartered public finance accountant and is currently a non-executive member of a number of boards and committees in NHS 24, the Scottish Public Pensions Agency, Transport Scotland and the Scottish Government. Mr Smith was commissioned by the Inquiry to provide a report on a number of management issues, including the way in which the Clyde area hospitals were brought within the management responsibility of Greater Glasgow Health Board. His report covers such matters as management within the Clyde Directorate, clinical governance arrangements and general oversight of infection control within Greater Glasgow and Clyde, and policy and guidance issued by NHSScotland on healthcare acquired infection. Mr Smith has worked in the NHS in Scotland since 1974 and has held several senior finance and management roles.

Dr Sheldon Stone

Dr Sheldon Stone BSc, MBBS, MD, FRCP is a General Physician for Older People, Stroke Physician and Senior Lecturer at the Royal Free Hampstead NHS Trust. He provided the Inquiry with preliminary guidance and created a framework within which the Inquiry went on to extend its research and investigation. Dr Stone is a Staff Governor of the Royal Free NHS Foundation Trust and Founding Member of the Hand Hygiene Alliance. He was secretary of the Department of Health/Health Protection Agency Joint Working Group on the prevention and management of *Clostridium difficile* infection. He has led an evaluation of the contribution of the national Cleanyourhands campaign in England to the reduction of *C. difficile* infection.

Mrs Sharon Stower

Mrs Sharon Stower RGN, MA, MBA (Health), Dip HSM, Cert MHS is an Independent Nursing and Health Care Consultant who has carried out work for the Royal College of Nursing (RCN) and the NHS. She is listed on the RCN Expert Witness database. Mrs Stower was commissioned by the Inquiry to provide written reports on the nursing care of nine focus patients who had contracted *C. difficile*, and to provide a separate overview report of her findings. As an experienced Director of Nursing she has worked extensively in both public and independent health care sectors and has worked for the Health Care Commission as a Clinical Nurse Advisor/Expert.

Dr Louise Teare

Dr Louise Teare MB BS, MSc, MBA, NEBOSH holds a Diploma in Hospital Infection Control, a Cardiff Expert Witness Certificate, and an Advanced Leader Certificate from the British Association of Medical Managers. She is currently Consultant Medical Microbiologist, Infection Control Doctor and Director of Infection Prevention and Control for Mid Essex Hospitals Trust. Dr Teare was commissioned by the Inquiry to provide written microbiology reports on eight focus patients and one other patient who had contracted *C. difficile*, and to provide a separate overview report of her findings. Dr Teare has made a significant contribution to national agendas and policy making on microbiology and infection prevention and control matters. She was a member of the Healthcare Commission Investigation Team into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust. Dr Teare is also a current member of the Public Health Topic Expert Group for the National Institute of Clinical Excellence, providing Public Health advice on healthcare associated infections.

Dr Rod Warren

Dr Rod Warren MB, BChir, MA, MRCPPath is lead consultant microbiologist at the Royal Shrewsbury Hospital. He was commissioned by the Inquiry to provide written microbiology reports on 19 focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. From his appointment as the first NHS full-time consultant microbiologist in Cambridge in 1977 Dr Warren has pursued applied research and published extensively, as well as being heavily involved in teaching and examining. He has a wealth of medical advisory experience in the NHS and is a member of a number of national and regional committees as well as committees in Shropshire. He is also a member of a number of professional associations and societies, including the Hospital Infection Society.

Dr Henry Woodford

Dr Henry Woodford BSc, MRCP, FRCP, CertClin Ed is a Consultant Physician in elderly medicine at North Tyneside Hospital. He was commissioned by the Inquiry to provide written reports on the medical care of 17 focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. Dr Woodford is currently head of service for Elderly Medicine at his hospital and has recently been training programme director for geriatrics within the Northern deanery. He has written two textbooks – Essential Geriatrics (which is now in its second edition) and Acute Medicine in the Frail Elderly.

Dr Tim Wyatt

Dr Tim Wyatt BTech, PhD, CBiol, FIBiol, FRCPath, MIHM retired from full-time work in 2010 and is currently employed as a Consultant Clinical Microbiologist at the Northern Ireland Public Health Agency. Formerly, he was Consultant Clinical Microbiologist at Belfast HSC Trust, Clinical Lead for Molecular Sciences and Infection Control Doctor with responsibility for the Mater Hospital and North and West Belfast Trust and Belfast Community. He was commissioned by the Inquiry to provide written microbiology reports on four focus patients who had contracted *C. difficile*, and to provide a separate overview report of his findings. Dr Wyatt undertakes advisory activities for the Department of Health, Social Services and Public Safety and the Public Health Agency in Northern Ireland, Public Health England and the Department of Health in London. He has produced 32 publications including original research and contributions to several books.

Assistance was also provided at an early stage of the Inquiry by two further experts, Dr Colin Currie, Senior Lecturer/Hon. Consultant, Geriatric Medicine, Edinburgh University and NHS Lothian until 2010, and Professor Cillian Twomey, Consultant Physician in Geriatric Medicine, Cork University/St. Finbarr's Hospitals, Cork.

Appendix 5

Witnesses who gave oral or written evidence

Syed Ahmed	Fiona Coulter	Donald Gray
Javed Akhter	Brian Cowan	Christine Griffin
Musa Al-Shamma	Morven Cowie	George Griffin
Linda Bagrade	Susan Craig	George Hamilton
Bruce Barnett	Andrew Crawford	Roisin Hannaway
Jean Beattie	Fiona Creech	Anne Harkness
Jack Bisset	Rosslyn Crocket	James Harnett
Katrina Black	Elizabeth Culshaw	Margaret Harnett
Catherine Booth	Evonne Curran	Mary Harrington
Robert Boulton-Jones	Linda Currie	Janine Hart
Gareth Bourhill	Myra Currie	Joanne Harvey
Brenda Bowes	Graham Curry	Elizabeth Hawkins
Susan Brimelow	Conal Daly	Gordon Herd
Christine Brodie	Stephanie Dancer	Mary Hesketh
John Burgess	Lorna Dannenberg	Joan Higgins
Elaine Burt	Linda de Caestecker	Elizabeth Hunter
Patricia Bynon	François de Villiers	Pauline Jack
Robert Calderwood	Deb den Herder	Annette Jeanes
Marjory Cambridge	John Dickson	Ann Johnston
Anne Cameron	Frank Dixon	Fiona Johnston
Roberta Campbell	Thomas Divers	Lily Johnston
Hugh Carmichael	Geoffrey Douglas	Mike Jones
Lorraine Casey	Donald Drummond	Laura Kean
Carol Cavana	Marion Drummond	Rosamond Kelly
David Chandler	Brian Duerden	Margaret Kelso
Sheila Chandler	Anne Eastaway	Kevin Kerr
Anne Chisholm	Alison Edwardson	Afaq Khan
Peter Christie	William Evans	Claire Kilpatrick
Patricia Clarke	Isabel Ferguson	Paul Kingsmore
Alison Claxton	Margo Ferguson	Charles Kinloch
John Coia	Elizabeth Fettes	Ann Lang
Elizabeth Colgan	Lance Forbat	Isobel Law
Elaine Connolly	Lesley Fox	Sarah Leslie
Martin Connor	Laura Gargaro	David Logan
Patrick Conroy	Mark Garthwaite	Nancy Logan
Charles Cook	John Gebbie	Allan Lynch
Marion Copland	Ysobel Gourlay	Heather Lynch
Peter Copland	Jane Grant	Alan MacDonald

Jonathan MacDonald	Sandra McNamee	Graeme Simpson
Agnes MacFarlane	Margaret Melvin	Alex Smith
Catherine MacGillivray	John Menzies	Caroline Smith
Simon Mackenzie	Deborah Mills	Doris Smith
Deborah Mack	Helen Mooney	William Cairns Smith
Anne MacPherson	Carol Moore	Lorna Sneddon
Anne Madden	Mary Morgan	William Somerville
Katy Madden	Eunice Muir	Anna Squires
Nancy Malcolm	Jean Murray	Diane Stavert
John Mallon	Karen Murray	Margaret Stevenson
Marie Martin	Helen Neeson	Janet Stewart
Paul Martin	Scott Nicol	John Stewart
Jim McCarroll	Craig Nixon	Sharon Stower
Melanie McColgan	Helen O'Neill	Marie Swan
Tilda McCrimmon	Margaret Owen	Catriona Sweeney
Pauline McCrossan	Anthony Palmer	Judy Taylor
Douglas McCruden	Christine Perry	Louise Teare
Alexander McDonald	Lynne Phair	Graeme Waddell
Anne McDonald	Gabby Philips	Pauline Waddell
Ciara McDonald	Ian Poxton	Margaret Walker
Eleanor McDonald	David Rainey	Thomas Walsh
Karen McDonald	Annette Rankin	Jan Warner
Anne McGarrity	Elizabeth Rawle	Rod Warren
Kim McGarrity	James Reid	Barbara Weinhardt
Charles McGinty	Robin Reid	Brian Wilson
Helen McGinty	Jacqui Reilly	Helen Wilson
Lisa McGinty	Eleanor Rennie	Susan Wilson
Michelle McGinty	Chris Robertson	Camilla Wiuff
Alexander McIntyre	Walter Scullion	Henry Woodford
Isobelle McIntyre	Jane Searle	Kevin Woods
Matt McLaughlin	Andrew Seaton	Tim Wyatt
Ally McLaws	Anne Shaw	Catherine Wrethman
Enid McMurdo	Maria Shaw	
Kathryn McNally	Ray Sheridan	

Appendix 6

Organisations which provided documentary evidence

Crown Office and Procurator Fiscal Service

Greater Glasgow Health Board (also known as NHS Greater Glasgow and Clyde)

Health Facilities Scotland

Health Protection Scotland

NHS Education for Scotland

NHS Quality Improvement Scotland

Nursing and Midwifery Council

Scottish Government

Strathclyde Police

Tayside Health Board

In addition, a number of individuals provided documentary evidence to the Inquiry.

Appendix 7

Acronyms

ACIC	Acute Control of Infection Committee
AHP	Allied Healthcare Professional
AMT	Antimicrobial Management Team
ARSSAP	Antimicrobial Resistance Strategy and Scottish Action Plan
BICC	Board Infection Control Committee
CCP	Cleanliness Champions Programme
CCU	Critical Care Unit
CDAD	<i>Clostridium difficile</i> associated diarrhoea/disease
CDI	<i>Clostridium difficile</i> infection
CG	Clinical Governance
CLO	Central Legal Office
CMO	Chief Medical Officer
COPFS	Crown Office and Procurator Fiscal Service
CPA	Clinical Pathology Accreditation
CSA	Common Services Agency
CSBS	Clinical Standards Board for Scotland
DNAR	Do Not Attempt Resuscitation
GGHB	Greater Glasgow Health Board
GMC	General Medical Council
GP	General Practitioner
GROS	General Register Office for Scotland
HAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEAT	Health Improvement, Efficiency, Access and Treatment
HEI	Healthcare Environment Inspectorate
HFS	Health Facilities Scotland
HIS	Healthcare Improvement Scotland
HPS	Health Protection Scotland
ICD	Infection Control Doctor
ICN	Infection Control Nurse
ICT	Infection Control Team
IRH	Inverclyde Royal Hospital
LIMS	Laboratory Information Management System
MAU	Medical Assessment Unit
MDDUS	Medical and Dental Defence Union of Scotland

MRSA	Meticillin resistant <i>Staphylococcus aureus</i>
MSSA	Meticillin sensitive <i>Staphylococcus aureus</i>
NES	NHS Education for Scotland
NHSGGC	NHS Greater Glasgow and Clyde
NMC	Nursing and Midwifery Council
NMUU	National Medicines Utilisation Unit
NAS	National Archives of Scotland
NRS	National Records of Scotland
NSS	NHS National Services Scotland
OCT	Outbreak Control Team
PACS	Picture Archiving Communications Systems
PCR	Polymerase Chain Reaction
PHPU	Public Health Protection Unit
PPE	Personal Protective Equipment
QIS	Quality Improvement Scotland
RAD	Rehabilitation and Assessment Directorate
RAH	Royal Alexandra Hospital
RCN	Royal College of Nursing
RQIA	Regulation and Quality Improvement Authority for Northern Ireland
SAPG	Scottish Antimicrobial Prescribing Group
SCN	Senior Charge Nurse
ScotMARAP	Scottish Management of Antimicrobial Resistance Action Plan
SE	Scottish Executive
SEHD	Scottish Executive Health Department
SG	Scottish Government
SHO	Senior House Officer
SMG	Strategic Management Group
SMT	Senior Management Team
SPC	Statistical Process Chart
SSSCDRL	Scottish Salmonella, Shigella and <i>Clostridium difficile</i> Reference Laboratory
TVN	Tissue Viability Nurse
UTI	Urinary Tract Infection
VOLH	Vale of Leven Hospital

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Timeline of investigations prior to the Inquiry

10 JUNE 2008	NHSGGC Outbreak Control Team established
10 JUNE 2008	NHSGGC Internal Investigation commenced
18 JUNE 2008	Scottish Government Independent Review of <i>Clostridium difficile</i> Associated Disease at the Vale of Leven Hospital from December 2007 to June 2008 set up
AUGUST 2008	Independent Review report published
11 JULY 2008	NHSGGC Internal Investigation report published
OCTOBER 2008	NHSGGC Outbreak Control Team report published
24 NOVEMBER 2008	Joint Health and Safety Executive and Strathclyde Police investigation commenced
JANUARY 2009	Scottish Government Follow Up Report on implementation of the recommendations from the Independent Review published
6 JANUARY 2009	C.diff Justice Group public petition lodged at the Scottish Parliament
22 APRIL 2009	Scottish Government – Announcement by Cabinet Secretary that there will be a Public Inquiry
31 MAY 2009	Strathclyde Police interim report on deaths at VOLH submitted to Procurator Fiscal
24 JUNE 2009	Crown Counsel instructed that no criminal proceedings were to be taken
1 OCTOBER 2009	Vale of Leven Hospital Public Inquiry commenced

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Health and Sport Committee

Tuesday 13 June 2017



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Tuesday 13 June 2017

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HEALTH AND SPORT COMMITTEE

16th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
 *Miles Briggs (Lothian) (Con)
 *Donald Cameron (Highlands and Islands) (Con)
 *Alex Cole-Hamilton (Edinburgh Western) (LD)
 *Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
 *Alison Johnstone (Lothian) (Green)
 *Ivan McKee (Glasgow Provan) (SNP)
 *Colin Smyth (South Scotland) (Lab)
 *Maree Todd (Highlands and Islands) (SNP)
 *attended

THE FOLLOWING ALSO PARTICIPATED:

Morag Brown (NHS Greater Glasgow and Clyde)
 Kirsty-Louise Campbell (City of Edinburgh Council)
 Robin Creelman (NHS Highland)
 Sir Robert Francis QC
 Innes Fyfe (Scottish Government)
 Ailsa Garland (Scottish Government)
 Geoff Huggins (Scottish Government)
 Cathy James (Public Concern at Work)
 Christine McLaughlin (Scottish Government)
 Shona Robison (Cabinet Secretary for Health and Sport)
 Eleanor Stanley (Scottish Government)
 Maureen Watt (Minister for Mental Health)
 Ruth Wilson (Scottish Government)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 13 June 2017

[The Convener opened the meeting at 09:15]

Subordinate Legislation

Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 [Draft]

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 16th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not take photographs or film proceedings.

Agenda items 1 to 11 are on subordinate legislation. Under agenda items 1 to 10, we will consider five instruments that are subject to affirmative procedure. As is usual with affirmative instruments, we will take evidence from the responsible minister and their officials. Once all our questions about the instrument have been answered, we will have a formal debate on the motion.

The first instrument that we will look at is the draft Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017. I welcome to the meeting from the Scottish Government Maureen Watt, who is the Minister for Mental Health; Ruth Wilson, who is a senior policy adviser in the mental health and protection of rights division; and Ailsa Garland, who is a solicitor.

I invite the minister to make a brief opening statement.

The Minister for Mental Health (Maureen Watt): Thank you for providing me with the opportunity to speak about the secondary legislation that the Scottish Government is introducing as part of the implementation of the Mental Health (Scotland) Act 2015. That act makes changes to the Mental Health (Care and Treatment) (Scotland) Act 2003 to allow service users with a mental disorder to access effective treatment quickly and easily. The 2015 act also amends the Criminal Procedure (Scotland) Act 1995 and the Criminal Justice (Scotland) Act 2003 to improve processes and to introduce a victim notification scheme for victims of mentally disordered offenders.

The implementation of the 2015 act is part of the Scottish Government's programme to streamline, simplify and clarify the system for the efficient and effective treatment of people with a mental disorder. It does not seek to overhaul mental health law; it simply seeks to make the changes that need to be made to improve further the operation of the law in that area.

When the provisions of the 2015 act come into force, they will build on the existing measures and principles that are set out in the Mental Health (Care and Treatment) (Scotland) Act 2003 to help to ensure that people with mental health problems know their rights, are at the centre of decisions about their own care and are empowered to participate.

There are five affirmative statutory instruments to talk about. One instrument is about the arrangements for patients who have absconded, three relate to cross-border matters, and the fifth clarifies the holding powers for nurses. As each instrument is to be considered individually, I will take a few minutes to explain the particular proposals, including our reasons behind them, before I take questions.

Policy was developed in consultation with stakeholders, and the draft policy proposals for the instruments were discussed with stakeholders before the proposals were finalised. Given the complexity and technical nature of some of the processes, it was not practicable to run a single public consultation. In order to maximise responses, two separate consultations were conducted. The aim was to engage as fully as possible while minimising pressure on stakeholders to consider several topics in one go.

Policy officials set up a reference group, which not only helped to shape the form of the consultations but focused on the implementation of the 2015 act. The reference group consists of a range of stakeholders; its membership includes the Mental Health Tribunal for Scotland, the Mental Welfare Commission for Scotland, professional groups, service providers and rights, advocacy and service user representation organisations. The group has had a key role in providing advice and recommendations.

The Scottish Government considers that the implementation of the 2015 act and the introduction of the instruments will help to improve the care and treatment of people with mental disorders.

I am happy to discuss the first instrument that the committee is to consider.

The Convener: Thank you. I invite questions from members.

Maureen Watt: Sorry, convener, but should I go on and introduce the first instrument?

The Convener: Yes—if that is what you were intending to do.

Maureen Watt: The first instrument relates principally to the provision of medical treatment to persons who have absconded to Scotland from elsewhere. The regulations have a dual purpose: to provide a process for the return of patients who have absconded from another European Union member state and to allow for the treatment of absconding patients pending their return.

When patients who are mentally disordered are detained in hospital, they sometimes leave without the agreement of the staff or go missing. That can be a concern, because many patients are detained in hospital because they are at risk of harming others or themselves in some way. We propose to make provision that follows the principle of least restriction and allows for such a person to receive medical treatment for their mental disorder. It is envisaged that the provision would be used when the absconding person is likely to be in Scotland for a short period before returning to their home jurisdiction once transport has been arranged. At present, the mental health legislation does not provide a framework to authorise giving treatment to a person who has absconded from detention in another jurisdiction and has been taken into custody pending return. We therefore propose to replicate some of the existing provisions that allow treatment of patients who are detained in hospital in Scotland.

The regulations set out a clear process for considering treatment, which includes confirming that the absconding person is subject to measures that correspond to Scottish measures involving detention. We hope that, in most cases, the person will be returned to their home jurisdiction within a few days. We have focused on what best meets the person's needs. It would have to be established that the absconding person has a mental disorder and, if they were not liable to be taken into custody under the absconding regulations, it would be necessary to detain them for treatment of that disorder.

I appreciate that one stakeholder would perhaps prefer us to take a different route. For example, it has recommended that absconding persons should be made subject to a short-term detention certificate. We have looked at the evidence in detail and officials have spoken to that stakeholder about its concerns. It acknowledges that a short-term detention certificate may not be appropriate in all cases, and we consider that additional provisions that it has requested are not needed. We are confident that the draft regulations are a suitable and proportionate way of allowing a person to be returned to their home jurisdiction

when that is appropriate and to receive treatment for their mental disorder as required pending their return.

In the consultation process, most respondents agreed with our proposals. The best interests of the person should be uppermost in any decision. Under the Mental Health (Care and Treatment) (Scotland) Act 2003, anyone in Scotland with a mental disorder as defined by that act has the right to access support from an independent advocate. That means that any patient who comes under the absconding regulations would have a right to access support from an advocate. If there was likely to be a longer delay, it would be open to the medical practitioner who was responsible for the person's treatment to consider whether the person should be brought within the Scottish system.

I am now happy to take questions on the proposals.

The Convener: Thank you.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, minister, and thank you for coming. At the top of your remarks, you referenced the fact that the instruments were produced in consultation with groups of stakeholders. I absolutely accept that, and that may well be the case, but it is clear from briefings that members of the committee have received from the Scottish Association for Mental Health that not all the concerns that were raised in the consultation process have been acted on.

I particularly want to address issues surrounding these regulations. First, the draft regulations allow the responsible medical officer to authorise any person to take someone into custody. Arguably, that definition is vague and does not ensure that the person who is specified will have appropriate qualifications or experience to fulfil the duties. SAMH flagged that up during the consultation process. Why did you decide to omit any qualification threshold for people who can take patients into custody?

Maureen Watt: In general terms, we are aware of SAMH's concerns. My officials met a representative from SAMH last week, and we thought that we had allayed most of their fears and concerns about the instruments, but after the representative went back and discussed the matter with colleagues, that does not seem to have been the case. Perhaps more reassurance of other people at SAMH is required.

The change is needed because there is currently a difference between the list of persons who can take an absconding civil patient into custody and return them, and the corresponding list for mentally disordered offenders. There is a list of people who can take people into custody, but the new provisions ensure similar specified

persons in the two cases by including persons who are authorised by the patient's responsible medical officer. The policy objective is to make both approaches similar to allow an RMO to authorise a person to take a mentally disordered offender into custody and return them to the hospital or other place from which the patient absconded. The accompanying code of practice will make clear which factors an RMO should consider when specifying a person.

Alex Cole-Hamilton: The regulations are subject to affirmative procedure, so we cannot amend them. You are asking the committee to rubber-stamp something with which not all of us are entirely happy. I do not see how the Government position would be weakened by redrafting and amending the regulations to include the word "qualified" and delineating in the subsequent guidance exactly what is meant by "qualified", otherwise that could be open to interpretation and it might be misused.

Maureen Watt: Qualified persons are already specified. They include members of hospital staff, mental health officers and constables. The addition will allow the RMO to make a decision about the suitability of a person to take an absconding patient into custody and return them to hospital or another place from which they have absconded. The accompanying code of practice will make clear what matters an RMO should consider when specifying a person.

Alex Cole-Hamilton: With respect, just listing groups of people who can do that does not specify what qualifications they should hold or what expertise or experience they should have. I am not satisfied that that qualification threshold has been met.

Maureen Watt: Does one of my officials want to come in on that? The RMO will always take the decision at the end of the day.

Ruth Wilson (Scottish Government): The addition will allow an RMO to use their judgment on who should fulfil the role of taking a person into custody. The RMO will look at who from the prescribed list is best placed at that moment.

Alex Cole-Hamilton: The human judgment element causes me concern. Just saying that hospital staff can take somebody into custody without specifying qualifications might lead the RMO to infer that any member of hospital staff could perform that role. Given the distress that the person in question might be in—they might have been without their medication, usual treatment and support for some time—there could be a particularly charged situation that requires a very finessed skill set. We have not covered that by just saying that it is up to the RMO and the person can be anyone from the hospital staff.

Ailsa Garland (Scottish Government): The amendment in the draft regulations simply replicates the system that we have at the moment for civil patients. We have the list that includes a mental health officer, a constable, a member of staff of a hospital and any other person who has been authorised by the RMO. We are simply replicating that for offenders who have absconded within Scotland and therefore leaving flexibility for the RMO to consider who is most suitable at the time, as my policy colleague said.

09:30

Alex Cole-Hamilton: I am all for giving the RMO flexibility but I want parameters around that flexibility, and I do not understand the problem with bottoming that out in guidance and using the word "qualified" so that RMOs can discharge that responsibility confidently.

Maureen Watt: As Ailsa Garland said, the provision brings the situation into line with the system for other patients. We are talking about very few people—people who are in danger of being a risk to themselves or to others. I think that you will agree that speed might be of the essence in some cases: we need to quickly ascertain what the problem is and make sure that the person is given the best possible treatment and returned from whence they came as quickly as possible.

Alex Cole-Hamilton: I do not question that. Speed is obviously important. However, when people have to make speedy decisions, they often make the wrong ones. I just want to protect the RMOs and the patients they are dealing with. If that means bringing the system into line with the system for domestic patients, perhaps the system for domestic patients needs to be tightened up. I am still not happy with the regulations.

Ailsa Garland: I clarify that the amendment is just about domestic offenders who have absconded in Scotland. We are amending two different sets of regulations and replicating what is in the civil system. RMOs already make decisions that they think are appropriate for civil patients, so we are creating a similar system. I am not sure whether we are aware of issues around the making of such decisions for civil patients at the moment. We are simply replicating the system for offenders.

Alex Cole-Hamilton: I do not think that we are going to reach agreement on this, but I am not satisfied that that qualification threshold has been reached.

If I may, convener, I will move on to the other problem that SAMH raised about medical treatment for people who have absconded from jurisdictions outwith Scotland. As the regulations stand, the Government is proposing to treat

people over several days without the same authorisation under mental health law that would be provided for someone who is resident and receiving treatment in Scotland. People who abscond to Scotland could be subject to prolonged detention and treatment without a right of appeal, which could be seen as an infringement of their human rights. The issue was raised in the European Court of Human Rights through a case in Finland. In its judgment, the court said:

“forced administration of medication represents a serious interference with a person’s physical integrity and must accordingly be based on a ‘law’ that guarantees proper safeguards against arbitrariness.”

In that case, those safeguards were missing. How confident are you that, if such a case were brought before the European Court of Human Rights, it would not be found similarly wanting?

Maureen Watt: The case of *X v Finland* involved a quite different set of circumstances and did not relate to absconding. We are content that the regulations provide significant safeguards in relation to the treatment of those who abscond to Scotland from other jurisdictions. Such medical treatment can be given only when the absconding person is subject to a measure in their home jurisdiction that corresponds to certain Scottish measures involving detention, all of which contain safeguards for the patients involved. Additionally, the absconding person needs to be medically examined before treatment is given. It needs to be established that they have a medical disorder, that they would need to be detained for the purposes of receiving treatment and that without treatment there would be a significant risk to the safety and welfare of the absconding person or to others.

On the safeguards, our mental health legislation is rights based, and we have sought to reflect that in the regulations. For some individuals, compulsory treatment is used to provide medical treatment to alleviate suffering and to protect the person and others and, as you know, compulsory treatment is allowed only in strictly controlled circumstances. Absconding patients are covered by the same safeguards.

Alex Cole-Hamilton: Okay. Going back to the judgment in *X v Finland*, we cannot hypothetise about the circumstances in which that would be applied under Scots law in terms of individual circumstances that might occur in relation to patients absconding to Scotland with regard to the regulations.

You talk about the approach being based on mental health legislation. The problem with that is that no protection under mental health legislation is afforded to patients who abscond to Scotland, because they are excluded from the provision of treatment authorised under the 2003 and 1995 acts. The regulations set out that the Scottish

Government therefore proposes to provide treatment to patients without those protections. In other words, despite what you said about the work that was done and the agreement that was reached about the use of short-term detention certificates not being appropriate, that is, effectively, what we are talking about.

Ailsa Garland: The Scottish Government is completely committed to maintaining human rights in Scotland. There is a clear system in the absconding regulations. I do not think that it is quite correct to say that, because they are set out in regulations rather than in primary legislation, there are no procedures and safeguards.

A number of checks need to be done before someone can be given medical treatment. It has to be established that they have a mental disorder and that were they not liable to be taken into custody it would be necessary to detain them to give the treatment. All of that has to be decided by a medical practitioner, who must also consider whether, without treatment, there would be some risk to the safety of the patient or others. There is then a process whereby certain sections of the 2003 act are applied and modified so that they work appropriately for absconding persons. I therefore do not think that it is correct to say that there is no scheme or system or that there are no safeguards. All of that is set out in detail in the regulations.

Alex Cole-Hamilton: My fundamental point is that absconding persons are not afforded the same rights and protections as Scottish citizens, who are protected by primary legislation. I cannot see why we cannot change the regulations to give them those same protections.

Ailsa Garland: Our position is that, as I said, a clear system is in place for those people. The fact that it is in regulations rather than in primary legislation does not mean that it is a lesser system. I take your point that they will not receive treatment under the 2003 act—I think that that is one of SAMH’s issues—but they will receive treatment in accordance with the conditions and requirements in the regulations. We feel that there is a clear system there.

Alex Cole-Hamilton: Access to justice is key. I would be anxious that people who are not protected by primary legislation, who will be dealt with through the hodgepodge of provisions in the regulations, will not have the same access to justice that they would have had if they had been protected in the same way that Scottish patients are protected under primary legislation.

Clare Haughey (Rutherglen) (SNP): I refer members to my entry in the register of members’ interests. I am a registered mental health nurse, and I am one of probably only two people around

the table who have worked with mental health legislation in practice.

What rights does someone who has absconded and is now in the care of a Scottish mental health facility have in terms of accessing advocacy and making complaints to the Mental Welfare Commission, and what rights do they have in general? Alex Cole-Hamilton has raised concerns in that regard, so it would be helpful if the minister could clarify what those rights are and where those people currently stand in that regard.

Maureen Watt: The 2015 act builds on the rights and duties in the 2003 act, including the right to access support from an independent advocate. The new provisions will require local authorities, health boards and the state hospital to provide information to the Mental Welfare Commission on how they currently exercise their duty to collaborate and to secure advocacy services for people with a mental disorder, and how they plan to do so in the future. That will help to ensure that information on the provision of advocacy is easily accessible and that independent advocacy is provided, as it should be. The Scottish Government will continue to work with the Mental Welfare Commission for Scotland on the implementation of the new provisions. As far as I understand, the commission is broadly in agreement with the instruments.

Clare Haughey: Anyone who is detained under mental health legislation in Scotland has additional support through a mental health officer, who oversees the process. Are there any plans for mental health officers to oversee any part of the regulations?

Maureen Watt: There is no statutory role for an MHO under the regulations, as persons will not be detained under the 2003 act. However, the statutory guidance will set out best practice in terms of how the clinical team will engage with social work.

Clare Haughey: Thank you for that reassurance.

Alex Cole-Hamilton has raised concerns about RMOs deciding who would take someone back into custody. I have personal experience of fulfilling that role. My understanding is that, in the vast majority of cases, the role would fall to registered mental health nurses and nurses who work on the ward from where the patient absconded or who are part of the wider clinical team, such as community staff who have worked with the patient. Will the regulations lead to any changes in who fulfils that role? Do you envisage that similar people, with similar experience and levels of qualification, would be involved?

Maureen Watt: The system would be absolutely the same. I bow to your practical knowledge in the field—you are absolutely right.

Colin Smyth (South Scotland) (Lab): Good morning. Under the current process, if someone requires further treatment over a longer period, doctors are required to issue short-term detention certificates—Alex Cole-Hamilton made that point. What are the disadvantages of maintaining that system?

Ailsa Garland: A patient who is made subject to a short-term detention certificate is effectively brought into the Scottish system. To be transferred back to their home jurisdiction, they would have to go through the cross-border transfer process, which might involve a lengthier process than would otherwise be the case. However, as I have said, by allowing medical treatment to be provided under the absconding regulations, we are setting out a clear process for that treatment and the conditions under which it can be given, and when the patient is medically fit to return to their own country that can be done without any delay.

Colin Smyth: How many people are we talking about? There may be only a few such patients—I think that that is what the minister said—but you say that you require to change the system.

Ruth Wilson: No official statistics have been kept, but you will see from the evidence that has been submitted, and we know from own evidence gathering, that we are talking about limited numbers. We need to be clear that, at the moment, there is no provision for such medical treatment and that is what the regulations will introduce. People have been doing a workaround, which is why the issue of STDCs came into play. As Ailsa Garland pointed out, a consequence of putting such people on STDCs is that most will be in Scotland for a longer period.

Alison Johnstone (Lothian) (Green): I have been listening to the discussion with interest, but I am still not entirely clear how the minister will ensure that the person authorised by a responsible medical officer to take someone into custody will have the appropriate experience and qualifications. I am also still not clear why we do not have a prescribed list. Furthermore, I am really concerned that one of our foremost mental health organisations has such reservations about the proposals. It has provided follow-up evidence to the committee in which it says that it remains concerned that the regulations do not include an appeals procedure and that they provide

“no access to a Mental Health Officer for people who will not be familiar with the law”.

I ask the minister to address those issues.

Maureen Watt: Ruth Wilson may want to take the question on someone being available to patients.

09:45

Ruth Wilson: All patients will have the right to an independent advocate. As part of that service, the advocate will ensure that the patient is aware of their rights. The treating clinician will also have a role in ensuring that the patient is aware of what is happening to them and what rights they have.

Alison Johnstone: Do you believe that there should not be a prescribed list? I am trying to understand your point. I cannot understand why you do not agree with what SAMH is asking for.

Ruth Wilson: There is an existing list of prescribed categories of people; we are simply adding a new line to allow an RMO to say who, in the circumstances, would be the best and most qualified person to take a patient into custody.

As Ailsa Garland said, we are equalling up what happens to those who are involved in mental disorder offences and who are likely to abscond during the transfer process with what already happens in civil cases.

Alison Johnstone: Why, therefore, is SAMH concerned about the regulations?

Ailsa Garland: You raise a couple of different issues. The first issue, which we have discussed, is the addition of RMOs to the list of people who are able to authorise people who they think are suitable to take an offender into custody.

SAMH has raised separate concerns. For example, with regard to the Finnish human rights case that we have discussed, SAMH feels that there is a lack of proper process. We are saying that there is a process set out in the regulations that we feel is sufficient. It allows someone to be returned fairly speedily to their home jurisdiction, which would probably be best for them in the circumstances, rather than having them remain in a country that is not their own.

Alison Johnstone: Okay—thank you.

The Convener: Depriving somebody of their liberty is a huge step. For me, the issue is the reference to “any” person. A number of us have a problem with that, and the Government really needs to reflect on it. Do you recognise that that is a problem?

Ailsa Garland: Two different issues are being amalgamated. The RMO issue is simply about adding to the list of people who can take an offender into custody for the purposes of returning them. That relates to absconding offenders in Scotland.

We are extending the existing regime for taking into custody and returning absconding persons to people from other EU member states, and we are allowing for medical treatment, which the 2003 act currently does not provide for.

While I have the floor, I should reiterate that we are using powers in the 2015 act to expand the regulation-making powers so that we can provide specifically for two different categories: first, we are extending the regime to people from the EU who abscond and, secondly, we are applying to all absconding persons the ability to be provided with medical treatment. That was fully debated as part of the bill process, and I submit that we are not doing anything particularly unusual in relation to the new powers that we have, as revised in relation to the 2003 act.

The Convener: The second element that I am concerned about is the fact that, for those who abscond to Scotland, there is no legal right to challenge treatment and no right of appeal. I have a fundamental problem with that.

Maureen Watt: SAMH suggests that the regulations offer the possibility of deprivation of liberty for an unlimited period without appeal. We have no reason to expect that that would be the case. We have made clear from the outset our intention that the absconding regulations should be subject to specific conditions and that any treatment should be given only for a short period of time. We would hope that, in most cases, absconding persons will be returned to their original jurisdiction within a few days. We have consulted on the issue, and there was no clear consensus from respondents on what the relevant time period should be. That takes us back to your question about a short-term detention certificate.

Because there is a range of variables, for example whether the person is well enough to travel and what transport arrangements have been put in place, each case would be different, and there would have to be a clinical decision on what was best for the particular person. That will be supported by guidance to determine the best course of action. That is why we are saying that it would be inappropriate for the regulations to specify a time limit.

Ailsa Garland: To clarify, we are talking about absconding people who are subject to measures equivalent to Scottish detention measures in their home jurisdictions. It is not that we are taking them into custody as an initial measure. They are already subject to measures in their own country, they have come to Scotland and it has been established that they have absconded. They are taken into custody for the purposes of return. So it is not—

The Convener: I think that we get that.

Ailsa Garland: Thank you.

Maureen Watt: I accept that the matter is extremely complicated, especially as most of us were not involved in the passage of the 2015 act. If the committee wishes, we could have an informal briefing to set out the issues in more detail and perhaps to answer more questions.

The Convener: Thank you for the offer. We will consider that.

Maureen Watt: I would prefer to do that and to take the proposals away, rather than see the motion go down. That would not help anybody with the act.

The Convener: Do you want to take the motion away?

Maureen Watt: I have heard what only a very few members feel about the regulations.

The Convener: We are about to move to the debate on the SSI. We can have the discussion, and it is up to you whether you then withdraw the motion.

Maureen Watt: Well, if you want to have the discussion.

The Convener: Thank you. Item 2 is the formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee that members should not put questions to the minister during this formal debate, and officials must not speak in the debate either.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Absconding) (Miscellaneous Amendments) (Scotland) Regulations 2017 [draft] be approved.—[Maureen Watt]

Alex Cole-Hamilton: I am grateful for the clarity that the minister and her officials have sought to bring, yet it has not given me satisfaction that the concerns that have been outlined by fellow committee members and by SAMH in its briefing to us have been met. I do not think that an informal briefing on the technical aspects of the 2015 act would assuage that. I do not think that what is being asked of the Government by way of taking the regulations away and redrafting them is particularly onerous. I do not think that that will jeopardise the thrust or spirit of what the Scottish Government is trying to do.

If anything, what has been suggested will improve the instrument and will offer protection for both staff and patients regarding the observance of human rights, rather than leaving us open to future litigation at a European level.

Clare Haughey: I am speaking about this subject with a background of professional knowledge. I hear the concerns that some of my

fellow committee members have, but I would offer them the reassurance about professional judgment being used in all areas and about the patient being at the centre of all care in mental health. That is how all healthcare professionals practise. The proposals are not as big a change to legislation as people might feel them to be. In practice, the proposals are about expediting patient care and, potentially, providing better safeguards, if people are currently practising outwith the guidance.

Alison Johnstone: I cannot help but think that the regulations could be improved. The committee has raised concerns about the fact that the RMO would be able to authorise anyone to take an absconded person into custody, so clarity around the prescribed list would be helpful. We have also heard concerns about safeguarding people's rights, the fact that no appeals procedure is outlined, the lack of access to a mental health officer and the fact that there is no mention of independent advocacy. Members have also raised concerns about the issuing of short-term detention certificates. I feel that the regulations could be brought back to the committee in an improved form.

Miles Briggs (Lothian) (Con): I want to touch on what Alison Johnstone said. To date, we have worked hard to ensure that all legislation is built using a rights-based approach, but the regulations do not feel right in that regard. The convener raised two points, on challenging treatment and the right to appeal. We would all appreciate it if the SSI was rewritten to take those two points into account.

The Convener: Minister, in reflecting on what the committee has said, do you still wish to pursue the motion?

Maureen Watt: Alex Cole-Hamilton perhaps wants the whole 2015 act to be revisited, but we are not in a position to do that. The subordinate legislation is bringing the act into play. As my officials and I have said, it is absolutely rights-based legislation. Further details will be set out in the code of practice—

The Convener: Minister, we are very short of time, so I really need you to decide whether you want to withdraw your motion or pursue it.

Maureen Watt: I will press the motion.

The Convener: The question is, that motion S5M-05753 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

For

Haughey, Clare (Rutherglen) (SNP)

Todd, Maree (Highlands and Islands) (SNP)

Against

Briggs, Miles (Lothian) (Con)
 Cameron, Donald (Highlands and Islands) (Con)
 Cole-Hamilton, Alex (Edinburgh Western) (LD)
 Findlay, Neil (Lothian) (Lab)
 Johnstone, Alison (Lothian) (Green)
 Smyth, Colin (South Scotland) (Lab)

Abstentions

Arthur, Tom (Renfrewshire South) (SNP)
 Gilruth, Jenny (Mid Fife and Glenrothes) (SNP)
 McKee, Ivan (Glasgow Provan) (SNP)

The Convener: The result of the division is: For 2, Against 6, Abstentions 3.

Motion disagreed to.

The Convener: I suspend the meeting briefly to allow the officials accompanying the minister to change.

09:58

Meeting suspended.

09:59

On resuming—

Mental Health

(Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [Draft]

The Convener: Item 3 is the second instrument that we are looking at today. The minister is now joined by the Scottish Government officials Eleanor Stanley, policy officer in the protection of rights unit in the mental health and protection of rights division; Nicola Paterson, head of the protection of rights unit; and Fraser Gough, parliamentary counsel.

I invite the minister to make a brief opening statement.

Maureen Watt: I am introducing three instruments covering cross-border issues. Two relate to cross-border transfers and the third relates to cross-border visits. The overall aim is to amend the regulations to reflect the changes in the 2015 act and, in the case of the cross-border transfer regulations, to improve their operation.

The 2015 act introduces a requirement that regulations relating to the cross-border transfer of patients detained or otherwise in hospital should make provision for the named person to appeal against a decision to transfer a patient from Scotland. There are also changes in the 2015 act that allow certain persons to act where there is no named person. Those changes are reflected in these regulations, and certain other appeal rights and notification requirements are introduced,

which are based on feedback from stakeholders under public consultation.

The 2015 act also allows for provisions in all three sets of regulations to be extended to patients who are subject to measures in other European Union member states. There is currently no process under the regulations for transferring a patient to Scotland from outwith the United Kingdom. That would include a situation in which somebody from Scotland who is taken unwell and detained under mental health legislation while on holiday in an EU country wants to return home to Scotland. By extending the provisions, we aim to fulfil the intention of the 2015 act in providing parity of treatment under the law for patients who are subject to measures in other EU member states. Similarly, changes to cross-border visits legislation will extend the ability of a patient to undertake an escorted visit—for example, to visit an unwell relative—to patients who are subject to measures in other EU states.

In addition to that, there are adjustments to the process that applies when the Scottish ministers make a decision to grant a warrant to transfer a patient from Scotland, which include introducing a fast-tracked transfer process for cases in which the patient and any named person agree to such a transfer. That change is based on feedback from stakeholders that it would be of benefit to any patient who agrees to a transfer, is eager to transfer quickly and does not intend to appeal the transfer. It will avoid unnecessary delay when the patient is in agreement with the proposed move.

I have set out the most significant changes in the regulations. The bulk of the changes relate to the transfer of patients detained or otherwise in hospital. Corresponding changes have been made, where relevant, to the regulations concerning the transfer of patients who are subject to community measures. The changes across the regulations, in particular the cross-border transfer regulations, will improve the effective operation of those regulations to the benefit of individuals who are transferring.

The Convener: Thank you very much. As there are no questions from members, we will move to item 4, which is the formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee and others that members should not put questions to the minister and that officials may not speak in the debate. I invite the minister to move motion S5M-05951.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Cross-border transfer: patients subject to requirements other than detention) (Scotland) Regulations 2017 [draft] be approved.—[Maureen Watt]

Motion agreed to.

**Mental Health
(Cross-border transfer: patients subject to
detention requirements or otherwise in
hospital) (Scotland) Amendment
Regulations 2017 [Draft]**

The Convener: Item 5 is the third instrument that we are looking at today. I invite the minister to make an opening statement.

Eleanor Stanley (Scottish Government): These regulations were covered in the earlier statement.

The Convener: As there are no questions from members, we will move to item 6, which is the formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee and others that questions should not be put to the minister during the formal debate and that officials must not speak in the debate. I invite the minister to move motion S5M-05950.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Cross-border transfer: patients subject to detention requirements or otherwise in hospital) (Scotland) Amendment Regulations 2017 [draft] be approved.—[Maureen Watt]

Motion agreed to.

**Mental Health (Cross-border Visits)
(Scotland) Amendment Regulations 2017
[Draft]**

The Convener: Item 7 is the fourth instrument that we are looking at today. Did you also cover these regulations in your statement, minister?

Maureen Watt: Yes.

The Convener: As there are no questions from members, we move to item 8, which is the formal debate on the affirmative SSI on which we have just taken evidence. Members should not put questions to the minister and officials must not speak in the debate. I invite the minister to move motion S5M-05752.

Motion moved,

That the Health and Sport Committee recommends that the Mental Health (Cross-border Visits) (Scotland) Amendment Regulations 2017 [draft] be approved.—[Maureen Watt]

Motion agreed to.

The Convener: Thank you very much. I suspend the meeting to allow a changeover of the minister's officials.

10:06

Meeting suspended.

10:06

On resuming—

**Criminal Justice and Licensing (Scotland)
Act 2010 (Consequential Provisions) Order
2017 [Draft]**

The Convener: Agenda item 9 is to consider the fifth instrument that we are looking at today—the draft Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017.

The minister is joined by Scottish Government officials Innes Fyfe, who is the team leader in the mental health and protection of rights division, and Lindsay Anderson, who is a solicitor. I ask the minister to make a brief opening statement.

Maureen Watt: The final instrument that is subject to affirmative procedure that I present today relates to an amendment to the Mental Health (Care and Treatment) (Scotland) Act 2003. The provision will help to clarify that nurses are able to use the power to hold patients for up to three hours to allow an examination to take place, if the patient is in hospital for treatment as part of a community payback order. The Mental Health (Scotland) Act 2015 act will simplify the nurses' holding power in order to support practitioners and to help patients to know their rights in such situations. The power is available in respect of patients who are in hospital by virtue of a probation order with a mental health treatment requirement.

The community payback order was introduced by the Criminal Justice and Licensing (Scotland) Act 2010 and has largely replaced the probation order. The mental health treatment requirement is rarely used by the courts when making community payback orders. However, it was considered helpful to put it beyond doubt that persons who are in hospital for mental health treatment by virtue of a community payback order can be detained in that way.

To be clear, the instrument does not extend the reach of the nurses' holding power provision; it simply clarifies it to reflect that probation orders have been largely replaced by community payback orders.

Alison Johnstone: Community payback orders were the result of legislative change arising from the Criminal Justice and Licensing (Scotland) Act 2010, so why has there been such a delay?

Maureen Watt: The 2015 act's provisions that simplify the nurses' holding power are due to come into force this month. The power is

described as being available in respect of patients who are in hospital by virtue of a probation order with a mental health treatment requirement. As I have said, the community payback order was introduced by the Criminal Justice and Licensing (Scotland) Act 2010 and has largely replaced the probation order. Although the law operates in such a way that the holding power can be interpreted as covering the new community payback orders, it was considered that it would be helpful to state clearly in the legislation that persons who are in hospital for mental health treatment by virtue of a community payback order could also be detained in that way.

Alison Johnstone: What training and training materials will be made available for mental health officers when the regulations come into force?

Innes Fyfe (Scottish Government): The regulations represent improvements that support practitioners. There are no wholesale changes, such as might have been seen with the introduction of the 2003 act. Officials have been working with the Scottish Association of Social Workers and Social Work Scotland on implementation of the 2015 act, including through the instruments that we have been debating, and they have been providing content and information to support updates to local training, which is the best environment in which to introduce the changes to practitioners.

Alison Johnstone: Thank you.

The Convener: There are no other questions, so we move on to agenda item 10, which is a formal debate on the affirmative SSI on which we have just taken evidence. I remind the committee and others that members should not put questions to the minister during formal debates and that officials may not speak in the debate. I invite the minister to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Criminal Justice and Licensing (Scotland) Act 2010 (Consequential Provisions) Order 2017 [draft] be approved.—[Maureen Watt]

The Convener: If no members wish to contribute, the question is that motion S5M-05949 be agreed. Are we agreed?

Motion agreed to.

Mental Health Tribunal for Scotland (Practice and Procedure) (No 2) Amendment Rules (SSI 2017/172)

Mental Health (Conflict of Interest) (Scotland) Regulations 2017 (SSI 2017/174)

Mental Health (Patient Representation) (Prescribed Persons) (Scotland) Regulations 2017 (SSI 2017/175)

Mental Health (Certificates for Medical Treatment) (Scotland) Regulations 2017 (SSI 2017/176)

The Convener: Item 11 is also subordinate legislation. We have four instruments that are subject to negative procedure to consider. Does the minister have any comments to make on the instruments?

Maureen Watt: No.

The Convener: Do members have any comments?

Members: No.

The Convener: The Delegated Powers and Law Reform Committee has not yet considered the instruments. The Health and Sport Committee will therefore consider them again at our next meeting following that committee's report on the instruments.

I thank the minister for her attendance this morning. I suspend the meeting to allow for a change of panel.

10:12

Meeting suspended.

10:15

On resuming—

Integration Authorities’ Engagement with Stakeholders and Draft Budget 2017-18

The Convener: Agenda item 12 is an evidence-taking session with the Cabinet Secretary for Health and Sport on integration authorities’ engagement with stakeholders and the draft budget 2017-18. I welcome to the meeting the Cabinet Secretary for Health and Sport, Shona Robison, and I welcome from the Scottish Government, Geoff Huggins, who is director of health and social care integration, and Christine McLaughlin, who is director of health finance.

I invite the cabinet secretary to make an opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): I thank the convener for the invitation to speak to the committee today.

I welcome the committee’s interest in the integration of health and social care and this opportunity to discuss in more detail integration authorities’ engagement with stakeholders and the budget-setting process. That process is important, not least because integration authorities now manage more than £8 billion of resources that used to be managed separately by national health service boards and local authorities. It is a big amount of money, but it is also a limited amount, and we recognise that it needs to be used more effectively and efficiently. By that, I mean that we need to shift resources towards more preventative activity, reduce reliance on reactive hospital-based care and provide the right care at the right time and in the right place, which will, I hope, be in the patient’s home as often as possible.

That said, integration should not be seen as being just about budgets; it is also about improving outcomes for people. That is why I want to focus in particular on stakeholder engagement. It was at the heart of our legislation on integrating health and social care, the aim of which was to put service users at the centre of things along with service providers to ensure that their voices are heard and that they are fully involved in decision making and in planning.

We should recognise that integration is still at a very early stage and is still evolving. We have seen a lot of progress in ensuring proper engagement of key stakeholders instead of their having tokenistic involvement, although we acknowledge that we still have some way to go. I think that that has been acknowledged in earlier

evidence-taking sessions. For example, the Coalition of Carers in Scotland noted that it had

“seen a lot of improvements and best practice development”—[*Official Report, Health and Sport Committee*, 25 April 2017; c 3.]

and, in the same meeting, Voluntary Action South Lanarkshire highlighted its involvement in strategic commissioning.

The strategic planning group in each integration authority, along with locality planning arrangements, is where engagement is particularly important, because those who know best how services should be delivered are those who receive the services and those who provide them. Their empirical evidence must be supported by data that must be readily available and accessible to stakeholders. We are working with NHS National Services Scotland on further developing a link to the health and social care data set known as “NSS source”, which I understand my officials have demonstrated to the committee and which will be key in informing future decision making.

Clearly, open sharing of data will require trust between and across sectors, and we are already seeing where that approach can work—for example, in the improvements to home care in NHS Highland, where the local Scottish Care representative co-chairs the strategic planning group.

I am happy to take questions.

The Convener: Thank you very much.

Alison Johnstone: Thank you for joining us this morning, cabinet secretary. I very much appreciate the tone of your opening statement, because it is clear that there is still work to be done on stakeholder engagement. For example, Amy Dalrymple of Alzheimer Scotland told us that she attended a meeting of an umbrella group of organisations and spoke to a chief officer of a health and social care partnership, and said that when she suggested the important contribution that third sector organisations could make

“The response that I got was that it would be very welcome if we were to help to communicate why certain decisions had been made”—[*Official Report, Health and Sport Committee*, 25 April 2017; c 25.]

instead of their being involved in the decision-making process. Andrew Strong of the Health and Social Care Alliance Scotland said:

“At the IJB governance level, the relationship between the statutory sector and the third sector, the independent sector and people who use supporting services is inherently unequal,”

and went on to mention

“the nature of voting rights and the number of people on the boards.”—[*Official Report, Health and Sport Committee*, 25 April 2017; c 21.]

Is local co-production achievable if, as organisations such as the Health and Social Care Alliance are suggesting, the relationship is “inherently unequal”?

Shona Robison: As I said in my opening statement, there are examples of good practice; Alison Johnstone has highlighted examples of not-so-good practice. We are still at a fairly early stage in the life of the integration authorities and we are seeing good practice across a number of fronts in many integration authorities, but it is fair to say that others still have some way to go on that journey—certainly in terms of the level of engagement.

Good practice has put stakeholders at the centre of planning and decision making. Stakeholder engagement should certainly never be seen as just a method of communicating decisions that have been made by others. That is not in the spirit of what was intended. I would be the first to acknowledge that the situation is still work in progress.

The Health and Social Care Alliance is an important partner in working to build the capacity of communities and third sector organisations on the integration agenda. When Parliament passed the legislation on integration, it considered carefully some of the structural issues. For example, there was a long debate about the voting rights of individual board members. The conclusion was that it was proper for voting rights on use of such significant public budgets to be held only by board members who are publicly accountable—in other words, elected council members and non-executive members of health boards.

That is important, but it should not mean that the role of stakeholders is limited to acting as a communication channel for decisions that have been made by others. That is not the intention or the spirit of the legislation. As the legislation lays out in considerable detail, it is extremely important that integration joint boards engage fully with stakeholders and partners. That was made very clear. It is also important that third sector partners, which can be a disparate range of organisations, organise themselves effectively to engage in the process. A lot of work has been done, a lot of support has been provided and a lot of resources have been put in to ensure that that is the case.

In summary, it is work in progress, but there are some really good examples of good practice. We want to roll out that good practice to help to address some of the less-than-good practice.

Alison Johnstone: Claire Cairns of the Coalition of Carers in Scotland said that there are other barriers to being fully involved in the

process, some of which are to do with cash, transport and access to meetings. She said:

“we hope that carers would get all their transport and replacement care costs reimbursed, but that is not always the case. Some carers use their own direct payments when they attend meetings, and that reduces the short breaks that they get for themselves”.—[*Official Report, Health and Sport Committee*, 25 April 2017; c 3-4.]

Those are other issues that are preventing people from being fully involved. Where should resources and support come from to enable stakeholders to participate fully in local service planning?

Shona Robison: Funding is available for third sector interfaces, as we call them—I think that about £8 million has been provided to the end of March 2018.

We expect the integration authorities to ensure that those who participate in the process can do so without detriment, and I would be concerned if that were not the case. We would certainly want to pick that up with the Coalition of Carers, because people are giving of their time and, if they have responsibilities that make it more difficult for them to do that, they should not be disadvantaged.

Geoff Huggins might want to add to that.

Geoff Huggins (Scottish Government): We can certainly pick that up with the chief officers. We can work to understand how they are engaging with people in a meaningful way and can act on that basis.

As the cabinet secretary said, more than £8 million is available for third sector interfaces to March next year, and a further £4 million is available to September. Beyond that, we will need to look at how we take that forward.

Can I say something on the first question?

The Convener: I am sorry—what are the £8 million and the £4 million for?

Geoff Huggins: Those moneys are to support third sector interface organisations to provide local support to the third and voluntary sectors to engage with integration.

The Convener: Thank you.

Geoff Huggins: A number of those who commented on engagement were national organisations. We have seen the challenges that national organisations with a Scotland-wide remit face in engaging with 31 integration authorities, given what that means in practice. Each chief officer has had multiple applications from many of the organisations to spend time on engagement.

In commissioning local services with local providers, whether those are voluntary or independent, chief officers have to put themselves in a different place by forming strategic

partnerships and engaging in different ways to deliver on policies such as the living wage commitment, as we have seen in our work on that area. The experience may be variable, as you say. In particular, the experience of local third and voluntary sector organisations might be different from that of the nationals but, again, that is just part of working through integration.

A key component of integration is the localisation of the agenda—the idea of building services in communities rather than simply building a national idea of what a service is and then rolling it out. The needs of different communities and individuals are very different. It might be helpful to get under the skin of the local experience a bit more, because those experiences will not always be the same as the national experience of an organisation such as Alzheimer Scotland, which is well connected, or the Health and Social Care Alliance Scotland.

Tom Arthur (Renfrewshire South) (SNP): I have a quick supplementary question. Cabinet secretary, you referred to integration authorities evolving, which I think we all recognise they are. We took evidence some time ago in which it was noted that the lead agency model in the Highlands took five years to bear fruit. How long do you expect the move to genuine co-production to take?

Shona Robison: We want it to happen as quickly as possible. In reality, some integration authorities are already co-producing in the true sense—we have seen a lot of evidence of good practice, some of which has been shared with the committee—while others are still on a journey and will take longer to get there.

Our role and the role of the ministerial strategic group that oversees integration is to share best practice and to push the agenda. We can do that in several ways, including through the provision of guidance and resources, data sharing and extolling the benefits of co-production, but inevitably not all partnerships will move at the same speed towards achieving that aim. The short answer is that it will be done as soon as possible.

Geoff Huggins may want to come in on that.

Geoff Huggins: The other issue is that different challenges require different solutions. For example, I looked at Glasgow's plan for this year. It is considering the implementation of an assess-to-admit service for Glasgow hospitals whereby people will be assessed at the point at which they present, which will probably not involve co-production other than with staff.

At the same time, however, in some of the work that we are seeing on the ground to tackle isolation and loneliness and to improve people's access to a wide range of services including leisure and recreation services, a different type of

conversation is taking place about how people live their lives. We need to think about that when we apply the idea of co-production rather than see it as the solution to everything. Chief officers—slightly more of them across the rural landscape—are trying to tap into the assets and capabilities in communities and are thinking about how they can use those to support people instead of simply looking at another statutory or independently delivered service. They are thinking differently about how to meet people's needs, and we are seeing a mix of things out there.

The Convener: I have a question on timescales. Time is a flexible phenomenon these days. A generation used to be a long time, but that is no longer the case.

You said that the new authorities are still at a very early stage of development. However, we have had two years and then a year of shadowing. What timeframe do you think we need to get all the different integrated authorities up to speed in developing alongside stakeholders?

10:30

Shona Robison: A lot has been achieved in a relatively short space of time, as a new organisation has brought together two large organisations and different cultures. Think about what has been achieved on, for example, the big issue of delayed discharge. About a third of partnerships have got delayed discharges into single figures, which is an enormous achievement in a fairly short space of time. That is a hard data measurement. Reports will come out in the autumn that will show progress across a number of the key outcomes, of which that is one. The reduction of the number of unscheduled hospital admissions is another.

Other things might not be hard data outcomes as such, but we would want to see them captured in the reports—for example, the progress that has been made on things such as the level of co-production and the meaningful involvement of stakeholders in shared decision making.

The issue is how we measure success. The hard data measurement of success will be measurement against the outcomes. However, although a range of other things about the culture and the way in which integration authorities go about their business are not as hard edged, they are just as important. I understand that we expect some of those things to be captured in the reports that will come out in the autumn—is that right, Geoff?

Geoff Huggins: Yes, we expect to see that.

When I have been out talking to chief officers and senior managers, it has been interesting to

see how they are thinking about the community and primary and social care landscapes. I have had conversations with a couple of chief officers about their thinking on how a range of different services that are provided by different professionals operate across the landscape.

When I was out a few weeks ago, I asked a chief officer who had previously done the job that they were doing to co-ordinate the landscape. The answer was that nobody had done it, as a social work department managed the social work component, a primary care commissioner managed primary care and a community health commissioner managed the community health aspect. In effect, they were operating down lines in the provision of services. The change is not particularly visible, but we should see the fruits of it as time goes on.

The idea that the chief officers and senior managers are thinking across the landscape about how the different services interact and that they can bring together teams that operate differently because they are no longer subject to the single silo way of seeing things is quite exciting and interesting, but it is not visible unless you get under the skin and talk to people about how different things are. That different way of thinking about things might be covered in a line in a report, but it is of fundamental importance.

The Convener: There are undoubtedly huge financial pressures on the new authorities. Given those financial pressures, it is clear that, when they make decisions about services, there will be significant service change. How do you envisage public consultation and public engagement happening during that period? Is it fair that those organisations are starting their journey with such financial pressures on them? They will bear the brunt of any kickback from the community, although they largely cannot do anything about the budget that they have been handed.

Shona Robison: The total budget under the control of integration authorities covering social care, primary care and unscheduled hospital care is £8.29 billion, and health boards are required to maintain funding at 2016-17 levels. There is also the additional £107 million funding for social care. The global budget is not insignificant—it is a big resource—but the important thing is how it is spent.

On shifting the balance of care, we have been clear with integration authorities—as they have been in their own discussions—about how to make the best use of the collective resources so as to keep people out of hospital by building up community health services with a change in how our services are delivered. For the first time, real inroads are being made into developing services whereby people can avoid ending up in hospital

for unscheduled care, which is a very positive development.

The integration authorities are starting life with a significant resource, although I would be the first to acknowledge that, in the financial climate that we all live in, the issue is to ensure that every part of the public sector makes the best use of resources. The aim is a more efficient and effective way of spending resources to keep people out of hospital when they do not need to be there, and we have the best chance of achieving that aim through the new world of integration.

Not everything will be in the domain of major service change. Some changes are about doing things in a different way, developing the community services that are demonstrated to work and have an evidence base to show that they work and prevent people from ending up in hospital. As I say, that is not necessarily in the domain of a major service change.

Where there is major service change, the processes for that are well laid out, and we would expect the public to be fully engaged with that change. We would also expect the public to be fully engaged with some of the new developments. For example, some of the services that are working to keep people out of hospital have come about through the engagement of local communities and the people who receive the services, and we know that they work very efficiently.

One such service is ELSIE—the East Lothian service for integrated care for the elderly. It has been very effective at triage, with people avoiding going anywhere near an acute hospital because of the services that are provided in their home. There has been a lot of public engagement in the testing of those services to ensure that they meet people's needs and are effective, safe and of good quality.

The Convener: The committee's problem lies in identifying whether there has been a shift in the balance of care and whether the actions that are being taken are efficient. It is proving difficult for us to find evidence on that. We have heard about it time and again from different authorities that tell us anecdotally what they are doing, but it is extremely difficult to get them to put figures on things.

Shona Robison: I accept that that is difficult and that it is difficult to achieve such a shift. We have been talking about it for many years and, as I said, our best chance of achieving it is through the integration authorities. We have set ourselves ambitious targets for the percentage of spend on community services, which means that the growth in spend will be greater in community health services than in acute services.

There are annual performance reports, and it has been agreed that data will be released to show the shift in spend so that that will be more visible. The resources that the Scottish Government has allocated are going in a direction of travel that will help with the momentum of that, as money is going into primary care, social care and mental health at a higher rate and a faster pace than it is going into acute services.

Christine McLaughlin (Scottish Government): I acknowledge that, as the convener said, it has been difficult to get the evidence to show the shift through clear, straightforward reporting. We are doing a lot of work with the NHS and the integration authorities to work out how we can start to see the shifts coming through—and not just in funding and the direction of funding. The feedback is that there is now more clarity about the direction that the cabinet secretary mentioned, and we need to see that flow through in expenditure.

From 2017-18 onwards, we will examine closely spend in the acute sector, in primary care and in community care. That will involve looking at areas such as prescribing so that we can understand the situation when we start to see the shift and can assess whether it is happening at the level that we would expect it to happen on an annual basis.

I agree that much of the current evidence involves what people say is happening, but I expect to have more clarity from 2017-18.

The Convener: Much of that is assertion.

Christine McLaughlin: It is asserted through funding, if I can put it that way.

The Convener: It is an assertion that the shift is happening, and it is an assertion that it will make things better and more efficient. We do not have evidence that the shift is actually happening.

Christine McLaughlin: We have some evidence. If I can clarify—

The Convener: Just a moment. Probably all of us around this table—in fact, probably all of us in this Parliament—think that shifting the balance of care is the right way to go. The problem is that we do not have evidence to show that it is working.

Christine McLaughlin: We have set up a couple of things to enable us to make it work. Doing things such as giving direction on maintaining spend is more than just making an assertion. Maintaining spend on health and social care integration means that we expect it to flow through in the financial year. How that needs to be managed to deliver the shift in the balance of care means that some shifts will be required in the current year. It is more than assertion: that is happening. Money is being put into primary care and investment is being made in new models, and

that money will be spent in those areas—it will not be spent in the acute sector.

There are sufficient building blocks to enable the shift to take place. Through 2017-18, we will see the extent of expenditure in those areas and the exact value of it. That is not just an assertion. There has been enough of a shift in the direction of funding, and that is what I am trying to distinguish.

The Convener: The money can be shifted, but we do not know whether it is being used more effectively.

Shona Robison: We have set the ambition that, by 2021-22, we expect more than 50 per cent of front-line spending to be on community health services. You are right, however, in saying that budgets can be set—we see the budgets that are being set this year moving in that direction—but we need to track the actual spend. That is the bit that needs to follow, and we are acutely aware of that.

Donald Cameron (Highlands and Islands) (Con): I return to the vexed issue of care home closures and public engagement. I know that Mr Huggins will be aware of several closures in Argyll and Bute, where feelings ran so high that a petition on the closures came first to the Public Petitions Committee and then this committee. We are all well aware of the issues: often there is a sense that decisions are predetermined, that consultation is superficial and that information is lacking.

To be fair to the IJB, I think that it will take lessons on board, but there remains a gap between the buzz words of “locality planning” and “co-production” and what is actually happening on the ground, where the fact is that there just is not the public support that we all want for the changes, if they are right, correct and need to be made.

A witness who gave evidence to this committee spoke about a real culture change. My fear is that although of course integration will take time, things are moving very slowly. How do we achieve the culture change that must happen?

Shona Robison: I will answer this with Geoff Huggins, who has been far closer to the issue than I have and has spent a fair bit of time in Argyll and Bute meeting those who have been directly involved.

Even if an integration authority believes that what it is putting forward is the right thing, it is important that that is explained properly and that time is taken to go out and properly consult, not just say, “This is what we’re doing. Take it or leave it.” More important than that is that time must be taken to demonstrate what the new replacement

services actually are. To be honest, health boards have not always been as good at doing that as they could be, so integration authorities need to look at best practice for demonstrating what new services will look and feel like for those who receive them.

It is right that the integration authority has taken more time to look at the proposals. Clearly, there are difficulties with service provision in the care home sector in that area.

Geoff, do you want to say a little bit about your involvement?

10:45

Geoff Huggins: We are talking particularly about some of the services in Campbeltown, are we not?

Donald Cameron: And Dunoon.

Geoff Huggins: Campbeltown is particularly interesting. What we have there is a care home that is significantly underoccupied. When I was last here talking about it, something like 12 or 13 of its 30 places were occupied. There were significant issues with the home's ability to have appropriate staff in place because of issues with recruiting in the area and the poor ratings that the home had received previously.

In other circumstances, the care home operators would probably have simply given notice to quit and indicated that they intended to close the home, which would have passed the problem to the integration authority, which would have had to find housing in the area for the 12 or 13 people in the home. That was clearly undesirable for all parties, because it would have required the people, who were from Campbeltown, to be moved away to receive care elsewhere. The integration authority in that space stepped in to have a conversation about how it could find a solution that better met the needs of the people in Campbeltown.

That is the point at which things became difficult. The solution that was initially seen as desirable was to find 17 more people to go into residential care in Campbeltown and occupy the home, making it value for money. Now, in the same way that we have a desire to shift the balance from hospital to community, we have a desire to shift the balance from residential care to care at home. In that context, the idea that we would simply increase the amount of residential care that is being offered in an area was not particularly desirable.

We have worked through the process with the partnership, but some of the public expectations were not in the same space as the expectations from the Parliament of more community care. In

that case, there was an expectation of more residential care, and that had to be worked through.

We have identified a solution. With the assistance of the council, the council leader and the local member of the Scottish Parliament, the partnership worked through the process to identify how to resolve the issues in Campbeltown and find an appropriate solution that meets the needs of people who live there while not requiring people to transfer externally.

The change that we had was that, rather than simply having a notice to quit, there was a process that resolved the situation. There was some trickiness, in that people had different views, but that is part of the process. I do not think that effective and constructive engagement will mean that every time that something happens, people will say, "That is great. We're doing it." There will continue to be a need to work through different views. We have to be careful not to say that working through different views and perspectives means that engagement is not working. In the end, engagement has worked in Campbeltown.

Donald Cameron: To be fair, a temporary resolution was achieved over the course of a year.

I was actually more interested in a slightly higher level. This demonstrates to me that engagement with communities has to be meaningful, and I do not think that it has been in these cases. What happens is that the public hear that their local care home is closing and there is a media campaign and so on. That does not work for anyone, to be frank. I am interested to hear about the lessons that can be learnt from such experiences and how we effect the culture change that we all accept requires to take place.

Shona Robison: The main thing would probably be earlier engagement. Sometimes things happen. Sometimes a care home, or whatever, will find itself in difficulty and that can have a range of knock-on effects and triggers.

It is about trying to have early engagement when there is a foreseeable problem, and to do it in a way that is not about dealing with a crisis. The process that we have just been talking about took time, but it was important to take that time to reach a better solution.

Whether it be the private, public or voluntary sector, it is important to have early discussion about potential issues and problems in a way that is not about responding to a crisis.

Geoff Huggins: The other thing that came out of the experience was a move away from seeing the change process as being about individual components of the overall service. The more general conversation that we have been having

with Argyll and Bute is about thinking about how services are applied across geographies. When we are talking about a unit or particular component of the service, the community and the public do not get the full picture of how a range of changes will effectively provide a better, more cost-effective, sustainable or deliverable service over time.

Part of the learning that we have taken from Argyll and Bute was about the context—for example, the home that we are talking about was one of two homes in the area. Some of the issues also related to how more people might be employed to work in the care-at-home sector rather than in the residential sector, and also about the quality and nature of training and upskilling in the area. A series of things took the solution from being simply about the one particular property to being about the wider environment. We are using that learning elsewhere.

Another issue was the importance of earlier engagement with elected members, including MSPs, because, to be fair, they are the ones who will tend to have the impetus to campaign to retain something. That appears to be something that is common across the piece, and there is a challenge around making the case against such campaigns in that situation.

Donald Cameron: With regard to changes in medical or clinical care, should medical professionals have a greater role in stakeholder engagement? Would that be helpful?

Shona Robison: I think clinical voices are really important in explaining why decisions are made on, for example, patient safety grounds. The best voices to explain that are the clinical voices. When service changes are proposed, clinical voices—not just medical voices but the voices of everyone who will be delivering the services across the piece—are an important component of that because they can explain how services will be delivered in a different and, in many cases, better way. For example, if a service is to be delivered in the community through primary care or community health services that had previously been delivered in a different way, it is important that the public are assured about the quality of that service, and those who will be delivering the service are often the most powerful voices in terms of explaining what that will look and feel like. We do not always use those voices as well as we could. It is important that those voices are heard, along with others.

The Convener: This is where I think that some of the problems arise with regard to the realistic medicine agenda, because I think that some people in the community might be willing to put up with a lesser service that is local, rather than a centralised service that is better in the eyes of

clinicians. From the point of view of patients and the public, that approach is also realistic medicine. That is part of the dilemma of the agenda that is being put forward.

Shona Robison: Those tensions are inevitable. I argue strongly that, often, the services that are being developed will be of better quality, and that that should always be the driving force. Again, it depends on the kind of service that we are talking about. If we are talking about a procedure that someone receives once or twice in a lifetime, the arguments are different from those about a procedure that somebody needs on a weekly basis—you can see the difficulties involved in someone having to travel further, for example.

What the realistic medicine approach says, alongside the national clinical strategy, is that we have the opportunity to deliver a lot of services more locally if we get the approach right, with a lot of services being delivered within primary care and community health services in a way that avoids people having to travel to the hospital. For example, a lot of diabetic care that people previously had to travel to hospital to receive is now delivered within the local community health services. There is a two-way process, but we have to explain the rationale and what the service will look like far better than we do at the moment.

The Convener: We have a number of questions on budget issues, so we will move on to that. Colin Smyth will ask the first one.

Colin Smyth: Local authorities set a balanced budget by a certain date and identify specifically where savings will come from for the year ahead. Obviously, a large part of what previously went into council budgets now goes into the budgets of IJBs.

A number of IJBs have still not set a budget for the year ahead, and a number have set budgets with savings targets but no detail on how they will meet those targets. Is that satisfactory? Why are IJBs having difficulty in identifying their savings if they are simply efficiency savings?

Shona Robison: I reiterate that we are talking about a total of £8.2 billion of resources being at the disposal of the integration authorities. Sometimes it is important to focus on the pot of money that is to be spent rather than just on the efficiency savings that require to be made.

I will make a couple of points about the budget-setting process. First, it is a lot better, as a lot of progress has been made on last year in terms of timeframes and the number of budgets that have been successfully set. Some issues remain. For example, for the six partnerships in the NHS Greater Glasgow and Clyde area, there remains a legacy issue—of, I think, £7.8 million of non-recurring funding—to be resolved from 2016-17.

To put that in some context, I note that those authorities have about £2 billion to spend between them, so they are looking at £7.8 million out of £2 billion. The issue remains, but it is being resolved. There are positive discussions and I am confident that, with support from the Scottish Government, the authorities will deliver a resolution very soon.

The only other one is the Fife partnership, where there are issues around the set-aside budget. Again, those are being worked through and I am confident that they will be resolved. That is a significant improvement from 2016-17, when 11 of the 31 IJBs had agreed a budget by the end of April. We are now in a position in which they have all done that, bar the seven that I mentioned, and those seven are working through the issues that they have to work through.

The public sector as a whole, including local authorities and health boards, is used to delivering efficiency savings and has done so for many years. We are asking the integration authorities to deliver 3.5 per cent efficiency savings. Again, I note that we expect them to use the opportunity to reform and deliver service changes in terms of both shifting the balance of care and how they prioritise and resource services to shift that balance, keeping people out of hospital and reducing unscheduled care admissions to hospital. We are confident that the plans that the integration authorities are developing will deliver that direction of travel.

Colin Smyth: Cabinet secretary, you made no reference to those IJBs that have set budgets that include savings targets, but have no detail whatsoever as to how they will meet even part of those targets. They simply have figures in their budgets. Why are those IJBs, having set a budget, unable to identify savings, if they are simply efficiency savings?

Shona Robison: Some of the savings that the integration authorities will deliver will be in-year savings, and they will work through those as they progress. Christine McLaughlin is closer to the finance officers who are working through those budgets, so she can say something about that, but we are confident that the integration authorities will deliver those savings, some of which will be in-year savings.

Christine McLaughlin: One factor is that the NHS does not treat the years as being entirely stand-alone. It is a rolling programme of savings. If we look at the history, even over the past three or four years, we see that there is always a component of one-off savings as well as the efficiency savings that Colin Smyth mentioned, which arise when people make changes to a service, and which they will have on a recurring basis. Typically, that has run at anything from a quarter to a third of the total savings.

The situation is not new and, if we look at the history, we see that health boards have been able to achieve those savings in-year. However, it is in the nature of the way in which services and budgets are defined that there can be swings, with in-year pressures in some areas and other areas where the actual expenditure improves on the budgets that were set, given that the budgets are targets that people set at the beginning of the year.

It is important to see it in that context. I do not think that any integration authority is in the position of having no plans to back up the savings that they have identified. However, it is not uncommon for savings not to be completely and fully identified at the beginning of the year. Of itself, that is not an indicator that there will not be balance, but it does mean that more in-year work will be needed to identify the savings. We focus our efforts on understanding the extent to which there is a level of risk with those unidentified savings. We also work hard on looking at where national or regional actions can be taken, beyond the boundaries of an individual integration authority, NHS board or local authority.

11:00

Colin Smyth: Can we look at the process that IJBs follow when budgets are set? The theory behind the budget setting process is that IJBs agree a strategic plan, identify what resources are required to meet that plan and align resources to outcomes. However, what happens in practice is that local authorities and health boards decide how much they will give to the IJB and then the IJB decides what it is going to spend that money on. Is that a satisfactory process? How would you improve it?

Shona Robison: The process has improved over the past year. A lot of work has been done through providing guidance on the issues that were raised concerning the budget setting process last year, and Christine McLaughlin has worked very closely with finance officers to get the budget setting process more into the former than the latter approach.

Christine McLaughlin: There is definitely evidence that integration authorities are more engaged with the NHS boards and local authorities through their chief officers and chief finance officers as part of the budget setting process. Because we set a clear direction at the beginning of this financial year about the need to maintain spend, that took away a lot of the negotiation that there was in the first year. It was one of the most positively received steps in the development of the 2017-18 budget, because it removed the negotiation about taking off an efficiency saving before handing over a budget to

the integration authority. We said very clearly that we expected the minimum spend to be the same in cash terms as it was in 2016-17, and my view is that that took away a lot of what we saw in that first year.

Geoff Huggins: The other thing that we are seeing is the interdependencies between integration authorities and the residual NHS services. The expectation in 2017-18 is a reduction in unscheduled care; that is clearly signalled in the delivery plan. However, we do not want the integration authority to take decisions without proper and full discussion with the residual health board. We cannot simply say to the chief executive of NHS Lothian, "By the way, we are going to give you 20 per cent less this year. Can you just get on and sort that out? We are not going to tell you how to manage your demand." They have to work through the complexities of their interdependencies, because the decisions that are made by the integration authority have implications for the NHS board in respect of other services that are provided within a hospital. Also, they need to have confidence that, if there is an intention to reduce attendances or admissions, it can be sustained across the year. Resolving all those issues before the start of the financial year is probably beyond either boards or integration authorities; it requires a continuing conversation through the year. It is important to see it in that way.

We are still working through the process of moving beyond seeing resources as continuing to be earmarked on the basis of their historical source or what they were previously allocated for. We had a conversation the last time that we came to the committee about the expectations from different interests—for example, that money that used to be spent on pharmacy will continue to be spent on pharmacy. As part of the process of change we are seeing conversations that go beyond simply finding an efficiency, which is doing something faster or cheaper, to deciding what we might do less of or where failure demand can be taken out of the system. We are also seeing different styles of solution going into the process.

Where we are this year in respect of efficiencies is not that different from where we were last year—

Colin Smyth: It is a problem.

Geoff Huggins: —but the consequence was that, during last year, the efficiencies were delivered. We reached the end of the year in the financial state in the integration landscape that we had wanted to reach. That shows that, rather than artificially pretending that all the issues can be resolved before the financial year starts, resolving some of the issues and continuing to work through the others has been an effective methodology.

Colin Smyth: I think that it is fair to say that a lot of the savings, which were made very late in the day, are non-recurring savings.

I want to return to my initial point. In what way do you see improvements being made? For example, an issue that was raised was that it was okay to put in a figure for savings without identifying when those will be made, because the budget is decided annually. Why do we not allow IJBs and local authorities to have three-year budgets? The Government sets a three-year budget, so it has certainty and it can set out the budget over a longer period. Why are we not moving in that direction?

How else do you see the budget process improving? You talk about giving IJBs more certainty by defining by how much local authorities can cut the budget allocation to them and where the £107 million, for example, goes to. Does that mean that you see more central direction being given to IJBs on how they set their budgets?

Shona Robison: On three-year budget setting, we will continue to have discussions about how we can give longer-term certainty. To be blunt, there have been challenges because of the whole Scottish budget setting process. The allocation from the United Kingdom Government was late, which had knock-on consequences for the Scottish Government's budget setting timeframe. That had a knock-on effect on those who receive resources.

Your point about looking to a longer-term timeframe is not unreasonable. That is something that we would want to do; it is an issue that we continue to discuss with partners.

Christine McLaughlin: We are moving to a longer time period. Part of the guidance is about moving to a rolling three-year cycle with integration authorities, which is not dissimilar to the situation in the NHS. It is similar with local authorities, too—they set a rolling budget for a longer period, although it is always the first year that is their real target budget, with the expectation that years 2 and 3 would be refined as they go. That is the direction in which we are headed. Part of the balance concerns the extent to which the Scottish Government can make clear assumptions about the high-level funding that is available. The way that we do that with the NHS is that we agree on a reasonable set of assumptions, to which it works.

It is not unreasonable to have a three-year rolling budget for integration authorities, but we all need to recognise that there will be changes to years 2 and 3 as the budget process moves forward. The more we see of that approach, the better it will be for everyone.

We have good working relationships with the integration authorities, and not just with the chief finance officers; we take feedback from them. It is in our gift to give more or less direction, when it is helpful to do so. I would like to hear back from the integration authorities about what they consider to be obstacles to good, longer-term planning and on the areas in which there could be improvements. We will take on board those views as we develop the budget for 2018-19.

Nothing really significant has been raised with me, other than the extent to which we can give greater certainty about funding from the Scottish Government. We will continue to work with integration authorities on the basis of reasonable assumptions as we go through that process.

The Convener: This will be your final point, Colin.

Colin Smyth: The cabinet secretary will not be surprised that it is on the issue of the living wage. Are we yet in a position in which people who carry out sleepover shifts are being paid the real living wage, or are IJBs and local authorities simply adhering to Her Majesty's Revenue and Customs guidance on the national living wage?

Shona Robison: We have given a commitment that, during this financial year, sleepover rates will be paid at the real living wage level, but work is on-going—as I am sure that you are aware—on some of the related complexities with service providers. Some of the service providers have made the point that we need to take time to enable them to make what are, in some circumstances, fundamental changes to how services are delivered. They were concerned about services potentially falling over if that time was not taken.

That is why, along with the Convention of Scottish Local Authorities and the service providers, we have taken a cautious, planned and careful approach to delivering the living wage for sleepovers, which will be delivered during 2017-18; we want to ensure not only that the move does not impact on service providers but, more important, that it does not impact on the service users who rely on the services.

Do you want to add anything, Geoff?

Geoff Huggins: Yes. The work that we have done on the living wage and on sleepovers has revealed a lot that we had perhaps not been aware of about the structure of the system and the differentials in different areas of the country. For a start, we had not been entirely aware of the number of people who were subject to sleepovers or the structure of their care packages. As a result, some of our work with partners, chief officers and others has been on whether in some places the service models are actually the best that can be used, whether sleepovers are being used

inappropriately or whether they can be used to deliver a better quality of service. We have therefore put in place a change programme that is looking at appropriate service models and the use of technology, and which is seeking to ensure that those for whom sleepovers are the most appropriate approach get a quality service in that respect.

As we have worked through the implications of paying the £8.45 rate for sleepovers, certain questions have arisen. For example, we think that it might be more difficult to recruit people to do work during waking hours if we are prepared to pay people £8.45 an hour to be available for sleepovers. That could lead to recruitment issues. Again, we are working through with providers our understanding of those challenges, but the problem is that, each time we think that we have resolved an issue, some other challenge develops.

Nevertheless, we will continue to do the work. We have said that we will come back with outcomes later in the year. We will look for a result that meets the commitment in question and the needs of provider organisations and people, but which works within the integrated landscape and the wider social care reform process.

Shona Robison: We have put resources aside for this, and we have left the door open for additional resources to be provided if the current resources are shown not to be adequate in meeting the commitment that has been made. Those discussions are on-going.

Colin Smyth: I presume that, if we are being realistic, the £10 million that has been allocated will not be sufficient to pay the real living wage.

Shona Robison: That work is on-going, but we have said that if it is not sufficient, more resources will be made available. Part of the work that Geoff Huggins has described has focused on the financial costings. The £10 million was a starting point based on certain assumptions, but as Geoff has said, the complexity that has arisen as more work has been carried out on the issue will guide us as to whether those assumptions were or were not accurate. However, the door has been left open for additional resources to be provided, should they be required.

Geoff Huggins: I think that that was part of the reason for the structure of the arrangement for 2017-18. When we tried to unpick the data to identify the marginal cost, things became quite complex not just because of some of the initial work that had gone into meeting HMRC requirements, but because of different expectations with regard to the structure of the service and our ability simply to cost and evaluate the difference between what had almost been single-payment packages of perhaps £35 to £40 a

night and what those would have been when converted to an hourly rate. When we came into this year, the data looked distinctly fragile with regard to our ability to say, “It will cost this amount to deliver the 2016-17 service in 2017-18 at a sleepover rate of £8.45 an hour.” There are so many moving parts that it is actually quite difficult to assess the full cost. In practical terms, it might be that the allocation for 2017-18 is sufficient, but that will make 2018-19 difficult in turn.

The Convener: When you have done that work and achieved a result, can you write to the committee to advise us of that?

Shona Robison: Absolutely.

The Convener: That would be helpful.

Miles Briggs: I would like to raise a small point. Children’s services are not covered by IJBs at the moment, but is any work being done to include them in the future? What impact might there be on such services as a result of the pressures that we have heard about on adult services?

Shona Robison: Some IJBs cover children’s services—I think that the figure is about a third. Is that right?

Geoff Huggins: Nearly all integration authorities have children’s health services, because by and large they are provided through primary care services, and a third have social care services. It is a mixed rather than a single picture.

Shona Robison: Yes, and I think that we would want to work with the integration authorities and certainly in the ministerial strategic group to look at what have been the benefits and, I guess, the downsides of including children’s services. If there are advantages of including children’s services and those are clearly demonstrated, we would want to evidence that and look at what lessons there might be for the authorities that currently do not do that. We have not mandated that approach; we want to continue to look at the relative benefits of including children’s services.

11:15

Miles Briggs: What sort of timetable are we talking about for that?

Shona Robison: The analysis is on-going. We will look at the annual reports that integration authorities will submit in the autumn and, for those that have children’s services, we will do an analysis of the benefits. We will probably do that through the MSG.

Geoff Huggins: Miles Briggs asked about financial pressures. It is instructive that, in the areas where children’s services are included, there have probably been additional financial pressures on the children’s side, which have then

squeezed the services for adults and the elderly. A number of integration authorities where children’s services are included have had to find additional resources from elsewhere in the budget to support services for things such as learning disability and autism. We have to see this as a set of issues that flow both ways.

Yesterday, we had a conversation between officials about the integration of children’s services. The issue is complex because, although people are generally in favour of integration, many areas are thinking about integration between children’s services and education rather than between children’s services and health. There is a question as to whether the Parliament or the Government wants to mandate a template or to allow for continued local decisions on the best way to structure that, but with a general commitment to working across boundaries—whether service-level or geographical boundaries—to get better value and be more effective. We are seeing a number of dynamics. It is seductive to see the issue just from our perspective in health, but other people are looking at the question through a completely different lens.

The Convener: On 30 May, we had a discussion about the distinction between efficiency savings and cuts, and Ms McLaughlin will recall the exchange that we had previously on that. In that session, Keith Redpath from West Dunbartonshire health and social care partnership said:

“There may be some aspects of efficiency and doing things a bit better that mitigate some of that, but the reality is that most people would recognise that as a potential cut to the level of service. That is why I used the term ‘cuts’.”

Katy Lewis from Dumfries and Galloway health and social care partnership said:

“There will be some things that we do that you might want to describe as cuts or budget reductions.”

Karl Williamson from Shetland health and social care partnership said:

“as budgets keep getting reduced, we might get to the position where we need to make cuts and reduce services.”—[*Official Report, Health and Sport Committee*, 30 May 2017; c 22-3.]

We have discussed the thesaurus that is used by chief officers in Scotland—some say “cuts”, some say “efficiencies” and some say “savings”. Do you now recognise the comments from those chief officers that cuts are being made?

Shona Robison: Well—

The Convener: Sorry, but I am asking Ms McLaughlin first.

Christine McLaughlin: The overall budget is increasing and not reducing, so there are not cuts

overall to health and social care. That is the point that we are trying to make.

The Convener: Do you recognise what is being said by chief officers who are on the ground operating budgets? They say that they are having to make what they call cuts in their services.

Christine McLaughlin: They are having to move money around the system and the money has to go further than it has before. That is what I recognise.

The Convener: You cannot bring yourself to say that there are cuts in services.

Christine McLaughlin: I have tried to answer your question as transparently as I can.

The Convener: No, I—

Shona Robison: Convener, if all budgets stay the same in every line, there will be no change. Change is required, and that will mean—

The Convener: No one is arguing about change. We are arguing about people being up front with the committee. Senior officers have told us that, on the ground, cuts are being made. There seems to be a gulf between what they are saying is happening on the ground in our communities, which is what our constituents are seeing day in and day out, and what people at Government level and senior civil servants are willing to accept. Why cannot we just accept that this is going on in our communities?

Shona Robison: It is because the situation is not as black and white as that.

The Convener: It is, according to those senior officers.

Shona Robison: Some budgets are increasing and some services are having more money spent on them. If you look at primary and community health services, you will see that more money is going to be spent in primary care. However, there might be other services where there is less money.

If all budgets stay the same and there is no shift of money, you will not see a shift in the balance of care. By definition, some budgets will be reduced and some will increase. Efficiency savings are used, in a way, to drive that change by ensuring that resources are freed up to be invested in the priority areas; otherwise, nothing will change.

The Convener: These are not efficiency savings. We are being told that they are cuts to services.

Shona Robison: Some services will be reduced and some funding for services will be reduced, but other services will have increases in funding.

The Convener: So some services will be cut.

Shona Robison: If we are going to change services and put more money into some services—as per the whole discussion that we have had for the last hour and a half and which everybody has agreed is a good thing—it is clear that other things will have to change and be reduced. You cannot spend the same amount of money on everything and therefore prioritise nothing. Some things will have to change and have less money spent on them so that more money can be spent on other things. Therefore, the priorities of community health services and primary care will see more money being spent on them, but other areas will see less money being spent on them.

The Convener: That will have an impact on people who use the services on the ground.

Shona Robison: People will see their services being delivered in a different way. Fewer people will have to go to hospital because more money is being spent on primary and community services. That is a good thing—people going to hospital less because their services are provided in the community is better for patients. That is why that is the direction of travel. We want to make services better, not worse, but that requires us to keep people out of hospital, in the community and in their own homes for as long as possible. People will receive their services in a different but better way—I do not agree that that will be detrimental to their services.

The Convener: Of course, time will tell on whether it is better or worse.

Shona Robison: Of course.

The Convener: As no one else has any final points to make, I thank the cabinet secretary and her officials very much for their attendance.

11:21

Meeting suspended.

11:25

On resuming—

NHS Governance

The Convener: Agenda item 13 is NHS governance. Today, we are going to look at whistleblowing. I welcome to the committee Sir Robert Francis QC; Cathy James, who is the chief executive of Public Concern at Work; Kirsty-Louise Campbell, who is senior manager of strategy and insight at the City of Edinburgh Council, and Laura Callender, who is the council's governance compliance manager; Robin Creelman, who is a non-executive director at NHS Highland; and Morag Brown, who is a non-executive director, co-chair of the staff governance committee and whistleblowing champion at NHS Greater Glasgow and Clyde. She will need a big business card to get all that on it.

We have around an hour, so I appeal to people to keep their questions and answers short. I will ask the first question. Is the whistleblowing system in Scotland fit for purpose? I am sorry—I should also have said that it is not necessary for everyone to answer every question.

Robin Creelman (NHS Highland): I am happy to kick off. The whistleblowing system is not yet fully developed or fully in place, and to judge it in isolation would be to judge it wrongly. To me, a whistleblowing system is basically a lifeboat for the culture of the national health service. If the rest of the culture is in place, we should seldom require the lifeboat, but we must have the lifeboat.

I am comfortable with where we are. In NHS Highland, we are still refining and making changes to the system, but I am generally comfortable with the direction of travel. I think that our work in the area is very worthwhile.

Cathy James (Public Concern at Work): I agree that this is a journey that the NHS in England and the NHS in Scotland are on. Many of the necessary parts are being put in place, but some progress is quite slow—for example, the national officer role is not in place yet, but it is coming. Thought is being given in Scotland to the structure of that role and to giving it a statutory footing. That is in stark contrast to what is going on in England, where the role has been put in place as a test to find out what best practice looks like. That approach has its problems. Slower progress is being made in Scotland because planning is being done.

The work on whistleblowing will never be finished. It will always need adaptation, review and consideration, which is why it is vital that we have a national role that is responsible for whistleblowing. Otherwise, it will get lost among all

the other requirements that are put on local organisations.

The Convener: Robin Creelman talked about the whistleblowing system being a lifeboat. I know from experience of dealing with constituents who have come to me that when some of them have tried to clamber aboard that lifeboat, they have been booted back into the water. Do you recognise that?

Robin Creelman: I recognise that every system can fail, but we must start from a position of recognising the differences between the Scottish and English systems. Whistleblowing really took off in Scotland after the first set of events at NHS Ayrshire and Arran, roughly four years ago. Learning had not been shared and there was a lack of transparency in the system.

As a result of that, Healthcare Improvement Scotland introduced the adverse events programme, which is a national standardised system for dealing with adverse events. That filled a huge gap in the system and it greatly affected the culture. As a non-executive director at NHS Highland, I was very comfortable to see an increase in the number of adverse events following the introduction of that programme, because I felt that it demonstrated a more transparent and open culture, in which people were less afraid to speak up.

We have other things coming in next year such as duty of candour and being open. All those things contribute to the culture of the organisation being to have whistleblowing as a lifeboat.

There is also initial confusion about the difference between what are just grievances and things that really require whistleblowing.

11:30

The Convener: What would be the consequence of adverse events not being investigated? There have been a number of cases: I have one in which serious adverse events were reported but there is a culture of cover up and of not investigating adverse events. The person who reported them was hung out to dry.

Robin Creelman: That is the perfect storm or disaster scenario. Mid Staffordshire NHS Foundation Trust got to where it got to because nobody thought it could happen, so I will never say that it cannot happen in our system—although I would be absolutely astonished if it did.

Adverse events usually initially come out through clinical governance and then, depending on the size of the event, there is a convention of four or five different experts. It is difficult to hush up something like that.

Morag Brown (NHS Greater Glasgow and Clyde): You raised a question about people who have lived through whistleblowing having a harmful or damaging experience. We need to recognise that we are at an early stage of a journey. We will seek to improve our arrangements and support to staff. The national officer role could be of great assistance in that.

We must also recognise that people are concerned about being the subject of victimisation. They are also concerned that something be done about that, so we have to work hard over the coming period to earn the trust of staff and to earn public confidence.

The Convener: On the process, my understanding is that when someone blows the whistle often, the issue goes to the board that they work for and can find its way to the manager on whom they might be blowing the whistle. Is that your experience or does that not happen? Someone in the organisation where the whistleblower works has to investigate.

Robin Creelman: The process is defined in the whistleblowing policy, which contains a range of options for the staff member. The policies are based on the code of practice that has been produced by the whistleblowing commission, which is Public Concern at Work. The initial point of contact can be the line manager or a manager in a different place—it can be one of a variety of people. If it had to be done through line management, the process would be devalued.

Kirsty-Louise Campbell (City of Edinburgh Council): The City of Edinburgh Council has a unique arrangement around governance of whistleblowing disclosures. We have an independent hotline provider that oversees the disclosures and the reports that come in through whistleblowing, and it reports directly to our scrutiny committee. In terms of ensuring that the whistleblowing report or disclosure is taken seriously and the investigation is carried out in full, that is our check and balance.

Alex Cole-Hamilton: Two weeks ago, when we first discussed the topic in committee, there was a heated discussion about the spectrum that lies between raising concerns and whistleblowing. There was a view that, in the majority of cases, NHS staff feel empowered to raise concerns, but whistleblowing feels like a different threshold. Could we have the witnesses' reflections on that spectrum? At what point does it become harder for staff to direct criticism against, say, a colleague or set of practices, over and above the normal day-to-day intervention of "This doesn't feel right—maybe we should do things differently"?

Sir Robert Francis QC: Perhaps I can speak from my overall experience. As you might know, I

am keen to get away from the term "whistleblowing", because it covers a huge range of things, including some that not even well-meaning people would think appropriate. It implies a barrier to speaking up. In an ideal world, everyone should be able to speak up, be listened to and see action being taken, but unfortunately that is, as we know, not the position.

Any division between what one might call speaking up and whistleblowing is likely to be counterproductive, and it seems to me that what we should be looking at is the reaction to someone who speaks up. Does it result in, at one end of the spectrum, victimisation and no action being taken or, at the other, positive end, the raising of the issue being welcomed and investigated, action being taken and the person who raised the concern being thanked? If what happens in one's organisation lies at the former end of the spectrum, alarm bells should be ringing about the culture in it.

That is a general answer. There is, of course, a spectrum, but it is all about speaking up. Some people become victims as a result of speaking up, while others become the champions of the issue that they have spoken up about.

Cathy James: I agree. The terminology is really crucial, and there is a lot of confusion. However, the danger of getting rid of the term "whistleblowing" altogether because of its being fraught with difficulty is that we would end up endlessly entrenching the negative view of it. We were not named "The Whistleblowing Charity" when we were set up 25 years ago; we were named Public Concern at Work because of the sense that to be a whistleblower is to take a risk.

I do not have a view about what the process should be called, but, internally, it should be about a process of escalation in an organisation that is very clearly set out and which people receive training on. In fact, that is what is starting to change. Training around whistleblowing is really gaining momentum in the health sector and the financial sector—which, interestingly, are the two sectors in which there have been huge scandals.

There is also, of course, also an external element to this. Sometimes that is seen as the whistleblowing aspect, while everything that happens internally in an organisation is soft and fluffy and works. However, according to our advice line, that is not the reality. Most whistleblowers try once or twice internally and then give up. If we want to see this as something that is in the interests of the NHS in Scotland, because it shows where the problems are, we need to capture those people, listen to them, act on their concerns and ensure that they are protected.

Robin Creelman: To be honest, I do not think that the terminology matters much. Perhaps I can give a fairly simple example. If, in a clinical setting, a member of staff sees a nurse or doctor not washing their hands, the staff member will normally record that sort of thing on a system known as Datix, which then goes to clinical governance in the health board and is acted on. However, if the member of staff records that occurrence, but nothing happens and the offender still does not wash their hands, day after day, week after week, there needs to be some outlet for raising the profile of that. Currently, that would be whistleblowing.

Alex Cole-Hamilton: Sir Robert talked about the two ends of the spectrum—either being victimised for whistleblowing or being thanked at the end of the process and helping things to improve. It also strikes me that at the more negative end of the spectrum there is the situation that we know from the NHS and other walks of life of complaints that go upwards being met with disbelief or inaction. How can we mitigate the two significant barriers to people taking action and putting their heads above the parapet and blowing the whistle—concern about victimisation, which we know happens, and cynicism about whether they will be believed or even listened to? What is in place to deal with those things just now, and what could we put in place that we do not currently have?

Sir Robert Francis: I will start from a general perspective. If someone raises an issue that is disputed, there must be a process to sort out the facts. You might think that I would believe that, because I am a lawyer. Often when people speak up, the matter immediately descends to the personal level and the question becomes who is to blame for the issue that has been raised, and if there is no one to blame it must be the fault of the person who raised it. We have to get used to the idea that there will be disagreement about what is right and what is wrong. However, we then need to sort out what is right in an authoritative, fair and proportionate manner. Until we do that, we will never proceed very far either in improving the service or in looking after the person who raised a no doubt genuine concern.

We have to recognise that not every issue that staff raise will turn out to be correct, but they must not be discouraged from raising those issues. If it is thought that the staff member is not correct, they should be given a proper explanation, which makes sense to everyone, as to why there is a difference of view.

Alex Cole-Hamilton: Is that the process?

Sir Robert Francis: What happens must depend on the facts, but there must be a process of authoritative investigation. If the issue is

potentially serious, it must be investigated by people who have the authority to investigate and are trained to do so. Often, things are looked into in an entirely impressionistic way. When that happens and no action is taken that satisfies the person who raised the concern, we begin to get trouble. The longer such sores are left unhealed, the more likely it is that there will be victimisation and, perhaps even more important, a failure to correct the issue that was raised in the first place.

Alex Cole-Hamilton: I absolutely agree with that, but my concern is a little bit further upstream. I am thinking of the adage, “Culture eats strategy for breakfast”, and my concern is the people who do not get into the process because the culture around them prevents them from having the confidence to raise a complaint, or even intervenes to prevent them from making a complaint or raising something important.

Sir Robert Francis: A way to address that is to ensure that you have mechanisms to collect data about what staff feel about things. The NHS staff survey is becoming a very instructive tool in relation to staff telling the system that they do not believe that they will be treated fairly if they raise a concern, that they are not being listened to, and matters of that nature. The figures can be looked at on the basis of individual organisations. We need to get out of a culture in which 51 per cent is thought to be a good result.

Alex Cole-Hamilton: I agree with that point—those numbers have prompted the committee to take on the issue. However, although we can measure it, I am not convinced that we are actively doing something to address the problem.

The Convener: Would anyone else like to make a brief comment on any of the points that Alex Cole-Hamilton has raised?

Kirsty-Louise Campbell: We introduced our whistleblowing arrangements in 2014 and from our experience the point about culture is absolutely critical. Over that period, we have built a position in which people feel that they can contact our whistleblowing hotline and service and be heard and listened to. If the person's concern is not a matter of whistleblowing within the policy or legislation, the matter is still investigated and they are given proactive feedback in a positive way. It is the same for people who make a disclosure, whether that is done anonymously or not. Building confidence through the good process that you have put in place allows colleagues and staff to feel that their views are being heard more appropriately.

Morag Brown: Alex Cole-Hamilton asked what we were doing about the problem and the point about culture is very important. I co-chair the staff governance committee and we have recently

established a subgroup to consider culture, because we wanted to address some of those issues and concerns in feedback from surveys and other areas. We are committed to reshaping and refocusing our culture so that one of our core principles is that the NHS is a good, safe place to work. That is very important.

We are developing a plan for our new modular approach to culture. It is also important to learn lessons where that has worked well. We will look at places such as Salford Royal NHS Foundation Trust, where there have been significant improvements and cultural change.

11:45

On whistleblowing, we have taken forward information sharing and encouragement through staff news and inserts in payslips. In the future, we want to extend that through roadshows and further training.

A couple of measures that are well worth exploring are how we share good practice—how we share the good news when people have reported concerns and we have acted on them. That is important. We have heard of two examples of good practice from my review of our whistleblowing cases this year, and we are looking at how we can best share them.

In addition, we need to give consideration to systems and processes that are open and helpful for supporting staff. We need to consider whether a buddy system would be helpful for people whether or not they already have a supporter, because of the impact on the individual who takes a very serious concern through the whistleblowing process.

We are looking at a number of areas, as well as others that we can take forward for the future.

Cathy James: There is a lot of work to be done to review internally. Just looking at the numbers is not enough, because the numbers will not be comparable across organisations. An organisation that has a culture of very high reporting may well not have much end-game whistleblowing. An organisation that has a low number of reports should be questioning why that is, or it might have got the balance about right.

You need to look at the survey work and at what is happening in other incident-reporting processes, and you need to speak to staff and have focus groups. All too often, quite a lot of resource is involved in doing those things. When pressures are on the NHS to deal with all sorts of other priorities, internal review work can go to the bottom of the pile, but it is where you will find out where the problems are, so it needs to be given priority.

Robin Creelman: One thing, convener—

The Convener: Be very quick.

Robin Creelman: Okay. With regard to governance, as soon as a whistleblowing incident occurs, I am notified. I get a monthly statement that covers progress on incidents, who the investigating officer is, outcomes, and good practice and how it is shared.

Alison Johnstone: Sir Robert, your freedom to speak up review referred to an NHS England staff survey in 2013, which showed that only 72 per cent of respondents were confident that it was safe to raise a concern. We had a lower figure here in Scotland. Do you think that things are improved? Would you expect that result to be better now, with the national confidential alert line?

Sir Robert Francis: You are testing my memory on what the result in the staff survey was in March this year. I do not think that it was much better, frankly—the process was still at an early stage.

The impression that I got at the time of my report was that the level of staff lack of confidence in the system was pretty dire compared with some other sectors. That is slightly surprising, but it seems to be the case. A lot of positive work needs to be done.

One issue that I found quite surprising was how difficult it was for me to find examples of good practice, which were seen as being successful, to put in my report. The reason for that cannot be that there were no examples; it is that in the good places, people just shrug their shoulders and think that what they do is a matter of routine, so they do not bother to collect data about it. We need far more leaders at a local level recognising the value of what they hear from their staff. That will encourage not only their institutions, but others.

Alison Johnstone: You suggested that we have to stop people becoming victims of speaking up, and blacklisting has been raised as an issue. What protections would you like to see put in place?

Sir Robert Francis: I recommended that legal protections should be extended outside the particular organisation in which the individual is working, so that people who are applying for jobs elsewhere in the national health service should be protected. They should not be discriminated against when applying for a job because they have a history of speaking up somewhere else.

In response to the draft regulations on that, our national guardian has suggested that such protection should be extended to include all employers. In other words, whistleblowers who are going through the non-NHS world should also be caught within the regulations. Doing that would be

more complicated, obviously, but I think that it would not be a bad thing.

I also recommended that the protection under the Public Interest Disclosure Act 1998 should be extended to trainees and students. That has been done, in part, in the sense that people who are the equivalent of an employer where the trainee is working are covered by the law. It is not clear that the bureaucratic central organisations—Health Education England and so on—are similarly covered. Those are technicalities that apply to England; I do not know whether they apply to Scotland.

Alison Johnstone: There seem to be specific key differences with the City of Edinburgh Council model, which seems to be a positive one. Are members of the panel aware of what is going on in Edinburgh? Should the national confidential alert line have further powers to investigate cases?

Cathy James: The national confidential alert line is an advice line for staff. It is one part of the jigsaw. Edinburgh has a reporting line, rather than an alert line. It enables the individual to report something to Expolink, which is the private company that runs the—

Kirsty-Louise Campbell: It is not—

Cathy James: It has an investigation arm as well, has it not?

Kirsty-Louise Campbell: It is not that organisation. We have an independent hotline that colleagues are able to contact directly. It is run by a company called Safecall. Where there is a major disclosure—for example, an issue that involves a PIDA matter, a breach of health and safety legislation or a matter of significant concern—that independent organisation can step in to investigate and report via the corporate leadership team, chief executive and the scrutiny committee.

Cathy James: The alert line that we run is an advice line, so it is legally privileged. It works on a basis of consent. If the individual wants us to report something for them, we can pick that up on their behalf. However, ultimately, we are trying to help them to report it themselves and give them some independent advice. They are not making a disclosure to Public Concern at Work or the alert line; they are seeking advice in an absolutely confidential space. That is a very different model, and it is complementary to the reporting line service that Edinburgh has.

An investigation line is different from a reporting line, but you probably need both models. I would not say that one is better than the other. In financial services, many organisations are considering having reporting lines as well as advice lines. The advice line is one part of the jigsaw, as opposed to being an exclusive

approach that is taken on the basis that one model is better than the other.

Alison Johnstone: That might be why we have a petition before Parliament calling for a hotline rather than a helpline.

Cathy James: The two things are very different, but they are complementary.

Sir Robert Francis: I agree that having both models is a good idea. Other industries, in the commercial sector, tend to have an external hotline to enable someone to speak to somebody in complete confidence, with a better guarantee of anonymity. Whether that is the best solution in the health service depends on various things. You would think that it would be possible to place the service within something as large as the health service in England, but that is a matter of opinion.

Maree Todd (Highlands and Islands) (SNP): I am a member of the pharmacy profession, which is regulated by the General Pharmaceutical Council. Until I was elected last year, I worked for 20 years in NHS Highland. During the time in which I worked as a clinical pharmacist, I saw the culture in the NHS transformed into a much more open one, with much more emphasis being placed on the duty of candour. When I raised that point a couple of weeks ago, one of my colleagues said that that was perhaps because there are now more things to be concerned about, but I do not agree. I think that, because of some of the huge and terrible scandals that have hit the NHS, there genuinely was a culture shift in people's understanding of just how important it is for professionals to speak up when they have concerns.

What will be added by extending the duty of candour to all NHS staff? The professions already have a duty of candour. Are the professions not speaking up?

Robin Creelman: My understanding of the duty of candour, which I think will come in in April 2018, is that, although the legislation talks about a "responsible person", that is not actually defined as an individual. In a specific case, it would be NHS Highland rather than an individual employee who would be the responsible person. It is about members of the public getting total honesty from the organisation that they have an issue with.

Sir Robert Francis: Of course, I recommended a legal duty of candour. There was already, and had been for decades, a professional duty of candour, but I am afraid that that did not help the patients in Mid Staffordshire. I remember that I met a senior consultant who would see me only in the confines of his own home and in secret because he was so afraid of what he had to tell me but, actually, I already knew what he had to tell me, because other people had told me it.

Another point is that the professional duty of candour puts the entire burden on the individual whereas, actually, an organisational response is often required to a particular issue.

We need to be careful in what we are talking about. The legal duty of candour is about candour to a patient on something that has gone wrong. However, I also recommended a duty on the part of the organisation to be open and transparent about its work generally, which is just as important. In other words, we should not be told by the board of a hospital only the good news; there should also be a recognition of any problems that the board needs to solve. If there is that sort of culture among the leadership, it becomes much easier for people elsewhere in the organisation to talk about and raise issues of concern.

Cathy James: I agree entirely. With the advice line, we sometimes see that the duty to report is used against the whistleblower or adds to a culture of silence. When people are a bit worried or, more than that, scared about reporting and there is a bad culture in an organisation, if one brave soul speaks up, others then follow when it is clear that the organisation is listening. However, we have seen cases in which, because of a duty to report that is put into a contract, perhaps in the care industry, individuals have been disciplined for failing to report, in the context of a really bad culture. We have to be careful of unintended consequences, because the duty can be used as a stick. I agree that professionals definitely should have a duty, but we should be careful about imposing that on all staff across the system.

Maree Todd: Thank you—that has clarified things for me. I am interested in the idea of not just reporting to the patient when things have gone wrong but reporting up the way. What system will be in place to collect and gather information? I imagine that, with some of the really bad scandals, people were speaking about the issues and concerns were raised but, somehow, the big picture was not put together.

Sir Robert Francis: That is absolutely correct. In Mid Staffordshire, many staff were reporting incidents and attributing them to, for instance, a lack of staffing, and then the pushback would be to discourage them from using that as a reason. We can seek to deal with the issue only by using some sort of process of audit inspection or oversight because, unless we get under the bonnet of the relevant organisation, we will never find the truth. We need transparency so that we can see not only that the organisation is receiving reports but what on earth it is doing about those reports. That is a board responsibility in most places.

Cathy James: One criticism of the Scottish system is that the number of reports to the advice line is used to consider whether the system is

working. That is not what should be looked at. It should be the number of reports going to people on the boards, the number of reports that boards get from their staff and the number that managers are dealing with. Sometimes, that can be difficult to track. It is possible to overbureaucratise the approach. Managers need to have discretion to deal with things, but we need to capture the really good business-as-usual organisational operations. That is why a bit of thinking about how to capture that, how to review, how to structure the review and how to ask staff will pay dividends in the long run. Perhaps the national officer will have some influence in helping boards to do that work. It is not about what is going to an external organisation; it is about what is going to the boards.

Robin Creelman: We get reports to the board quarterly, and we will periodically have a committee session for a deep dive into an individual case to discuss things that cannot be looked at in public.

12:00

Sir Robert Francis: I forgot to mention that our national guardian has started a survey of all the local guardians. She has just received the first set of results; although they have not yet been properly analysed, she has discovered that about 25 per cent of all concerns that have reached the guardians are about patient safety—that is only a fraction of the total level of concerns, one would hope. I understand that she will, in the future, analyse what she hears from the guardians about what has happened about those concerns. I emphasise that she is not a regulator, but she has access to information via the guardian network. That is perhaps less bureaucratic than setting up an inspectorate to get round and look at things.

Morag Brown: Bringing together a lot of information to get the whole picture in a complex and large organisation can be a challenge. Careful consideration about how to bring together incident reporting through our Datix system is important; examples are significant clinical incidents, whistleblowing reports, complaints, ombudsman reports and reflections by committees on individual cases. How to bring together the bigger picture—the work on staff governance and clinical governance, which can then be complemented by specific reviews and surveys—is very important.

Maree Todd: I have a final very quick supplementary question. You mentioned the Datix system, which I was familiar with when I worked in a hospital. I understand that it is not used in primary care, which has a different system. How do the two systems work together?

Morag Brown: My experience is more with the acute sector. Independent contractors have their means and measures to record incidents. We have access to that information through our monitoring of independent contractors for clinical governance. I can ask my colleague who leads on clinical governance to provide information to the committee.

The Convener: That would be helpful.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): Morag Brown spoke about the importance of developing an NHS culture in which folk feel able to speak out. The committee has taken evidence from the Scottish Ambulance Service, in which, according to the staff survey, only 20 per cent of staff felt consulted about changes in their work. Nearly half had not had a staff review in the past year. Most importantly, with regard to whistleblowing, only 31 per cent said that they felt safe to speak up, which was the lowest figure of NHS boards nationally. Are panellists aware of any boards that have been tackled about their staff governance when such issues are flagged up in staff surveys? That is quite a specific example—are you aware of any action being taken on those figures?

Morag Brown: Sorry; do you mean action not specifically about the Scottish Ambulance Service figures?

Jenny Gilruth: No. Those figures are quite specific for the Scottish Ambulance Service, but there is quite a disconnect with previous evidence that we took from the service. What is the point of carrying out a staff survey if there is no reaction at the end of it?

Morag Brown: On staff governance, the information from our staff survey, along with other indicators and drivers, prompted us to set up a sub-group to look at how to reshape and refresh our culture. The iMatter survey has had much higher response rates in our area and other areas across Scotland—we had something like a 64 per cent response rate, which is a much higher response. iMatter is a more responsive survey, because it gives more immediate feedback to the team and it allows a team and management to test the temperature of their culture, to reflect on it and work together to change it. The information from surveys helps us with big-picture, large-scale cultural change and it also helps us to manage and create open, discursive team cultures—iMatter is very important to that.

Robin Creelman: One of the challenges for a board is knowing the temperature at the front line. That was touched on in Sir Robert's report. In Highland, we have a thing called the Highland quality approach, which is a full-fat version of lean methodology. It uses phrases such as gemba—it

is based on the Toyota working principles. As part of that, the non-executive directors and board members are encouraged to go to the gemba regularly, where they have informal chats with front-line staff and take time to mingle with them and hear what they are saying. That is not the answer, but it helps to give people a feeling of the pressures at the front line.

Jenny Gilruth: Is there capacity to use that as an example of good practice and share it with other boards so that folk can learn from it in developing a supportive culture?

Robin Creelman: I would not claim that we are unique in that regard, although we are probably the ones who have taken it the furthest. We have senior staff trained at the Virginia Mason hospital in the States, and there is an interchange of staff there. We have probably taken it a degree further than others, but I am not suggesting for a moment that other boards are not doing similar things.

Jenny Gilruth: Thank you.

Clare Haughey: Thank you for coming along today. The committee received a written submission that quotes you, Sir Robert, in calling into question the independence of whistleblowing champions who are employed by authorities that the whistle is being blown on. It says:

"Sir Robert Francis in his 'Freedom to Speak Up Review', following the Mid Staffs inquiry, stated that these appointments should be seen 'by all' as independent, fair and impartial—that they should not be adjuncts to existing posts."

Will the non-execs who are whistleblowing champions with NHS boards comment on how they reconcile their different roles and whether they see any pitfalls in their being board members as well?

Robin Creelman: I think that it is implicit in the role of a non-exec. If I thought that I was a board member to do what the executive board members thought I should do, the whole system would have failed. I am there to form my own views about things and act on them.

Morag Brown: That is right. We are appointed by the minister and we have that independence. We should certainly be able to speak up and challenge, and I think that we do that. However, I can understand why members of the public and people who have had bad experiences could have concerns about that, and why there is potential for public concerns about independence.

I think that the independent national officer can offer some assistance in reconciling that, in that there will be guidance. There will be an opportunity for the independent national officer to monitor and benchmark boards' performance and openness and transparency in relation to

whistleblowing, and to produce national materials and training for whistleblowers. There has been some consideration of whether the independent national officer should become the final, independent stage in the whistleblowing process. There could also be potential in the role, given its independence, to provide a forum for patients and the public around whistleblowing and how it is responded to, and a forum for staff who have concerns or have had experiences in the area that they want to talk about.

Clare Haughey: There may well be potential for that, but I am keen to explore a bit further your role as non-execs who sit on a board. How do you convince NHS staff that you are neutral and that you are not part of the system or culture that they perhaps have concerns about?

Morag Brown: As Robin Creelman said, our appointment process suggests that independence, but it is also seen in how we handle the business. With some of the issues that I have dealt with, or some of the scrutiny, I have raised the level of investigation and highlighted limitations in investigations. I think that we have our own personal integrity in being open and transparent and in challenging systems.

Clare Haughey: How has that message been transferred to the staff on the ground?

Morag Brown: As we said earlier, we have been developing our communications with staff through our various newsletters and roadshows and through the visibility of non-executive directors and senior managers and so on. That is how we convey our openness in the system.

Robin Creelman: I think that you have touched on something that needs to be explained a bit more to staff. According to whistleblowing policies, which tend to be relatively standard across all boards, the whistleblowing champion, who is not named but just mentioned, is not part of the investigatory process at all—they are divorced from it. Our role is to oversee the process. As part of that, I carry out a kind of exit interview with whistleblowers to find out how the system can be improved, but I think that we need to explain things a little bit better to staff and emphasise the independent nature of our view.

Clare Haughey: How long have you been in this role?

Robin Creelman: Just over a year. It is a relatively new thing.

Morag Brown: I think that Mr Creelman is right—we should also explain what we do not do. We do not carry out investigations or take part in that process. Instead, we play an assurance role.

Clare Haughey: And that assurance role has been in place for only a year.

Morag Brown: Yes.

Robin Creelman: The whole whistleblowing thing has been around for only a little over a year.

Clare Haughey: I wonder whether Sir Robert, whom I quoted at the start of my questions, can share with us his opinion on the appointment of non-executive directors at board level as whistleblowing champions.

Sir Robert Francis: I am not going to speak about the situation in Scotland—

Clare Haughey: I was not talking about individuals as such.

Sir Robert Francis: Perhaps I can speak more generally from an English perspective.

When I made this recommendation—and I am choosing my words carefully here—I did not have it in mind that the role should be the same as the role of a non-executive director in a whistleblowing process. When I wrote my report, many trusts had a board director who, as part of their portfolio, had oversight of the whistleblowing process, and what I recommended was the creation of a guardian, because it seemed to me that every organisation needed someone who had the confidence of the staff and the management and who could, when problems arose, unlock the right door to a solution.

I knew that, in different organisations, there would be different solutions, and because this was such a novel recommendation, I did not go very much deeper than that. However, every trust in England now has a freedom to speak up guardian; they come from a wide range of backgrounds—some are non-executive directors—and time will tell whether that approach has worked. The concern that some people have expressed and which I think we have to look at is that a non-executive director has a corporate responsibility to the running of the organisation that, to some, might be seen as conflicting with their role of helping to oil the wheels of the system for challenging the organisation. I am not saying that the situation is impossible, but we have to work it out; however, I would emphasise that the issue of the right person to be a guardian might come down to an individual's personal qualities and how they are respected in an organisation rather than the position that they actually hold in it. As I have said, time will tell.

Cathy James: The model in Scotland was deliberately different in making the whistleblowing champion an oversight rather than an operational role. Because the freedom to speak up guardian is an operational role, they are expected to help and protect the whistleblower, to get the information that is needed and to ensure that the wrongdoing or malpractice is investigated and addressed. The

freedom to speak up guardian is therefore very different from the whistleblowing champion.

Where confusion arises is that, with cases that are perceived not to have been dealt with properly—or which have not been dealt with properly—no one might know where the top of the tree is in the organisation in question. Many NHS staff—indeed, staff in any organisation—will think, “There’s a whistleblowing champion; I’ll go to them,” but if they get told, “No. no, no—we can’t deal with you,” trust gets undermined very quickly.

There is academic research from all over the world that suggests that it is about trust—it is so hard to build up that trust and so easy to lose it. Whistleblowing systems need to be very flexible and have multiple channels. They must not have barriers. Sometimes the protection of the senior person can create the barrier that undermines the system.

12:15

Clare Haughey: Can you clarify a point? You are whistleblowing champions and there is a perception that you guys are the ones who oversee the process, but I am hearing that you do not oversee it and have no operational responsibility for it, so what is your role?

Robin Creelman: Our role is to oversee the process. The role is clearly defined in the whistleblowing policies—that is certainly the case in the Highlands and Islands and is probably the same for the other boards.

Clare Haughey: So your role is to oversee policy.

Robin Creelman: No, it is to oversee the process.

Clare Haughey: Sorry. What authority do you have if the process is not being followed and how would you know if the process were not being followed?

Robin Creelman: When I am not satisfied with the process, as has happened in a very few cases in the Highlands and Islands, I suggest changes and continue to suggest them until I get general agreement and they are implemented. I discuss any change with the staff governance committee, the chair of staff governance, the chair of the board and then I assume that it is agreed and we do it.

Clare Haughey: The fact that you keep suggesting until it is changed suggests that there is some resistance.

Robin Creelman: At the end of the day it is a consensual change. I keep trying to make my point in the hope that other people will agree and then we change the process.

Clare Haughey: As a whistleblowing champion, what authority do you have?

Robin Creelman: I try to influence change where I see that the process is not working properly.

Donald Cameron: I have questions on two areas. First, Jenny Gilruth mentioned the Scottish Ambulance Service, and one of the most startling figures that I picked up from the papers was that less than a third of its staff feel that it is safe to speak up. Given the importance of the Ambulance Service, does anyone have observations on that?

My other question returns to the legal duty of candour. From a technical point of view, how is that duty to be enforced through sanctions and remedies?

The Convener: I ask everyone to be brief, because we are really up against time.

Donald Cameron: Linked to that point is the fact that one of the most interesting tensions is in the relationship between organisations and individuals in relation to taking responsibility. Cathy James hinted at that. It is as difficult for a board or an organisation to front up to a failing as it is for an individual. Will you explore that as briefly as possible?

Cathy James: There is an absolute lack of accountability for those who have meted out retribution or retaliated against a whistleblower. We rarely see any sanction against decisions that have been made when whistleblowers have been treated badly. If there were the will to take that seriously and do something about it in the senior leadership of an organisation, that would change the perception that nothing changes.

I do not have a magic bullet. Time and again in all the scandals that have hit the public and private sectors, people have seen accountability as being missing. If we never see any accountability, people will endlessly fail to trust the system.

Robin Creelman: The question is so big that it could not be answered even if we had all the time in the day. Another issue is unintentional detriment. If, for all the best reasons and with good intentions, someone raised a whistleblowing concern in a ward setting but it was not proved correct, it is inevitable that the relationship in that ward area would break down. In such cases, the person who raised the concern often has to be moved from the area, even though they did nothing wrong. We need to address that situation. I understand that work is being done in health improvement in England to find a way to make that happen.

Cathy James: A re-employment scheme is being worked on in England. It is very much in its pilot stages, although it is operating.

Sir Robert Francis: Accountability is important. I will say one more thing about culture, which is that it is about people making the right decisions in the interests of their patients and the NHS in general. Victimising a whistleblower or a person who has raised a concern is the absolute antithesis of that.

Sometimes that has happened almost because of legal advice; there is a sort of adversarial culture that we need to get away from. However, when someone at a senior level has been proven to have acted in the way that I just described, there should be a means of holding them to account. Half the problem that we have is that managers in the NHS are not subject to the degree of regulation that registered healthcare professionals are. In general terms, perhaps that needs to be looked at.

Miles Briggs: I will pick up on the question of people who are having a whistleblowing aspect looked into. How many current NHS employees have been suspended, have been signed off because of stress or are on gardening leave and have not had the complaint looked into but are still being paid by the health service? I have been trying to get those numbers but I have had no luck. How many such people are suspended?

Cathy James: I do not have the specific numbers, but we did research on the whistleblower's journey that looked at 1,000 of our cases. In the public sector, and in the NHS and the healthcare sector specifically, more people were suspended, whereas in the private sector, more people were dismissed. We looked at a skewed sample, because people come to us when they are in difficulty with whistleblowing, but we have seen that trend in the statistics. I am afraid that I do not have absolute numbers.

Miles Briggs: Can you provide the committee with a breakdown of those statistics for Scotland?

Cathy James: I suspect that I cannot do that easily, but I will have a go and look at what we have in our system. We are a small charity that advises individuals; we are not a regulator, so we do not collect such data, but I will have a look.

Miles Briggs: Thank you.

The Convener: I would like to raise a couple of issues now that we are at the end. Alison Johnstone mentioned blacklisting. I have been heavily involved in that issue in the construction industry. I am absolutely of the opinion that some form of blacklisting operates in the health service, although not on the formal basis that it did in the construction industry.

I was involved in the case of Dr Hamilton, who provided evidence to us. She had an unblemished record in the health service as a psychiatrist and

was well respected until she blew the whistle and eventually lost her job. Despite the huge need for psychiatrists in Scotland and the vacancies all over the place, she cannot get employed in Scotland.

Is that a coincidence? Are you seeing that happening elsewhere? Scotland is a small place. It would take a human resources officer only half an hour to phone round the 13 other health boards and say, "What do you think of this one?" and for someone else to say, "Don't take that." There would be nothing official and nothing written down. The system could easily operate in that way. Is that happening elsewhere?

Robin Creelman: I can honestly answer no, not to my knowledge, but—

The Convener: The second part is important—whether it is to your knowledge.

Robin Creelman: I can speak only for the board that I work in. However, your hypothesis implies a fairly large degree of collusion. Relatively senior clinicians would not be appointed by an HR person. I am not saying that what you described is not happening or dismissing it, but collusion would have to be quite sophisticated, because an appointment panel is usually made up of three or four people. I am not dismissing the possibility, but I would find it hard to believe. I certainly have no personal—

The Convener: The example that I gave is in the public domain, so I am not giving away any secrets. There were a number of vacancies in one health board's area and, when the person I mentioned applied for those vacancies, they suddenly did not exist any more. Such things lead to all sorts of conspiracy theories, but there clearly seems to be an issue.

Cathy James: I think that what you described happens. If someone gets the label of whistleblower, it is the label of a troublemaker. That is why we have always campaigned to have the kind of provision that Sir Robert Francis recommended, which gives people the same rights against discrimination pre-employment as they have when they are employed, so that they can say, "I have not been offered that job." The problem with the current legal protection is that, until someone is in a job, they do not get that right. I think that that has been changed—

Sir Robert Francis: It is on the way to being changed.

Cathy James: It is on the way to being changed in the health sector only. I imagine that that applies in Scotland, because it involves the Public Interest Disclosure Act 1998, which definitely applies in Scotland, although not in Northern Ireland.

I do not see why that provision should not apply across the entire piece of legislation. The legislation protects all workers, so why would the problem be seen to be only in the health sector? It is a problem in all sectors.

Another point is on computerised staff records. Some whistleblowers are looking at how the back end of the computerised staff record is being used in an unofficial way to record information that managers put on their systems. I do not know whether that is happening just in England or what the system is in Scotland, but there is a sense that information that is not covered by a subject access request is sitting in those databases and it ends up being detrimental to people who are looking for a job elsewhere.

Sir Robert Francis: I did not know about the case that the convener mentioned but, if someone with such experience was of colour and did not get a job, there would be at least an automatic question mark about whether there was racial discrimination. I believe that whistleblowing, or whatever you want to call it, should be treated in the same way. If a whistleblower has been refused a job by a public sector organisation, there ought to be a reverse burden of proof. The question would be why that otherwise perfectly qualified individual had not got the job.

The Convener: As a final point, has there been whistleblowing by board members?

Sir Robert Francis: Yes.

Cathy James: We get board members as whistleblowers all the time, not just from the health sector but from all sectors.

The Convener: We are talking specifically about health.

Cathy James: I imagine that this applies to health. I do not have a specific case in mind, but we certainly get whistleblowers who are board members and at senior levels.

Sir Robert Francis: The committee can read in my inquiry report about a whistleblower from the board of the Care Quality Commission who gave evidence to me quite effectively.

The Convener: Thank you very much for your interesting evidence.

12:26

Meeting continued in private until 12:41.

This is the final edition of the *Official Report* of this meeting. It is part of the Scottish Parliament *Official Report* archive and has been sent for legal deposit.

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STATEMENT OF SIR ROBERT FRANCIS QC FOR THE HEALTH AND SPORT COMMITTEE OF THE
SCOTTISH PARLIAMENT AT THEIR HEARING ON 13 JUNE 2017

I, SIR ROBERT ANTHONY FRANCIS, say as follows:

Personal

1. I am grateful for the invitation by the Committee to attend their hearing and offer this statement as an introduction to my perspective on whistleblowing, or as I prefer to call it, freedom to speak up, in the National Health Service. I make this statement in a personal capacity and nothing in it should be understood to be endorsed by or made on behalf of any organisation with which I am involved, including those to which I expressly refer below.
2. By way of background, I am a barrister in self-employed practice at the Bar of England and Wales. I was called to the Bar in 1973, and took silk in 1992. I have been a Recorder since 2000, and am authorised to sit as a Deputy High Court Judge. I am a governing Bencher of the Honourable Society of the Inner Temple. Between 2003 and 2005 I was chairman of the Professional Negligence Bar Association. For many years I have specialised in medical law, in particular clinical negligence, in which I regularly act for claimants and defendants, professional regulation, in which I have generally assisted registered practitioners, medical ethical decision-making on behalf of those lacking capacity to make their own decisions. I am not a specialist in employment law in general or public interest disclosure in particular, but have a general knowledge of the area developed through the work I will describe below.
3. I have appeared professionally for core participants at a number of important public inquiries in England, including the Bristol Royal Infirmary Inquiry [report 2001], the Royal Liverpool Children's Inquiry [report 2001], and the Inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale [report 2004]. I have chaired three independent inquiries into the care and treatment of persons who have been convicted of homicide while under the care and treatment of mental health services.
4. Of more central relevance to the Committee's considerations I was appointed by the Rt Hon Andy Burnham, then Secretary of State for Health to chair the Independent Inquiry into the care provided by Mid-Staffordshire NHS Foundation Trust [report February 2010],¹ and the Rt Hon Andrew Lansley, his successor, to chair the subsequent Mid-Staffordshire NHS Foundation Trust Public Inquiry [report February 2013]² and lastly by the Rt Hon Jeremy Hunt, the current Secretary of State to lead the Freedom to Speak Up Review [report March 2015]³.

1

http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf

² <http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report>

³ http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

5. Following on from this work I am now a non-executive director of the Care Quality Commission. I also have the honour of being the President of the Patients Association, Patron of the Florence Nightingale Foundation, and a trustee of the Point of Care Foundation, a charity dedicated to enhancing the capability of healthcare staff to provide high quality care to patients through support such as Schwartz Rounds,⁴ a Heads Of Patient Experience [HOPE] network and support for experienced based co-design.⁵ I am an honorary Fellow of the Royal College of Surgeons (England), the Royal College of Anaesthetists and the Royal College of Pathologists.

Perspective derived from the Mid Staffordshire inquiries

6. The story of the appalling experiences suffered by too many patients at Stafford Hospital shocked all who read about it, and the experience of meeting patients and their families as they shared their stories with me has motivated my continued involvement in the healthcare sector ever since. I have often been asked how such a departure from acceptable standards had gone undetected for so long. The answer is that in fact many people were aware of parts of the picture, but in adequate action was taken to address the concerns that many of them raised.⁶ There was evidence that over a number of years staff had repeatedly reported incidents which they attributed to inadequacies in staffing.⁷ Not only was an impression that feedback – and therefore encouragement to raise concerns – was rare, there was also highly worrying evidence of a culture of fear promoted by some staff resulting in some of those who raised concerns being victimised. The most striking example came from the evidence of Helene Donnelly who reported being pressurised by senior colleagues to falsify discharge times in A&E records in order to given an appearance of compliance with target waiting times. Her evidence of the impact of this on her is worth recalling. She told me the following:

The culture in the department gradually declined to the point where all of the staff were scared of the Sisters and afraid to speak out against the poor standard of care the patients were receiving in case they incurred the wrath of the Sisters. Nurses were expected to break the rules as a matter of course in order to meet target, a prime example of this being the maximum four-hour wait time target for patients in A&E. Rather than “breach” the target, the length of waiting time would regularly be falsified on notes and computer records. I was guilty of going along with this if the wait time was only being breached by 5 ... or 10 minutes and the patient had been treated ... [but] when wait times were being breached by 20–30 minutes or more and

⁴ Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. They are increasingly used by NHS providers to assist in the support of the well-being of their staff.

⁵ Experience-based co-design (EBCD) is an approach that enables staff and patients (or other service users) to co-design services and/or care pathways, together in partnership. The approach is different to other service improvement techniques

⁶ For a full chronological account of the warning signs I found, please see chapter 1 of the Public Inquiry report [vol1 pp47 et seq]

⁷ See Chapter 2 paras 2.324-332 of the Public Inquiry report [Vol 1 pp222-225]

the patient had still not been seen, I was not prepared to go along with what was expected. I was concerned about the terrible effect that our actions were having on patient care. I did raise this with Sisters [X] and [Y], however their response was extremely aggressive basically telling me that they were in charge and accusing me and anyone else who agreed with me of not being team players.⁸

The fear factor kept me from speaking out, plus the thought that no one wanted to know anyway, due to the lack of response to the Incident Report forms I had logged. I felt that external bodies would have told me that it was necessary to exhaust all internal mechanisms first before they would fully consider my complaints.⁹

When she did report her concerns she was abused and threatened:

... [T]he first sister ... made it very clear that she was very displeased with me and the fact that I'd spoken out ... [T]hreats were made, both directly and indirectly, friends of hers and the other sisters would make threats to me. People were very often coming up to me in – trying I think in a helpful way to tell me to, I quote “watch my back”, ... and people were saying, “Oh, you shouldn't have done this, you shouldn't have spoken out.” And then physical threats were made in terms of people saying that I needed to – again, watch myself while I was walking to my car at the end of a shift. People saying that they know where I live, and basically threats to sort of my physical safety were made, to the point where I had to at the end of a shift ... at night would have to have either my mum or my dad or my husband come and collect me from work because I was too afraid to walk to my car in the dark on my own.¹⁰

7. I made recommendations all of which were intended to assist in changing the negative culture which persisted in too many places in the NHS through a combination of emphasis on putting the patient at the centre of healthcare, regulation, leadership development, support for staff and, above all, increased openness, transparency and candour about matters of concern. Among the recommendations I made were those designed to bring about:
 - An obligation on staff to report safety concerns and to give including action taken or reasons for not acting [R12][
 - A legal duty of candour to patients [organisations and professionals] [R173-183][
 - Banning of “gagging clauses” in “compromise” agreements [R175][
 - Assessment of nursing applicants for compatible values and compassion [R188, 191][
 - Enhancement of nurse leadership capability at all levels[R195-197][
 - Strengthening of nursing professional voice [R201-206].
8. The great majority of my recommendations were accepted and steps taken to implement them. I draw particular attention to the following developments:

⁸ Chapter 1 para 1.197 of the Public Inquiry report [Vol 1 p 108]

⁹ Chapter 2 para 2.374 of the Public Inquiry report [Vol 1 p 235]

¹⁰ Chapter 22 para 22.18 of the Public Inquiry report [Vol 3 p 1504]

- a. The creation of a legal duty of candour, aligned with obligations under commissioning arrangements. Compliance is overseen by the CQC.
- b. An enhancement of the requirement that directors of healthcare providers be fit and proper persons and are disqualified from being such if, among other things, they have committed serious mismanagement or misconduct in office.
- c. An improved system of inspection and rating of all NHS providers by CQC. A significant amount of information on which assessments are made derives from staff.

The Freedom to Speak Up Review

9. In 2014 Jeremy Hunt asked me to undertake a review of whistleblowing in the NHS, principally as a result of a number of reported experiences of staff who had suffered serious adverse consequences as a result of raising concerns. Although I received some helpful contributions from sources in Scotland, my remit was limited to considering the situation in England. On considering the evidence submitted to me I found that:

- raising concerns could be a “harrowing and isolating process with reprisals”;
- bullying and oppressive behaviour were common;
- there was a lack of support for staff and confidence that there would be any effective action when concerns were raised;
- concerns were often handled poorly;
- people who spoke up too often suffered a devastating impact as a result of doing so;
- employers often felt challenged in how to separate safety concerns from disciplinary issues, culpability and responsibility;
- the area was not helped by an adversarial legalistic culture

The accounts offered by staff and former staff were often of considerable concern. A small selection of quotes from the evidence included in the report make the point”

- *I have often been so depressed by this experience that I have often considered suicide. I live in fear that the hospital will carry out its threat to sue me and take my home from me if I don't pay their costs quickly. I have lost all faith in the NHS and the employment tribunal system (which I believe colludes with these big employers to cover up their abuses of whistleblowers).*
- *...false allegations made under the cover of whistleblowing have left myself and a number of my colleagues deeply traumatised.*
- *Colleagues often quietly agreed with my concerns but refused to speak out in fear of reprisals*
- *(There is) a culture of delay, defend and deny.*

10. I set out 20 Principles which I considered should inform and support a change of culture to make speaking part of the normal business of healthcare rather than a dangerous activity resulting in little action other than detrimental treatment for the member of staff brave enough to raise a concern. In summary they were:

1. Every organisation involved in providing NHS healthcare should actively foster a culture safety and learning in which all staff feel safe to raise concerns.
2. Raising concerns should be part of the normal routine business of any well-led NHS organisation.
3. Freedom to speak up about concerns depends on staff being able to work in a culture which is free from bullying and other oppressive behaviours.
4. All employers of NHS staff should demonstrate through visible leadership at all levels in the organisation that they welcome and encourage the raising of concerns by staff.
5. Employers should show that they value staff who raise concerns, and celebrate the benefits for patients and the public from improvements made in response to the issues identified.
6. There should be opportunities for all staff to engage in regular reflection of concerns in their work.
7. All NHS organisations should have structures to facilitate both informal and formal raising and resolution of concerns.
8. When a formal concern has been raised, there should be prompt, swift, proportionate, fair and blame-free investigation to establish the facts.
9. Consideration should be given at an early stage to the use of expert interventions to resolve conflicts rebuild trust or support staff who have raised concerns.
10. Every member of staff should receive training in their organisation's approach to raising concerns and in receiving and acting on them.
11. All NHS organisations should ensure that there is a range of persons to whom concerns can be reported easily and without formality. They should also provide staff who raise concerns with ready access to mentoring, advocacy, advice and counselling.
12. Where a NHS worker who has raised a concern cannot, as a result, continue in their current employment, the NHS should fulfil its moral obligation to offer support.
13. All NHS organisations should be transparent in the way they exercise their responsibilities in relation to the raising of concerns, including the use of settlement agreements.
14. Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising, or receiving and handling concerns. There should be personal and organisational accountability for
 - a. Poor practice in relation to encouraging the raising of concerns and responding to them
 - b. The victimisation of workers for making public interest disclosures
 - c. Raising false concerns in bad faith or for personal benefit
 - d. Acting with disrespect or other unreasonable behaviour when raising or responding to concerns.
 - e. Inappropriate use of confidentiality clauses.

15. There should be an independent National Officer resourced jointly by national systems regulators and oversight bodies and authorised by them to carry out the functions described in this report, namely:
 - a. Review the handling of concerns raised by NHS workers and/or the treatment of the person or people who spoke up where there is cause for believing that this has not been in accordance with good practice.
 - b. Advise NHS organisations where they have failed to follow good practice, or advise the relevant systems regulator to make a direction to that effect.
 - c. Act as a support for local Freedom to Speak Up Guardians
 - d. Provide national leadership on issues relating to raising concerns by NHS workers
 - e. Offer guidance on good practice about handling concerns
 - f. Publish reports on the activities of this office.
 16. There should be coordinated action by national systems and professional regulators to enhance the protection of NHS workers making protected disclosures and of the public interest in the proper handling of concerns.
 17. CQC should recognise NHS organisations which show they have adopted and apply good practice in the support and protection of workers who raise concerns.
 18. All principles in this report should be applied with necessary adaptations to education and training settings for students and trainees working towards a career in healthcare.
 19. All principles in this report should apply with necessary adaptation in primary care.
 20. Legal protection for those who make public interest disclosures should be enhanced by extension of the prescribed bodies for this purpose and the extension of protection to students in nursing and medicine.
11. Implementing the recommendations associated with these principles has not been as expeditious as some expected, but in my view there has been significant progress:
- a. I believe that every NHS Trust has now appointed a Freedom to Speak Up Guardian. A variety of approaches has been taken to the functions of the post, the experience and background of the persons appointed and the support offered. Time will help in the assessment of which approaches work better than others.
 - b. The post of National Freedom to Speak Up Guardian has been set up and funded and appointed jointly by CQC, NHS Improvement and NHS England. While the post is hosted by CQC the Guardian works independently. An appointment has been made: Dr Henrietta Hughes. I respectfully suggest that she is asked to offer the Committee a summary of the work she has been undertaking, but it includes a number of events bringing together the local Guardians enabling them to share good practice, challenges, and to set up self-support networks.
 - c. NHS England is working on a support scheme for staff who have lost their jobs as a result of speaking up.

- d. Many trusts have reviewed their whistleblowing policies to ensure consistency with the Principles.
- e. The case review function of the National Guardian's Office is being developed and may be expected to commence operation in the near future.

Conclusion

- 12. I hope this short statement indicates the areas in which I may be of assistance to the Committee and I am naturally content to be asked to expand on any particular point.

6 June 2017

SIR ROBERT FRANCIS QC



The Scottish Parliament
Pàrlamaid na h-Alba

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Health and Sport Committee Comataidh Slàinte is Spòrs

The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland



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Health and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.



<http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/health-committee.aspx>



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Introduction

1. The NHS in Scotland marks its seventieth anniversary this year. The NHS was founded on the principle of providing comprehensive health services, free at the point of use and based on need. This principle remains primarily unchanged in today's NHS. However, the demands on the NHS, the services it provides and its administration are almost unrecognisable from those of seventy years ago.
2. As 2018 is a landmark year for NHSScotland it provides an appropriate juncture to not only reflect on the changes it has faced but also ensure it is equipped to adapt and respond to future changes. The Health and Sport Committee has been considering these issues within the context of the governance of the NHS.
3. At the heart of the NHS is the patients it serves and we have sought to reflect this in the approach taken to our inquiry. The Committee has focused on looking at the culture of the NHS and the way this impacts on patients. We have received written evidence and hosted both informal meetings and formal committee evidence sessions with NHS patients to further understand their experiences and views of the NHS and to shape our approach and focus to the inquiry. These sessions have been invaluable and we wish to express special thanks for the willingness of individual patients to share information on often very difficult and emotive personal experiences.
4. Governance has many facets and we have considered the issue of NHS Governance under three broad areas – staff, clinical and corporate governance. The Committee's inquiry into NHS Governance has been its longest running inquiry to date. The Committee's evidence gathering has included receipt of over one hundred written submissions and ten formal evidence sessions.
5. The first main strand of our inquiry looked at how NHS staff are managed in a fair and effective way. We took evidence from front-line staff, trade union representatives, senior NHS managers and the Scottish Government.
6. During our evidence gathering on the second strand to our work on clinical governance we considered the process and procedures through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services, and ensuring they safeguard high standards. We received evidence from patients about their experiences of care, staff representative organisations, a range of patients and third sector organisations and organisations responsible for ensuring and overseeing good clinical governance.
7. The third and final strand to our work considered the structures and processes for decision making, accountability, control and behaviour at the upper levels of the NHS. It included a survey issued to all NHS board members exploring areas considered key to good governance. Following receipt of the results of the survey the Committee took oral evidence from a range of stakeholders external to NHS boards but affected by the decisions they take. The Committee also took evidence from individual NHS board members and concluded its inquiry with an evidence session with the Cabinet Secretary for Health and Sport.
8. Health boards are all accountable directly to the Scottish Parliament and this report considers the issues of staff, clinical and corporate governance in turn. It looks at

the specific areas under each of these strands of governance which we consider need to be addressed to ensure NHS Governance is flexible and sufficiently responsive and robust to ensure delivery of the best healthcare for the people of Scotland.

9. Before going on to discuss each of these specific areas, we would like to highlight one over-arching theme which emerged during the inquiry, which is the importance of ensuring that the NHS in Scotland is adequately funded and resourced.
10. During each strand we heard about funding impacts from a wide variety of witnesses covering:
 - Staff governance, including challenges around recruitment and retention
 - Clinical governance issues on clinical care; and
 - Corporate governance challenges in meeting targets.
11. While the question of the resourcing of the NHS in Scotland is clearly a very important one, the focus of this particular report has been the governance of the NHS, rather than the question of the resourcing of health services. This inquiry has sought to examine the scope for improvements which can be made to the governance arrangements of the NHS in Scotland. Nevertheless, we acknowledge the importance of NHS budgets and resources as a subject, and we will make reference to them at points in this report. However, we commit to return to this subject in more detail during our ongoing scrutiny of the Scottish Government budget.

Staff Governance

12. Staff governance can be considered as a system of corporate accountability for the fair and effective management of all staff.
13. The most valuable resource the NHS in Scotland has is undeniably its staff. There are over 162,000 NHS employees who work tirelessly to deliver health care for the people of Scotland.
14. It is essential that every NHS employee feels valued, listened to and appreciated. They have an important role in developing and improving health services.
15. We looked at the governance arrangements for staff in the NHS. It is important that these work effectively, ensuring staff are supported and motivated to do the best job that they can.

Staff Governance Standard

16. A national Staff Governance Standard was introduced by the NHS Reform (Scotland) Act 2004, placing a duty on NHS boards to monitor their management of staff governance.
17. The duty requires all boards to achieve five standards, demonstrating that staff are:
 - Well informed
 - Appropriately trained and developed
 - Involved in decisions
 - Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and
 - Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.
18. The Staff Governance Standard was widely welcomed in evidence to the Committee. It was described as a positive set of principles designed to ensure there is genuine staff and trade union involvement and engagement in decisions affecting the operation of NHS boards.¹
19. Unison Scotland considered the Staff Governance Standard to be an ‘exemplar model’ and noted that NHSScotland “has enjoyed an unprecedented period of industrial harmony”.²
20. The Scottish Government was asked what progress had been made in relation to the Staff Governance Standard since monitoring had begun. Shirley Rogers of the Scottish Government stated “We have worked closely with the staff side to make sure that the five standards of staff governance are achieved as frequently as possible, and the survey results and staff governance audit results have shown

considerable improvement in the 10 or 15 years since their introduction. There is, however, more to be done.”³

Monitoring views of NHS Scotland staff

21. The Staff Governance Standard sets out high level principles which clearly have been broadly welcomed. However, the Committee was keen to explore how these principles have been applied in practice. In particular we wanted to understand how NHS workers themselves feel about their working life.
22. Given the number of staff in the NHS in Scotland and their diverse range of working experiences, it can be challenging to capture their views.
23. However, national staff surveys of NHS workers have attempted to gather information about how employees feel about their place of work. These opinion gathering exercises can help us get a sense of how well the NHS is meeting the Staff Governance Standard.
24. From 2006 until 2015, the annual NHS staff survey was the main mechanism used to gather the views of NHS staff. In 2015, the NHS staff survey was replaced by the iMatter questionnaire which was rolled out over a three year period.
25. iMatter is described as a Continuous Improvement Model and involves more localised monitoring of staff experiences, as well as the opportunity for more local feedback on what can be done differently.
26. In addition, a Dignity at Work Survey was issued in November 2017. The Survey addressed areas not currently covered by iMatter including bullying and harassment, discrimination, abuse and violence from patients and the public, resourcing and whistleblowing.
27. Together, iMatter and the Dignity at Work Survey aim to provide a rounded overview of the national NHS staff experience. Their findings were summarised in the Health and Social Care Staff Experience Report 2017⁴ which was published in March 2018.

Staff Governance - themes raised in evidence

28. The Committee took wide ranging evidence on the subject of staff governance.
29. Many people we spoke to took the opportunity to comment on the wider challenges and pressures facing the NHS. Others commented on how management policies and decisions were impacting on their ability to work effectively. We also looked at the information contained in the Staff Experience Report to obtain insights into the views of staff across the NHS in Scotland.
30. The Committee would wish to highlight some of the main insights it received.

Pressure on staff - what witnesses told us

31. The pressures being faced by the NHS workforce was a recurring theme during our consideration of staff governance. Staff resourcing was mentioned by many witnesses.
32. The 2017 Staff Experience Report recorded that 34% answered positively to the question 'there are enough staff for me to do my job'. This was a 1% increase from the 2015 survey. The question 'I can meet all the conflicting demands on my time at work' was answered positively by 46% of respondents (no change from 2015).
33. Clearly there is scope for these figures to improve.
34. It is worth noting, however, that overall staff levels in the NHS are at the highest level ever with 140,261.9 whole-time equivalent staff employed as at December 2017. The most recent Information Service Division figures show that the number of staff employed by NHS Scotland increased by 0.7% over the last year. However, these figures do not tell us whether the level of staff is enough to fulfil the NHS' requirements.
35. We heard that vacancy levels are high in certain areas with a rise in the number of vacant posts being unfilled for six months or more. A number of witnesses felt that increasing demands were being placed on staff, creating stress. For example, Ros Shaw of RCN described nursing staff as being under "immense pressure" due to "huge vacancy levels" in the community and hospital setting.⁵
36. BMA Scotland stated in relation to primary care "the clinical workload is becoming unmanageable". They pointed to the difficulty in the recruitment and retention of doctors as both a cause and an effect of what they described as "stressful working conditions for doctors".
37. We heard similar views from NHS frontline staff at our informal evidence sessions.
38. The issue of low pay was raised by some witnesses such as the RCN.
39. Other witnesses commented that there was pressure to meet targets. This was a point raised by middle managers in our informal evidence sessions. Some suggested that operating in a target-driven culture resulted in innovative suggestions or concerns raised by staff being set aside as this was not the focus of their work.
40. Some witnesses also suggested that time pressures were making it difficult for staff to access continuing professional development.⁶
41. We explored some of these issues with the Cabinet Secretary for Health and Sport. The Cabinet Secretary made reference to the Scottish Government's forthcoming legislation on safe staffing.ⁱ She stated "We want to put the workload tools on a statutory footing and to make sure that we can use them to good effect.[...] It is about having the right staff at the right time in the right place and being able to flex the rotas to take account of patients with a high level of acuity, such as patients with dementia."⁷

42. In addition, the Cabinet Secretary made reference to the Scottish Government's approach to workforce planning which has involved the publication of a workforce plan in three stages. The first publication covered the NHS workforce and was published in June 2017. The second publication covered the social care workforce and was published in December 2017. The third publication covered the primary care setting and was published in April 2018.
43. We recognise that NHS staff are working within resourcing and financial pressures against a backdrop of high public expectations, changing demographics and new approaches to service provision. Improving workforce planning is a key component to addressing these issues.
44. We note the work the Scottish Government is currently undertaking regarding production of a workforce plan. The Scottish Government's plans should enable better local and national workforce planning to support improvements in service delivery and redesign. However, the workforce plans should be more than a broad framework within which to consider future workforce planning issues. We recommend that the Scottish Government ensure its workforce plan assesses the current capacity issues around long-term vacancies and proposes specific steps which can be taken to address them. We recognise that the answer to addressing staff pressures is not always to grow the workforce but further recognition needs to be given to the current staff pressures and steps taken to improve the situation.
45. We also believe that it would be helpful if assessment moved away from determining whether the workforce was growing towards consideration of what size the staff establishment should be to meet demand in different areas and how this compares against current staff levels.
46. Since the Committee began its NHS governance inquiry the Scottish Government has introduced the Health and Care (Staffing) (Scotland) Bill. As a Committee we will scrutinise this Bill to determine if it will deliver its aim of ensuring appropriate staffing to provide safe and high quality care.

Consultation and staff relations

47. Another recurring theme was staff engagement in organisational decisions and the relationships between senior management and front-line staff. One issue that arose in particular was the question of trust in senior management.
48. In the 2017 Staff Experience Report one of the questions that had the lowest average score was 'I have confidence and trust in senior managers responsible for the wider organisation'.
49. During our informal evidence sessions with NHS frontline staff, some attendees spoke positively about their colleagues but said they rarely felt thanked with any

i This legislation has since been introduced: 23 May 2018 Health and Care (Staffing) (Scotland) Bill

sincerity by management. Many felt senior management did not understand the pressures frontline staff were facing and communicated poorly.

50. This view tallies with the 2017 Staff Experience Report on the iMatter question 'I feel involved in decisions relating to my organisation'. This question had the lowest average score.
51. We explored frontline staff's apparent disconnect with management with witnesses.
52. BMA Scotland suggested that engagement could be tokenistic: "There is an element of rubber stamping in that fully formed ideas are brought to be validated rather than staff being involved from the bottom up." ⁸
53. Unison Scotland spoke of the pressures on local managers to implement savings plans. It suggested that it was easier to work in partnership with staff during times of growth, because there was a positive message to deliver, whilst it was more difficult during periods of retraction and change. ⁹
54. Managers in Partnership also raised concerns about the pressures being faced by management. They spoke about a lack of appreciation of managers and blame apportioned to them. This was resulting in managers suffering ill health and individuals requiring mental health support. ¹⁰
55. Barriers to engagement were also raised. The BMA said there were difficulties for staff to engage in the decision making process due to restraints on time and resources. The BMA also highlighted that the influence and activity of existing mechanisms for influencing health board decisions (e.g. area medical committees, consultant subcommittees and specialty subcommittees) were patchy and varied greatly between NHS boards. These views were supported by the RCN and the Allied Health Professions Federation (AHPF), although the AHPF highlighted their lack of access to decision making mechanisms.
56. We heard of work undertaken by some NHS boards to address concerns regarding management visibility. Elaine Mead of NHS Highland told the Committee how her board had encouraged and supported managers – particularly middle managers – to see the work of teams and managers were buddied with wards in some areas. ¹¹

Discrimination, bullying and harassment

57. Another aspect of staff relationships explored by the Committee was around issues of discrimination, bullying and harassment.
58. The Dignity at Work Survey highlighted that the majority of NHS staff members had not experienced these issues. However, of those who had, only a minority had reported them. Reasons for not reporting unacceptable behaviour included a belief that nothing would happen as a result, concern with what would happen if it was reported, and concerns about confidentiality.
59. Managers in Partnership stated in its written submission that its members reported that "the NHS is blame oriented with a culture of formal grievances to resolve matters that should be discussed informally first. We need to develop a culture of talking about difficulties without blaming with a focus on finding a mutually agreeable solution for all." ¹²

60. Managers in Partnership also expressed frustration that, where staff have raised grievances, managers are often unaware that problems had escalated to that extent. They considered there to be a lack of opportunity for managers to use the informal stages of the Partnership Information Network (PIN) guideline on bullying and harassment which encourages issues to be talked through first.¹³

61. It is clear from the evidence we heard that it is important to ensure good communication between all staff levels within an organisation. We believe it is even more vital when there are staff pressures and changes to service provision. To deliver changes effectively staff must be involved in shaping and influencing decisions as well as implementing them.

62. We heard of good practice examples of management being encouraged to engage with frontline staff in NHS boards. It is important this is encouraged and the time and opportunity provided to facilitate this. We ask the Scottish Government what barriers it believes prevent this approach from being adopted across all NHS boards and what steps are being taken by NHS boards to address this.

63. Bullying, discrimination and harassment in the workplace are unacceptable. NHS staff must feel confident to raise concerns regarding colleagues' behaviour and treatment towards them. It is concerning that of those who experience these issues only a minority feel confident to raise them. We believe further steps need to be taken to increase confidence in the response individuals expect to receive when raising concerns. We ask the Scottish Government what steps it is taking alongside NHS boards to increase staff confidence to report bullying, discrimination and harassment.

Whistleblowing

64. Whistleblowing and the systems in place for staff to raise concerns are a key aspect of staff governance. We think it is essential that individuals feel confident to speak out when they feel they need to raise concerns.

65. Robin Creelman of NHS Highland used the metaphor of the whistleblowing system as a lifeboat "To me, a whistleblowing system is basically a lifeboat for the culture of the NHS. If the rest of the culture is in place, we should seldom require the lifeboat, but we must have the lifeboat."¹⁴

Confidence to speak out

66. The Dignity at Work Survey 2017 found that 65% of respondents believed it was safe to speak up and challenge the way things are done if they have concerns about quality, negligence or wrong doing by staff. This is a marked increase of 9% from the 2015 survey. However, the findings show that over a third of staff felt it was unsafe to speak up.

67. Sir Robert Francis QC, who conducted the Freedom to Speak Up review into whistleblowing in the NHS in England, stated in his review "there are disturbing

reports of what happens to those who do raise concerns. Yet failure to speak up can cost lives.”¹⁵

68. He told the Committee “In an ideal world everyone should be able to speak up, be listened to and see action being taken, but unfortunately that is, as we know not the position.”¹⁶
69. Claire Pullar of Managers in Partnership told us “senior managers think that there is still blame attached when someone has the temerity to raise concerns through whistleblowing. The attitude is “How dare they?””¹⁷
70. Dr Gordon McDavid of The Medical Protection Society Scotland spoke of concerns raised by its Members “They are scared of what will happen if they speak up or are honest when something goes wrong. Will they be sued?”¹⁸ The Medical Protection Society in its written submission called for a culture of improved openness “...We need an environment where staff are trained and supported to be open about mistakes and to learn from them, and where senior clinicians lead by example.”¹⁹
71. Many witnesses mentioned the importance of having a culture where individuals felt confident and supported to speak out.
72. Ros Shaw of RCN suggested that there needed to be a culture which was both supportive and enabling of staff who raised concerns.²⁰

How concerns are raised and dealt with

73. It is important that where NHS staff have concerns, there are systems in place to allow these concerns to be reported and acted upon.
74. We looked into the question of how NHS staff members can report concern about activities in the workplace.
75. We heard during our inquiry that NHS boards are expected to have local policies for staff raising concerns. They are also expected to adhere to the Staff Governance Standard, which involves implementing Partnership Information Network (PIN) policies such as ‘Implementing and Reviewing Whistleblowing Arrangements in NHSScotland’.
76. We also explored with witnesses whether more could be done at an earlier stage to prevent staff from feeling they had to whistleblow because their concerns were not being taken seriously. For example, the Datix computer software system seeks to promote a culture of learning by recording, investigating and analysing incidents and near misses. Matt McLaughlin of Unison Scotland told us that Datix offered a route to raising an issue at a local level but noted that it did not provide feedback to people when they made a referral or a report at a local level.²¹

Duty of candour

77. The Committee also noted that the new legal duty of candour, which came into force in April 2018, might help create within the provision of clinical care a culture of openness, thereby negating the need for some whistleblowing.
78. In Scotland the duty is being implemented via the enactment of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016. The duty of candour provisions require health and social care organisations to inform people of any unintended or unexpected incidents which result in death or harm.
79. The Cabinet Secretary explained that the duty of candour would be a legal requirement and aims to drive cultural change and lead to more transparency and openness in how the NHS operates.²²

National Confidential Alert Line

80. One specific mechanism for staff to raise concerns which we examined was the National Confidential Alert Line (NCAL). It is run by Public Concern at Work which is an independent whistleblowing charity.
81. The NCAL aims to complement existing whistleblowing policies by providing a safe space for staff to raise concerns about patient safety and malpractice. The NCAL does not investigate concerns but legally trained staff offer support and advice.
82. Where appropriate, concerns can be passed to the appropriate regulatory body or NHS boards.
83. Since its launch in 2013 the hotline has received 309 calls from staff.²³
84. Some of the written submissions we received criticised the fact that callers to the alert line were often referred back to their employer.²⁴ The BMA Scotland representative noted "the flaw in the helpline that always refers people back to the internal arrangements, so there is no escape from the inward-looking way of addressing things".²⁵

Independent National Whistleblower Hotline

85. During this inquiry we also considered Petition PE1605 which is calling for an independent national whistleblowing hotline to replace NCAL.
86. The Petitioner would like the new hotline to have the power to investigate individual reports about mismanagement and malpractice without recourse to NHS managers. This would avoid the current situation where calls to the alert line are referred back to the caller's employer.
87. The Petitioner suggested the NHS should adopt a reporting line similar to that operated by the City of Edinburgh Council. The Edinburgh hotline is operated by an external provider, although it is managed internally by senior staff. It is the hotline staff who interview whistleblowers and categorise their concerns as major or minor.

A course of action is then agreed in consultation with senior staff. In cases of major issues, this involves an investigation led by the provider of the hotline service.

88. We note that the NCAL is predominantly an advice line for staff while the City of Edinburgh Council hotline is a reporting line with a role in investigating a concern.
89. Sir Robert Francis told the Committee that having both models [a reporting line and an investigative line] was a good idea.²⁶
90. Cathy James of NCAL Public Concern at Work, who gave evidence to the Committee, commented in a BBC article that “an investigatory service aimed at whistleblowing cases across the NHS could make a real difference to the experience of those raising concerns in the health sector, but this is not the service we provide to NHS Scotland”.²⁷
91. The contract for the NCAL was re-tendered in June 2017 and it has remained predominantly an advice line for staff. The Cabinet Secretary stated that this fulfilled the Freedom to Speak Up review’s recommendation that an external support service is available to staff.

Whistleblowing Champions and the Independent National Whistleblowing Officer

92. The Committee also took evidence about the idea of whistleblowing champions.
93. Following the recommendation of the Freedom to Speak Up review, whistleblowing champions were appointed in each health board in Scotland. The purpose of the Champion is to provide an oversight and assurance role on whistleblowing.
94. The review considered that the whistleblowing champion should be someone “who is recognised as independent and impartial, has the authority to speak to anyone within or outside the trust, is expert in all aspects of raising and handling concerns, has the tenacity to ensure safety issues are addressed, and has dedicated time to perform this role”.
95. The Scottish Government’s view is that champions “provide independent assurance at a local level” and the role does “not form any part of whistleblowing policy”.²⁸
96. The Scottish Government also intends to establish an Independent National Whistleblowing Officer (INWO) to review independently the handling of whistleblowing cases in NHSScotland and “provide independent challenge and oversight”.²⁹ The Cabinet Secretary detailed that legislation would be introduced in 2018 to allow the INWO role to be hosted within the Scottish Public Services Ombudsman office (SPSO). It was expected that the post would be established in late 2018.³⁰
97. The Committee heard some concerns about the independence of the whistleblowing champions.
98. One concern was that health boards had been instructed in a Chief Executive Letter to appoint a non-executive director to the role.

99. Rab Wilson (who identified himself as an NHS Whistleblower) indicated his view was that this meant the appointments were neither independent, fair or impartial.
100. Sir Robert Francis also noted the risk that a non-executive director taking the role could be perceived as leading to a conflict of interest. He noted that “a non-executive director has a corporate responsibility to the running of the organisation that to some might be seen as conflicting with their role of helping to oil the wheels of the system for challenging the organisation.”³¹
101. On the other hand, some of the current whistleblowing champions provided examples of when their role had operated effectively, for example by upgrading the level of an investigation resulting from whistleblowing. Morag Brown, non-executive director and whistleblowing champion at NHS Greater Glasgow and Clyde, discussed being able to “speak up and challenge” in her role. She acknowledged, however, that there was potential for public concern about the independence of the role.³²
102. She suggested that the new Independent National Whistleblowing Officer could play a role in monitoring boards’ performance in relation to whistleblowing and producing national materials and training for whistleblowers.³³
103. The Cabinet Secretary was asked about the potential conflict of interest of non-executive directors being whistleblowing champions. She stated that the role of whistleblowing champions “was intended to provide a level of local scrutiny and assurance, independent of the direct management or handling of whistleblowing concerns, so that there would be a go-to person who would be separate from someone’s line manager. That go-to person was also seen as someone who could promote and champion whistleblowing as a concept in its own right”. She also provided a specific example of where the role had operated effectively to improve the information that was gathered and recorded about the nature and number of whistleblowing cases.³⁴

Treatment of Whistleblowers

104. One of the keys to encouraging staff to speak out is for individuals to have confidence in how they will be treated.
105. Some of the case studies referred to in the Freedom to Speak Up review, and in the evidence we received, highlighted cases of bullying, harassment and threats against whistleblowers.
106. In the Freedom to Speak Up review, Sir Robert Francis wrote: “Whistleblowers have provided convincing evidence that they raised serious concerns which were not only rejected but were met with a response which focused on disciplinary action against them rather than any effective attempt to address the issue they raised.”³⁵
107. Some of the written evidence received by the Committee also detailed examples of alleged mistreatment of staff who had raised concerns.³⁶

Blacklisting

108. One concern raised in written evidence by Dr Sukhomoy Das and Dr Jane Hamilton following their experiences of whistleblowing, was the subsequent difficulties they faced when applying for other jobs in the NHS.
109. There was a suggestion made by some witnesses that the NHS in effect operates a 'blacklist' and that whistleblowers are discriminated against when seeking employment in another board.
110. This allegation was strongly refuted by NHS board representatives. Kenneth Small of NHS Lanarkshire stated "There is no such thing as a blacklist. I would play no part in that, personally or professionally."³⁷
111. The Employment Rights Act 1996 protects people from "suffering a detriment" from their employer as a result of making a public interest disclosure, however, it does not give them legal protection from the actions of a potential future employer.
112. Sir Robert Francis reiterated in evidence to the Committee the recommendation in his review that legal protections should be extended outside the particular organisation in which an individual is working, so that people who are applying for jobs elsewhere in the NHS would be protected.³⁸
113. The law in this area is largely reserved. The UK Government consulted on the draft Employment Rights Act 1996 (NHS Recruitment – Protect Disclosure) Regulations 2018. These regulations will allow a whistleblower to take a potential NHS employer to a tribunal and potentially receive compensation if they feel they have been discriminated against. The UK Government responded to the consultation in March. The UK Government stated it would implement the regulations at the earliest opportunity.³⁹

Junior Doctors

114. We also received specific concerns about the whistleblowing protections being afforded to junior doctors. BMA Scotland told the Committee in March 2017 that the current legal position meant that if a junior doctor suffered detrimental treatment from NHS Education Scotland (NES) as a result of whistleblowing, they would not receive the equivalent legal protection they would have obtained had they been mistreated by the territorial health board which employed them. BMA Scotland stated that this was "one area where the NHS is falling short of what is expected" in relation to whistleblowing and the Staff Governance Standard.⁴⁰
115. Following BMA Scotland's evidence session with the Committee the Scottish Junior Doctors Committee met with NHS Education Scotland to work together to achieve a solution to the issue. On 1 March 2018 the Scottish Government announced that legal protections were now in place for junior doctors and other postgraduate trainees if they are subjected to detrimental treatment by NES for raising any concerns.⁴¹

116. One of the witnesses described whistleblowing as a lifeboat, which should seldom be required if an open and transparent culture is in place. If we apply this metaphor to our assessment of whistleblowing our conclusion is that at present the lifeboat is not viewed as a safe haven as many staff are not willing to enter into it and those who do can find it is to their detriment.
117. Whilst there has been an increase in NHS staff feeling confident to speak up, there is still over a third of staff who feel unwilling to do so. We believe this issue must be addressed. Ultimately there needs to be a culture of openness and transparency. There must also be mechanisms in place for staff to raise concerns in an environment where the support and guidance offered to NHS staff is both valued and trusted.
118. We welcome the acknowledgement by the Scottish Government that changes need to be made to support individuals to feel more confident to raise concerns. We welcome the recent introduction of the Duty of Candour and the forthcoming creation of the post of Independent National Whistleblowing Officer (INWO). We believe these measures have the potential to make valuable contributions to achieving a cultural change in how the NHS in Scotland treats whistleblowing. We ask the Scottish Government to provide further information on how it will monitor and assess the implementation and impact of these new policies and what difference it expects them to deliver. In particular we expect to see a significant improvement in the percentage of staff feeling 'confident to speak out' and ask the Scottish Government what level it expects to see in the 2018 Staff Experience Report as a result of these changes.
119. Whilst welcoming these new policies we do believe there are still further steps which need to be made to the current whistleblowing system to ensure it is as robust and fit for purpose as possible. We support the work of the National Confidential Alert Line and believe it provides a useful function for staff wishing to raise concerns. However, it is predominantly an advice line for staff and not an investigative line. We note the comments made by Sir Robert Francis that having both a reporting line and an investigative line is a good idea. We also received evidence on how an investigative line can operate effectively at a local authority level. We believe the introduction of a reporting line for NHS whistleblowers would further enhance the external support services available to NHS staff. We recommend that the Scottish Government introduce an investigative line for whistleblowing. We believe that an investigative line would work well in conjunction with the new role of Independent National Whistleblowing Officer in providing external oversight and support to the whistleblowing system.
120. Looking at the systems currently in place we recognise the merits of non-executive board directors operating as Whistleblowing Champions. They are well placed to understand NHS structures and board processes and have the authority to speak out and challenge poor practice. However, we recognise there is a potential conflict of interest in a non-executive director taking on the role whilst also having a corporate responsibility to run the NHS board. Whilst the issue may be one of perception if this is a barrier to staff feeling confident about speaking out, steps need to be taken to try to change that perception. We therefore recommend that the Scottish Government allow NHS boards to appoint individuals other than non-executive board directors to the role of Whistleblowing

Champion. We also recommend there is staff involvement in the appointment process. A mixture of non-executive board members and non-board members which staff have been involved in appointing may assist in instilling confidence in the system. It will also enable a comparison to be made between the two different types of Whistleblowing Champion to determine if there is any difference in outcome depending on who is in the role.

121. Staff must have confidence in how they will be treated if they speak up. We were concerned to hear of cases of alleged mistreatment of staff when they had raised concerns. NHS employees are meant to be protected from detrimental treatment when raising concerns. We believe the new INWO will have a key role to play in ensuring whistleblowers are treated fairly. We ask the Scottish Government what avenues for redress will be open to the INWO if they establish that an individual has been treated unfairly as a result of raising concerns. We also ask the Scottish Government what sanctions it believes would be appropriate to impose on individual NHS employees who mistreat whistleblowers. We are keen to ensure that the NHS in Scotland encourages and supports whistleblowers and when faced with unfair treatment there should be a clear line of recourse and redress.
122. We were concerned by accounts from some individuals alleging that they had faced discrimination when seeking employment in another board as a result of having whistle-blown. We must ensure that legal protections are extended to protect those in that situation. We therefore welcome the commitment made by the UK Government to extending protection in relation to recruitment.
123. In relation to protections provided to junior doctors, we are pleased that since BMA Scotland first raised its concerns with the Committee legal protections have now been put in place for junior doctors if they suffer detrimental treatment from NES as a result of whistleblowing. It is vitally important that all NHS staff at all stages of their careers are offered the same legal protection if they are treated unfairly within any areas of the NHS.

Regulation of Managers

124. Another issue explored during the course of consideration of staff governance was the regulation of professions. There is currently statutory regulation of 32 healthcare professions across nine professional regulatory bodies in the NHS.
125. The Committee received some calls for NHS managers to be regulated in the same way that other health professionals are. This stemmed from the Sir Robert Francis Review which recommended the following principle:

“An enhancement of the requirement that directors of healthcare providers be fit and proper persons and are disqualified from being such if, among other things, they have committed serious mismanagement or misconduct in office.”
126. The difference in regulation between health professionals and NHS management was raised in the written submissions to the Committee. Dr Hamilton in her written submission stated “Front line staff are now additionally obliged by a ‘duty of

candour' to raise concerns where they become apparent, with legal consequences (such as being 'struck off' or prosecuted) if they do not. Curiously and discrepantly, no such legal 'duty' applies to senior management nor are they ever held legally accountable for wrong-doing or incompetence, as would occur in the private sector for example." ⁴²

127. A poll in the British Medical Journal found that 91% of doctors who responded believed that healthcare managers should be regulated in the same way as doctors.
128. The poll was accompanied by an editorial that quoted Sir Robert Francis "When we look at what really goes on in a hospital, in the engine room, we've got consultants and, alongside them, managers. Together they are meant to manage a service and yet one side is subject to a regulator, and could be in jeopardy for any decision that they make, whereas the other side is not." ⁴³
129. We raised with NHS managers the prospect of regulation. Elaine Mead of NHS Highland said she would welcome external validation. She felt that a lot of managers would be happy to be subject to the same scrutiny faced by their clinical colleagues. ⁴⁴
130. While the regulation of health professions that were regulated prior to devolution is a reserved matter, the regulation of new professions would be devolved to Scotland.
131. Paul Gray, Chief Executive of NHS Scotland said that he would "welcome proposals for the regulation of managers and leaders in the NHS because it would bring parity" with other health professionals in the NHS. He added that thought would have to be given to the "risks and opportunities" regulation would present. ⁴⁵

132. The issue of regulation of management has been raised during the course of our inquiry. NHS managers are not currently regulated in the same way that other health professionals are. This creates an imbalance between clinical and managerial staff. We note the Chief Executive of NHS Scotland's comments that he would welcome proposal for the regulation of managers and leaders in the NHS and that thought would have to be given to the risks and opportunities this presented. We believe the time is right for this issue to be given further detailed consideration by the Scottish Government. For such a change in approach to the regulation of NHS management to be delivered successfully it will require the support and involvement in development by NHS managers. They will need to recognise the benefits it could bring to them in their role and the wider NHS service and its patients. We recommend the Scottish Government undertake a review of the case for regulation of NHS management to determine the merits, steps and requirements that would be needed to deliver this change.

Integration Authorities

133. Another issue we wish to raise on the subject of staff governance is the impact the establishment of integration authorities is having on the delivery of the Staff Governance Standard.

134. Integration Authorities do not currently operate under the same partnership working model set out in the Staff Governance Standard. Unison Scotland described local authorities as “another big complex beast” which “does not necessarily have at its heart that commitment to staff governance”.⁴⁶
135. We heard of the practical impact of some health services and their staff now being managed on a daily and strategic basis by non-health professionals.⁴⁷ Some examples were provided of where concerns had arisen with proposed changes to service provision and staff terms and conditions. Unison Scotland suggested that the nature and construction of Integrated Joint Boards created the potential for there to be “a culture clash”. It called for further guidance from the Scottish Government to address these issues.⁴⁸
136. We asked the Cabinet Secretary if there were any plans to have a single governance standard for health and social care staff. In response she detailed there had initially been some sensitivities regarding one system being seen to impose its approach on another. However, the merits of the staff governance principles had been recognised by Integration Authorities with a gradual adoption of staff governance principles across a number of Integration Authorities. She stated that the expectation was that more would follow.⁴⁹
137. We are pleased to learn that the NHS staff governance principles are gradually being adopted across a number of Integration Authorities. Integration Authorities are now into their third year of operation and we believe there is merit in ensuring these principles are embedded across all Integration Authorities. If the integration of services across health and social care is to be achieved there must be consistency in the values and treatment of staff across both the health and social care sectors to ensure there is a collegiate and united approach. We expect parity of treatment for all staff and that creating a single Staff Governance Standard across health and social care would greatly assist in meeting this objective. We ask the Scottish Government to work with local authorities, NHS boards, trade unions and Integration Authorities to establish such a standard and to focus on how its delivery would assist in meeting the wider aim of integration of health and social care services.

Staff Survey and iMatter

138. Our consideration of the issues around staff governance has been informed by the Health and Social Care Staff Experience Report 2017. We wish to make some comments on staff engagement in this process, the presentation of the information and the action taken as a result of the survey findings.

Response rates

139. It is clear to us that opinion gathering exercises are most valuable when there is a good participation rate by NHS staff.

140. The response rate for the iMatter survey (63% across NHSScotland and 23 integration authorities) has been higher than that for the Dignity at Work Survey (36% across NHS Scotland and 12 integration authorities).
141. We heard from witnesses this was because the iMatter survey was much more meaningful for staff as it related to their experience of the day-to-day workplace and their team.⁵⁰
142. We also heard that for both surveys there were both regional variations in response rates between NHS territorial boards and also variations between NHS territorial boards and special health boards. The response rate for iMatter ranged from 52% (NHS Western Isles) to 85% (NHS Health Scotland). The response rate for the Dignity and Work Survey ranged from 30% (NHS Greater Glasgow and Clyde) to 84% (NHS Health Scotland).
143. We believe that it is essential that the NHS listens to the views of its staff - its most valuable resource. There should be effective mechanisms in place to gather these views, with the objective being to encourage a high response rate.
144. We welcome the introduction of iMatter as it has led to an increase in staff participation in the monitoring of NHS staff governance. The more staff who engage with iMatter the more accurate the picture of staff experiences across the NHS.
145. The response rates for both the iMatter questionnaire and the Dignity at Work Survey vary significantly between different boards and NHS organisations. We therefore question how accurate a picture the Staff Experience Report is able to provide of the staff experience across the whole of the NHS in Scotland. We ask the Scottish Government to detail its explanation for this variation in response rates and the steps it proposes to take, alongside health boards, to improve participation where engagement is currently low. We also ask the Scottish Government to detail what response rate it hopes to achieve in the next annual report of iMatter.
146. The 2017 Dignity at Work Survey only achieved a 36% response rate in comparison to a 63% response rate for iMatter. The issues covered by the Dignity at Work Survey, including bullying and harassment, discrimination, abuse and violence from patients and the public, resourcing and whistleblowing are central to staff governance and it is important as complete a picture as possible is obtained of these issues. Given the increased engagement achieved through the iMatter approach, the Committee recommends that the Scottish Government examines whether these issues should be included within the scope of the iMatter questionnaire. There should be a high level of engagement by staff across all issues relevant to staff governance.

Employee Engagement Index Score

147. One aspect of the Staff Experience Report we raised with the Scottish Government was about how the scores for the iMatter questionnaire are calculated and presented.

148. The Staff Experience Report uses an Employee Engagement Index (EEI) Score as a key indicator of performance against various iMatter questions. The questions invite respondents to pick a number on a scale from 6 (strongly agree) to 1 (strongly disagree).
 149. The Staff Experience Report explains that the EEI score is shown as a percentage of the total score available. The EEI score is the number of responses for each point in the scale multiplied by its numerical value (6 to 1) added together, then divided by the overall number of responses.
 150. As we understand it, the scale used for responding to each question starts at 1 rather than 0, which means the lowest possible EEI score is 16.6% rather than zero.
 151. We were concerned that, as presented, the EEI score is potentially inflated and that it was not clear from the report whether this had been adjusted for.
 152. We wrote to the Cabinet Secretary for Health and Sport ⁵¹ to seek further clarification on this issue and assurance that the EEI could not inadvertently give a misleading impression. We wanted to be clear that the way the EEI was calculated creates an accurate picture of performance against the staff governance standard.
 153. The Cabinet Secretary's response stated that a "mistake was made" in the weighting of the scores. Her response detailed "For a 1-6 weighting to be applied a different formula would be required to transfer the EEI into a percentage. This has led to the iMatter results with the Health and Social Care Staff Experience Report unintentionally referring to the index scores in percentage terms when they were not." ⁵²
 154. Her letter detailed that this issue would be taken into account when considering recommendations for the intended approach for the iMatter model in 2018. A review of the measurement of the EEI will also be built into the scope of the work for an external evaluation of the Scottish Government approach to staff experience through the iMatter and Dignity at work surveys.
155. It is important that the way the EEI is calculated creates an accurate impression of staff experience. We therefore welcome the Scottish Government's acknowledgement that it will review the measurement of the EEI going forward.

Acting on the survey results

156. Several witnesses made the point that it was important that the results of the survey were acted upon.
157. Individual teams within each part of NHS Scotland are expected to complete and agree action plans based on the findings of their responses to iMatter. However, the Staff Experience Report shows that there is a huge variation between NHS boards in the share of teams completing the required action plans, ranging from 12% (NHS Western Isles) to 97% (NHS Health Scotland).

158. When asked about the staff survey, a witness from Unison Scotland stated “If people act on what they are told, it will be a raging success; if they do what they did with the existing staff survey, which was to completely ignore it, it will just be the same again.”⁵³
 159. This view was echoed by Gary Wilson who was a Non-Executive member of the Board of NHS Health Scotland until 2013. He was supportive of the aims of the Staff Governance Standard, but stated “the problem is with the lack of any action when these standards are not being implemented”.⁵⁴
 160. RCN was critical of the annual assessment of performance against the Staff Governance Standard which was conducted between an Area Partnership Forum and the Scottish Government. Meetings tended to focus on the positive examples rather than the points of concern raised by the staff survey.⁵⁵
 161. Other views were more positive. Kenneth Small of NHS Lanarkshire told the Committee that he did not agree that the staff survey results were ignored. He explained the former annual staff survey results had been used to inform priorities for action and improvement by the Board's staff governance committee.⁵⁶
 162. We also heard from some witnesses who commented that the move to the iMatter questionnaire had been helpful. BMA Scotland noted that iMatter had the potential to deliver improvements in staff governance as it could help generate local solutions to issues.⁵⁷
 163. Kenneth Small of NHS Lanarkshire considered that another advantage of iMatter was that, as well as enabling an assessment of performance at an NHS corporate and individual board level, in time it could also assess performance within specific department and clinical areas in boards.⁵⁸
164. The Staff Experience Report provides a useful tool for measuring performance against the staff governance standard. We also believe that it should be used as a tool to drive improvements in performance. To facilitate this approach we recommend that within three months of the publication of the annual Staff Experience Report, the Scottish Government should publish an action plan for areas for improvement. This should detail the steps the Scottish Government proposes to take, and which it expects specific NHS boards to take, to deliver improvements. We also recommend that the Scottish Government should make it clear what level of improvement in performance against the staff governance standard it expects in each individual board with minimum levels for improvement set and explanations provided for variance with high performing areas.
 165. There is currently a huge variation across NHS boards in the extent to which iMatter action plans are being completed. We ask the Scottish Government to explain the reasons for this variation and detail what steps it is taking to increase the usage of action plans by NHS boards who are currently performing poorly. We also ask the Scottish Government to detail what percentage share of action plans completed it would expect each NHS board to achieve in 2018.

166. iMatter assessment is conducted at a team level. This provides an opportunity to drill down to a departmental and clinical specialist level to identify areas of good practice and areas for improvement. We believe that this information should be used to assess whether there are any common trends being experienced by the same types of NHS staff or in the same clinical areas across NHS boards. We ask the Scottish Government in the next Staff Experience Report to provide an analysis which looks at trends across staff groups or clinical specialisms as well as by NHS board.

Clinical Governance

167. The second strand of our inquiry considered clinical governance. Clinical governance has been defined as:

"A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." ⁵⁹

168. Patients are entitled to expect the care they receive to be safe, effective and tailored to their needs. They also expect services will treat them with dignity and respect.
169. During this phase of the inquiry we looked at the systems which are in place to maintain and improve patient care and the systems to address failings if things go wrong.
170. In this section we explore some of the themes and issues that arose during our consideration of clinical governance.

Standards and guidelines of care

171. A key part of clinical governance is the setting and meeting of standards for good quality care. NHS boards are expected to abide by national service standards and guidelines. This includes meeting Local Delivery Plan (LDP) standards which are one of the key mechanisms for performance managing health boards. Most of the standards are former 'HEAT' targets, with HEAT being an acronym relating to four key objectives:
- Health Improvement
 - Efficiency and Governance Improvements
 - Access to Services
 - Treatment Appropriate to Individuals. ⁶⁰
172. In addition to LDP standards there is a range of other standards and guidelines produced by the Scottish Government, its arms-length bodies and other professional bodies, which NHS boards are expected to pay due regard to.
173. Sources of guidance include:
- The Scottish Government – for example Chief Executive Letters
 - NHS Healthcare Improvement Scotland – produces standards for care. NHS Healthcare Improvement Scotland also incorporates organisations such as the Scottish Intercollegiate Guidelines Network (SIGN) (which produces guidelines on clinical practice) and the Scottish Medicines Consortium (which advises boards on the clinical and cost-effectiveness of newly licensed medicines)

- Health Protection Scotland – issues guidance on the management of infectious and environmental hazards
 - National Institute for Health and Care Excellence (NICE) – although the guidance it provides is officially for England, some is applicable and relevant in Scotland
 - Professional bodies – including the Royal Colleges.⁶¹
174. Healthcare Improvement Scotland (HIS) is tasked with improving the quality of care in the NHS and has a key role in setting standards for care and treatment. HIS describes itself as an improvement body rather than a regulator and it has few legal powers to enforce sanctions against NHS boards. Instead it works with boards to bring about improvements. As a result, NHS boards still have a large degree of autonomy over what health services they deliver to the population and how they do so.
175. HIS also incorporates the Scottish Health Council (SHC) which is tasked with overseeing how well NHS boards consult with the public and how boards support the public to get involved.
176. We explored with HIS its role in the development, implementation and monitoring of the standards and guidelines detailed above. In evidence to the Committee Robbie Pearson, Chief Executive of Healthcare Improvement Scotland stated that HIS “has a pivotal role in supporting the production of the guidelines and standards.”⁶² and has a key role in their dissemination too.
177. We examined how care and treatment standards and guidelines are developed, implemented and monitored and the extent to which this ensures the consistent delivery of effective care for patients.
178. The general opinion expressed by witnesses was that in the areas standards or guidelines exist, they are good. However, some witnesses expressed concern that awareness of existing standards and guidelines was not high amongst practitioners and service users.
179. For example Clare Ogden of Action for ME discussed the usage of the Scottish Good Practice Statement on ME-CFS published in 2010. A survey issued to GPs four years after publication found two-thirds of GPs were unaware of the statement. Clare Ogden felt this was reflected in the patient experience, with many patients believing their GP had a lack of understanding of the condition which led to poor advice being provided.⁶³
180. Some written evidence we received highlighted there are some conditions which have no standards or guidelines for diagnosis and treatment. In such instances it is a matter for professionals to ensure quality.⁶⁴
181. Some questions were also raised about the suitability of clinical guidelines. Dr Peter Bennie of the BMA suggested that clinical guidelines may have “limited or no relevance” because they do not take account of co-morbidity, something which is fairly typical of many patients today.⁶⁵

Implementation

182. In evidence we heard there can be variations in how standards and guidelines are implemented. This can affect the experience of patients and the services provided to them.⁶⁶
183. Down's Syndrome Scotland reported that the quality of care for patients with Down's Syndrome often varied depending on where they lived and who was supporting them.⁶⁷ The Royal College of Pathologists also highlighted a wide variation in practice regarding the use of laboratory requests for specific tests. According to its evidence, the under and over requesting of particular tests raised patient safety issues as a result of under-diagnosis and over-treatment.⁶⁸
184. The Health and Social Care Standards published in June 2017 set out what service users should expect when using health, social care or social work services in Scotland. These standards are underpinned by five key principles which include dignity and respect.⁶⁹
185. Whilst several NHS boards emphasised that dignity and respect were core values of NHSScotland, we received evidence which suggested this was not always reflected in patients' experiences.
186. Carolyn Lochhead of SAMH highlighted its survey of people who had used NHS mental health services in the last year, which found that 40 per cent of respondents said they had been treated disrespectfully.⁷⁰ Derek Young of Age Scotland stated that for patients, being treated with dignity and respect was as important as the quality of care delivered. He highlighted that whilst dignity and respect are included within standards these aspects of care do not yet form the basis of enough inspections.⁷¹
187. We explored with staff representatives why patients may not always be treated with dignity and respect. Dr Peter Bennie of the BMA emphasised that "No one receives poor treatment deliberately, and very few receive poor treatment because of thoughtlessness".⁷² Dr Lorna Greene of the Royal College of Nursing summed up the view expressed by several witnesses that whilst there was a requirement to deliver care in a dignified and respectful way, "resources, pressures on time and staffing will all impact on the quality of care that is delivered".⁷³

Volume

188. In the course of our consideration of clinical governance, we heard a number of suggestions as to why there might be variation in the implementation of standards and guidelines.
189. The volume of standards or guidelines was raised as an issue. Reference was made to there being a "plethora of guidance".⁷⁴
190. Dr Peter Bennie of the BMA said that whilst new guidelines were well publicised "it was difficult to keep up to date with everything that comes through".⁷⁵

191. Jason Leitch, National Clinical Director, Scottish Government raised a similar point stating "it is almost impossible for people to keep up with the guidelines in their own specialties, never mind the generic guidelines". He placed emphasis on ensuring implementation by making sure that guidelines can be applied to the clinical environment.⁷⁶
192. One specific issue which the Committee explored with witnesses was whether staff had the time to undertake Continuing Professional Development (CPD), to keep up to date with new standards and guidelines. We received suggestions that a lack of resources meant staff did not have time to take stock and undertake CPD.
193. In its written submission RCN mentioned day-to-day service pressures as a barrier to accessing CPD, as well as nursing staff having a lack of protected study time.⁷⁷
194. We also heard that there appears to be a variation between professions as to whether staff are able to access time for CPD.
195. Dr David Chung of the Royal College of Emergency Medicine Scotland told us that whilst he had protected time, nurses did not "As a doctor with protected CPD and so on, I find it incredibly incongruous to have to watch my nurses come in on their days off to do courses because they cannot do them as part of their normal work. That is completely unfair."⁷⁸
196. We raised the issue of staff accessing CPD with Professor Jason Leitch, National Clinical Director, Scottish Government. In a letter to the Committee he stated "For nurses and midwives there is a 2% predictable absence allowance for CPD which is built in to the workforce planning tools."⁷⁹

Inspection and Monitoring

197. We heard about the importance of monitoring the implementation of guidelines and standards. The Scottish Public Service Ombudsman told the Committee "Putting standards in place and disseminating them are important but, once they are in place, we must continually monitor their implementation and, if they do not deliver the outcomes that we expect learn from that."⁸⁰
198. The role of Healthcare Improvement Scotland (HIS) was raised within this context.
199. We received some examples of HIS assessing how standards were being implemented through its inspection activity, including Healthcare Environment Inspections and Older People in Acute Hospitals inspections. Robbie Pearson, the Chief Executive of HIS, highlighted that the Healthcare Environment Inspectorate had produced around 270 reports and the number of 'requirements and recommendations' had fallen consistently year on year and there had also been a reduction in infection, with MRSA rates falling by 90%.⁸¹
200. However, the implementation of other standards does not appear to be routinely monitored by HIS.

201. For example, Rachel Le Noan of Down's Syndrome Scotland explained that her organisation had been invited by HIS to be a member of a group creating the national screening standards for Down's Syndrome. However, she noted that HIS had no role in implementing and monitoring the standards which she considered to be "quite troubling".⁸²
202. We also heard concerns expressed about the role of HIS as both a scrutiny body and an improvement body, and the potential conflict of interest this could present (this issue is explored further in this report under consideration of 'regulatory regime').

Consistency in Outcomes

203. Another issue which was raised during discussions about the guidelines and standards of care was consistency in the standard of care delivered. We received calls for improvements to be made in collecting patient outcome data and for there to be better use of routinely collected data to inform good practice.
 204. Dr Calderwood, the Chief Medical Officer, discussed variations in care and explained that an Atlas of Variation was being developed which will look at unnecessary variations in practice across Scotland. She told the Committee this was due to be published in April and would cover three operative procedures - hip replacement, knee replacement and cataract surgery. It would provide data at both population level and by health board.⁸³
 205. The Cabinet Secretary added "we are concerned about unwarranted variation, where there is no reason, other than people continuing to do things in the same way, for having different outputs and outcomes. We think there is a lot of scope, particularly in elective care, to make big inroads into variation."⁸⁴
206. Clinical standards and guidelines have a key role to play in ensuring patients receive high quality, safe care and are treated with dignity and respect.
 207. Where standards and guidelines exist they have been generally welcomed. However, we believe that they are not being used as effectively or consistently as they should be, which is resulting in current variations in patient experience and outcomes. There are also occasions where guidelines do not take account of issues such as co-morbidity.
 208. Staff awareness, knowledge and understanding of standards and guidelines is critical to ensuring effective use. We note the challenges faced by staff in keeping up to date with the frequently wide-ranging standards and guidelines relevant to their work. Having the time to undertake Continuing Professional Development is very important if this objective is to be met.
 209. We were concerned to learn that, whilst the Scottish Government highlighted that time to access CPD was built into workforce planning tools for nurses and midwives, there were examples of staff in these roles who reported not being

- able to access CPD during their normal working day. We do not consider this to be acceptable.
210. We do not consider having a predicted absence allowance for CPD built into workforce planning tools is enough. We recommend the Scottish Government conduct a review of NHS board performance on the implementation of the allowance for CPD as set out in the Scottish Government's workforce planning tools. It is important that NHS boards are ensuring that nursing and midwifery staff are able to access the time they are entitled to for CPD.
 211. We also believe there must be parity between all NHS staff in being given access to their allocated time to conduct CPD. We recommend the Scottish Government place statutory requirements on boards to ensure delivery of appropriate CPD time for all NHS staff.
 212. Treating patients with dignity and respect is arguably as important as the quality of the care they receive. We were concerned to learn of instances where patients felt they had not been treated with dignity and respect. These are core values of NHSScotland and should be as central to good clinical governance as the quality and safety of the care that is provided.
 213. We believe there must be a focus on the patient's whole experience of their health care. Ultimately treating individuals with dignity and respect will result in a more positive experience which in turn can assist in ensuring a positive outcome for the patient.
 214. We therefore welcome the inclusion of dignity and respect as principles underpinning the new Health and Social Care Standards. We heard from some staff representatives that there can be instances where the quality of care they provide can be affected by resources, pressures on time and staffing. We seek assurances the inspection regime for the new standards will include ensuring the views of service users are sought. We also believe inspections must assess not only where issues lie with regards to performance against standards but also seek to identify the reasons for poor performance and assess whether there are systematic issues faced across NHS boards which need to be addressed.
 215. There appears to be variations in the current dissemination, implementation, inspection and monitoring of standards and guidelines. We heard of the key role Healthcare Improvement Scotland can play in monitoring and inspecting certain standards and guidance.
 216. However, HIS only undertakes this role for some standards and guidelines. We believe the rationale for what is inspected and monitored and what is not is unclear. We recommend the Scottish Government should undertake a fundamental review of HIS's function with a view to implementing a more systematic and coherent approach to its work. We believe there is merit in consideration being given to HIS having a broader look at how standards and guidelines are delivered and how well they are designed for the purposes they are seeking to address. We believe this would also assist in enhancing its roles as an improvement body. Its reporting on standards and guidelines would provide a benchmark for performance and encourage adequate implementation. We also

believe consideration should be given to HIS being given greater enforcement powers in this role. We consider this enhanced role for HIS would also allow it to assist in streamlining guidance and standards where required and help with dissemination. This might address concerns regarding the wide range of standards and guidelines which currently exist and the concerns which have been raised regarding variation in care provided.

Learning and improvement when things go wrong

217. Learning from mistakes or near misses in the provision of healthcare and services is key to creating a culture of improvement.
218. The issue of this culture of improvement was first raised in our discussions regarding whistleblowing. It was raised again during our consideration of the complaints system and the framework for managing serious adverse events (SAEs). We heard that it was important that these systems and frameworks operated in a culture of openness, transparency and learning.
219. Some witnesses suggested that changes need to be made to the current culture of how the NHS responds to mistakes. Dr Bennie of BMA told the Committee “In much of the health service, there is a culture of learned helplessness – a sense that passing on bad news will have no effect and, therefore, there is no point in doing it.”⁸⁵
220. Witnesses including HIS and SPSO emphasised the importance of learning from near misses and mistakes and ensuring that changes were made to clinical practice as a result. Professor Fluck, Medical Director of NHS Grampian summarised the view expressed by several witnesses when he argued that the focus on complaints should be on the “culture processes and behaviours around how we use the information to learn from it.”⁸⁶

Datix system

221. During our consideration of whistleblowing some concerns were raised that the Datix computer software system which records incidents and near misses lacked a system for providing feedback. This meant the Datix system did not provide the opportunity for lessons to be learnt from incidents.
222. Dr Chung of the Royal College of Emergency Medicine said that “feedback is crucial for quality improvements of any kind” but the Datix system was “cumbersome”. Dr Chung described it as a “not very slick system and it is a barrier to getting proper feedback and learning.”⁸⁷
223. Other witnesses including Lorna Greene of the Royal College of Nursing echoed this view. She said that having a system where people can log their concerns is a vital part of an improvement culture. She emphasised the importance of receiving

feedback on what data recorded in the Datix system had been used for and its role in delivering improvements.⁸⁸

224. In response to Dr Chung's concerns, Professor Leitch, National Clinical Director, Scottish Government stated that Datix was used well in health boards and that there was a national Datix user group where users come together to share best practice.⁸⁹

Complaints

225. Complaints about NHS services are an important mechanism for gathering feedback and a route to improving services.
226. The new NHS complaints procedure came into effect in April 2017. Under the procedure complaints should be made directly to an NHS board. This can be a two stage process. Under stage one the NHS board should seek to resolve the complaint within five working days. If the complaint is more complex or requires more detailed investigation it proceeds to stage two. Under normal circumstances the NHS board then has up to 20 working days to provide a decision on the complaint. If an individual is unhappy with the NHS board's final decision they can ask for it to be considered by the Scottish Public Services Ombudsman or seek a judicial review.

Barriers to making complaints

227. We explored with witnesses the current operation of the complaints procedure. Several witnesses suggested there were barriers to patients providing feedback on their experiences and making a complaint about their treatment. Carolyn Lochhead of SAMH stated there was a lack of awareness about complaint procedures.⁹⁰ This was a view supported by Parkinson's UK in Scotland who said in its written submission that whilst there were positive opportunities for patients to provide feedback on services anonymously through Care Opinion, they were little known by the public.⁹¹
228. Another potential barrier to making complaints, which was highlighted by Derek Young of Age Scotland, was that each NHS board has its own complaints process. He explained that this meant a patient who wished to raise concerns regarding a range of NHS services across NHS boards would have to raise numerous complaints, which he felt was an onerous task.⁹²
229. We heard in our informal evidence sessions with NHS patients that patients often feared recriminations if they raised concerns especially when they or family members were still receiving treatment. Some felt the complaints process should be external to the NHS board in order to give patients the same protection as staff and bring greater objectivity to the procedure. Sue Lavery, who provided insights into her experience raising concerns about her late mother's NHS care, stated "No matter how serious the complaint, complaints automatically supported NHS staff as if mum and I wrote fictional complaints!"⁹³

230. Derek Young of Age Scotland emphasised the importance of ensuring that patients felt the complaints service was consistent and could be trusted to “be on their side”. He considered that the complaints system would be supported by patients where they felt that it would ultimately result in changes either for them or for other individuals facing similar clinical issues.⁹⁴

Ensuring positive outcomes from complaints

231. We also heard concerns that the procedure for handling complaints can sometimes result in a disconnect between the patient and the clinician. Professor Fluck of NHS Grampian told the Committee it would be helpful if there was an increase in the involvement of patients at an early phase of a complaint investigation.⁹⁵ Sue Lavery said in her written submission that after she raised a complaint no one came to speak to her or her mother to discuss it.⁹⁶
232. This concern was also acknowledged by clinicians. The British Dental Association said in its written submission “Responses to patient complaints can be delayed and non-specific. Clinicians’ feedback is often ignored and a vague (diplomatic) version of the truth is sent back to patients. BDA Scotland is concerned that generic responses are issued with no intention of dealing with the root of the problem”.⁹⁷
233. Ella Brown, whose father died following a fall at Victoria Hospital in Fife, also suggested that initially she had felt “abandoned” by the NHS board having raised her concerns about the care her father had received. However, the experience she relayed to the Committee about the handling of her complaint had ultimately been a positive one as it had resulted in service changes. She told the Committee that the NHS board had contacted her and she had been able to play a key role in helping to shape services and bring about changes aimed at reducing hospital falls.⁹⁸
234. Some NHS board representatives including Dr Gillies of NHS Lothian suggested that an advantage of the complaint system being managed within individual NHS boards is that boards can take ownership of driving the change that is required as a result of the complaint and ensuring changes are embedded in everyday practice.⁹⁹
235. The SPSO stated that learning from complaints was the most important performance indicator of the new complaints procedure. The SPSO highlighted several areas where she felt improvements could be made in the operation of the current system. This included improvements to how the NHS learns from complaints and changes that were made to the system as a result. She also believed improvements could be made to the consistency of complaint handling by NHS boards. There were examples where a corporate explanation for a response to a complaint had been given which had not had the right level of clinical input.¹⁰⁰
236. Finally the SPSO emphasised that the new system needed an opportunity to become embedded to deliver a shift in culture.¹⁰¹

237. Learning from mistakes or near misses in the provision of healthcare and services is key to creating a culture of improvement. We were concerned to hear suggestions that there is currently a culture of “learned helplessness”. Steps must be taken to challenge and address this.

238. The Datix computer software system has an important role to play in recording incidents and near misses. We were therefore concerned to hear suggestion, from staff using Datix that it lacked a function for providing feedback to staff on what action has been taken as a result. Professor Leitch, National Clinical Director, Scottish Government highlighted the work of the national Datix user group. We recommend that the Scottish Government asks the national Datix user group to determine if the concerns expressed to the Committee are widespread and, if so, what further steps need be taken to improve the provision of feedback through the Datix system. We believe it is important that routine feedback on Datix entries is provided as this will assist in reassuring staff that something is done with the issues that they raise.

239. We were also concerned to learn that NHS patients can face barriers to making complaints. We heard for some patients there was a lack of awareness and understanding of complaints procedures. We also heard concerns about the complexities caused by each NHS board having its own procedure for complaints. The need for trust in the system was also emphasised with some witnesses questioning the objectivity of the complaints procedure, which led to concerns that raising a complaint would have a detrimental impact on the care they receive. There was also a lack of confidence that raising a complaint would result in changes to their or others care and treatment.

240. We believe that some of these concerns have arisen because the current complaints system can often be too process driven. There can be a disconnect between the patient and the clinician. Complaints are dealt with at a corporate level with limited input from clinical staff directly involved in providing the care and treatment. This results in little liaison taking place with the patients and families involved in raising the complaint. We believe changes need to be made to this approach.

241. Complaints should be dealt with promptly and effectively and, where appropriate, resolved at a local level. We believe improving the approach taken to handling complaints will also empower staff to learn and deliver changes in practice and procedure as a result of their involvement in complaint handling. We recommend that at an NHS board level an individual within its complaints management team is tasked to lead on driving these improvements in complaint handling.

242. We heard good practice examples of where NHS boards had engaged with patients and family members who had made complaints and this had resulted in positive changes to clinical practice. We need to ensure that this positive experience is one experienced by more patients who raise a concern.

Serious Adverse Events

243. One of the key areas we examined in the clinical governance strand of the inquiry was the investigation of serious adverse events (SAEs).
244. An adverse event can be defined as an event that could have caused, or did result in, harm to people or groups of people.
245. HIS first published a national framework for managing SAEs in September 2013, and this was refreshed in 2015. The framework aims to support NHS boards to standardise processes. It includes a national definition of an adverse event, and guidance on reporting, accountability, responsibilities and learning.¹⁰²
246. The framework aims include to provide:
 - a consistent national approach to the identification, reporting and review of adverse events, and allow best practice to be actively promoted across Scotland.
 - national resources to develop the skills, culture and systems required to effectively learn from adverse events to improve services across Scotland.

Concerns with the operation of SAEs monitoring and reporting

247. Fraser Morton's baby son, Lucas, was stillborn at Crosshouse Hospital in Kilmarnock in November 2015.
248. In response to his death, NHS Ayrshire & Arran apologised over failures during the later stages of pregnancy to identify complications which contributed to the infant's "very tragic and unnecessary death". Mr Morton and a number of families called for a public inquiry into infant deaths at the maternity unit. The Cabinet Secretary subsequently instructed an investigation by HIS into the management of adverse events in the maternity unit. The report from that investigation was published in 2016 and made a number of recommendations for both NHS Ayrshire & Arran and for the whole of the NHS in Scotland.
249. Fraser Morton's written and oral evidence to the Committee provided valuable insights into the current monitoring and reporting of SAEs. We wish to thank Mr Morton for sharing his very difficult personal experience with the Committee and for his powerful evidence.
250. Fraser Morton questioned how effectively the current national framework identified concerns and problems with the quality and safety of the care and services provided.
251. In particular he expressed concern that health boards were able to determine for themselves what events require to be categorised as 'adverse events' within the general framework. He suggested this leads to inconsistencies across health boards in the numbers of such events recorded and the investigations that take place. Mr Morton called for standardisation of what constitutes a SAE to help identify their occurrence and also to determine whether there were recurring themes in events across health boards.¹⁰³

252. Fraser Morton also raised concerns that there was no central monitoring of SAEs. This was a concern also raised in the Organisation for Economic Co-operation and Development (OECD) report '[Reviews of Health Care Quality: United Kingdom 2016](#)'. The report's chapter on Health care quality in Scotland discusses adverse event reporting in Scotland being done locally, not nationally. The report states "The lack of a national system for reporting/counting adverse events is another weakness, despite other innovations in promoting patient safety." ¹⁰⁴
253. Fraser Morton suggested the Cabinet Secretary's intervention in relation to the situation in Ayrshire and Arran had followed 'adverse national publicity', rather than due to monitoring by the NHS board or the Scottish Government. He believed there had been missed opportunities to identify concerns earlier as there was no central gathering or analysis of SAEs. ¹⁰⁵
254. Fraser Morton also told the Committee that when he had raised concerns regarding his son's death he had been told to pursue the individual doctors/midwives involved. "We were challenged to sue-that is the best way that I can describe it. We were actually challenged: Why don't you just sue us? That was in response to difficult questions that we were asking about the failings surrounding our son's death." ¹⁰⁶ He told the Committee that he did not think it was appropriate that individuals should be held personally responsible for what he deemed to be a service failure.
255. This issue was also raised by some witnesses in relation to the Dr Bawa-Garba case.ⁱⁱ
256. The suggestion was made that this case was an example of where an individual had been held to account but there was no equivalent system for picking up service failures.

HIS and Scottish Government response to concerns regarding SAEs monitoring and reporting

257. We explored with Robbie Pearson, the Chief Executive of HIS and Professor Jason Leitch, National Clinical Director, Scottish Government whether improvements could be made to the monitoring and reporting of SAEs.
258. HIS stated that it was in the process of revising the national framework to improve current approaches to the management of adverse events. ¹⁰⁷
259. Both the Scottish Government and HIS acknowledged there were concerns with the current operation of the SAEs system. Dr Calderwood, Chief Medical Officer, told the Committee in relation to SAEs "We have had inconsistency in what is reported and in our responses". ¹⁰⁸

ⁱⁱ Dr Bawa-Garba was a specialist trainee in England who was found guilty of manslaughter by gross negligence and struck off the medical register. This was following mistakes in her care of a 6 year old boy who subsequently died. Many in the medical profession feel that a number of systemic failures were significant factors in the boy's death but that Dr Bawa-Garba was the only one held to account.

260. Robbie Pearson, the Chief Executive of HIS, made a similar point “there is an issue with the consistency and quality of reporting and with the quality of investigations”.
109
261. However, when asked about the possible merits of creating a national reporting system for SAEs, Robbie Pearson stated “I would caution against creating an accounting system alone” stating that “the numbers are only part of the system”.¹¹⁰ He stated that the priority should be to work to create a culture of openness, transparency and learning.¹¹¹
262. When asked about central reporting of SAEs, Professor Leitch stated the Scottish Government is aware of developments in NHS boards via a ‘performance management infrastructure’.¹¹² He believed that a significant change in the number of adverse events would be picked up nationally.
263. Professor Leitch confirmed that there was no central monitoring of the number of SAEs and questioned the usefulness of such an approach: “The addition of adverse events into a table would not help us, because the definitions are so broad and varied. Individual clinicians make the judgements”.¹¹³
264. He said that in countries that had a national reporting system for adverse events, most have abandoned it.
265. In Professor Leitch’s letter to the Committee on 5 February 2018 he referred to the quarterly Hospital Standardised Mortality Ratios forming the basis of a HIS investigation into mortality in Lanarkshire hospitals. Whilst this example highlights routinely collected data being instrumental in the identification of possible systematic problems in other areas and acting as a catalyst for further investigation Professor Leitch remained clear that the Scottish Government was “unconvinced that holding numbers of adverse events centrally would service a meaningful purpose.”¹¹⁴
266. We returned to the issue of SAEs in the Committee’s final evidence session with the Cabinet Secretary for Health and Sport in February 2018.
267. The Cabinet Secretary highlighted that the Chief Medical Officer had written to all boards with a reminder of the need for consistency on what constitutes a SAE review and how reviews should be handled. The Cabinet Secretary stated: “The boards look at their adverse events and trend analysis to see whether trends are emerging, and HIS has an overview. If HIS identifies a serious concern with a board, because something has emerged from trend analysis or HIS scrutiny work, it can escalate the matter to the board’s accountable officer, the chief executive, the chair and the Scottish Government”.¹¹⁵

Duty of candour

268. As part of its consideration of SAEs, the Committee considered the implications of the introduction of the duty of candour.

269. Robbie Pearson, the Chief Executive of HIS, stated in written correspondence that the duty of candour may impact on the monitoring and reporting of adverse events: "It would be a legal requirement for NHS boards to publicly report on adverse events where the duty of candour has been applied and on the learning and improvement actions resulting from the review of these adverse events." ¹¹⁶
270. The introduction of the duty of candour is considered an important tool in ensuring a cultural shift to a system of openness and learning. Professor Jason Leitch explained: "It is well established that being candid promotes accountability for safer systems, better engages staff in improvement efforts, and engenders greater trust in patients and service users." ¹¹⁷
271. He emphasised that the "duty of candour is not about apportioning blame." He explained that most instances of failures in the provision of treatment or care related to a need to focus attention on "quality improvements through the range of improvements and change mechanisms available, supported by strong leadership in a culture of openness and continuous learning." ¹¹⁸
272. The Cabinet Secretary expressed similar sentiments. She emphasised that the duty of candour "provides another level of reassurance and an extra level of transparency." She detailed that it places a legal duty on organisations and the individuals within them to publish annual reports on all incidents that have instigated the duty of candour procedures. ¹¹⁹
273. In response to concerns that there was no central record of adverse event she stated "The duty of candour requires those reports to be published, and it requires learning and changes to be made on the back of a report." ¹²⁰
274. The Cabinet Secretary also made reference to the case of Dr Bawa-Garba in England within the context of ensuring there is openness when issues arise. ¹²¹

275. Learning lessons from Serious Adverse Events (SAEs) can help the NHS in Scotland manage adverse events in the future, and support preventative measures so as to reduce the risk of serious harm to patients.
276. However we believe there is a need for greater consistency in how SAEs are dealt with.
277. There is currently a national framework setting out how to deal with SAEs. Healthcare Improvement Scotland supports a consistent national approach to identification, reviewing, reporting and learning from adverse events. However, as has been acknowledged by the Chief Medical Officer, there are concerns with how the arrangements for recording SAEs are working in practice. For example there appear to have been inconsistencies in what incidents are being reported as adverse events.
278. The arrangements for recording SAEs represent a key tool for managing risk. Ultimately if these arrangements are not operating effectively, this could put lives at risk. Steps must be taken to ensure that the procedures for recording SAEs are working as effectively and consistently as they can.

279. At present NHS boards are given discretion regarding how they translate the national framework for dealing with adverse events into their day to day operations. However we think there is little justification as to why NHS boards are afforded this discretion and it should be revisited. For example, there may be merit in a standardised definition for SAEs being established across all NHS boards to set out what constitutes a SAE. There may also be advantages in common procedures for investigating SAEs being established so best practice can be shared and promoted. We believe this will help promote consistency and transparency in the system for dealing with SAEs. We recommend that Healthcare Improvement Scotland should be tasked with bringing forward these changes in order to improve the operation of the current system.
280. We also believe that centralised reporting of SAEs should be introduced. To date the Scottish Government has not been convinced of the need for a national reporting of SAEs. However, we do not share this view and, while we accept it would not be a magic bullet, we believe that encouraging a national overview to be taken of SAEs would enable wider systemic issues to be identified more swiftly and then acted upon. As noted by Professor Leitch in his letter to the Committee, routinely collected data has been instrumental in the past in picking up on possible systemic problems in other areas and acting as a catalyst for further investigation and we believe adopting this systematic approach for SAEs will be beneficial.
281. Emphasis is placed on ensuring there is a culture of openness and learning and we believe this could be enhanced by regular monitoring to identify systemic issues as it will give staff the reassurance that they are not the only ones who are accountable. The approach to centralised reporting of SAEs could follow a similar model to that which has already been established for the duty of candour, where there is a requirement to report annually.
282. It is important to be able to identify in a timely manner similar SAEs which have occurred across boards, and to avoid the build-up of systematic issues which affect the provision of safe and appropriate care. We therefore recommend that consideration is given to moving to a quarterly reporting requirement for the duty of candour, including SAEs. We believe this increased level of reporting would assist in identifying any common issues across NHS boards and help facilitate a timely response which addresses these issues.

Regulatory regime

Independent regulator

283. HIS overarching purpose is “better quality health and social care for everyone in Scotland.”¹²²
284. HIS is an organisation which is at the centre of ensuring delivery of good clinical governance in NHS Scotland. It has a key role in relation to the standards that

underpin clinical care and in setting the frameworks for what happens when things go wrong.

285. The suitability of the role and remit of HIS was a recurring theme throughout the course of the Committee's governance inquiry.
286. We received some suggestions that there was a need for an independent regulator of the NHS to be established. These submissions were generally critical of HIS being a special health board of the NHS, with a limited role in the investigation of complaints and service failures. We also heard views suggesting that there was a conflict of interest inherent within the constitution of HIS, as it combines scrutiny with improving service delivery.
287. The Royal Society of Edinburgh suggested there may be merit in expanding the role of HIS. The Royal Society noted there is not an equivalent body in Scotland to the one that operates in England to independently investigate system failure. The Royal Society of Edinburgh suggested that HIS, along with other organisations who carry out investigation into health service in Scotland, should be “empowered to expand their remit to support more robust investigations.” ¹²³
288. Fraser Morton called for an independent investigatory body to be established with expanded powers, compared to HIS. Fraser Morton told the Committee that HIS “is an organisation which has suffered from mission creep since its inception [...] HIS is effectively hamstrung in its efforts due to the fact that it is not a regulator, has no powers, and is not entirely independent of the NHS.” ¹²⁴
289. Fraser Morton also suggested that HIS should have greater powers to enforce sanctions on NHS boards. He told the Committee “we cannot continue to expect HIS to continue with their flawed ideological hands off holistic approach to the clinical governance of healthcare in Scotland. Speaking softly and not being armed with a big stick is clearly not working.” ¹²⁵
290. In contrast, Dr Bennie of BMA Scotland told the Committee there may be limited merit in having an independent regulator. Dr Bennie was critical of the role of the Care Quality Commission as the independent regulator of health and social care in England. He suggested that there had been instances where the Commission had not identified systematic problems with care provision. He stated “An external regulator will often miss what is really going on. Ownership by managers and clinicians on the ground is what will change what is really going on.” ¹²⁶
291. The OECD report which reviewed healthcare quality in the UK was critical of the dual role of HIS as a scrutiny and improvement body: “Although the strengthening of HIS’ competence is welcome, Scotland should reconsider whether the mixing of scrutiny and quality improvement activity within [HIS] represents a conflict of interest. The mix of these roles means that the system's inspector risks “marking its own homework.” ¹²⁷
292. While the report goes on to note the efforts HIS makes to ensure the functions of assessment and improvement are kept separate, it also explains that OECD countries are increasingly placing the scrutiny function at arms length from service delivery. It recommends that Scotland should make the Scrutiny and Assurance

directorates of HIS a separate entity and that it should consider publishing a comprehensive assessment of the quality of care in Scotland.¹²⁸

293. We explored with the Cabinet Secretary for Health and Sport these calls for an independent regulator to be established and the suggestion that the Scrutiny and Assurance Directorate should be separated from the rest of HIS.
 294. The Cabinet Secretary told the Committee that the strength of HIS was that it had been developed to have a dual function of delivering improvement through its inspections. She gave the example of the Healthcare Environment Inspectorate (HEI) within HIS. She explained that not only was the HEI able to identify issues that need to be resolved by an organisation but it also had the ability to work with them to deliver these improvements. "We could have set up an inspecting body that sat separately, but if it did not have an improvement arm we would have been left with inspected organisations with a set of problems but no solutions to go with them."¹²⁹
 295. She said that the inspection reports produced by HIS were robust and that as an organisation it did not "pull its punches" in terms of exposing areas of concerns. Indeed, she noted that it often called on external expertise to conduct its work. The Cabinet Secretary believed that HIS had worked effectively to improve patient safety.¹³⁰
296. We recognise the central role HIS plays in ensuring delivery of good quality care and clinical best practice.
 297. However, HIS's scrutiny function and its approach to delivery of improvements to the performance of NHS boards is not systematic. As highlighted earlier in the report HIS's role in relation to implementation, inspection and monitoring of standards and guidelines is not consistent and there does not appear to be a clear rationale for its areas of focus.
 298. In relation to SAEs HIS becomes involved at the request of the Scottish Government. We consider HIS's role should be more proactive including a greater surveillance function to help identify and preferably prevent systemic failures at an earlier stage.
 299. There should therefore be a review of the role of HIS with the principal aim of ensuring its scrutiny function is as effective as possible. We recommend a review should include the areas we have highlighted earlier including consideration of a greater role for HIS in relation to the monitoring and delivery of clinical standards and guidelines. We also recommend HIS be tasked to make further improvements to the current operation of the SAEs national framework.
 300. We are concerned a special health board is not perceived by the public as being sufficiently independent to enforce sanctions. Nor do we consider they currently have adequate powers. A central part of this review should therefore be to give consideration to the advantage and disadvantages of making the scrutiny and assurance directorate of HIS a separate entity. We acknowledge the merits in one body being well placed to identify problems and offer solutions through undertaking both scrutiny and improvement functions. The key concern is to

operate with a greater degree of objectivity and independence while also having sufficient powers to bring about necessary change.

301. We recognise the value from being able to maintain the dialogue HIS has between and within its separate areas and would expect this to be replicated in the event that the functions of HIS are separated while at the same time improving the public's perception of independence.

Corporate Governance

302. The third and final strand of our inquiry considered corporate governance.

Overview, background and purpose

303. It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. The main purpose of boards is to provide effective leadership, direction, support and guidance to organisations and ensure that the policies and priorities of Scottish ministers (and the Scottish Government) are implemented. In most cases, the board is the most senior group in the organisation and provides important oversight of how public money is spent.¹³¹
304. Central to the NHS delivering the best healthcare for Scotland is ensuring appropriate structures and processes for decision making, accountability, control and behaviour at the upper levels of the organisation are in place.
305. NHS boards are required to have a code of corporate governance in place and good governance is ensured through a Committee structure within each NHS board. The membership of NHS boards comprises, Executive Members, Non-Executive Lay Members and Non-Executive Stakeholder Members. Executive Members hold a place by virtue of their employed position within the Board (e.g. Chief Executive or Medical Director). Non-Executive Lay Members are appointed by Ministers after open competition and Non-Executive Stakeholder Members are appointed and paid in the same way as lay members but are representatives of specific interests that must be represented on the Board (e.g. chair of the area clinical forum).
306. In considering this area we do not set out to examine the detail of all aspects of governance; there are numerous guides and reports on this available. Rather we seek to consider the overarching principles we expect NHS boards to operate against and in particular consider their core strategic purposes as stewards of public resources. We looked at how NHS leadership was providing the vision and the strategic direction to deliver the transformational change required in health and social care. As well as considering the functions boards should perform, we also considered whether the approach and behaviours adopted at the senior levels of the NHS were fostering a culture of openness and improvement.
307. In 2010 Audit Scotland reported on [The role of boards](#) which examined the role and work of boards in the public sector. That report remains relevant, although we understand some updating is imminent. In its report Audit Scotland state: "Most public bodies are governed by a board which provides oversight of how they are performing, how they spend their money and a link through the Scottish Parliament to the electorate. Boards are in place to ensure the good corporate governance of public bodies, defined by the Scottish Government as 'the structures and processes for decision-making and accountability, controls and behaviour at the top of organisations' ".¹³²
308. Scottish Government guidance for board members defines the role of the board as:-

- "giving leadership and strategic direction
 - defining control mechanisms to safeguard public resources
 - supervising the overall management of the body's activities
 - reporting on stewardship and performance." ¹³³
309. In March 2017 the Scottish Government published On Board guidance for Board members. The guidance covers the roles and responsibilities of Boards including their decision-making responsibilities and the operational and statutory accountability responsibilities of the Chief Executive. ¹³⁴
310. The guidance details the four main functions of a board as being:
- to ensure the body delivers its functions in accordance with Ministers' policies and priorities;
 - to provide strategic leadership;
 - to ensure financial leadership;
 - and to hold the Chief Executive and senior management team to account.
311. We used the above functions in the Scottish Government's good practice guidance for boards and the roles set out by Audit Scotland as the framework by which to consider the performance of NHS boards.

Evidence gathering

312. Our evidence gathering on corporate governance included undertaking a survey of NHS territorial board members. The survey covered a number of areas which are considered key to good governance, including board members' challenge and scrutiny function and their confidence in decision making and achieving strategic aims. The Committee received responses from 126 NHS board members. This equates to 47% of all NHS board members in Scotland. A SPICe research analysis of the survey results was produced. ¹³⁵
313. We wish to take this opportunity to thank all those board members who took the time to respond to the Committee's survey. Board members' responses provided valuable insights into how they perceived themselves and their role.
314. In addition to the survey we also issued a general call for views seeking opinions on how well NHS boards adhere to the key principles of good corporate governance as outlined by the UK Code of Corporate Governance (leadership, effectiveness, accountability, relations with stakeholders).
315. We held an oral evidence session with a range of stakeholders who are external to NHS boards but are familiar with how they function. We also took formal evidence from a selection of NHS board members and held a final evidence session on the governance inquiry with the Cabinet Secretary for Health and Sport.

316. This part of our report is divided into three sections:

- the board, membership and role;
- board engagement with stakeholders; and
- the impact on the role of the board from IJBs and regionalisation.

The role of the NHS board member

317. NHS board members' primary role is in ensuring the delivery of good corporate governance.

318. The Scottish Government 'On Board' guidance for board members emphasises that they must adhere to collective corporate responsibility, confidentiality and the highest standards of conduct. The guidance also states that individual board members should contribute fully to board deliberations and exercise a healthy challenge function.

319. During the course of our consideration of corporate governance a range of issues were raised in relation to the work of NHS board members. They included how board members are equipped for their role, how effective they are in carrying it out and the diversity of board membership.

Role of NHS boards in setting strategic direction and financial planning

320. The On Board guidance details that two of the main functions of a board are to ensure strategic leadership and financial stewardship. The guidance details this should include developing and agreeing the organisation's strategy and ensuring financial information is accurate and financial controls and systems of risk management are robust and defensible.

321. The Cabinet Secretary for Health and Sport told us "Our NHS boards are responsible for providing the vision and the strategic direction through which they deliver high-quality, safe and effective care to our communities." ¹³⁶

322. However, some responses to the NHS board survey suggested that boards faced challenges in delivering this strategic leadership. There was a perception from some board members that NHS boards were powerless to set strategy and affect the change they want. They attributed this largely to the delegation of board functions to IJBs, the greater regional planning of services, and their assertion that much of the strategic direction is set centrally by the Scottish Government.

323. This lack of freedom was also felt by some to be compounded by other factors outwith the board's control such as financial and work constraints.

324. In addition, some respondents to the survey of board members also expressed frustration about the ability of boards to plan for the longer term. Witnesses also

highlighted difficulties in boards being able to provide long-term strategic direction due to the focus on the delivery of short-term targets. Dr Brian Montgomery highlighted that boards are held to account on their performance management, targets and resource allocation. He suggested that not only did this create difficulties in focusing on long-term planning but there was little to encourage collaboration across boards, as boards were only accountable for what happened to patients and services in their own board area. ¹³⁷

325. Dr Montgomery also spoke about NHS boards balancing the triangle of quality of care, performance targets and resources. He explained that when there are pressures on resources, in order to maintain quality of care, targets are “what is most likely to suffer, in an attempt to maintain and enhance the quality of care with a finite budget”. ¹³⁸
326. Rachel Cackett of RCN was critical that the focus on targets made it more challenging to have conversations about long-term transformation of services. ¹³⁹
327. Financial resourcing was also discussed. Some evidence we heard was critical that financial sustainability had been allowed to dominate decision making in governance bodies. RCN suggested there was not enough focus on the clinical implications or potential consequences on the outcomes of decisions. ¹⁴⁰
328. Claire Sweeney of Audit Scotland welcomed the development of a financial framework to underpin the Scottish Government's 2020 strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland. She believed it should set out the steps that need to be taken to realise the vision that has been set out and assist with long-term planning. “The connection between the policy aspiration and what it means for local areas has been missing; everyone understands and signs up to the overall visions, but it has been very difficult to realise it in practical terms.” ¹⁴¹

329. The Cabinet Secretary was clear NHS boards are responsible for providing strategic direction. However, we received evidence which suggested that NHS boards consider they face challenges in delivering this strategic leadership.
330. While we understand the constraints boards now face in setting the strategic direction - particularly since the creation of IJBs - we feel that this is as intended and therefore not a matter of concern in and of itself. However, we do have sympathy that there has not been the commensurate shift in accountability and NHS boards are still being held to account for strategy set by others. The Committee would like to see a strengthening of the accountability mechanisms for IJBs and regional planning boards.
331. In relation to strategy set by the Scottish Government, again we understand the frustration felt by boards although it is appropriate the Scottish Government retains such a role. However, we would like to see more constructive challenge by NHS boards relating to the relative prioritisation of the ways in which strategic direction impacts locally. Our perception is that board Chairs and Chief Executives are reluctant to speak up or criticise in a public forum. However, board members have a duty to act in the best interests of the organisation and should

be pursuing and pushing the appropriate strategic approach which best meets the needs of the Board. We feel that this external challenge function is lacking at present.ⁱⁱⁱ

332. Equally we do not accept an inability to undertake financial planning exists. Boards have historically received annual settlements at or above health inflation levels and there is no suggestion this is likely to change in the near future. Boards are in a more advantageous position to plan financially than most other public bodies or indeed private bodies.
333. We received evidence which described NHS boards as balancing the triangle of quality of care, performance targets and resources. We believe the approach by NHS boards does not need to be a triangle if targets are aligned with quality of care and outcomes. We request an update from the Scottish Government on the actions it is taking following the Targets and Indicators in Health and Social Care in Scotland review by Sir Harry Burns.

Effectiveness of Board members – Board performance

334. As noted earlier, the Scottish Government ‘On Board’ guidance for board members states that board members should contribute fully to board deliberations and exercise a healthy ‘challenge function’. It details it is important that no individual board member (or Chair) should dominate debates held by the board or should have an excessive influence on board decision-making. The guidance also states that board members should not hesitate to challenge the Chair if they believe that a decision is wrong.
335. Some responses to the NHS board survey commented on the relationship between the executive and non-executive members. Some of these respondents felt that challenge by non-executive members was not welcomed by the chief executive and/or the executive members and could lead to defensiveness. Some also thought that there could be a lack of appreciation of the challenge function of non-executive members.
336. There was some discussion in evidence about the effectiveness of boards in undertaking this ‘challenge function’.
337. Claire Sweeney of Audit Scotland emphasised the importance of non-executive board members being confident enough to provide a ‘challenge function’. In relation to board performance she stated that “one of the healthy signs is a respectful but challenging relationship, particularly between the chief executive and the chair”.¹⁴²
338. Claire Sweeney suggested there was scope for improvements in how board members undertake the challenge function. She told the Committee “It worries us when we go to boards and audit committees and find that there is not sufficient challenge. The position is not as healthy as we would like it to be in all areas, and some areas need to work a bit harder to make sure that their non-executive directors are challenging and are given the right information.”¹⁴³

ⁱⁱⁱ Ash Denham, Kate Forbes, Emma Harper and Ivan McKee dissented from this paragraph.

Undertaking the role

339. A number of responses to the board survey also raised the difficulty in recruiting people to boards and highlighted the complexity of the job and the need for skills and experience.
340. Many witnesses spoke of the level of responsibility that came with the post and the high workload. Ruchir Shah of SCVO said “we need to ensure that people know the weight of responsibility that will fall on them when they are on a board, I do not think that we do enough to support people to understand their governance role and its implications, including for themselves.” ¹⁴⁴
341. Dr Graham Foster, Director of Public Health and Strategic Planning at NHS Forth Valley told the Committee: “I have the hugest respect for the non-execs on our board; I see them working incredibly hard to get to grips with extremely complex and difficult challenges, often in situations that they are not used to.” He told the Committee that in recent years the expectations of the role had increased and changed. ¹⁴⁵
342. In relation to workload, the high volume of paperwork that board members dealt with was discussed. Christine Lester non-executive board member of NHS Grampian suggested that board papers could be presented in a more concise and accessible form. Linda Dunion non-executive board member at NHS Tayside highlighted that work had been undertaken in her board to reduce the workload of non-executive board members. This had included reductions in the volume of papers and increasing the delegated responsibilities to committees and streamlining reporting around performance. ¹⁴⁶
343. Christine Lester of NHS Grampian told the Committee that the low salary for a non-executive board member meant the post could not be considered either a full or part time job, however the role's commitments prevented an individual from having another job at the same time. She also highlighted that the remuneration for the post could affect people's ability to claim welfare benefits. ¹⁴⁷
344. Christine Lester was also critical of the exclusively competency based approach to public appointments and considered this to be a barrier to potential recruits. ¹⁴⁸
345. Linda Dunion of NHS Tayside, also suggested the way posts were advertised was misleading as the time commitment for the role was far greater than the eight hours a week that was advertised. ¹⁴⁹

Equipped for the role

346. Another area considered in relation to board membership was whether the induction and training that new board members received equipped them for the role.
347. NHS board members who responded to the Committee's survey were generally positive about the adequacy of the induction, training and assessment that is provided. However, training was the aspect which received the most comments. Many responses called for better training, particularly for non-executive members.

Respondents felt this was required due to the complexity of the NHS, the language that is used and the challenges facing the NHS. Some responses called for a national programme of induction and training in order to ensure greater consistency.

348. Claire Sweeney of Audit Scotland told the Committee that auditors of public bodies had a particularly important role to play in providing non-executive board members with training and support in their development. She stated that developing financial skills was an area new board members often highlighted that they required to develop.¹⁵⁰
349. We received some suggestions that time is required for board members to build up the expertise and the understanding that is required. Christine Lester, Non-executive board Member of NHS Grampian said “I am now coming to the end of the second of my two four-year terms, but it is only in the past three or four years that I have felt myself to be as well informed as I need to be.”¹⁵¹
350. Linda Dunion of NHS Tayside suggested that to support new non-executive board members there should be an opportunity for a pre-induction programme. Individuals could learn about the language, culture and the issues facing the board through buddying or shadowing existing non-executive board members before they officially began their post.¹⁵²

Board diversity

351. Several witnesses emphasised the importance of delivering diversity in board membership. They considered that board diversity is a route to ensuring decisions would be sufficiently challenged at a board level.¹⁵³
352. In the Committee's survey of NHS board members and in oral evidence some concerns were raised regarding the current diversity and representativeness of NHS board members. These concerns centred on the relative lack of representation of people with disabilities, people from minority ethnic groups, young age groups and people from a range of social backgrounds.
353. Bill Scott of Inclusion Scotland discussed a concern raised by a number of witnesses, namely that the same type of people were being appointed as board members. In some cases the same public appointees were on a number of different public bodies. He suggested that board membership was not very inclusive and described it as “a closed club rather than an open one.”¹⁵⁴
354. To increase applications from more diverse groups, Bill Scott said “you will have to target specific groups in society that are underrepresented, and ensure that they feel that their service will be valued and their voices heard in the process.” He highlighted the work being undertaken by the Highland localisation and employment project to address the lack of representation of people with disabilities in decision making in community partnerships and in health governance.¹⁵⁵
355. We also heard suggestions that the time commitment, level of remuneration and recruitment methods for board posts created barriers to achieving diversity in representation.

356. Some respondents to the board survey suggested the focus should be on the ability of members rather than membership diversity. They stressed the difficulty in getting people of a high enough 'calibre' to apply for board posts.
357. Other witnesses in oral evidence also suggested board diversity should not be seen as the only focus in order to ensure a range of perspectives were taken into account at a board level.
358. Dr Montgomery, former Interim Chief Executive at NHS Fife, suggested it was "unreasonable and unrealistic to expect every interest to be represented around the board table" and that it could result in "cumbersome bodies on which many of the people round the table are interested in only a fraction of the agenda." Instead he suggested it was more important to ensure the committees and bodies that sit below the board structure included involvement from a wide range of stakeholders and that board members responded well to this input. ¹⁵⁶
359. The views we heard about diversity in board membership primarily focused on non-executive board members. However, there were calls from Allied Health Professions Federation Scotland that the diversity of Executive Board Membership should also be considered. They were critical of the lack of representation of allied health professionals (AHP) in decision making in the NHS. They noted that there were no AHP Directors on any territorial or special health boards. ¹⁵⁷
360. The Cabinet Secretary for Health and Sport responded to the evidence we received on board diversity. She stated that the Scottish Government was committed to providing gender balance 50:50 by 2020. In addition, the Scottish Government was moving away from a traditional competency-based approach to recruitment. As well as considering individuals' skills and experience, it was focusing more on ensuring individuals values matched those of the NHS. ¹⁵⁸
361. The issue of NHS board governance was raised at the Conveners Group evidence session with the First Minister on 18 April 2018. The First Minister told the Conveners Group that at the end of 2017 the Scottish Government commissioned a pilot review of corporate governance in NHS boards which was being led by John Brown in NHS Greater Glasgow and Clyde. The First Minister told the Conveners Group that a report of findings would be published before the summer recess. ¹⁵⁹

362. NHS board members have an essential role to play in the delivery of good corporate governance. It is important to ensure that the right people are appointed to the posts and those board members are provided with appropriate training and support to enable them to carry out their role effectively.
363. We welcome the comments from the Cabinet Secretary for Health and Sport regarding moving beyond a traditional competency-based approach to recruitment. We ask what assessment the Scottish Government will conduct to determine if this change in approach is leading to more diversity in board appointments.
364. As the Scottish Government On Board guidance details a key function of the board and its members is to provide strategic leadership and to hold the Chief Executive and senior management team to account. We are concerned by Audit

Scotland's assessment that boards' 'challenge function' is not operating as effectively in some areas as it could, in particular we expect there to be a respectful but challenging relationship between the Directors (of all types) to the chief executive and the chair. We received evidence of occasions where there could be a lack of appreciation by executive members of the challenge function of non-executive members. We ask the Scottish Government what steps it will take to ensure executive directors understand and respect the key role of non-executive members in delivering a challenge function.

365. We believe the complexity of the non-executive board member post, the time commitment and the volume of paperwork all suggest that some board members may not be able to focus primarily on their strategic overview role. We are concerned that board members' involvement in operational issues may be at the cost of providing these core strategic functions. In our ongoing work with Health Boards we will pursue this issue but also look to the Scottish Government to advise what steps it will take to support non-executive directors.
366. While we agree that it would be impossible to represent every interest around the board table, the current way in which boards recruit, operate and remunerate non-executive members, limits opportunities for certain demographic groups to get involved. The Committee strongly recommends that the Scottish Government's review of corporate governance looks for ways to modernise the foundations of boards and how they operate in order to better reflect the populations that they serve while taking advantage of the knowledge and skills of a broader range of people.
367. We also believe that further steps should be taken to ensure board members are equipped with the skills, knowledge, expertise and confidence to fulfil their role.
368. We heard calls for better training to be given to non-executive board members. Concerns were raised about the length of time non-executive board members take to feel well placed to carry out their role. Financial skills were highlighted as an area that often required development.
369. The above are all matters that should be investigated in the review of corporate governance commissioned by the Scottish Government. We expect this review to make recommendations about changes that can be made to improve the delivery of the core functions of boards.
370. We believe there is merit in the idea of offering all new non-executive board members the opportunity to shadow or buddy an existing member before they begin in post. We understand this may already be happening informally in some board areas. There may be merit in this becoming the standard practice for all new members as this would assist in building the confidence and expertise of non-executive board members before they formally take up post.
371. We believe it is important that diversity in board membership is achieved. Board diversity is a key route to ensuring there is a range of skills, experience and perspectives represented. We welcome the Scottish Government commitment to provide gender balance on boards by 2020. However this is not the only aspect of diversity on boards which needs to be taken into account. We are concerned

that currently there is an under representation of people with disabilities, people from minority ethnic groups and people from different social groups. We expect the Scottish Government to take steps to increase the extent to which under-represented groups are represented on boards.

372. One other aspect of board diversity that was raised was the call made for the lack of representation of allied health professional directors on territorial or special health boards to be addressed. Given the key role that AHP increasingly plays in integrating health and social care, we are surprised at this lack of overall representation and mechanisms for their involvement and ask the Scottish Government how this can be addressed.

NHS board relationships with stakeholders

373. The Scottish Government “On Board” guidance emphasises the importance of a board managing its relationship with stakeholders to ensure their concerns and needs are taken into account.
374. The guidance states that board stakeholders and the general public “should have access to full and accurate information on the decision-making processes and activities of each public body and have the opportunity to influence decisions and actions.”
375. The guidance also details the expectation that “public bodies should communicate clearly with their stakeholders, make information widely available, consult thoroughly and imaginatively and seek feedback on the public body’s performance, acting on it as appropriate.”
376. NHS boards’ performance against this criteria is looked at in this part of our report using the evidence collected during the course of the Committee’s inquiry and our other recent work including our ongoing scrutiny of individual Health Boards.

Consultation

377. Witnesses expressed a general perception that boards had a tendency to consult and inform rather than involve or in any way allow stakeholders and the general public to influence decision-making on an ongoing basis. There was a call made for greater use of vehicles like Public Partnership Forums to bring patients, carers and the third sector together.¹⁶⁰ Several witnesses expressed the view that public consultation on service change was tokenistic and that boards viewed this as an inconvenience.
378. Derek Young of Age Scotland told the Committee “It is not about just people’s ability to put their views across, or their confidence in feeling that they have an opportunity to do that; it is about what is done with those views once they are received.”¹⁶¹ As a result some witnesses felt it became a tick box exercise with a pre-determined outcome .

Openness and transparency

379. Concerns about the openness and transparency of communications between the board, its stakeholders and the general public were also raised. Respondents to the Committee's survey were largely confident about the openness and transparency of their own board, with ratings for their openness and transparency with staff being slightly higher than with the public. However, some responses acknowledged that this perception of openness and transparency is not shared by the public. Some of the survey responses attributed these attitudes to negative publicity arising from scrutiny by the press and politicians, as well as a general opposition to changes being proposed by boards.
380. Issues around openness and transparency were raised by staff bodies. The BMA in its written submission was critical of decisions regarding service prioritisation and resourcing being taken below board level. It considered the decision making process at this level was often less clear. The BMA commented that "It is not open and transparent to simply put a decision into the public domain and communicate it to staff. Instead, the reasoning and evidence for such decisions should be clear and easily available."¹⁶²
381. Several witnesses emphasised the importance of ensuring openness and transparency not only with regard to the decision taken but also the reason behind the decision making. Some witnesses noted that, whilst some board decisions may have been the result of constrained finances, there was a lack of openness in sharing this reason with the public. The National Pharmacy Association provided the example of patient safety reasons often being cited by NHS boards as the explanation for a change in its preferred product decision, when financial reasons may have been the actual reason due to the cost of a product increasing.¹⁶³

Changing the conversation

382. We heard that ensuring public awareness of the challenges faced by health boards was of key importance. Dr Montgomery told the Committee "Some very difficult choices and discussions lie ahead and it is not for the professions or, indeed, the boards to make those decisions by themselves: they have to be made collaboratively with the wider public."¹⁶⁴
383. There was a call made for the nature of the relationship between NHS boards, stakeholders and the public to change. Claire Sweeney of Audit Scotland described this as a "need for a very different conversation with the public" which was "more open and honest" and considered the "difficult decisions" that now had to be made due to financial pressures and the integration of health and social care.¹⁶⁵
384. We heard some suggestions as to how NHS boards can improve their approach to openness and transparency.
385. For example, Chest Heart and Stroke Scotland noted that service users and carers were members on integrated joint boards. In its view, this raised questions about the current composition of NHS boards "why if this public involvement approach is

fit for new health and social care governance arrangements, is it not fit for existing structures also?”.¹⁶⁶

386. Claire Sweeney of Audit Scotland suggested that integration of health and social care was having an impact on health boards as the way IJBs are constituted places a duty on them to be more open and transparent.¹⁶⁷
387. Audit Scotland in its most recent NHS Overview report had suggested practical steps health boards should take to improve their openness and transparency. This included the publication of all board and committee papers and minutes, public attendance at meetings and the filling of gaps in data in key areas of the NHS (especially primary care).¹⁶⁸
388. We also heard that the Open Government Partnership had the potential to deliver improvements in the relationship between boards and the public. The Open Government Partnership is an international programme aimed at improving government's openness, accountability and responsiveness to citizens. The SCVO is involved in the Scottish Government's work in taking this forward through the [Open Government Partnership Scottish Action Plan](#).¹⁶⁹
389. Ruchir Shah of SCVO highlighted work being undertaken on participatory budgeting in which the general public are given a “genuine say” and a clearer sense of how decisions are reached. He felt that the same principles could be applied to engaging with the public on politically contentious issues such as hospital closures.¹⁷⁰
390. During the course of this session we have twice taken evidence from the Scottish Health Council, initially on its role and latterly on the progress of the long running review it has been conducting into its own functions. The Scottish Health Council monitors how NHS boards carry out their statutory duty to involve patients and the public in the planning and delivery of NHS services. On 24 January 2017 and in subsequent correspondence we criticised the transparency and approach of the Scottish Health Council initial review which led to further work being undertaken. Some 15 months later, on 1 May 2018, we were disappointed to hear the review was still incomplete and proposals for a change of approach and emphasis unavailable. Work was still ongoing in “defining, very clearly, the role and contribution of the Scottish Health Council”¹⁷¹

391. Public and staff confidence in NHS boards is critical to ensuring they retain the support of the people who work for them and those they serve.
392. The delivery of transformational change in the provision of health and social care can only be achieved with the support of stakeholders and the general public. These changes are not something that should be done to them but done with them. This requires a fundamental change in the relationship between NHS boards, their stakeholders and the public.
393. Boards must move to a relationship that goes beyond consulting and informing, to focus on collaboration and coproduction. Boards must become more open and honest about the pressures and challenges they face which will ultimately help stakeholders understand and have confidence in the decisions being taken.

394. Integration has the potential to encourage NHS boards to improve their openness and transparency given that IJBs have this focus. We also note the potential of the Open Government Partnership Scottish Action Plan to deliver improvements in the relationship between boards and the public.
395. However the drive for this change must come from NHS boards. They must be equipped with the necessary skills and resources to involve the public and staff in decisions in a meaningful way.
396. We recognise there is a role to be undertaken in overseeing how well NHS boards consult with the public and how boards support the public to get involved in their work. Equally the role should encompass the work of the integrated boards and regionalisation proposals where these are distinct. This role is currently allocated to the Scottish Health Council (itself part of a Board) in whom we have no confidence and we recommend this function is re-allocated to a fully independent body.
397. We ask the Scottish Government what changes to national and board-level resourcing and best practice will be needed to enable the public, staff and the third sector to become involved in NHS decision making on an ongoing basis.

Integration Joint Boards and Regional Planning

398. In the last few years the health and social care landscape has changed with initially the creation of 31 Integrated Joint Boards and latterly three regional boards. This part looks at the consequential implications for governance structures.
399. The framework to implement health and social care integration came into force in April 2016. As a result, 31 IJBs are now in operation and managing over £8 billion of health and social care funding.
400. The National Health and Social Care Delivery Plan committed to putting in place new arrangements for the regional planning of some services. In 2017, an existing NHS Chief Executive was appointed to each of the three regional boards:
 - John Burns (NHS Ayrshire & Arran) in the West
 - Tim Davison (NHS Lothian) in the East and
 - Malcolm Wright (NHS Grampian) in the North.
401. Each of the three regions were asked to gather expertise and write a regional delivery plan for submission to the Delivery Board in 2017.
402. A recurring theme throughout our consideration of corporate governance was how the IJBs and regional planning were affecting governance and accountability.

Integration Joint Boards

403. The board survey and the written and oral evidence we received suggested specifically in relation to IJBs that there was some confusion among board members about roles and responsibility in the new structure, with a feeling that some administrative work was being duplicated.
404. Dr Foster of NHS Forth Valley highlighted that, for a small board like his, it was a challenge for non-executives and executive members to support the volume of meetings associated with the new structures. He told the Committee that IJBs had resulted in an increased administrative burden for board members “We have to support a number of IJBs and community planning partnerships as well as the board, where previously we just had the one structure. There is a lot of duplication of the administration and governance but not of the actual work.”¹⁷² We are unclear why the Health Board feel they are “supporting” an independent body.
405. We were also interested in the implications of the comment by Dr Foster who described working with IJBs as being challenging because IJBs operated in a very different environment to NHS boards. He highlighted that non-executive board members were now sitting alongside local authority councillors and they had different backgrounds, experience and expectations of structure and process.¹⁷³ In some respects this is a heartening comment as a purpose of the IJBs was to bring together the different experiences and cultures of the previous bodies involved in delivering these services. Yet we have concerns to learn that to deliver similar services as previously delivered is considered “challenging”. In many respects these two comments encapsulate the problems of integration which require to be resolved if governance is to become fit for purpose.
406. Cultural differences were also highlighted by Rachel Cackett of RCN who spoke of the learning curve being experienced by nursing leaders on integration joint boards. She highlighted that on an NHS board an executive nurse director has a voting role, whereas on an IJB they do not. She felt it was important to consider how they could ensure their expertise in clinical quality and assurance was taken into account in both structures.¹⁷⁴
407. We also learned of concerns from service users that under IJBs there was a lack of transparency regarding where responsibility lay for service delivery. Parkinson's UK in Scotland, in its written submission, gave the example that in one NHS board area there was ambiguity regarding where accountability for decision making on Parkinson's service rested “the buck is being passed between the board and the IJB with nobody taking responsibility for decision making.”¹⁷⁵
408. These concerns reiterated the point made by Audit Scotland in its report of 2015 on integration which stated “The proposed governance arrangements are complex, with some uncertainty about how they will work in practice. This will make it difficult for staff and the public to understand who is responsible for the care they receive.”¹⁷⁶
409. Audit Scotland in its NHS in Scotland overview report called for the Scottish Government to develop a robust governance framework for the delivery of the Health and Social Care Delivery Plan which should “... simplify and make clear the lines of accountability and decision making authority between the Health and Social

Care Delivery Plan Programme Board and major work programme delivery oversight groups, regional boards, NHS boards and Integration Authorities.”¹⁷⁷

410. Whilst we heard much evidence about ensuring the appropriate structures and procedures were in place for delivering changes through IJBs and regionalisation, other witnesses suggested the focus should be on the actual changes to services the new governance structures were set up to deliver.¹⁷⁸
411. Christine Lester of NHS Grampian said that her personal view was that concerns about the new governance and accountability structures were a “red herring”. Ultimately it was not that the changes were unclear but people did not like them because there was a loss of control for the local authority and the NHS board.¹⁷⁹
412. However NHS Lothian on 24 April when asked about accountability for delayed discharges advised: “Who is accountable? The trite answer is that we all are. The chief executive of NHS Lothian, as the accountable officer, is accountable; the chief officer of the IJB is accountable and the chief executive of the City of Edinburgh Council is accountable. That is the model that we have set up so it is a shared accountability. At the end of the day, accountability still rests primarily with the chief executive of the health board as accountable officer.”¹⁸⁰
413. We asked the Scottish Government whether further changes needed to be made to the current governance structures.
414. In response Christine McLaughlin of the Scottish Government pointed to Audit Scotland's forthcoming report on IJBs as providing an independent assessment of what progress had been made.
415. Christine McLaughlin stated that “The purpose of IJBs is to bring parties together in joint working and that purpose has certainly been achieved. [...] A lot of the governance is about looking at having a three-year commissioning plan as much as it is about day-to-day operations. There is a lot for us to build on. Governance is operating in a different way and we need to make sure that people understand and are comfortable with those differences and that, where there is a sense of conflict, we take action to ensure that that is not the case. I am relatively confident we can see signs of progress there.”¹⁸¹
416. We also explored with the Scottish Government whether there is a framework for governance at a regional level or if the role of the regional planning boards is more to act as a co-ordinating structure.

Regionalisation

417. The potential merits of regionalisation were highlighted by some witnesses. Dr Foster believed there could be benefits for the patient in a more joined up approach to service delivery. There would be less focus on NHS boards' individual performance on waiting lists and more focus on ensuring all patients across the country achieved access to services as quickly as possible.¹⁸²

418. Dr Montgomery also recognised the potential benefits of regionalisation, however like many witnesses he highlighted that there was no formal framework for holding regional structures to account.
419. Rachel Cackett of Royal College of Nursing described the current delivery and governance of services as in a “great state of flux”. She emphasised that it was important to ensure there was “transparency and clarity” on decision making and lines of accountability on issues such as clinical safety and quality of care. She called for frameworks to be developed to support this. She asked “Who is held accountable for decisions about those regional services within our current structures, and what might we need to change in order to make those structures transparent and robust for the future?”
420. One example given in the survey illustrating how accountability may be blurred was that NHS boards are held responsible for performance against the cancer waiting time targets, despite cancer services increasingly being planned and delivered on a regional basis.
421. Christine McLaughlin of the Scottish Government told the Committee “The introduction of the regional collaborative planning and delivery has not taken away the governance structures in place [...]”
422. She went on to explain “The regional structures plan those services that can best co-operate with one another to deliver a better service for patients regionally. The national delivery plan, which you will be aware of, has the national boards providing solutions. The national boards focus on things such as digital platforms. There is a regional tier, which at the moment is in the process of planning the production of a series of proposals that we will consider in due course on things that could be delivered in a slightly different way.”¹⁸³
423. She confirmed the expectation that regional and national plans would be submitted at the end of March 2018.¹⁸⁴
424. The issue of regionalisation was also raised by the Committee Convener Lewis Macdonald in questions to the First Minister's during her evidence session with the Conveners Group.
425. The First Minister described individual health boards as “the building block of regionalisation”.¹⁸⁵
426. In relation to accountability structures she stated that “increasingly we are thinking about whether there are changes required”. “My view and it's not a view that everybody agrees with I think we need to allow regionalisation to evolve in the way that it is; [...] I tend not to be of the view that we should go for hardwired structural changes to embed that in a firmer way that means the health board continues to be the building block. The link of accountability that we have just now continues to be the appropriate one.”¹⁸⁶
427. The lines of accountability for IJBs and regional boards are not always clear. For example, there is confusion regarding where responsibility as well as accountability for delivery of some services lies. We recommend immediate

attention is given to Audit Scotland's call for the Health and Social Care Delivery Plan to simplify and make clear the lines of accountability and decision-making between the Health and Social Care Delivery Plan Programme Board and major work programme delivery oversight groups, regional boards, NHS boards and Integration Authorities.

Role of the Scottish Government

428. The Audit Scotland Role of Boards report details that the Scottish Government Health Directorates have a well-established framework of support and monitoring for NHS bodies. The Finance and Delivery Directorates provide ongoing support for health boards to help them meet their performance and financial targets.
429. The Cabinet Secretary told the Committee that there is “regular dialogue between the Scottish Government and NHS boards on developing strategy and emergent issues”. Monthly meetings are held between the chairs of NHS bodies and the Cabinet Secretary for Health and Sport to discuss strategic issues, while the Director-General for Health meets the chief executives of each NHS board monthly to discuss operational issues. ¹⁸⁷
430. Every year there is a public review of each NHS board. The 2010 Role of Boards report suggested these sessions were chaired annually by a member of the Ministerial team. The Cabinet Secretary detailed that these are now chaired by Ministers biennially and officials from the Scottish Government chair them in alternate years. She told the Committee that the board review provides an opportunity to look back over the board's performance in the last year and to look forward to the board's plans for the following year. Board reviews also involve the Scottish Government meeting with representatives from the Area Partnership Forum, staff, clinical community and patients. ¹⁸⁸
431. At the annual review the Cabinet Secretary detailed that following the public session along with Scottish Government officials they will consider in private with the board more of the detail, including the financial plans. The Cabinet Secretary summed up the role of the reviews “It is an opportunity for the board to showcase some of the work that it is doing, but it is also an opportunity for us to hold it to account.” ¹⁸⁹
432. The Cabinet Secretary explained “The mix of legislation and guidance that is in place, along with the regular open and constructive dialogue that we have with senior executive and non-executive board members, gives me sufficient assurance about the performance of NHS Scotland, but I am certainly not complacent.” She referenced the changed landscape as a result of the introduction of health and social care integration and more regional co-operation. She added “We continue to seek new ways to improve and strengthen our governance of the NHS, which we do with our partners and in the light of best practice.” ¹⁹⁰
433. Yet in our scrutiny of individual boards we have frequently encountered recommendations continuing year on year without any discernible improvement occurring nor could we identify any sanctions applying when actions are not met.

434. There are a range of mechanisms used by the Scottish Government to ensure the provision of support and monitoring of performance of NHS boards. The annual review of each NHS board is a central component of this model. We note that there have been changes in approach to these annual reviews in recent years with Ministerial attendance no longer being required at all reviews. We ask the Scottish Government for further information on the reasons for this change and assurances this does not signify a change in the value and importance of these reviews.
435. We expect these reviews to properly hold NHS boards to account for their performance. During the course of our inquiry we heard little reference to the function the reviews perform. Whilst we note action points flow from these reviews, there appears to be no transparent and clear course of action taken when boards fail to deliver the recommendations made. Combined with inconsistent scrutiny by HIS and important matters such as serious adverse events being dealt with internally by boards, we feel the oversight of NHS boards is inadequate. We ask the Scottish Government to review these annual reviews and bring forward proposals to demonstrate the annual reviews are a core component of its accountability mechanism.

Director Conflicts of Interest

436. The Committee's inquiry has highlighted the important role governance at an individual health board plays in ensuring delivery of the best healthcare for Scotland. Our inquiry has not sought to evaluate individual NHS boards' performance in delivering this function but to provide commentary on how boards' performance can be improved and enhanced. However, following the conclusion of our oral evidence sessions on our inquiry allegations were made regarding NHS Tayside's misuse of the Tayside NHS Board Endowment Fund monies.
437. On 16 April 2018, David Robb, Chief Executive of the Office of the Scottish Charity Regulator wrote to the Committee attaching a letter to Paul Gray. The letter details: "it is the responsibility of the charity trustees to comply with their legal duties in managing the charity – as regulator we will intervene where we judge it to be in the public interest to investigate possible misconduct [...]. In particular, trustees must ensure that they act in the best interests of the charity at all times, that all expenditure is in line with the charity's purposes and that any grants or donations are used for the purposes for which the charity accepted them, and in line with any conditions imposed. This is what we are investigating with the Tayside Endowment Funds and, in light of the strong public interest in this case, we are pursuing it as a top priority."¹⁹¹
438. The Public Audit and Post-Legislative Scrutiny Committee has taken evidence on the 2016/17 audit of NHS Tayside.
439. The Committee notes the series of reviews and investigations that have been initiated as a result of the recent revelations in respect of NHS Tayside. We

welcome the work being undertaken by our colleagues in the Public Audit and Post-legislative Scrutiny Committee to consider the specifics regarding the situation in NHS Tayside. Given the focus of our work on NHS Governance we are interested in the wider implications this has for broader governance and structural issues.

440. One concern raised by the situation in NHS Tayside is whether there are any conflicts of interest in NHS board members also being charity trustees. Given the statutory duties of a director and the close connection between endowment boards and NHS Boards we do not see how it can be possible for persons to be members of both boards simultaneously and give the perception of independence in each role. Accordingly we recommend that no member of an NHS Board should be permitted to be a member of an endowment board.
441. Given the above and the issues we have heard about the difficulties directors have had in being members of both health boards and IJBs we also have concerns around how a member of both boards can simultaneously act in the best interests of bodies who may have competing priorities for finance. Equally this gives rise to similar perception issues as above and we recommend the government review examining governance consider the board membership of IJBs and how members who are also members of other bodies, particularly local health boards and local authorities can avoid similar conflicts.

Annex A - Minutes of Meeting

4th Meeting, 2017 (Session 5) Tuesday 7 February 2017

1. NHS Governance (in private): The Committee considered and agreed its approach to the inquiry.

8th Meeting, 2017 (Session 5) Tuesday 21 March 2017

3. NHS Governance: The Committee discussed this morning's informal evidence session with NHS Scotland patients.

9th Meeting, 2017 (Session 5) Tuesday 28 March 2017

3. NHS Governance: The Committee discussed this morning's informal evidence session with NHS frontline staff.

11th Meeting, 2017 (Session 5) Tuesday 25 April 2017

3. NHS Governance: The Committee discussed last week's informal evidence session with NHS senior managers.

12th Meeting, 2017 (Session 5) Tuesday 9 May 2017

10. NHS Governance (in private): The Committee considered and agreed its approach to the inquiry.

15th Meeting, 2017 (Session 5) Tuesday 30 May 2017

2. NHS Governance: The Committee took evidence from—

- Donald Harley, Deputy Scottish Secretary, British Medical Association;
- Ros Shaw, Senior Officer, Royal College of Nursing Scotland;
- Kenryck Lloyd-Jones, Public Affairs and Policy Manager for Scotland, Chartered Society of Physiotherapy Scotland, representative of the Allied Health Professions Federation Scotland;
- Matt McLaughlin, Secretary to the Health Committee, UNISON Scotland;
- Claire Pullar, National Officer, Managers in Partnership.

5. NHS Governance (in private): The Committee considered the evidence heard earlier in the meeting.

16th Meeting, 2017 (Session 5) Tuesday 13 June 2017

13. NHS Governance: The Committee took evidence from—

- Sir Robert Francis QC;
- Cathy James, Chief Executive, Public Concern at Work;

- Kirsty-Louise Campbell, Senior Manager of Strategy and Insight, and Laura Callender, Governance Compliance Manager, City of Edinburgh Council;
- Robin Creelman, Non-Executive Director and Whistleblowing Champion, NHS Highland;
- Morag Brown, Non-Executive Director, Co-chair of the Staff Governance Committee and Whistleblowing Champion, NHS Greater Glasgow and Clyde.

15. NHS Governance (in private): The Committee considered the evidence heard earlier in the meeting.

[17th Meeting, 2017 \(Session 5\) Tuesday 20 June 2017](#)

6. NHS Governance (in private): The Committee considered its approach to phase two of its inquiry - Clinical Governance and agreed to issue a call for views over the summer recess.

[20th Meeting, 2017 \(Session 5\) Tuesday 19 September 2017](#)

2. NHS Governance: The Committee took evidence on staff governance from—

- George Doherty, Director of Human Resources, NHS Tayside;
- Jennifer Porteous, Director of Human Resources and Workforce Development, NHS Western Isles;
- Elaine Mead, Chief Executive, NHS Highland;
- Kenneth Small, Director of Human Resources, NHS Lanarkshire.

4. NHS Governance (in private): The Committee considered the evidence heard earlier in the meeting.

[21st Meeting, 2017 \(Session 5\) Tuesday 26 September 2017](#)

3. NHS Governance: The Committee took evidence on staff governance from—

- Shona Robison, Cabinet Secretary for Health and Sport;
- Paul Gray, Director General Health & Social Care and Chief Executive NHSScotland, and
- Shirley Rogers, Director of Health Workforce and Strategic Change, all Scottish Government.

5. NHS Governance (in private): The Committee considered the evidence heard earlier in the session and agreed to issue a letter to the Scottish Government at this interim stage.

[22nd Meeting, 2017 \(Session 5\) Tuesday 3 October 2017](#)

6. NHS Governance (in private): The Committee considered a summary of written evidence and agreed its approach to Clinical Governance.

[25th Meeting, 2017 \(Session 5\) Tuesday 7 November 2017](#)

2. NHS Governance: The Committee discussed this morning's informal evidence session with NHS patients.

[26th Meeting, 2017 \(Session 5\) Tuesday 14 November 2017](#)

1. NHS Governance: The Committee took evidence on clinical governance from—

- Rachel Le Noan, Policy Officer, Down's Syndrome Scotland;
- Clare Ogden, Head of Communications and Policy, Action for M.E.;
- Carolyn Lochhead, Public Affairs Manager, SAMH;
- Derek Young, Senior Policy Officer, Age Scotland.

2. NHS Governance (in private): The Committee considered the NHS clinical governance evidence heard earlier in the session.

[27th Meeting, 2017 \(Session 5\) Tuesday 21 November 2017](#)

3. NHS Governance: The Committee took evidence on clinical governance from—

- Dr David Chung, Vice President, Royal College of Emergency Medicine Scotland;
- Dr Peter Bennie, Chair, BMA Scotland;
- Sara Conroy, Professional Adviser, Chartered Society of Physiotherapy representing the Allied Health Professions Federation Scotland;
- Lorna Greene, Policy Officer, Royal College of Nursing (Scotland);
- Dr Gordon McDavid, Medicolegal Adviser, The Medical Protection Society.

4. NHS Governance (in private): The Committee considered the evidence heard earlier in the session.

[28th Meeting, 2017 \(Session 5\) Tuesday 28 November 2017](#)

2. NHS Governance: The Committee took evidence, in a round table format, on clinical governance from—

- Robbie Pearson, Chief Executive, Healthcare Improvement Scotland;
- Dr Tracey Gillies, Medical Director, NHS Lothian;
- Professor Nick Fluck, Medical Director/Responsible Officer/Caldicott Guardian, NHS Grampian;
- Dr Christopher Mackintosh, Medical Director, South Lanarkshire Health and Social Care Partnership;
- Sheena Morrison, Head of Public Protection and Quality Assurance, Glasgow City Health and Social Care Partnership;
- Professor Jason Leitch, National Clinical Director, Scottish Government;

- Rosemary Agnew, Ombudsman, Scottish Public Services Ombudsman.

6. NHS Governance (in private): The Committee considered the evidence heard earlier in the session.

30th Meeting, 2017 (Session 5) Tuesday 12 December 2017

2. NHS Governance: The Committee took evidence on clinical governance from—

- Fraser Morton; and
- Ella Brown.

4. NHS Governance (in private): The Committee considered the evidence heard earlier in the session.

5. NHS Governance: The Committee considered and agreed its approach to the next phase of its inquiry work on corporate governance.

31st Meeting, 2017 (Session 5) Tuesday 19 December 2017

4. NHS Governance (in private): The Committee considered and agreed a further approach to its inquiry work on corporate governance.

3rd Meeting, 2018 (Session 5) Tuesday 23 January 2018

6. NHS Governance (in private): The Committee considered and agreed follow up correspondence.

4th Meeting, 2018 (Session 5) Tuesday 30 January 2018

7. NHS Governance (in private): The Committee considered and agreed a draft paper on witness selection for Corporate Governance.

6th Meeting, 2018 (Session 5) Tuesday 20 February 2018

1. NHS Governance (Corporate): The Committee took evidence on corporate governance, in a round table format, from—

- Dr Brian Montgomery, Independent Healthcare Consultant, (former Medical Director and Interim Chief Executive, NHS Fife);
- Ruchir Shah, Policy Manager, Scottish Council for Voluntary Organisations;
- Bill Scott, Director of Policy, Inclusion Scotland;
- Rachel Cackett, Policy Adviser, RCN Scotland;
- Kenryck Lloyd-Jones, Public Affairs and Policy Manager, Chartered Society of Physiotherapy, representative of the Allied Health Professions Federation Scotland;
- Claire Sweeney, Associate Director, Audit Scotland.

2. NHS Governance (Corporate) (in private): The Committee considered the evidence heard earlier in the meeting.

7th Meeting, 2018 (Session 5) Tuesday 27 February 2018

2. NHS Governance (Corporate): The Committee took evidence on corporate governance from—

- Linda Dunion, Non-Executive Board Member, NHS Tayside;
- Christine Lester, Non-Executive Board Member, NHS Grampian;
- Dr Graham Foster, Director of Public Health and Strategic Planning, NHS Forth Valley;

and then from—

- Shona Robison, Cabinet Secretary for Health and Sport;
- Christine McLaughlin, Director of Health Finance;
- Dr Catherine Calderwood, Chief Medical Officer, and
- Shirley Rogers, Director of Health Workforce and Strategic Change, all Scottish Government.

3. NHS Governance (Corporate) (in private): The Committee considered the evidence heard earlier in the session. The Committee agreed to produce a report on NHS Governance for consideration at a future meeting.

11th Meeting, 2018 (Session 5) Tuesday 27 March 2018

6. NHS Governance (in private): The Committee considered a paper from the Clerk and agreed to seek clarification from the Scottish Government in relation to the NHS Staff Experience Report.

18th Meeting, 2018 (Session 5) Tuesday 5 June 2018

1. NHS Governance (in private): The Committee considered a draft report .

12. NHS Governance (in private): The Committee continued its consideration of a draft report and agreed to continue consideration at its next meeting.

19th Meeting, 2018 (Session 5) Tuesday 12 June 2018

3. NHS Governance (in private): The Committee continued its consideration of a draft report and agreed to continue consideration at its next meeting.

20th Meeting, 2018 (Session 5) Tuesday 26 June 2018

3. NHS Governance (in private): The Committee considered and agreed a revised draft report.

Annexe B - Evidence

Written evidence - staff governance

- [NHSG001 Anonymous 1](#)
- [NHSG002 BMA](#)
- [NHSG003 Dr Peter Gordon](#)
- [NHSG004 Mr Gary Wilson](#)
- [NHSG005 NHS National Services Scotland](#)
- [NHSG006 RCN Scotland](#)
- [NHSG007 Royal College of Physicians of Edinburgh](#)
- [NHSG008 UNISON Scotland](#)
- [NHSG009 Sukhomoy Das](#)
- [NHSG010 Joan Fraser](#)
- [NHSG011 Allied Health Professions Federation \(AHPF\) Scotland](#)
- [NHSG012 Coalition for Racial Equality and Rights](#)
- [NHSG013 Dorothy S McHaffie](#)
- [NHSG014 Dr Ian Kerr](#)
- [NHSG015 Rab Wilson](#)
- [NHSG016 GMC](#)
- [NHSG017 Dr Jane Hamilton](#)
- [NHSG018 Managers in Partnership \(MiP\)](#)

Additional written evidence - staff governance

- [BMA Scotland follow-up submission](#)
- [Sir Robert Francis QC](#)

Written evidence - clinical governance

- [CGOV001 Alec Scott](#)
- [CGOV002 NHS Fife](#)

- [CGOV003 Healthcare Improvement Scotland](#)
- [CGOV004 Down's Syndrome Scotland](#)
- [CGOV005 NHS24](#)
- [CGOV006 Royal College of Physicians of Edinburgh](#)
- [CGOV007 Scottish Disability Equality Forum](#)
- [CGOV008 The Royal College of Psychiatrists in Scotland \(with specific input from the Child and Adolescent Faculty\)](#)
- [CGOV009 National Pharmacy Association](#)
- [CGOV010 Action for M.E](#)
- [CGOV011 Community Pharmacy Scotland](#)
- [CGOV012 NHS Education for Scotland](#)
- [CGOV013 Dorothy-Grace Elder](#)
- [CGOV014 Royal College of Emergency Medicine Scotland](#)
- [CGOV015 NHS Lothian](#)
- [CGOV016 Scottish Women's Convention](#)
- [CGOV017 Royal College of Pathologists](#)
- [CGOV018 NHS Orkney](#)
- [CGOV019 SPSO](#)
- [CGOV020 Kathleen Powderly](#)
- [CGOV021 RCN Scotland](#)
- [CGOV022 Macmillan Cancer Support in Scotland](#)
- [CGOV023 SAMH](#)
- [CGOV024 The Royal College of Paediatrics & Child Health](#)
- [CGOV025 NHS National Services Scotland](#)
- [CGOV026 BMA Scotland](#)
- [CGOV027 Allied Health Professions Federation Scotland](#)
- [CGOV028 Royal College of Speech and Language Therapists](#)
- [CGOV029 HIV Scotland](#)
- [CGOV030 Health and Social Care Alliance Scotland \(the ALLIANCE\)](#)

- [CGOV031 Royal Pharmaceutical Society](#)
- [CGOV032 The Medical Protection Society](#)
- [CGOV033 Fraser Morton](#)
- [CGOV034 BDA Scotland](#)
- [CGOV035 Glasgow City HSCP](#)
- [CGOV036 NHS Forth Valley](#)
- [CGOV037 Scottish Independent Advocacy Alliance](#)
- [CGOV038 NHS Centre for Integrative Care Campaign Team](#)
- [CGOV039 Age Scotland](#)
- [CGOV040 Anonymous 1](#)
- [CGOV041 NHS Ayrshire and Arran](#)
- [CGOV042 General Medical Council](#)
- [CGOV043 RCGP Scotland](#)
- [CGOV044 NHS Grampian](#)
- [CGOV045 North Ayrshire HSCP](#)
- [CGOV046 Parkinson's UK in Scotland](#)
- [CGOV047 Sue Lavery](#)
- [CGOV048 The Royal Society of Edinburgh](#)
- [CGOV049 South Lanarkshire Health and Social Care Partnership](#)
- [CGOV050 Dorothy Gibson](#)

Additional written evidence - clinical governance

- [Letter from Dr Peter J Gordon](#)
- [Letter from Dr Peter Bennie, Chair, BMA Scotland](#)
- [Royal College of Surgeons of Edinburgh](#)
- [Anonymous Carer submission re NHS Adverse Incident Review](#)
- [NHS Grampian response to CPD question](#)
- [NHS Grampian response to Dignity and Respect question](#)
- [NHS Lothian response to CPD question and Dignity and Respect question](#)

- [Letter to Professor Jason Leitch, National Clinical Director, Scottish Government from David Cullum, Clerk to the Health and Sport Committee - 7 December 2017](#)
- [Letter to Robbie Pearson, Chief Executive, Healthcare Improvement Scotland from David Cullum, Clerk to the Health and Sport Committee - 7 December 2017](#)
- [Letter to Rosemary Agnew, Ombudsman, Scottish Public Services Ombudsman from David Cullum, Clerk to the Health and Sport Committee - 7 December 2017](#)
- [Letter from Robbie Pearson, Chief Executive, Healthcare Improvement Scotland to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017](#)
- [Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to David Cullum, Clerk to the Health and Sport Committee - 18 December 2017](#)
- [Letter from Rosemary Agnew, Ombudsman, Scottish Public Services Ombudsman to Neil Findlay MSP, Convener of the Health and Sport Committee - 18 December 2017](#)
- [Letter to Professor Jason Leitch, National Clinical Director, Scottish Government from Lewis Macdonald MSP, Convener of the Health and Sport Committee - 24 January 2018](#)
- [Letter from Professor Jason Leitch, National Clinical Director, Scottish Government to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 5 February 2018](#)

Written evidence - corporate governance

- [CORP001 Rab Wilson](#)
- [CORP002 Sandesh Gulhane, Scottish Lead for BMA GP trainees Subcommittee](#)
- [CORP003 Andrew Muir](#)
- [CORP004 W. Hunter Watson](#)
- [CORP005 David Byrne, Emeritus Professor of Applied Social Sciences, Durham University](#)
- [CORP006 Ms R J Pengelly - ScotSectorLink](#)
- [CORP007 Professor Catriona Paisey, University of Glasgow](#)
- [CORP008 NHS National Services Scotland](#)
- [CORP009 Chris Bridgeford, Founder, affasair](#)
- [CORP010 The Royal College of Psychiatrists in Scotland](#)
- [CORP011 British Standards Institution](#)
- [CORP012 RCN Scotland](#)

- [CORP013 National Pharmacy Association](#)
- [CORP014 Dorothy-Grace Elder](#)
- [CORP015 British Homeopathic Association](#)
- [CORP016 Community Pharmacy Scotland](#)
- [CORP017 Chest Heart and Stroke Scotland](#)
- [CORP018 Scottish Health Campaigns Network \(SHCN\)](#)
- [CORP019 Parkinson's UK in Scotland](#)
- [CORP020 Dorothy Gibson](#)
- [CORP021 Kenneth Barr](#)
- [CORP022 NHS Orkney](#)
- [CORP023 BMA Scotland](#)
- [CORP024 Scottish Independent Advocacy Alliance \(SIAA\)](#)
- [CORP025 Allied Health Professions Federation Scotland](#)
- [CORP026 RCGP Scotland](#)
- [CORP027 BDA Scotland](#)
- [CORP028 Dr Minh Alexander](#)
- [CORP029 Inclusion Scotland](#)
- [CORP030 Dr Sheena B Pinion](#)
- [CORP031 UNISON Scotland](#)
- [CORP032 Joyce Harvie](#)
- [CORP033 Allan J Tubb](#)
- [CORP034 NHS Centre for Integrative Care Campaign Team](#)
- [CORP035 Dr George Venters](#)
- [CORP036 Catherine Hughes](#)
- [CORP037 Evonne McLatchie \(previously submitted for SOS Edinburgh Cleft Group\)](#)
- [CORP038 Royal College of Physicians of Edinburgh](#)

Additional written evidence - corporate governance

- [Letter from Shona Robison MSP, Cabinet Secretary for Health and Sport to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 21 March 2018](#)

- [Letter to Shona Robison MSP, Cabinet Secretary for Health and Sport from Lewis Macdonald MSP, Convener of the Health and Sport Committee - 28 March 2018](#)
- [Letter from Shona Robison MSP, Cabinet Secretary for Health and Sport to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 24 April 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee - 23 February 2018 \(plus attachments 1 and 2 below\)](#)
- [Attachment 1 - NHS Tayside Transformation Support Team Second Report - 23 February 2018](#)
- [Attachment 2 - Letter to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland from Lewis D Ritchie, Chairman, NHS Tayside Assurance and Advisory Group - 23 February 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee - 7 March 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 5 April 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 6 April 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 12 April 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to David Robb, Chief Executive, Office of the Scottish Charity Regulator - 12 April 2018](#)
- [Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee and Lewis Macdonald MSP, Convener of the Health and Sport Committee - 16 April 2018](#)
- [Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland - 16 April 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee - 21 May 2018](#)

- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee regarding the Grant Thornton Report on financial governance in NHS Tayside - 22 May 2018](#)
- [Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland re NHS Endowment Funds risk assessment - 30 May 2018](#)
- [Letter from David Robb, Chief Executive, Office of the Scottish Charity Regulator to Lewis Macdonald MSP, Convener of the Health and Sport Committee re 2016/17 Audit of NHS Tayside - 31 May 2018](#)
- [Letter from Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland to Jenny Marra MSP, Convener of the Public Audit and Post-Legislative Scrutiny Committee regarding the 2016/17 Audit of NHS Tayside - 12 June 2018](#)
- [Letter from Sharon Fairweather, Director of Internal Audit, Scottish Government to Paul Gray, Director-General Health and Social Care and Chief Executive, NHSScotland regarding the Internal Audit review of the actions taken by the Scottish Government in response to the Independent Review by Grant Thornton on e-Health Funding - 18 June 2018](#)

Official Reports of Meetings

- [Tuesday 21 March 2017](#) - evidence from stakeholders
- [Tuesday 28 March 2017](#) - evidence from stakeholders
- [Tuesday 25 April 2017](#) - evidence from stakeholders
- [Tuesday 30 May 2017](#) - evidence from stakeholders
- [Tuesday 13 June 2017](#) - evidence from stakeholders
- [Tuesday 19 September 2017](#) - evidence from stakeholders
- [Tuesday 26 September 2017](#) - evidence from the Scottish Government
- [Tuesday 7 November 2017](#) - evidence from stakeholders
- [Tuesday 14 November 2017](#) - evidence from stakeholders
- [Tuesday 21 November 2017](#) - evidence from stakeholders
- [Tuesday 28 November 2017](#) - round table evidence from stakeholders
- [Tuesday 12 December 2017](#) - evidence from stakeholders
- [Tuesday 20 February 2018](#) - round table evidence from stakeholders
- [Tuesday 27 February 2018](#) - evidence from stakeholders and then from the Scottish Government

- 1 BMA. Written submission and RCN Scotland. Written submission, Staff Governance
- 2 UNISON Scotland. Written submission, Staff Governance
- 3 Health and Sport Committee. *Official Report 26 September 2017*, Col 26.
- 4 Scottish Government (2017). *The Health and Social Care Staff Experience Report 2017*
- 5 Health and Sport Committee. *Official Report 30 May 2017*, Col 28.
- 6 Health and Sport Committee. *Official Report 30 May 2017*, Col 28-29.
- 7 Health and Sport Committee. *Official Report 27 February 2018*, Col 35.
- 8 Health and Sport Committee. *Official Report 30 May 2017*, Col 26.
- 9 UNISON Scotland. Written submission, Staff Governance, Health and Sport Committee. *Official Report 30 May 2017*, Col 27.
- 10 Managers in Partnership. Written submission, Staff Governance
- 11 Health and Sport Committee. *Official Report 19 September 2017*, Col 4.
- 12 Managers in Partnership. Written submission, Staff Governance
- 13 Managers in Partnership. Written submission, Staff Governance
- 14 Health and Sport Committee. *Official Report 13 June 2017*, Col 45.
- 15 Sir Robert Francis QC (2015). *Freedom to speak up: An Independent Review into creating an open and honest reporting culture in the NHS*.
- 16 Health and Sport Committee. *Official Report 13 June 2017*, Col 48.
- 17 Health and Sport Committee. *Official Report 30 May 2017*, Col 31.
- 18 Health and Sport Committee. *Official Report 21 November 2017*, Col 16.
- 19 The Medical Protection Society. Written submission, Staff Governance
- 20 Health and Sport Committee. *Official Report 30 May 2017*, Col 34.
- 21 Health and Sport Committee. *Official Report 30 May 2017*, Col 33.
- 22 Health and Sport Committee. *Official Report 26 September 2017*, Col 34.
- 23 Health and Sport Committee. *Official Report 26 September 2017*, Col 32.
- 24 Rab Wilson. Written submission and Dr Jane Hamilton. Written submission Staff Governance
- 25 Health and Sport Committee. *Official Report 30 May 2017*, Col 35.
- 26 Health and Sport Committee. *Official Report 13 June 2017*, Col 54.

- 27 [BBC article \(14 October 2016\). *NHS whistleblowing helpline dubbed 'completely toothless'*.](#)
- 28 [Submission to Public Petitions Committee 14 October 2016.](#)
- 29 [Scottish Government submission to Petition and Health and Sport Committee. *Official Report 26 September 2017*, Col 24.](#)
- 30 [Health and Sport Committee. *Official Report 27 February 2018*, Col 34.](#)
- 31 [Health and Sport Committee. *Official Report 13 June 2017*, Col 60.](#)
- 32 [Health and Sport Committee. *Official Report 13 June 2017*, Col 58.](#)
- 33 [Health and Sport Committee. *Official Report 13 June 2017*, Col 58-59.](#)
- 34 [Health and Sport Committee. *Official Report 27 Feb 2018*, Col 33.](#)
- 35 [Sir Robert Francis QC \(2015\). *Freedom to speak up: An Independent Review into creating an open and honest reporting culture in the NHS*.](#)
- 36 [e.g. Dr Peter Gordon, Dr Sukhomoy Das, Dorothy McHaffie, Dr Ian Kerr, Rab Wilson, Dr Jane Hamilton. Written submissions, Staff Governance](#)
- 37 [Health and Sport Committee. *Official Report 19 September 2017*, Col 11.](#)
- 38 [2.](#)
- 39 [The Draft Employment Rights Act 1996 \(NHS Recruitment - Protected Disclosure\) Regulations 2018: Response to the consultation on protecting whistleblowers seeking jobs in the NHS](#)
- 40 [BMA Scotland. Written submission, Staff Governance](#)
- 41 [Scottish Government \(2018\). *More protection for junior doctors*.](#)
- 42 [Dr Jane Hamilton. Written submission, Staff Governance](#)
- 43 [BMJ \(24 April 2017\) *NHS Managers should face the same regulations as doctors*](#)
- 44 [Health and Sport Committee. *Official Report 19 September 2017*, Col 26.](#)
- 45 [Health and Sport Committee. *Official Report 26 September 2017*, Col 35.](#)
- 46 [Health and Sport Committee. *Official Report 30 May 2017*, Col 28.](#)
- 47 [RCN Scotland. Written submission, Staff Governance](#)
- 48 [Health and Sport Committee. *Official Report 30 May 2017*, Col 36- 37.](#)
- 49 [Health and Sport Committee. *Official Report 26 September 2017*, Col 37.](#)
- 50 [Health and Sport Committee. *Official Report 19 September 2017*, Col 3, George Doherty, NHS Tayside.](#)

- 51 [Letter from Lewis Macdonald MSP, Convener of the Health and Sport Committee to Shona Robison MSP, Cabinet Secretary for Health and Sport - 28 March 2018](#)
- 52 [Letter from Shona Robison MSP, Cabinet Secretary for Health and Sport to Lewis Macdonald MSP, Convener of the Health and Sport Committee - 24 April 2018](#)
- 53 [Health and Sport Committee. *Official Report 30 May 2017*, Col 43.](#)
- 54 [Gary Wilson. Written submission, Staff Governance](#)
- 55 [RCN Scotland. Written submission, Staff Governance](#)
- 56 [Health and Sport Committee. *Official Report 19 September 2017*, Col 3.](#)
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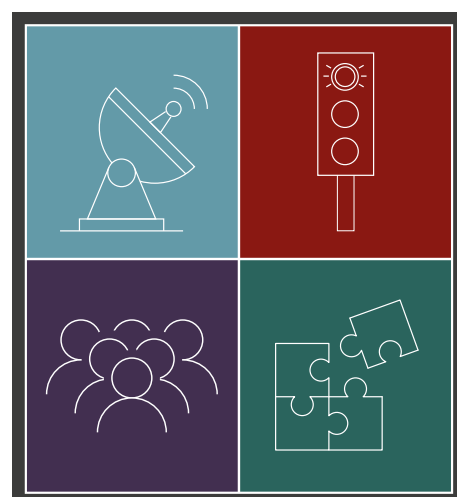
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Recognising and responding to early warning signs in public sector bodies

**A review by the Committee
on Standards in Public Life**

**The Committee
on Standards
in Public Life**





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Recognising and responding to early warning signs in public sector bodies

**A review by the Committee
on Standards in Public Life**

Chair, Doug Chalmers CB DSO OBE

March 2025



Chair's foreword

Grenfell, Windrush, Infected Blood, Post Office Horizon IT: each scandal very different in nature, but all with a catastrophic impact on human lives.

It isn't hard to find common themes among these scandals – a failure to listen to and act on concerns raised, a failure to learn lessons from similar incidents, and a failure to identify and share emerging risks.

Of course, hindsight is an unforgiving prism through which to view past decisions made in complex environments. But there is value in taking a step back and asking why so many of the same themes come up time and again in public life and to consider whether there is more that public sector bodies can do to spot problems at the earliest possible stage – while there is still time to act and potentially avert a disaster.

That is the task we set ourselves for this review. What did we find? That there are things organisations can do to increase the likelihood of risks and issues being uncovered. That culture and leadership, at all levels, are central to ensuring that these processes are effective. And that building an organisation where it is second nature for people to speak up about concerns is an art and not a science. By this I mean that there is no blueprint to follow, but when leaders are committed to advocating the benefits of an open culture and listen with curiosity when staff raise concerns, or suggestions for better ways of doing things, organisations can catch risks or make improvements and, as a result, are better able to deliver their purpose in the public interest.

It is not always easy to speak up – it requires moral courage to be the person who says, 'I'm not sure this is going to plan,' or, 'is there a risk that if we do X, it will have these negative consequences?' But in doing so, we honour the basic contract that we as holders of public office have with the public we serve.

Readers of our reports will notice that we revisit and expand on some of the themes we first discussed in our 2023 report, 'Leading in Practice', as well as exploring new areas. We share the same aspiration that we had for Leading in Practice, that this report will stimulate discussion and be a useful resource for leaders in the public sector as they reflect on how they can best equip their organisations to identify and resolve problems or issues that might get in the way of delivering the core purpose of their organisation. With this in mind, we have included 20 points for reflection to assist leaders and which employees can use to hold their leaders to account.

Doug Chalmers CB DSO OBE

Chair, Committee on Standards in Public Life

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Executive summary

The common themes among organisations that have failed the public in recent years are clear for all to see.

Many of the reports of public inquiries and other independent reviews have revealed weaknesses in organisational culture, characterised by defensiveness and a reluctance to listen to and act on concerns raised by employees and members of the public. There was often a failure to identify and address emerging issues before they escalated and a failure to learn from previous mistakes or similar incidents and failures.

While addressing failures in public life requires clear and unambiguous law to sanction misconduct, it is equally important to focus on what public sector bodies can do to stop these failures from happening in the first place.

The purpose of this review is to support public sector bodies to put in place the processes needed to recognise the early warning signs of emerging problems and to facilitate a culture where speaking up about concerns and learning from mistakes are seen as a personal duty and are valued by everyone in the organisation. Our aspiration is better outcomes for the public by mitigating the risk of harm, saving taxpayers' money and leading to the more effective delivery of public services.

We include examples of how organisations have sought to identify and respond to the early warning signs of emerging problems and have identified **20 points for reflection** which we hope will assist leaders to consider whether improvements can be made to their organisations' processes and culture, and which employees can use to hold their leaders to account.

Chapter 1: The Principles of Public Life and the public interest

The Principles of Public Life – honesty, openness, objectivity, selflessness, integrity, accountability and leadership – require holders of public office to act solely in terms of the public interest.

The public interest should guide the actions and behaviours of public office holders at all times. At the most prosaic level, pursuing the public interest means getting the basics right and providing a good service. Public bodies must be cognisant of the power imbalance between them and the users of their services and should be approachable and responsive when people have cause to complain.

Acting in line with the public interest is an obligation. But it also offers huge benefits. It promotes public trust, which, in turn, is necessary for compliance, supports good decision-making in complex and fast-moving situations and builds a culture where the workforce is unified by a common purpose.

Chapter 2: Accountability within the delivery chain

Public service delivery is complex, which is why it is crucial that there are robust accountability mechanisms running through each delivery chain. The specific mechanisms and processes will vary between organisations and sectors but there are four basic characteristics that should be common to all organisations:

1. A clear governance and accountability structure.
2. A well-defined set of objectives.
3. Effective systems for monitoring performance, finance and risk.
4. A strong and active sponsorship relationship between organisations in the same delivery chain.

This chapter explores these factors with reference to the relationship between government departments and their arm's length bodies (ALBs). We share examples of best practice with the intention that they will be of assistance to departments and their ALBs as they work together to deliver public services in the public interest. In particular, we include examples of how departments ensure an ongoing dialogue with their ALBs about the ALBs' objectives and examples of the methods used by departments to gain assurance about their ALBs' management of risk and performance.

Building strong relationships based on trust matters. When these relationships work well, they enable effective accountability. The importance of sponsorship can sometimes be underplayed within departments. Effective sponsorship can help to identify and address risks and potential problems before they escalate.

Chapter 3: Risk and data

Successful organisations are effective at managing risk. This does not mean that all risk can or should be avoided, rather it means that controls should be put in place to manage risk, to the tolerance level agreed by the senior leadership.

Everyone within a public sector body has a responsibility to identify and report risks. People working in public-facing roles often see the first signs that there may be an emerging problem in the delivery of public services. It is therefore crucial that frontline workers and their managers have processes in place that enable them to identify potential issues. Creating a culture where people feel safe to speak up is a core part of an organisation's ability to identify and act on risks.

Bringing together high-quality data and interpreting it intelligently allows links to be made across the records held by an organisation and can enhance understanding of the risks it carries. Organisations need analysts who can triangulate data and spot trends, but they also require leaders to be curious about what the data is saying about their organisation and, as one of our contributors put it, to "poke in the dusty corners".



AI has the potential to support risk management, given its capability to process huge volumes of data at speed. On the evidence that we heard, the use of AI to help public sector organisations with understanding the risks to which they are exposed is at an early stage.

However, it is crucial that wherever AI is procured, deployed and monitored, it is done so appropriately and in line with the Nolan Principles of openness, accountability and objectivity. Our 2020 report on AI and Public Standards contained recommendations about the safeguards and standards required as AI becomes adopted more widely across the public sector.

Chapter 4: Effective scrutiny by the board

There have been many high-profile failures in public life, where the governance structures and mechanisms were in place but for a variety of reasons the board failed to grasp the significance of red flags and failed to act before it was too late.

The quality and timeliness of the information to which a board has access and the thoroughness with which it exercises its challenge role are critical to the exercise of the board's scrutiny function. Providing effective challenge means asking difficult questions constructively.

We heard how a breadth of skills and experience on a board can mitigate the risk of groupthink. Equally, refreshing membership of boards by setting limits on the length of tenure or staggering appointment terms can ensure a board remains responsive and alert to new issues. Considering values and motivation at the recruitment stage helps with the appointment of people with a public service ethic and sends the message that how board members go about their work will be considered central to the delivery of their role.

The culture of the board is a crucial factor in its effectiveness and will be heavily influenced by the quality of the relationships between and among the executive leadership and non-executive directors.

Bringing an independent, external perspective to board meetings and hearing directly from the users of public services enhances insight into the organisation's delivery of its services.

Chapter 5: Being open to public scrutiny

Making information available about what an organisation does and how it does it enables the public and those bodies charged with holding the organisation to account to scrutinise its performance and expenditure. Withholding information merely to protect the institution (or its members) from scrutiny does not meet the Nolan Principle of openness.

The more power an organisation has over citizens' lives, the more transparent it needs to be about what it is doing and how. Meaningful transparency also requires that information is presented in a manner that is clear, intelligible and, where appropriate, in context so that the full significance of the information can be understood.

Good records management is a prerequisite for an accountable organisation. It means that information about why decisions were made is preserved should it be necessary to

review these decisions in the future. The contemporaneous nature of the record provides some assurance that it is an accurate reflection of what happened. Documenting decisions accurately also enables organisations to learn lessons when things go wrong and to evaluate comprehensively the success or failure of projects or policies.

Accountability requires bodies to be approachable and to make it easy for people to raise issues with them. It also requires organisations to engage proactively with the public to increase understanding of how they can best meet their needs.

Parliament, ombudsmen, regulators and inspectorates all have a role in scrutinising public sector bodies and holding them to account for their delivery of public services. Public sector bodies need to support these scrutiny bodies in their task by being responsive to requests for information and by seeing them not as a threat, but as a provider of constructive challenge and a source of insight about how they can be better.

Chapter 6: Learning from successes and failures

Failing to make time to ensure that lessons are learnt when things go wrong may mean that opportunities to avert subsequent disasters are missed.

Organisations need to have processes in place for reviewing scenarios where things do not go according to plan, identifying the lessons that can be learned and then ensuring that these lessons are embedded within the organisation. Public sector bodies should also take note of recurring themes when things go wrong elsewhere in public life and consider what their own organisation might learn from these crises.

Putting the public first also requires public office holders to share learning when projects, policies and procedures work well so that these successes can support improvements in public service delivery elsewhere.

Complaints can provide valuable insight for an organisation into how the public is experiencing its services and flag issues that warrant closer investigation.

Whether complaints are viewed as an opportunity or a threat is determined by the tone set by the leadership of an organisation. It requires leaders to value and prioritise the learning to be gained rather than resorting to blame, defensiveness and reputation management.

Chapter 7: Leadership and culture

It is clear to us that leadership is the most important factor in an organisation that successfully identifies and addresses emerging issues promptly and is willing to learn from its mistakes.

Clarity. Leaders must be clear that they welcome potential problems being brought to their attention early and that everyone in the organisation has a duty to deal with the public with openness and honesty.



Consistency. Leaders must be role models for the standards they expect of others, even when they are under pressure. When employees speak, leaders must listen.

Consequences. Leaders must address behaviour that is inconsistent with a culture that values people raising concerns. In public life, the ‘how’ is as important as the ‘what’ in getting things done.

This chapter discusses existing duty of candour obligations in public life and the government’s commitment to legislate to introduce a duty of candour for public servants.

We have seen in the reports of independent inquiries how, when the public has suffered as a result of action or inaction by a public sector body, it is often the defensive response of the body and its failure to admit where it went wrong and apologise, that compounds the pain suffered by those affected by its actions. When public officer holders make mistakes, they must acknowledge the failure and offer a meaningful apology.

An organisation that approaches public scrutiny openly and transparently, does not seek to defend the indefensible and treats the public with respect, needs an open internal culture that supports employees to speak up if they become aware of actions or behaviours that are falling short of these standards.

Employees need to feel that leaders are genuinely interested in what they have to say, and leaders need to be visible and available. The way leaders respond when people raise concerns has a ripple effect through an organisation – for good or bad. Strong leadership requires leaders to be curious about their organisation and to welcome concerns and complaints as information that will enable them to make improvements.

While the aspiration is a culture where people feel comfortable raising concerns as and when they arise, formal speak up/whistleblowing mechanisms are a crucial safety net and there will always be a need to have effective and trusted formal processes in place.

Public sector organisations must train their leaders how to handle a crisis appropriately so that they are better prepared when things go wrong and less inclined to minimise problems that are raised with them. Leaders must also actively search out the first signs of issues that may be bubbling under the surface.

Organisations need to be careful not to disincentivise leaders from identifying issues and learning lessons from them. How expectations and priorities are communicated is very important. If it is made clear that leaders will be judged by the way they learn from complaints rather than how they manage them, this approach may have a positive impact throughout the organisation.

One of the perceived barriers to leaders escalating concerns to the organisation at the next level in the accountability chain is concern about that organisation’s response. Providing the right targeted leadership and improvement support may help people feel that it is worth raising concerns and asking for help.

Points for reflection

Building accountable organisations

1. How do you support your employees in understanding how their role, and the purposes of your organisation, serves the public?
2. Is it clear to your employees how decisions are made within your organisation and who is accountable for them?
3. What do you do to build strong relationships with those bodies that report to your organisation as well as those bodies you are accountable to?

Identifying and assessing risks

4. How do you know that the arrangements you have in place for the identification and mitigation of risks are effective?
5. How do you assure yourself that the data your organisation collects to assess its activities is of a high quality and that there is sufficient capability within the organisation to interpret the data intelligently?
6. How do you ensure your organisation views complaints as valuable feedback reflecting the public's experience of its service and uses that data to spot systemic issues and make improvements?

Speaking up

7. What do you do to build an open culture where people feel comfortable raising issues, asking questions and sharing their ideas?
8. How do you help your employees to understand that everyone in your organisation has a responsibility to speak up when they see something going wrong?
9. Are there clear and well-understood ways for people to raise concerns formally? How do you know these routes are trusted? How do you ensure that when people speak up, they are protected and not victimised?

Development and performance management

10. How does your organisation support the development of leaders who have the skills and confidence to handle a crisis appropriately?
11. How is listening to feedback and embedding learning incorporated into the process for assessing your organisation's executive and non-executive leaders?



Public scrutiny

12. Is your organisation as transparent as it can be when deciding what information to publish about its activities, including the provision of contextual detail where appropriate?
13. Could your organisation do more to engage proactively with the public and to understand the public's perspectives on how to improve your organisation's public services?
14. When things go wrong, how quickly do you acknowledge the failure and offer a meaningful apology?

Learning lessons

15. Does your organisation have mechanisms in place to support a robust corporate memory of why previous decisions were or were not taken?
16. How do you ensure that the lessons learned from evaluating projects and policies are shared within the organisation and that these lessons inform future decisions?
17. How do you ensure that your organisation regularly considers what it can learn from the successes and failures of other public bodies?

Board scrutiny

18. How do you ensure that your board receives the information it needs about risks and issues in a format that is most useful to board members, enabling them to evaluate the significance of that information?
19. How is your board encouraged to scrutinise robustly the decisions made by your organisation? Is it sufficiently curious? Does it listen to the views of public service users?
20. What do you do to ensure that your board has the right balance of skills, backgrounds, experiences and independence of judgement? Is understanding prospective board members' values and commitment part of the recruitment process?

Introduction

Why this review matters

1. In recent years we have seen a number of catastrophic failures within public life, with a high cost to the individuals affected, the public purse and trust in public institutions. In the most serious cases there has been avoidable loss of life. Chairs presiding over public inquiries into disasters such as the Infected Blood scandal and the Grenfell Tower fire have described in stark terms the catalogues of failures, why they happened and who was responsible.
2. The areas of public life examined by public inquiries and other independent reviews have been varied, yet the reports reveal that many of the same organisational failures were present within the different public sector bodies involved. Many of the reports describe weaknesses in organisational culture, characterised by defensiveness and a reluctance to listen to and act on concerns raised by employees and members of the public. There was often a failure to identify and address emerging issues before they escalated and a failure to learn from previous mistakes or similar incidents and failures. Figure 1 identifies some of the common themes evident in four recent examples.
3. We are not claiming that identifying and acting on these factors would necessarily have averted disaster in each of these cases. Indeed, it is important to read the individual reports to understand each inquiry chair's conclusions and the complex mix of elements which contributed to the flawed decision-making. Instead, we include this table to illustrate the types of factors that are common among organisations that have failed and to which public sector bodies would therefore do well to pay close attention. They may indicate that the initial conditions are present for problems to emerge and grow and for warning signs to go unheeded.
4. The pattern in themes across different cases was echoed in the evidence we took from contributors to our review who had experience of multiple inquiries.

“What I discovered was that the patterns of behaviour that you are talking about spread across different sectors. Bishop James Jones and I summed that up in the phrase ‘the patronising disposition of unaccountable power’, which is the report we prepared in 2017.¹

Those words came from what the Hillsborough Independent Panel found, looking at Hillsborough, but they have recurred in pretty well every scandal that has emerged since we wrote that report in 2017. The Grenfell families contacted us and said, ‘In this report, you have written our story.’ In East Kent, there were similar patterns of behaviour from the Trust.”²

Ken Sutton, secretary to the Hillsborough Independent Panel and secretary to the reviews into maternity care at East Kent Hospitals NHS Trust, 11 July 2024

1 HM Government, ‘The patronising disposition of unaccountable power’, 1 November 2017, available at: www.gov.uk/government/publications/hillsborough-stadium-disaster-lessons-that-must-be-learnt

2 Department of Health and Social Care, ‘Reading the signals’, 19 October 2022, available at: www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report



5. When major failings occur, members of the public will want to know that those identified as culpable will face consequences. They rightly will want those responsible to be ‘held accountable’. But how much better would it be if public sector bodies took steps to mitigate or even prevent such crises from happening in the first place? How much suffering could be prevented? And how much time and money could be saved to spend on public services rather than dealing with the aftermath?³
6. The law can punish and it can act as a deterrent. However, for the law to be effective, it must be clear and unambiguous. The Law Commission has identified shortcomings in the offence of Misconduct in Public Office, which it found was outdated and confusing. In 2020, the Law Commission recommended replacing the current common law offence of Misconduct in Public Office, which has existed for hundreds of years, with two offences – an offence of corruption in public office and an offence of breach of duty in public office.⁴ It argued these new offences would make the law clearer and easier to follow.
7. We note the government’s announcement in the 2024 King’s Speech that the government would legislate to introduce a duty of candour for public servants and the Prime Minister has said that the law will include criminal sanctions for those who breach it.^{5, 6}
8. The law must be backed up by a culture of accountability. While the principle of accountability is often concerned with how people are held to account for their actions after the event, it must also guide the decisions and behaviour of public office holders in the daily exercise of their roles. Leaders have a responsibility to make sure that the processes and culture are in place to both support the identification and reporting of issues up through the chain of command. They must also respond appropriately to requests for information from the public and those organisations who are tasked with holding the public body to account.
9. The purpose of this review is to support public sector bodies to equip their employees to identify and address problems when they first start to emerge and before they deteriorate into a full-scale crisis. Hence, our focus is on those matters that are within the direct control of public sector organisations. We examine the role of leaders in facilitating a culture where speaking up about concerns and learning from mistakes are seen as

3 The cost to the public purse when organisations fail the public was illustrated by the whistleblowing charity, Protect, in their report, ‘The Cost of Whistleblowing’, February 2025, available at: https://public-concern-at-work.s3.eu-west-1.amazonaws.com/wp-content/uploads/images/2025/01/30100543/PROTECT_Costs-of-Whistleblowing-ONLINE.pdf

4 Law Commission, ‘Misconduct in Public Office’, 4 December 2020, available at: <https://lawcom.gov.uk/project/misconduct-in-public-office/>

5 Prime Minister’s Office, ‘The King’s Speech 2024’, 17 July 2024, available at: www.gov.uk/government/speeches/the-kings-speech-2024

6 Civil Service World, ‘New ‘duty of candour’ for officials will include criminal sanctions, Starmer says’, 25 September 2024, available at: www.civilserviceworld.com/professions/article/duty-of-candour-public-servants-criminal-sanctions-starmer-says

personal duties and are valued by organisations. This would result in better outcomes for the public by mitigating the risk of harm, saving taxpayers' money and leading to the more effective delivery of public services.

Barriers to overcome

10. Public office holders are dealing with some of the most difficult challenges we face in the UK today, particularly those who work in parts of the public sector that have an impact on the safety and health of the British public. While general policy may be framed at the national, and to some extent, the local levels, the delivery of services on which the public necessarily relies is undertaken by a wide variety of bodies. These bodies include government departments, NHS England, the different police forces across the United Kingdom, councils and executive agencies such as HM Prison and Probation Service and the Driver and Vehicle Licensing Agency. Some bodies such as the Post Office combine public service and commercial goals. These bodies employ a wide variety of personnel – civil servants, police officers, nurses and council officers in addition to the ministers and councillors who determine policy.
11. The size, constrained resources, multiple levels of authority and outsourcing to other bodies all mean that decision-making across the wide span of the public sector is challenging. Errors will on occasion be made and inevitably some things will go wrong. We believe that if people in public office respond quickly to correct errors, learn the wider lessons and apply them to improve public services, the benefit to the public will be considerable.
12. To gain a sense of the barriers to identifying and addressing problems, we asked contributors to our review what they saw as the main reasons that public bodies might fail to act quickly and decisively at the first sign of a problem within an organisation. Given the broad scope of our review, no report could analyse the processes and cultures of individual public bodies. Instead, we have sought to identify themes. Some selected themes that came out strongly were: institutional defensiveness and reputation management, groupthink, poor relationships, fear of speaking up and failure of board scrutiny. Figure 2 discusses their meaning.
13. There are no easy answers and what works for one organisation might not work for another. We hope that the examples and stories we have included will offer food for thought and challenge those working in the public sector to reflect on whether there are barriers to identifying problems within their own organisation and how those barriers might be overcome. Central to this process is keeping at the forefront the primary purpose of the organisation and the underlying responsibility to serve the public interest while nurturing open organisational cultures where problems are reported without fear.



Figure 1: Common themes from recent inquiries

This table identifies themes common to a range of recent inquiries and reviews that contributed to the failure of public sector organisations to identify warning signs and act appropriately. See appendix 1 for some relevant quotations from the reports.

	Theme	Windrush Lessons Learned Review ⁷	Ockenden Review ⁸	Infected Blood Inquiry ⁹	Grenfell Tower Inquiry ¹⁰
1	Failure to listen to and act on concerns raised by employees and/or the public				
2	Failure to investigate properly when things went wrong				
3	Failure of the board to have effective oversight of issues and concerns				
4	Overly defensive organisational culture				
5	Failure to support a ‘speak up’ culture				
6	Poor relationships within the organisation				
7	Failure to understand the unintended consequences of policy decisions				
8	Failure to learn from past mistakes, or similar incidents and failures				
9	Failure to identify and share emerging themes that might have alerted the organisation to a developing risk				

7 Home Office, ‘Windrush Lessons Learned Review’, 19 March 2020, available at: www.gov.uk/government/publications/windrush-lessons-learned-review

8 Department of Health and Social Care, ‘Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust’, 30 March 2022, available at: www.gov.uk/government/publications/final-report-of-the-ockenden-review

9 Infected Blood Inquiry, ‘The Inquiry Report’, 20 May 2024, available at: www.infectedbloodinquiry.org.uk/reports/inquiry-report

10 Grenfell Tower Inquiry, ‘Grenfell Tower Inquiry: Phase 2 Report. Report of the public inquiry into the fire at Grenfell Tower on 14 June 2017’, September 2024, available at: www.grenfelltowerinquiry.org.uk/phase-2-report

Figure 2: What are the barriers to identifying, addressing and learning from problems in public sector bodies?

We asked contributors to our review what they saw as the main reasons why public sector bodies might fail to act quickly and decisively at the first sign of a problem within the organisation.

These are the themes that were raised with us.

Institutional defensiveness and reputation management

It can be tempting for leaders to minimise the problems they are presented with and choose to focus on the facts that are more convenient. There can be a cultural disposition to prioritise the protection of the organisation's reputation over addressing mistakes. If problems are routinely denied or explained away, this is at odds with an organisational culture that values people being curious when things go wrong and asking appropriately probing questions.

"We counted eight separate occasions when there were what should have been clear red flags for the trust in East Kent, every one of which they managed to explain away, ignore, think that they had addressed the problem by writing an action plan that was never implemented. The problem went on for at least 10 years."

Dr Bill Kirkup, Chair of reviews into maternity care at East Kent Hospitals NHS Trust and Morecambe Bay maternity services

Groupthink

Groupthink has a number of causes. It can occur when people think the same way because they have similar backgrounds and skills, or when micro-cultures develop due to isolated workplaces that have little interaction with other teams. It can also arise when people are reluctant to challenge or to be seen as an outlier.

"If you look, for example, at leadership teams within public bodies, they tend to be people who think very similarly, people who come from a very similar background and people who will not challenge because they do not want to be the outlier. You always need somebody who will think a bit differently and ask those difficult probing questions to perhaps change the course in which they are going. Bringing some external lens into that leadership group is really important."

Amerdeep Somal, Local Government and Social Care Ombudsman



Poor relationships within organisations

Often scandals in public life are the result of poor relationships. We have seen this in the many reports of inquiries into the failures of maternity services and in the relations between the Tenant Management Organisation and the residents of Grenfell Tower as described in the report of the Grenfell Tower Inquiry.

“The culture which exists in the NHS is informed by ministerial steers, ill-functioning legislation on duty of candour and whistle-blowing, insensitive handling of clinicians by Boards and management and sometimes by the consequences of a hierarchy of clinicians. There are disputes between professions, between clinicians, and between midwives and nurses, and all this gets in the way of listening to patients and patient safety.”

Sir Rob Behrens, Former Parliamentary and Health Service Ombudsman

Failure to build a speak up culture

If employees feel that they won’t be listened to or supported if they speak up, or that they will be blamed for the problem they are raising, the organisation loses a valuable opportunity to bring potential problems to awareness and resolve concerns before they escalate.

“I do think the most powerful thing you can have is a culture that says it is actually alright to say to your leaders, ‘Something is going really wrong here,’ or, ‘I do not like how this looks,’ or, ‘Actually, my ward is under-resourced’. That you are not going to get sat on from a height if you do that. To me, that is one of the most powerful things senior leaders ought to be doing.”

Mark Fisher, Chief Executive, NHS Greater Manchester Integrated Care Board

Failure of board scrutiny

The board performs an important role in scrutinising the decisions and practices of the organisation. We have seen examples in independent inquiries and reviews where a lack of curiosity or robust challenge on the part of the board meant that opportunities to identify and act on issues of concern were missed.

“Ultimately the final responsibility for an organisation failing should rest with the board, creating a system where oversight stops problems developing at an early stage, and where this fails, the board are then held to account. However, the failings at the Post Office, and repeated failings in the NHS, show the cost organisations can pay where they have weak boards.”

Protect, open consultation, submission 20

Chapter 1: The Principles of Public Life and the public interest

1. The primary obligation of public office holders is to the public. Public service is central to the Principles of Public Life, which were set out by the first chair of CSPL, Lord Nolan, in 1995.¹¹ The principles are: honesty, openness, objectivity, selflessness, integrity, accountability and leadership. Our 2021 report, ‘Upholding Standards in Public Life’, found that the Nolan Principles have stood the test of time and are reflected in rules and codes of conduct across public life.¹²
2. The Principles of Public Life require holders of public office to act solely in terms of the public interest. Yet the notion of the public interest being front and centre will not have been evident to those who have suffered as a result of the failures of public sector bodies over recent decades – cases such as the Infected Blood scandal, the Post Office Horizon IT scandal, the failure of multiple maternity services and the response to the Hillsborough disaster.
3. In his 2017 report, ‘The patronising disposition of unaccountable power’, Bishop James Jones called for a substantial change in the culture of public bodies. To help bring about that cultural change, he proposed a Charter for Families Bereaved through Public Tragedy, inspired by the experience of the Hillsborough families and made up of a series of commitments to change.¹³ Point 2 commits public bodies adopting the charter to “place the public interest above our own reputation,” which explicitly addresses what Bishop Jones describes as one of the core features of the patronising disposition of unaccountable power: “an instinctive prioritisation of the reputation of an organisation over the citizen’s right to expect people to be held to account for their actions.”
4. Acting in line with the public interest certainly means responding appropriately to public tragedy, but it should also guide the actions and behaviours of public office holders in their day-to-day work. At the most prosaic level, pursuing the public interest means getting the basics right and providing a good service. Most people just want the services they need to be there when they need them. They do not want to feel they have no choice other than to make a complaint. Should a complaint be necessary, organisations need to be approachable and responsive. There is, inevitably, an imbalance between public service users and the body they are dealing with and it is important that public bodies recognise this. That people who try

11 The Principles are referred to interchangeably in this report as the Principles of Public Life and the Nolan Principles.

12 Committee on Standards in Public Life, ‘Upholding Standards in Public Life’, 1 November 2021, available at: www.gov.uk/government/publications/upholding-standards-in-public-life-published-report

13 HM Government, ‘The patronising disposition of unaccountable power’, 1 November 2017, available at: www.gov.uk/government/publications/hillsborough-stadium-disaster-lessons-that-must-be-learned



to raise issues with public institutions can end up locked in a ‘David and Goliath’ type battle has been seen vividly in the experiences of sub-postmasters who sought to raise concerns about the Horizon computer system but were wrongly prosecuted.¹⁴

“Public service users, however educated and powerful, will face situations where they are heavily outgunned by the public body they are up against. We have to challenge ourselves to make it easier for that person to raise a concern or red flag and for us to provide that route to accountability.”

Rebecca Hilsenrath, Ombudsman and Chair, Parliamentary and Health Service Ombudsman, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024

5. Acting solely in terms of the public interest is a requirement for all public office holders but being guided by the public interest also offers considerable benefits, both to individuals and to the institutions for which they work.
6. First, public confidence that a public institution is committed to the public interest is crucial for trust in the organisation, which in turn is necessary for compliance. Two examples illustrate this point: the tax system and policing. To take the first, voluntary compliance is at the heart of how the tax system works in the UK. While HMRC has methods and mechanisms to support compliance, high levels of trust, transparency and customer focus are critical to a culture of people paying their taxes. In the second example, the British model of policing is based on the Peelian principles of policing by consent. Those principles recognise that the power of the police to fulfil their functions and duties is dependent on the public approval of the police’s existence, actions and behaviour and on their ability to secure and maintain public respect. Damage has been caused in recent years by some very high-profile failings and erosion of standards, but public trust continues to be of critical importance to the operation of the British policing model. Transparency and public engagement are critical to building public confidence that an institution is committed to acting only in the public interest. We discuss these subjects further in chapter 5.
7. Secondly, public office holders are often required to make complex decisions, sometimes in ambiguous and fast-moving operational environments. In such circumstances, taking a step back and viewing problems through the prism of the public interest can help public office holders focus on what really matters. The Principles of Public Life provide a compass to help navigate decisions. Figure 3 features examples of the tools used by public sector bodies to support employees to act in line with them.

14 BBC News, ‘Post Office Horizon scandal: Why hundreds were wrongly prosecuted’, 30 July 2024, available at: www.bbc.co.uk/news/business-56718036

8. Thirdly, we heard compelling testimony that a shared understanding among employees of the objectives that the organisation is there to achieve, and how they serve the public interest, plays an important role in building a culture where people are valued for spotting and addressing potential problems. Tying the culture of an organisation to its purpose can unify a workforce and give meaning to its work. This is in keeping with evidence to the committee’s 2023 review, *Leading in Practice*.¹⁵ Contributors to that review explained how defining organisational values that link to the purpose and mission of their organisation gave the values resonance and had a galvanising effect.

“Strong connection to purpose is really important. Ideally, colleagues care about the organisation that they are a part of. They care about the customers that they serve, they do not see it as just a transaction. It is important as leaders to set really clear standards and expectations about values and how we do things around here, how we expect managers and their teams to behave to each other. We also have to be really clear about how we expect to deal with our customers.”

Angela MacDonald, Deputy Chief Executive and Second Permanent Secretary, HMRC, 11 July 2024

9. It is important to note that what the public interest requires in any situation will depend on the relevant facts in each case. Further, the ‘public’ is not a single homogeneous group – the public is often both the users of a public service and the taxpayer, and the balance between whose needs should have precedence may vary according to the circumstances.¹⁶ But resolving tensions between different dimensions of the public interest calls for active, critical and reflective engagement within the organisation, and clarity about the organisation’s core purposes.
10. Ensuring that the public interest is at the forefront when decisions are made within public sector bodies will support high quality conversations and a deeper understanding of the trade-offs that are part of public life.

15 Committee on Standards in Public Life, ‘*Leading in Practice*’, 24 January 2023, available at: www.gov.uk/government/publications/leading-in-practice

16 Committee on Standards in Public Life, ‘*The Nolan Principles: Public Standards, the Public Interest and Public Service*’, 24 October 2024, available at: www.gov.uk/government/publications/30th-anniversary-of-the-nolan-principles



Figure 3: Codes and guidance to support employees to act in line with the Nolan Principles

Board members of NHS organisations are subject to the Fit and Proper Person Test (FPPT) supervised by the Care Quality Commission. Adherence to the Seven Principles of Public Life is included in the guidance for assessing good character.

Care Quality Commission, open consultation, submission 4

The 2024 Code of Ethics for policing sets out the professional behaviours that the public can expect to see from officers, staff and volunteers. It is intended to help police professionals to do “the right things in the right way for the right reasons.”¹⁷ The three ethical policing principles: courage, respect and empathy, and public service, draw from the policing principles contained in the 2014 Code of Ethics, which included the Seven Principles of Public Life.

Academy Trusts are required as a condition of their funding agreements with the Secretary of State for Education to commit to uphold the Seven Principles of Public Life. The Academy Trust Handbook provides the overarching framework for implementation of effective financial management and other controls. It states that accounting officers must adhere to the Seven Principles of Public Life.¹⁸ The board chair and the accounting officer must manage personal relationships with related parties to avoid both real and perceived conflicts of interest, promoting integrity and openness in accordance with the Seven Principles of Public Life.

The Chartered Institute of Public Finance and Accountancy (CIPFA) has incorporated the Seven Principles of Public Life into its professional standards and guidance to the local government sector.

CIPFA, open consultation, submission 5

17 College of Policing, ‘2024 Code of Ethics’, January 2024, available at: www.college.police.uk/ethics/code-of-ethics

18 Education and Skills Funding Agency, ‘Academy trust handbook 2024’, July 2024, available at: https://assets.publishing.service.gov.uk/media/66a3909aab418ab055592dda/Academy_trust_handbook_2024_FINAL.pdf

The Framework for Ethical Leadership in Education adapts the descriptors of the Seven Principles of Public Life to explain what they mean in the context of educational leadership and sets out a set of personal characteristics or virtues expected of leaders.¹⁹ The National Governance Association's (NGA) Pathfinder Project has supported schools and college leaders to use the framework to navigate through ethical thinking and decision-making. The NGA has integrated the framework into its guidance, publications and professional development.²⁰

"I am not sure that we have done anything that has been so positive, especially in terms of one of the results being that adopting this did not add to overstretched workloads. It gave leaders and boards confidence. It gave them permission to have these conversations. It gave us all common language, but it did not add to their workload. That was phenomenally positive."

Emma Knights, then CEO, National Governance Association, 10 May 2024

"We use the Nolan Principles in the training that we give to our staff. We audit against them where we have either been asked to do a specific piece of work in that area, so in behaviour or culture, but also, if we were looking at something like a financial management review that was drawing on the managing public money framework, that would be aligned to the Nolan Principles."

Harriet Aldridge, Chief Executive, Government Internal Audit Agency, 24 May 2024

The Principles of Public Life are core and fundamental to the principles of the Civility and Respect project led by the National Association of Local Councils (NALC), One Voice Wales and the Society of Local Council Clerks.

"The pledge is easy for councils to sign up to and it will enable councils to demonstrate that they are committed to standing up to poor behaviour across our sector and to driving through positive changes which support civil and respectful conduct."

NALC open consultation, submission 16

19 ASCL, 'Framework for ethical leadership in education', 2019, available at: www.ascl.org.uk/ASCL/media/ASCL/Our%20view/Campaigns/Framework-for-Ethical-Leadership-in-Education.pdf

20 National Governance Association, 'Paving the way for Ethical Leadership in Education', January 2021, available at: www.nga.org.uk/media/ylteeeuz/ethical-leadership-report-final.pdf



Chapter 2: Accountability within the delivery chain

Accountability mechanisms

1. When a member of the public engages with the government, in most cases, they will be interacting with a public body or a private provider delivering a service on the government's behalf. Public bodies may be linked in a hierarchy, with each body being accountable to the body that sits above it. Where companies are providing a service paid for by the taxpayer, there must be proper governance of these outsourcing arrangements.
2. The organisations in a delivery chain have different roles, but a common overarching purpose. For example, NHS England and the Department for Health and Social Care do different jobs but their combined purpose is to support the Secretary of State to deliver the goal of improving the health of the nation.
3. Public service delivery is complex, which is why it is crucial that there are robust accountability mechanisms running through each delivery chain. The specific mechanisms and processes will vary between organisations and sectors and no review could examine them all. Instead, we highlight the following four basic characteristics that should be common to all organisations and explore these characteristics with reference to government departments and their ALBs.²¹
 - A clear governance and accountability structure.
 - A well-defined set of objectives.
 - Effective systems for monitoring performance, finance and risk.
 - A strong and active sponsorship relationship between organisations in the same delivery chain.
4. In selecting government departments and their ALBs to discuss the characteristics of accountable organisations, we are not saying that the system is perfect. We are aware of criticism that the ALB landscape is opaque and that ALBs are subject to insufficient oversight. Lord Maude's 2023 report on governance and accountability in the Civil Service contains recommendations on ALBs.²² In December 2024 the Parliamentary Administration and Constitutional Affairs Committee announced an inquiry into public bodies policy.²³

21 CSPL is an arm's length body sponsored by the Cabinet Office

22 'Independent Review of Governance and Accountability in the Civil Service: The Rt Hon Lord Maude of Horsham', 13 November 2023, available at: www.gov.uk/government/publications/review-of-governance-and-accountability/independent-review-of-governance-and-accountability-in-the-civil-service-the-rt-hon-lord-maude-of-horsham-html

23 Public Administration and Constitutional Affairs Committee, 'Public Bodies: Inquiry', 13 December 2024, available at: <https://committees.parliament.uk/work/8745/>

5. In this chapter we discuss some of the themes that arose in the evidence and share examples of best practice that were drawn to our attention with the aspiration that they will be of assistance to departments and their ALBs as they work together to deliver public services in the public interest.

Accountability and independence

6. ALBs are administratively classified by the Cabinet Office. While there are three categories of ALBs (executive agencies, non-departmental public bodies and non-ministerial departments), in practice, public bodies of the same classification can operate very differently.²⁴ Government departments sponsor the ALBs within their remit, supported by advice from the Public Bodies team in the Cabinet Office, which provides guidance to departments and issues the ALB sponsorship code of good practice.²⁵ There is no statutory framework for ALBs in the UK.
7. We heard how the level of scrutiny and oversight of ALBs practised by departments will vary according to the degree of independence that the ALB requires from government to deliver its functions. Some ALBs are set up to have a high level of scrutiny and oversight, with clear direction set through departmental plans. Regulators usually require a high degree of independence to maintain confidence in their impartiality and tend to be set up to be free from political interference. For example, in the case of the Office for Students (OfS), the independent regulator of higher education in England, while ministers can guide the OfS on its strategic priorities for the sector, the OfS is only required to have regard to this guidance. Furthermore, the OfS is completely independent from government in terms of its operational priorities.
8. When we spoke to ALBs we picked up on a sentiment from some bodies that there has been a shift in the degree of oversight exercised by departments in recent years. A non-executive who has worked in a number of large public bodies over the last six years told us that these bodies felt that “the arm was getting shorter” and there was a greater tendency for departments to micromanage. We were told that this is problematic because it muddies accountability.

24 Cabinet Office, ‘Public Bodies Handbook – Part 1, Classification Of Public Bodies: Guidance For Departments’, page 8, available at: www.gov.uk/government/publications/classification-of-public-bodies-information-and-guidance

25 Cabinet Office, ‘Arm’s length body sponsorship code of good practice’, 23 May 2022, available at: www.gov.uk/government/publications/arms-length-body-sponsorship-code-of-good-practice/arms-length-body-sponsorship-code-of-good-practice



A clear governance and accountability structure

9. The wide range of ALBs and differences in the intended degree of independence from government mean the governance and accountability mechanisms required will vary. The HM Treasury document, ‘Managing Public Money’, explains that the terms of engagement between a department and its ALBs should be documented in a framework agreement. This describes the governance and accountability framework that applies between the body and its sponsor department and sets out how the day-to-day relationship should work in practice.²⁶
10. The board of an ALB provides leadership, strategic direction, advocacy and independent scrutiny to both the ALB and the department. The Chief Executive of the ALB is usually the Accounting Officer (AO), who has a set of obligations to the Principal Accounting Officer (PAO), who is normally the department’s Permanent Secretary. The PAO is accountable to Parliament for the management of public money. Routine oversight of each ALB within the departmental group should be led by a senior sponsor, who is normally supported by a sponsorship team.
11. The Secretary of State is ultimately accountable to Parliament for the performance of each ALB for which their department is responsible. We spoke to Lord Maude, who was commissioned by the previous government to conduct a review into governance and accountability in the Civil Service.²⁷ Lord Maude raised with us his observation that ministers frequently have little exposure to the work and delivery plans of public bodies and it is unrealistic therefore to expect ministers to be accountable for an ALB’s performance. He told us, “There needs to be a much richer connectivity between ministers and the public bodies.”
12. Other contributors acknowledged the complexities that exist around the accountability of ALBs.

“I agree there is a potential accountability gap there, but when you work with good ministers, they accept that it is a joint endeavour and that is what we should be trying to achieve together. They cannot do it on their own. They have to rely on the system underneath them to help them deliver it.”

Kathryn Cearns, Non-Executive Director, Nuclear Decommissioning Agency, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024

26 HM Treasury, ‘Managing Public Money’, May 2023, available at: www.gov.uk/government/publications/managing-public-money

27 ‘Independent Review of Governance and Accountability in the Civil Service: The Rt Hon Lord Maude of Horsham’, 13 November 2023, available at: www.gov.uk/government/publications/review-of-governance-and-accountability/independent-review-of-governance-and-accountability-in-the-civil-service-the-rt-hon-lord-maude-of-horsham-html

A well-defined set of objectives

13. A strong ALB has a clear set of objectives articulated by the department. We spoke to a group of departmental sponsorship leads about how their departments communicate objectives and priorities to their ALB. One department, which has a range of different types of ALBs, told us how it takes a proportionate approach to how it engages with its ALBs on priorities and deliverables, with the degree and intensity of engagement depending on the size and nature of the entity and the level of oversight and assurance required by the department.
14. The departmental sponsorship leads described a range of methods, both formal and informal, set out below, that they use to ensure that dialogue around the objectives is ongoing.
 - Ministers send annual chair's letters with ministerial priorities (noting the degree of independence from government in some cases means that this is not always appropriate).
 - Departmental representation on ALB boards.
 - Letter from the senior sponsor to the CEO of the ALB setting out the agreed programme funding.
 - Regular meetings between the senior sponsor and the CEO (with the frequency differing between bodies).
 - Regular engagement with customers receiving services provided by the ALB.
 - Yearly chair appraisal process, some conducted by ministers, some by departmental officials.
 - Sponsor meetings between the departmental and ALB finance and policy counterparts.
 - Ministerial meetings with the ALB.
 - An annual conference run by the department, which brings together the department's ALBs and provides an opportunity to talk through the department's strategic objectives and key priorities.



Effective systems for monitoring performance, finance and risk

15. Outcome assurance, financial oversight and risk management are three of the six key capabilities set out in the sponsorship code (the other three are: agreeing strategy and setting objectives, governance, and accountability and relationship management).
16. Harriet Aldridge, Chief Executive of the Government Internal Audit Agency (GIAA) told us that there is variation in whether departments have appropriate oversight of the delivery risks held by ALBs.

“If you are looking at the flow through of red flags there is an interesting question around, where significant delivery is done by an arm’s length body, whether the delivery risks that that arm’s length body holds are making their way through to the central department’s risk register. We absolutely see variation in that respect. In some departments audit committee chairs will speak regularly to their arm’s length body audit committee chairs and that flow of information up and down is really in place, but there are other departments where there is not that level of engagement at all, and therefore, I am confident that those delivery risks – which really are part of the central department’s – are not getting through.”

**Harriet Aldridge, Chief Executive, Government Internal Audit Agency,
24 May 2024**

Examples of methods for monitoring performance, finance and risk

17. Set out below are examples of the methods used by government departments to gain assurance relating to their ALB’s management of performance, finance and risk.

“ We do an annual assurance assessment, which red-amber-green (RAG) rates the arm’s length bodies against a number of criteria, establishing the risk that they present to the department. We ask the bodies for a self-assessment as well. We do not always agree, but we work through the issues and decide on an overall RAG rating as well as individual ratings against those criteria. A paper is then taken to our department audit risk and assurance committee. That allows the risks to be socialised with a bigger group, and we update against those risks on a quarterly basis. If, for example, we think there is a change or digital capability gap, it enables us to connect the right parts of the department with the bodies to try to support them and help them lift those capabilities.”

“ We have a system of monthly pillar meetings with the relevant team that principally covers risk, performance and finance, but also governance, which is one we are bringing on stream. We also have intelligence streams. There are 16 of those. We find that that is quite effective in terms of getting a sense of the pulse of an organisation. It encourages the team to be factfinders and to be curious. For example, it would include HR, anti-fraud and commercial, and we look at those individually. There is a named lead within the team on that, and we look at those collectively once a month and look for patterns and resonances. As sponsors, we have that cross-cutting perspective that others working on each of those individual areas do not, so we can maybe see patterns that would then collectively constitute what we could judge as a red flag.”

“ We have policy deep dives. Where we see a risk that looks, from a common sense point of view, as if it might be quite complex, and we want to test the rationale for it and whether the mitigations are right, we increasingly reach out to the relevant [departmental] policy teams and join them up with the relevant policy teams in the body. We convene and participate in that conversation. We also just recently started attending internal meetings of the risk teams and the group leads inside our ALB, so we can understand a bit better their internal process for escalating, and we can take a view as to whether they are making the right judgement calls there.”

“ In terms of risk, my Deputy Director sits on the board and so would expect any risks to come to the board. Then we have fortnightly meetings with [the ALB] where they would raise risks with us and we would feed them up through the [department] chain.”



“ [The department] has a central online reporting system for reporting risks, which is managed by our risk team. As well as getting the discussions, every quarter, policy sponsors will update those risk registers for their organisations, which the risk team can then look at centrally to spot any trends across the organisations and, if necessary, escalate that to our senior board in the department. In addition to discussions between policy sponsor teams and arm’s length bodies, the risk team and the central team with oversight of sponsorship have introduced regular meetings with individual policy sponsors to discuss risks.”

“ Our performance and risk committee (PRC) has appointed an independent member who attends the [ALB] risk committee approximately twice a year, so we have that independent oversight. The [ALB] also shares its risk report with us regularly, which we are sighted on as part of the [ALB] board papers, which we receive six times a year. Our senior sponsor attends the [ALB] board meetings as well. In addition, we also have regular meetings with the [ALB’s] director of finance, where we discuss risk, finance and governance issues.”

“ One member of the [department] Audit and Risk Assurance Committee (ARAC) is like an ARAC buddy for [ALB]. They do not formally sit on the committee, but they attend the sponsored body’s ARAC meetings. Similarly, we have a lot of interactions with the relevant functional leads for digital risks. We discuss them fairly regularly.”

“ Our standard practice is to have somebody to be a member of both the [ALB’s] board and the audit and risk committee. In that position, I will look at the internal risk register of the organisation alongside the other ARAC members and can therefore help to make sure that the serious things are escalated.”

“The functional capability of the organisations is quite often critical. Whether it is their change capability or HR capability or finance, we have fairly regular forums with the ALB functional lead. The finance directors will come in and meet our finance function. The digital directors will come in and meet our digital function. That is a way of setting standards with functions. What are the department’s expectations of the bodies? Are there capability issues? Are there risks emerging? Can the department lend more support to the bodies? It is about making sure that ALB professions are plugged into our professions.”

A strong and active sponsorship relationship

18. A factor to which departments and ALBs gave equal weight is the importance of building strong relationships based on trust. When these relationships work well, they enable effective accountability. Conversely, when trust breaks down, it is less likely that issues will be exposed transparently at an early stage. A department can act as a critical friend, providing challenge and supporting an ALB to be at its most effective in delivering its purposes.

“Trust and relationships are so important, so I think as an accounting officer it is my job to have a close, trusted relationship with the chairs and the chief executives of all of my ALBs. I want them to feel able to come to me with any questions, concerns, and advice, and I want them to know that I take an interest and I care about what they are doing. That takes time to build that level of relationship and trust.”

Cat Little, Permanent Secretary, Cabinet Office, 24 July 2024

19. A department’s working level relationship with the ALB is held by the sponsorship team, with oversight led by a senior sponsor. It is critical that the sponsorship team really understands the ALB and we heard from a number of ALBs how a lack of continuity, as a result of people moving on within departments, can impact on that depth of shared understanding.
20. We were told that there can on occasion be a lack of alignment between different teams in the same department, which can make ALBs feel they are getting pulled in different directions. One ALB chair told us that ensuring that people from both the departmental finance and policy teams attend meetings with the ALB was an effective way of overcoming this problem.
21. The level at which departments engage with their ALBs is variable. In one department, the sponsorship team has quarterly meetings with the permanent secretary to talk about each ALB. Another department told us how the level of seniority varies. In some cases the senior sponsor is the Permanent Secretary and in other cases it is the Director General, depending on the size of the ALB and the importance of what it is delivering.



22. We heard from departments that ministerial engagement with the ALBs within their remit also varies and is influenced by their level of interest in the entity. Some ALBs told us that they would welcome greater exposure to ministers but had a sense that this was not actively encouraged.

“Ministers are not exposed at all to what these bodies do, or they are encouraged to think that it is not really their business, and that is wrong too. It is important that the Permanent Secretary as part of his or her duty to the minister should make it possible and encourage it. If ministers do not want to do it, then you cannot make them. It is making it possible that is important. A lot of problems occur because ministers do not know what they can do and what they cannot do. There is often a lack of clarity over what their powers are. They are often discouraged from getting involved with things that they are perfectly entitled to be involved with, and very often should be involved with.”

The Rt Hon Lord Maude of Horsham, 31 May 2024

23. The importance of sponsorship can sometimes be underplayed within departments. Senior leaders can be very focused on what is happening on the ground and we heard that it is sometimes challenging to get the balance right between sponsorship activity and focusing on matters that are more pressing in the moment. We heard that resourcing constraints mean that sponsorship can sometimes lose out to “shinier and newer programmes and priorities such as digital and AI.” Lorna Horton, Deputy Director of the Cabinet Office Public Bodies team told us that departmental sponsorship teams are usually very small, and they often have other responsibilities as well, which then makes it difficult to focus on good sponsorship and the building of relationships. For example, many departments combine their public appointments and public bodies’ sponsorship teams. Public appointments can generate more immediate, short-term activity that has to be prioritised, in comparison to the work of sponsorship, which is more long-term activity.
24. When done well, effective sponsorship can help to identify and address risks and issues before they escalate. Success in the sponsorship context may go under the radar, but supporting ALBs, through quiet competence, is of critical importance to departments.

“You just need to have sufficiently experienced people doing the sponsorship and sitting on the boards and making sure that you have enough resource. That comes down to people knowing what sponsorship is there for and what value it has. A lot of what you do is trying to prevent things going wrong, so it is not always that visible what you have done, but the whole point is not to have a splash.”

Departmental sponsorship lead, roundtable, 18 July 2024

Chapter 3: Risk and data

Risk Management is the co-ordinated activities designed and operated to manage risk and exercise internal control within an organisation.

The Orange Book: Management of Risk – Principles and Concepts²⁸

1. This chapter sets out examples that were shared with us of the role of risk management in identifying emerging issues, and the benefits of data in building a deeper insight into these risks. We illustrate the value of maximising the use of high-quality data to enhance understanding of risks across an organisation and look at how AI is starting to be used as a tool to draw together these insights.
2. We do not seek to summarise the key principles of risk management or provide guidance on risk management techniques as these are readily available from professional bodies, specialists and consultants. The first port of call for government departments and their ALBs should be The Orange Book, which sets out the applicable standard for risk management in government.

Understanding and managing risk

3. Successful organisations are effective at managing risk. This does not mean that all risk can or should be avoided, but that controls should be put in place to manage risk, to the tolerance level agreed by the leadership of the organisation. In the case of public sector organisations, the risk appetite will be influenced by the potential impact on public lives and expenditure but also the appetite for innovation in specific areas.
4. Governance in government departments reflects the political environment, with ministers working with the executive and supported by non-executive advisors. Cat Little, Permanent Secretary at the Cabinet Office, told us that while there is variation in how boards at the top of government departments operate, the executive functions of government departments operate in accordance with normal corporate governance standards and are publicly accountable to Parliament through the annual report and accounts process. Every government department sets out their performance on governance and is accountable to Parliament for it.
5. Home Office lead non-executive director, Tim Robinson, set out in the Home Office Annual Report and Accounts for 2023 to 2024 how the department has redefined the Home Office operating model to ensure greater clarity of accountability through the line management chain.²⁹ Sir Matthew Rycroft, Permanent Secretary at the Home Office, told us how this involved cutting some executive committees, including the Risk and Delivery Committee and instead folding the consideration of risk into each

28 UK Government, 'The Orange Book: Management of Risk – Principles and Concepts', page 57, May 2023, available at: www.gov.uk/government/publications/orange-book

29 Home Office, 'Annual report and accounts 2023 to 2024', 30 July 2024, available at: www.gov.uk/government/publications/home-office-annual-report-and-accounts-2023-to-2024



element of the department's Outcome Delivery Plan, which is the substance of what the department is trying to achieve. In addition, the Executive Committee looks at performance and risk across the piece in order to ensure that performance and risk are also considered holistically.

"The thing that we have done, which I would advocate every other department doing, is to have a monthly stocktake between the Permanent Secretary and the direct report, so the Director General or the Second Permanent Secretary, on the basis of a standardised pack of data. It is still relatively early days, but I would say it has made a really big difference. On anything to do with the finance, I hold the chief operating officer to account, or, if it is down the line, the relevant Director General. Each of these stocktakes is structured around six rows: performance, risk, people, finance, our portfolio and commercial arrangements. Those are the six headings, which are accompanied by a standardised set of data. We are measuring changes in the same things each month."

Sir Matthew Rycroft, Permanent Secretary, Home Office, 16 May 2024

6. Risk is not a matter that is reserved for senior leaders and boards. Everyone within a public sector body has a responsibility to identify and report potential risks. People working at the sharp end of an organisation, such as frontline officers who come into direct contact with the public, often see the first signs that there may be an emerging problem. It is therefore crucial that frontline workers and their managers have processes in place that enable them to identify and report potential issues.

"Public bodies should consider what their 'frontline defence' looks like – one core aspect of spotting problems at an early stage is ensuring that frontline managers and middle managers have processes in place to help them identify patterns and problems, which can then be escalated to the senior management team (SLT) as needed."

Northern Ireland Public Sector Chairs' Forum, open consultation, submission 19

7. Creating a culture where people feel safe to speak up is a core part of an organisation's ability to identify and act on risks. Protect, the whistleblowing charity, told us in their response to our consultation that whistleblowing is one of the best early warning systems for organisations and a key tool to manage risk. In our 2023 report, *Leading in Practice*, we explored how leaders can create a speak up culture, supported by effective whistleblowing arrangements and we return to this subject in chapter 7.

“My starting point is that, when something does go wrong, as it did on Windrush, and often elsewhere in organisations, it is never the case that no one knew what was going on. There is always someone who knew. Quite often they are relatively junior, relatively frontline, and feel as though they do not have a voice. They feel as though it is not their job to wave a red flag. On top of the specific things we have done, the cultural change is to make sure that every single person knows that they do have a voice and they use that voice to flag their concerns.”

Sir Matthew Rycroft, Permanent Secretary, Home Office, 16 May 2024

8. We heard that maturity of risk management varies across government. Harriet Aldridge, Chief Executive at the Government Internal Audit Agency (GIAA), told us that she has seen a tendency within government to focus on mitigations that will prevent risk indicators from materialising. This approach can mean corrective action comes too late when things do go wrong. If there was a clearer acceptance at the outset that a major project or initiative is likely to experience setbacks, those responsible would be better equipped to manage the setbacks and ensure the original intended benefits do not become lost. GIAA often sees customers continue with a project or initiative after initial assumptions have changed (e.g. spiralling costs being mitigated by project scope reductions) without properly determining whether the intended benefits remain sufficiently achievable, or whether they could be better achieved in a different way.
9. GIAA has an important role to play in supporting Accounting Officers (both Permanent Secretaries and ALB chief executives) to discharge their responsibilities, but this is not always fully understood. We would encourage Accounting Officers to make the most of this valuable resource.
10. We heard about the checks and balances in place in local government to test how a council is managing its risks. Key internal controls include: appropriate policies and procedures which are regularly reviewed and reflect good practice; regular reporting on performance, finance, risk and project management; internal audit; corporate statutory officers; and overview and scrutiny, audit and standards committees. Heather Wills, Principal Adviser, Finance and Governance at the Local Government Association (LGA), described the complex environment in which local government operates – the challenge of understanding the compound implications of identified risks, within a ‘shrinking envelope of finances’.
11. External audit is an important part of delivering accountability and transparency within local government. Councillor Marianne Overton, Vice Chair of the LGA, shared her concern about the delays in external audits, with the system unable to cope with demand.



“The lack of good external audits, which is just not coping with the volume, is very worrying. It is just not coping at all. The proportion of councils who have had a proper external audit in good time is very small, and that is not good enough. We need to get that right.”

Councillor Marianne Overton, Vice Chair and Leader of the Independent Group, Local Government Association, 14 June 2024

12. The LGA has developed an improvement and assurance framework for local government that can be used by councils to help them to identify all of the checks and balances and parts of the system that should be supporting councils to identify any issues.³⁰ All local authorities are required to conduct an annual review of the effectiveness of controls in the organisation and publicly report the findings of this review and the actions they are taking to address areas for improvement in their annual governance statement. Through its guidance and analysis services, the Chartered Institute of Public Finance and Accountancy (CIPFA) also provides tools to support local authorities in their management of risk. CIPFA provides a Financial Resilience Index and a range of statistical data and analysis tools, offering comparators through the Nearest Neighbour Model tool and a Value for Money toolkit that compare costs and performance score against a range of services.
13. Emma Knights, then CEO of the National Governance Association (NGA), told us about the big issues that represent risks for the schools and trusts sector: falling pupil numbers; funding levels; increasing numbers of pupils with special education needs; and challenges recruiting teachers and classroom assistants. She explained how, fifteen years ago, consideration of risk was not something local authority-maintained schools did or talked about but that, with the development of the Multi-Academy Trust system, it is now taken very seriously.

“Risk management is now absolutely part of the process we would expect to see any board managing, not just on the surface, but with purpose and impact.”

Emma Knights, then CEO, National Governance Association

14. The Confederation of School Trusts has worked with a group of sector organisations, including the NGA, to develop the Academy Trust Governance Code, which is based on the Charity Governance Code and sets out all of the duties in law and in regulation that apply to trust governance.³¹ It starts with the fundamental principle that academy trusts’ directors are aware of and accept the Seven Principles of Public Life and that they understand the legal, regulatory and contractual obligations that they must meet, and adhere to the statutory guidance published by the Secretary of State.

30 Local Government Association, ‘Improvement and assurance framework for local government’, 24 May 2024, available at: www.local.gov.uk/publications/improvement-and-assurance-framework-local-government

31 Academy Trust Governance Code, available at: <https://atgc.org.uk/>

Data

The value of data

15. Bringing together and interpreting data intelligently allows links to be made across the records held by a department. It can provide a level of insight that is more than the sum of its parts. It is not just a tool that is ‘nice to have’, but a critical instrument for understanding an organisation and assessing its performance and the risks it faces.
16. Failing to identify patterns in the data held by an organisation can have grave consequences. A real-world example can be seen in Baroness Casey’s review into the Metropolitan Police Service. The review concluded that the Met’s misconduct process did not identify and discipline officers with repeated or patterns of unacceptable behaviour. “We noted the crucial result is that repeated or escalating misconduct is not spotted. The Met therefore misses those who potentially pose the most risk to others.”³²
17. Contributors to our review were clear that the answer to identifying and acting on issues in an organisation does not lie in data alone, rather, it can be an indicator that something requires a closer look. Hard data is one lens but must be combined with soft indicators to maximise insight. We also heard that leaders should not be slaves to data, nor default to requesting more data to defer making a decision. Collecting more and more data points does not in itself provide the answer to complex problems, which requires the application of the right standards and values, along with contextual understanding, in assessing the relevant information. Leaders must be willing to scrutinise what is really happening within their organisation and ask probing questions of the various sources of information to which they have access.

“Numbers will never tell you anything unless you are curious. It is curiosity and willingness, which is sometimes quite hard as a leader, to go, ‘Could this happen in my organisation? Could this be happening here?’”

Steve Russell, Chief Delivery Officer, NHS England, 24 July 2024

“All the systems, processes and data in the world only takes you so far. You just have, as a leader, to have a degree of curiosity about what is going on in your organisation. Poke in the dusty corners, get around, be visible, and try and promote a culture whereby it is the teams themselves who tell you what is going on rather than relying wholly on data.”

Mark Fisher, Chief Executive, NHS Greater Manchester Integrated Care Board, 20 June 2024

32 Metropolitan Police Service, ‘Baroness Casey Review’, March 2023, page 213, available at: www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/baroness-casey-review/update-march-2023/baroness-casey-review-march-2023a.pdf



Data quality

18. There is a lot of data in organisations, but it is the quality of data and how an organisation makes sense of it that determines its value.

“One of the essential components to enable good governance is accurate and reliable data. Instead of having a debate about what is happening, you start debating what you are going to do about it. Too often, the discussion in policing is arguing over incomplete data in an inaccurate position rather than saying, ‘This is what has happened. This is what we should do about it’. Having accurate data and an accurate picture of what is happening is essential to so many things.”

Chief Constable, Sir Andy Marsh, CEO, College of Policing, 31 May 2024

19. The Statistics Code of Practice, which sets the standards which producers of official statistics should uphold, is instructive on data quality (one of three pillars on which the code is based, the others being trustworthiness and value). The code outlines the principles and practices that producers of official statistics should adhere to to ensure their data is reliable, accurate and fit for purpose. The data must be relevant, the methods must be sound and the assurance around the outputs must be clear so that statistics are the best available estimate of what they aim to measure, are not misleading and are therefore worthwhile.³³
20. We heard from the NHS that consistency in reporting of data really matters. This can be improved by increased use of real-time extracts from electronic systems over inputting data second-hand for secondary datasets or data extracts. Real-time data capture reduces error and has obvious resourcing benefits over manual data entry. It also eliminates time lag, which makes it more difficult to identify trends.

“On the data point, the key message is that, although there is a lot of it, it is about how you make sense of it, how you ensure that there is one source of the truth, because some of the data gets put in manually. What we would like to do over time is to ensure that it comes up through electronic patient records. For instance, when I am visiting all the comprehensive stroke services in the country, we go through the data with them and we always find there are discrepancies between what is reported nationally and what their local data shows. The more we can get to real-time extracts from electronic systems, the better.”

Professor Stephen Powis, National Medical Director, NHS England, 24 July 2024

33 UK Statistics Authority, ‘Code of Practice for Statistics Edition 2.1’, 5 May 2022, available at: <https://code.statisticsauthority.gov.uk/wp-content/uploads/2022/05/Code-of-Practice-for-Statistics-REVISED.pdf>

21. In a recent cross-government study of data management, the Government Internal Audit Agency (GIAA) identified a relatively immature approach within government departments in terms of the management of data, the quality of data and the way it is shared across government. GIAA has identified only limited examples of predictive data being used effectively.

Examples of the data points available to multi-academy trusts

Finance data. “If the school is overspent – that is often a lead indicator that there is more wrong in the school.”

Data on performance and standards. “That data is often lagged data. By the time you get that, things have already gone wrong. You need to know your schools, work alongside your schools and be in your schools. That soft intelligence, the qualitative intelligence, makes a huge difference.”

Workforce data. “For example, if you have a good school, which has been securely good, and you suddenly start to see very significant staff turnover, that might be an indicator that all is not well in that school. It will be different for different schools. If you have just taken into your trust a school that has failed its Ofsted inspection, you might expect to see staff turnover. In that case, staff turnover would not worry you. Context matters hugely in your analysis of the data.”

Pupil attendance data. “What is the story that attendance data is telling you? More or less, everybody in the Western democracies is struggling with school attendance [post pandemic] If you have a school where you are seeing declining attendance, that would be a cause for concern. You would want to go in and look at what is happening in that school.”

“There is a lot of data that trusts will have about their schools. It is about making sure that somebody is looking at the data, trends in the data and where the data does not look quite right or is going in the wrong direction. ‘That is unusual’. ‘That has not happened before’. Those are important red flags to go and make an inquiry.”

Leora Cruddas, Chief Executive, Confederation of School Trusts, 25 June 2024

Data analysis capability

22. To get the most out of the available data, organisations require the capacity to interpret data intelligently. This can be a problem for some organisations who lack analysts who can triangulate data, spot trends and present the data to leaders in a way that enables them to make decisions. The data analytics capability needs to bring all of the information together to determine what is going on in the organisation. Analysis within discrete business areas can lead to more detailed understanding of specific issues but it needs to be brought together to get the full contextual view.



23. Chief Constable Sir Andy Marsh told us how, when he was Chief Constable of Avon and Somerset Police, his team developed a tool that harvested data automatically collected through a ‘digital twin’ system, creating a data trail that was used to help the organisation, individuals and teams use the insight from the data to learn, improve and solve both organisational and operational problems. The data could also be used to identify the early warning signs of poor performance and corruption, giving the opportunity of intervening early to improve officer wellbeing and service to the public. The system is fed by approximately 30 different databases and includes data such as body worn video activation data, geolocation data, computer use captured through keystrokes, stop and search data, and complaints.
24. Dr Bill Kirkup has led independent investigations into aspects of healthcare, including maternity services. He told us that there is a lot of data in maternity services but very little of it is clinically meaningful. One of the recommendations in his review into maternity services at East Kent Hospital NHS Trust was to introduce a signalling system that was related to outcomes – to allow trusts to compare the way their units were functioning on the basis of a meaningful outcome measure around deaths of babies and severe brain damage to babies.³⁴ This would allow those responsible for the provision of maternity services to see how they were doing and where they might do better. If they did not take that seriously and act, that would flag a signal further up the chain, so that regulators, like the Care Quality Commission or NHS England, would be able to identify outliers and investigate appropriately. The NHS has committed to developing the maternity outcomes signal system to highlight safety issues promptly.³⁵
25. HMRC told us how the department brings together data from a range of sources to identify trends in customer experience and levels of trust in HMRC. They compile a weekly customer insight dashboard for internal use, which includes customers’ interaction with digital, telephony and post channels, stakeholder sentiment and social media sentiment. If any worrying trends are spotted, they can be escalated and fixed. The department externally commissions three annual customer surveys for their main customer groups which are published annually on GOV.UK.³⁶ HMRC also gathers insights and information from the parts of the tax system that operate outside of the department by running a number of stakeholder forums and groups. Angela MacDonald, Deputy Chief Executive at HMRC, told us that when it comes to spotting trends, the

34 Department of Health and Social Care, ‘Maternity and neonatal services in East Kent: ‘Reading the signals’ report’, 19 October 2022, available at: www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

35 NHS England, ‘An update on delivery of the first year of the Maternity and neonatal three-year delivery plan and next steps’, 16 May 2024, available at: www.england.nhs.uk/long-read/an-update-on-delivery-of-the-first-year-of-the-maternity-and-neonatal-three-year-delivery-plan-and-next-steps/

36 HM Revenue & Customs, ‘Individuals, Small Businesses and Agents Customer Survey 2023’, 30 July 2024, available at: www.gov.uk/government/publications/individuals-small-businesses-and-agents-customer-survey-2023

annual cycle can be really important. Methods such as their annual customer surveys as well as their reporting on how the department is meeting its charter standards all provide an opportunity to stand back and assess whether sentiment has shifted over time.³⁷

Data-benchmarking

26. We heard how benchmarking is used in different parts of the public sector to compare performance between similar organisations. This can flag areas where performance is below the expected standard but can also identify those organisations with strong performance from whom others may be able to learn. Some examples are listed below:

- The ‘Model Hospital’ allows NHS hospital providers to compare how they are performing compared to other providers. It is part of the Model Health System, which is, “a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity. By identifying opportunities for improvement, the Model Health System empowers NHS teams to continuously improve care for patients.”³⁸
- The local government sector has LG Inform, the LGA’s data benchmarking platform, which enables council officers, councillors or local authority users to compare any council’s performance with any other council or group of councils.³⁹
- The Public Bodies team in the Cabinet Office is developing a Corporate Function Benchmarking resource for the biggest ALBs. The primary aim is for benchmarking to be used by departments and ALBs to ask questions about whether corporate functions could be procured and used more efficiently.

27. The disclosure of data to the public, which can include comparative data between organisations and public service providers, is discussed in chapter 5.

Data-sharing

28. Some contributors told us about the responsibility they have to share data about concerns with other organisations. The Local Government and Social Care Ombudsman (LGSCO) shares information with the Care Quality Commission, Ofsted and other bodies where there is a crossover in remits, when they have a concern that is sufficiently serious for it to be recorded in the LGSCO’s decision notice. The NHS comes together with ALBs and regulators to share any concerns they have about services.

37 HM Revenue & Customs, ‘HMRC Charter annual report: 2023 to 2024’, 30 July 2024, available at: www.gov.uk/government/publications/hmrc-charter-annual-report-2023-to-2024

38 NHS England, ‘The Model Health System’, available at: www.england.nhs.uk/applications/model-hospital/

39 Local Government Association, ‘LG Inform’, available at: <https://lginform.local.gov.uk/>



“As a publicly funded body we have a responsibility to share what we and only we know. For example, the Care Quality Commission (CQC) has a responsibility for overseeing the quality and standards of social care. We investigate social care. We have a mechanism that wherever we see concerns about social care that are sufficiently serious for us to formally note them down in our decision, we will pass it on to the CQC, we will publish that. We will let the various parties, the body in our jurisdiction, the person who made the complaint and the CQC know that we are doing that. We do exactly the same with Ofsted in relation to children’s services. We do the same with any organisation where there is likely to be a crossover and other ombudsmen as well. By sharing information in a timely and useful way is the way that we try to do that.”

**Nigel Ellis, Chief Executive, Local Government and Social Care Ombudsman,
10 May 2024**

“It is important to say that we and others spend a lot of time visiting and getting information. Of course, CQC and other regulators have a statutory role in doing that, and we link in with them very closely. Some red flags and concerns may well come through CQC inspections, for instance, and not just CQC, but also GMC [General Medical Council] and NMC [Nursing and Midwifery Council]. We have mechanisms both regionally and nationally to ensure that we come together as a set of ALBs and regulators to share any concerns we have about services. The alignment with the other regulators is important.”

**Professor Stephen Powis, National Medical Director, NHS England,
24 July 2024**

29. The Information Commissioner’s response to our open consultation notes that Part 5 of the Digital Economy Act (DEA) creates legal gateways to share information for public service delivery, allowing important data sharing to take place. The response explains that any organisation which uses personal information must protect that information but notes that protecting personal information from harm and unlocking its potential should not be seen as conflicting.

“Protecting personal information from harm and unlocking its potential should not be seen as conflicting. Organisations who put transparency, privacy and public trust at the heart of their processes will see much more effective results. Especially when using personal information for public service delivery.”

Information Commissioner’s Office, open consultation, submission 10

30. The Information Commissioner’s Office’s response notes that public authorities should minimise the use of personal information in data collection, publication and analysis. The consultation response from the Royal Statistical Society notes there are ways to make data available for independent analysis while maintaining control over risks to

security and privacy. Examples given are the Secure Research Service currently run by the Office for National Statistics for academic research access to sensitive data produced by government and other bodies, and the deposit of data relating to school examinations in England so that the impact of the grading developed and then withdrawn could be better understood retrospectively.⁴⁰

Can AI help with understanding risks?

31. The use of AI in public life is a particular area of interest for the committee. Our report on AI and public standards, published in February 2020, considered: the risks and opportunities for the Nolan Principles of openness, accountability and objectivity; whether the broader regulatory framework for AI in the public sector was fit for purpose; and the responsibilities of those in public bodies using AI. The report contained recommendations about the safeguards and standards required as AI becomes adopted more widely across the public sector.⁴¹ Since our report was published, AI technologies have been continuing to develop at a rapid pace and governments around the world are grappling with how to harness its benefits while mitigating the risks it presents. In March 2024 we held a seminar with experts to revisit some of the themes discussed in our 2020 report, with a particular focus on how to ensure that public office holders remain accountable for advice and decisions derived from, or made by, AI.⁴²
32. Given the capability of AI to process huge volumes of data at speed, we were interested to find out whether AI is yet being used in the public sector to support risk management. During our review, we came across only a few examples of AI being used for this purpose.

“If the big strength of this technology [AI] will be reading large volumes of data, interpreting them in an artificially intelligent way, and presenting it in a useful form, then it has to be really helpful, particularly for organisations with large transaction workloads. HMRC and DWP are the two classic examples in government. It would be able to give you much more rapid and relevant information about what is happening in their systems, what is happening to the service quality they are providing, preventing fraud, and so on. You can just see how there are many use cases there, given the scale of data that lots of public bodies deal with.”

**Gareth Davies, Comptroller and Auditor General, National Audit Office,
24 May 2024**

40 Royal Statistical Society, Data Ethics and Governance Section, open consultation, submission 22

41 Committee on Standards in Public Life, Artificial Intelligence and Public Standards: report, 10 February 2020, available at: www.gov.uk/government/publications/artificial-intelligence-and-public-standards-report

42 Committee on Standards in Public Life, ‘AI and Public Standards: 2024 AI seminar summary note’, 24 May 2024, available at: www.gov.uk/government/publications/ai-and-public-standards-2024-ai-seminar-summary-note



33. Steve Russell, Chief Delivery Officer at NHS England, told us that complaints are a really good example of an area where AI tools could be used to identify themes but where this technology is not yet in place.

“Complaints are a really good example [of an area where AI tools could be used to identify themes]. You can see the numbers, but spotting a pattern and going, ‘there has been the same cluster of complaints about these issues or this practitioner over a longitudinal period,’ is less sophisticated in most, but not all, organisations. One thing we have been considering is the opportunity to use AI to spot patterns in complaints. I am not an expert in this [area], so I do not know the extent to which it is widely available, although it could be.”

Steve Russell, Chief Delivery Officer, NHS England, 24 July 2024

34. The consultation response from the Care Quality Commission drew attention to an example of using AI to improve care in a care home from their State of Care report 2022/23.

Example of using AI to understand and manage risk in a care home

Staff at one care home were noticing that large quantities of antipsychotic medicines were being prescribed for people with dementia. When people were distressed and were communicating this through behaviour, there appeared to be little consideration of the reasons why, and so they were given antipsychotics in response. But staff were convinced that these distress responses were a reaction to pain – not because the person had a diagnosis of dementia. The care home therefore worked with developers to pilot a new app that used artificial intelligence (AI) technology to help care staff identify when people were in pain. The app helps the caregiver to recognise and record facial muscle movements and identify other behaviours that indicate pain. It then calculates an overall pain score and stores the result. After it was introduced in 2021, the care home has not only been able to offer more pain relief to people, but there have been fewer conflict-related safeguarding referrals and more time available for staff. Importantly, there has also been a 10% decrease in antipsychotic medicine use across all 23 homes. This has improved the quality of life for people with dementia.⁴³

Care Quality Commission, open consultation, submission 4

43 Care Quality Commission, ‘State of Care 2022/23’, 20 October 2023, available at: www.cqc.org.uk/publications/major-report/state-care/2022-2023

35. We discussed with the Government Internal Audit Agency (GIAA) the use of AI in providing third-line assurance for organisations. The GIAA has developed an ‘insights engine’ which allows them to quickly undertake sentiment analysis of a specific area of work to identify themes of good as well as poor practice that can then be shared more widely across government and prompt areas for further investigation.
36. GIAA is also at the early stages of using AI as part of a concept of continuous auditing that involves real-time checking of data against defined criteria. We were told that within this context, it would be possible to train AI to detect a drift towards alert thresholds and the reporting of early warning signs. GIAA is starting to make its AI tools available to other parts of government so that they can also be applied within the first and second lines of assurance. Harriet Aldridge explained that the GIAA’s design philosophy for their Insights Engine, and all their AI tools, is that they always have a human in the loop, meaning, “the AI output becomes an input into the analysis of a trained human.”

“Given that it is typically not one big thing that leads to organisational failure, but a series of smaller things occurring in concert, investment in human intelligence continues to be needed to interpret the implications of different indicators veering off track (‘joining the dots’). This is particularly the case where confidence in the completeness and accuracy of data is lacking. While AI will help organisations to undertake assurance at greater scale and speed than with a human alone, the effective application of human intelligence continues to be a vital part of the landscape of risk, assurance and controls.

Within three years we expect generative AI to be able to reliably analyse numerical (e.g. financial) data and to create reports that present this analysis in a meaningful way. It will continue to be important to train people to ask the questions (prompt engineering) of the AI. Even where the AI can analyse scenarios taking into account risks, the ultimate decision-making, and therefore accountability frameworks will need to evolve, alongside appropriate training, to ensure decision-makers have sufficient assurance around the inputs and outputs of any AI tool. Whilst larger and more complex in an AI-enabled world, similar principles exist today in the way in which government relies on the integrity of financial models (e.g. actuarial models, operational service demand models and budgeting tools).”

**Harriet Aldridge, Chief Executive, Government Internal Audit Agency,
31 July 2024**



37. One of the core findings of our 2020 report on AI and Public Standards was the importance of public officials retaining involvement in all automated decision-making processes and taking responsibility for decisions made by AI systems. The models for upholding human responsibility can be placed on a spectrum from limited to full responsibility and we said that the senior leadership will have to choose which level of responsibility is most appropriate for the application of AI in their organisation. It is also critical that public sector bodies understand and make available an explanation of an AI system's decision-making process so as to uphold the principle of accountability.⁴⁴
38. Our 2020 report made recommendations to providers of public services, both public and private, to help them develop effective risk-based governance for their use of AI, and which put into practice the Nolan Principles of openness, accountability and objectivity.
39. We discussed with Gareth Davies, Comptroller and Auditor General, the challenges around ensuring human accountability is maintained when AI outputs inform decisions. He suggested that the governance processes for auditing the use decisions would need to be very clear; a standard control that will need to be in place, where the risk is high enough, is to take a sample of the recommendations coming out of the AI system, manually reproduce those decisions using experts, and have a failure threshold that triggers a review of whether the system is operating as intended.

“This is obviously a developing field, but working through the risks involved, and anything where there are consequences for people of decisions being made by machines, we are going to have to build in a sufficient human check to make sure that it is operating as intended.”

**Gareth Davies, Comptroller and Auditor General, National Audit Office,
24 May 2024**

40. On the evidence that we heard, the use of AI to help public sector organisations with understanding the risks to which they are exposed is at an early stage and there is potential for AI to be used more widely for this purpose. However, it is crucial that wherever AI is procured, deployed and monitored, it is done so appropriately and in line with the Nolan Principles of openness, accountability and objectivity.

44 Committee on Standards in Public Life, ‘Artificial Intelligence and Public Standards: report’, 10 February 2020, available at: www.gov.uk/government/publications/artificial-intelligence-and-public-standards-report

Chapter 4: Effective scrutiny by the board

1. Chapter 2 set out that clear governance and accountability structures are an essential requirement if public sector bodies are to be accountable. There must be a defined reporting line through the hierarchy of an organisation, with a clear sight of the risks to which the organisation is exposed. However, there have been many high-profile failures in public life, where the governance structures and mechanisms were in place but for a variety of reasons the board failed to grasp the significance of red flags and failed to act before it was too late.
2. In this chapter we explore four key themes in the evidence we took that seem to us to be fundamental to the effective exercise of the board's scrutiny function, before concluding with some examples of how public bodies have used Board Effectiveness Reviews:
 - **Information and challenge.** Ensuring the board has the information it needs and is willing to ask the difficult questions.
 - **Appointing people with the right skills and motivations.** Populating the board with people with a breadth of skills and experience and a strong public service ethic.
 - **Board culture.** Building an open and trusting relationship between and among the executive leadership and non-executive directors.
 - **External perspectives.** Bringing an independent, external perspective to board meetings and hearing directly from the users of public services.

Information and challenge

3. For non-executive directors to be able to provide constructive challenge to an organisation, they must have good access to information. The responsibility for ensuring this happens is two-way – the executive needs to provide accurate and candid information about the organisation's performance and any emerging issues that may stand in the way of the organisation delivering its objectives, but non-executives also have a responsibility to ask for the information they need.
4. New non-executive directors need to develop a good understanding of the organisation and the risks it is facing and need to do so quickly. Phase 6 of the Post Office Horizon IT Inquiry revealed how, "Many Post Office directors started their roles with an incomplete understanding of the issues facing the organisation. There was an absence of corporate memory, with each director seemingly starting from a blank sheet. Unresolved historical issues only became visible to board members when it was too late." The Institute of Directors has recommended that directors "undertake rigorous due diligence of organisations before they accept board roles. Following appointment, the induction process needs to be systematic and expose them to the history and culture of the organisation."⁴⁵

45 Institute of Directors, 'The Post Office Scandal: A failure of governance', October 2024, available at: www.iod.com/app/uploads/2024/10/IOD-The-Post-Office-Scandal-%E2%80%93-A-Failure-of-Governance-1-f04f78664e5242c6bebb0a01035806c2.pdf



5. Contributors to our review told us that how board papers are presented is important, with the issues needing to be clearly and succinctly identified and set out and supported by verbal explanation in board meetings.

“It is very important that people do not assume reports should be taken as read. It is important that officers in the context of local authorities, or executives in the context of my current employer, take board members through it and identify the salient issues so if they have not read every word, they have the opportunity to at least understand it in summary form. I also think things like reading rooms, where additional data and linked information can be posted, are very useful because sometimes people need to go away, think about it and come back to it. There are all sorts of tools and techniques that you can use to make sure that people get the right information. It is an ongoing challenge because people learn, disseminate, distinguish and assimilate information in different ways. It depends on what sort of a learner you are.”

**Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust,
24 May 2024**

6. Depending on the complexity of the information and the background and skillset of the non-executive directors, it may be necessary for staff with the necessary expertise to explain what the information means so that the board is able to evaluate the significance of the information they are presented with. In chapter 3 we noted that there is no shortage of data in organisations, but that interpreting the data intelligently can require specific expertise. We also noted in our Leading in Practice report that it is helpful to boards to have data from a range of sources brought together in a way which allows them to connect the dots and understand the bigger picture.⁴⁶

“It is vitally important that those charged with governance understand the complex information that is being presented to them and that they are in a position to make a meaningful evaluation of it. To aid in this, suitably qualified data analysts or operational staff members should be made available to present complex data to the board to provide clarity and explain what the data means, rather than members being given the information without sufficient context or explanation.”

**Northern Ireland Public Sector Chairs’ Forum, open consultation,
submission 19**

7. We heard that the timeliness with which the board receives information is important. One chair of an ALB shared an example where an executive told the chair that the executive had received a report about an issue that they were looking at and they would give the report to the board with the organisation’s response once this had

⁴⁶ Committee on Standards in Public Life, ‘Leading in Practice’, January 2023, available at: www.gov.uk/government/publications/leading-in-practice

been prepared. “My answer to that is, ‘No, give us the information now. We have to respond properly at the board to that, but I do not want you to hold back. I want you to be willing to give us the information straight away and deliver it.’”

8. To help non-executive directors deepen their understanding of the organisation and to hear perspectives other than those presented by the executive leadership, it can be valuable to make site visits and speak to staff working on the frontline of the organisation.

“In my experience as a non-executive director, I could achieve very little sitting in a four or five hour trust board meeting looking at reams and reams of grids with red, amber and green squares on them. But, by going out and visiting some wards, some clinics and some theatres, saying to people, ‘What is on your mind? How is it going?’ I found a wealth of information that can make you very curious about where there may be problems beneath the surface.”

Dr Bill Kirkup, Chair of reviews into maternity care at East Kent Hospitals NHS Trust and Morecambe Bay maternity services, 11 July 2024

9. Providing effective challenge means asking difficult questions constructively. For organisations in the public sector, an important aspect of this should be testing the ethical implications of strategic or operational decisions or business practices undergoing change and ensuring that the public interest is a central part of the conversations that take place.
10. Alan Kershaw, Chair of the Legal Services Board, pointed out that challenge goes both ways and having executive to non-executive challenge is important too. He also found the presence of apprentices from the Government Board Apprentice Scheme helped challenge the established ways of doing things.

“I like the executive to challenge the board as well, and that is quite helpful. Recently executive members have challenged me on the way I put some things in an interview, and that is fine. I am very happy about it. I am happy to give the lead of saying, ‘I did not get that as right as I would like to. Let us see how we can all learn from this.’ That is okay. Challenge both ways because they [the executive] know the stuff day-by-day in ways that we do not necessarily. We even have apprentices from the government board apprentice scheme. We encourage them to challenge as well, to ask the extremely naive questions: Why do you do it this way? Why is that important? That makes us think as well. Challenge in all directions.”

Alan Kershaw, Chair, Legal Services Board, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024

11. In a local government context, the full council can be considered to be the equivalent of a council’s board. The National Association of Local Councils told us that councillors must be prepared to ask questions and hold the council’s officers to account for their actions.



“Councillors should brief themselves fully on the contents of the agenda for local council meetings, read council reports and be prepared to ask questions. Councillors must overcome any reluctance to question the clerk or the chair, it is important that councillors hold the council’s officers to account for their actions. As soon as new councillors, clerks and chairs are in post they should be offered a one-to-one meeting, offered finance training and have a journey pack.”

National Association of Local Councils, open consultation, submission 16

Appointing people with the right skills and motivations

12. A board will be capable of exercising constructive challenge only if its members have the skills and experience necessary to ask the pertinent questions. We heard how a breadth of backgrounds and expertise can mitigate the risk of groupthink, as can refreshing membership of boards through setting limits on the length of tenure or staggering appointment terms.

“You need the competence within the organisation and on the board to spot the red flags. It is having a broader view of the range of competencies you need, both at the executive level, but more importantly on the board. There is no point in having four identikit non-executive directors who are all the same. I would also add to that, a regular churn of non-executive directors, so you do not start to develop groupthink, or think, ‘I will not challenge him, because he is a great guy and we have known each other for 12 years while we have been on this board.’ You need to bring awkward new faces who will not be worried about upsetting their colleagues and who will ask the open questions and prod the accepted nostrums.”

Kate Ellis, Chair, Oil and Pipelines Agency, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024

13. Ministers are responsible and accountable to Parliament for appointments to the boards of public bodies, generally referred to as public appointments. Sponsoring departments are responsible for running the recruitment process for these appointments in consultation with ministers. The Governance Code on Public Appointments says that departmental advice to ministers must include information on the make-up and diversity of the current board and that departments “should ensure there is sufficient opportunity for ministers to engage with the chair of the board the role is being appointed to. Chairs are well placed to advise on the skills and experience needed to ensure the board as a whole is effective.”⁴⁷

47 Cabinet Office, ‘Governance Code on Public Appointments’, 31 January 2024, available at: www.gov.uk/government/publications/governance-code-for-public-appointments

14. The chair of a public body will be a member of the Advisory Assessment Panel that assesses candidates for non-executive board members positions and submits appointable candidates to ministers for them to make the final appointment. One chair with experience of being on the board of a variety of public bodies raised the importance of appointing people with the right values and motivations. In interviews for board positions, she questions people about their adherence to the Principles of Public Life and seeks to glean whether they truly understand how to live and breathe the principles in difficult situations.

“When interviewing now, we spend a lot of time really trying to understand people’s motivations, what they think about these things, how do they do the right things, in quite difficult situations sometimes, and try to get them out in an interview. Of course, that is quite hard, but people do develop reputations around that when they become more experienced, which can help. I would say that getting the right people there with the right motivations is one way of getting a good start.”

Kathryn Cearn, Non-Executive Director, Nuclear Decommissioning Agency, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024

15. We touched on values-based recruitment in our report, *Leading in Practice*, and encouraged organisations to embed the Principles of Public Life within their recruitment and selection processes. We noted how focusing on values at the recruitment stage also helps set expectations that the public interest should guide behaviour and decision-making and that how board members go about their work will be considered central to the delivery of their role. This is particularly important when appointing non-executive directors who have come from other sectors and may be used to a different operating culture.

“We would encourage public sector organisations to consider how they can best incorporate within their recruitment and selection processes an assessment of how the personal values of candidates align with the Principles of Public Life, particularly for senior leadership positions.”

Committee on Standards in Public Life, *Leading in Practice*, January 2023

16. Several contributors to our review raised frustrations with delays within the public appointments process and the impact this has on securing the best people for the job. We heard that this is a major problem for ALBs and one of the hardest aspects for departmental sponsorship leads in managing the relationship with them. We heard that the process needs to be faster and communication needs to be better for people who have applied and are left waiting to hear if they have been successful.



“People who are building portfolio careers and want to apply for non-executive director positions will have a number of irons in the fire. They will nearly always have applications in with organisations that are nimbler than the machinery of government, so we find that, quite often, some of our best candidates drop out of the process because it is just so long. Typically, our appointments can take a year, and so we find all the time that good-quality non-executive directors either cannot take the position when it is finally offered or drop out. The chairs are frustrated about that, particularly with roles that require particular professional expertise, such as somebody to advise on digital transformation in a non-executive capacity. We often go down to our second or third choices just because of the time that it takes to navigate the decision points across government.”

Departmental sponsorship lead, roundtable, 18 July 2024

17. Once appointed it is important that non-executive directors and their organisations invest in their on-going development. To take the health sector as an example, a leadership competency framework for board members was introduced in 2024, which will support the appraisal and development of board members.⁴⁸

Board culture

“In my experience there are good boards and there are bad boards, in short. The good boards, effective ones, are those that have an open relationship with the chief executive and the executive team. There are no secrets, nothing is hidden, and the board have carte blanche to ask for any information they want so they can really get under the skin of the organisation but are non-executive. The ones which I have seen to be ineffective are those where the relationship between the chair and the chief executive has been dysfunctional. That is when information is hidden from the board and that is when things go very badly wrong. It sounds very basic, but it really does come down to relationships and trust and integrity and openness.”

**Amerdeep Somal, Local Government and Social Care Ombudsman,
10 May 2024**

18. The culture of the board is a crucial factor in its effectiveness and will be heavily influenced by the quality of the relationships between and among the executive leadership and non-executive directors. An open and trusting relationship will support the exchange of ideas and perspectives and allow risks to be exposed more quickly, even though conversations will not always be comfortable. How a chair chooses to perform their role really matters to the smooth running of a board. If a chair is too assertive, this

⁴⁸ NHS England, ‘NHS leadership competency framework for board members’, 28 February 2024, available at: www.england.nhs.uk/publication/nhs-leadership-competency-framework/

can create a climate of fear, which can get in the way of good quality decisions, but a weak chair can be equally damaging. Being an effective chair requires good judgement, strong people skills and a firm commitment to the public interest.

“We at the Welsh Revenue Authority brought in an external consultant to look at ourselves and decide what people we were and how we operated both individually and collectively as a board. We had two days of doing it, but we decided that this should be done with the executive and non-executive members involved. We learnt an awful lot as individuals, which helped when it got to developing a culture within the board and also from the point of view of getting ourselves in a place where we could challenge in a positive way and move forward as a unit, as they say.”

Rheon Tomos, Non-Executive Director, Welsh Revenue Authority, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024

External perspectives

19. Some organisations have found they benefit from bringing an external perspective to their board meetings. Examples are the Pension Protection Fund, which has co-opted members on many of its committees with specialised backgrounds, and the General Medical Council, which has co-opted external members of the Audit and Risk Committee. The recruitment of independent co-opted members with specialist backgrounds in areas such as accounting or risk management is strongly recommended by the LGA as a way of supplementing the skills of local government audit committees.⁴⁹
20. Some boards of public bodies have in place mechanisms for hearing directly from the users of their services. The Local Government and Social Care Ombudsman has an advisory forum made up of a majority of members of the public who have used their service.⁵⁰ The Parliamentary and Health Service Ombudsman (PHSO) has a Public Engagement Advisory Group formed of members of the public who use the PHSO’s services. Both organisations find these bodies enhance executive and non-executive understanding of how the public experience aspects of their service and bring a good source of constructive challenge.
21. In the NHS, many trusts include patient stories at their board meetings, told by the patient or relative or by staff who provided the care. We heard that these can give a powerful and helpful insight into the patient experience, but we also heard a view that it may be tempting to select the stories that show the organisation in a good light.

49 Local Government Association, ‘Ten questions for audit committees’, 12 April 2024, available at: www.local.gov.uk/publications/ten-questions-audit-committees

50 Local Government & Social Care Ombudsman, ‘Advisory Forum’, available at: www.lgo.org.uk/information-centre/about-us/public-advisory-forum



“At every meeting we have a patient story. They are poignant, informative and thought provoking. It is our attempt to make sure we are open to direct access from people who use our services or who we employ, and I think that they are generally well received.”

**Sir Neil McKay, Chair, Shrewsbury, Telford and Wrekin Integrated Care Board,
4 July 2024**

Board effectiveness reviews

22. Board effectiveness reviews (also referred to as board performance reviews) are used by public and private sector organisations to identify and act on weaknesses, including whether the board has the structure, processes, people and performance to deliver its purpose. The Sponsorship Code of Good Practice lists completing an annual board effectiveness review and, at least triennially, an externally-led board effectiveness review, as one of the activities which government departments should require of the ALBs they sponsor.⁵¹ UK Government Investments has issued guidance on the principles that should underpin the board effectiveness review.⁵²
23. We asked contributors to our review how public sector bodies should conduct their annual board effectiveness evaluations. The following is a summary of some of the examples and best practice shared with us.
- The Financial Reporting Advisory Board (FRAB) commissioned the National Audit Office (NAO) to carry out an external board effectiveness review. The FRAB committed to making significant changes as a result and published its action plan for doing so.⁵³ The NAO cited this as an example of a Board Effectiveness Review making a positive difference.
 - In schools and multi-academy trusts, governing boards are expected to carry out an annual self-evaluation and commission independent external reviews of governance every third year. The National Governance Association (NGA) has developed questions for schools and multi-academy trusts to use when conducting their own reviews.⁵⁴

51 Cabinet Office, ‘Arm’s length body sponsorship code of good practice’, 23 May 2022, available at: www.gov.uk/government/publications/arms-length-body-sponsorship-code-of-good-practice/arms-length-body-sponsorship-code-of-good-practice

52 UK Government Investments, ‘Board effectiveness reviews’, 11 April 2022, available at: www.gov.uk/government/publications/arms-length-body-boards-guidance-on-reviews-and-appraisals/board-effectiveness-reviews-principles-and-resources-for-arms-length-bodies-and-sponsoring-departments

53 HM Treasury, ‘Financial Reporting Advisory Board effectiveness review: October 2020’, 22 July 2021, available at: www.gov.uk/government/publications/financial-reporting-advisory-board-effectiveness-review-october-2020

54 NGA, ‘Governing board self-evaluation questions’, 29 March 2022, available at: www.nga.org.uk/knowledge-centre/governing-board-self-evaluation-questions/

- One contributor shared an example of an internal review at a public body. He described three elements:
 - The senior independent director gathered all the non-executive directors together without the chair in the room and had a very open discussion about how the board felt about the way that the chair operated and how the board meetings were conducted.
 - The senior independent director then had individual conversations with the non-executive directors.
 - The non-executive directors were then sent a detailed questionnaire with approximately 35 questions.

The collective feedback was then compiled into a report to be reviewed by the board.

“In my view, the questions were searching. They were not drafted to prevent an opportunity for criticism or constructive challenge. I think that is a good board effectiveness review. It is not the board sitting around for 10 minutes at the end of a meeting and saying, ‘We need to do an internal board effectiveness review. Are we all happy with how it is all going?’ I think that is self-evident.”

- The Northern Ireland Public Sector Chairs’ Forum drew our attention to the NI Audit Office board effectiveness good practice guide⁵⁵ which contains sample templates for assessing chairs and board members.⁵⁶
- In local government there is no formal requirement to conduct an annual board effectiveness evaluation, although CIPFA told us the annual review of the system of internal control should consider decision-making and leadership arrangements. The scope of the annual review should cover each of the seven principles of good governance in the framework. CIPFA and Solace will be undertaking a review of its guidance for the annual review during 2024 to 2025. In their response to our consultation, LGA told us, “the outcome of this review [annual review of the effectiveness of controls] should be documented clearly and transparently in their [local authority] annual governance statement. Best practice includes ensuring that there has been engagement across the council to inform the review, and that statements are easily understood and accessible to residents, partners, government, external auditors, inspectorates and regulators. Statements should openly and honestly identify issues and remedial actions and provide an update on progress in addressing issues previously identified. The audit committee will review the draft statement before it is finalised, providing challenge to ensure that it is honest and robust. The content of statements should inform the internal audit plan for the next year.”⁵⁷

55 Northern Ireland Audit Office, ‘Board Effectiveness: A Good Practice Guide’, June 2022, available at: www.niauditoffice.gov.uk/publications/board-effectiveness-good-practice-guide-june-2022

56 Northern Ireland Public Sector Chairs’ Forum, open consultation, submission 19

57 Local Government Association, open consultation, submission 14



Chapter 5: Being open to public scrutiny

1. The Nolan Principle of accountability requires holders of public office to be accountable to the public for their decisions and actions and to submit themselves to the scrutiny necessary to ensure this. Being open to public scrutiny is also central to the Hillsborough Charter, which, in point 6, commits organisations that sign it to strive to “Recognise that we are accountable and open to challenge. We will ensure that processes are in place to allow the public to hold us to account for the work we do and for the way in which we do it. We do not knowingly mislead the public or the media.”⁵⁸
2. This chapter explores how public sector bodies submit themselves to scrutiny and shares the examples we heard in our evidence of how they have sought to do so. We focus on matters that are within the control of public sector bodies, widely defined, with the intent of supporting them to live up to the high standards of accountability that the public are right to expect.

Transparency

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.⁵⁹

3. Making information available about what an organisation does and how it does it enables the public and those bodies charged with holding the organisation to account to scrutinise its performance and expenditure. The Nolan Principle of openness is clear that information should not be withheld from the public unless there are clear and lawful reasons for doing so. Withholding information merely to protect the institution (or its members) from scrutiny does not meet this high bar.

“Openness and transparency are not ends in themselves; they empower people, among other things, to hold government and public authorities to account.”

Information Commissioner’s Office, open consultation, submission 10

58 Cabinet Office, ‘Hillsborough Charter’, 13 December 2023, available at: www.gov.uk/government/publications/hillsborough-charter/hillsborough-charter-accessible

59 Committee on Standards in Public Life, ‘The Seven Principles of Public Life’, 31 May 1995, available at: www.gov.uk/government/publications/the-7-principles-of-public-life

“... self-serving institutional self-protection is not a plausible interpretation of the fiduciary responsibilities that the institutions of government owe to the public and that the principles set out. Derelictions from openness must not be self-serving, and they must not be institution serving; they could only ever be a temporary expedient that calls for a special justification that is able to appeal to the wider public interest, and must, through accountability, be made to that wider public in a transparent way as soon as it is possible to do so.”

Professor Mark Philp, Chair of CSPL’s Research Advisory Board, The Nolan Principles: Public Standards, the Public Interest and Public Service, 24 October 2024⁶⁰

4. The more power an organisation has over citizens’ lives, the more transparent it needs to be about what it is doing and how. To take policing and health as an example, these are areas where intervention into physical or mental rights or wellbeing require particularly high levels of transparency.

“I think that there has to be a conceptual change: the more power you hold over a citizen’s life, the more responsibility you have to be transparent about why you are doing something and how. It is about understanding the responsibilities of people in public positions who hold public office, be it a surgeon, a doctor, a police officer or a nurse, where you actually have control over people’s lives and their bodies in a very physical way and mental way. I think you have to have a different responsibility towards that.”

Baroness Casey of Blackstock, 17 July 2024

5. Meaningful transparency also requires that information is presented in a manner that is clear and intelligible. It may also need to be seen in context so that the full significance of the information can be understood.
6. Being transparent is not always the easy option. Making available information that is in the public interest, but that does not show the organisation in the best light, can be uncomfortable. It requires strong leadership because such revelations may result in bad publicity in the short term. Leaders who advocate proactive disclosure in these circumstances are setting a good example for their teams to follow and are helping to shape an open and transparent culture. As well as being the right thing to do, being transparent is also a pragmatically wise option, since the information may end up becoming public anyway and being accused of a cover-up can be additionally damaging in the long run.

⁶⁰ Committee on Standards in Public Life, ‘The Nolan Principles: Public Standards, the Public Interest and Public Service’, 24 October 2024, available at: www.gov.uk/government/publications/30th-anniversary-of-the-nolan-principles



7. It is a requirement under the Freedom of Information Act for Public Authorities in England, Wales and Northern Ireland to make information available to the public. In their response to our open consultation, the Information Commissioner's Office (ICO) drew attention to an open letter that the commissioner sent to public authorities, calling on senior leaders to take transparency seriously. The letter emphasised the need to dedicate resources to improving access to information and to ensuring that the right training, processes and culture are in place. The letter includes case studies that show how organisations have implemented good practice or made improvements in their handling of FOI requests.⁶¹

"Transparency is essential if people and communities are to have confidence in the way public services are delivered. Proactive publication is a key to this."

Information Commissioner's Office, open consultation, submission 10

8. The ICO told us that the International Conference of Information Commissioners have published 'Principles Relating to Transparency by Design', recognising "the value of Transparency in supporting democratic accountability, good governance, good administration and the effective use of public funds, enhancing public accountability, fighting corruption and maladministration, and in empowering people, enabling their participation in decision-making processes."⁶²
9. The Office for Statistics Regulation has issued regulatory guidance on the transparent release and use of statistics and data, informed by the Code of Practice for Statistics.⁶³ The 2024 Parliamentary Administration and Constitutional Affairs Committee (PACAC) report, 'Transforming the UK's Evidence Base', says this has "helped to unlock important evidence for Parliament, business, researchers and citizens, but there remains more to do."⁶⁴ In their report, PACAC also endorsed the recommendation made by Lord Maude in his 2023 report of his review of governance and accountability in the Civil Service that, when a major policy decision is announced, the government should proactively publish the evidence and data underpinning that decision.⁶⁵

61 ICO, 'Information Commissioner calls for senior leaders to take transparency seriously', 4 March 2024, available at: <https://ico.org.uk/about-the-ico/media-centre/news-and-blogs/2024/03/information-commissioner-calls-for-senior-leaders-to-take-transparency-seriously/>

62 International Conference of Information Commissioners, 'Principles Relating to Transparency by Design', June 2024, available at: <https://home.redrta.org/wp-content/uploads/2024/06/TbD-Paper-WG-approved.pdf>

63 Office for Statistics Regulation, 'Regulatory guidance on intelligent transparency', 2 February 2022, available at: <https://osr.statisticsauthority.gov.uk/publication/regulatory-guidance-on-intelligent-transparency/>

64 PACAC, 'Transforming the UK's Evidence Base, Fifth Report of Session 2023–24', 21 May 2024, available at: <https://committees.parliament.uk/publications/44964/documents/223187/default/>

65 'Independent Review of Governance and Accountability in the Civil Service: The Rt Hon Lord Maude of Horsham', recommendation 32, 13 November 2023, available at: www.gov.uk/government/publications/review-of-governance-and-accountability/independent-review-of-governance-and-accountability-in-the-civil-service-the-rt-hon-lord-maude-of-horsham-html

10. We have summarised below some of the examples shared with us of how public sector organisations seek to practise transparency.

- The Parliamentary and Health Services Ombudsman and the Local Government and Social Care Ombudsman publish their decisions on their websites with the names anonymised.⁶⁶
- HMRC publishes complaints data as part of the HMRC Annual Report and Accounts.⁶⁷ The Adjudicator's Office provides an independent tier of complaint handling for HMRC and investigates complaints that have gone through HMRC's internal two-tier complaints process, where the complainant remains dissatisfied. Each year, the adjudicator's office publishes an annual report that looks at their own performance and also provides commentary on HMRC's performance. HMRC's response to the adjudicator's annual report sets out how they have learned from customer complaints to improve their services.⁶⁸ The adjudicator can publish thematic reports looking at a specific issue, for example, the 2023 to 2024 annual report includes an insight report on how to apply customer circumstances to decision-making.⁶⁹
- NHS England publishes data on areas of high public interest such as monthly cancer treatment waiting times.⁷⁰ Professor Sir Stephen Powis, National Medical Director for NHS England, told us that a lot of data about performance is public so people can compare the performance of their provider with those in other locations.⁷¹
- The LGA told us that councils make decisions based on openly available written advice, and an overwhelming majority of decisions are made in public meetings. The full council approves the annual budget in public and external audit reports and any findings of maladministration are considered in public meetings.
- The Public Bodies team in the Cabinet Office has produced an interactive transparency report of all ALBs of the UK government. The tool brings together data on ALBs to show the landscape as a whole.⁷²

66 Parliamentary and Health Services Ombudsman, 'Decisions', available at: <https://decisions.ombudsman.org.uk/>; Local Government and Social Care Ombudsman, 'Decisions', available at: www.lgo.org.uk/decisions

67 HMRC, 'HMRC's annual report and accounts 2023 to 2024: performance analysis', 30 July 2024, available at: www.gov.uk/government/publications/hmrc-annual-report-and-accounts-2023-to-2024/hmracs-annual-report-and-accounts-2023-to-2024-performance-analysis

68 HMRC, 'HMRC and VOA's response to the Adjudicator's Office 2023 annual report', 14 December 2023, available at: www.gov.uk/government/news/hmrc-and-voas-response-to-the-adjudicators-office-2023-annual-report

69 The Adjudicator's Office, 'The Adjudicator's Office annual report 2024', 26 September 2024, available at: www.gov.uk/government/publications/the-adjudicators-office-annual-report-2024

70 NHS England, '2024-25 Monthly Cancer Waiting Times Statistics', available at: www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/monthly-data-and-summaries/2024-25-monthly-cancer-waiting-times-statistics/

71 NHS England, 'Data dashboards', available at: <https://digital.nhs.uk/dashboards>

72 Cabinet Office, 'Public Bodies 2023', 17 December 2024, available at: www.gov.uk/government/publications/public-bodies-2023



“One of our objectives was to be an exemplar around transparency, FOI responses and so on, so we hired somebody who was very experienced at running a good FOI system. We said to her, ‘Your job is to make sure that we are 100% on all of the measures on freedom of information requests. Our culture is that we provide as much as we can and we get it out quickly.’ That has had a big impact over a few years. They won a prize this year for being FOI team of the year. You might say, ‘If the NAO cannot do that, who can?’ but that did not just happen because we are the NAO. We made it a priority. We keep putting management effort in. The team leader comes along to the management team quite regularly, to give us an update, and we show an interest in whether it is working or not, whether she has the resources, and so on.”

**Gareth Davies, Comptroller and Auditor General, National Audit Office,
24 May 2024**

Records management

11. Good records management is a prerequisite for an accountable organisation. It means that information about why decisions were made is preserved should it be necessary to review these decisions in the future. The contemporaneous nature of the record provides some assurance that it is an accurate reflection of what happened.
12. Documenting decisions accurately also enables organisations to learn lessons when things go wrong and to evaluate comprehensively the success or failure of projects or policies.
13. The Infected Blood Inquiry showed the disastrous consequences that can result from poor record keeping. It found there was no mechanism to ensure that there was a sufficient corporate memory in the Civil Service of why previous decisions were, or were not taken, and the facts that informed those decisions so the reasons behind them could be understood. This weakened corporate memory led to the repeated use of inaccurate, misleading and defensive ‘lines to take’ first adopted in the 1980s and then used repeatedly by successive governments without an understanding of the facts underpinning them. These lines were either liable to be misunderstood – for example, the unqualified line that there was “no conclusive proof that AIDS can be transmitted by blood or blood products” – or were wrong, such as the assertion that patients had received “the best available treatment in the light of medical knowledge at the time.”⁷³ The report also found that documents had been lost or destroyed.

73 Infected Blood Inquiry, ‘The Inquiry Report, Vol. 1’, page 215, 20 May 2024, available at: www.infectedbloodinquiry.org.uk/sites/default/files/Volume_1.pdf

14. The ICO consultation response to our review states, “Openness and transparency should be seen as core functions on a day-to-day basis, but they are particularly important at times of crisis. Indeed, the FOIA s.46 Code of Practice in force at the start of the covid pandemic made clear the importance of record keeping by public authorities in crisis situations. This included maintaining good quality records in situations where public bodies may “need to explain and, if necessary, justify past actions in the event of a... public inquiry.”
15. In his 2022 report ‘Behind the Screens’, the Information Commissioner carried out an investigation into concerns about the use of non-corporate channels and the risk of key information not being appropriately recorded and retained by ministers and officials.⁷⁴ Following a letter from the ICO to her consultation on the Covid Inquiry’s terms of reference, Baroness Hallett, the chair of the inquiry agreed to consider the quality of record keeping during the pandemic as part of the Inquiry.

Public engagement

16. How organisations handle queries and complaints from the public speaks volumes about the culture of the organisation and the importance it attaches to the principle of accountability. People working for public sector bodies should be cognisant of the inherent imbalance between the organisation and the member of the public who is coming to them with a concern. Accountability requires bodies to be approachable and to make it easy for people to raise issues with them. As we have sought to emphasise throughout this report, it is also in the interests of the organisation to listen to concerns raised from within and outside the organisation. These concerns provide an opportunity for issues to be dealt with before they get worse and a number of complaints raising similar themes may flag up a systemic problem which can then be addressed.
17. As well as reactive complaints handling, accountability requires organisations to engage proactively with the public to increase understanding of how they can best meet the needs of the public. Baroness Casey noted that when seeking the perspective of the service-user it is important to ask the right question – users should be asked about their own practical experience and views on the system rather than just seeking wider views on how the organisation or system should be run.

⁷⁴ ICO, ‘Behind the screens – maintaining government transparency and data security in the age of messaging apps’, July 2022, available at: <https://ico.org.uk/media/about-the-ico/documents/4020886/behind-the-screens.pdf>



18. Contributors to our review from different parts of the public sector shared some examples of how they have sought to engage with the public.
- Various bodies, such as local councils, NHS Trusts, Integrated Care Boards and the Care Quality Commission hold board meetings which are open to the public. In some cases, the public can ask questions from the floor. In other cases, the body will take questions and commit to reply to the question in writing within a certain period and report it to the next board meeting.
 - Some local authorities conduct budget and financial strategy consultations to provide greater transparency over decisions about spending priorities. These seek the views of the public on the choices to be made, such as whether to turn off all streetlights at midnight.⁷⁵
 - The Parliamentary and Health Services Ombudsman holds roadshows, where they go to different parts of the country to hear the views and experiences of people who access their services.
 - Some sectors have independent bodies which act as the customer voice. Transport Focus provides this role for transport users, making research available about what people think about their experience of the road, rail, bus and tram network.
19. The Institute of Chartered Accountants (ICAEW) told us there is a need for public bodies to make it easier for the public to engage in the work that they do, for example by holding regular online events at which the public can get involved, ask questions and participate in debates. They also called for the inclusion in the public sector of ‘formal accountability events’ that are a feature of the private sector, such as annual results presentations and annual general meetings, at which boards provide an account to their key stakeholders of their performance and at which stakeholders can ask questions and receive answers on how boards have discharged their duties.⁷⁶
20. When there are failures in public services, being accountable means that leaders need to make themselves available to listen to the people affected. We heard from Anthony May, Chief Executive of Nottingham University Hospitals NHS Trust about how the trust leadership is engaging with the families impacted by the maternity services scandal.⁷⁷

75 CIPFA open consultation, submission 5

76 Institute of Chartered Accountants (ICAEW), open consultation, submission 12

77 BBC News, ‘Nottingham maternity review to become UK’s largest’, 10 July 2023, available at: www.bbc.co.uk/news/uk-england-nottinghamshire-66151746

“At our annual public meeting last year, we invited the families and we said we would be happy to make a public apology. Their view was it was too soon and what we should instead say is that we wanted to build a new relationship with them. That is what we did, and we built our whole day around it. There are systems and processes you can put in place, like making sure it really is a public meeting and broadcasting it, for example, and there are symbolic things that you can do which show that you really mean it. Recently, the families affected by the maternity review have been engaging with a production company to produce a documentary about their experiences. The last time we met them, in a room like this, in a hotel, they asked me whether I would be happy to have a microphone taped to my chest and be filmed throughout the whole meeting. I have to say, the natural inclination of the people that advise me was not to do that, but I did and the chairman of the trust did it with me. That is not a system or a process. It is a symbol that when you say you are going to be open and transparent, you really mean it because that is a stressful thing to do for three hours but we did it.”

**Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust,
24 May 2024**

Supporting Parliament, ombudsmen and regulators to hold public bodies to account

21. Parliament, ombudsmen, regulators and inspectorates all have a role in scrutinising public sector bodies and holding them to account for their delivery of public services. The powers, mechanisms and processes for doing so vary and we will not explore these here. One theme that is common to all is the importance of supporting those bodies with oversight and scrutiny responsibilities to do their job effectively. This theme is about leaders needing to be responsive to requests for information and making themselves available to account for their decisions. It is also about seeing these ‘scrutiny’ bodies not as a threat, but as a provider of constructive challenge and a source of insight about how they can be better.
22. Officials with experience of Parliamentary select committees shared what they have learned about how best to approach Parliamentary scrutiny. Based on their input we have identified some key principles:
 - Try to respond quickly to requests.
 - Stick to professional judgement and facts.
 - Be as transparent as possible within the parameters set by ministers.
 - Think of the select committee as an important stakeholder rather than an inconvenience. In addition to public sessions, private meetings allow information to be shared that it would not be in the public interest to disclose openly.
 - For major projects, be proactive in holding events in Parliament to build a base understanding among MPs about the project, the benefits and how constituents might be affected.



23. A sector's relationship with its regulators or inspectorates will always be complex, but it is important that it is based on trust. Building trust is a two-way process and requires investment from both sides. We heard that the need to maintain personal relationships can be underestimated and it is important that leaders make time to get to know senior people in regulatory bodies.
24. It is also important to ensure that public sector bodies have sufficient capacity and processes in place to be able to report to the regulator or inspectorate and provide the level of service needed. Gareth Davies, Comptroller and Auditor General, told us that the NAO's job is made easier when organisations have a dedicated person to facilitate the department's work with them who become experts in the NAO's approach and what they need to do the job efficiently. He also identified the value of a mindset that sees a NAO audit as a learning experience from which the organisation can improve.

"Every piece of our work has an improvement objective as well as an accountability objective, so, as people become experienced in that kind of role, they become helpful in encouraging the teams that we are working with and that we are auditing to make the most of the opportunity. It can sound a bit counterintuitive, but it is a big learning opportunity as well for them and for us. It is helpful to have that mindset in that relationship, and for that reason it is also helpful to have that person experienced in the way the process works."

**Gareth Davies, Comptroller and Auditor General, National Audit Office,
24 May 2024**

25. Investing in engaging with those holding bodies to account naturally extends to independent inquiries. Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust, shared his experience of engaging with the Ockenden inquiry into maternity services. He told us how he put in place a team of people whose job it was to engage with the inquiry team, to build good relationships, and about the approach he took to supporting the review within the organisation and in the media.

"We have a team of people whose job it is to engage with the inquiry. My job is to make sure that Donna [Ockenden] gets exactly what she needs, when she needs it and in a format that her reviewers can use to analyse the cases and bring out the themes. It is also then my job to make sure that I build and sustain a good relationship with Donna because she has a difficult job to do. My job is to make sure that we respect the terms of reference and respect Donna's role and then lastly, it is about relentlessly communicating in the organisation and in the media that we think this is a good thing. The corporate position is that we welcome it. We think it will make things better for women and families and we will engage positively with it and we will put the resource aside to make sure it is done properly."

**Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust,
24 May 2024**

Chapter 6: Learning from successes and failures

1. It may be tempting for organisations under pressure to meet targets to concentrate solely on them. But making time to ensure that lessons are truly learnt, when things go wrong, pays dividends. We have repeatedly seen, in the reports of inquiries into major public service failures, that not doing so may mean that opportunities to avert subsequent disasters are missed. Putting the public first also requires public office holders to share learning when projects, policies and procedures work well so that these successes can support improvements in public service delivery elsewhere.

Sharing what works

2. There are, of course, many public bodies who share learning and expertise among the sectors in which they operate. Within the government, two examples – whose chief executives we spoke to for this review – are the Government Internal Audit Agency (GIAA), which provides internal audit services and support for the UK government, and the Infrastructure and Projects Authority (IPA), which is the government's centre of expertise for infrastructure and major projects.

How the Government Internal Audit Agency shares best practice

The Government Internal Audit Agency uses a variety of methods to share information across government about best practice: voluntary sharing by departments, sharing based on a formal sharing protocol and thematic reports in which GIAA draws together anonymised material across departments. These cross-government insight reports review risks across departments and agencies and share examples of good practice from which others can learn and improve their own performance. The reports are launched into each department's audit committee and spark discussion about how the material relates to that department and what the committee needs to consider to improve.

The GIAA has an Insights Engine which enables staff in different departments to search a large volume of documents and reports to find and retrieve content quickly and effectively.

3. There is value in reviewing examples of successful ventures in order to distil core principles that can guide future activity. An example of this is the IPA's principles for project success, a short guide for everyone delivering projects and programmes across government, to help ensure that practitioners get the basics right and deliver government projects successfully.



The IPA’s eight principles for project success ⁷⁸	
Principle 1: Focus on outcomes	“You really have to be clear on what it is that you are trying to deliver as an outcome and not rush to the scope of a thing. Once you have decided on what that outcome looks like and what the criteria for success would be, you have to align everybody to what you are endeavouring to deliver. Then you have to estimate it with accuracy and work out how long it is going to take you, because the starting point is all agreeing on the size of the thing.” Nick Smallwood, Chief Executive, Infrastructure and Projects Authority, 18 April 2024
Principle 2: Plan realistically	
Principle 3: Prioritise people and behaviour	
Principle 4: Tell it like it is	
Principle 5: Control scope	
Principle 6: Manage complexity and risk	
Principle 7: Be an intelligent client	
Principle 8: Learn from experience	

4. We heard examples from different parts of the public sector where membership organisations with a sector-wide remit seek to share good practice and provide support to public bodies through the training they provide and by bringing together organisations to learn from each other. From the Local Government Association to the Confederation of School Trusts, to the Public Chairs Forum, these organisations perform an important role in connecting and professionalising their sectors, ensuring that experiences are shared and best practice is promulgated.

Learning lessons when things go wrong

5. Organisations need to have processes in place for reviewing instances where things did not go according to plan, identifying the lessons that can be learned, and then ensuring that these lessons are embedded within the organisation. To support this, organisations need sufficient corporate memory of why previous decisions were or were not taken and the facts that informed those decisions.

78 Infrastructure and Projects Authority, ‘Principles for project success’, 2020, available at: www.gov.uk/government/publications/principles-for-project-success

“Overall, a culture of curiosity within our organisations where we are keen to identify and learn from things that have gone wrong requires documenting those things and having open ‘lessons learned’ conversations. That will hopefully reduce the incidence of taking actions purely on the basis of reputation and the imperative to protect the organisation over a particular public interest.”

John Edwards, Information Commissioner, Joint Association of Chief Executives and Public Chairs’ Forum event, 3 July 2024

6. A topic of conversation at a roundtable with public body chairs and chief executives hosted by the Association of Chief Executives and the Public Chairs’ Forum was how public bodies should take note of recurring themes when things go wrong elsewhere in public life and consider what their own organisation might learn from them. For example, a constant theme in maternity services failures is the poor relationships between nurses, midwives and doctors. Poor relationships should therefore be viewed as a warning sign that the conditions are present for problems to develop in the delivery of public services. Learning from this insight, leaders may wish to reflect on, and invest in, the health of the working relationships within their own teams. Another example is the Post Office Horizon IT inquiry, which is considering the failings of the Horizon IT system which led to sub-postmasters being wrongly prosecuted for theft, fraud and false accounting. Leaders of organisations that use ‘black-box’ systems should be asking themselves whether they are confident that they have sufficient understanding and oversight of how these systems operate or whether they need greater assurance about their use.

“It is crucial that public bodies do not overlook learning from previous experience and good practice, both inside and outside of the organisation, as this can also lead to failings. This includes implementing recommendations from external reviews of organisations. For example, the Francis Report, the RHI inquiry report, and the independent review of Invest NI. Good practice specifically on raising concerns is set out in ‘Raising Concerns: A Good Practice Guide for the Northern Ireland Public Sector.’”

Northern Ireland Public Sector Chairs’ Forum, open consultation, submission 19

7. We asked Chief Constable Gavin Stephens, Chair of the National Police Chiefs’ Council (NPCC), how the NPCC ensures that learning from independent inquiries into the police is shared across all the police forces in the UK. The NPCC has a series of co-ordinating committees on topics such as crime, local policing, workforce and finance, each chaired by a chief constable. Within these co-ordinating committees, there are a series of portfolios and working groups. When an independent inquiry reports, the chief constables of all the police forces come together through the Chiefs’ Council to consider the recommendations and the individual portfolios are tasked as appropriate.



“If we take a current [inquiry] the Angiolini Inquiry Part 1 report has a series of recommendations in there. I will chair a gold group looking at the series of recommendations. Naturally, they will fall into individual portfolios within that committee structure. They will do the work. We will come together in a national co-ordinating mechanism and take lessons or any key decisions through what we call the Chief Constables’ Council. Effectively, that is all the chiefs coming together to address those issues. Alongside that, we have a series of other mechanisms, such as all chief officer education days, feedback into Andy [Chief Constable Andy Marsh] at the college’s [College of Policing] service provision, executive leadership courses and middle management leadership courses.”

**Chief Constable Gavin Stephens, Chair, National Police Chiefs’ Council,
10 May 2024**

8. Some contributors mentioned how fear of blame can inhibit learning when things go wrong. An example of an approach to investigations that addresses this potential obstacle to putting learning first is the Health Services Safety Investigations Body, set up in October 2023 to investigate patient safety concerns across the NHS in England and in independent healthcare settings. The body’s core role is to carry out independent patient safety investigations that do not attribute blame or liability to individuals or organisations. Taking as a model the approach of other ‘safety-critical’ industries such as aerospace, aviation, maritime, rail, oil and gas, defence and nuclear power, the Health Services Safety Investigations Body investigates with a focus on system factors, rather than human error, with the aim of reducing the likelihood of patient safety incidents from happening.⁷⁹

Improvement and evaluation

9. We were told about various mechanisms for improvement and evaluation in the public sector. Cat Little told us how evaluation in government has been improving over the last few years, in particular through the Evaluation Task Force and the What Works Network. The Evaluation Task Force is a joint Cabinet Office-HM Treasury unit that provides departments with evaluation advice and support (in response to department requests), as well as a ‘proactive’ scrutiny and challenge function.⁸⁰ The What Works Network, which is a network of research centres covering a range of policy areas from education to crime to health, aims to improve the way government and other public sector organisations create, share and use high-quality evidence in decision-making.

79 Health Services Safety Investigations Body, ‘Annual Report and Accounts 2023/24’, 22 July 2024, available at: <https://hssib-ovd42x6f-media.s3.amazonaws.com/production-assets/documents/hssib-annual-report-and-accounts-2023-24-accessible.pdf>

80 Evaluation Task Force, ‘The Evaluation Task Force Strategy 2022 – 2025’, 22 March 2024, available at: www.gov.uk/government/publications/the-evaluation-task-force-strategy-2022-2025

“I think if you do not evaluate and humbly get people to properly evaluate things, how else do you learn lessons? I would like to see much more evaluation and evaluation strategies at the start of policy development.”

Cat Little, Permanent Secretary, Cabinet Office, 24 July 2024

10. The College of Policing holds the evidence base for policing. Chief Constable Sir Andy Marsh told us that as well as hosting the What Works Centre for Crime Reduction, the College of Policing has a practice bank for innovative and promising practice which is not yet fully evaluated. The college has produced a piece of research called Perennial Problems in Policing that clusters recommendations from His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Coroner’s Court and the Independent Office for Police Conduct into 10 perennial problems to guide their research, training and investment. These include the prioritisation of short-term reactive policing, a lack of structured problem solving by frontline officers, limited assessment of the impact of specific interventions and strategies, and challenges in sharing information across partners.⁸¹ The What Works Board, chaired by Chief Constable Marsh and attended by the NPCC, HMICFRS, APCC and other senior leaders prioritises the areas of learning, knowledge and innovation for testing.

“We are turning more and more of these gaps into knowledge, and we are turning more and more of this knowledge into insight, which we share.”

Chief Constable Sir Andy Marsh, Chief Executive, College of Policing, 31 May 2024

11. Chief Constable Sir Andy Marsh and Chief Constable Gavin Stephens share the view that there is under-investment in central capacity to help police forces to improve. There is a focus within the policing system on understanding why things have gone wrong, but insufficient investment in central capacity to help organisations with routine learning and improvement. Policing is a localised system, but at the local level, police forces are often wrestling with many conflicting priorities including balancing the budget, implementing the latest IT system or doing the latest training programme to ensure legal compliance.

“In a policing landscape or system that is heavily localised, I feel like we underinvest in the central capability. For example, policing is a £18 billion service or industry. The College of Policing – you have learned a little bit about our role, which I would characterise, by the way, as standards, performance, leadership – is a £70 million organisation.”

Chief Constable Sir Andy Marsh, Chief Executive, College of Policing, 31 May 2024

81 College of Policing, ‘Problem-oriented policing’, January 2021, available at: <https://assets.college.police.uk/s3fs-public/2021-05/problem-solving-scope-of-practice-guidelines-250521.pdf>



“There is a real absence of change and improvement capability in policing. I will put that alongside there is not an absence or a shortage of diagnostics about the things that are going wrong so whether that is coming from the Independent Office for Police Conduct (IOPC) who produce very good and effective learning reports, or HMICFRS, who have also produced lots of recommendations. We have probably struggled since the years of austerity and the closure of what was called the National Policing Improvement Agency. We lost that during the years of austerity. So, what is missing in policing is that there is not any central capacity to help forces improve.”

**Chief Constable Gavin Stephens, Chair, National Police Chiefs’ Council,
10 May 2024**

12. In the health sector there are various programmes and schemes that NHS England have in place to support hospital trusts and Integrated Care Boards (ICBs). NHS England has statutory accountability for oversight of ICBs, NHS Trusts and foundation trusts. The NHS oversight framework describes how this oversight operates.⁸²
13. The support provided by NHS England to an ICB or trust is based on earned autonomy principles. The NHS will identify the scale and nature of support needs by making an assessment about the maturity of the leadership in place within an ICB or trust and its performance. This will vary from a high degree of autonomy at one end of the scale and at the other end, mandated intensive support delivered through the Recovery Support Programme.⁸³
14. We were also told about the Getting it Right First Time programme (GIRFT) which is a NHS England programme designed to improve treatment and care by reviewing health services in England.⁸⁴ GIRFT assists organisations to understand where they might be out of line with national data in the delivery of services by asking why variation might be occurring and, where it is unwarranted, assisting local teams to do the work that is needed to improve. Often, the NHS does this by pointing to another organisation that has had similar issues and has successfully put in place measures to resolve them.

82 NHS England, ‘NHS oversight framework’, June 2022, available at: www.england.nhs.uk/publication/nhs-oversight-framework-22-23/; ‘A consultation on a draft updated NHS Oversight and Assessment Framework’, May 2024, available at: www.england.nhs.uk/long-read/consultation-on-the-draft-updated-nhs-oversight-and-assessment-framework/

83 NHS England, ‘Recovery Support Programme’, available at: www.england.nhs.uk/system-and-organisational-oversight/national-recovery-support-programme/

84 NHS England, ‘About the GIRFT programme at NHS England’, available at: <https://gettingitrightfirsttime.co.uk/what-we-do/>

“Let me give you a case, at the moment, I am visiting all 24 comprehensive stroke centres in the country. We go through the data with them, and that allows us to ask questions around, ‘Why are fewer of your population having a certain procedure?’ The GIRFT programme partly physically visits, and partly looks at the data and issues reports based on analysis of that data, but fundamentally it is there to assist.”

**Professor Stephen Powis, National Medical Director, NHS England,
24 July 2024**

15. Peer challenge can be a valuable tool to support improvement in public services. In the local government sector, the LGA facilitates a programme of corporate peer challenges (CPCs) for councils.

Corporate peer challenges for councils

Openness to external challenge contributes to honesty and openness. The LGA facilitates a programme of corporate peer challenges (CPCs) for councils, where a team of member and officer peers from local authorities provide ‘critical friend’ challenge on the themes of: local priorities and outcomes; organisational and place leadership; governance and culture; financial planning and management; and capacity for improvement.

CPCs are recognised as an effective tool for identifying any cultural and relationship weaknesses in councils and recommending improvements that help to mitigate individual or systemic risks. The government has set out its expectation in the Best Value Standards that all local authorities have a corporate or finance peer challenge at least every five years, to help identify any issues an authority might be facing and suggest possible solutions.⁸⁵

Following each CPC, a report outlining the key findings and recommendations from the peer team is shared with the council. In the spirit of openness and transparency, councils are required to publish this report, alongside an action plan, within three months of the CPC. If the council is unable to publish the plan with the report, it is required to publish the plan no later than five months after the CPC. In 2023/4, 61 CPCs were conducted: reports are also published on the LGA website.

Local Government Association, open consultation, submission 14

⁸⁵ Ministry of Housing, Communities & Local Government, ‘Best value standards and intervention: a statutory guide for best value authorities’, 8 May 2024, available at: www.gov.uk/government/publications/best-value-standards-and-intervention-a-statutory-guide-for-best-value-authorities



Complaints

16. Complaints can provide valuable insight for an organisation into how the public is experiencing its services. A spike in the volume of complaints in a specific geographical area or about particular policies or practices can be an early warning sign that there are issues that warrant closer investigation. Problems may start to reveal themselves in the complaints data before they materialise elsewhere in the department.
17. Whether complaints are viewed as an opportunity or a threat is determined by the tone set by the leadership of an organisation. It requires leaders, at all levels, to value and prioritise the learning to be gained rather than resorting to blame, defensiveness and reputation management.

“Creating a learning organisation and one that does not blame is absolutely essential. You need all kinds of ways of doing that. We brought into our office former complainants who described what it was like to be on the receiving end of the behaviour of our people. We [also] brought in ombudsman leaders from Canada, Africa and across the world to talk about their experience and what they had done.”

**Sir Rob Behrens, Former Parliamentary and Health Service Ombudsman,
26 April 2024**

18. The role of the complaints caseworker is of critical importance to an organisation, in resolving issues that the members of the public are experiencing with public services and in identifying early warning signs of emerging problems. It is another role, like that of managing the sponsorship relationship with ALBs, which is crucial to the effective operation of public services but is at risk of being undervalued.

Government departments, public bodies and the NHS

19. The Parliamentary and Health Service Ombudsman (PHSO) was set up by Parliament to consider complaints that government departments, other public bodies and the NHS in England, have not acted properly or fairly or have provided a poor service. The PHSO also works with organisations to help them improve how they handle complaints and in 2022 published the UK Central Government Complaint Standards and the NHS Complaint Standards. The complaint standards have professionalised complaints handling by promoting a consistent cross-government approach to complaint handling.
20. The complaints standards encourage a learning culture by supporting organisations to see complaints as opportunities to improve services. The standards were developed in collaboration with departments and supported by the Cross Government Complaints Forum, which has the aim of improving the quality of complaint handling across government by enabling cross-departmental engagement and learning.

21. We were keen to hear the perspective of complaint handlers and were grateful to be invited to a meeting of the working level branch of the forum. It was clear to us that the forum is hugely valued by its members as a mechanism for bringing together people from a wide range of departments with contrasting complaints functions. Some departments may have a single person who handles complaints and may receive around 100 complaints a year. The larger departments will have large customer services departments and may receive around 90,000 complaints a year. The forum allows complaints handlers from all types of departments to come together to share best practice and experiences.
22. We were interested to hear how departments identify themes in the complaints they receive and how they use this to identify and resolve issues. We heard that departments that have the largest number of complaints as a consequence of the high volume of their customer service interactions, have a data analysis capability that is able to identify and report on trends and themes. In some smaller departments, the analysis is carried out by the team investigating the complaints.
23. There is also variation in the technical systems for recording and analysing the complaints data. For example, one larger department has a new handling system which pulls themes and outcomes into a performance report which is sent monthly to their board. We heard that the technology is lacking in some of the smaller departments. In some departments the case management system does not allow more than one reason for a complaint to be recorded or for detailed analysis of the data to be extracted. Some departments were in the process of building better systems, while others had not been supported by the resources necessary to invest in more appropriate systems for capturing the level of data necessary. For departments without sophisticated case management systems, complaints teams were relying on manual sifts to identify the granularity needed to pull out useful data.
24. One participant from an ALB shared with us an example of how they use their complaints data to identify red flags. The agency overlays data on the volumes of complaints about specific themes with the peaks that they would expect to see based on seasonal factors that impact on the work of their organisation. This method reveals increases that it is able to discount because they are in line with expectations. The agency is looking for peaks that are not attributable to seasonal variations, which might therefore suggest an anomaly which requires closer investigation.
25. We heard that there are some initial conversations taking place around whether AI can and should be used to support analysis of themes in complaints. One complaints handler noted that early dialogue within their public sector body seemed to be focused on the scope for AI to make efficiencies through potentially generating acknowledgments and complaint responses and not, rather worryingly, on how it can be used to facilitate learning and improvement.



26. We heard several examples where there was a clear route for themes identified in the complaints received to be escalated through the organisation to the executive leadership team and to the departmental board, including how the data is fed into the organisation's risk and assurance committee. Timeliness is important if the red flags are to be spotted and addressed before issues become more serious.
27. One participant at the forum shared how complaints handlers are able to see the changes that happen as a result of the feedback they are recording and the work of the data analysts to bring the reports together. This approach reinforces the message that identifying problems at the first opportunity and making improvements is a priority for the organisation. In contrast, another contributor spoke about how they thought that the staff handling complaints within their department would feel encouraged to collect the best data if they knew that change would happen once they collect the data. They felt that if the senior civil servants within their department were more visible, listening and taking on board the opinions of staff, this would encourage feedback to come from the frontline staff up the chain. We also heard that in some cases boards can be more interested in reducing backlogs and meeting key performance indicators than in asking what learning the organisation can take from the complaints.
28. One complaints handler from an ALB that operates nationally with regional offices told us how variations in the complaints that were being received for the regions led them to establish that the body was applying different processes in different regions. They were able to use complaints data to help them to determine what the policy should be nationally, and to publicise it to the public. This led to an increase in complaints in the short term, but in the long term it led to an overall decrease in complaints.

“Complaints are not necessarily a bad thing. They are a way of ably informing you about how we can focus our efforts, and that has caused an overall benefit to our customers and the business in general.”

Participant, Cross Government Complaints Forum, 24 October 2024

29. One participant from an ALB explained how common themes in the complaints received revealed that customers were unhappy with the service the agency was providing. Customers were having difficulty getting through on the helplines, the waiting times were too long and when they did get through, the staff in the customer service centres were not trained well enough to be able to answer their queries. They were offered callbacks that then never happened. As a result of the complaints received, there was recognition that change was needed and this led to a huge culture shift in the agency.

“There has been a really big push on, ‘Let us pick up the phone. Let us talk to our customers. Let us get to know our customers again.’ We have gone full circle back to the good old days when we used to speak to customers. It is a work in progress. We are not there yet, but I think that has been a really big change that we have seen just through complaint handling. That has been some of the things that we have put in play because of what we saw coming through complaints.”

Participant, Cross Government Complaints Forum, 24 October 2024

Local government

30. The Local Government and Social Care Ombudsman (LGSCO) conducts independent investigations into complaints about local councils (excluding town and parish councils) and some other authorities and organisations. The LGSCO also investigates complaints about adult social care providers in both the public and private sectors.
31. The LGSCO published the Complaint Handling Code in 2024, which sets out guidance on how local councils should handle complaints. Like the complaints standards issued by the PHSO, the Complaint Handling Code promotes a learning culture.⁸⁶ It advises organisations to look beyond the circumstances of the individual complaint and consider whether service improvements can be made as a result of any learning from the complaint.
32. The LGSCO shared with us an example of a council which has demonstrated that it is moving to a learning culture. Liverpool City Council had been through serious problems and was subject to a government intervention. It approached the LGSCO to ask for guidance on how to handle complaints effectively and on how to use the information gained from complaints to improve their services. Investigators from the ombudsman spent some time at the council and produced a report, which the council then implemented.⁸⁷

86 Local Government & Social Care Ombudsman, ‘Complaint Handling Code’, February 2024, available at: www.lgo.org.uk/information-centre/information-for-organisations-we-investigate/complaint-handling-code

87 Local Government & Social Care Ombudsman, ‘Ombudsman encouraged by Liverpool’s response to complaints review’, 27 July 2023, available at: www.lgo.org.uk/information-centre/news/2023/jul/ombudsman-encouraged-by-liverpool-s-response-to-complaints-review



“Liverpool City Council have seen an absolute shift in internal culture, whereby they have started listening to people in a different way. It has not been that immediate defensive, ‘No, it is not us.’ People get caught up in that, where there is no direction within the organisation. Somebody then makes a complaint about something they have done, and it is the last thing they want to hear. If you shift the attitude to say, ‘Okay, if we listen to what this person is saying, give them the space and time to express their views, it is likely that is going to help us understand how what we are doing is landing with the people who are relying on our service.’ Liverpool is a very good example of an open mind and a bold approach.”

**Nigel Ellis, Chief Executive, Local Government and Social Care Ombudsman,
10 May 2024**

33. The LGSCO shares learning that it has identified through the complaints it investigates in thematic reports, which conclude with a list of questions for councillors to ask when scrutinising services in their authority.⁸⁸
34. Councillor Marianne Overton, Vice Chair of the LGA, shared the LGA view that it is good practice for an annual report on complaints to go to the full council. Councillor Overton also drew attention to a web service called Fix My Street run by the charity mySociety, which allows people to report problems in their local area, such as potholes or graffiti, using a shared ‘front door’. The service sends the report to the right council which sends instructions directly to their contractors to fix the problem before a formal complaint is necessary. We heard from many contributors to our review that people do not tend to want to make complaints – they just want their problem to be fixed.

“It is again about culture, because you have to be prepared to see every complaint, not as something to defend against, but as a lesson. It is so vital.”

**Councillor Marianne Overton, Vice Chair of the Local Government
Association, 14 June 2024**

88 Local Government & Social Care Ombudsman, ‘Focus Reports and Good Practice Guides’, available at: www.lgo.org.uk/information-centre/reports/focus-reports

Chapter 7: Leadership and culture

The role of leaders in setting the tone

“If you have the ‘right’ people, people with the right skills, the right attitudes, the right behaviours, the right experience and confidence to do the right thing, that is a large part of the battle on this. The best governance systems in the world and the best data in the world cannot protect an organisation or the public interest against the wrong individuals. People and behaviour are, in my experience, always the biggest single factor, but they are then part of a whole system.”

**Gareth Davies, Comptroller and Auditor General, National Audit Office,
24 May 2024**

1. It is clear to us that leadership is the most important factor in an organisation that identifies and addresses emerging issues promptly and is willing to learn from its mistakes. Leaders, at all levels, must create an expectation that employees will speak up if they notice something that ‘doesn’t quite feel right’ and that doing so will be welcomed and valued. This goes deeper than warm words shared in a ‘town-hall’ meeting or an all-staff email. It is about how leaders demonstrate day in and day out through their actions and behaviours that they believe problems should be identified and confronted head-on.
2. In our 2023 report, *Leading in Practice*, we said that leaders must communicate the high standards they expect from their workforce with **clarity** and **consistency**, and that there must be **consequences** for people whose behaviour does not align with the values of the organisation. We discuss below what these themes mean for building a culture that supports identifying and addressing problems.
3. **Clarity.** Leaders must be clear that they welcome potential problems being brought to their attention early, before matters start to deteriorate, and they must emphasise that they expect all line managers to be receptive to issues and concerns being raised with them. Leaders must look for opportunities to help the people working in their organisation to understand how serving the public interest should guide their actions and behaviour. They must be clear that everyone in the organisation has a duty to deal with the public with openness and honesty.
4. **Consistency.** Leaders must be role models for the standards they expect of others, even when they are under pressure. They should demonstrate that they welcome people sharing their concerns or opinions by listening attentively. The organisation’s internal culture should align with its public interactions. Ensuring consistency between its internal and external behaviours fosters honesty and transparency.
5. **Consequences.** Leaders must address behaviour that is inconsistent with a culture which values people raising concerns. The appropriate response will depend on the circumstances. Where malpractice has occurred, such as deliberately concealing relevant information, disciplinary action may be appropriate. In other instances, it may be right for the leader to call out a particular type of behaviour and explain why it is not acceptable.



Leaders must be careful not to reward people who downplay problems or sweep them under the carpet through favourable performance management decisions. In public life, the ‘how’ is as important as the ‘what’ in getting things done.

6. In the report of the Infected Blood Inquiry, Sir Brian Langstaff drew attention to the high number of high-profile failures of care over the last five decades that have been the subject of inquiries of different types which have ended with a recommendation that the culture needed to change to be more open and forthcoming.⁸⁹ He noted how these concerns have led to a statutory duty of candour being placed on health service bodies in England, Scotland and Wales, warnings from the Parliamentary and Health Service Ombudsman and a strengthening of whistleblower protection. However, he noted that there had not yet been the desired culture change.

“Whistleblowers are recognised as capable of providing a valuable service. The protection given to them consists of ensuring they do not suffer a detriment for making the revelations which they do. However, the system is one in which it is almost assumed that, but for the Act [Public Interest Disclosure Act 1998], a whistleblower would otherwise be subject to blame. It is that cultural assumption which most needs to be addressed. What most needs to be valued is ensuring that reporting near misses (‘sentinel events’) as well as harmful acts is prized, so that we may learn how to avoid them next time a similar situation occurs.”

Infected Blood Inquiry, The Inquiry Report, Vol. 1, page 238

7. One of these inquiries was Sir Robert Francis’ 2013 report into Mid Staffordshire NHS Foundation Trust, in which he recommended that, “Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon.”⁹⁰ Sir Brian Langstaff said that insisting on the reporting of concerns on the part of those in leadership roles was vital if culture is to change, along with the better organisation of the systems dealing with safety across healthcare. “Rather than seeing a whistleblower as needing protection from retribution which would otherwise follow, the culture should be one in which the reporting of the concerns of which Sir Robert Francis speaks is recognised as a human, professional and statutory duty.” The duty should also rest on those to whom a report is made. Sir Brian recommended that those in leadership positions be required to record, consider and respond to any concern about the healthcare being provided and any person in authority to whom such a report is made should be personally accountable for a failure to consider it adequately.

89 Infected Blood Inquiry, ‘The Inquiry Report’, 20 May 2024, available at: www.infectedbloodinquiry.org.uk/reports/inquiry-report

90 ‘Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry’, 6 February 2013, available at: www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

“Where an individual is responsible for something going wrong that was, or might have been, harmful, they should not usually be blamed for ‘owning up’ (for that enables patient safety to be better achieved), but they should certainly be blamed if they keep silent.”

Infected Blood Inquiry, The Inquiry Report, Vol. 1, Sir Brian Langstaff, page 241

8. In his 2017 report, ‘The patronising disposition of unaccountable power’, Bishop James Jones proposed a charter intended to support leaders of public bodies to demonstrate to their employees that they are in favour of openness and against defensiveness. The Hillsborough Charter has since been adopted by the government, the National Police Chiefs’ Council on behalf of all 43 police forces, the College of Policing, the Crown Prosecution Service, National Fire Chiefs’ Council and others.⁹¹

“The Hillsborough Charter works by looking to public authorities to adopt principles. It is about principles and the principles are about openness, candour and transparency. There needs to be that signal sent through the organisation, so that, when there are signs then staff feel, ‘Yes, I want to bring this to the attention of others up the line’, not, ‘My job is to somehow pretend that this signal is a false signal or a minimal signal.’ That can make all the difference.”

Ken Sutton, secretary to the Hillsborough Independent Panel and secretary to the reviews into maternity care at East Kent Hospitals NHS Trust, 11 July 2024

9. There has been a statutory duty of candour for health and social care providers since November 2014 and an organisational duty of candour for policing was put in place though the 2023 Code of Practice for Ethical Policing.^{92, 93} Campaigners have long called for a Hillsborough Law to set out in statute that all public authorities and public servants must tell the truth and act with candour. The government announced in the 2024 King’s Speech that it would legislate to introduce a duty of candour for all public servants and the law would include criminal sanctions for those who breach it.⁹⁴

91 Oral statement to Parliament, ‘Hillsborough Charter is legacy of victims’ families’, 6 December 2023, available at: www.gov.uk/government/speeches/hillsborough-charter-is-legacy-of-victims-families

92 A review of the operation of the statutory duty of candour for health and social care providers in England was announced in the government’s response to the Hillsborough disaster report on 6 December 2023. A call for evidence was launched in April 2024 and the findings were published in November 2024, available at: www.gov.uk/government/publications/findings-of-the-call-for-evidence-on-the-statutory-duty-of-candour

93 College of Policing, ‘Code of Practice for Ethical Policing’, 7 December 2023, available at: www.college.police.uk/ethics/code-of-practice

94 BBC News, “Hillsborough Law’ on the table by anniversary – PM”, 24 September 2024, available at: www.bbc.co.uk/news/articles/c0jwzgpzzjxo



10. We welcome the government's commitment to increasing candour and openness in public life. The new legislation will need to be supported by sustained attention from leaders of public bodies to ensure that the law is both the catalyst for change and is supported by a culture that values and promotes openness over defensiveness.
11. We have seen in the reports of independent inquiries how, when the public has suffered as a result of action or inaction by a public sector body, it is often the defensive response of the body and its failure to acknowledge where it went wrong and offer a meaningful apology, that compounds the pain suffered. Point 5 of the Hillsborough Charter calls on organisations which sign it to strive to, "Ensure all members of staff treat members of the public and each other with mutual respect and with courtesy. Where we fall short, we should apologise straightforwardly and genuinely."
12. Some contributors to our review noted the difference between a legalistic approach and an approach centred on ethics and values. For example, a CEO may feel pressure from legal advisers to protect against potential legal liability and will need to balance this with the delivery of timely and effective public services in line with the organisation's values. Leaders need to decide what kind of culture they want for their organisation.

"If you make a mistake, and we all do, I make them all the time, be able to say, 'Yes, I got that wrong.' That goes such a long way. It is not trying to live by some kind of virtuous code that other people cannot aspire to. It is trying to do the basic things which are about humanity and humility."

**Anthony May, Chief Executive, Nottingham University Hospitals NHS Trust,
24 May 2024**

Building a speak up culture

Speaking up and whistleblowing

'Speaking up' can include 'whistleblowing'. Whistleblowing of certain categories of wrongdoing is protected in law. Where a concern falls within the scope of the Public Interest Disclosure Act 1998 (PIDA), a worker making a 'protected disclosure' will be protected from negative treatment or unfair dismissal.

When we refer to speaking up in this report, we have in mind formal speak up and whistleblowing complaints, supported by effective policies and procedures for people to raise concerns. But we also have in mind a culture where people feel comfortable flagging issues informally, asking questions and sharing their ideas. This can enhance the engagement and collaboration that makes for good decision-making in the public interest.

13. An organisation that approaches public scrutiny openly and transparently, does not seek to defend the indefensible and treats the public with respect, needs an open internal culture that supports employees to speak up if they become aware of actions or behaviours that are falling short of these standards.
14. The annual ‘Ethics at Work’ research published by the Institute of Business Ethics consistently finds that the main barriers to speaking up are fear and futility. People fear that speaking up will have a negative impact on their career and lack confidence that any action will be taken if they do raise their concerns. Other reasons that may apply include a fear of blame or not wanting to be seen to undermine colleagues.⁹⁵
15. To inform their contribution to our public consultation, the Society of Local Council Clerks conducted a survey of their membership. The survey asked whether members feel safe to speak up about concerns with 62% responding ‘yes’ and 38% responding ‘no’. The survey asked those who had responded no, what they believed were the reasons for this response. 37% said their negative response was due to a lack of proper sanctions for poor behaviour which in turn can mean that councillors and staff feel it is not worth raising an issue.⁹⁶
16. Some contributors raised with us the importance of psychological safety for creating a culture where people are willing to speak up. Academic and author, Dr Amy Edmondson, defined team psychological safety in 1999 as, “a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes, and that the team is safe for interpersonal risk taking.”⁹⁷
17. In our 2023 report, *Leading in Practice*, we explored the role of leaders in creating an environment where people feel they can speak up. Three observations from that report are worth summarising here:
 - People need to feel that leaders are genuinely interested in what they have to say, and leaders need to be visible and available.
 - The way leaders respond when people raise concerns has a ripple effect though an organisation – for good or bad.
 - Strong leadership requires leaders to be curious about their organisation and to welcome concerns and complaints as information that will enable them to make improvements.
18. These themes continued to be prominent in the evidence we took for this report. When leaders take action, this demonstrates that leaders take seriously the matters being raised with them. Baroness Casey described the chicken and egg nature of the problem, “If you do not take action, people will not come forward. If people do not come forward, you will not be able to take action.”

95 Institute of Business Ethics, open consultation, submission 11

96 Society of Local Council Clerks, open consultation, submission 23

97 Amy C. Edmondson, ‘Psychological Safety’, available at: <https://amycedmondson.com/psychological-safety/>



“If your first action on receiving a whistleblowing complaint internally, or negative feedback from somebody outside the organisation, is to get into reputational protection mode then, however good your policy, you have lost that point. It is again leadership, culture, behaviour and so on.”

**Gareth Davies, Comptroller and Auditor General, National Audit Office,
24 July 2024**

“In our confidential staff surveys, since 2016, you can see that there is appreciation for the leaders getting out, talking to their colleagues and staff, listening to them, taking onboard what they say and welcoming when they have done something wrong, to be told that they have done something wrong. The leaders have to practise what they preach. If they do not, people become cynical and fearful.”

**Sir Rob Behrens, Former Parliamentary and Health Service Ombudsman,
26 April 2024**

“A key part of building a speak up culture is for managers to be trained in active listening, for all contributions, challenges and ideas to be valued, and to maintain the virtuous triangle through following up when issues are raised, to let colleagues know what has happened to their feedback – speak up, listen up, feed back.”

Institute of Business Ethics, open consultation, submission 11 Speak up and whistleblowing processes

19. We have discussed in this chapter the importance of an open culture in which people feel it is their duty to speak up about concerns and near misses. It could be said that there has already been a failure of an organisation’s culture if an employee feels that they need to report a concern formally. However, it is also the case that formal mechanisms are a crucial safety net and there will always be a need to have effective and trusted processes in place.⁹⁸
20. Five key components of an effective speak up/whistleblowing system came through in the evidence we took.
 - It is important that there are a range of routes for people to speak up and that these are publicised within the organisation. There should be regular training and awareness programmes on the process, which are available to staff and board members.

⁹⁸ There has been much debate in recent years about whether existing whistleblowing law is sufficient. Proposals have been made for improvements to the regime. For example, see: <https://protect-advice.org.uk/campaign-for-a-new-whistleblowing-bill/>

“It is important that there are regular training and awareness programmes on the whistleblowing process, which are available to staff and board members as appropriate.”

Northern Ireland Public Sector Chairs’ Forum, open consultation, submission 19

- Organisations have a duty of care to people who speak up and need to support employees through what can be a difficult and emotionally challenging time.

“We want to get the information from the whistleblower as quickly as possible, to reassure them that it has been understood and is being dealt with properly, which is often a challenge, but let them get back to their job. We have seen really serious effects on whistleblowers’ mental health and their performance in the job. While everybody was well intentioned about protecting them, it has almost become impossible because they are under such stress. There is a duty of care point there, which is still not well managed.”

Gareth Davies, Comptroller and Auditor General, National Audit Office, 24 May 2024

- All too often people who raise concerns face aggression and denial. Organisations should ensure that victimisation is dealt with firmly and that this is seen to happen.

“We are aware of employers in the public and private sector who successfully use a victimisation risk assessment to prepare and address the risk of victimisation of a whistleblower at a very early stage. A risk assessment can also identify risks to breaches to a whistleblower’s confidentiality as well as situation.”

Protect, open consultation, submission 21

- Boards should regularly review the operation of the speak up system and make improvements where necessary. So that the board can understand the experiences of people who report concerns, organisations need to collect data on the operation of the speak up system.

“Ensuring the effectiveness and awareness of a whistleblowing policy that empowers employees to disclose any serious wrongdoing or unlawful conduct without fear of victimisation is vital. Regular review of the policy and supporting training and communication is essential.”

Local Government Association, open consultation, submission 14

- Boards should ensure that speak up reports are analysed for themes and patterns and that this information is combined with other datasets to form a single insight into the culture of the organisation.



“I think it is partly about training. I think it is about rewarding whistleblowers. I do not mean necessarily financially. I think it is about building it into the culture of the organisation. In particular, I think the boards of both public and commercial bodies need to be specifically trained on why whistleblowing can be a positive, its importance and the risks and costs of ignoring whistleblowers.”

**John Bowers, Principal of Brasenose College, University of Oxford,
25 June 2024**

21. Protect, the whistleblowing charity, has developed a whistleblowing benchmark, which has codified best practice into an evaluation tool to support employers to analyse their performance in three areas: governance (policies and procedures, accountability, review, and reporting arrangements), staff engagement (communications and training) and operations (support and protection, recording and investigations, resolution, and feedback). On completion, an organisation receives a score under each area, allowing comparisons with other organisations and against best practice, and providing a gap-analysis so that organisations know where to improve.⁹⁹

Developing leaders

22. It is clear that leaders – at all levels of an organisation – are critical to a culture where people both feel that it is their duty to report mistakes and concerns and that they will not be unfairly treated for doing so. So how can public sector organisations ensure they are populated by leaders who have the motivation, character and skills necessary to build these cultures?
23. Dr Bill Kirkup shared his view with us, based on his experience of the health sector, that leaders often do not feel confident that they have solutions to problems so would rather not hear about them. He felt that if people were better prepared for the fact that things will go wrong and have thought about how they would deal with the challenges that could arise, they may be less inclined to minimise problems.

“Very often, when you first go to do an investigation in somewhere like Morecambe Bay, the first thing that everybody tells you is, ‘Everybody knew that there was a problem.’ ‘Yes, but why did you not say so?’ ‘Because we thought that people were not ready to listen.’ If you are prepared to listen to those and you show that a report of potential problems is going to be welcomed and not rejected, that will add a lot to it. If people, again, thought that they had solutions to some of these problems, they would not be so frightened of them and they would not want to minimise them quite so much.”

Dr Bill Kirkup, Chair of reviews into maternity care at East Kent Hospitals NHS Trust and Morecambe Bay maternity services, 11 July 2024

⁹⁹ Protect, open consultation, submission 21

24. Developing the confidence of leaders to deal with problems in the right way seems to us to be a worthwhile area of focus in leadership training. This should include how to handle a crisis appropriately and how to get comfortable delivering bad news to their leaders and ministers – and doing it early.
25. We heard from contributors how leaders need to be curious in order to uncover and address issues as early as possible. Leaders must take action when issues are raised with them, but this alone is insufficient. Leaders must actively search out the first signs of issues that may be bubbling under the surface. We discussed in chapter 3 how hard and soft data across a range of areas can provide indicators that something may be going wrong and requires a closer look. But for this data to be used to best effect, leaders must want to listen to and interpret the story it is telling.

“I am constantly looking for corroborating evidence or dissonance with the formal paperwork I see through governance. When there is dissonance, then you start pulling at the thread. Is the whistleblowing process not being used? Why are those the complaint numbers that we get? I see one of my roles, as part of the senior team, as making sure there is enough grit in the machine which ensures the infrastructure that I set up is asking some of the challenging questions, to make sure that things are what they appear to be.”

Angela MacDonald, Deputy Chief Executive and Second Permanent Secretary, HMRC, 11 July 2024

26. This is not the place for an in-depth summary of the different forms of leadership training and development that are available in the public sector. However, the following schemes and methods are examples that were shared with us of training that supports leaders to develop organisational cultures where issues are addressed when they arise and the public interest comes first.
 - The Infrastructure Project Authority (IPA) Project Hub and Major Project Leadership Academy (MPLA) train people to be accountable. All Senior Responsible Officers must go through the MPLA course, which is 18 months duration and is equivalent to a master’s degree. The MPLA course includes a mix of training and experience-based work. The IPA has also given training to ministers.
 - Immersive learning uses realistic environments to simulate major incidents and real-world scenarios. This allows participants to practise making decisions in a safe learning environment. Immersive learning is used by the police and in health, among other sectors.^{100, 101}

¹⁰⁰ College of Policing, ‘Immersive learning’, available at: www.college.police.uk/career-learning/immersive-learning

¹⁰¹ NHS England, ‘Simulation and immersive technologies’, available at: www.hee.nhs.uk/our-work/technology-enhanced-learning/simulation-immersive-technologies



- UK Government Investments (UKGI) has a shareholder non-executive director development programme and an aspiring shareholder non-executive director development programme to build a pipeline of expertise. They hold formal training sessions three or four times a year. Every time the UKGI produces an internal good practice note, they hold a seminar on it to disseminate expertise across the organisation. They currently have a programme where every six to eight weeks they bring in a FTSE 100 Chair to talk to the group about how effective boards operate. Charles Donald, Chief Executive of UKGI told us, “It is all about trying to build a group of people who a) do not feel like they are on their own and b) feel like they are being trained and developed to understand a good way to operate on a board. Those people also encounter problems that may exist in one ALB and a shared understanding of which means colleagues might be in a better position to recognise them elsewhere in another ALB. It is amazing how many themes that are common.”
- Cross-sector learning allows for cross-fertilisation of ideas across the public sector. An example is the Ethos Network, attended by senior representatives from the Police, Military, NHS, Civil Service and academics researching ethics in diverse public services. Subject to securing funding, the Ethos Network will develop a cross-sector research agenda and evidence base for ethics in (and of) public service, facilitate mutual learning on, and advancement of, ethics in (and of) public service, through interprofessional and multidisciplinary networking and engagement, and identify and share best practice on education, standards, and services for ethics in public service.
- The LGA's member and officer development programmes promote the importance of fostering open and transparent communication and engagement in local authorities between Cabinet/committee chairs and senior officers and with the public and stakeholders to facilitate information exchange and feedback in an open, honest and accountable way.¹⁰²

27. In our Leading in Practice report, we were clear that while the tone at the top of the senior leadership is important for setting culture, most people working in organisations will have limited visibility of the top team but daily interactions with their more immediate managers. Line managers at all levels need training and support so that they are able to create the right atmosphere for their staff to feel safe saying they have made a mistake, or that they feel a project may not be going to plan, and line managers need to know how to handle such challenging conversations.
28. Another area we touched on in Leading in Practice was the role of professional standards in supporting members of the professions to maintain high standards and act as role models within the public sector organisations where they work.

¹⁰² Local Government Association, open consultation, submission 14

“As part of the professional training [for accountants], there is an ethics module, and professional staff must review and remind themselves of their ethical responsibilities under the Standard of Professional Practice on Ethics. Things like honesty and courage are part of that, being able to speak truth to power and to do the right thing where required. It is absolutely acknowledged that that can be hugely difficult, and sticking your head above the parapet when circumstances are hard is a personally very challenging thing to do.”

Diana Melville, Governance Advisor, The Chartered Institute of Public Finance and Accountancy (CIPFA), 24 May 2024

29. Cat Little told us that she would like to see greater professionalisation of what it means to be a civil servant and uphold the Civil Service Code.

“We have got good frameworks, but I think we need to go further. The Civil Service Code, for example, has our four core values. We talk about honesty and impartiality, but we do not really have a professionalisation of what that means in practice. I compare that to my experience as a chartered accountant, where every year I had to explain how I had upheld my professional duties. I think the same is required of the Civil Service as professionals in policy making and with the responsibilities that we have.”

Cat Little, Permanent Secretary, Cabinet Office, 24 July 2024

Removing disincentives to identifying issues and learning from them

30. We heard a view that some chief executives, when things go wrong, view their role as managing the organisation through a period of turbulence, rather than being curious about the cause. And when it comes to complaints, these can be seen as unwelcome rather than a source of helpful intelligence about the operation of the organisation. Part of the reason for this perspective may be down to how expectations and priorities are communicated. If it is made clear that leaders will be judged by the way they learn from complaints rather than how they manage them, this approach may have a positive impact on behaviour throughout the organisation.
31. One of the perceived barriers to the leaders of organisations escalating concerns to the organisation at the next level in the accountability chain is concern about that organisation’s response. NHS England told us that it is a challenge to find a mechanism to protect and reward people for curiosity without layering on more processes. When concerns are raised in a trust, the regulatory process is engaged and a leader will need to go through a process of reviews and, potentially, special financial measures. As regulation can sometimes be a blunt tool for improvement when used in isolation, NHS England is focused on finding ways to ensure that the leadership and improvement support from the NHS available to trusts means that people feel it is worth raising concerns, asking for help and building a culture of learning.



32. We have discussed how addressing issues is the right thing to do in the public interest, but there is another consideration that leaders would do well to have in mind. With social media, it is becoming harder for organisations to avoid transparency. Organisations that construct a narrative to defend a situation are more likely to be exposed. This creates an opportunity to help people to recognise that it is better to be straightforward and upfront, rather than have to face the consequences for their reputation and career and if they are later revealed to have been responsible for a cover-up.

Recognising and responding to early warning signs

33. We have discussed in this chapter how public office-holders have a duty to speak up when they notice something going wrong and the importance of an organisational culture that values and facilitates open communication between colleagues. In many recent public sector failures, such as those mentioned in this report, there were warning signs that things were not as they should be. These warning signs were either not recognised or, for a variety of reasons, they were not acted on.
34. Public sector leaders have a responsibility to lead organisations that put the public first, and this means recognising mistakes, correcting course when things are going wrong and learning the wider lessons, even when this may be uncomfortable in the short term.
35. It is imperative that leaders make time to reflect on whether their organisation's processes and culture support recognising and responding to early warning signs. We have included in this report suggestions for how this might be achieved by sharing the experiences of people we spoke to from different parts of public life. But each organisation is different and constantly evolving, and what works for one organisation might not be the right approach for another.
36. Our 20 'points for reflection' are intended to help leaders to think deeply about the processes and culture in their organisation and consider whether there are improvements to be made. But the questions are not only for leaders. They are a resource to help public office holders at all levels to challenge their leaders to think about these important matters.
37. The 'points for reflection' must be read alongside the Principles of Public Life. As we explored in chapter 1, the Nolan Principles help to keep the decisions and behaviours of public office holders rooted in the public interest when priorities change and difficulties arise. Hindsight may show decisions to have been flawed – it is futile to expect perfection, but being guided by the Nolan Principles ensures that decisions are taken in the right way, for the right reasons. The public deserves no less.

Appendix 1: Common themes from recent inquiries

1. Failure to listen to and act on concerns raised by employees and/or the public

Windrush Lessons Learned Review

“Our evidence shows individual cases being brought to the attention of the Home Office, and people living in the UK legally feeling the force of Immigration Enforcement measures as far back as mid-2000s, well before the 2014 and 2016 hostile environment measures were in full effect.”¹⁰³

Ockenden Review

“It appears from our survey and interviews, albeit with limited staff numbers engaging, that many staff had raised concerns about safe staffing levels over a protracted period of time. Within the survey, 61% of respondents said that they escalated staffing concerns but just 33% of these received an adequate response.”¹⁰⁴

Infected Blood Inquiry

“One of the most striking aspects of the evidence has been a failure adequately to listen to patients and to hear what they wanted, rather than assume the “listener” already knew.”¹⁰⁵

“It is, in my view, of particular importance that where it is known (as is beyond doubt here) that there is a voice to be heard, but that it is currently speaking in a very quiet whisper, steps must be taken, as best can be done, to enable those who should listen to it to hear it far more loudly.”¹⁰⁶

Grenfell Tower Inquiry

“Some, perhaps many, occupants of Grenfell Tower regarded the TMO [Tenant Management Organisation] as an uncaring and bullying overlord, which belittled and marginalised them, regarded them as a nuisance or worse, and simply failed to take their concerns seriously.”¹⁰⁷

103 Windrush lessons learned review, page 44, 20 March 2020

104 Final report of the Ockenden review, page 187, 30 March 2022

105 Infected Blood Inquiry, Volume 1, page 272, 20 May 2024

106 Infected Blood Inquiry, Volume 1, page 274, 20 May 2024

107 Grenfell Tower Inquiry: Phase 2 report, Volume 3, page 37, 4 September 2024



2. Failure to investigate properly when things went wrong

Windrush Lessons Learned Review

“Ministers set the policy and the direction of travel and did not sufficiently question unintended consequences. Officials could and should have done more to examine, consider and explain the impacts of decisions.”¹⁰⁸

Ockenden Review

“... by early 2009 there was already a systematic failure within the Trust to investigate its maternity services. Following on from their failure to investigate the deaths of Joshua, Thomas and Kate, the Shrewsbury and Telford Hospital NHS Trust completely failed to identify appropriate actions for learning from the deaths of these babies.”¹⁰⁹

“Our consideration of clinical governance processes and documents at the Trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings and some significant cases of concern were not investigated at all.”¹¹⁰

Infected Blood Inquiry

“The NHS did not respond to the infection of thousands of people with HIV and hepatitis, through transfusion or treatment with blood products, by undertaking investigations, providing detailed explanations, making sincere apologies and doing everything that could be done to learn lessons. Instead, what is apparent is a defensive closing of ranks.”¹¹¹

Grenfell Tower Inquiry

“... we consider that more should have been done to investigate the propensity of composite panels to contribute to the downward spread of fire, the adequacy and clarity of the statutory guidance on the construction of external walls, including the suitability of Class 0 as a criterion and whether the use of materials liable to create flaming droplets when exposed to fire ought to be regulated.”¹¹²

108 Windrush lessons learned review, page 7, 20 March 2020

109 Final report of the Ockenden review, page 17, 30 March 2022

110 Final report of the Ockenden review, Executive summary, page xi, 30 March 2022

111 Infected Blood Inquiry, Volume 1, page 190, 20 May 2024

112 Grenfell Tower Inquiry: Phase 2 report, Volume 1, page 143, 4 September 2024

3. Failure of the board to have proper oversight of issues and concerns

Windrush Lessons Learned Review

“In this review, the evidence shows that for the hostile environment measures ministers and officials did not fully consider risks and, after the measures were implemented, gave inadequate attention to understanding their effect, including whether discrimination had occurred. The review also found that mitigating action was insufficient and that ministers and officials neither considered nor requested a broader range of policy options. Arrangements for senior oversight were unclear and unstructured, as were the levels of approval for decisions.”¹¹³

Ockenden Review

“The review has found the Trust leadership team up to Board level to be in a constant state of churn and change. Therefore, it failed to foster a positive environment to support and encourage service improvement at all levels. In addition, the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans.”¹¹⁴

Grenfell Tower Inquiry

“The board of the TMO [Tenant Management Organisation] was the body ultimately responsible for its affairs, including strategic decisions relating to matters affecting fire safety in the buildings it managed. It was therefore important that it be kept informed of developments as they occurred, but regrettably there were many instances in which important information was not drawn to its attention. RBKC [Royal Borough of Kensington and Chelsea] was responsible for the oversight of the TMO which reported to its scrutiny committees. Reports to the scrutiny committees did not always contain the information that might reasonably have been expected.”¹¹⁵

¹¹³ Windrush lessons learned review, page 149, 20 March 2020

¹¹⁴ Final report of the Ockenden review, Executive summary, page x, 30 March 2022

¹¹⁵ Grenfell Tower Inquiry: Phase 2 report, Volume 3, page 14, 4 September 2024



4. Overly defensive organisational culture

Windrush Lessons Learned Review

“Given its [the Home Office’s] sensitivity to public criticism, there is the sense that priorities and decisions have been driven by an overwhelming desire to defend positions of policy and strategy – often at the expense of protecting individuals from the impact of the policies.”¹¹⁶

Ockenden Review

“The Trust consistently demonstrated negative behaviours and practices, resulting in many staff learning to accept poor standards as it became the cultural norm; this constitutes organisational abuse, similar to that found in the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013).”¹¹⁷

Infected Blood Inquiry

“Standing back, and viewing the response of the NHS and of government, the answer to the question “was there a cover up?” is that there has been. Not in the sense of a handful of people plotting in an orchestrated conspiracy to mislead, but in a way that was more subtle, more pervasive and more chilling in its implications. To save face and to save expense, there has been a hiding of much of the truth. This failure to bring the true facts to life has come partly from the inertia of groupthink; but partly, it must be recognised from instinctive defensiveness, to save face and to save expense.”¹¹⁸

Grenfell Tower Inquiry

“The Department [for Communities and Local Government] displayed a complacent and at times defensive attitude to matters affecting fire safety.”¹¹⁹

“... for its part, the TMO ought to have reacted less defensively and, instead of retreating, should have made a greater effort to engage with Mr Daffarn, both on a personal and public level. It allowed its fear and personal mistrust of him and his methods to influence the way in which it engaged with the residents more generally. As custodian of the safety and security of its residents, it must take responsibility for the breakdown in trust.”

116 Windrush lessons learned review, page 90, 20 March 2020

117 Final report of the Ockenden review, page 66, 30 March 2022

118 Infected Blood Inquiry, Volume 1, pages 190 to 191, 20 May 2024

119 Grenfell Tower Inquiry: Phase 2 report, Volume 1, page 10, 4 September 2024

5. Failure to support a ‘speak up’ culture

Ockenden Review

“Many staff members told the review team of the fear of speaking out within maternity services. This included those who are currently working in maternity services at the Trust.”¹²⁰

“During the staff voices interviews some staff stated to the review team that there was a culture of bullying within the leadership team, and that this was not confined to the senior maternity management team but went across the Trust management structure.”¹²¹

Infected Blood Inquiry

“The fifth theme is that of institutional defensiveness, from the NHS and in particular from government, compounded by groupthink amongst civil servants and ministers, and a lack of transparency and candour. These factors drove the response of government over the decades.”¹²²

Grenfell Tower Inquiry

“It is disappointing that when officials became aware of matters which posed serious risks to life, effective steps were not taken to draw those risks to the attention of ministers. The failure to foster a culture in which concerns could be raised and frank advice given represents a serious failure of leadership on the part of ministers and senior officials.”¹²³

120 Final report of the Ockenden review, page 184, 30 March 2022

121 Final report of the Ockenden review, page 67, 30 March 2022

122 Infected Blood Inquiry, Volume 1, page 14, 20 May 2024

123 Grenfell Tower Inquiry: Phase 2 report, Volume 1, page 160, 4 September 2024



6. Poor relationships within the organisation

Ockenden Review

“... there was a culture of ‘them and us’ between the midwifery and obstetric staff, which engendered fear amongst midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes. Unfortunately, these poor working relationships were also witnessed by families, and in some cases mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives. In addition, repeatedly throughout this review we have heard from parents about a lack of compassion expressed by staff either while they were still receiving care or in follow-up appointments and during complaints processes.”¹²⁴

Grenfell Tower Inquiry

“... between 2011 and 2017 relations between the TMO and many of the residents of the tower were increasingly characterised by distrust, dislike, personal antagonism and anger ... for the TMO to have allowed the relationship to deteriorate to such an extent reflects a serious failure on its part to observe its basic responsibilities.”¹²⁵

7. Failure to understand the unintended consequences of policy decisions

Windrush Lessons Learned Review

“Warning flags about the potential consequences of the policy were raised at various stages, in various ways and by various interested parties. Yet ministers and officials were impervious to these warnings because of their resolute conviction that the implementation of the relevant policies was effective, should be vigorously pursued and would achieve the policy intent.”¹²⁶

Grenfell Tower Inquiry

“In the years that followed the Lakanal House fire the government’s deregulatory agenda, enthusiastically supported by some junior ministers and the Secretary of State, dominated the department’s thinking to such an extent that even matters affecting the safety of life were ignored, delayed or disregarded.”¹²⁷

124 Final report of the Ockenden review, page 184, 30 March 2022

125 Grenfell Tower Inquiry, Volume 3, page 40, 4 September 2024

126 Windrush lessons learned review, page 137, 20 March 2020

127 Grenfell Tower Inquiry, Volume 1, page 11, 4 September 2024

8. Failure to learn from past mistakes, or similar incidents and failures

Windrush Lessons Learned Review

“A defensiveness borne of dealing with issues in the past, coupled with an inadequate comprehension of the potential scale and complexity of the problem, led to a lack of curiosity or willingness to learn or reflect.”¹²⁸

Ockenden Review

“In our interactions with families, we have seen clearly that the Shrewsbury and Telford Hospital NHS Trust failed to learn, failed to improve and failed to safeguard families over a prolonged period of time.”¹²⁹

“The review team ... found evidence, over many years, of how a failure to investigate harm appropriately at the time meant learning opportunities were missed and subsequently led to other women suffering similar harm.”¹³⁰

Infected Blood Inquiry

“When it became apparent in the mid 1980s how many people had suffered serious illness as a result of their treatment with blood or blood products by the NHS, there was little apparent effort to establish precisely why that was, and to learn the lessons for the future.”¹³¹

Grenfell Tower Inquiry

“Both the department and BRE [Building Research Establishment] were warned on a number of occasions about the problems that could be caused by the use of combustible materials in the external walls of tall buildings with specific reference to cladding fires that had occurred abroad. Those warnings appear to have generated at best some informal conversations between BRE and the department, but more could and should have been done.”¹³²

“Although we recognise that the Lakanal House fire had particular features that were not directly relevant to what occurred later at Grenfell Tower, there were lessons that could and should have been learnt from it which might have improved the robustness and clarity of the regulatory regime before the Grenfell refurbishment took place.”¹³³

128 Windrush lessons learned review, page 88, 20 March 2020

129 Final report of the Ockenden review, page 149, 30 March 2022

130 Final report of the Ockenden review, page 40, 30 March 2022

131 Infected Blood Inquiry, Volume 1, page 219, 20 May 2024

132 Grenfell Tower Inquiry, Volume 1, page 129, 4 September 2024

133 Grenfell Tower Inquiry, Volume 1, page 143, 4 September 2024



9. Failure to identify emerging themes that might have alerted the organisation to a developing risk

Windrush Lessons Learned Review

“When we were looking for information about specific issues, we found it impossible to access all the complaints, correspondence, press queries, Freedom of Information requests and Parliamentary questions which came into the department before Windrush became a departmental label. This information is held on disparate IT systems, and in no standardised format. The systems monitor response times and service standards rather than the emerging themes that might help the department more broadly as to the full extent of a risk once it’s identified.”¹³⁴

Ockenden Review

“In summary, this was a Trust which had a number of problems, but the perception was that until 2017 the maternity service was not a major risk... The review team believes that the Trust Board and the CCGs [Clinical Commissioning Groups] were ‘reassured’ rather than ‘assured’ with regards to governance and safety within the maternity service. Although independent and external reports consistently indicated that the maternity service should improve its governance and investigatory procedures, this message was lost in a wider healthcare system which was struggling with other significant concerns.”¹³⁵

Infected Blood Inquiry

“It was not until May 1983 that there was within the DHSS [Department of Health and Social Security] any real focus on how best to respond to the risks of AIDS from blood or blood products and that was as a response to press reporting.”¹³⁶

Grenfell Tower Inquiry

“There was no analysis of the lessons to be learnt from significant single incidents, from the identification of patterns across different reporting periods, or from significant fires overseas. The work was being carried out at such a high level of generality that it would have been difficult for BRE [Building Research Establishment] to identify any patterns indicating that changes to the statutory guidance were necessary to ensure that it remained relevant to the risks posed by the built environment.”¹³⁷

134 Windrush lessons learned review, page 88, 20 March 2020

135 Final report of the Ockenden review, page 13, 30 March 2022

136 Infected Blood Inquiry, Volume 4, page 21, 20 May 2024

137 Grenfell Tower Inquiry, Volume 1, page 130, 4 September 2024

Appendix 2: About the Committee on Standards in Public Life

The Committee on Standards in Public Life (CSPL) advises the Prime Minister on ethical standards across the whole of public life in England. It monitors and reports on arrangements for upholding ethical standards of conduct across public life in England. The committee is an advisory non-departmental public body sponsored by the Cabinet Office. The chair and members are appointed by the Prime Minister.

CSPL was established in October 1994, by the then Prime Minister, with the following terms of reference:

“To examine current concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in present arrangements which might be required to ensure the highest standards of propriety in public life.”

The remit of CSPL excludes investigation of individual allegations of misconduct. On 12 November 1997, the terms of reference were extended by the then Prime Minister:

“To review issues in relation to the funding of political parties, and to make recommendations as to any changes in present arrangements.”

The terms of reference were clarified following the Triennial Review of CSPL in 2013. The then Minister for the Cabinet Office confirmed that CSPL “should not inquire into matters relating to the devolved legislatures and governments except with the agreement of those bodies”, and that “the government understands the committee’s remit to examine ‘standards of conduct of all holders of public office’ as encompassing all those involved in the delivery of public services, not solely those appointed or elected to public office”.

CSPL is a standing committee. It not only conducts inquiries into areas of concern about standards in public life but can also revisit those areas to monitor whether and how well its recommendations have been put into effect.



CSPL membership

Doug Chalmers CB DSO OBE, Chair
Professor Gillian Peele
Ewen Fergusson
The Rt Hon Lady Arden of Heswall DBE
John Henderson CB
The Rt Hon Baroness Beckett GBE
Baroness Finn
The Rt Hon Ian Blackford
Councillor Ruth Dombey OBE (from November 2024)

Chair of CSPL's Research Advisory Board

Professor Mark Philp

Secretariat

CSPL is assisted by a secretariat formed of Lesley Bainsfair (Secretary to the Committee), Nicola Richardson (Deputy Head of the Secretariat), Peter Keheller (Senior Policy Adviser), Amy Austin (Senior Policy Adviser) and Lesley Glanz (Executive Assistant). Press support is provided by Maggie O'Boyle.

Declarations of Interest

Members' declarations of interest can be found on CSPL's website and are updated regularly.¹³⁸

Maggie O'Boyle also provides part-time press support to the Office of the Commissioner for Public Appointments, the Advisory Committee on Business Appointments, the House of Lords Appointments Commission, and the Civil Service Commission.

¹³⁸ Committee on Standards in Public Life, available at: www.gov.uk/government/organisations/the-committee-on-standards-in-public-life

Appendix 3: The Seven Principles of Public Life

The Seven Principles of Public Life apply to anyone who works as a public office holder. This includes all those who are elected or appointed to public office, nationally and locally, and all people appointed to work in the Civil Service, local government, the police, courts and probation services, non-departmental public bodies (NDPBs), and in the health, education, social and care services. All public office holders are both servants of the public and stewards of public resources. The principles also apply to all those in other sectors delivering public services.

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty

Holders of public office should be truthful.

Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.



Appendix 4: Stakeholders

Methodology

The committee used the following methods for gathering evidence for the review:

- An open consultation, which received 29 responses.
- 25 individual stakeholder meetings.
- Three roundtables.

Stakeholder meetings

	Organisation	Name and role
1	Cabinet Office	Cat Little, Permanent Secretary
2	Cabinet Office, Public Bodies Team	Lorna Horton, Deputy Director
3	Chartered Institute of Public Finance and Accountancy	Diana Melville, Governance Advisor
4	College of Policing	Chief Constable, Sir Andy Marsh QPM, Chief Executive
5	Confederation of School Trusts	Leora Cruddas CBE, Chief Executive
6	Government Internal Audit Agency	Harriet Aldridge, Chief Executive Karen Holland, Operational director
7	Home Office	Sir Matthew Rycroft KCMG CBE, Permanent Secretary
8	HMRC	Angela MacDonald CBE, Deputy Chief Executive and Second Permanent Secretary
9	Infrastructure and Projects Authority	Nick Smallwood, Chief Executive
10	Local Government Association	Cllr Marianne Overton, Vice-Chair and Leader of the Independent Group Heather Wills, Principal Adviser – Finance and Governance
11	Local Government and Social Care Ombudsman	Amerdeep Somal, Ombudsman Nigel Ellis, Chief Executive
12	Lower Thames Crossing	Matt Palmer, Executive Director
13	National Audit Office	Gareth Davies, Comptroller and Auditor General
14	National Governance Association	Emma Knights, Chief Executive (to August 2024)

Organisation		Name and role
15	NHS England	Amanda Pritchard, Chief Executive Professor Stephen Powis, National Medical Director Steve Russell, Chief Delivery Officer
16	NHS Greater Manchester Integrated Care	Mark Fisher CBE, Chief Executive
17	National Police Chiefs' Council	Chief Constable Gavin Stephens, Chair
18	Nottingham University Hospitals NHS Trust	Anthony May OBE DL, Chief Executive
19	Shrewsbury, Telford and Wrekin Integrated Care Board	Sir Neil McKay, Chair Simon Whitehouse, Chief Executive
20	UK Government Investments	Charles Donald, Chief Executive

Individuals		Name
21	Independent reviewers into public service failures	Dr Bill Kirkup CBE Ken Sutton
22	Independent reviewer into public service failures	Baroness Casey of Blackstock
23	Author of Independent Review of Governance and Accountability in the Civil Service	The Rt Hon Lord Maude of Horsham
24	Former Parliamentary and Health Service Ombudsman	Sir Rob Behrens CBE
25	Academic	John Bowers KC, Principal of Brasenose College, University of Oxford

Roundtables

1	Sponsorship officials from a range of government departments (hosted by Cabinet Office ALB sponsorship team)
2	Working level branch of Cross Government Complaints Forum
3	Chief Executives and Chairs of public bodies (hosted by the Association of Chief Executives and the Public Chairs' Forum)



NHS Greater Glasgow and Clyde Emergency Department Review

March 2025

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Foreword

We would like to thank all the staff within NHS Greater Glasgow and Clyde who participated and contributed to this review for their courage and willingness to share their experiences and concerns with honesty and openness. We recognise that staff are striving to deliver the best care they can despite the unrelenting pressures, difficulties and circumstances within which they are working.

Every member of staff to whom we spoke, at every level of the organisation and from every discipline, were clear in their ambition to improve the current situation for patients and their families. It was evident that all staff are committed to delivering high quality and safe care.

We have conducted this review at a difficult time for the health and care system across the whole of Scotland. The NHS in Scotland is asking teams to deliver consistent high quality care in an ever increasingly complex landscape. At a time of financial and resource constraint, public bodies such as the NHS rely on the goodwill of staff to deliver services. When staff do not feel valued and respected, goodwill is eroded and an effective strategy is required to reduce demand and give hope for better times for staff and patients.

Emergency departments reflect the pressures of the whole system as they are a key point of entry for the public to access healthcare. Stresses in these departments are a marker of challenges across the whole health and social care system from first presentation of illness to final discharge destination.

This review within NHS Greater Glasgow and Clyde has considered relevant national data, and drawn on strengths and learning identified in each of the three emergency departments, to share understanding of good practice together with opportunities for improvement.

We were clear that it was important to hear the views of patients that had accessed the three emergency departments during the relevant time period, and we would like to thank all of the patients that responded to our bespoke patient survey.

In response to the concerns and issues raised in this report, the review has made a range of recommendations for NHS Greater Glasgow and Clyde to take forward.

The review also recognised that the wider urgent and unscheduled care system is also under pressure and is struggling to meet demand. This can only be changed by national, strategic intervention. A coordinated multi-agency response is needed, with clear priorities and strong effective leadership. This intervention must happen quickly to deliver sustained improvements in the quality and safety of care for patients and our communities. The review has therefore set out wider recommendations for the Scottish Government and several national bodies.

As Co-Chairs, we have aimed to conduct this review in a respectful and compassionate manner to encourage staff to feel able to come forward and candidly share their views. We acknowledge this was not always easy for them to do, and we hope that the review findings and recommendations will initiate the journey towards improvement. The time and commitment taken to inform and undertake this review is greatly appreciated and we hope that it can be used as a lever for positive change. We would encourage all NHS boards across Scotland to consider the recommendations made for NHS Greater Glasgow and Clyde within their own systems to identify any opportunities for improvement locally, with their health and social care partners.

Dr Pamela Johnston
Co-Chair

Prof Hazel Borland
Co-Chair

Executive Summary

People rely on urgent and unscheduled¹ care at some of their most vulnerable moments. Having access to urgent and unscheduled care and knowing that care is available if they face a serious or life-threatening illness or injury is a priority for the public.

Yet NHS Scotland's emergency departments – like those elsewhere in the UK – are facing sustained and substantial pressures. These pressures are reflected in deteriorating waiting times, patient flow and quality of care. A key issue for emergency departments is crowding due to the inability to admit patients to hospital wards in a timely way.

NHS Greater Glasgow and Clyde is similarly experiencing a range of pressures. Despite this, staff are extremely committed to providing the best care possible in challenging circumstances. However, patients are clear that long waits in emergency departments are difficult and distressing. One patient illustrated this by saying: *"I spent the night on the trolley in A&E. I was not updated on the expectation of how long I would be there for. It was very cold due to the doors constantly opening. I asked for a second blanket and was kindly given one, as was a drink of water when I asked. But neither the blanket nor water was offered without asking, neither did anyone ask if I was ok, nor any food offered."*

Purpose of the review

This review was initiated in response to significant concerns raised by consultants within the emergency department at the Queen Elizabeth University Hospital. NHS Greater Glasgow and Clyde agreed to fully support the review and to work with Healthcare Improvement Scotland throughout the review process.

The review provides an independent and evidence-based analysis of the key challenges facing the main receiving emergency departments in NHS Greater Glasgow and Clyde at the Queen Elizabeth University Hospital, the Royal Alexandra Hospital and the Glasgow Royal Infirmary. Since NHS Greater Glasgow and Clyde is Scotland's largest NHS board, it is also anticipated that the review will inform wider learning for NHS boards across Scotland.

The review focused on three key areas: patient experience, quality of care and patient safety, and leadership and culture. It considered a range of data and other information about quality of care, patient safety, performance, workforce and inspection reports. It drew on professional and clinical standards. It was also informed by expert opinion, and structured engagement with both staff and patients.

¹What is urgent and unscheduled care? [What is urgent and unscheduled care? - Overview - About urgent and unscheduled care - Urgent and unscheduled care - Healthcare system - Public Health Scotland](#). Public Health Scotland. October 2024.

Summary of findings

This review found that NHS Greater Glasgow and Clyde is facing similar challenges of crowding and poor patient flow as other emergency departments across Scotland and indeed across the UK.

Within NHS Greater Glasgow and Clyde however, there is a need for an explicit, stronger and practical demonstration of whole system working across urgent and unscheduled care. This includes between the three hospitals in the review, between emergency departments and other specialties, and between the NHS board and its associated health and social care partnerships and primary care providers. This needs to be underpinned by compassionate, proactive, respectful and positive leadership at all levels of the organisation, with a commitment to listen and appropriately respond to concerns raised by staff in a timely manner.

The review also found that there has been a serious breakdown in relationships between and within emergency department staff groups at the Queen Elizabeth University Hospital and between emergency department staff and senior leadership/management² in NHS Greater Glasgow and Clyde which is impeding potential solutions.

Patient experience

Patients that responded to a bespoke patient survey carried out for this review reported a largely positive experience of care in emergency departments in NHS Greater Glasgow and Clyde. The majority of patients felt staff provided care in a person-centred way, and that they were treated with dignity and respect. This contrasted with staff perception of patient experience and their view that care was not of a standard they would want to provide.

The improvement to care patients most wanted to see was to reduce waiting times in emergency departments. Where waits occur, there is a need to improve patients' experience of waiting. This includes ensuring patients are given clear communication about how long they may wait, both at arrival and frequently during their wait, and to ensure patients are appropriately supported while they are waiting. Some patients raised concerns about how safe they felt around other patients and visitors to the emergency department.

Quality of care and patient safety

Similar to other emergency departments across Scotland, the sustained and substantial pressures in emergency departments have resulted in an unacceptable normalisation of care in non-standard bed areas (such as in emergency department corridors and other ward spaces) in the Glasgow Royal Infirmary and the Royal Alexandra Hospital. A different approach has been taken in the Queen Elizabeth University Hospital where ambulance stacking has become a normalised solution for emergency department crowding – this is also unacceptable. Both approaches pose risks to patients and are contrary to the requirement that all patients are treated with dignity and respect. We acknowledge that neither approach is unique to NHS Greater Glasgow and Clyde, but it cannot and should not be tolerated.

^{2,2,3} Senior leadership/management here refers to leadership/management at sector director level and above.

The current situation within the emergency departments in NHS Greater Glasgow and Clyde is having a negative impact on staff morale and wellbeing. Staff views reflected serious concerns about insufficient management support to frontline staff at various levels of management across the three hospitals. Staff also raised serious concerns about the quality of care they were able to provide, including patient safety.

The emergency departments are isolated from other specialties and there is insufficient collective ownership across all three hospitals to resolve the serious challenges for the delivery of quality patient care. All parts of the system must take a shared responsibility to develop whole system pathways to improve patient experience and safety in the delivery of urgent and unscheduled care. This includes wider health and social care partners.

Staff described feeling that their health and wellbeing was not explicitly supported during periods of high demand. The review found a need to build a more cohesive approach to the systemic challenges facing urgent and unscheduled care. Systems for learning were not found to be consistent to ensure that safety concerns and risks are identified and reflected on, including incident reporting, significant adverse event reviews and risk management. It was not evident that NHS Greater Glasgow and Clyde is able to consistently commit to investigating and responding to matters of concern in a timely manner and maintain a strong commitment to sharing wider learning with staff and making improvements.

Leadership and culture

The senior leadership at executive and director level of NHS Greater Glasgow and Clyde was not seen as visibly and actively engaged in positively addressing the serious challenges in urgent and unscheduled care. There must be commitment and investment from the Board in a clear programme of NHS board-wide cultural change for the benefit of all patients and staff.

The significant and sustained deterioration in relationships over several years both between teams in the emergency department in the Queen Elizabeth University Hospital, and between staff in the department and senior leadership/management² in NHS Greater Glasgow and Clyde is evidenced by disrespectful behaviours, poor teamwork and incivility.

Clinical leadership roles did not have effective support and appropriate investment to achieve their objectives. These roles are crucial in maintaining a focus on clinical effectiveness, innovation, quality of care, patient safety and experience, and the health, well-being and engagement of staff. Patterns of joint working across specialties and sectors within NHS Greater Glasgow and Clyde were not well established in order to better meet the needs of patients and improve patient flow through the whole system.

There is a strong perception among staff at the point of care that targets and budgetary matters have gained a greater priority for senior leadership/management³ over the quality and safety of care.

Next steps

In summary, evidence examined during this review identified that the current model of urgent and unscheduled care is struggling both in NHS Greater Glasgow and Clyde and nationally; with patients who attend emergency departments suffering the consequences. This has resulted in pressure on acute services leading to non-standard bed care, including corridor care, which is directly impacting on the quality of care for patients. This review did not explore the impact on primary care and community health services.

The national data analysed during this review indicates that despite their best efforts, individual territorial NHS boards have been unable to make sustained improvements to performance in emergency departments in the recent past. This review found that this situation is of critical concern and the status quo cannot continue.

This review makes 41 recommendations, the majority of which are for NHS Greater Glasgow and Clyde and others are wider reflections for Scotland. A national, coordinated, multi-agency response is urgently required to improve the quality and safety of urgent and unscheduled care. With strong leadership, clear prioritisation and a wide commitment across Scotland, change can be achieved.

The recommendations for NHS Greater Glasgow and Clyde largely fall into four areas:

1. Establish a whole system response, and strengthen whole system models of care, to reduce crowding and improve safety in emergency departments. This includes improving patient flow across and outwith the hospitals, establishing a credible response to escalation, and better supporting patients during waits.
2. Improve clinical and care governance processes including systems for learning about safety so staff feel able to raise concerns about patient care and have confidence that actions have been taken forward as a result.
3. Address low staff morale, poor wellbeing and moral distress to drive a significant change to a more positive culture.
4. Improve relationships, leadership and team working at the Queen Elizabeth University Hospital. External mediation is required to re-build relationships within and between teams, and with senior management at director and executive level.

The wider reflections for the NHS across Scotland focus on three main areas:

1. Define new national standards for urgent and unscheduled care to underpin a whole system approach across specialties. This includes eliminating use of non-standard care areas such as corridor care and improving approaches to escalation.
2. Review the current workforce tools for safe staffing levels that are not sufficiently robust in today's context of urgent and unscheduled care.

3. Ensure systems are in place that underpin staff's ability to confidently raise concerns about patient safety.

In NHS Greater Glasgow and Clyde, taking forward these recommendations requires everyone – staff, management and Board members – to commit to building more positive relationships and to enable healing. This means everyone needs to act with humility and take a kinder, more compassionate approach in all interactions.

1. Recommendations

Patient experience

1. NHS Greater Glasgow and Clyde should improve waiting times in emergency departments. Where waits occur, communication with patients about waiting time length should be improved, both at initial arrival and through frequent updates during the wait. People should be appropriately supported during their wait.
2. NHS Greater Glasgow and Clyde should undertake specific engagement with people who are actively waiting in emergency departments to better understand the specific information and support people would find valuable while waiting.
3. NHS Greater Glasgow and Clyde should enable, expect and ensure that all staff involve patients in making decisions about their care.
4. NHS Greater Glasgow and Clyde should ensure patients are provided with information about their follow-up care, including who to contact if their condition worsens, before leaving the emergency departments.
5. NHS Greater Glasgow and Clyde should take action to reduce patients' concerns about personal safety around other patients/visitors in emergency departments to create a safer, more secure environment.
6. NHS Greater Glasgow and Clyde should provide more opportunities to ask patients about their experience of using emergency departments and clearly demonstrate how this feedback is valued and used to continually drive improvements and shape services.
7. NHS Greater Glasgow and Clyde should enable and expect all staff to treat patients with dignity and respect and provide suitable surroundings for this to occur.

Quality of care and patient safety

8. NHS Greater Glasgow and Clyde, and its six aligned Health and Social Care Partnerships, should strengthen their whole system unscheduled care plan to urgently reduce use of non-standard care areas, improve waiting times and reduce crowding by addressing:
 - management of patient flow and redirection
 - referral pathways to specialties from within and outwith the emergency departments
 - delayed discharges, and
 - models of care, same day delivery of care options and consideration of maximising 24/7 services including flow navigation.

9. NHS Greater Glasgow and Clyde should ensure its escalation and business continuity plans are practical and effective in addressing pressures at each hospital and are implemented across the whole system to ensure there is good awareness and ownership of them by teams across the hospitals. The effectiveness of the plans should be monitored and regularly reviewed through appropriate NHS board governance structures.

10. NHS Greater Glasgow and Clyde must demonstrate recognition of the low morale, poor wellbeing and moral distress among staff and take actions to address these. This should include engaging with staff in all three emergency departments to identify appropriate improvement actions needed beyond the other recommendations covered in this review.

11. NHS Greater Glasgow and Clyde must take action to protect the physical safety of staff from aggressive behaviour by patients.

12. NHS Greater Glasgow and Clyde should identify and make the necessary improvements to the physical environment in the emergency departments at Glasgow Royal Infirmary and the Royal Alexandra Hospital and to staff facilities, including spaces for teams to easily meet, across all three hospitals, to ensure the environment is as safe and supportive as possible for staff and patients.

13. NHS Greater Glasgow and Clyde must improve its systems for learning about safety concerns including the use of significant adverse event reviews, post-incident debriefs and incident reporting. It must enhance its processes for sharing learning and feedback with staff and making improvements in response to learning.

14. NHS Greater Glasgow and Clyde should review the risk management processes for emergency departments to ensure they provide an accurate and comprehensive assessment of current risks and steps being taken to mitigate these, with appropriate regular monitoring and oversight. The risks need to reflect the impact on quality and outcomes for patients rather than purely focusing on performance.

15. NHS Greater Glasgow and Clyde must undertake a comprehensive multi-disciplinary workforce review, utilising the Common Staffing Method, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

16. NHS Greater Glasgow and Clyde should prioritise introducing robust systems and processes for the assessment of real time staffing and the escalation and monitoring of severe and recurrent risk, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

17. NHS Greater Glasgow and Clyde should ensure that staff are given the time and resources to undertake required training to undertake their role, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

Leadership and culture

18. NHS Greater Glasgow and Clyde's board must ensure that compassion and respect are at the centre of the leadership culture demonstrated through behaviours that enable the values of NHS Scotland to be consistently upheld.

19. NHS Greater Glasgow and Clyde should take urgent action to collectively heal the relationships across and within staff groups and sector and corporate management levels. This is a critical step to establish shared responsibility for the delivery of safe urgent and unscheduled care with visible leadership from the corporate management team and strong clinical leadership at a local level. The aim should be to devolve authority and responsibility as much as possible to team leaders at the service level, supported by greater availability, visibility and responsive support from senior and sector leaders. The solutions and outcome should be jointly owned by all involved.

20. NHS Greater Glasgow and Clyde should commission urgent and credible external mediation within and between Queen Elizabeth University Hospital emergency department professional teams (medical and nursing) and separately for mediation between the professional teams and senior management (sector and corporate) in NHS Greater Glasgow and Clyde to support improved professionalism and team working amongst consultants, nursing staff and management.

21. NHS Greater Glasgow and Clyde should ensure sector management at the Glasgow Royal Infirmary are engaged and responsive to the needs of staff at the point of care to ensure that patient care and safety receive the necessary management attention and intelligent action.

22. NHS Greater Glasgow and Clyde should ensure sector management focus at the Royal Alexandra Hospital appropriately balances emergency department performance and flow in line with maintaining and managing the quality and safety of care.

23. NHS Greater Glasgow and Clyde should ensure job plans appropriately reflect the time and support required to undertake the clinical director, deputy clinical director and clinical lead roles across all three sites.

24. NHS Greater Glasgow and Clyde should review the appropriate use of the clinical and care governance framework for systematically and consistently escalating serious concerns.

25. NHS Greater Glasgow and Clyde should strengthen multi-disciplinary input to the clinical governance arrangements as these currently appear to be too reliant on the singular voice and participation of the medical profession.

26. NHS Greater Glasgow and Clyde should ensure that all staff feel able to speak up and their voices are consistently heard at all levels of management – especially in matters related to safety – and that there is confidence that individuals will be protected, and their concerns acted upon. Specifically, there is a need to ensure that the current NHS Greater Glasgow and Clyde whistleblowing procedures are known, understood, effective and trusted. This is particularly relevant for staff at the Queen Elizabeth University Hospital. It is vital that staff have confidence in the board's commitment to the National Whistleblowing Standards and the Public Interest Disclosure Act 1998.

27. NHS Greater Glasgow and Clyde needs to enhance its governance of the operational management of urgent and unscheduled care. This includes ensuring robust documentation, transparency in decision-making, and greater involvement of clinicians in the design and delivery of care.

28. NHS Greater Glasgow and Clyde needs to adopt a balanced approach to sector leadership, ensuring that the quality and safety of care is not inappropriately overshadowed by other performance targets or financial considerations.

29. NHS Greater Glasgow and Clyde needs to ensure there is an active engagement and participation across the clinical leadership and wider community in the delivery of the Board's recently approved quality strategy.

30. NHS Greater Glasgow and Clyde should establish a stronger commitment to a unified approach across all sectors. This should be based on clearly defined care pathways and suitable admitting rights, supported by appropriate operational structures and a well-trained and nurtured workforce in all emergency departments throughout NHS Greater Glasgow and Clyde.

National Recommendations

Scottish Government

31. Scottish Government should commission Healthcare Improvement Scotland to lead the development of a national approach to improving the quality and safety of urgent and unscheduled care in NHS Scotland, consistent with the Quality Management System, including the development of national standards in partnership with a range of agencies including the Royal Colleges. This will build on work already commenced by The Centre for Sustainable Delivery and include urgent work needed to work towards eliminating the unacceptable use of non-standard care areas given the risks to patients and the impact on staff. This will require significant national focus and support.

32. Scottish Government should explore with Healthcare Improvement Scotland how best to gather patient views about experiences of accessing urgent and unscheduled care services and waiting in emergency departments to inform more detailed national recommendations on how to improve the patient experience and shape services for the future.

33. Scottish Government should engage with relevant national agencies to commission a review of the national guidance for specific health and care demand, capacity escalation and business continuity, which recognises the need to ensure a credible, robust and practical whole system response. This is essential and complementary to the current Multi Agency Major Incident Guidance.

34. Scottish Government should engage with relevant national agencies to commission a review of the professional advisory committee arrangements in NHS boards to ensure they have a transparent, independent and objective mechanism for the board to consider matters of safety and concern. There is an opportunity to refresh the previous national guidance and make these arrangements clearer and more open for all professions to understand.

Public Health Scotland

35. Reliable and comparable whole-system datasets are essential to support improvement in urgent and unscheduled care and optimise flow through the health and social care system. Public Health Scotland should be commissioned by Scottish Government to work with other national and local partners with the aim of progressing existing work and further developing datasets that are designed with, and available to NHS boards to support continuous improvement.

The Centre for Sustainable Delivery

36. The Centre for Sustainable Delivery should strengthen its collaboration with territorial and national NHS boards to engage in improvement activities aimed at:

- Reducing unwarranted variation in urgent and unscheduled care performance to enhance the quality and experience of care, as well as patient outcomes.
- Rethinking access to urgent and unscheduled care to ensure equity and that individuals are treated in the right place, the first time.
- Ensuring appropriate representation, including clinical leaders, in the recently formed Strategic Delivery Groups to drive improvement, set standards, and deliver change.
- Participating in the acute hospital site visit process to ensure that change is driven by clinical teams and tailored to meet the needs of local communities.

NHS Education for Scotland

37. NHS Education for Scotland should strengthen and further develop structured development programmes to identify and support clinical and non-clinical leaders in NHS Scotland. These programmes will enable NHS boards to focus on developing whole system multidisciplinary working and relationships which foster innovation, improvement and inclusivity in decisions that explicitly benefit quality of care and patient safety

38. NHS Education for Scotland should be supported by Scottish Government to explore the implications, and work towards the shift to whole time equivalent medical trainee recruitment in order to strengthen the learning experience, reduce gaps in service and build a more sustainable, effective medical workforce for the future.

39. The review has highlighted the critical role of effective and supportive leadership by the NHS Board. It is recommended that the Scottish Government commission NHS Education for Scotland to evaluate the current national and local induction and support arrangements for NHS Non-executive Board Members. This evaluation should aim to identify and implement any necessary improvements to ensure that Non-executive Board Members can perform their roles as effectively as possible, and consistent with the requirements set out in the NHS Scotland Blueprint for Good Governance.

Healthcare Improvement Scotland

40. The review has identified that the tools for appropriate staffing levels with regard to emergency departments are not sufficiently robust. Healthcare Improvement Scotland's Healthcare Staffing Programme should prioritise the development of new tools which reflect the current operating context and multi-disciplinary working to ensure safe and effective care.

41. Healthcare Improvement Scotland should collaborate with the Independent National Whistleblowing Officer, and other relevant bodies, to develop clear and unambiguous guidance for staff in NHS boards on the national routes for staff to raise concerns under Whistleblowing and the Public Interest Disclosure Act. This will enable NHS boards to ensure that they have effective arrangements in place and improve staff awareness and understanding.

2. The Review Structure, Scope and Methodology

This section provides information about the background, aim and scope of this review. It also sets out the methodology which was used to carry out the review.

Background

- 2.1. Healthcare Improvement Scotland announced this review on 4 April 2024. The original terms of reference for the review were to focus on the Queen Elizabeth University Hospital emergency department.
- 2.2. The subsequent and final terms of reference, published in July 2024 (see Appendix 2), extended the scope to include the Glasgow Royal Infirmary and the Royal Alexandra Hospital.³

Aim of the review

- 2.3. The aim of the review was to:
 - Provide an evidence-based, balanced, objective and proportionate analysis of the key challenges facing the emergency department at the Queen Elizabeth University Hospital.
 - Consider any wider implications for the emergency departments at the Royal Alexandra Hospital and the Glasgow Royal Infirmary.
 - Offer support to NHS Greater Glasgow and Clyde to identify practical, evidence-based and sustainable actions that may be required to improve quality and safety in emergency departments in NHS Greater Glasgow and Clyde.
 - Consider any wider evidence-based learning for emergency departments and NHS boards across NHS Scotland.

Scope of the review

- 2.4. The review was undertaken by Healthcare Improvement Scotland in the context of its existing legal powers and statutory duties.

³ NHS Greater Glasgow and Clyde Emergency Department Review. [GGC-ED-Review-ToR-July-2024.pdf](#). Healthcare Improvement Scotland. July 2024

- 2.5. The review has adopted the guiding principles and other appropriate elements of the Healthcare Improvement Scotland *Quality Assurance System Framework*⁴ and the Healthcare Improvement Scotland *Essentials of Safe Care*⁵. The *Quality Assurance System* is underpinned by five core guiding principles, with the central principle being ‘user focus’. This reflects that people’s rights when accessing healthcare services, the outcomes of the care they receive, and their views and experiences of that care, are central to Healthcare Improvement Scotland’s quality assurance work.
- 2.6. Consistent with the original terms of reference, the review has considered relevant national data and drawn on strengths and learning identified in each of the emergency departments to share understanding of good practice, along with potential improvements in:
- **Patient Experience:** the extent to which individuals receive timely, person-centred care; and the extent to which patient feedback and wider community engagement informs the planning and delivery of services
 - **Safety:** the extent to which patients are treated in a safe environment and are protected from avoidable harm.
 - **Leadership and Culture:** the extent to which the service is well led, supported by robust governance arrangements, effective working relationships and team working, and has a supportive culture both within and beyond the emergency department.

Approach

- 2.7. The review has focused on assessment and evaluation of relevant systems and processes within NHS Greater Glasgow and Clyde. It did not consider the detail of individual patient cases. The review has drawn upon the following:
- A range of sources of data and information including quality of care and patient safety data, relevant performance data, safe delivery of care inspection reports, patient experience data, workforce data and staff experience data. This has included publicly available data, data and evidence provided by NHS Greater Glasgow and Clyde, and data provided by Public Health Scotland.

⁴ [The quality assurance system and framework – Healthcare Improvement Scotland](#). Healthcare Improvement Scotland. 2022

⁵ [Essentials of safe care | Scottish Patient Safety Programme \(SPSP\) | ihub - SPSP Essentials of Safe Care](#). Healthcare Improvement Scotland. 2021

- Evidence from proportionate engagement with patients (primarily via a questionnaire with follow-up conversations if requested), a range of staff groups with a combination of group and individual discussions, a confidential mailbox and a staff survey, to obtain their views and perspectives on the safety and quality of care, culture, experience of raising concerns, and areas for improvement.
- Recognised professional and clinical standards where available, and relevant best practice principles and/or expert opinion to inform assessments of the above.

Leadership for the review

Core Review Group

- 2.8. A Core Review Group was established in May 2024 with terms of reference published in July 2024.⁶ The Core Review Group was co-chaired by Dr Pamela Johnston, former Medical Director at NHS Tayside, and Professor Hazel Borland, former Nurse Director and Deputy Chief Executive, at NHS Ayrshire and Arran.
- 2.9. The Core Review Group comprised external and internal representatives and clinicians (membership at Appendix 3). The Core Review Group was responsible for the effective and efficient conduct of the review and the achievement of its aims within the agreed scope of the review. The Core Review Group was supported by dedicated programme management staff.
- 2.10. The Core Review Group formed three sub-groups to enable delivery of this work covering:
 - Staff and patient experience
 - Quality of care and patient safety
 - Leadership and culture.

External Reference Group

- 2.11. An External Reference Group was also established, and the terms of reference were published in July 2024⁷. It was chaired by Professor Sir Lewis Ritchie OBE FRSE, James Mackenzie Professor of General Practice, University of Aberdeen.

⁶ NHS Greater Glasgow and Clyde Emergency Department Review. [GGC-ED-Review-ToR-July-2024.pdf](#). Healthcare Improvement Scotland. 2024

⁷ NHS Greater Glasgow and Clyde Emergency Department Review. [GGC-ED-review-ERG-ToR-July-2024-1.pdf](#). Healthcare Improvement Scotland. 2024

- 2.12. The External Reference Group has operated as a consultative body and worked closely with, and supported the work of, the Core Review Group through constructive challenge and provision of expert advice, sharing of specialist knowledge, expertise, and national or operational perspective. The intention of this input was to help assure that the review met its stated objectives and was of appropriate quality in respect of both the methodology and approach to how the review would be conducted, and the findings and outputs of the review.
- 2.13. The External Reference Group met on six occasions throughout the review offering advice, support and constructive challenge on the process, findings and recommendations of the Core Review Group. The Core Review Group also availed itself of the opportunity to seek the assistance of the specific expertise of individual members of the External Reference Group where appropriate. All External Reference Group members received a confidential copy of the draft Review Report. All members subsequently provided separate individual comments for consideration by the Core Review Group and Healthcare Improvement Scotland.

Executive leadership

- 2.14. The Executive Sponsor of the review was Robbie Pearson, Chief Executive of Healthcare Improvement Scotland. The Senior Responsible Owner was Lynsey Cleland, Director of Quality Assurance and Regulation, from 4 April until 31 October 2024 and Ann Gow, interim Director of Quality Assurance and Regulation, and Deputy Chief Executive, from 1 November 2024 to 31 March 2025. Jane Byrne, Head of Multiagency Inspections, was the Programme Director responsible for operational delivery within Healthcare Improvement Scotland.
- 2.15. Latterly the senior leadership of the review has been enhanced with leadership support from Clare Morrison, Director of Engagement and Change, at Healthcare Improvement Scotland.

Undertaking the review

Introductory meetings

- 2.16. Three introductory meetings took place at the beginning of the review process to discuss the terms of reference for the review, the planned approach for the review and to seek initial feedback.

- 2.17. On 30 May 2024, an introductory meeting (in-person) was held with the members of the NHS Greater Glasgow and Clyde executive team. Participants were:
- Co-Chairs of the review
 - NHS Greater Glasgow and Clyde – Chief Operating Officer (acute), Executive Medical Director, Deputy Medical Director (acute), Executive Nurse Director, and
 - Healthcare Improvement Scotland – Director of Quality Assurance and Regulation, Head of Multiagency Inspections.
- 2.18. On 30 May 2024, an introductory meeting (in person) was held with emergency department consultants at the Queen Elizabeth University Hospital. Participants were:
- Co-Chairs of the review
 - NHS Greater Glasgow and Clyde – 13 emergency department consultants, and
 - Healthcare Improvement Scotland – Medical Director, Director of Quality Assurance and Regulation, Head of Multiagency Inspections.
- 2.19. On 13 June 2024, a second introductory meeting (by MS Teams) was held with emergency department consultants at the Queen Elizabeth University Hospital. Participants were:
- Co-Chairs of the review
 - NHS Greater Glasgow and Clyde – seven emergency department consultants, and
 - Healthcare Improvement Scotland – Medical Director, Director of Quality Assurance and Regulation, Head of Multiagency Inspections.

High level findings meeting

- 2.20. On 6 February 2025, a meeting was held (by MS Teams) with representatives from NHS Greater Glasgow and Clyde to share the high-level findings of the review. Participants were:
- Co-Chair⁸ of the review
 - Chair of the Review External Reference Group

⁸ Only one of the Co-Chairs attended on this occasion.

- NHS Greater Glasgow and Clyde – Chief Operating Officer (acute), Deputy Medical Director (acute), Deputy Nurse Director (acute), single point of contact for the review;⁹ and
- Healthcare Improvement Scotland – Interim Director of Quality Assurance and Regulation and Deputy Chief Executive, Associate Director of Quality Assurance and Regulation.

Key lines of enquiry

- 2.21. In July 2024, each of the three review sub-groups defined key lines of enquiry that were used to identify the evidence that was required to be gathered. These were developed from the scope of the review as set out in the terms of reference, and the focus was refined where appropriate as the review progressed.
- 2.22. Staff and patient experience sub-group key lines of enquiry:
- What are staff's experience of working in the emergency department?
 - What are staff's experience of the staffing provision/resource within the emergency department?
 - What are staff's experience of NHS Greater Glasgow and Clyde's organisational leadership and culture?
 - What are patients' experience of accessing the care and services they required?
 - What are patients' experience on arrival at the emergency department?
 - What are patients' experience of the care they received in the emergency department?
 - What are patients' experiences of providing feedback on the care they received in the emergency department?
- 2.23. Leadership and culture sub-group key lines of enquiry:
- **Is the service well-led?** There is a clear and well-communicated vision and purpose that aligns with its goals and values. The services should be designed with collaborative input from staff, patients, and other stakeholders.
 - **Are robust governance arrangements in place?** There is strong leadership promoting a positive culture, accountability, and transparency.

⁹ The single point of contact for the review was a staff member nominated by NHS Greater Glasgow and Clyde to work with Healthcare Improvement Scotland to support the coordination of the review.

- **Is there effective team working?** There is collaborative working within and between teams, and involving all relevant stakeholders in the design and delivery of services.
- **Is there a supportive culture?** A supportive culture encouraging respect, collaboration, and well-being among staff.

2.24. Quality of care and patient safety sub-group key lines of enquiry:

- Do individuals receive timely, person-centred care when accessing the emergency department?
- Are patients treated in a safe environment and protected from avoidable harm when accessing the emergency department?
- What are the outcomes for people accessing care in the emergency department?
- How well is flow of patients through the emergency department monitored and managed (what and where are the barriers to flow)?
- Is staffing in the emergency department appropriate, numbers, skills mix etc?
- How are real time staffing concerns monitored and escalated within the emergency department, and what mitigations are in place?
- How are real time staffing concerns responded to and acted on?

Familiarisation visits

- 2.25. In order to understand the physical environment of the three emergency departments and to observe ways of working in each, the Core Review Group's Co-Chairs, along with medical and nursing members of the Core Review Group, conducted half-day visits to the three emergency departments during the day on 4 and 5 September 2024.
- 2.26. During these familiarisation visits, Core Review Group members spoke with staff who were on shift at the time. The time available during the visits meant there was limited scope to discuss matters in detail. In response, the Core Review Group decided it would be beneficial to offer an opportunity for any member of staff to be able to speak with a Core Review Group member, and this was arranged.
- 2.27. Members of the Core Review Group visited the three emergency departments again on Sunday 1 December 2024 to observe ways of working in the early to late evening period, and to speak with members of staff on shift at the time.

On-site visits

- 2.28. Core Review Group members visited the emergency department at each of the three hospitals for planned activities as follows:
- Queen Elizabeth University Hospital – 30 and 31 October 2024
 - Royal Alexandra Hospital – 6 November 2024
 - Glasgow Royal Infirmary – 7 November 2024.
- 2.29. The on-site visits were planned with the support of NHS Greater Glasgow and Clyde. The timetables for the on-site visits included visits to clinical areas; observation of hospital and department huddles; safety pauses and handovers; and planned discussion sessions with different groups of staff. Healthcare Improvement Scotland specified the groups of staff to include in these discussions, and staff in these groups were identified by NHS Greater Glasgow and Clyde. The on-site visits were promoted to staff via information bulletins.
- 2.30. In addition to the planned activities, site visits also included opportunities for any staff member to “drop-in” to speak confidentially with members of the Core Review Group. Additionally, Core Review Group members spoke with staff during visits to the clinical areas, and at the huddles, safety pauses and handover sessions.
- 2.31. A total of 128 staff were engaged with during the planned and drop-in sessions. Staff were within the following groups: emergency department consultants and medical management, emergency department nursing and nurse management, emergency department management (general, clinical services and sector), allied health professionals, Scottish Ambulance Service staff and hospital ambulance liaison officers, administrative and clerical staff, staff from facilities, domestic services and portering, partnership forum representatives, and human resources staff.

Individual staff discussions

- 2.32. Opportunities for staff to have individual, confidential discussions with members of the Core Review Group via MS Teams were offered to staff during October and November 2024. Staff were made aware of this opportunity through a written information bulletin circulated by NHS Greater Glasgow and Clyde on behalf of the review team. This bulletin also highlighted the other options for engaging with the review (on-site visits, email to a confidential inbox and staff survey).

- 2.33. Around 30 staff from all three emergency departments participated in individual discussions. This included a range of staff from medical, nursing and management roles. Since the discussions were confidential, staff roles are purposively described here at a high level. Whenever possible, the staff role was matched to the professional role of a relevant Core Review Group member to enable a peer-to-peer discussion.

Senior leadership discussions

- 2.34. The Co-Chairs of the Core Review Group met with members of the NHS Greater Glasgow and Clyde senior leadership team¹⁰ during the weeks commencing 18 and 25 November 2024. In total, 15 meetings took place by MS Teams.
- 2.35. The purpose of the sessions was to understand senior leaders' perspectives on the issues that had been identified, and to seek clarification and further understanding on matters that had emerged during the review.

Confidential email submissions

- 2.36. A dedicated email mailbox was opened at the start of the review in April 2024 to enable staff to confidentially share information relevant to the review. The mailbox address was provided to emergency department consultants at a face-to-face meeting on 31 May 2024. It was subsequently shared with staff in all three emergency departments via information bulletins sent by NHS Greater Glasgow and Clyde. The mailbox address was also included in later materials shared with staff about the staff survey, such as on posters displayed in the emergency departments.
- 2.37. Sixty-seven submissions of information were sent to the confidential email mailbox during May to November 2024. Submissions were predominantly received from emergency department consultants from the three sites (85%) and a number made several submissions to the mailbox. A smaller number of submissions were received from other staff groups including nursing staff and other medical professionals. Since submissions were confidential, staff roles are purposively described here at a high level.

¹⁰ NHS Greater Glasgow and Clyde senior leadership team members involved were: Previous Clinical Director, South, South Sector Director and Queen Elizabeth University Hospital Triumvirate, Chief Officers, West Dunbartonshire HSCP and Renfrewshire HSCP and Co-chairs of UUC Board, Clyde Sector Director and Royal Alexandra Hospital Triumvirate, Chief Executive, Director of Clinical and Care Governance, Executive Director of Nursing, Chair, NHS Greater Glasgow and Clyde, Chief Operating Officer, Chair of the Area Clinical Forum, Director of Human Resources and Organisational Development, Employee Director, Deputy Nurse Director, Medical Director and Chair of the Acute Clinical Governance Committee, Chair of the Area Partnership Forum. Sessions were also held with the Deputy Medical Director - Primary Care and the Clinical Director for GP Out of Hours Services in October 2024.

Staff experience survey

- 2.38. In addition to the on-site sessions and individual discussions, staff were also offered an option of sharing their experiences via a staff experience survey. The survey was available for the month of November 2024. The survey was highlighted to staff in an information bulletin shared by NHS Greater Glasgow and Clyde to all staff based in the three emergency departments, as well as on posters displayed in the departments which aimed to reach staff who worked in peripatetic roles but were regularly in the department (e.g. portering, administrative roles).
- 2.39. The staff survey primarily used an electronic MS Forms format and collected responses anonymously. A hyperlink to the form was included in the information bulletin or could be accessed via a QR code on the posters. A key reason for a staff survey being included in the range of approaches to gathering staff experience was to provide an anonymous option. To ensure accessibility, staff could also request a paper copy of the survey for completion.
- 2.40. The survey included a mixture of multiple choice and open-ended questions. Questions were adapted from three validated questionnaires that focused on safety in emergency departments: Petrino et al (2023)¹¹, SECURE¹² and safety in the wider healthcare environment – the Safety Attitudes Questionnaire (SAQ)¹³. The questions were developed to reflect the staff and patient experience sub-group's key lines of enquiry and were refined with the sub-group's input.
- 2.41. A Data Protection Impact Assessment was completed to ensure compliance with data protection requirements.

Patient experience survey

- 2.42. Patient experience was gathered from a random sample of patients who had a documented attendance at one of the three emergency departments included within the review.

¹¹ Petrino, R., Tuunainen, E., Bruzzzone, G. and Garcia-Castrillo, L. Patient safety in emergency departments: a problem for health care systems? An international survey. *European Journal of Emergency Medicine*, 30(4), pp.280-286; 2023.

¹² Flowerdew, L. and Tipping, M. SECURE: a multicentre survey of the safety of emergency care in UK emergency departments. *Emergency Medicine Journal*, 38(10), pp.769-775; 2021.

¹³ Sexton, J.B., Helmreich, R.L., Neilands, T.B., Rowan, K., Vella, K., Boyden, J., Roberts, P.R. and Thomas, E.J. The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. *BMC health services research*, 6, pp.1-10; 2006.

- 2.43. The primary method of gathering patient experience was using a survey that could be completed electronically (accessed via a link or QR code), by a paper questionnaire using a reply-paid envelope, or by telephone. Providing these different options was vital to avoid accessibility barriers to participating. In addition, patients were invited to opt in to participate in a follow-up individual interview if they wished to provide further information beyond the questions covered in the survey.
- 2.44. The survey included a mixture of multiple choice and open-ended questions. It was designed using the staff and patient experience sub-group's key lines of enquiry and was informed by the Care Quality Commission's emergency care survey.¹⁴ Permission was sought from the Care Quality Commission to use and refine some of the questions from its survey, which was granted providing an acknowledgement was given in this report. The questions were developed iteratively with input from the staff and patient experience sub-group. The survey can be accessed here.¹⁵
- 2.45. The Care Quality Commission's survey provided a benchmark to estimate a 20% response rate to the survey. This provided an aim of 380 responses across all three sites which would give a +/-5% confidence interval (error rate) at the 95% confidence level. This is a standard level of feedback considered robust in statistical terms for a large population size in social research.
- 2.46. A stratified random sample of patients who had attended one of the three emergency departments included in the review was generated by NHS Greater Glasgow and Clyde from their patient records system using a sample frame provided by Healthcare Improvement Scotland. The sample required patients to have attended one of the specified emergency departments over the past year stratified by age and sex, and month and location of attendance.
- 2.47. An initial sample of 2,000 patients was generated for contact by post. Letters inviting patients to participate by paper/electronic/telephone with copies of the paper questionnaire were printed by a mail/print firm and supplied in pre-prepared envelopes to NHS Greater Glasgow and Clyde where labels were added to the envelopes which were then franked. The letters/questionnaires were posted to patients in batches between 31 October and 4 November 2024. The deadline for completing the survey was 29 November 2024, giving patients around three weeks to complete the survey. A second sample of 6,000 patients was sent a text message with a link to the electronic survey on 26 November 2024. We acknowledge NHS Greater Glasgow and Clyde's support for the sampling and distribution of the patient survey.

¹⁴ <https://www.cqc.org.uk/publications/surveys/urgent-emergency-care-survey>. Care Quality Commission. 2024

¹⁵ [NHS Greater Glasgow and Clyde Emergency Department Review 2025 – Patient Experience Survey – Healthcare Improvement Scotland](#)

- 2.48. A Data Protection Impact Assessment was completed to ensure compliance with data protection requirements.

Other sources of evidence

- 2.49. Initial information was gathered through four sources: information and data submitted via a Healthcare Improvement Scotland “Responding to Concerns” process¹⁶ that led to this review; existing data and information relating to safe delivery of care hospital inspections in NHS Greater Glasgow and Clyde; information from NHS Education for Scotland about clinical staff training including medical trainee and student nurse feedback; and data from Public Health Scotland.
- 2.50. A gap-analysis of the evidence was then undertaken by the review’s Co-Chairs, the three review sub-groups and subject matter experts. This resulted in bespoke evidence requests to NHS Greater Glasgow and Clyde.
- 2.51. The evidence sourced and reviewed included:
- Organisational arrangements in place in NHS Greater Glasgow and Clyde including organisational structures, bed numbers, capacity, governance arrangements, performance reporting and tracking.
 - A range of relevant NHS Greater Glasgow and Clyde policies and operational processes including flow, redirection, escalation, risk assessment, staffing monitoring and escalation, on-call arrangements and patient pathways.
 - Healthcare Improvement Scotland recent safe delivery of care inspection reports for the three hospitals included in the review.
 - Minutes of NHS Greater Glasgow and Clyde meetings including: board meetings, emergency department meetings, partnership forum, area clinical forum, unscheduled care oversight board, acute clinical governance forum, acute strategic management group.
 - Workforce information including workforce data, needs analyses, rotas, information on staff in training from NHS Education for Scotland, reports of staffing concerns, medical trainee and student nurse feedback.
 - National datasets of key measures in emergency departments, mostly held by Public Health Scotland.
 - Medical and nursing handover documents.
 - Safety huddle notes.
 - Incident and Datix reports.
 - iMatter reports.

¹⁶ [Healthcare Improvement Scotland \(HIS\) process for responding to concerns](#). Healthcare Improvement Scotland. March 2024

Analysing the evidence

Initial analysis

- 2.52. The initial body of data and evidence was consolidated in a single location and in the first instance was reviewed for relevance to the areas of focus for the review. Subject matter experts within three sub-groups of the review assessed the initial evidence and undertook a gap analysis against their key lines of enquiry. Additional evidence identified through the gap analysis was sought either directly from NHS Greater Glasgow and Clyde or from other relevant sources. Areas where further information was required were followed up through engagement with NHS Greater Glasgow and Clyde.
- 2.53. An independent researcher commissioned by Healthcare Improvement Scotland supported the work of the Core Review Group by undertaking thematic analysis of qualitative data relating to staff experience. The researcher undertook the analysis from 30 October to 9 December 2024. The Core Review Group considered this analysis alongside the other evidence available to them when triangulating the key themes emerging from the review.
- 2.54. Relevant domains, criteria and indicators from Healthcare Improvement Scotland's Quality Assurance Framework and Scottish Patient Safety Programme Essentials of Safe Care were used to guide the assessment of the evidence. Additional references of relevance, such as the indicators of a high-quality care culture produced by The King's Fund¹⁷ were mapped to the criteria as appropriate.

Review of medical and nursing shift handover documents

- 2.55. A number of medical and nursing shift hand-over documents were included in the body of evidence as described above. These documents describe each shift in the emergency department and contain information of relevance to hand over to the incoming emergency department teams at shift changeover.
- 2.56. During the course of the review, consultants from the Queen Elizabeth University Hospital proactively shared examples of handover documents as evidence of particular issues of concern within the emergency department on given days.

¹⁷ Collins B. Staff Engagement; Six building blocks for harnessing the creativity and enthusiasm of NHS staff. [The King's Fund – Improving NHS Culture](#); 2015.

- 2.57. A range of other nursing and medical hand-over documents were available to the review within evidence previously supplied for recent safe delivery of care inspections in the Queen Elizabeth University Hospital and Glasgow Royal Infirmary. These documents, amounting to approximately 120 examples, were considered by the Core Review Group. They also formed part of the qualitative dataset reviewed by an independent analyst. Themes and observations arising from the consideration of these have informed the review.
- 2.58. To allow a balanced and objective view of the general functioning of all three departments a further sample of hand-over documents was requested. The sample included periods of interest relating to safety, using 12 hour waits as a proxy measure. In addition, a sample drawn from mid-October – mid-November 2024 was requested from each site to correspond with the period of the review's engagement activity.
- 2.59. NHS Greater Glasgow and Clyde provided the requested sample for the Queen Elizabeth University Hospital and Glasgow Royal Infirmary. There was no sample supplied for the Royal Alexandra Hospital emergency department. It was advised that the Royal Alexandra Hospital emergency department does not record shift handovers in this way.
- 2.60. A systematic review of this further sample of 141 shift handover documents was carried out. This was with the aim of determining if these additional reports demonstrated: significant and persistent themes relating to patient safety and harm; commonly recurring themes related to other key lines of enquiry for the review, or any other recurrent issues of significant concern not previously identified.
- 2.61. The reports were reviewed for evidence of issues related to staffing, departmental congestion and reduced flow, safety concerns, escalations, impact on patients and impact on staff and rated as to whether the issues were considered significant, moderate or minimal as recorded in the reports.
- 2.62. There were differences in format and layout between the handover forms. The Queen Elizabeth University Hospital forms had better defined sections which made it easier for Core Review Group members to form an assessment. The Glasgow Royal Infirmary medical handover reports were less formalised making it more difficult to form assessments for many areas in the same way.
- 2.63. Completion of the shift handover documents was also inconsistent across and within the hospital sites. Some contained large amounts of information, and some were more limited in terms of content. Those reviewing the reports did not make assumptions based on their subject matter expertise. The assessments and ratings were based solely on the information available within the reports. Where reviewers were unable to determine a rating based on the information available, they did not allocate one. Across the entirety of the sample and the question range, reviewers were unable to determine a rating in just under a third of cases.

- 2.64. It is important to note that the handover documents in and of themselves may only represent one element of the data, reports and information shared within the emergency department team and the wider hospital, related to the daily functioning of the emergency departments.

Analysis of national datasets

- 2.65. An iterative process of exploratory data analysis, consideration of this and further analysis was undertaken over several months. The quantitative data used for the review were sourced from existing Scotland-wide datasets, mostly held by Public Health Scotland. Some of the underlying data are publicly available, and others were provided on request. The methods for analysing the data were chosen specifically for the purpose of informing this review, and some further details of methods and data sources are included. The analysis has been carried out so that the data for the three relevant hospitals in NHS Greater Glasgow and Clyde can be considered over a period of time, and to enable comparison with selected peer hospitals in Scotland. This analysis has been considered throughout the review and was also updated so that the most recently available data can be included in this report.
- 2.66. To enable consideration of the data for NHS Greater Glasgow and Clyde's hospitals in the context of emergency departments in Scotland more generally, a peer group of ten other emergency departments in Scotland was established, using the number of unplanned attendances to select an appropriate group. The ten hospitals included in the peer group are set out in chapter 4.

Staff experience survey

- 2.67. Responses to the staff experience survey were gathered electronically using MS Forms which resulted in an output of quantitative data as tables and charts in Excel format.
- 2.68. The survey was distributed by email to around 540 staff across the three emergency departments. It was completed by 114 staff in the following groups:

- 23 (20%) emergency department consultants
- 10 (9%) resident doctors
- 67 (59%) nurses

Smaller numbers (<5% each) of the following staff groups also responded to the survey:

- Allied health professionals
- Healthcare support workers
- Managers
- Administrative roles

- Other – clinical (e.g. pharmacy) role, and
- Preferred not to disclose.
- Agenda for Change banding of staff was: 2% Band 8a and above, 12% band 7, 48% band 5/6, 4% band 2/3/4, 30% medic and 4% preferred not to say.
- Staff had worked in an emergency department for: 13% less than 1 year, 19% 1-2 years, 20% 3-5 years, 47% more than 5 years and 1% preferred not to say.

2.69. Quantitative data were reported directly from the MS Forms survey.

2.70. A thematic analysis approach was undertaken to analyse the qualitative data gathered through the staff experience survey. Two researchers took the following steps:

1. Explore the data to identify potential themes.
2. Code and classify the data into themes and subthemes.
3. Explore relationships for similarities, differences, patterns and associations between the different themes and sub-themes.
4. Interpret the data by developing possible explanations for the patterns observed in the data.

2.71. The analysis included a comparison of themes emerging from each of the three sites and amalgamating the findings. Involving two researchers in the analysis provided triangulation and quality assurance of the findings.

Patient experience survey

2.72. The total response to the patient experience survey was 571 responses from 8,000 patients plus two qualitative interviews. The response rates for different methods of contacting patients are shown in Table 1 below and were:

Method	Number of responses from 2,000 letters	Number of responses from 6,000 texts	Total number of responses
Web Link	4	385	389
QR Code	22	-	22
Telephone Interviews	1	1	2
Postal Returns	160	-	160
Total Returned	187	386	573
Response Rate	9.4%	6.4%	6.4%

Table 1: Patient experience survey response rates by method of contact

- 2.73. Equality monitoring questions included in the survey demonstrated a good spread of responses across different demographics. Male patients were slightly under-represented (45%) compared with females who were slightly over-represented (54%), and 1% of respondents selected 'Prefer not to say'. There was a good spread across age groups, although an over-representation of older patients compared with younger patients. The time of year the patient attended the emergency department was spread from August 2023 to November 2024 with a good response in most months.
- 2.74. The response rates in each of the three sites is shown below in Table 2, with a slight difference from the attendance rates:

Emergency department	% Response to survey	Actual % attendance 2023/24 ¹⁸
Queen Elizabeth University Hospital	47%	41%
Glasgow Royal Infirmary	26%	35%
Royal Alexandra Hospital	31%	25%

Table 2: Patient experience survey site response rates

- 2.75. An analysis of the responses to the survey questions from the three emergency departments showed only a slight difference in responses to some questions: all of these differences were within the margin of error.
- 2.76. A total of 571 responses to the patient experience survey gives a confidence interval (error rate) of +/- 4.1% at the 95% confidence interval. The survey was designed to achieve a +/-5% confidence interval, making the sample slightly more robust than aimed for. All comparisons made from the patient experience survey are statistically significant unless otherwise stated. This ensures that the differences observed are due to actual differences in opinions or experiences rather than random chance.
- 2.77. The survey included one open-ended question. Responses were coded into response categories to enable frequency analysis to be undertaken. A list of thematic response categories or "codes" were created from an initial reading of the responses. The coding process then involved assigning each response to a code. Responses were coded into multiple categories where more than one point is communicated.

¹⁸ Attendance rates sources from NHS Greater Glasgow and Clyde Board Report 30 April 2024. [NHSGGC Board Meeting Documents - 30 April 2024 - NHSGGC](#). NHS Greater Glasgow and Clyde; April 2024

- 2.78. To consider whether the recommendations drawn from this patient experience survey had a wider applicability across NHS Scotland, an analysis of Care Opinion¹⁹ stories about urgent and unscheduled care was undertaken. Stories were extracted from January 2022 to December 2024. Urgent and unscheduled care was defined as emergency departments and minor injury units. Care Opinion stories are tagged by the person writing the story and by Care Opinion moderators. These tags identify what was good (positive experiences of care) and what could be improved (negative experiences of care). The percentage of all tags about specific aspects of care in NHS Greater Glasgow & Clyde and the rest of NHS Scotland was compared. Wilson Score confidence intervals were calculated to identify any differences. Within this review, a total of 2,899 distinct stories with a “what was good tag” and 1,218 distinct stories with a “what could be improved” tag were included. Of these, 834 and 313 respectively were about NHS Greater Glasgow and Clyde.

Evidence search and summary

- 2.79. An evidence search and summary service was conducted by information scientists within Healthcare Improvement Scotland’s Research and Information Service. This was a rapid summary of evidence to answer the following questions:
- What solutions are UK health and care services employing to respond to crowding in emergency departments, with resultant impact on safety and quality of care?
 - How effective are those solutions?
- 2.80. A systematic search focused on the specified questions was conducted in MEDLINE²⁰ and the Health Management Information Consortium. The results from this main search were augmented by a previous search on crowding conducted by NHS Ayrshire and Arran library service using Trip database, Cochrane, Medline, Embase, the Health Management Information Consortium, the Royal College of Emergency Medicine and Google, and by input from several members of the External Reference Group convened by Healthcare Improvement Scotland. In total, over 800 articles were retrieved. These were screened to filter down to systematic reviews which included UK studies and published from 2022 onwards, i.e. post-Covid 19 pandemic.

¹⁹ <https://www.careopinion.org.uk/services/nhs-scotland>. Care Opinion. 2022 – 2024

²⁰ [MEDLINE](#), National Library of Medicine

Inclusion of quotes from NHS Greater Glasgow and Clyde staff in this review report

- 2.81. A range of mechanisms were used during this review process to hear the views and experiences of relevant NHS Greater Glasgow and Clyde staff that have a role in relation to the three emergency departments considered by the review. This included receiving submissions from staff to a dedicated confidential review email inbox, meetings between staff and members of the Core Review Group, and a staff experience survey as outlined above. This review report includes quotes drawn from across the breadth of that staff engagement. Not all quotes have been included in this report, but all have been read and considered. Care has been taken to protect the anonymity and confidentiality of staff who engaged in the review process within the representative sample of quotes for inclusion in this report. This includes, for example, omitting where possible the staff role and the relevant hospital site associated with the quotes and in some instances redacting elements of the quotes. The convention [...] indicates where text has been removed.

Report structure and commonly used terms

- 2.82. For chapters 5-7, the report is structured so that for each a section a summary of the findings is provided in bold, followed by an explanation and more detailed findings underneath.
- 2.83. We use the term urgent and unscheduled care throughout this report with the exception of in Chapter 5. When we say urgent and unscheduled care we mean one of the following:
- care that may be needed to treat an injury following an accident
 - care for serious life-threatening conditions, or
 - for less serious conditions that will get worse if left untreated (particularly during the night or at the weekend, when other types of healthcare services are not available).²¹

Urgent and unscheduled care is provided by a range of services including emergency departments and minor injury units.

- 2.84. In Chapter 5 we use the term 'emergency care' which refers to urgent and unscheduled care as described above. This was the terminology adopted for the patient experience survey.

²¹ What is urgent and unscheduled care? [What is urgent and unscheduled care? - Overview - About urgent and unscheduled care - Urgent and unscheduled care - Healthcare system - Public Health Scotland.](#) Public Health Scotland. October 2024.

3. Emergency Department Provision in Scotland

This section provides context regarding emergency department provision in Scotland and outlines:

- a general overview of emergency departments and emergency medicine
- information on emergency departments and trauma centres and trauma units in Scotland
- the UK-wide context.

General overview of emergency departments and emergency medicine

- 3.1. The following descriptions of emergency departments and emergency medicine have been summarised from the Royal College of Emergency Medicine.²²

Emergency medicine

- 3.2. The specialty of emergency medicine provides round the clock care to patients of all ages, who present with symptoms of acute illness and injury. In the UK, emergency medicine as a specialty is continually adapting and developing. This may be in response to external pressures, such as changes in the provision of out of hours and acute care, changes in medical practice, expectations of patients, or government targets, including waiting time targets. There is also ongoing discussion and debate about the future direction of urgent and unscheduled care.
- 3.3. Emergency medicine has evolved significantly over the years and is very different to how it was in the 1960s and 1970s when “casualty surgeons” first emerged. It now includes critical and acute care for a much wider range of challenges. When patients first present at emergency departments, there is often no clear diagnosis, and there may be little information available beyond what the patient can tell healthcare staff, what is known about the patient’s history, what can be learned on initial examination and bedside investigations. It can be very challenging to provide rapid and appropriate treatment within the first hours of the patient’s arrival but ensuring that there is effective early diagnosis, and treatment can make a big difference in short and longer-term outcomes in many cases.
- 3.4. Since it is not possible to have experienced staff from every hospital specialty or sub-specialty standing by in the emergency department, emergency physicians have developed expertise as “specialised generalists”. This enables them to make

²² [Home](#) | [RCEM](#), Royal College of Emergency Medicine

working diagnoses and start appropriate treatment, and where appropriate refer on to other specialists. Many emergency physicians now sub-specialise, for example, they may become experts in the fields of children's emergencies, acute medical emergencies, poisoning, life-threatening emergencies needing critical care skills, and emergencies in the pre-hospital setting.

- 3.5. Many departments are increasing their capacity for practising observation medicine where patients remain in a ward style environment for up to 48 hours under the care of the emergency medicine consultant. This allows time for more detailed investigation and treatment, or support for those who have a temporary condition that prevents them being safe at home after discharge.
- 3.6. Emergency medicine has a well-developed curriculum and specific examinations. Resident doctors in the emergency department receive high quality training and experience under direct supervision of senior doctors who are dedicated to medical education and to the development of emergency medicine as a specialty.

Emergency departments

- 3.7. Emergency departments are based at the “front door” of a hospital and specialise in the care of acutely ill and injured patients who need immediate treatment. Most emergency departments provide care for patients of all ages and with all conditions, although there are some that see only children or only adults, or only patients with eye problems. Most emergency departments are open 24 hours a day, 7 days a week. All will have resuscitation facilities for people who are critically ill, cubicles to see patients, and access to investigations (such as blood tests and x-rays) to help make diagnoses.
- 3.8. Various advanced healthcare practitioners work in emergency departments, including nurses, allied health professionals (AHPs), mental health nurses, and doctors. The care in emergency departments is supervised by specialists in emergency medicine (emergency physicians) whose job is to ensure that patients receive care of the highest possible standard.

When someone visits an emergency department they can expect to be asked for their personal details (such as name and address) and to be registered onto the computer system. They may be seen by a nurse briefly before seeing the doctor or nurse practitioner. This process is sometimes called “triage” or “assessment”. The purpose is to find out who can best deal with the problem and in which part of the department, whether any treatment or investigations can be started, and whether there is a need to be seen very urgently. Sometimes patients can be treated on the spot or directed to a more appropriate service. Most emergency departments will allocate each patient to a “triage category”, which indicates the order in which patients should be seen. This process also allows patients to be given pain killers as soon as possible.

- 3.9. When a patient is seen by a doctor or nurse, their condition will be assessed and a decision made on the best treatment for their condition including whether they need to be seen by a specialist or by their own GP after discharge. Some patients can be treated and discharged, and some will need to be admitted to hospital. Many emergency departments have their own wards to which patients can be admitted for short periods of observation or treatment. They may also be referred to other hospital specialists for advice or treatment. This is because other specialists may be able to provide the right care for a particular problem as well as providing follow up care to ensure the condition responds to the treatment.

Emergency departments in Scotland

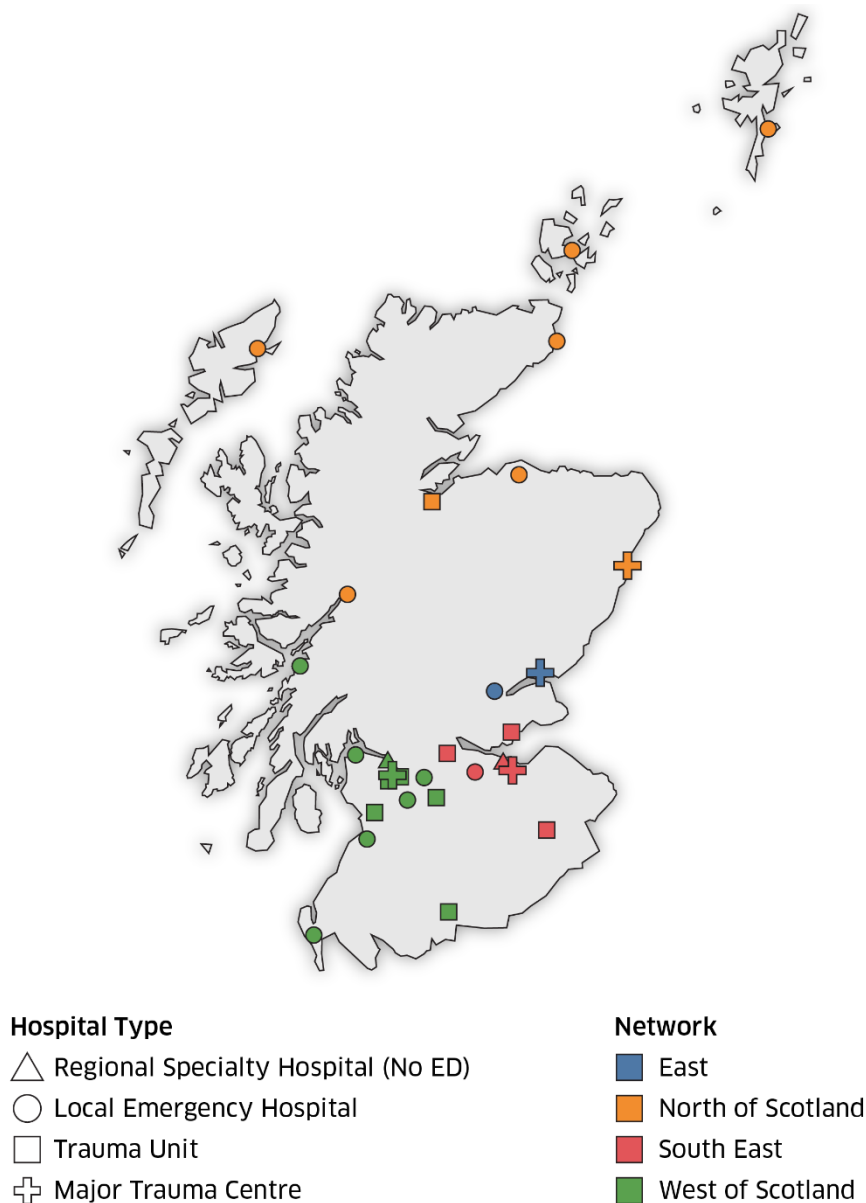
- 3.10. Collectively the term “accident and emergency services” includes the following site types:
- emergency departments
 - minor injury units,
 - community accident and emergency departments or community casualty departments that are GP or nurse-led.
- 3.11. There are 30 consultant-led emergency departments in Scotland and around 60 minor injury units.²³

Scottish Trauma Network

- 3.12. In 2016, the Scottish Government followed through on a commitment to develop four major trauma centres in Scotland, including one for the West of Scotland to be based in the Queen Elizabeth University Hospital.
- 3.13. The Scottish Trauma Network was established in 2017 by the Chief Medical Officer with the aim of “Saving lives, Giving life back”; establishing an integrated trauma care system across Scotland which would improve the delivery of care from prehospital intervention through to rehabilitation.
- 3.14. Central to this plan was the creation of four major trauma centres to cover the North, East, South-East and West of Scotland.
- 3.15. The Queen Elizabeth University Hospital opened as the West of Scotland major trauma centre on 30 August 2021 following postponement of original opening in March 2021 due to the ongoing Covid 19 pandemic and high Covid prevalence across the West of Scotland at that time.

²³ [Overview - Accident and emergency - Urgent and unscheduled care - Healthcare system - Public Health Scotland](#). Public Health Scotland; October 2024.

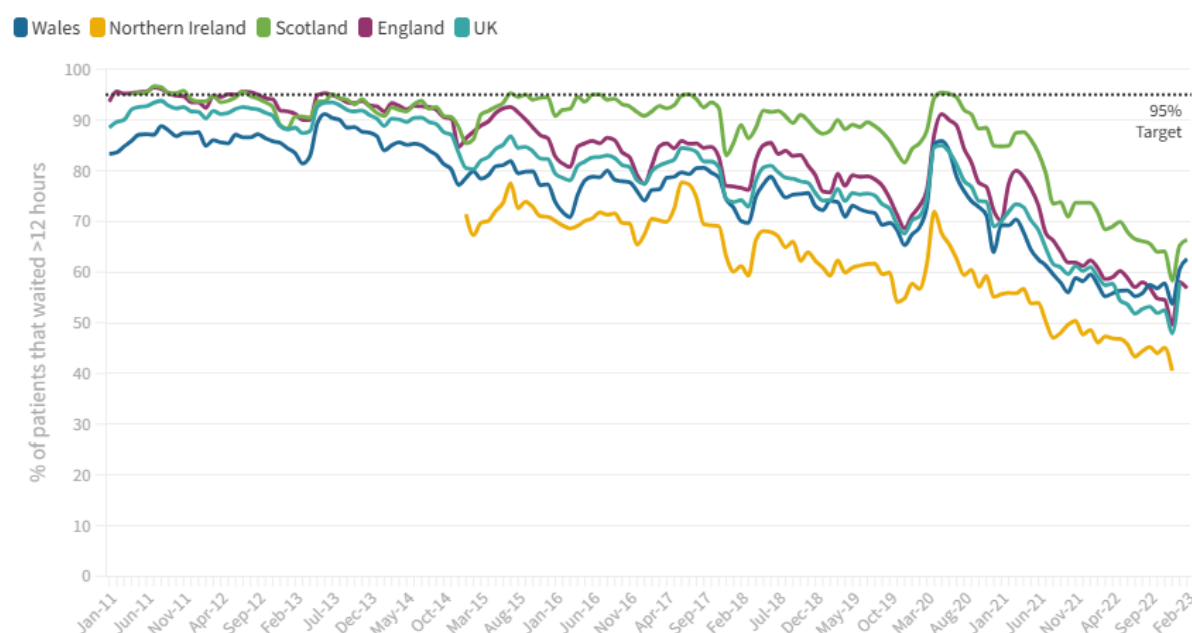
- 3.16. All neighbouring West of Scotland trauma units (NHS Lanarkshire, NHS Ayrshire & Arran, NHS Dumfries & Galloway) required to be operational when the Major Trauma Centre opened. These units feed into the Queen Elizabeth University Hospital major trauma centre.



- **Trauma centres** provide high quality specialist services within a 45-minute journey time from the incident. The estimate is that 86% of the Scottish population are within 45 minutes of one or more of the trauma centres.
- **Trauma units** provide high quality specialist services to patients significantly over the 45 minutes maximum travel time. Many of these will be initially admitted to a trauma unit and may then require a secondary transfer to the trauma centre.

UK-wide and general context

- 3.17. In terms of the UK context, the Royal College of Emergency Medicine provides a UK performance tracker²⁴ to describe attendances and four-hour and 12-hour waits in the four home nations. Each devolved health system operates under a different model and therefore direct comparisons cannot necessarily be attributed to “better” or “worse” performance. The data does, however, provide some context as to how each health system is functioning over time.
- 3.18. The figure below (Figure 3.1) shows that each nation has broadly followed a similar pattern over time. The Royal College of Emergency Medicine explained that emergency department attendances across the UK are now relatively stable and consistent with pre-Covid pandemic levels. However, each of the four UK countries has shown a broadly similar declining trajectory on performance in relation to the four-hour standard.



Four-hour performance figures have been sourced from NHS England, Stats Wales, Public Health Scotland and Department of Health Northern Ireland.
Analysis by RCEM.



Figure 3.1: Four-hour performance across the UK

- 3.19. The King’s Fund in 2024²⁵ concluded that the sustained decline in performance in relation to the four-hour standard is a clear marker of the growing and significant pressures on emergency departments and the wider health and care system. These pressures are felt by the patients and families who use, and the staff who work in, these services.

²⁴ [Data & Statistics | RCEM](#). Royal College of Emergency Medicine. 2024

²⁵ What’s Going on with A&E Waiting Times. [What’s Going On With A&E Waiting Times? | The King's Fund](#). The King’s Fund; 2024.

- 3.20. When considering waits exceeding 12 hours from arrival at the emergency department, data from each UK nation shows an increase in recent years, with more patients than ever before now experiencing extremely long waits.
- 3.21. Twelve hour waits represent a significant failure of the healthcare system and under normal conditions would prompt a review of how and why each one came to be, with the aim of learning and improving. When these very long waits are relatively rare occurrences there is more opportunity to conduct such reviews. However, a system where such waits occur more frequently may not be able to conduct these reviews and therefore miss crucial learning to avert future instances.
- 3.22. According to the Royal College of Emergency Medicine UK performance tracker, NHS Scotland appears to consistently have the lowest Type 1²⁶ emergency department attendances per 1000 population (matched by NHS Wales), the highest percentage of patients meeting the four-hour emergency department standard, and the lowest percentage of patients waiting more than 12 hours. The 12-hour wait measure is perhaps the most striking among these: before the Covid 19 pandemic, Scotland was the only nation that was seeming to keep 12-hour waits under 1% of waits, whereas all other nations were non-zero (between 1% and 4%) and rising (to between 4% and 11%) from June 2018 to January 2020. Since mid-2021, Scotland's percentage of 12-hour waits climbed to 7.6% up to December 2022 (the last month where data from all four nations is available in the tracker), with the other nations operating at a level between 14% and 19%. At this point the UK level of 12-hour waits stood at 14.6%.

Emergency departments in Scotland – performance data

- 3.23. Feedback from NHS boards suggests that, following the Covid 19 pandemic, there has been an increase in the complexity and acuity of patients presenting to hospital, such as patients with multiple co-morbidities or presenting at a later stage of disease or deterioration. Some evidence that is consistent with this view is provided by analysis, recently carried out by Public Health Scotland looking at the case-mix of hospital admissions post-Covid (April 2022 – March 2024) compared with pre-Covid (April 2018 – March 2020). This analysis found that post-Covid, a significantly higher proportion of patients admitted to hospital are: (i) aged 60 years and over, and (ii) have a higher number of prior morbidities (prior morbidities are based on the main condition recorded as a result of previous hospital admissions). This analysis focused on acute inpatients/day-cases (and not attendances at emergency departments) and provides some

²⁶ The Royal College of Emergency Medicine defines Type 1 emergency departments as major emergency departments that provide a consultant-led 24-hour service with full facilities for resuscitating patients.

evidence that post-Covid there is greater pressure on hospital services resulting from an increase in the complexity/acuity of admissions.²⁷

National initiatives to improve performance

- 3.24. The national Urgent and Unscheduled Care Collaborative was refreshed in June 2022. This whole system approach is part of the Scottish Government's wider Recovery Plan which seeks to reset NHS services following the Covid 19 pandemic; with the understanding and renewed commitment to making the necessary system changes to modernise the NHS in Scotland.
- 3.25. The Collaborative's programme of improvement activities is being taken forward by the Centre for Sustainable Delivery, which has been commissioned to support NHS boards to implement a range of measures to reduce emergency department waiting times and improve patient and staff experience.
- 3.26. The Centre for Sustainable Delivery's Unscheduled Care programme delivers implementation support, develops national tools, and manages system capacity and capability diagnostics to help NHS boards improve unscheduled care delivery. Its strategic priority is to define best practice in key areas within unscheduled care which improve the timeliness and safety of patient care and patient and staff experience. Current national improvement workstream areas include:
 - Strategic programme development
 - Community urgent care
 - Flow navigation
 - Hospital at home
 - Front door medicine
 - Optimising flow²⁸

²⁷ Unpublished analysis (management information). Public Health Scotland. 2025

²⁸ Centre for Sustainable Delivery Annual Plan 24/25. [CfSD Annual Plan 2024-25](#). Centre for Sustainable Delivery; 2024

4. The Delivery of Urgent and Unscheduled Care in NHS Greater Glasgow and Clyde

This section provides context for the delivery of urgent and unscheduled care within NHS Greater Glasgow and Clyde. It explains the current urgent and unscheduled care provision in the Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital, set within the overall operating context for NHS Greater Glasgow and Clyde.

This section also includes performance data for all three hospitals on:

- Performance against the four-hour standard
- Number of attendances
- Percentage of unplanned attendances with over eight hours or over 12 hours wait
- Percentage of unplanned admissions from the emergency department into the hospital
- Ambulance turnaround times
- Length of stay
- Delayed discharges
- Bed occupancy.

Observations are included where relevant about what this data may suggest for the areas of focus for this review i.e. care provision and safety; staff and patient experience; and leadership and culture.

NHS Greater Glasgow and Clyde board overview

- 4.1. NHS Greater Glasgow and Clyde is the largest NHS organisation in Scotland and one of the largest in the UK. It serves a population of approximately 1.2 million people, equating to over a fifth (21.7%) of Scotland's total population, across six local authority areas: East Dunbartonshire, East Renfrewshire, Glasgow City, Inverclyde, Renfrewshire and West Dunbartonshire.
- 4.2. According to preliminary 2022 census data, the population of Greater Glasgow and Clyde is increasing faster than Scotland as a whole (3.6% since the previous census in 2011 compared to 2.7% for Scotland).

- 4.3. There are 23 hospitals of different types across NHS Greater Glasgow and Clyde. The NHS board employs around 41,000 staff with around 22,500 of those working within acute services. The NHS board has an annual budget of £4.4 billion.
- 4.4. There are six Health and Social Care Partnerships. These are formal partnerships between each of the six Local Authorities and NHS Greater Glasgow and Clyde. The Health and Social Care Partnerships are responsible for jointly planning and delivering community health and social care services for people in their areas.
- 4.5. There is wide demographic variation both between and within these Health and Social Care Partnerships. Life expectancy varies across the NHS board area from 73.4 years in Glasgow City to 80.5 years in East Dunbartonshire, a difference of 7.1 years. Life expectancy Scotland-wide (data from 2021 – 2023) is 80.8 years for females and 76.8 for males²⁹.
- 4.6. Healthy life expectancy (years of life an individual lives without any life-limiting illness) is lower in NHS Greater Glasgow and Clyde when compared with much of the rest of Scotland, 58.0 years for males and 58.7 years for females, compared to 60.4 and 61.1 respectively for Scotland (data from 2019 – 2021).³⁰
- 4.7. Paragraphs 4.7–4.10 are extracts from NHS Greater Glasgow and Clyde’s public health strategy 2018-2028³¹ which highlights that this is explained by life circumstances, chiefly socio-economic factors which impact across the life-course, starting in the antenatal period and influencing education, employment, health behaviours and patterns of healthcare use.
- 4.8. Inequalities in income, health and quality of life persist and in some parts of NHS Greater Glasgow and Clyde are widening. There are specific concerns regarding the health and wellbeing of population groups such as lone parents, children and young people in low-income families, and frail isolated older people. There are also growing concerns about mental health and wellbeing across all age groups. All of these factors contribute to increasing demands on the health and social care system.
- 4.9. Unhealthy behaviours are common across all communities in NHS Greater Glasgow and Clyde. However, poverty increases the higher risk of illness and premature mortality through factors which are related to unhealthy behaviours. Those living in poverty are more likely to follow trajectories of limited school attendance and educational attainment, limited job opportunities and unemployment, and are more likely to smoke, consume hazardous or harmful levels of alcohol, have a poor diet and have limited physical activity.

²⁹ [Life Expectancy in Scotland 2021-2023 - National Records of Scotland \(NRS\)](#)

³⁰ [Healthy Life Expectancy 2019-2021 - National Records of Scotland \(NRS\)](#)

³¹ [Public Health Strategy 2018-2028 - NHSGGC](#). NHS Greater Glasgow and Clyde; 31 March 2023

- 4.10. While health inequalities as a result of poverty may be partially explained by risk factors such as smoking and diet, it is likely that use of and access to health services also underpin this issue. Across all countries, healthcare costs and use rise steeply with age and with the prevalence of long-term conditions. Poverty is strongly associated with patterns of emergency and unscheduled care; 72% of the variation in unscheduled care is explained by poverty and social factors, not by system factors. This appears to be true in both primary and secondary care. These findings are found across a number of different health systems and relate to accessibility of services, but also how patient-centred such services are and the culture of how people use services.

Right Care, Right Place model

- 4.11. NHS Greater Glasgow and Clyde implemented the national “Right care, Right place”³² (2021) model for all urgent and unscheduled care. This model aims to ensure patients access the most appropriate care quickly and safely and will help protect the accident and emergency departments so they can look after those patients with life-threatening conditions such as strokes, heart attacks, head injuries, breathing difficulties or severe bleeding.
- 4.12. Emergency department attendances across the NHS Greater Glasgow and Clyde board area from 2021- 2024³³ are shown in Table 3 below. Attendance data specific to the three emergency departments included in this review is presented later in this chapter.

Year	2021–22	2022–23	2023–24
Emergency department attendances	431,125	465,199	494,201

Table 3: NHS Greater Glasgow and Clyde board-wide emergency department attendances by year

- 4.13. While overall emergency attendances (including to minor injuries units) have increased year on year since 2021 (7% over 2021–22 to 2022 –23 and 6% over 2022 –23 to 2023 – 24) they remain lower than pre-pandemic levels.

³² [Accessing The Right Care From The Right Place](#). NHS Scotland. December 2021.

³³ NHS Greater Glasgow and Clyde Annual Report and Consolidated Accounts 2023-2024 [Annual Report and Consolidated Accounts 2023-2024 - NHSGGC](#). NHS Greater Glasgow and Clyde. October 2024.

NHS Greater Glasgow and Clyde's clinical strategy

- 4.14. NHS Greater Glasgow and Clyde's medium to long-term clinical strategy called "Moving Forward Together" is aligned to its delivery plan, corporate objectives and operational priorities. The key principles established through the strategy are summarised in the graphic below:



- 4.15. The "Moving Forward Together" vision is described by NHS Greater Glasgow and Clyde as a holistic approach to healthcare focused on integration across primary, community, specialist and acute care, supported by the right infrastructure. A revised clinical vision and roadmap³⁴ have been produced to support this. Moving Forward Together was not mentioned by staff that engaged in this review process in their discussions with members of the review group.

Capacity in the emergency departments and hospitals at April 2024³⁵

- 4.16. Glasgow Royal Infirmary
- Resuscitation – 5 spaces, including a paediatric bay, a negative pressure room and a decontamination room with external direct access.
 - Majors A – 19 spaces including 3 side rooms and 2 monitored bays. Further 5 labelled trolley spaces around the zone.
 - Majors B – 11 spaces including 2 side rooms.
 - Corridor – up to 7 labelled trolley spaces are used in extremis.

³⁴ Moving Forward Together Clinical Road Map. Greater Glasgow and Clyde dated August 2024

³⁵ NHS GGC overview of hospitals provided as evidence

4.17. Royal Alexandra Hospital

- Total capacity is now 34 spaces due to the recent addition of a minor injury area.
- Resuscitation – 5 spaces, including 1 single room.
- Rooms – 10 spaces.
- Cubicles – 19 spaces.
- Corridor – up to 7 trolley spaces in corridors for lower acuity patients (depending on staffing) are used in extremis.

4.18. Queen Elizabeth University Hospital

- The emergency department has a total capacity of 53 spaces.
- Resuscitation – 7 spaces.
- Emergency department high dependency – 16 spaces (all cubicles).
- Majors – 25 spaces.
- Minor injury unit – 5 cubicles (plus small waiting area).
- No corridor care, but there is a “cohort room” with a capacity of two trolleys that can be used in escalation to cohort two patients to release ambulance crews.

4.19. The NHS Greater Glasgow and Clyde emergency departments have some admitting rights to general medicine, but these are not consistent or comparable across the three sites. An electronic “SBAR” report comprising situation, background, assessment, recommendation is used to hand over patients. Depending on acuity, a patient may be seen by a doctor in the emergency department before being transferred. For all other specialties, the emergency department will contact the specialty doctor for review before being accepted for a bed within the specialty. If a patient needs to be transferred to another site, a referral is made by the emergency department doctor or consultant to the specialty team who would “accept” the patient, and bed management teams are made aware to plan for the offsite transfer.

Comparison with other emergency departments in Scotland

4.20. The Core Review Group agreed it was important to consider analysis of national data for emergency departments to provide context for the review. For the purpose of providing context, some established indicators were selected, and the data were analysed i) so the data for the three relevant hospitals in NHS Greater Glasgow and Clyde can be considered over a period of time, and ii) to understand how these three sites compare to other hospitals in Scotland. Some of the data presented here highlight challenges being experienced by healthcare systems across Scotland. In such instances, even if the data for the three NHS Greater Glasgow & Clyde sites are not markedly different from other hospitals across Scotland, the challenges for these three sites remain relevant.

- 4.21. It is important to note that, for the separate purpose of NHS Greater Glasgow and Clyde's work locally to understand and redesign/improve services, a fuller array of whole system measurement is required – together with the in-depth knowledge of local systems to use these data. While this is not the purpose of this section of the review, it is noted that the Centre for Sustainable Delivery has developed a data pack, specifically for use by NHS boards locally as part of their whole system redesign and improvement work.
- 4.22. To identify whether or not the data for the three emergency departments in NHS Greater Glasgow and Clyde are different from other hospitals, a valid comparator group was established. A peer group of ten other emergency departments in Scotland was established, as listed below, using the number of attendances to select an appropriate group.
- 4.23. Owing to the size of NHS Greater Glasgow and Clyde, it often has a notable influence on a dataset. For this reason, the NHS Greater Glasgow and Clyde sites are excluded from any measure of spread in the following analyses. The intention is to describe the performance of the peer group and then overlay the data for the NHS Greater Glasgow and Clyde sites onto this, to observe where NHS Greater Glasgow and Clyde sites fall in comparison to this range.
- 4.24. The peer group was selected by analysing the distribution of the monthly attendances for all emergency departments, to isolate the cluster of emergency departments related by the highest number of unplanned attendances.
- 4.25. The following ten hospitals were considered to comprise an appropriate peer group for the analysis carried out for this review:
- Aberdeen Royal Infirmary, NHS Grampian
 - Forth Valley Royal Hospital, NHS Forth Valley
 - Ninewells Hospital, NHS Tayside
 - Royal Infirmary of Edinburgh, NHS Lothian.
 - St John's Hospital, NHS Lothian
 - University Hospital Crosshouse, NHS Ayrshire & Arran
 - University Hospital Hairmyres, NHS Lanarkshire
 - University Hospital Monklands, NHS Lanarkshire
 - University Hospital Wishaw, NHS Lanarkshire
 - Victoria Hospital, NHS Fife

- 4.26. Whilst these emergency departments are selected for broad similarity on number of attendances, there will also be differences among these hospitals on factors including demographics of the local population, case-mix, and models for delivering unscheduled care. In particular, implementation of the redesign of the urgent care pathway in late 2020, discussed in Paragraph 6.23 has varied across Scotland both in terms of how pathways are operating, and how related accident and emergency data is coded.³⁶ For more information on comparability of emergency department data, please consult Public Health Scotland's metadata page which has provided invaluable information for the purposes of this review.³⁷
- 4.27. The figures included in this report are based on 'unplanned' emergency department attendances only, which has been standard for reporting accident and emergency activity. From February 2025 Public Health Scotland accident and emergency statistics include new 'planned' scheduled attendances by default.³⁸
- 4.28. This method was devised to fulfil the specific objectives of this review of NHS Greater Glasgow and Clyde emergency departments and does not attempt to define an appropriate method for analysis of emergency department performance across NHS Scotland.

Four-hour waits

- 4.29. Figure 4.1 shows the performance of Queen Elizabeth University Hospital, the Royal Alexandra Hospital and Glasgow Royal Infirmary against the four-hour standard between 2017 and 2024. While this time is routinely referred to as a "wait", it describes the time spent in the emergency department until admission, transfer or discharge, including any time spent on treatment within the emergency department itself.

³⁶ [Executive Summary - Health - redesign of urgent care: evaluation - main report - gov.scot](#). Scottish Government. January 2025.

³⁷ <https://publichealthscotland.scot/healthcare-system/urgent-and-unscheduled-care/accident-and-emergency/metadata/data-quality/>. Public Health Scotland.

³⁸ [Performance monitoring - Overview - Accident and emergency - Urgent and unscheduled care - Healthcare system - Public Health Scotland](#). Public Health Scotland.

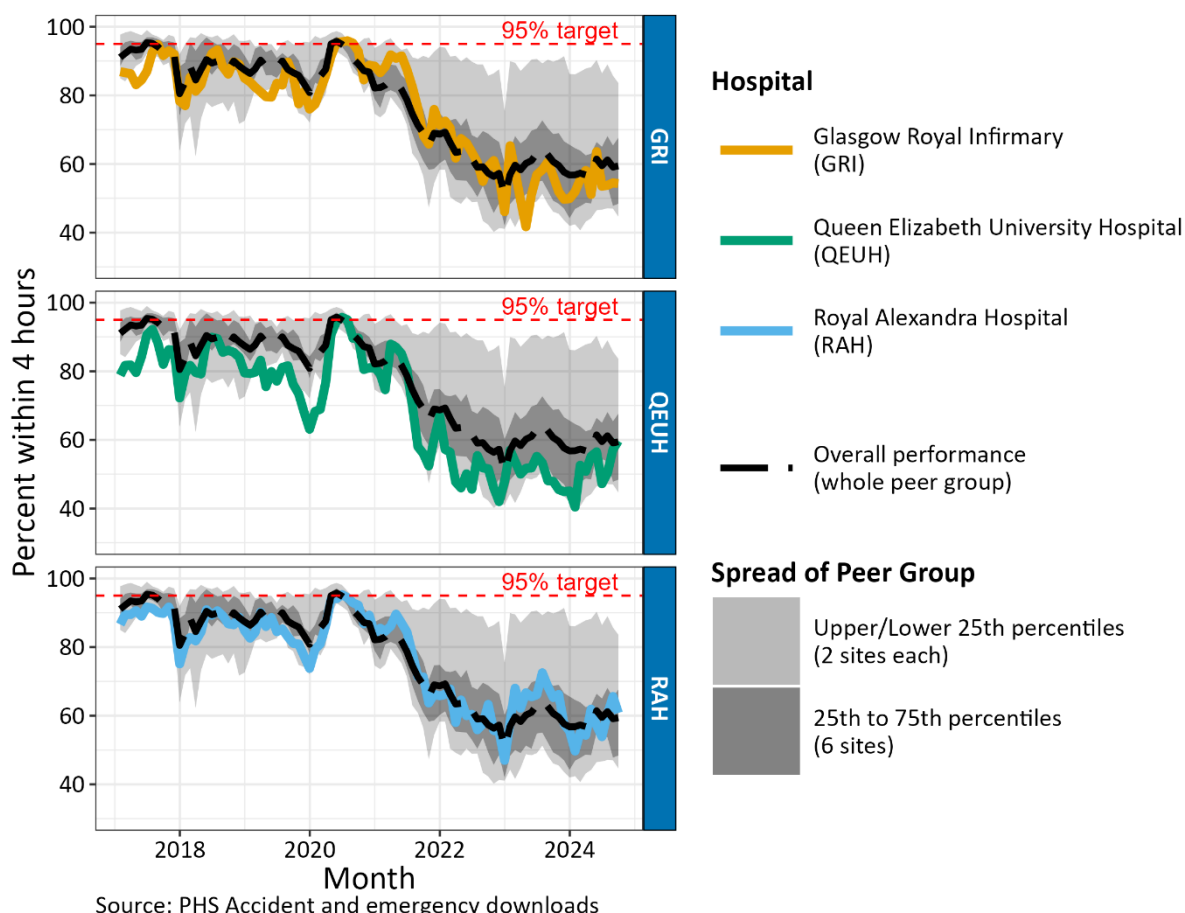


Figure 4.1: Emergency department performance among sites with highest attendances: percent admitted, transferred or discharged within 4 hours

- 4.30. The peer group is represented by the dashed black line (the overall performance of the emergency departments in the peer group) together with the grey shaded area. The shaded area shows the spread of the peer group and provides a background range of performance for the ten other Scottish emergency departments experiencing the highest numbers of attendances. We have used the interquartile range: for each month the dark band shows the range of the six sites in the middle of the peer group, while the lighter band either side shows the range of the two highest and two lowest sites. We have also presented this range over time: the order of sites can vary from month to month as each site's measure varies.
- 4.31. This allows analysis of the measures in two main ways. One is comparison of the NHS Greater Glasgow and Clyde emergency departments against a background distribution of emergency departments with similar numbers of attendances, showing where sites sit relative to each other. The other is comparison of the measures at different timepoints, both for the NHS Greater Glasgow and Clyde emergency departments and the peer group, showing whether the measure has gone up or down. A number of key observations were made from this chart:

The performance for this group of 13 highest attendance emergency departments in Scotland (three Glasgow plus ten peer group) in relation to the four-hour standard can be described in three phases:

- A pre-Covid phase during 2017 to 2019, where performance for the peer group overall and for each of the three NHS Greater Glasgow and Clyde sites was typically between 80% and 99%. The original 95% target (red dashed line) was consistently missed by a subset of the peer group and also all three sites.
- A peri-Covid phase where, similarly to time trend analysis for many healthcare metrics over this period, normal trends were severely disrupted. In this case, significantly reduced numbers of emergency department attendances (see later information on attendances) at the start of the 2020 national Covid 19 lockdown resulted in high performance on the four-hour standard. This was followed by a steep downward trend: by mid-2022 each of the three NHS Greater Glasgow and Clyde sites, as well as the peer group overall, had reached or passed below 60% on the four-hour standard.
- A post-Covid phase where, from early 2022, performance stabilises at a level lower than pre-Covid levels – varying between 40% and 75% for the three NHS Greater Glasgow and Clyde sites, and a wider range for the peer group.

4.32. These phases are relevant context, and they enable us to observe and compare the states of healthcare systems over time. The trends observed for this group of Scottish hospitals broadly mirror the trends in England. The King's Fund's conclusion that the sustained decline in performance in relation to the four-hour standard is a clear marker of the significant pressures on the health and care system also appears to be relevant for these Scottish hospitals. In addition, the post-Covid stable period is selected as a time period for closer analysis of all other measures used in this review.

4.33. There are also some important observations about how, over time, the data for each of the three NHS Greater Glasgow and Clyde sites compare with the peer group for the four-hour standard:

- Queen Elizabeth University Hospital's performance on the four-hour standard can be observed to be consistently lower than the overall peer group performance. This is particularly so in the pre-Covid phase where over three separate periods it sits below the range of the peer group. These periods of deviation from the peer group would be considered evidence that a site is performing at a level that is exceptional relative to the peer group. Post-Covid, Queen Elizabeth University Hospital remains largely within the grey shaded area below the overall performance, spending a roughly equal proportion of months in the

lower quartile (light grey band) and the interquartile range (dark grey band), putting it among the lowest-performing sites. There are two periods where Queen Elizabeth University Hospital is the lowest-performing site relative to the peer group: March, April and June of 2022 and January 2024.

- Glasgow Royal Infirmary can be observed to roughly track the overall performance of the peer group largely falling within the dark band. One major exception to this is in April 2023 where Glasgow Royal Infirmary's performance sits outside that of the peer group.
- The Royal Alexandra Hospital's performance tends to fall within the dark band, putting it in the middle of the peer group performance, particularly post-Covid.

4.34. Variation observed on the data over time also shows seasonality, with performance on the four-hour standard tending to be lower in winter than in summer. This is a known phenomenon in healthcare, also observed for hospitals in England.

4.35. These data demonstrate a marked drop against the four-hour standard among the largest emergency departments in Scotland. The exception to this is Ninewells Hospital, Dundee which despite resisting the large drop in performance over Covid, sees between 80% and 90% of unplanned attendances within four hours over the latter period of the data presented. Waiting time measures are reasonable indicators of problems within a system, but they do not provide explanations as to what the problems are, why they are occurring and how they might be addressed. While certain challenges may be shared between sites, no two sites will have an identical set of challenges with an identical set of solutions, and the challenges are unlikely to reside solely within the emergency department. Deeper analysis of the underlying data, conducted with and by those with knowledge of the local systems, processes and practices, is an important part of understanding and improving the situation in emergency departments both in NHS Greater Glasgow and Clyde and across Scotland. We present here a set of analysis that seeks to contribute to this process of understanding and improving. As mentioned previously, the Centre for Sustainable Delivery has produced a set of analysis at a more detailed level specifically for use by NHS boards locally as part of their whole system redesign and improvement work.

Longer waits

4.36. The standard for emergency department performance focuses on unplanned attendances that are admitted, transferred or discharged from the emergency department within four hours of arrival. Waits are also reported under eight-hour and 12-hour thresholds. These represent waits that are, progressively, potentially less safe. For some patients, increased delays to

assessment/treatment might result in them experiencing greater harm. A recent study by the Office for National Statistics found a relationship between time spent in emergency departments over and above two hours and the risk of post-discharge mortality, for patients requiring non-immediate care³⁹. This risk was greater the longer time the patient spent in the emergency department, up to twelve hours and above. As such, the percentages of these longer waits are relevant when considering the safety of the healthcare system. The data presented below include only waits in emergency departments themselves, but the urgent and unscheduled care system involves a variety of pathways where waits can occur outside of the emergency department. These pathways, and the recording of waits and activity, varies by site across Scotland and are not routinely monitored or reported in the Public Health Scotland data.

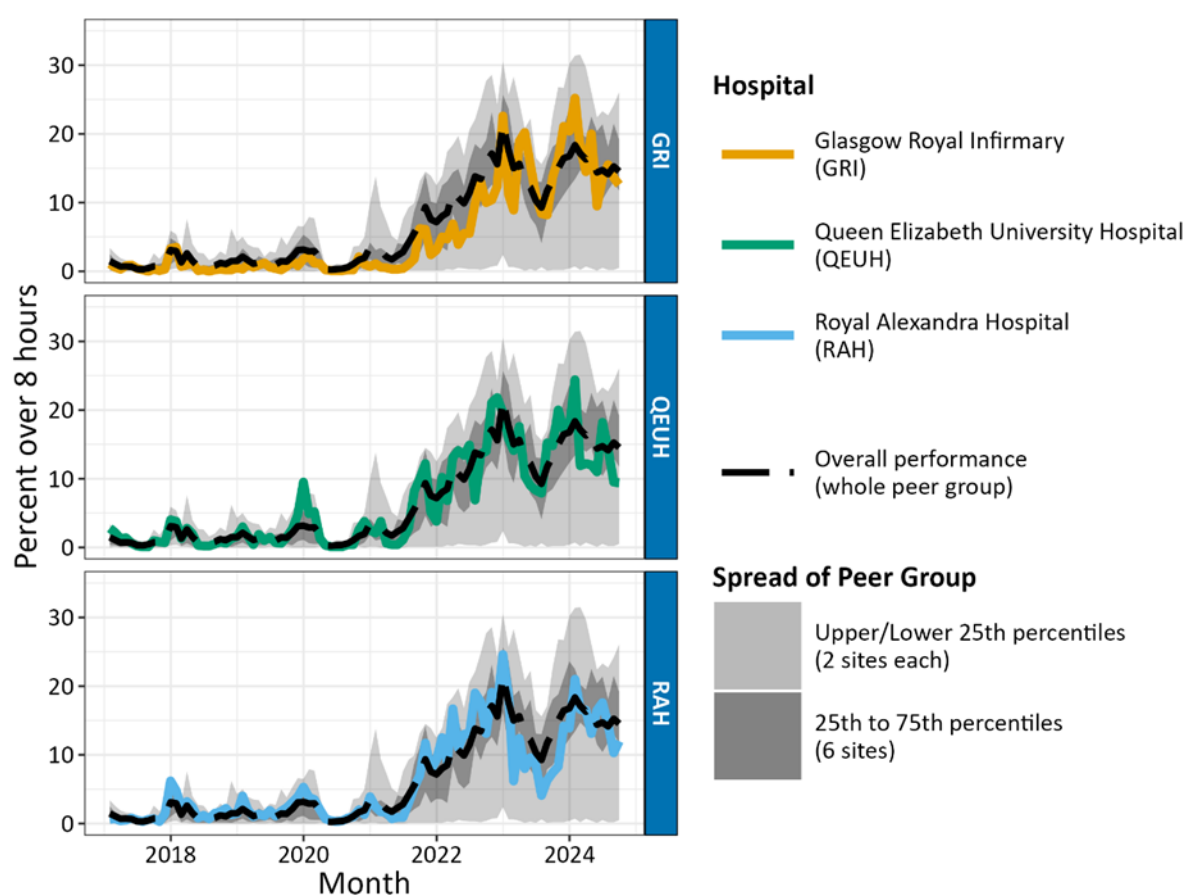


Figure 4.2: Emergency department performance among sites with highest attendances: percent admitted, transferred or discharged over 8 hours

³⁹ ONS website, statistical bulletin. [Association between time spent in emergency care and 30-day post-discharge mortality, England: March 2021 to April 2022](#). Office for National Statistics (ONS). 17 January 2025. [See also](#) Jones S, Moulton C, Swift S, et al Association between delays to patient admission from the emergency department and all-cause 30-day mortality *Emergency Medicine Journal* 2022;39:168-173

- 4.37. Pre-Covid, emergency department waits of eight hours or more were a relatively rare occurrence. While they still happened every month since 2018, they peaked at around 10% of attendances at the very worst, with the overall peer percentage never exceeding 5%. The NHS Greater Glasgow and Clyde sites mirrored this pattern. Since 2021 these have risen steeply, and in the post-Covid phase, eight-hour waits are a more common occurrence. The overall percentage for the ten peer group sites has ranged from around 10% to 25% since 2022. Each of the three NHS Greater Glasgow and Clyde sites roughly tracks this overall percentage for the peer group.

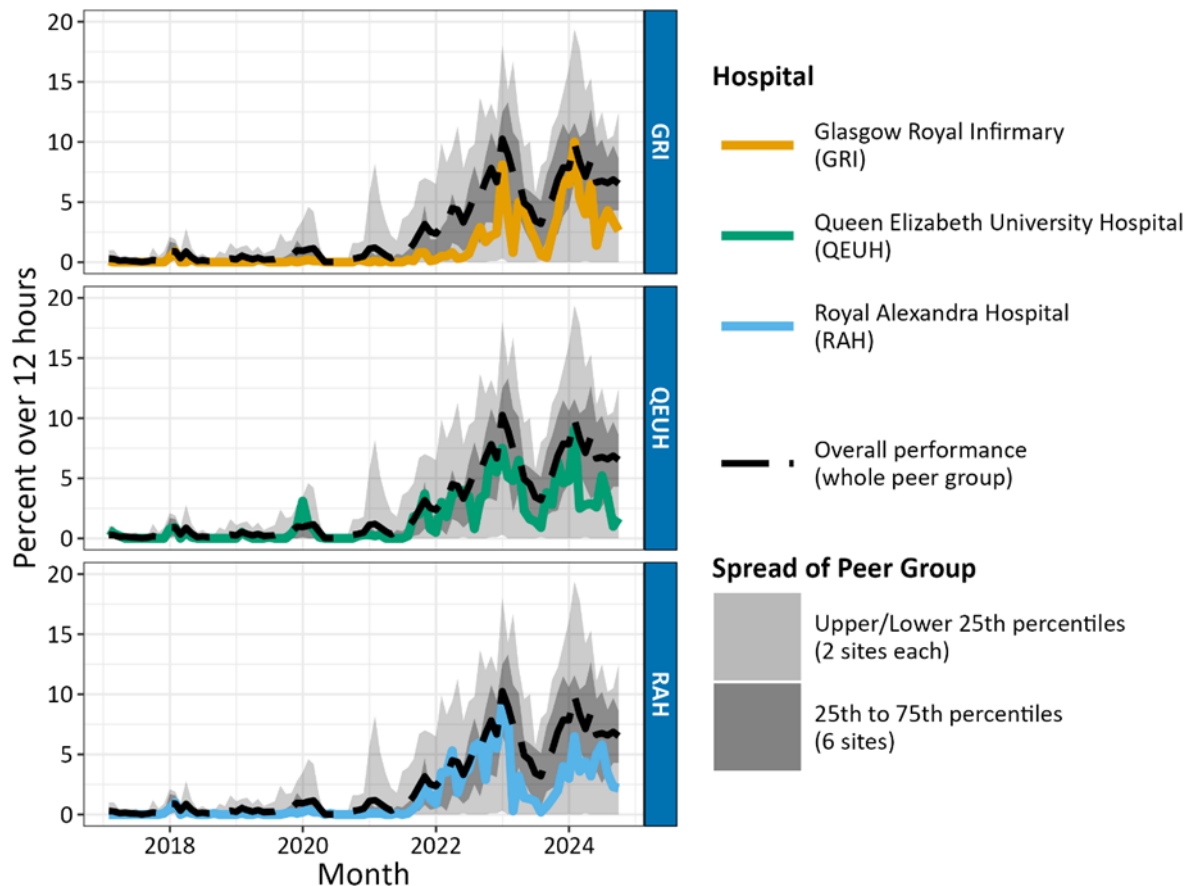


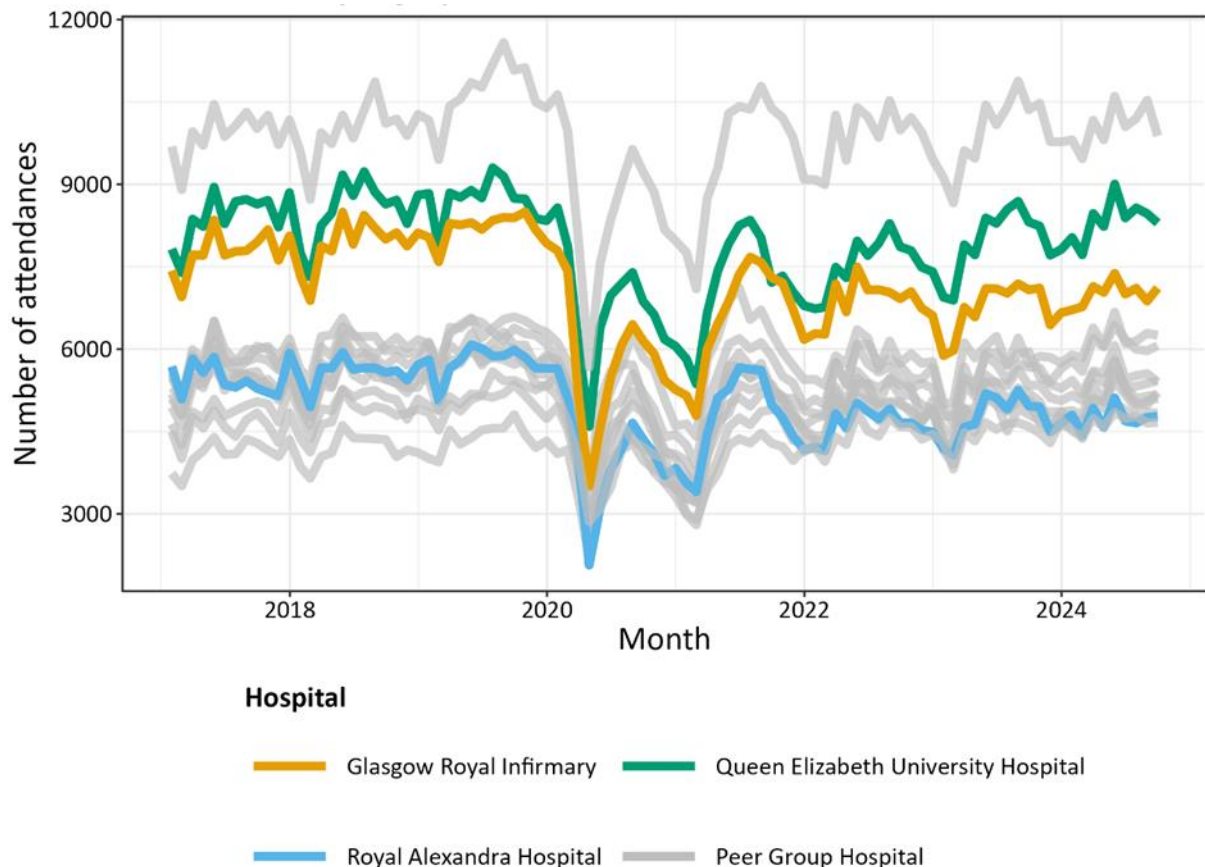
Figure 4.3: Emergency department performance among sites with highest attendances: percent admitted, transferred or discharged over 12 hours

- 4.38. A broadly similar pattern can be observed for the percentage of waits that are over 12 hours. In Figure 4.3 above, each of the three NHS Greater Glasgow and Clyde sites can be seen to consistently stay below the overall peer group in the post-Covid period.
- 4.39. It must be noted that these are waits of 12 hours and above, meaning that these data do not quantify the total length of wait.

- 4.40. If eight-hour and 12-hour waits can be considered to be good proxy indicators of emergency department safety, then these data provide some evidence that, across Scotland, emergency department care is likely to be less safe now overall than it was pre-Covid. The three NHS Greater Glasgow and Clyde sites do not have a higher level of eight-hour and 12-hour waits compared with the peer group overall and indeed have a consistently lower percentage of 12-hour waits. By themselves, these data do not provide evidence that the emergency department care systems in NHS Greater Glasgow and Clyde are less safe compared with the peer group of hospitals from across Scotland. The data do, however, provide some evidence that in absolute terms the emergency department care systems in each of the three Greater Glasgow and Clyde sites have become less safe over time – as they have in the peer group. That long waits have been at this level for three years or more risks contributing to a perception that this is a normal state of affairs. In later chapters, the risks associated with the normalisation of potentially unsafe care is a common theme for the review.
- 4.41. It is important to note that this analysis of emergency department waiting times focuses on the percentage of all attendances for which the wait exceeds eight or 12 hours. However, these data do not describe which patients are experiencing these long waits or why they waited that long. To more fully understand the implications for patient safety associated with these long waits, then knowledge of local decision making needs to be considered. For example, to what extent do triage processes and hospital flow result in the most unwell patients being admitted, transferred or discharged from the emergency department without waiting excessively long? Discharges home after a long wait can indicate a lack of access to observation beds. What is clear is that the increase in waits of over eight and 12 hours represents a significant challenge to patient safety across Scotland.

Number of unplanned attendances at emergency departments

- 4.42. It was important to select an appropriate peer group in order to discuss the NHS Greater Glasgow and Clyde sites in context. These are large hospitals which, especially in the case of the Queen Elizabeth University Hospital, provide specialist (“tertiary”) care to patients from across Scotland. Number of unplanned attendances was used to select this group and is shown below.
- 4.43. Figure 4.4 shows the attendance pattern over time since 2017, as measured by the number of unplanned attendances to the emergency department for the three NHS Greater Glasgow and Clyde sites and the ten hospitals in the peer group.



Source: PHS Accident and emergency downloads

Figure 4.4: Number of emergency department unplanned attendances over time: NHS Greater Glasgow and Clyde sites and peer group sites

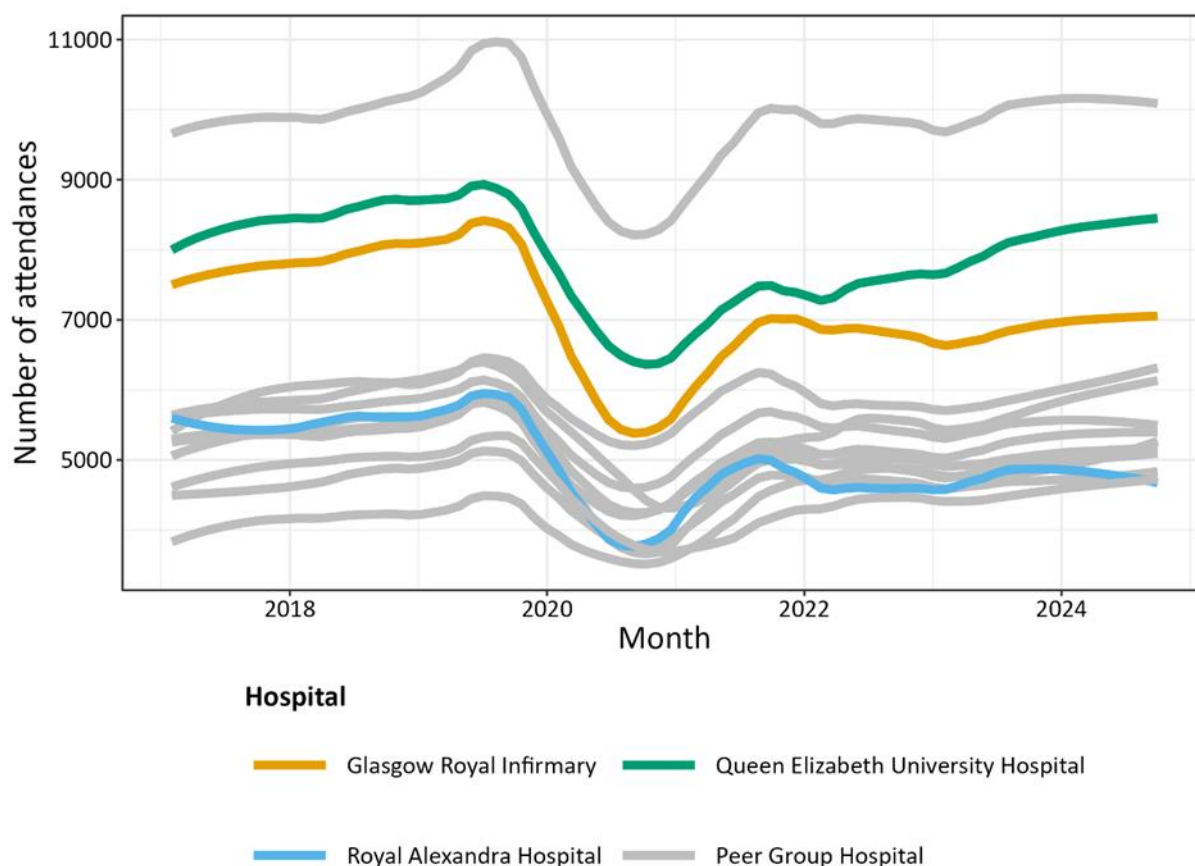
4.44. A number of key observations can be made:

The three phases described above, when considering performance on the four-hour standard, can also be observed here:

- Pre-Covid, attendances tended to increase.
- Peri-Covid, attendances dipped sharply, then cycled through peaks and troughs corresponding to national Covid lockdowns.
- Post-Covid, attendances restabilised.

4.45. There is strong seasonality, with higher numbers of emergency department attendances in summer. Although there are fewer emergency department attendances in winter, the King's Fund⁴⁰ highlighted that at this time of year there is increased demand for more intensive medical care and hospital admissions. This results in people waiting longer in emergency departments during the winter months. It is important to bear in mind that not every emergency department attendance is equal in terms of acuity and complexity, nor are the models of service delivery.

⁴⁰ <https://www.kingsfund.org.uk/>. The King's Fund.

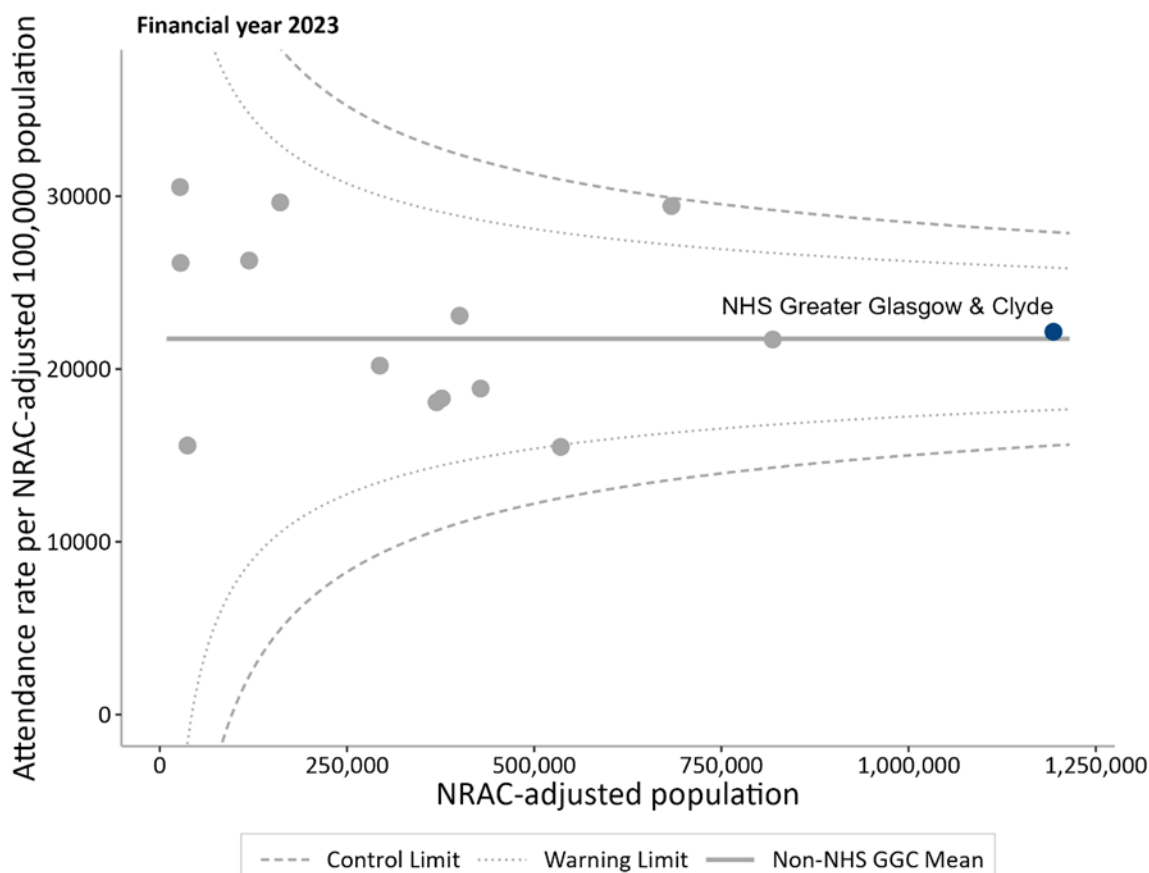


Source: PHS Accident and emergency downloads

Figure 4.5: Number of unplanned emergency department attendances over time: NHS Greater Glasgow and Clyde sites and peer group sites (smoothed)

- 4.46. In Figure 4.5 above, the attendances have been smoothed in order to get a sense of the underlying pattern. The post-Covid increase in emergency department attendances can be seen to be strongest for Queen Elizabeth University Hospital, where it is still climbing. Whilst this may relate to the change in the Queen Elizabeth University Hospital status to a Major Trauma Centre, it has significant implications for emergency department flow. For Glasgow Royal Infirmary and the Royal Alexandra Hospital, the number of emergency department attendances post-Covid has stabilised at a lower level than pre-Covid.
- 4.47. These data describe only volume of attendances and give no indication of the acuity or complexity of attendances. Some indication of acuity or complexity is provided in this section, for example a comparatively high admission rate from Queen Elizabeth University Hospital emergency department attendances, and later some indication that unscheduled length of stay is comparatively long for NHS Greater Glasgow and Clyde as a whole. Whilst there is no one “measure” for complexity or acuity for the range of conditions, episodes and/or injuries that an emergency department might encounter, paragraph 3.23 refers to some early indications that a significantly higher proportion of patients admitted to hospital

(from anywhere) are: (i) aged 60 years and over, and (ii) have a higher number of prior morbidities.



Sources: NRS mid-year population estimates
PHS Accident and emergency downloads
PHS Resource Allocation Formula (NRAC) 2023/24

Figure 4.6: Rate of emergency department attendances by NRAC-adjusted population

- 4.48. Figure 4.6 above shows emergency department attendances per 100,000 head of population. The populations of each NHS board have been adjusted by the national resource allocation formula (NRAC) which normalises populations on age, sex, morbidity and life circumstances and rurality. As with all comparisons produced in this report, NHS Greater Glasgow and Clyde is not included within the calculation of the measure of spread, it is overlaid onto the chart afterwards. Whole NHS boards are presented, and all NHS boards are included within the funnel plot, as the measure is adjusted for population.
- 4.49. Despite NHS Greater Glasgow and Clyde not being included within the calculation of the measures of spread, it sits almost exactly on the mean for emergency department attendances for other NHS boards across Scotland. This suggests that, taking into account some important characteristics of local populations, the rate of emergency department attendances is not unusual for the population of NHS Greater Glasgow and Clyde.

Admissions from the emergency department to the hospital

- 4.50. Also considered were data on the percentage of emergency department attendances that were subsequently admitted to the same hospital as inpatients/day-cases. Interpretation of the percentage admitted from the emergency department depends on the service and the pathways in operation. The measure is sensitive to policies that are effective at redirecting patients away from the emergency department and streaming patients towards the emergency department. Figure 4.7 below shows that, following the onset of the Covid 19 pandemic, the Queen Elizabeth University Hospital appears to be admitting a higher percentage of patients from its emergency department than it was pre-Covid. During the time period corresponding to the Covid 19 pandemic, Queen Elizabeth University Hospital had among the highest rate of admissions following an attendance at the emergency department relative to the peer group. Post-Covid the Queen Elizabeth University Hospital rate of admissions remains high relative to the peer group, though this is not as pronounced as during Covid.

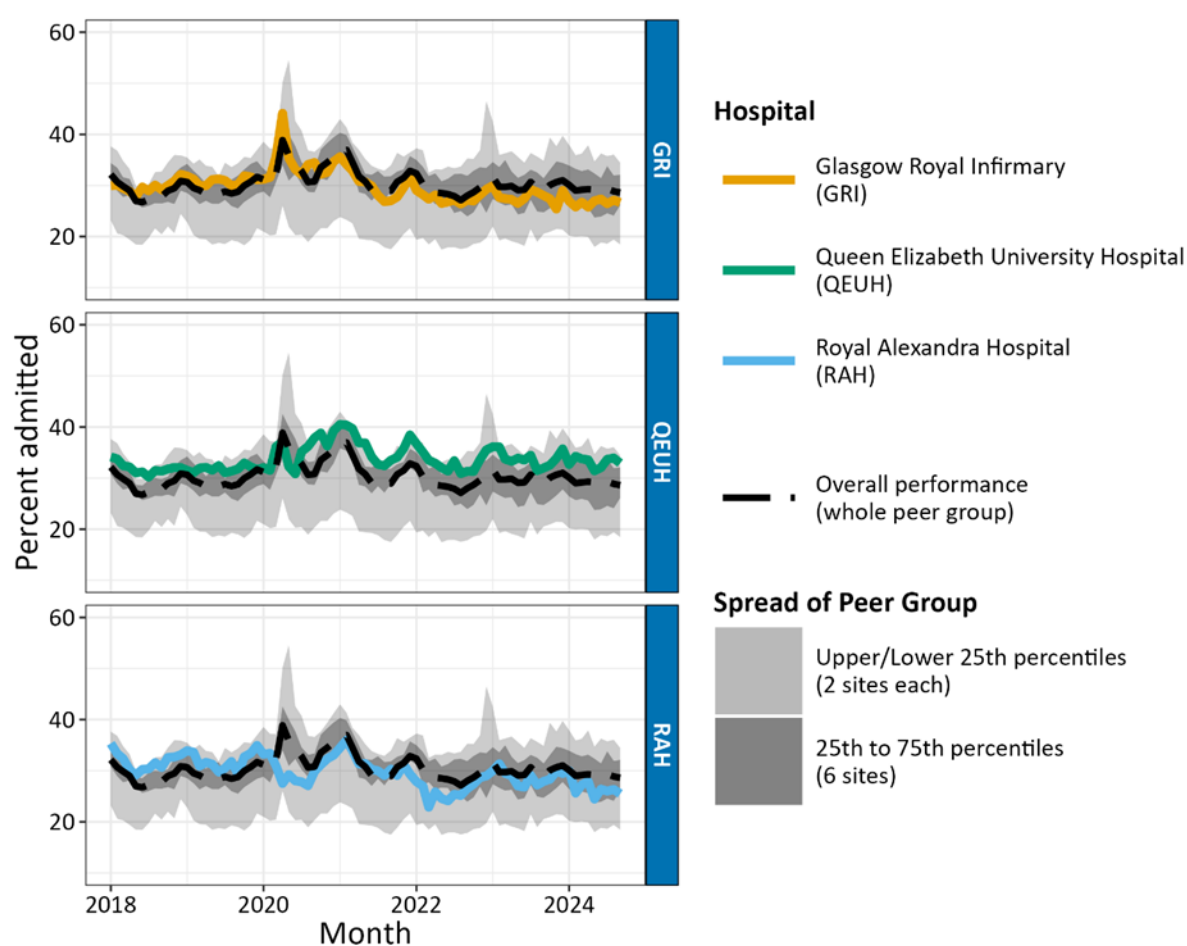
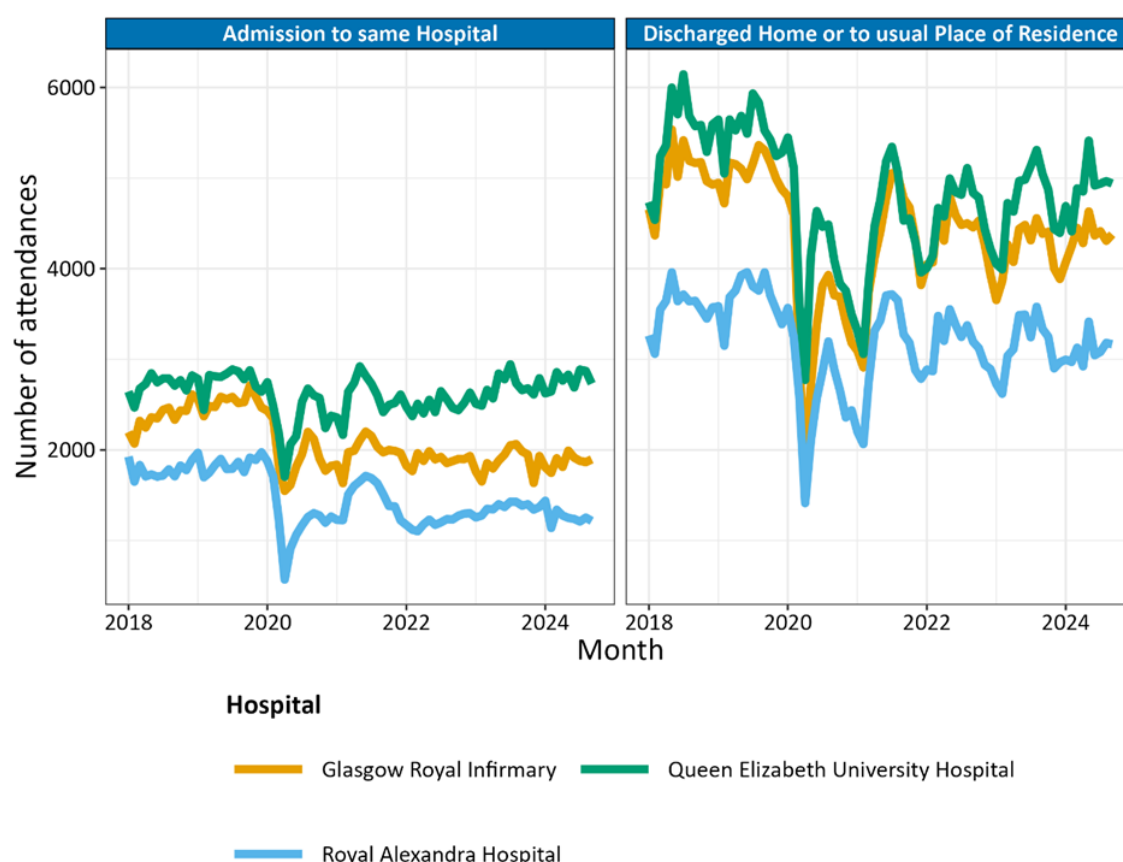


Figure 4.7: Percentage of emergency department attendances admitted to same hospital: NHS Greater Glasgow and Clyde site against peer group spread

- 4.51. Again, knowledge of the local system is required to understand which factors are influencing the level of emergency department attendances at the Queen Elizabeth University Hospital that are then admitted to hospital. Other pathways for unscheduled care that do not pass through emergency departments exist. Additionally, and as noted in paragraph 4.26, recording of activity in short stay urgent and unscheduled care services is not consistent across Scotland, therefore comparisons with other sites should be treated with caution.
- 4.52. Attendance at an emergency department can primarily result in admission to hospital or discharge home or to usual place of residence. In Figure 4.8 we can see the divergence of the NHS Greater Glasgow and Clyde sites on percentage admissions to same hospital is based on the balance between these two destinations. While the number of admissions to Glasgow Royal Infirmary and the Royal Alexandra Hospital drops during the Covid 19 pandemic and settles at a level lower than before, Queen Elizabeth University Hospital's admissions drop to a much lesser extent, and by 2024 had rebounded to the same level as pre-Covid. There was a concurrent drop in the number of attendances that were subsequently discharged from all three sites. This may be a result of redirection policies aimed at providing care via an alternative to the emergency department, resulting in fewer attendances that result in discharge.



Source: PHS Accident and Emergency downloads

Figure 4.8: Number of emergency department attendances by destination

Ambulance turnaround times

- 4.53. Ambulance turnaround times can also be useful indicators of how the healthcare system is performing. Ambulance care (the Scottish Ambulance Service calls this pre-hospital care) aims to assess, stabilise and convey patients to the hospital, where they can be further assessed and treated appropriately. Ambulance care should end almost immediately on arrival at the emergency department; however, delays can occur when ambulances are unable to hand patients over due to departments having no capacity to receive them. Ambulances stacking outside emergency departments is indicative of blockages to patient flow through the hospital site signalling significant pressures on the healthcare system. Along with the associated challenges of patients being assessed and treated timeously, so is the urgency of enabling ambulance crews to promptly get back on the road to attend to other patients.

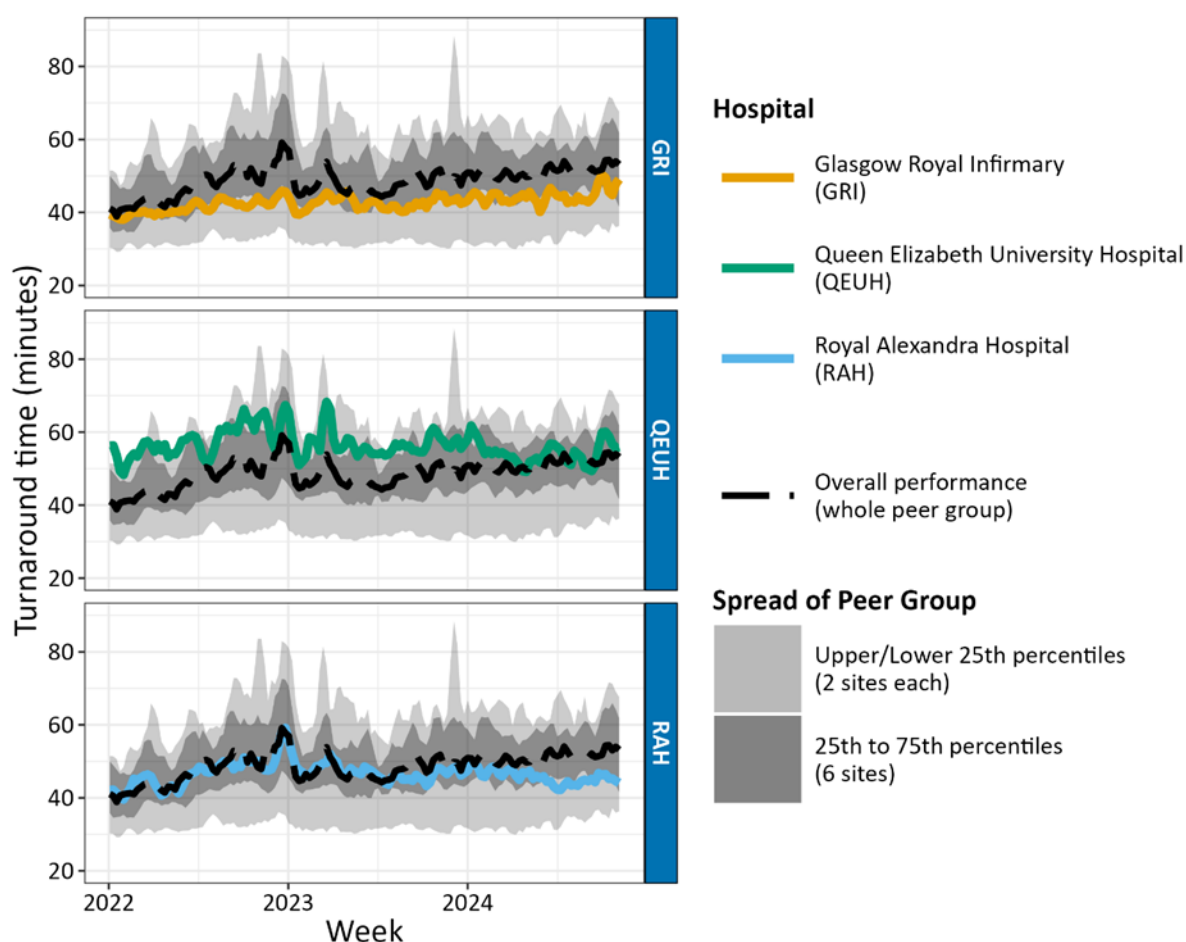


Figure 4.9: Ambulance turnaround times: Three week rolling mean of weekly median turnaround time, NHS Greater Glasgow and Clyde sites and peer group

- 4.54. Median turnaround times for each NHS Greater Glasgow and Clyde site have been compared against the peer group. Turnaround times are published as weekly medians; therefore, a three-week rolling average has been used to smooth the granular weekly numbers whilst maintaining broad trends in the data and significant peaks/troughs. Each data point is the mean for that week and the week either side.
- 4.55. Ambulance turnaround times are consistently higher for the Queen Elizabeth University Hospital than for the peer group overall throughout 2022 and 2023, occasionally sitting above the range of the peer group, before dropping to meet the peer group median in 2024 at 50-55 minutes. March 2023 appears to be a particularly challenging time for the Queen Elizabeth University Hospital, with turnaround times peaking above 65 minutes. This is shortly prior to the time of the initial letter to Healthcare Improvement Scotland raising concerns (see Appendix 1). This was also preceded by a period of higher turnaround times at all three NHS Greater Glasgow and Clyde sites, as well as the peer group, at the end of 2022 which appears to be a time of significant pressure across the country.
- 4.56. Whilst initially the Royal Alexandra Hospital tracks the median for the peer group, from mid-2023 it has consistently shorter ambulance turnaround times. Turnaround times for the Glasgow Royal Infirmary have risen steadily over the three-year period. For both these hospitals, turnaround times throughout 2024 have been around 45 minutes.
- 4.57. In terms of the waiting times statistics, the official start time for the four-hour standard (for those patients arriving by ambulance) is the time at which the ambulance arrives at the emergency department. The turnaround time includes any time spent waiting to hand over the patient, and also the time it then takes to prepare the ambulance to leave the emergency department (cleaning down, replenishing supplies etc). In an optimally performing system, the turnaround time would represent only the time taken to refit the ambulance, with a minimal time taken to hand over the patient after arrival. There is a long-term aim for handover of a patient conveyed by ambulance to hospital of 15 minutes⁴¹.
- 4.58. Approaches to corridor-care, cohorting and offloading differ between NHS boards and indeed between sites. Whilst approaches like cohorting and corridor care may offer some level of surge capacity in exceptional circumstances, they are unlikely to have a significant impact on turnaround times. It is generally understood that variation in ambulance turnaround times relate to the ability of emergency departments to provide cubicle space, which is in turn a product of upstream (demand), downstream (acute hospital) and on-site (emergency department capacity) factors.

⁴¹ [Principles for Safe Transfer to Hospital: Ensuring the Timeous Handover of Ambulance Patients](#)

- 4.59. Whilst median turnaround times show the middle value of turnaround times, 90th centile turnaround times show the length of time above which 10% of the longest waits occur. 90th centile turnaround times are sensitive to extreme situations where ambulances are unable to offload patients and are forced to wait outside hospital. Figure 4.10 below shows that Queen Elizabeth University Hospital was high relative to the peer group for much of 2022, though within the range of values experienced by the peer group. Two periods, the end of 2022 in particular December of 2022, and March of 2023, demonstrate particularly high 90th centile turnaround times. By the middle of 2023 these had returned to levels resembling the peer group median.

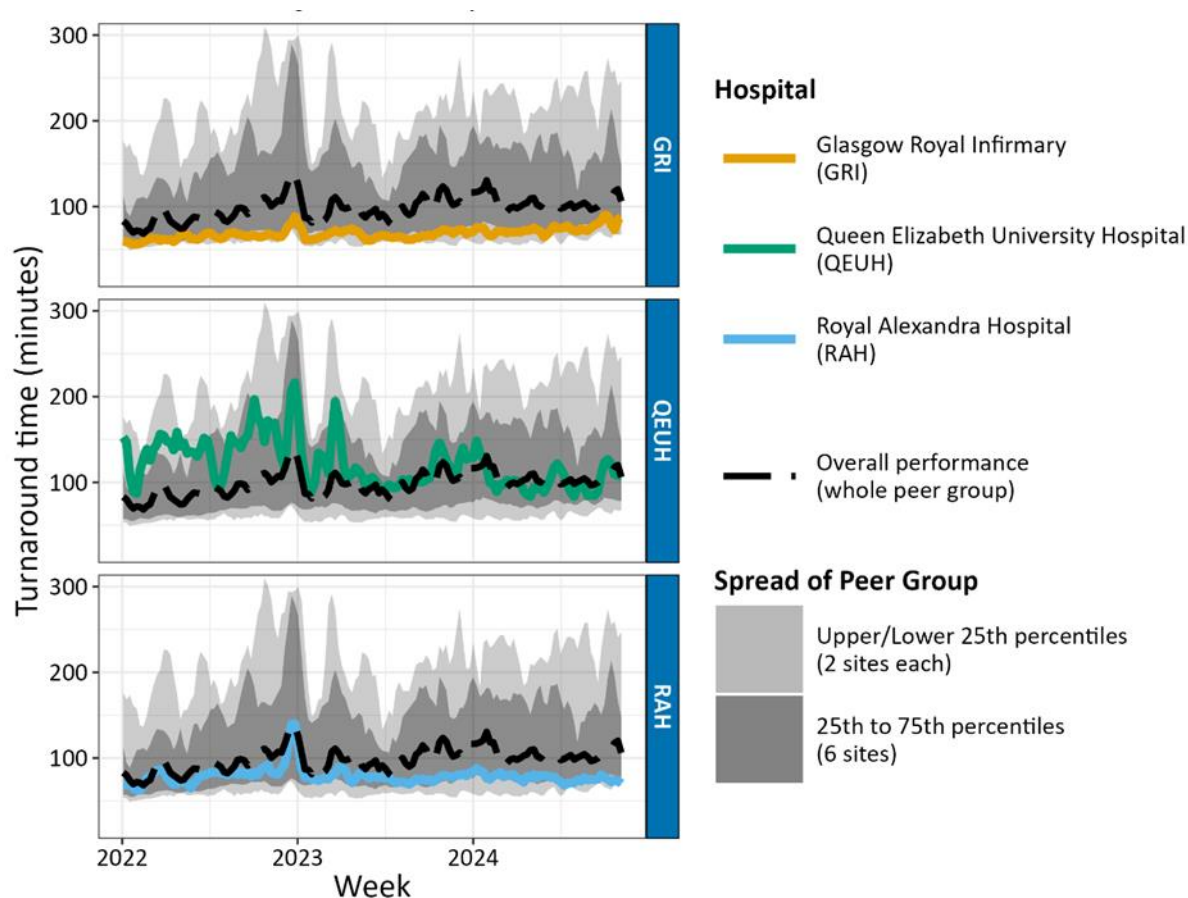
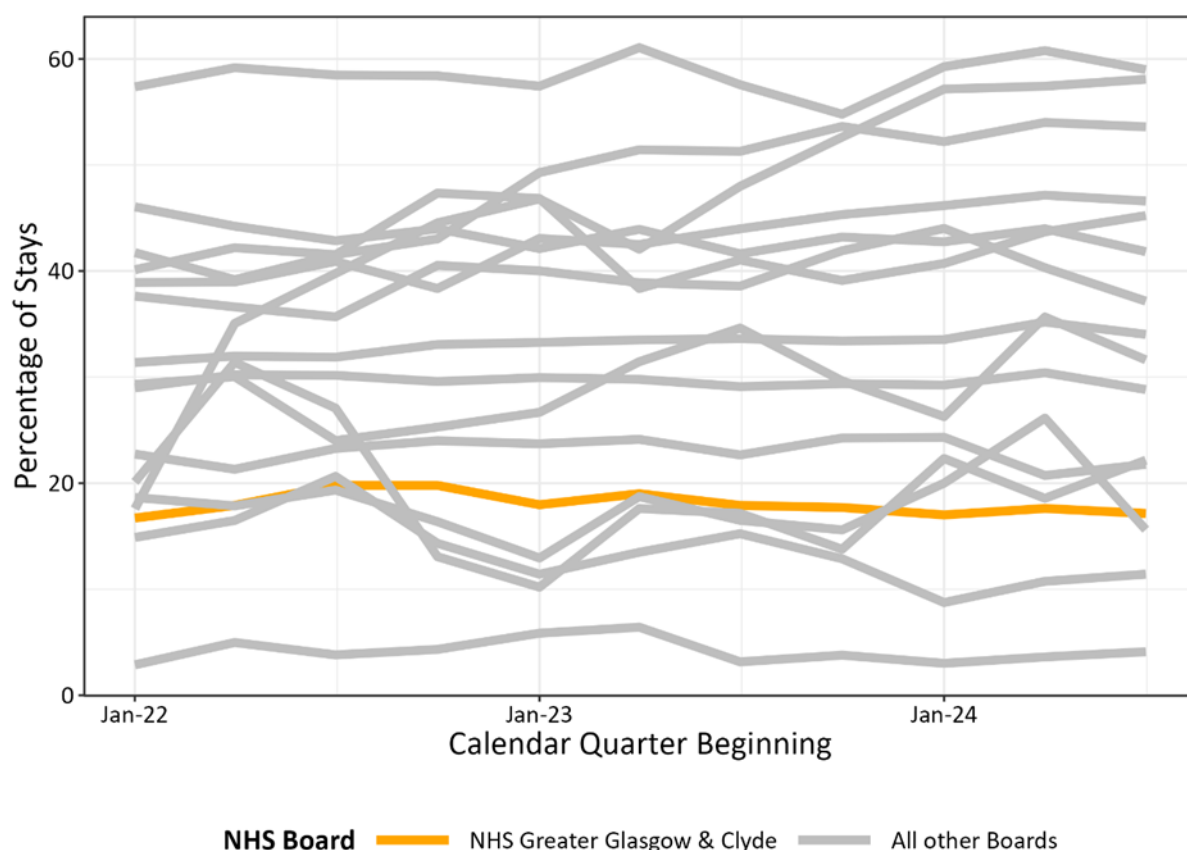


Figure 4.10: Ambulance turnaround times: three week rolling mean of weekly 90th centile turnaround time, NHS Greater Glasgow and Clyde sites and peer group

- 4.60. This consistently high level of 90th centile turnaround times in 2022 and into 2023 described an emergency department that was experiencing significant difficulties accepting patients into the emergency department. 90th centile turnaround times then improved and have remained close to the level for the peer group overall.

Length of stay

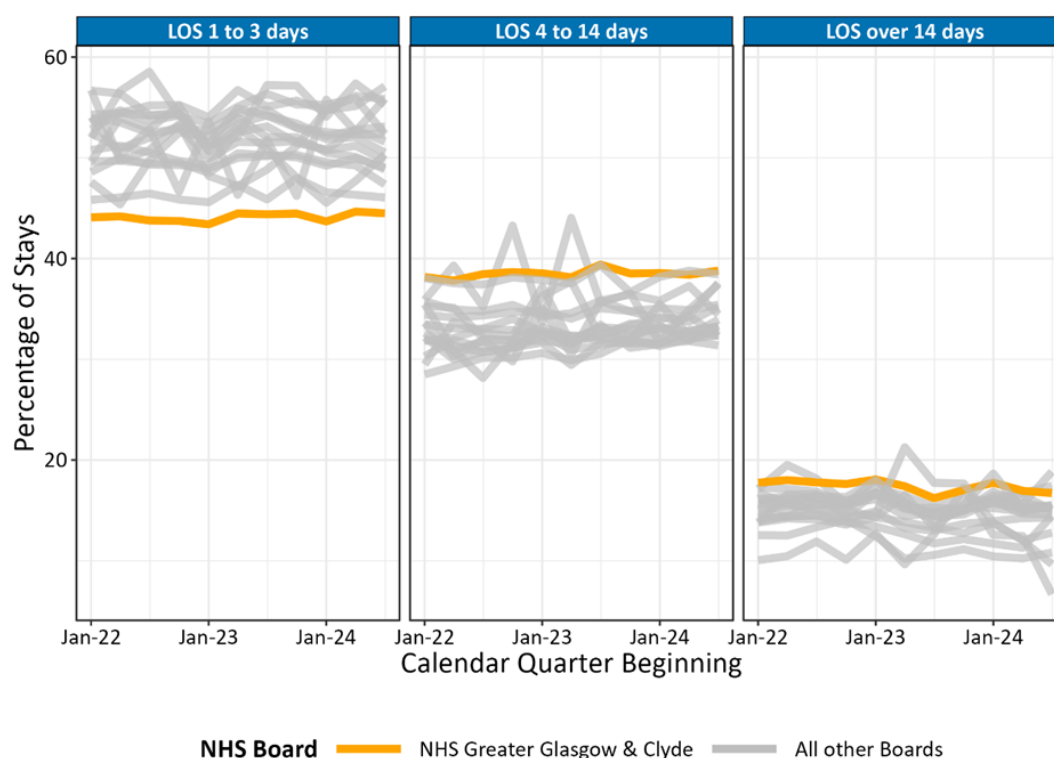
- 4.61. Length of stay refers to the amount of time (usually measured in days for inpatient care) a patient spends in a particular care setting – this can be a single specialty, a single hospital, or an entire care journey involving multiple settings. How long a patient stays in hospital will be strongly related to the acuity and complexity of their condition, but it can be affected by external factors such as delays to discharge (see paragraph 4.71). Generally, both patients and clinical staff have an interest in minimising length of stay, as outcomes worsen with increasing length of stay even after accounting for acuity (i.e. it would be expected that sicker patients have longer stays). In addition, minimising length of stay also helps with hospital flow. This is because a higher turnover of patients means beds become free faster, and also wards can plan and allocate better in terms of discharging patients to admit others. Length of stay is therefore particularly relevant to managing the flow of unscheduled patients into the hospital from the emergency department.



Source: PHS Discovery CIS length of stay (treatment)

Figure 4.11: Percentage of continuous inpatient stays with zero day length of stay: all zero day CIS beginning with an unscheduled admission to the NHS Greater Glasgow and Clyde sites

- 4.62. Figure 4.11 above shows the percentage of continuous inpatient stays lasting less than one day for stays resulting from an unscheduled admission, reflecting the delivery of same day care for unplanned admissions. These data are representative of acute and community sites across the entire of NHS Greater Glasgow and Clyde, but the three sites included in this review make up the vast majority of the admissions represented in the data. NHS Greater Glasgow and Clyde can be seen to show a quarterly percentage of between 16% and 20% for the years 2022 through 2024, meaning that between one in five and one in six unscheduled admissions are discharged on the same day. This is towards the lower end of all NHS Scotland boards. Same day care can be a reflection of acuity and complexity, but it can also be influenced by local processes and senior decision makers. Understanding whether a higher percentage of same day care could be delivered, and in which specialties, could provide opportunities to improve flow, to the benefit of both patients and the emergency department.
- 4.63. In Figure 4.12 below, the length of stay for unscheduled admissions for each NHS board is shown, in bands of short (1-3 days), medium (4-14 days) and long (over 14 days). Stays of less than one day are removed from the data for the purpose of calculating percentages of total stays. The location of continuous inpatient stays is based on the location of admission, but it is important to note that a continuous inpatient stay can consist of multiple spells in different locations, including different hospitals and NHS boards.



Source: PHS Discovery CIS length of stay (treatment)

Figure 4.12: Percentage of continuous inpatient stays by length of stay: All non-zero day CIS beginning with an unscheduled admission to the NHS Greater Glasgow and Clyde sites

- 4.64. For all NHS boards, roughly half of all non-zero-day unscheduled stays last between one and three days, with progressively fewer stays lasting between four and 14 days, and over 14 days. In the national context, NHS Greater Glasgow and Clyde has the lowest proportion of stays lasting between one and three days, and among the highest proportion of stays lasting four days or more.
- 4.65. Since case-mix, demographics and other factors will influence length of stay, this relative positioning of NHS boards using non-adjusted percentages might be expected: as a regional admitting centre NHS Greater Glasgow and Clyde sites will admit higher acuity cases, and Glasgow's population experiences more deprivation than many other places in Scotland. However, since long stays are likelier to result in worse outcomes this presents a significant challenge to unscheduled care in NHS Greater Glasgow and Clyde.
- 4.66. This pattern represents a challenge to flow within NHS Greater Glasgow and Clyde. Regardless of whether this relative positioning is expected, a higher degree of longer stays makes it more difficult to plan and allocate the finite number of beds, staffing and equipment required as part of a hospital stay. Faster turnover for stays of one to three days means higher throughput, meaning that receiving wards are more able to accept patients from the emergency department. Slower and more variable turnover for stays lasting four days or more means patients move through the hospital system at a slower rate, leading to blockage of beds for patients transitioning out of the emergency department (and between wards). A deeper local analysis of specialty-level length of stay may provide opportunities to examine where bottlenecks in the system might be arising. The Centre for Sustainable Delivery have been conducting such analysis for use locally as part of conversations directed towards improvement.

Bed occupancy

- 4.67. Bed occupancy is the percentage of beds occupied and is a key indicator of pressure in a hospital. There is no agreed standard for bed occupancy, but pragmatically hospitals with occupancy of more than 90% are operating at maximum capacity.^{42 43} High bed occupancy throughout a hospital can be expected to make it hard to find beds for unplanned admissions, increase delays in emergency departments, cause patients to be placed in non-standard care areas, reduce the nurse-to-patient ratio, and increase the rate of hospital-acquired infections.

⁴² <https://www.england.nhs.uk/publication/2023-24-priorities-and-operational-planning-guidance/>

⁴³ <https://www.nice.org.uk/guidance/ng94/evidence/39.bed-occupancy-pdf-172397464704>

- 4.68. Before 2020, the average available staffed acute beds (for both planned and unplanned admissions) that were occupied for each of the three NHS Greater Glasgow and Clyde sites in this review was approaching 90%. During the Covid 19 pandemic, bed occupancy fell but then increased above pre-pandemic levels. During 2022/23 and 2023/24, occupancy for each of the three sites averaged over 90%. These hospital-wide occupancy rates can obscure the fact that some specialties are consistently operating above this figure, and that it is likely that there are periods when some specialties experience occupancy of 100%.
- 4.69. These trends correspond with performance against the four-hour standard and lend support to the concept of exit block within NHS Greater Glasgow and Clyde emergency departments. Exit block in this context of this report refers to inability to move patients out of the emergency departments into hospital beds. Further analysis may explore what underlies the rise in occupancy above levels that would allow for good flow. Has the number of staffed beds changed over time or is this a factor of efficient use of beds in the wider hospital? The use of community beds as a whole-system resource is an avenue for relieving occupancy within a system that at a high-level is operating at maximum capacity.

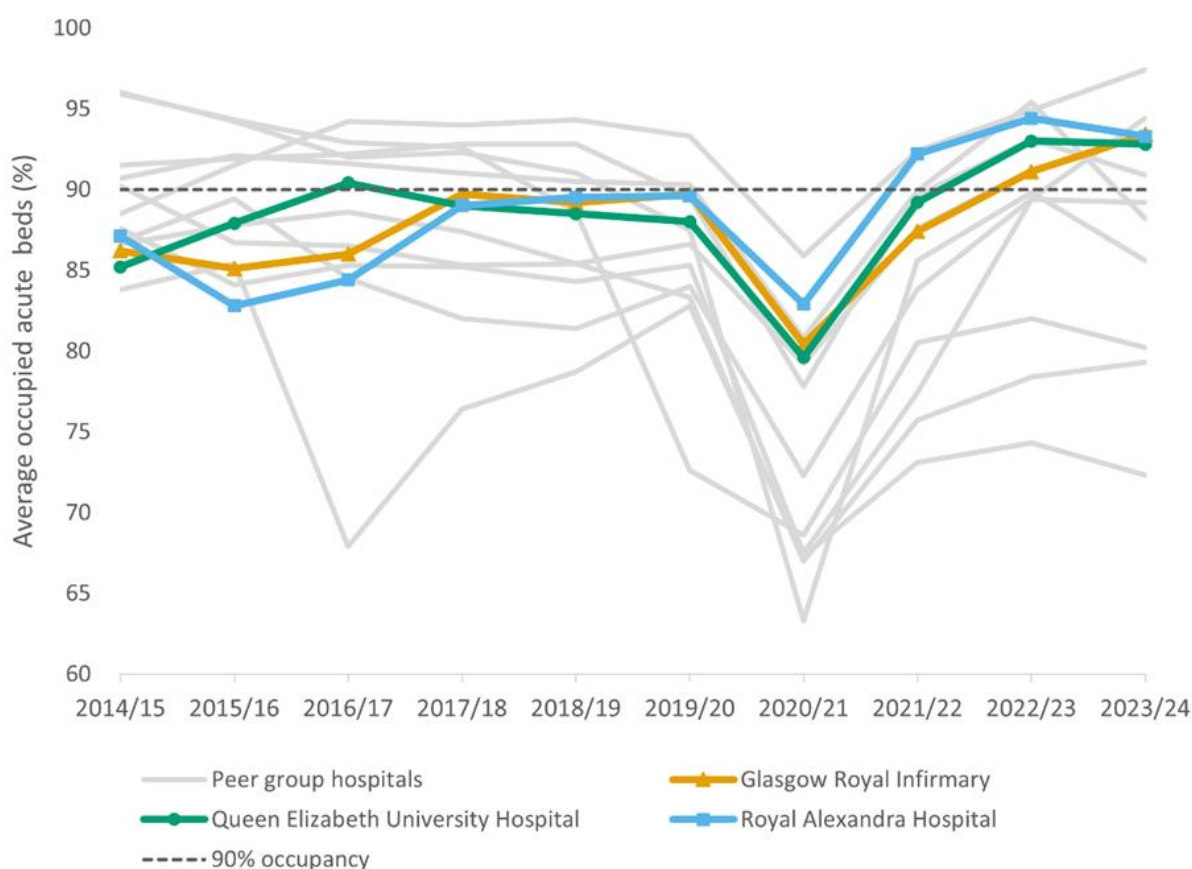


Figure 4.13: Average percentage of occupied acute staffed beds (planned and unplanned admissions)
Source: PHS ISD(S)1

Delayed discharges

- 4.70. When patients are not discharged from hospital when they are ready, fewer beds are available for new patients who need a bed, including patients coming from an emergency department. Reasons for delays come under three categories: *Health and Social Care reasons* where a person remains inappropriately in hospital after treatment is complete and is awaiting appropriate arrangements to be made by the health and social care partnership for safe discharge; *Patient, family and carer related reasons* which includes delays due to legal reasons and disagreements; and *Code 9 complex reasons* where it is acknowledged that some discharge arrangements may be more complex due to the specific care needs of the person. Delays at discharge from the acute hospital can lead to longer waiting times for patients in the emergency department who need to be admitted.

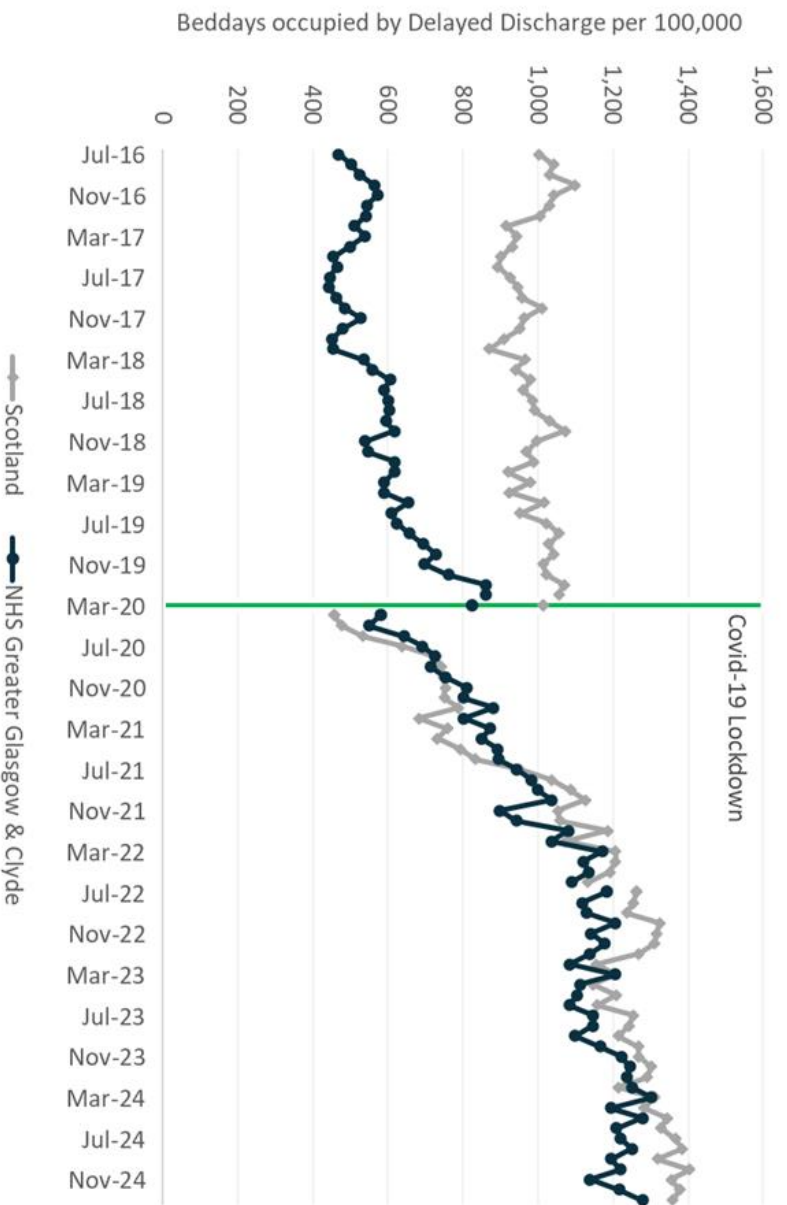


Figure 4.1.4: Bed days occupied by delayed discharges, adjusted for population

- 4.71. In NHS Greater Glasgow and Clyde, the number of bed days occupied by patients delayed at discharge started to increase pre-Covid, from around 4,500 bed days a month in 2017/18 to over 8,000 bed days at the start of 2020. With admission to hospital restricted during Covid, bed days occupied by delayed discharges fell abruptly, before increasing steadily and in 2024 reaching almost 12,000 bed days a month. The published delayed discharge figures presented in Figure 4.14 cover both acute hospitals and mental health services meaning these are not exclusively delays experienced as part of an acute stay. This near tripling of the bed resource occupied by patients waiting to leave hospital since 2017/18 in this NHS board must be treated with caution, however it is likely to represent a significant challenge to good patient flow. Figure 4.14 above shows these numbers as a rate per population. NHS Greater Glasgow and Clyde had a level of delayed discharges that was consistently lower than the national level before the pandemic, and it has then had a similar rate to Scotland over the subsequent four years.

5. Patient Experience

This section sets out the results of a bespoke patient experience survey carried out for the review. The survey was designed to obtain a representative sample of patients' views on the care that they received in the emergency departments at Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital. It also includes recommendations based on the survey findings.

Patients reported a largely positive experience of care within the three emergency departments in NHS Greater Glasgow and Clyde. This is a powerful validation of staff's commitment to caring for patients despite the challenges they face. Care was broadly reported to be provided in a person-centred way, delivered with dignity and respect. However, a quarter of patients did not receive a positive experience of care, with some reporting serious concerns. Patients want to see improvements in waiting times in emergency departments and on the communication, they receive about waiting. Patients had mixed feelings about how safe they felt in emergency departments: they reported feeling safe with staff, but less so around other patients or visitors.

Introduction

This chapter reports patients' views of care in the three emergency departments in NHS Greater Glasgow and Clyde. Importantly, views were collated from a randomised, stratified sample of patients with a recorded attendance at one of the three emergency departments to ensure they reflected experiences at these specific locations and to minimise self-selection bias. To consider whether these findings could be applicable in other NHS boards in Scotland, a comparison of patient experience was undertaken using published stories from other NHS boards. This found that patient experience was similar in all boards and therefore it is likely that many of the recommendations from the patient experience survey in NHS Greater Glasgow and Clyde could apply to other emergency departments experiencing high demand.

Patient experience survey: key findings

- 5.1. Most patients reported a positive experience of care at the emergency departments. Three quarters of respondents (75%) rated their care as very good or good, 9% as neither good nor poor, and 16% rated their care as poor or very poor.
- 5.2. The majority of patients reported being treated with dignity and respect while receiving care at the emergency department. Almost 9 in 10 (88%) felt they were 'yes, definitely' treated with dignity and respect or 'yes, to some extent'. In terms of privacy, around the same figure (89%) felt they 'yes, definitely' had enough privacy or 'yes, to some extent' when discussing their condition with staff.

- 5.3. Patients wanted to see improvements around waiting in the emergency department, in terms of both communication about waiting times, the length of the waiting and the care provided while waiting: 45% felt uninformed about their wait time. 56% reported they were not kept updated during their wait. 64% reported they received appropriate care while waiting (meeting all or some of their needs), however 25% reported not receiving appropriate care.
- 5.4. The majority of patients reported that staff delivered person centred care: 89% felt staff 'yes, definitely' or 'yes, to some extent' listened to them. 87% 'yes, definitely' or 'yes, to some extent' understood the explanations given about their condition. 82% 'yes, definitely' or 'yes, to some extent' had enough time to discuss their care. 71% 'yes, definitely' or 'yes, to some extent' felt involved in decision-making regarding their care although almost a quarter (24%) said they were not involved in decision-making regarding their care.
- 5.5. In terms of patients' perception of their personal safety in the emergency department, 83% responded that they definitely felt safe with staff. In contrast, only 58% of patients definitely felt safe with other patients and visitors to the department, with 28% feeling safe to some extent, 1 in 10 (11%) saying they did not feel safe, and 3% of respondents did not know or could not remember.
- 5.6. When asked about follow-up care before departure 68% of respondents said staff 'yes, definitely' or 'yes, to some extent' discussed follow-up care before departure, while around a quarter (24%) stated this did not occur, and 8% did not know or could not remember.
- 5.7. In terms of giving feedback about their experience, almost three quarters of respondents (72%) said they were not asked for feedback by staff. Just over 1 in 10 (12%) said they were 'yes, definitely' asked for feedback or were to some extent. Of those that gave feedback 3 in 10 (30%) felt their feedback was 'yes, definitely' valued or valued to some extent, with around the same proportion (27%) feeling it was not valued. A further 43% did not know or could not remember if their feedback had been valued.
- 5.8. Respondents were asked to highlight suggestions for improvement in an open question box, and many people used this box to provide general comments. Of the 383 comments received (from 571 total respondents), the following were the main themes:
- Long waiting times (38%)
 - Good quality of care (28%)
 - Poor communication (13%)
 - Concerns about care quality (11%)
 - Negative staff approach (10%)
 - Positive staff approach (9%)
 - Physical discomfort (9%)
 - Staffing issues (6%).

Background

- 5.9. The NHS Scotland Patient Charter⁴⁴ defines what is expected of people who use and provide NHS services. It covers peoples' rights when they access NHS services, communication, privacy and feedback.
- 5.10. NHS bodies have a legal duty on public involvement. Meaningful engagement leads to improved understanding, higher quality and safer services, and better health and care outcomes.⁴⁵
- 5.11. Patient experience was gathered directly and specifically from patients who had a recorded attendance at one of the three emergency departments included within the review. A survey was distributed to a stratified, randomised sample of patients in November 2024. This was undertaken after patients had attended the emergency department, with multiple options for how to respond and with equality monitoring to ensure a response across different demographics. A paper survey was sent to a sample of 2,000 patients (response rates 9.4%) and a text message to a sample of 6,000 patients (response rate 6.4%). For further details on methodology, see Chapter 2, paragraphs 2.42–2.48 and 2.72–2.78.
- 5.12. The results presented in this chapter are aggregated feedback from all three sites: there were only slight differences between sites, and these were within the margin of error. All comparisons made in this chapter are statistically significant unless otherwise stated. The percentages for responses to questions have been rounded and some may not add to 100%.
- 5.13. Patients had attended the emergency departments over the previous 16-month period (August 2023 to November 2024), with feedback being well-distributed over the period.
- 5.14. 45% of respondents stated that they attended Queen Elizabeth University Hospital, 30% Royal Alexandra Hospital, and 25% Glasgow Royal Infirmary's emergency departments.
- 5.15. Almost 4 in 10 (37%) respondents were taken to the emergency department by ambulance. Of these, 65% waited under an hour for their care to be handed over, while 15% waited 1 - 2 hours. Of the 63% who did not arrive by ambulance, a third (33%) of respondents were spoken to by staff within 5 minutes of arrival, 29% waited between 5 -15 minutes, 13% waited between 15 and 30 minutes, and 20% waited over 30 minutes for initial triage. A further 5% did not know or could not remember how long they waited.

⁴⁴ [The Charter of Patients Rights and Responsibilities | NHS inform.](#) NHS Scotland. May 2023

⁴⁵ <https://www.hisengage.scot/equipping-professionals/why-engage/>

Patient experience survey detailed findings

The first section gathered information about which emergency department the patient attended, when and how they attended.

Which emergency department attended

- 5.16. The first question (Figure 5.1) asked which emergency department site they had most recently attended. A total of 558 people answered this question, although a few answered more than one site giving 579 responses in total. Almost half of the responses were from Queen Elizabeth University Hospital (45%), followed by 3 in 10 from Royal Alexandra Hospital (30%) and just over a quarter from Glasgow Royal Infirmary (25%).

Answer Choices			Response Percent	Response Total
1	Queen Elizabeth University Hospital		45%	261
2	Royal Alexandra Hospital		30%	171
3	Glasgow Royal Infirmary		25%	147
			answered	579

Figure 5.1: Which emergency department patients attended

- 5.17. After an analysis of the responses to the survey questions from the three sites there was only a slight difference by each site to some questions. Where there are differences, they are within the margin of error.

Date of attendance

- 5.18. Respondents were asked to enter the date they attended the emergency department. This was to ensure feedback was considered from patients who experienced the emergency department services at different times of the year. We received 530 responses to this question with the most during July 2024 with 50 responses (9.4%) and the least in August 2023 with 17 responses (3.2%). Table 4 below shows when respondents used the emergency departments over the 16 - month period from August 2023 to November 2024 in four month sections and shows a good spread of respondents throughout this period.

	Aug – Nov 23	Dec 23 – Mar 24	Apr – Jul 24	Aug – Nov 24	Total
No. of responses	91	137	171	131	530
% of responses	17%	26%	32%	25%	100%

Table 4: Spread of patient survey responses by month and year of attendance

Route of attendance

- 5.19. When attending the emergency department, just over a third (37%) said they were taken there in an ambulance and nearly 2 in 3 respondents (63%) said they were not.

Ambulance handover

- 5.20. Question: Once you arrived at this emergency department, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?
- 5.21. Of those that arrived at the emergency department by ambulance, nearly 2 in 3 respondents (65%) told us that they waited under an hour with the ambulance crew before their care was handed over to the emergency department staff. 15% waited between 1–2 hours, with 1 in 20 (5%) participants waiting 4 hours or more. A further 4% waited between 2–3 hours and 2% between 3–4 hours. 9% of respondents did not know or could not remember how long they waited.

Triage

- 5.22. Question: When you first arrived at the emergency department, how long was it before a member of staff talked to you about the reason you were there?
- 5.23. Patients were asked when they first arrived at the emergency department, how long it was before a member of staff talked to them about the reason for attending. 1 in 3 respondents (33%) said they waited less than 5 minutes, 29% waited between 5 and 15 minutes, and 1 in 5 (20%) waited over 30 minutes. A further 13% waited between 15 and 30 minutes for initial triage. 5% of respondents did not know or could not remember how long they waited.

Care received while waiting

Patients reported poor experiences of waiting in the emergency department: nearly half were not informed about how long they would have to wait, two-thirds were not updated during their wait and many expressed concerns about their care while waiting.

Informed about waiting time

- 5.24. Question: Were you informed how long you would have to wait to be examined or treated?
- 5.25. Patients were asked if they were informed how long they would have wait to be examined or treated. Nearly half of respondents (45%) said they were not informed on how long they would have to wait to be examined or treated, compared to just over 1 in 4 (27%) who were kept informed to some extent and 16% who said they were 'yes, definitely' kept informed. 13% of respondents did not know or could not remember.

Updated during wait

- 5.26. Question: Were you kept updated on how long your wait would be?
- 5.27. Only 1 in 3 respondents said they were kept updated on how long their wait would be (13% said 'yes, definitely', 21% said 'yes to some extent') compared to over half of respondents (56%) who did not agree that this had happened. 10% of respondents did not know or could not remember.

Appropriate care while waiting

- 5.28. Question: While you were waiting, was there appropriate care if you needed it?
- 5.29. Respondents were then asked if they had received appropriate care if they needed it whilst waiting. Of the respondents, 37% stated they did receive appropriate care, just over 1 in 4 (27%) said that some but not all of their care needs were addressed, and a quarter (25%) disagreed. 11% of respondents did not know or could not remember. In terms of care while waiting: 31% of all females stated they did not get appropriate care while they were waiting compared with 18% of all males.

Assistance for using a toilet

- 5.30. Question: Could you get assistance to go to the toilet if needed?
- 5.31. When asked if assistance was available to go to the toilet if needed, respondents were positive that this was the case (36% said 'yes, definitely', 18% said 'yes to some extent'), whereas nearly 1 in 4 (23%) were not offered assistance and 24% did not know or could not remember. 29% of all females could not get assistance to go to the toilet compared with 16% of all males.

Accessing food and drink

- 5.32. Question: Were you able to get food and drink if required?
- 5.33. Half of respondents said they were able to get access to food and drink when required whilst they were waiting in the emergency department (26% said 'yes to some extent', 24% said 'yes, definitely') compared to 1 in 3 respondents (34%) who said this was not the case. A further 16% did not know or could not remember. 43% of all females could not get food and drink if required compared with 25% of all males.

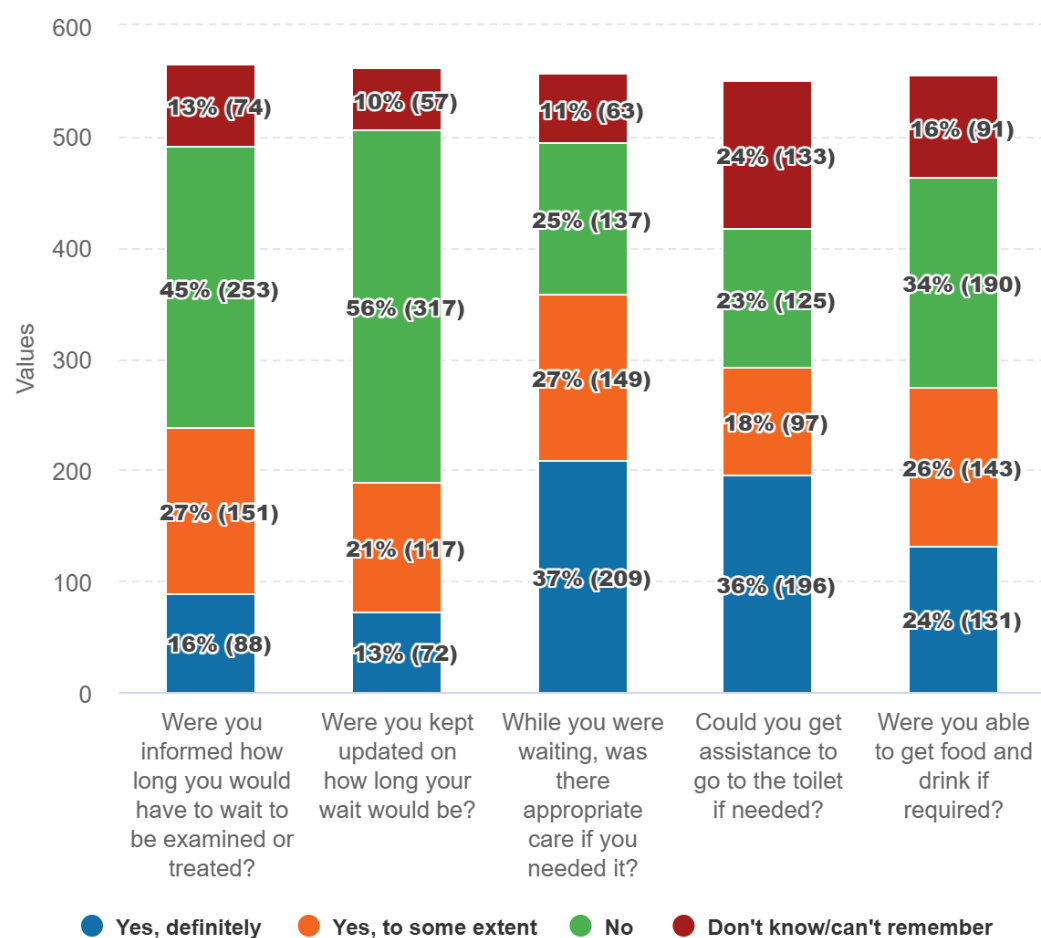


Figure 5.2: Care received while waiting

Recommendation 1: NHS Greater Glasgow and Clyde should improve waiting times in emergency departments. Where waits occur, communication with patients about waiting time length should be improved, both at initial arrival and through frequent updates during the wait. People should be appropriately supported during their wait.

Recommendation 2: NHS Greater Glasgow and Clyde should undertake specific engagement with people who are actively waiting in emergency departments to better understand the specific information and support people would find valuable while waiting.

Person centred care and communication

Patients reported positive experiences of person-centred care, including feeling that staff listened to them, explained information and provided time for a discussion. Less positive was patient involvement in decision making and a quarter of patients were not given information about follow-up care for after discharge from the emergency department.

Staff listening to patients

- 5.34. Question: Did staff listen to what you had to say?
- 5.35. Almost 9 in 10 participants (89%) said that staff listened to what they had to say, with 68% saying 'yes, definitely' and 21% saying 'yes, to some extent'. Around 1 in 10 (8%) said that staff did not listen to what they had to say and 3% did not know or could not remember. 61% of all females stated 'yes, definitely' compared with 77% of all males.

Staff explaining information to patients

- 5.36. Question: Did staff explain your condition and treatment in a way you could understand?
- 5.37. Most participants (87%) said that staff explained their condition and treatment in a way that they could understand, with 65% saying 'yes, definitely' and 22% saying 'yes, to some extent'. 10% answered 'no' to this question and 3% did not know or could remember.

Time for discussion

- 5.38. Question: Did you have enough time to discuss your condition and treatment with the staff?
- 5.39. Most participants (82%) said that they had enough time to discuss their condition and treatment with the staff, with 61% saying 'yes, definitely' and 21% saying 'yes, to some extent'. 14% answered 'no' to this question. 4% did not know or could not remember.

Patient involvement in decisions about care and treatment

- 5.40. Question: Were you involved in decisions about your care and treatment?
- 5.41. Just over 7 in 10 respondents (71%) said that they were involved in decisions about their care and treatment, with 45% saying 'yes, definitely' and 26% saying 'yes, to some extent'. However, nearly one quarter of participants (23%) said they were not involved in decisions about their care and treatment. 5% of respondents did not know or could not remember.

Answer Choices	Yes, definitely	Yes, to some extent	No	Don't know/can't remember	Response Total
Did staff listen to what you had to say?	68% 387	21% 120	8% 44	3% 18	569
Did staff explain your condition and treatment in a way you could understand?	65% 367	22% 125	10% 56	3% 18	566
Did you have enough time to discuss your condition and treatment with the staff?	61% 346	21% 121	14% 80	4% 22	569
Were you involved in decisions about your care and treatment?	45% 254	26% 148	23% 133	5% 31	566
				answered	570

Table 5: Patient involvement in decisions about care and treatment

Communication support needs

- 5.42. Question: Did you require any communication support during your attendance at the emergency department? Please select all options that apply to you.
- 5.43. When asked whether they required communication support during their attendance at the emergency department, most participants (93%) said they did not have any communication needs (n=558).
- 5.44. In terms of communication support, 2 participants said they needed translation or an interpreter, 2 said they needed Sign language or Braille materials, 8 needed Easy read materials and 4 Large print materials. Some respondents offered other communication needs such as support required due to hearing difficulties (7) dementia (6), and brain injury (3).

Staff support for communication needs

- 5.45. Question: If you needed communication support, did staff help you with your communication needs?

- 5.46. People who needed communication support were asked if staff helped them with their communication needs. Over half of those who answered this question (54%, n=45) said that staff did help them with their communication needs, with 27% saying 'yes, definitely' and 27% saying 'yes, to some extent'. However, over a third of those who answered this question said 'no' (36%) and 11% did not know or could not remember.

Answer Choices			Response Percent	Response Total
1	Yes, definitely		27%	12
2	Yes, to some extent		27%	12
3	No		36%	16
4	Don't know/can't remember		11%	5
			answered	45

Figure 5.3: Staff support for communication needs

Family/friend/carer involvement

- 5.47. Question: If a family member, friend or carer wanted to talk to staff about your care, did they have enough opportunity to do so?
- 5.48. When asked if a family member, friend or carer had enough opportunity to talk to staff about their care if they wanted to, over half of the participants said that they did have this opportunity (54%), with 36% saying 'yes, definitely' and 18% saying 'yes, to some extent'. Nearly a third of participants said that they did not need this (31%). 12% said 'no'. 2% of respondents did not know or could not remember.

Answer Choices			Response Percent	Response Total
1	Yes, definitely		36%	206
2	Yes, to some extent		18%	99
3	No		12%	69
4	I did not need this		31%	177
5	Don't know/can't remember		2%	14
			answered	565

Figure 5.4: Family/friend/carer involvement

Follow-up care

- 5.49. Question: Before you left the emergency department, did a staff member talk with you about follow-up care? This may have been about how to take care of yourself at home and what to expect, or whether you needed a follow-up appointment.
- 5.50. Participants were asked whether a staff member talked with them about follow-up care before they left the emergency department (n=562). This may have been about how to take care of themselves at home and what to expect, or whether they needed a follow-up appointment. Most participants (68%) said that staff had discussed this with them. However, nearly a quarter of participants (24%) said that this did not happen. 8% said they did not know or could not remember.

Recommendation 3: NHS Greater Glasgow and Clyde should enable, expect and ensure that all staff involve patients in making decisions about their care.

Recommendation 4: NHS Greater Glasgow and Clyde should ensure patients are provided with information about their follow-up care including who to contact if their condition worsens before leaving the emergency departments.

Patient experience of safety

Patients felt safe with staff in the emergency department, however there were some concerns about safety around other patients and visitors.

Safety in the emergency department

- 5.51. The first of the questions explored how safe patients felt in the presence of other patients or visitors, and question two asked about feeling safe in the presence of staff.
- 5.52. Just under 6 in 10 patients (58%) said they definitely felt safe in the presence of other patients and visitors, 28% said they felt safe to some extent, whereas 1 in 10 (11%) said they did not feel safe. 3% did not know or could not remember.
- 5.53. In relation to staff, just over 8 in 10 respondents (83%) reported that they definitely felt safe whilst being treated by staff, 12% said they felt safe to some extent, and 3% said they did not feel safe whilst being treated by staff. 2% did not know or could not remember.

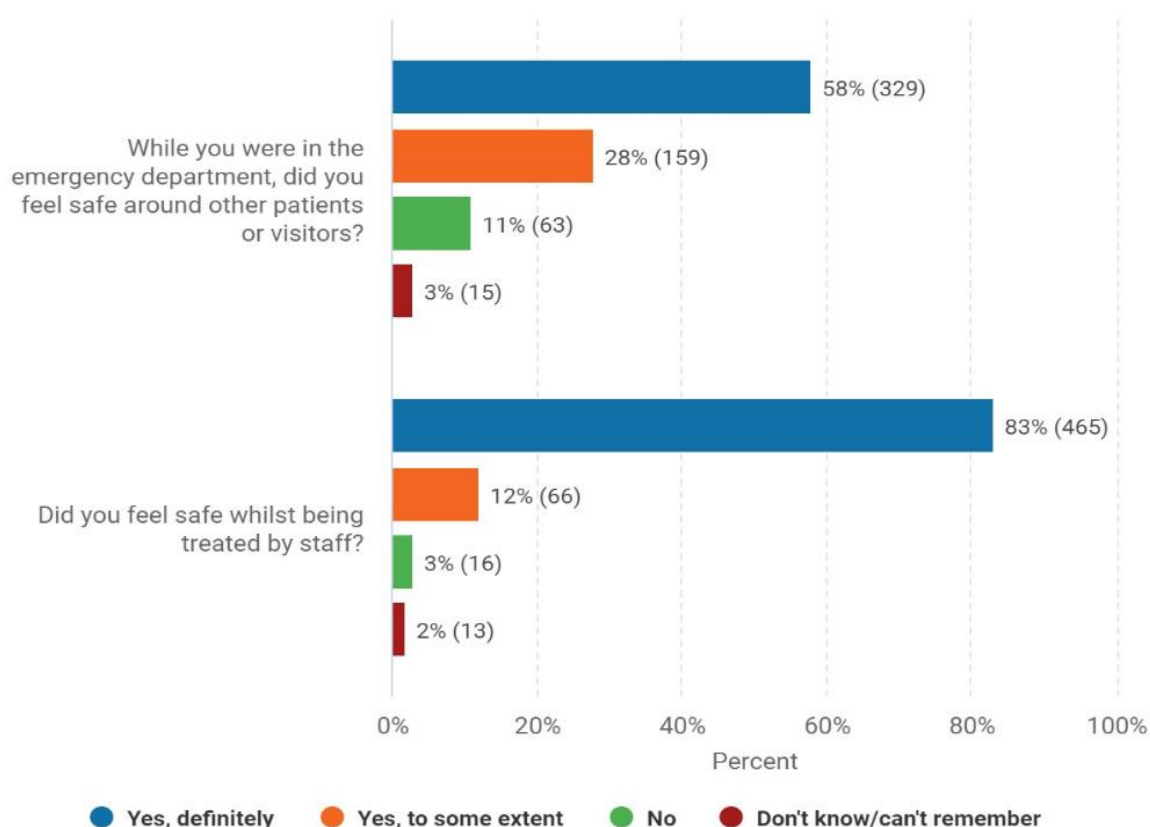


Figure 5.5: Safety in the emergency department

Recommendation 5: NHS Greater Glasgow and Clyde should take action to reduce patients' concerns about personal safety around other patients/visitors in emergency departments to create a safer, more secure environment.

Patient feedback

The majority of patients were not asked by staff for feedback about their care, and they had concerns that feedback is not valued.

Offering feedback to staff

- 5.54. Question: Did you offer to give feedback about your care to staff?
- 5.55. Respondents were asked if they had offered to give feedback to staff about the care they had received (n=561). 14% answered they definitely offered this, 13% said they had offered feedback to some extent, and the majority, 57% or almost 6 in 10, said that they had not offered to give feedback to staff. Less than 2 in 10 (16%) responded they didn't know if they had offered or could not remember if they had or not.

Staff asking for feedback

- 5.56. Question: Were you asked by staff to give feedback about your care?
- 5.57. Respondents were asked whether staff asked them to give feedback about their care (n=564). Only 7% answered with a definite yes, 6% responded they were asked to some extent, whereas a large majority of over 72%, that is 7 in 10 respondents, answered 'no'. A further 16% didn't know or had no recollection of being asked to provide feedback by a member of staff. 81% of all females were not asked for feedback by staff compared with 61% of all males.

Value of feedback

- 5.58. Question: If you provided feedback, did you feel your feedback was valued by staff?
- 5.59. The last of the questions in relation to feedback, asked about respondents' perception of how their feedback was received by staff. 3 in 10 participants in the survey felt that their feedback was either definitely valued (18%) or valued to some extent (12%). A similar number, 27% did not think their feedback was valued, and 43% did not know or recall if their feedback had been valued. 31% of all females did not think their feedback was valued compared with 23% of all males.

Answer Choices			Response Percent	Response Total
1	Yes, definitely		18%	76
2	Yes, to some extent		12%	48
3	No		27%	112
4	Don't know/can't remember		43%	180
			answered	416

Figure 5.6: Value of feedback

Recommendation 6: NHS Greater Glasgow and Clyde should provide more opportunities to ask patients about their experience of using emergency departments and clearly demonstrate how this feedback is valued and used to continually drive improvements and shape services.

Dignity and respect

Patients reported that they were treated with dignity and respect, and that their privacy had been respected.

Treated with dignity and respect

- 5.60. Before the questions about dignity and respect, respondents were offered a brief definition of what dignity and respect encompasses in the context of health and care:

“Dignity and Respect focusses on the value of every individual, respecting their views, choices and decisions, not making assumptions about how they want to be treated and working with compassion.”

- 5.61. Question: Overall, did you feel you were treated with dignity and respect while you were in the emergency department?
- 5.62. The first question enquired about respondents’ overall impression of whether or not they had been treated with dignity and respect during their stay in the emergency department. Of the 568 responses received, 67% said they were definitely treated with dignity and respect, whereas 21% felt they had been treated with dignity and respect to some degree, with the two answer choices combined accounting for 88% (just under 9 in 10 participants) of the response total. However, 10%, or 1 in 10 respondents, reported that they had not been treated with dignity and respect and 2% did not know or could not remember. 60% of all females stated they were definitely treatment with dignity and respect compared with 76% of all males.

Privacy in discussions

- 5.63. Question: Were you given enough privacy when discussing your condition with the staff?
- 5.64. Of the 567 respondents to this question, 70% said they had definitely experienced enough privacy when discussing their condition with staff, and 19% felt they had enough privacy to some extent. Again, with a combined figure of 89% or 9 in 10 respondents, this accounts for the majority of responses, leaving only 8% feeling they did not have enough privacy. 3% did not know or could not remember.

Privacy in examination and treatment

5.65. For the third question, respondents were asked if they felt they had had enough privacy when being examined or treated. Of the 566 patients responding to this question, 78% agreed that they were definitely afforded enough privacy whilst being treated and 16% said that they had had enough privacy to some extent. 4% of respondents felt they did not have enough privacy and 2% did not know or could not remember.

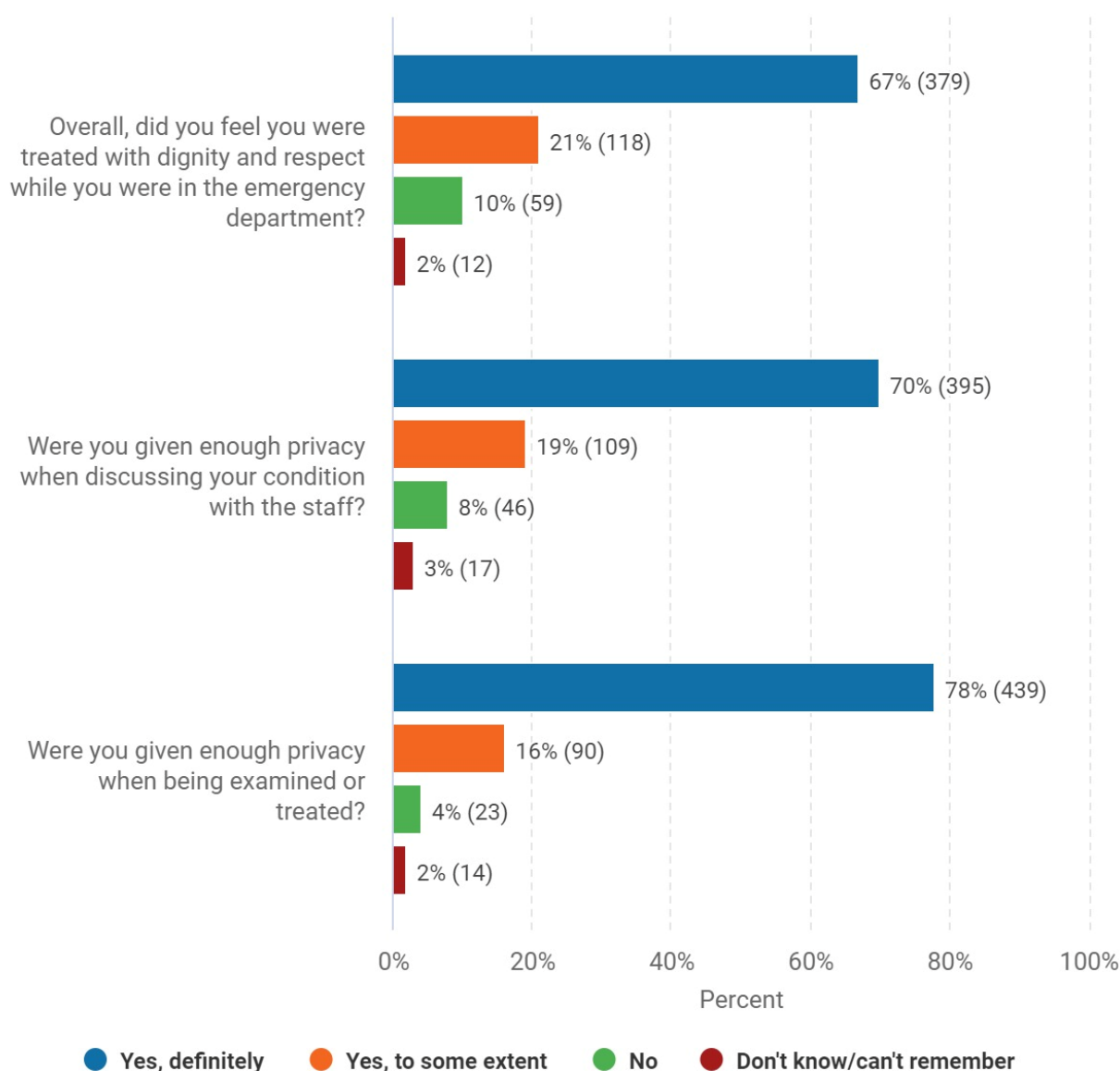


Figure 5.7: Privacy in examination and treatment

Recommendation 7: NHS Greater Glasgow and Clyde should enable and expect all staff to treat patients with dignity and respect and provide suitable surroundings for this to occur.

Overall rating of care

Patients rated their care positively, with three-quarters rating it either very good or good.

Rating of care

- 5.66. Overall, how would you rate the care you experienced at this emergency department on this occasion?
- 5.67. Respondents were asked how they would rate their care at the emergency department. Figure 5.8 below shows that of the 561 respondents that answered this question, three quarters (75%) rated their care as very good or good, 16% rated their care as poor or very poor and 9% rated it neither good nor poor.
- 5.68. There were large differences between males and females to how they rated their care. Whilst 7 in 10 (70%) females rated their care as very good or good, over 8 in 10 (82%) males rated their care as very good or good. Over double the rate of females rated their care as very poor (9%) than males (4%).

Answer Choices			Response Percent	Response Total
1	Very good		53%	297
2	Good		22%	126
3	Neither good nor poor		9%	50
4	Poor		8%	46
5	Very Poor		7%	42
			answered	561

Figure 5.8: Rating of Care

Improvements to care

The patient experience survey included an open -ended question in which patients were invited to make suggestions about what would improve the care they received in the emergency department. Some patients used this question to provide comments. The most frequently suggested improvement was to tackle long waiting times. The second most frequent comment was to praise the quality of care and individual staff.

- 5.69. Out of the 571 patients who responded to the survey, around two thirds of respondents answered this question (383 responses). An analysis identified 17 themes highlighted in Figure 5.9 below. Comment on the main themes is given after the chart to briefly explain the theme and provide specific quotes attributed to the themes to understand in more detail patients' views. It should be noted that while some people attempted to answer the question directly, others gave their view on their experience and other comments didn't relate directly to the question.

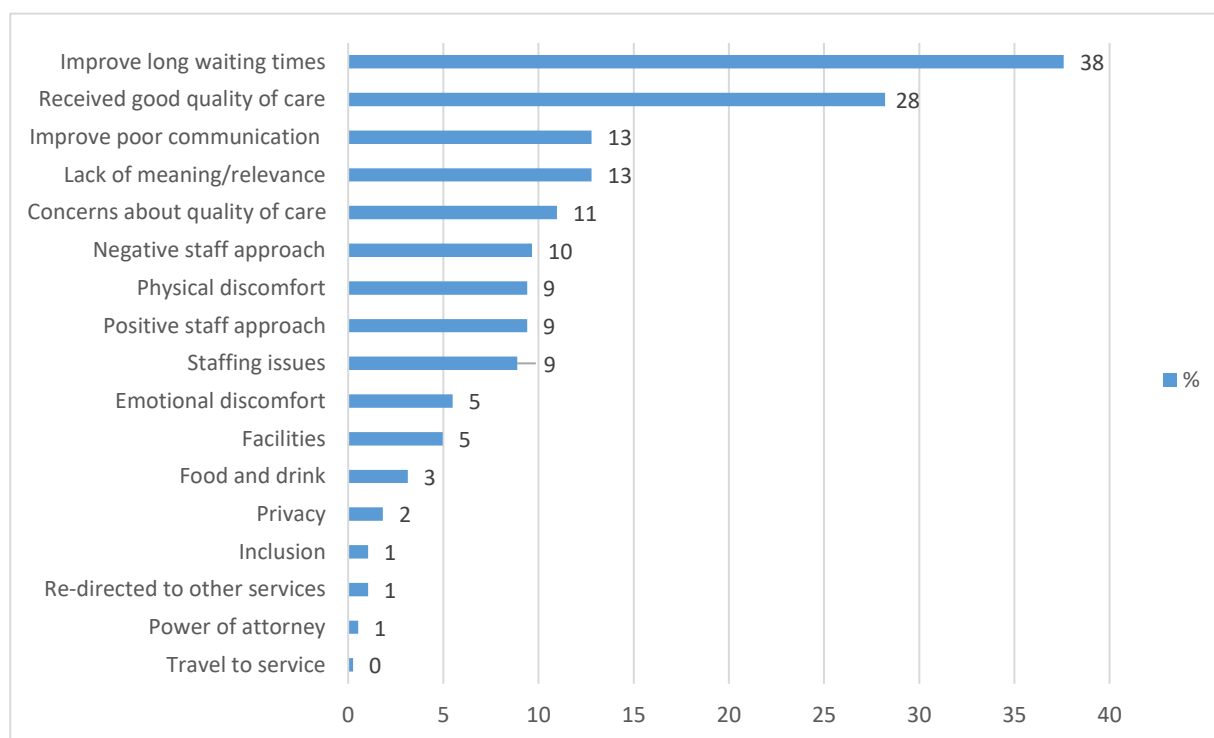


Figure 5.9: Themes for suggested improvements to care

Improve long waiting times

- 5.70. This theme was mentioned 144 times (38% of respondents).

- 5.71. A significant number of patients expressed dissatisfaction with the long waiting times in the emergency departments. Many reported waiting anywhere from several hours to over 12 hours before being seen by a doctor. This theme recurred throughout the feedback, with many comments directly referencing the need for shorter wait times.



Patients said:

- *Improvement to waiting times would eradicate a lot of anxiety and worry - knowing what is wrong with you takes away a lot of worry.*
- *I had to wait nearly 12 hours to be admitted, luckily after about 6 hrs I got to lie on a trolley. All members of staff once I got to see them were very kind and compassionate.*
- *Shortage of staff was evident, but the attitude was excellent, if the time waiting was shortened that would help everyone.*



Received good quality of care

- 5.72. This theme was mentioned 108 times (28% of respondents).
- 5.73. While there were many complaints about waiting times, patients praised the quality of care they received once they were seen. Many described the individual staff and teams as kind, caring, and professional, indicating that the treatment they received in the examination room or ward was satisfactory.



Patients said:

- *The treatment I received was very good, professional, friendly and efficient. It was a busy A&E so waiting was expected, if my condition had deteriorated, I believe the hospital would have stepped in asap.*
- *Nothing. I was treated exceptionally well. And was admitted to hospital for continued care.*
- *Care was first class and much appreciated.*



Improve poor communication

- 5.74. This theme was mentioned 49 times (13% of respondents).

- 5.75. Many patients felt that communication could be improved, particularly regarding updates on waiting times and the status of their care. Several mentioned feeling left in the dark about how long they would have to wait and expressed a desire for more frequent check-ins from staff. Related terminology such as ‘listening’, ‘understanding’, ‘talking to’; or texts descriptive of person-to-person situations where communication was an issue were also noted.



Patients said:

- *Just to have been kept more informed of what was happening.*
- *Communication in the emergency waiting room could be a lot better. We lost my mum for a good while and nobody knew where she was.*
- *The nurse needed to listen to the symptoms I was describing, as she would then have realised, they didn't match the diagnosis she was giving. In general, she was incredibly rude and invalidating and it felt like her priority was getting me to leave, rather than helping.*



Concerns about quality of care

- 5.76. This theme was mentioned 42 times (11% of respondents).
- 5.77. Several patients reported dissatisfaction with the treatment they received, including misdiagnosis or inadequate assessment of their conditions, some leading to further complications.



Patients said:

- *I felt that the priority was to give me painkiller and crutches and get me out. There was no advice about what to do if I did not improve. Two days later my GP sent me back to A&E. This was little better.*
- *Was told I had undiagnosed infection, discharged then collapsed at home that night. Very ill all night. Called GP for home visit who immediately called ambulance, and I was readmitted to A&E.*
- *I was in great distress at the time. I had to wait hours. There was no water machine or anything. What upset me the most is that I was clearly distressed, in pain, with pus running down my face. Nurses would just walk by me... a simple acknowledgment from a nurse, cup of water, a seat, a smile, would have made all the difference. I had to ask for a dressing.*



Negative staff approach

- 5.78. This theme was mentioned 37 times (10% of respondents).
- 5.79. It highlights patient narratives focusing on staff behaving, acting or communicating in a way that impacted on respondents' perception of being cared for in an appropriate and safe manner.



Patients said:

- *Triage nurse huffed and puffed and was shaking her head like I was a pest for being there.*
- *Left in corridor on trolley for 7 hours. With broken pelvis in great pain. Deranged man in chair next to me tried to inject himself with drugs and the doctor told me to mind my own business.*



Positive staff approach

- 5.80. This theme was mentioned 36 times (9% of respondents).
- 5.81. It highlights patient narratives focusing on staff behaving, acting or communicating in a way that impacted positively on respondents' perception of being cared for in an appropriate and safe manner.



Patients said:

- *Waiting time was about 6 hours, which was too long, other than that staff were great and supportive even when being so busy and under pressure.*
- *I was delighted with the care I received. Obviously, there was some waiting around (and it was really cold in the A&E main waiting room) but when I did get seen every member of staff I encountered was cheerful and respectful. A scan was organised, and I could wait for results. I felt I had the best care – only waiting times could be improved and everyone already knows this.*



Physical discomfort

- 5.82. This was mentioned 36 times (9% of respondents). Some patients reported experiencing physical discomfort (including pain) because of circumstances which from their perspective should have been avoided.



A patient said:

- *I was left alone on a trolley in severe pain on trolley. Doctor had prescribed Oramorph, but there was a delay in being given it. Cot sides were up, and I had to shuffle to end of trolley to get help and collapsed. Another patient had to go and get help.*



Staffing Issues

- 5.83. This was mentioned 34 times to this question (9% of respondents).
- 5.84. Numerous responses highlighted a lack of staff, which contributed to the long wait times and patients feeling neglected. Some comments indicated that staff were overworked and overwhelmed, which affected the quality of care provided.



A patient said:

- *On this occasion my level of care was very good. However, I did notice that there's not enough staff to attend patients' needs. Nurses and doctors are under so much pressure.*



Qualitative interview findings

- 5.85. Two people expressed a desire to take part in an interview discussion about their experience of the emergency department, one at Queen Elizabeth University Hospital and the other at Royal Alexandra Hospital. A short summary of their experience is given below and chimes with some of the findings from the open question above.
- 5.86. Both participants reported positive experiences overall, feeling safe, cared for, and respected during their visits. They praised the cleanliness of the facilities and the helpfulness of the staff, with one participant noting that they felt reassured about their visit's necessity.
- 5.87. However, there were some highlighted issues, particularly related to communication and waiting times. One participant experienced a discrepancy between being told they would be seen immediately and having to wait 30 minutes, while another mentioned a 2 hour wait. They expressed concerns about reception staff's awareness of their urgent needs and noted that communication is essential.

- 5.88. Both participants felt safe during their visits but mentioned that their experiences could vary significantly depending on the time and day they visited. They also noted that they were not asked for feedback regarding their care.

Patient experience: comparison with other NHS boards

- 5.89. To consider whether the recommendations drawn from the patient experience survey in NHS Greater Glasgow and Clyde could be more widely applicable across NHS Scotland, an analysis of Care Opinion posts about emergency care in all boards was undertaken. The purpose was to understand whether patient experience was similar in all boards. Care Opinion stories about emergency care (which includes emergency departments and minor injury units) from January 2022 to December 2024 were included (see Chapter 2, section 2.78).

Positive experiences of emergency care

- 5.90. The most positive common themes about people's emergency care experience are provided below (Figure 5.10). The qualities patients identified as "good" care are similar in NHS Greater Glasgow and Clyde and the rest of Scotland.

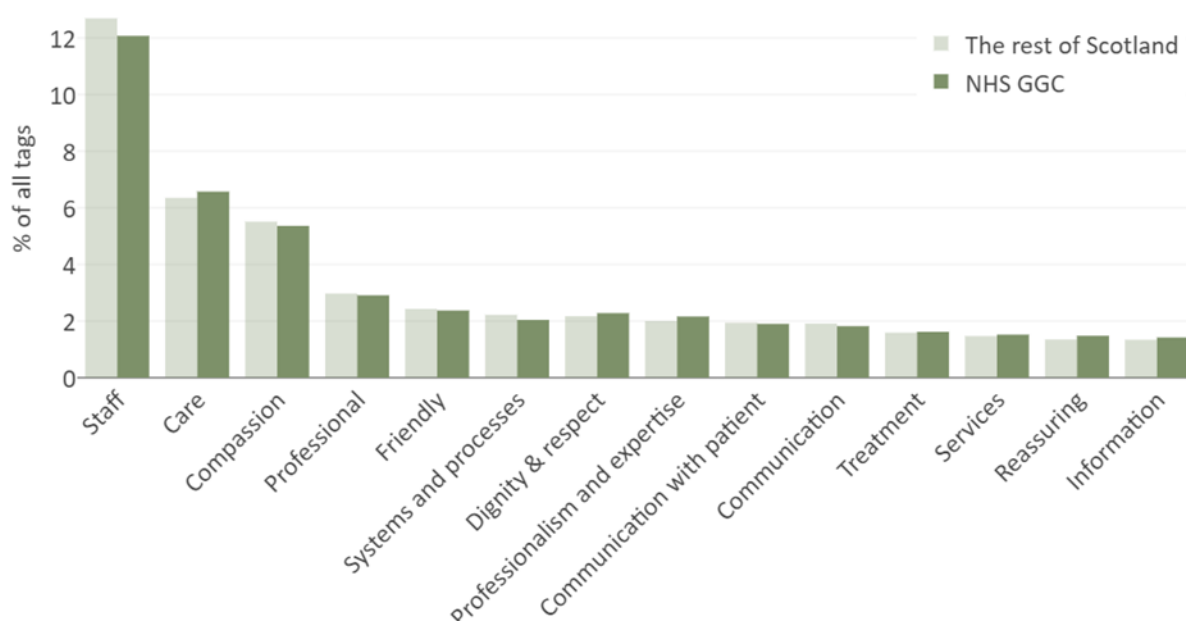


Figure 5.10: Positive qualities about care in the emergency department

Negative experiences of emergency care

- 5.91. The most common negative themes about people's emergency care experience are provided below (Figure 5.11). The issues patients identified that could have been better were similar in NHS Greater Glasgow and Clyde and the rest of NHS Scotland, with "communication" mentioned more often in NHS Greater Glasgow and Clyde although this difference was not significant.

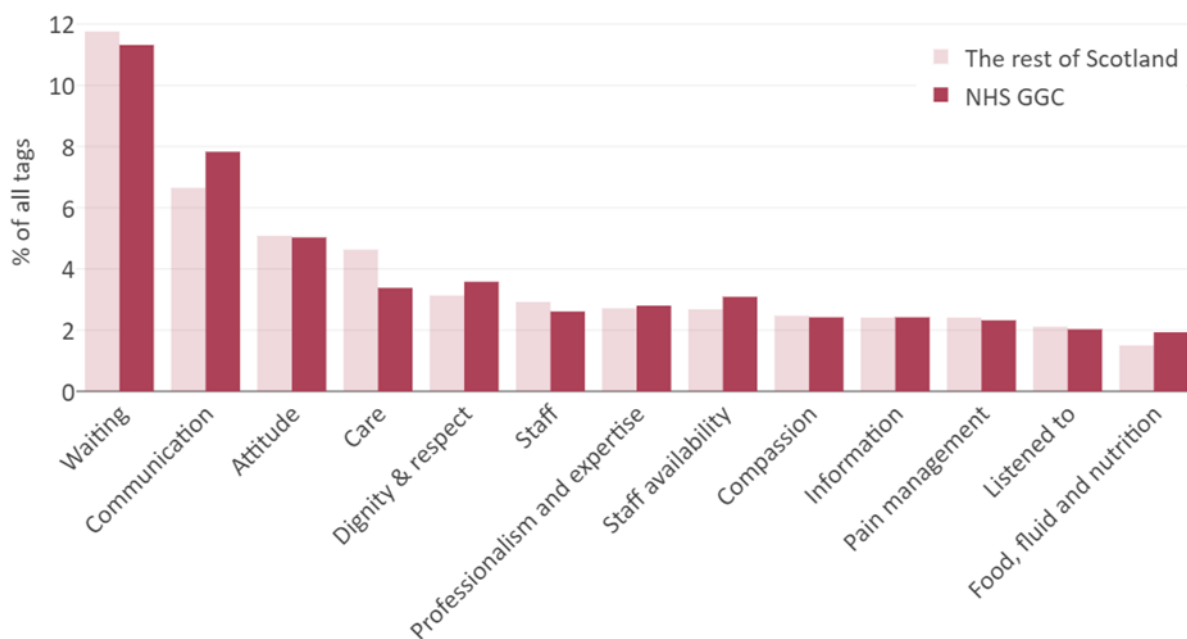


Figure 5.11: Negative themes about care in the emergency department

- 5.92. This analysis of Care Opinion data indicates that patient feedback about emergency care experience is similar in NHS Greater Glasgow and Clyde and the rest of NHS Scotland. From this, it is likely that many of the recommendations from the patient experience survey in NHS Greater Glasgow and Clyde could apply to other emergency departments.

Patient Experience: conclusions

- 5.93. The patient experiences gathered for this review provide vital insight into patients' experience of care in the three emergency departments in NHS Greater Glasgow and Clyde. It is likely that this learning will be useful for other emergency departments however, to be able to draw wider recommendations for the whole of NHS Scotland, further engagement work across the country is needed. In particular, focused engagement on patients' experience of waiting in emergency departments (which patients highlighted as the area in greatest need of improvement) would be especially useful.

5.94. In the context of this review, it is also useful to reflect on patients' rights when receiving health care in NHS Scotland, which are defined in the Patient Rights (Scotland) Act 2011⁴⁶ and described in the Charter of Patient Rights and Responsibilities.⁴⁷

5.95. These rights include that patients have a right to be treated with dignity and respect, and be provided with all the information and time they need to be able to participate fully in decisions relating to their care.⁴⁸ They also state that NHS boards must encourage patients to provide feedback, comments, concerns and complaints about their experiences of care.⁴⁹ The patient experience survey indicated neither of these rights were universally experienced by patients.

⁴⁶ [Patient Rights \(Scotland\) Act 2011](#). Legislation.gov.uk. 2011.

⁴⁷ [The Charter of Patients Rights and Responsibilities | NHS inform](#). NHS Scotland. May 2023

⁴⁸ [Patient Rights \(Scotland\) Act 2011](#) (section 2) and [Patient Rights \(Scotland\) Act 2011](#) (section 12,13)

⁴⁹ [Patient Rights \(Scotland\) Act 2011](#) (section 14). Legislation.gov.uk. 2011

6. Quality of Care and Patient Safety

This section addresses issues relating quality of care and patient safety in the emergency departments at Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital. It includes:

- the views of staff working in the three emergency departments on the quality of care and patient safety
- consideration of relevant processes including flow, escalation and incident reporting
- data on safe staffing and staff views on levels of staffing.

It also includes recommendations based on the review findings.

Introduction

- 6.1. Ensuring high quality, safe care improves outcomes for patients and reduces the risk of harm. The Scottish Patient Safety Programme is a national quality improvement programme that aims to improve the safety and reliability of care and reduce harm.
- 6.2. To assess the quality and safety of care within this review, Healthcare Improvement Scotland has used the Scottish Patient Safety Programme's Essentials of Safe Care⁵⁰ as a framework for this element. The Essentials of Safe Care are evidence-based and were originally defined with partners across the health and care system in Scotland. The framework consists of four sections:
 - Person centred systems and behaviours
 - Safe communication
 - Leadership to promote a culture of safety
 - Safe consistent clinical and care processes.
- 6.3. The Essentials of Safe Care have been mapped against the more recently published Patient Safety Principles⁵¹, produced by the Patient Safety Commissioner in NHS England. They have also been compared with the seven foundations for patient safety (published in What Good Looks Like in Patient Safety⁵²) produced by the UK charity Patient Safety Learning. Both of these

⁵⁰ Scottish Patient Safety Programme Essentials of Safe Care. [Essentials of safe care | Scottish Patient Safety Programme \(SPSP\) | ihub - SPSP Essentials of Safe Care](#). Healthcare Improvement Scotland. 2021

⁵¹ Hughes, H. Patient Safety Principles. [PSP-A3-Principles](#). Patient Safety Commissioner. 2024

⁵² What Good Looks Like in Patient Safety. ['What Good Looks Like' in patient safety - Patient Safety Learning](#). Patient Safety Learning.

documents reinforce the Scottish *Essentials of Safe Care* which provides assurance of their relevance for use as a framework for this element of the review.

- 6.4. Two aspects of the *Essentials of Safe Care* – safe communication and leadership – are explored in greater depth in Chapter 7 of this review (Leadership and Culture). This is due to significant concerns being found in these areas which necessitated a more detailed analysis.
- 6.5. This chapter contains a selection of anonymised quotes in *italic* text from staff that shared their views and experiences during the review process (see 2.81 above). These quotes may have been drawn from the staff survey, submissions to the confidential mailbox or from discussion sessions with staff.

Essential of Safe Care 1: Person-centred systems and behaviours

Long waiting times, poor flow, non-standard bed care and crowding are impacting on the quality and safety of care across all three emergency departments, and none of these concerns are unique to NHS Greater Glasgow and Clyde. Healthcare Improvement Scotland's safe delivery of care inspections have found similar issues across Scottish hospitals. There is a need to review how patient flow and redirection are managed within all three emergency departments so that this is not normalised.

- 6.6. This section includes consideration of structures and processes that enable care, inclusion and involvement, and workforce capacity and capability.

Prioritisation of patient safety

- 6.7. Staff raised concerns that patient experience and safety was not at the standard they hoped to provide. The staff survey identified a difference between the three emergency departments about whether patient safety and care is seen as coming first (Figure 6.1). Respondents from the Royal Alexandra Hospital perceived that patient safety comes first 'always' or 'usually' 91% of the time, in comparison to 45% of Queen Elizabeth University Hospital respondents and 69% of Glasgow Royal Infirmary respondents. It is of concern that 53% of Queen Elizabeth University Hospital respondents indicated that patient safety 'rarely' or 'never' came first.⁵³
- 6.8. The review of shift handover documents identified safety concerns that were rated as significant within the reports across both the Queen Elizabeth University Hospital and Glasgow Royal Infirmary sites on nearly every day of the week.

⁵³ NHS Greater Glasgow and Clyde Emergency Department Review - Staff Survey. Healthcare Improvement Scotland. 2025.

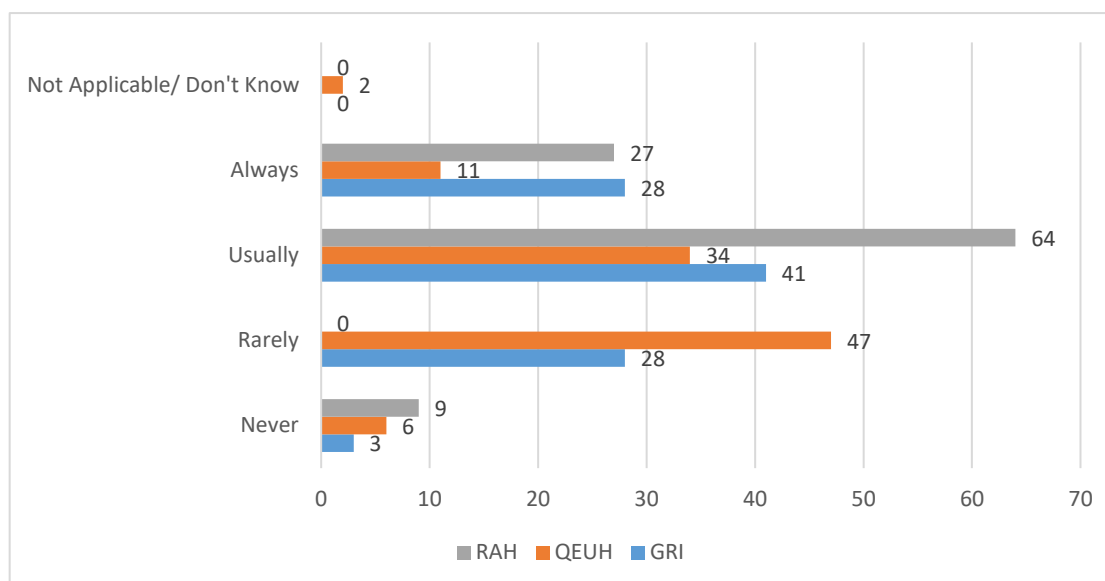


Figure 6.1: Staff views on prioritisation of patient safety and care (% of staff)

Appropriate and timely care

- 6.9. Performance against the four-hour standard across Scotland has dropped considerably since 2018 (see Chapter 4). In terms of the three emergency departments within this review, performance against the four-hour standard at the Queen Elizabeth University Hospital is consistently lower than that of an overall peer group across Scotland, with Glasgow Royal Infirmary and the Royal Alexandra Hospital tracking the centreline of the peer group. For waits of eight hours or more, all three emergency departments roughly track with the percentage for the peer group, while they consistently have a lower percentage of 12-hour waits.
- 6.10. Staff perceived that patient experience in the emergency department is commonly negative. No major differences were noted in responses from across the three sites regarding how often patients receive appropriate and timely care (Figure 6.2). Taking the three sites together, around two thirds (66%) of survey respondents felt patients 'rarely' or 'never' received appropriate and timely care.⁵⁴



Have virtually no time to have conversations with patients anymore. Too many tasks, not enough staff to keep patients safe, [...] I miss talking to patients and delivering holistic care, it currently feels like I'm doing bare minimum for everyone and it's so deflating.



⁵⁴ NHS Greater Glasgow and Clyde Emergency Department Review - Staff Survey. Healthcare Improvement Scotland. 2025.

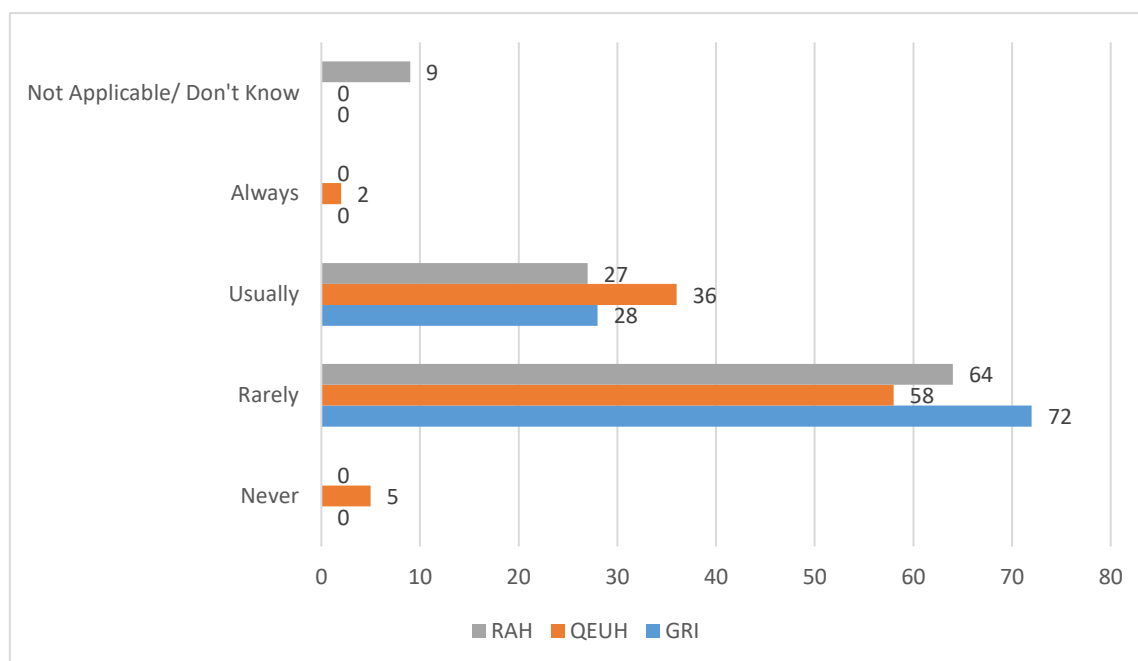


Figure 6.2: Staff views on provision of appropriate and timely care (% of staff)

- 6.11. A member of staff described waiting times as “*unacceptably long*”. Another staff member acknowledged: “*We are rarely able to give patients the care that they deserve*”. Staff at the Glasgow Royal Infirmary were more likely to provide patients with regular updates about their care, reporting that this usually happened 74% of the time compared with 39% at the Queen Elizabeth University Hospital and 27% of the time at Royal Alexandra Hospital (Figure 6.3).⁵⁵

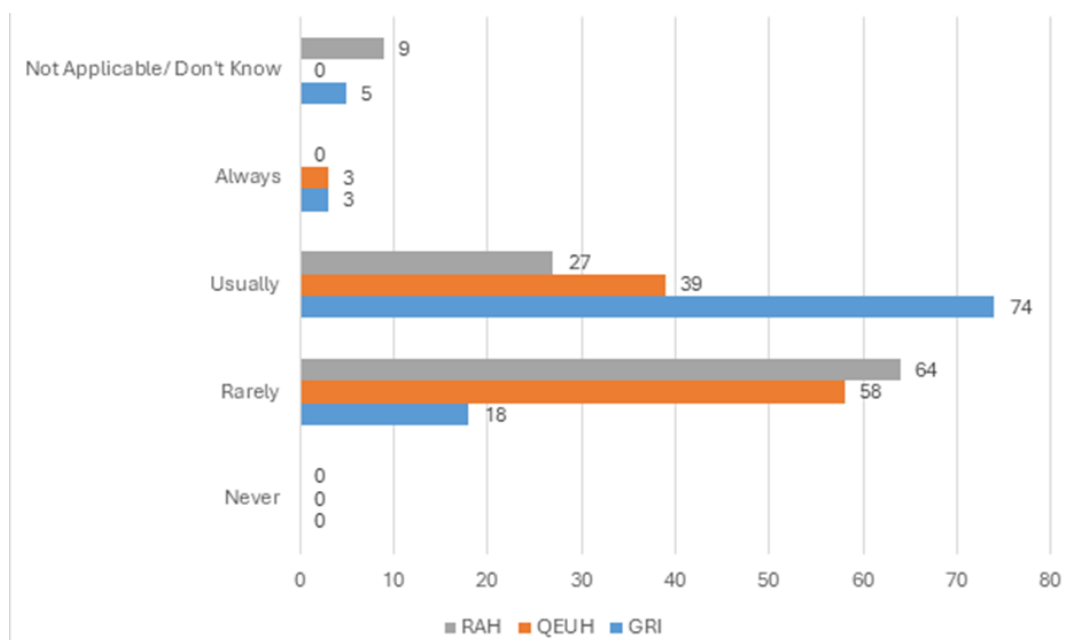


Figure 6.3: Staff views on provision of regular updates to patients (% of staff)

⁵⁵ NHS Greater Glasgow and Clyde Emergency Department Review - Staff Survey. Healthcare Improvement Scotland. 2025.

Patient Flow: GlasFLOW model

- 6.12. Patient flow models are used to support the movement of patients through a hospital from admission to discharge. Some of these models mandate that at times of pressure a set number of patients are moved from the emergency department to inpatient wards regardless of immediate bed availability but based on predicted patient discharge data. This aims to free space in the emergency department and spread the risk and responsibility for patient care throughout a hospital. However, it can result in patients placed in additional beds taking wards above capacity or in non-standard care areas (areas not designed for patient care) such as corridors or treatment rooms. This has implications for the ability of staff to provide safe, dignified patient care. A range of flow models have been introduced across NHS Scotland and the UK.
- 6.13. In December 2022, NHS Greater Glasgow and Clyde introduced its continuous flow model. This is known as GlasFLOW at the Queen Elizabeth University Hospital and 'continuous flow' at Glasgow Royal Infirmary and the Royal Alexandra Hospital, however the function is the same. The model works in supporting the appropriate flow of patients to downstream wards and away from the emergency department. This was a positive step by management to improving flow in the hospitals in response to safety concerns, capacity issues and long delays in accessing inpatient beds. However, there are some potential improvements that should now be considered.
- 6.14. It was noted that the continuous flow model only functions in Glasgow Royal Infirmary and the Royal Alexandra Hospital during the day (until 6:00 pm). GlasFLOW is used 24/7 in the Queen Elizabeth University Hospital with an initial planned phase and then additional moves based on escalation status. There tends to be a build-up of patients in the latter half of the late shift and through the night on all three sites. During the review we also noted difficulties in increasing admissions over the GlasFLOW numbers per hour. This apparent lack of flexibility in GlasFLOW does not allow the system to react dynamically to aid management of surges in emergency department attendances. A significant issue of concern, particularly for staff on the Glasgow Royal Infirmary site, is the impact of transferring patients into inappropriate environments in downstream wards and into non-standard patient areas, which needs to be balanced with the lack of space in emergency departments and delays in offloading ambulances.
- 6.15. Staff reported poor flow out of the emergency department, crowding, feeling overwhelmed and a sense that the system is chaotic. This led to a perception of a negative impact on quality and safety of care. Different working hours and arrangements of different specialties was a barrier to flow, with some evidence of reduced services at weekends especially, resulting in fewer ward rounds and discharges at these times. At the Royal Alexandra Hospital, medical admissions after 5pm are diverted to the emergency department for triage with consequent impact on emergency department workload.

- 6.16. Significant issues with departmental congestion and reduced flow were apparent in the shift handover documents reviewed for both the Queen Elizabeth University Hospital and Glasgow Royal Infirmary. Across both sites, and both staff groups, significant issues with congestion and flow were evident in the reports on every day of the week.
- 6.17. During our engagement with staff, we heard that despite existing agreements already being in place between the emergency departments and specialties, these arrangements were often not followed, leading to “*daily sources of conflict with receiving specialties*”. By way of examples, patients were often attending the emergency department with a GP letter, but the relevant specialties were not taking responsibility for them. Additionally, GP and out of hours services were often unable to contact relevant inpatient teams for referral with the consequence of patients attending the emergency department as the only route into the specialty team.



General lack of flow, things gradually getting worse and worse, like we are in eternal winter. It's probably a lack of flow through the hospital, no slack in the system, lack of social care options for patients ultimately getting home. Improved efficiencies might make a little bit of difference, but only partly and for a short time, then the work will expand to fill the gaps. There is an increasing old and frail population, with multiple co-morbidities.



I think that emergency department is more challenging with the volumes of patients and is severely impacted by the hospital flow [...].



Specialty referrals being triaged and then waiting in the emergency department for hours so we cannot manage our own substantial workload, push back from specialties when GPs have referred patients to them so they end up being sent to the emergency department with no specialty taking ownership, specialties asking that junior emergency department staff arrange further investigations for their patients that are not indicated whilst in the emergency department.



Redirection

- 6.18. The aim of redirection is to support patients to use the services that are most appropriate for their healthcare needs. People often self-refer to emergency departments when they have a healthcare need, and it is recognised that some of these patients do not require this type of urgent and unscheduled care. Appropriate care and support could be provided closer to home by other

services, for example by a pharmacy or GP practice providing care or support to self-manage with appropriate advice. Effective redirection can help release capacity enabling the emergency department to provide care for people most in need, reduce delay in assessment and treatment for clinically urgent cases, and reduce risk of crowding in the departments. To ensure redirection is a safe and well governed process, it must be performed by an appropriately trained workforce with dedicated senior decision maker involvement.

- 6.19. A national framework for redirection⁵⁶ was published by the Scottish Government in December 2021. It includes a definition of redirection as: “The referral of patients who are assessed as not requiring emergency care away from the emergency department. This may be to another service or with self-care advice”. Feedback sought during in the development of this framework suggested all emergency departments in Scotland undertook some form of redirection, but arrangements were often informal and inconsistent in application.
- 6.20. NHS Greater Glasgow and Clyde introduced the national redirection framework in 2023 as a step to address the volume of Flow 1 patients. In NHS Greater Glasgow and Clyde, redirection is carried out by senior nurses, with escalation as appropriate to emergency department medical staff. The AE2 A&E Data Recording Reference Manual version 2.6⁵⁷ defines Flow 1 as minor illness or injury and includes care provided in emergency departments, minor injury units and through schemes such as “paramedic see and treat”. In practice however, the mechanism for categorising patients as Flow 1 is retrospective and allows inclusion of patients who may have required extensive investigations to exclude major illness. For example, a negative computerised tomography (CT) scan result to rule out subarachnoid haemorrhage. These flow categories do not reflect changes in current emergency department practice and research allowing earlier discharge of patients who would previously have required admission to hospital, or the increased use of ambulatory pathways developed to aid flow and capacity.
- 6.21. The Board performance reports⁵⁸ highlight the significance of Flow 1 for the achievement of the four-hour standard. Staff feedback was that the focus on Flow 1 patients meant that these patients could be seen at the expense of other more acutely unwell patients who ended up waiting longer to be seen – and that this made staff uncomfortable.

⁵⁶Emergency Department Signposting/Redirection Guidance. [Supporting documents - Emergency Department signposting/ redirection guidance - gov.scot](#). Scottish Government. 2021.

⁵⁷ AE2 A&E data recording reference manual v2.6. [AE2](#). Public Health Scotland 2024

⁵⁸ Board Performance Report. NHS Greater Glasgow and Clyde. Dated 30 April 2024

- 6.22. In addition, NHS Greater Glasgow and Clyde has established two minor injury units co-located at the Queen Elizabeth University Hospital⁵⁹ and Glasgow Royal Infirmary, and a separate dedicated minors area at the Royal Alexandra Hospital. This is in addition to other standalone minor injury units for example at New Stobhill Hospital and the Vale of Leven Hospital. Minor injury units aim to provide access to treatment for patients with less severe injuries such as cuts and minor burns and scalds. Patients can be safely redirected to these units from emergency departments which reduces pressure on the emergency departments so they can focus on serious and life-threatening cases.
- 6.23. Scottish Government launched the Redesign of Urgent Care Programme in December 2020. Establishment of flow navigation centres was one of the key national changes for NHS boards as a result of this programme. Flow navigation centres seek to minimise the need to attend emergency departments and bring an element of scheduling to the traditional model of urgent and unscheduled care. Every mainland NHS board operates a flow navigation centre. They are configured differently in different NHS boards. Some operate on a 24/7 basis, some do not. Flow navigation centres are still developing in response to local requirements. Some have evolved to be a hub for coordination of primary care referrals into secondary care sites or to reflect other region-specific pathways. A recent evaluation of the redesign of the urgent care pathway highlighted variations between NHS boards in the scope and scale of flow navigation centre input to the pathway.⁶⁰
- 6.24. NHS Greater Glasgow and Clyde's flow navigation centre is also known as "virtual accident & emergency".⁶¹ It provides virtual urgent and unscheduled care appointments via NHS 24 111. NHS 24 can arrange scheduled arrival times for the minor injury units or emergency departments if it is deemed that a patient requires face-to-face assessment. The flow navigation centre covers the whole of NHS Greater Glasgow and Clyde and is not a 24-hour service. It operates seven days a week between the hours of 10am to 10pm.
- 6.25. Staff perception of redirection is that the whole system is under pressure and there are limitations arising from the redirection policy. This may mean the potential value of this process is not being fully realised. Some staff suggested that patients came to the emergency department because of difficulties accessing primary care. Others highlighted that to see a specific specialist at the Queen Elizabeth University Hospital who may be already treating the patient, an assessment must first be undertaken by either a GP, or within the emergency department. NHS Greater Glasgow and Clyde advised that whilst there are some pathways in place to ensure patients seeking specialist services avoid the

⁵⁹ [Minor Injuries Unit - NHSGGC](#). NHS Greater Glasgow and Clyde.

⁶⁰ Redesign of Urgent Care (RUC) Evaluation Main Report. [Redesign of Urgent Care \(RUC\) Evaluation Main Report](#). Scottish Government, January 2025.

⁶¹ [Virtual Accident & Emergency \(A&E\) - NHSGGC](#). NHS Greater Glasgow and Clyde

emergency department, some patients under specialists at the Queen Elizabeth University Hospital do require an assessment first by a GP or within the emergency department. This adds further pressure on the Queen Elizabeth University Hospital emergency department. Evidence seen and heard by the Core Review Group indicated that there are few specialty pathways that provide direct access for their patients without the need for the emergency department to be used as a 'gatekeeper'.

- 6.26. NHS Greater Glasgow and Clyde supplied redirection data for the Queen Elizabeth University Hospital (Table 6) and Glasgow Royal Infirmary (Table 7) as evidence to inform this review. This data had been prepared on an ad hoc basis for specific NHS Greater Glasgow and Clyde internal purposes. At the time of the review, NHS Greater Glasgow and Clyde did not have similar data for the Royal Alexandra Hospital hence there is no associated data table in this report. A redirection dashboard was under development, with the anticipation it would be published to the live environment by the end of November 2024.
- 6.27. In reports and data supplied for September to November 2024, NHS Greater Glasgow and Clyde had identified that at the Queen Elizabeth University Hospital⁶² and Glasgow Royal Infirmary⁶³ redirection numbers are lower than they would expect. The Queen Elizabeth University Hospital report stated that: "The number of patients recorded as a minor injury or illness redirection remain low with inconsistency in weekly data recorded. There is still opportunity to improve on-site Trak recording processes to more accurately reflect the numbers. Positively, in those records with a redirection outcome, the majority are being redirected off site to primary care. The number of records with an 'unknown' outcome has also reduced during October".
- 6.28. It is of concern that for 64% of redirected patients at the Queen Elizabeth University Hospital no known outcome was recorded between the start of September and end of November 2024. It is therefore difficult to ascertain the efficacy or safety of the model for patients.

⁶² QEUH DWD & Redirection update. NHS Greater Glasgow and Clyde Dated week ending 24 November 2024.

⁶³ GRI DWD & Redirection update. NHS Greater Glasgow and Clyde Dated week ending 24 November 2024.

Week commencing	01/09	08/09	15/09	22/09	29/09	06/10	13/10	20/10	27/10	03/11	10/11	17/11	24/11
Redirection refused	0	0	0	0	0	0	0	0	0	0	0	0	0
Redirection to community pharmacy	1	0	0	0	0	0	1	1	2	0	0	5	0
Redirection to minor injury unit	0	1	2	0	1	0	5	0	9	0	2	8	1
Redirection to primary care	9	11	22	5	3	5	19	19	28	11	15	8	14
Redirection to self-care	4	3	1	5	1	1	15	10	10	4	4	3	12
Number of patients records of redirection	14	15	25	10	5	6	40	30	49	15	21	24	27
% of Flow 1 patients redirected	1.9%	2.0%	3.5%	1.4%	0.7%	0.8%	5.5%	4.9%	7.0%	2.4%	3.2%	4.2%	4.5%
Unknown outcome recorded	48	57	45	48	66	79	71	23	17	15	13	11	17

Table 6: Queen Elizabeth University Hospital minor injury or illness redirection data September to November 2024

Week commencing	01/09	08/09	15/09	22/09	29/09	06/10	13/10	20/10	27/10	03/11	10/11	17/11	24/11
Redirection refused	0	0	1	0	0	0	2	0	0	0	0	0	0
Redirection to community pharmacy	1	1	1	0	1	1	0	2	1	0	1	1	1
Redirection to minor injury unit	4	19	17	12	12	22	16	14	15	28	20	17	4
Redirection to primary care	4	10	6	4	11	7	22	7	24	21	14	20	12
Redirection to self-care	1	2	3	1	1	3	9	3	4	2	3	5	3
Number of patients records of redirection	10	32	28	17	25	33	49	26	44	51	38	43	20
% of Flow 1 patients redirected	1.9%	5.3%	5.5%	2.8%	4.9%	6.3%	9.4%	4.8%	7.8%	10.2%	7.2%	8.6%	4.2%
Unknown outcome recorded	14	12	11	15	18	15	15	14	19	10	16	15	14

Table 7: Glasgow Royal Infirmary minor injury or illness redirection data September to November 2024

- 6.29. Other NHS boards have introduced “hot clinics” in parallel with redirection arrangements and have found this to be effective. Hot clinics are a rapid access clinic to enable quick access to a specialist review to facilitate early discharge or prevent unnecessary admission after an assessment in the emergency department.⁶⁴ Hot clinics exist, but the review did not see evidence that they are consistently used across the three relevant sectors in NHS Greater Glasgow and Clyde.

Demand, crowding and non-standard care

- 6.30. The issues around crowding in emergency departments are not unique to NHS Greater Glasgow and Clyde. Crowding occurs when demand outstrips capacity and needs to be viewed in the context of the wider system. The Royal College of Emergency Medicine does not view crowding as inevitable and states that it worsens mortality and morbidity for patients and increases stress, burnout and sickness for staff.⁶⁵ The Royal College of Emergency Medicine calls for local leaders to adopt good practice and reduce unwarranted variation.
- 6.31. Crowding in the emergency department impacts the ability of ambulances to transfer patients timeously and safely. This causes ambulance queues and ultimately limits access to ambulance services for acutely unwell patients. The Scottish Ambulance Service set a longer-term aim of handover of patients within 15 minutes with a maximum wait of no longer than an hour by August 2023. Median of three-week rolling average of weekly ambulance turnaround times during 2024 across the peer group of Scottish hospitals was between 48 and 55 minutes. Within NHS Greater Glasgow and Clyde, ambulance turnaround times were consistently higher in the Queen Elizabeth University Hospital than the peer group, and lower in the Glasgow Royal Infirmary and the Royal Alexandra Hospital. This may be due to differences in use of non-standard bed care (see Chapter 4 and non-standard bed care section below).
- 6.32. Despite the data demonstrating that the volume of demand in the emergency departments has not increased, staff perception was of increased demand on the available capacity which was impacting on the quality and safety of care. Higher acuity/complexity and crowding were seen by staff as impacting on the quality and safety of care at all three sites. Every respondent to the staff survey reported that the number of patients in the emergency department either ‘always’ or ‘usually’ exceeded the department’s capacity (Figure 6.4). Staff do not feel they are delivering the best care they can due to capacity.

⁶⁴ Imtiaz, MR, Sreelekha, A, Shatkar, V. Surgical Hot Clinic – An Effective Pathway of Reducing Emergency Admissions and the Associated Costs. [Surgical Hot clinic – an effective pathway of reducing emergency admissions and the associated costs](#). International Journal of Healthcare Sciences (Online) Vol. 4, Issue 2, pp: (198-205), Month: October 2016 - March 2017.

⁶⁵ [Emergency Department Crowding | RCEM](#). Royal College of Emergency Medicine. 2024

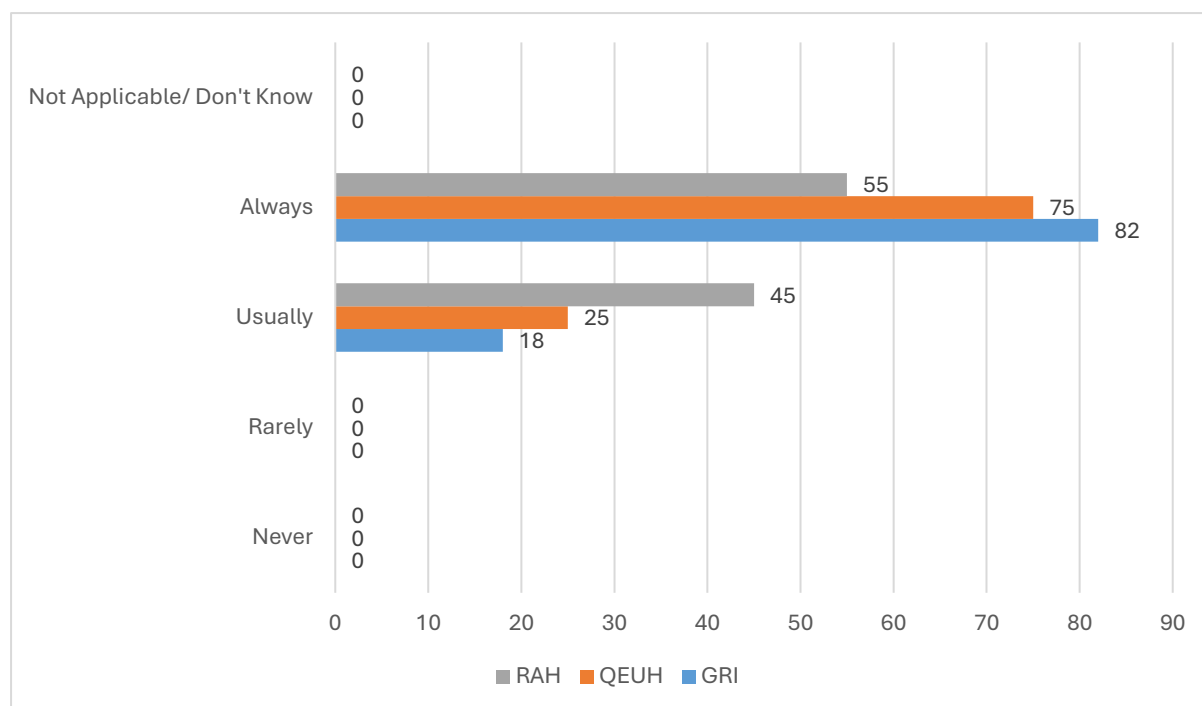


Figure 6.4: Staff views on capacity being exceeded in the emergency department (% of staff)

6.33. As a result of this high demand, most staff across all three emergency departments said they did not have enough time to spend with patients (Figure 6.5).

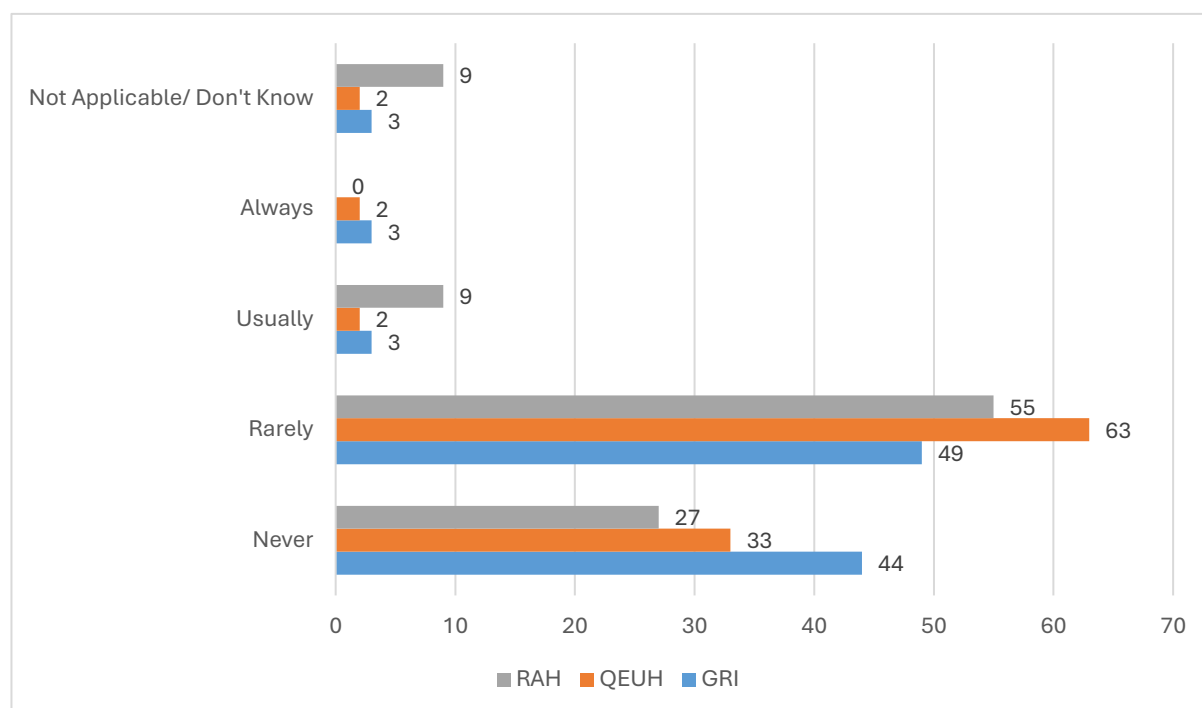


Figure 6.5: Staff views on having enough time to spend with patients (% of staff)

- 6.34. A number of staff highlighted the focus on emergency departments to resolve waiting times at the front door was the wrong approach, and that a focus on flow across the whole hospital would be more useful. Without this, they noted that patients are waiting for hours in the emergency department to be admitted to a ward. Some staff reported that previous attempts to escalate these concerns had been unsuccessful.

We are overwhelmed on a daily basis, and the wider organisation does not appear to care [...]. Quite simply, there is insufficient capacity in the system for the demand placed on it. And the truly galling part is the impression given that if we just all worked a bit harder it would be solvable.

Non-standard bed care

- 6.35. Hospital crowding can lead to care of patients in non-standard care areas. This can include: placement of extra beds in wards or in ward corridors, placement in emergency department corridors, patients receiving care while placed on chairs, care in treatment or non-clinical rooms and patients awaiting treatment in ambulances and waiting rooms.
- 6.36. The Royal College of Nursing⁶⁶ highlighted in a report “*Corridor care: unsafe, undignified and unacceptable*” that: “Patient privacy and dignity can be compromised when care is provided in inappropriate settings. Access to life-saving equipment such as oxygen, suction and monitoring can be unavailable, and patients can have limited or no access to toilet facilities and handwashing provision. Emergency call buttons are unavailable. Infection prevention controls are compromised. Health and safety regulations are breached. Medication cannot be stored safely, and patients’ personal belongings are not secured.”
- 6.37. Furthermore, the Royal College of Emergency Medicine said in a statement⁶⁷ about corridor care in December 2024: “It is not possible to provide safe and good quality care in temporary escalation spaces such as corridors. Where such spaces are in use it is inevitable that this will be associated with long waits in emergency departments. We know that long waits in emergency departments are associated with measurable harm to patients. Care will therefore not be safe.” Long emergency waits have been found to be associated with a doubling of risk of death.⁶⁸

⁶⁶ Corridor Care: unsafe, undignified, unacceptable [Publications | Royal College of Nursing](#). Royal College of Nursing. June 2024

⁶⁷ ‘[Normalisation of the dangerous](#)’ – RCEM hits back at NHSE ‘Corridor Care’ guidance | [RCEM](#). Royal College of Medicine. 16 December 2024.

⁶⁸ British Medical Journal News. <https://www.bmj.com/content/388/bmj.r119>. British Medical Journal. 20 January 2025.

- 6.38. Use of such spaces has previously been noted by Healthcare Improvement Scotland in safe delivery of care inspections across NHS Scotland boards. They can be a planned feature of flow models to minimise pressure on emergency departments in extremis. However, we heard from staff, and both the Royal College of Nursing and Royal College of Emergency Medicine have stated, that use of non-standard care spaces is being “normalised” with the Royal College of Nursing report (January 2025) *“On the Frontline of the UK’s Corridor Care Crisis”*⁶⁹ stating that 66.81% of respondents reported caring for patients daily in non-standard areas with 90.8% stating that care and safety were compromised.
- 6.39. NHS Greater Glasgow and Clyde use corridor beds and chair spaces across the Glasgow Royal Infirmary and the Royal Alexandra Hospital to increase capacity in the emergency department, but not at the emergency department in Queen Elizabeth University Hospital. It is also a feature in downstream wards in all three hospitals as part of the GlasFLOW/continuous flow models. Data on the use of these spaces is not routinely collected either at national or local level in Scotland. In 2024, the Scottish Executive Nurse Directors group carried out a snap-shot day of care audit of non-standard bed space/care area use across acute inpatient and mental health units to try to ascertain the size of the issue; however, NHS Greater Glasgow and Clyde did not take part in the audit, and the opportunity to understand the position across NHS Scotland was lost. NHS boards need to monitor these additional patients requiring care so that appropriate additional staffing can be put in place.
- 6.40. Staff within NHS Greater Glasgow and Clyde have raised a range of DATIX reports about crowding, corridor care and patient safety concerns associated with delays in providing care. The negative impact of corridor care was highlighted by many staff in terms of insufficient staffing, dignity, privacy, direct view of patients and consequent harm. These descriptions reflected a common observation that patient experience was impacted by high workload which meant staff were unable to spend time providing person-centred care.

Recommendation 8: NHS Greater Glasgow and Clyde, and its six aligned Health and Social Care Partnerships, should strengthen their whole system unscheduled care plan to urgently reduce use of non-standard care areas, improve waiting times and reduce crowding by addressing:

- management of patient flow and redirection
- referral pathways to specialties from within and out with the emergency departments
- delayed discharges, and
- models of care, same day delivery of care options and consideration of maximising 24/7 services including flow navigation.

⁶⁹ On the Frontline of the UK’s Corridor Care Crisis [Corridor care crisis | Publications | Royal College of Nursing](#). Royal College of Nursing. 16 January 2025.

Essential of Safe Care 2: Safe communication within and between teams

A lack of safe communication within and between teams is one of the most significant issues identified by this review. There was a lack of awareness of escalation plans, and they were not used robustly or effectively.

- 6.41. This section includes communication skills and practice, including the format, content and tools used, and management of communication in critical situations.
- 6.42. Due to the significance of the lack of safe communication within and between teams, this issue is explored in depth within the Leadership and Culture chapter. However, its significance is noted here because of the evidence-based link between civility within teams and patient safety. This evidence is captured by the charity Civility Saves Lives⁷⁰ which states that when a team values and respects its members, benefits include not just improved staff satisfaction and health but also reduced hospital standardised mortality rates and reduced patient complaints. Incivility is rude or unsociable behaviour, such as shouting, aggression, belittling, talking over others and being difficult.

How staff feel management respond to patient safety concerns

- 6.43. Staff expressed concern that management did not adequately address patient safety concerns raised and instead placed more focus on achieving targets (Figure 6.6).

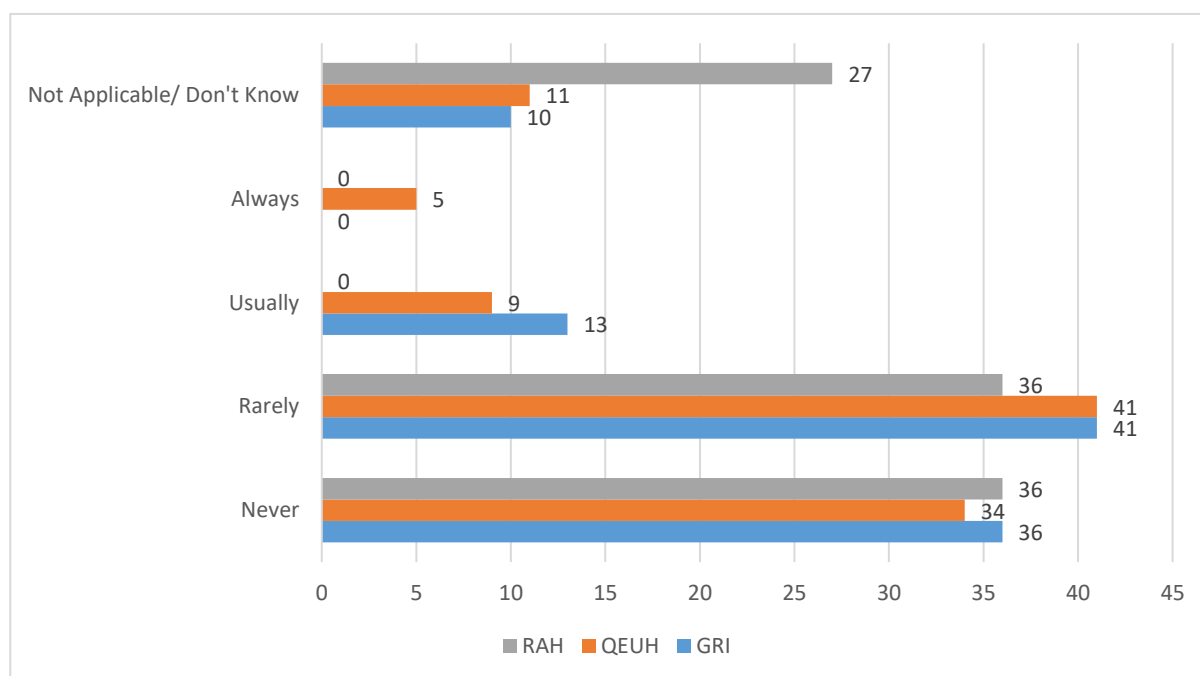


Figure 6.6: Staff views on whether management prioritise patient care over achieving targets (% of staff)

⁷⁰ [The Evidence | Civility Saves Lives](#). Civility Saves Lives.



It's a constant battle to keep patients and staff safe, it is clear there is no support from management about patient safety and they often care more about 'breach reports' than the patients we have in ED.



Communication in critical situations: escalation

Escalation plans are intended to ensure a graded response to pressures from rising demand in emergency departments, for example due to high volume of patients, complex patients or lack of workforce. The issue of escalation was one of the most significant issues raised by some staff during the review. Although all three hospitals covered by the review have an escalation plan, there did not appear to be sufficient awareness of them, robust use of them, ownership by teams nor any perceptible impact of their deployment by in-patient teams on the pressures in the emergency departments. There were concerns about their ability to practically and credibly address serious and immediate pressures.

- 6.44. Staff viewed the escalation plans as being very reactive to the situation rather than being proactive in anticipating difficulties. They described variability across the three sites in the systematic engagement with staff within the emergency departments or the wider specialties in their development. There was no clear evidence of any specific escalation plans within other acute assessment areas outwith the emergency departments. In the absence of a cohesive multidisciplinary approach to development of escalation plans, there will be a lack of understanding of capacity issues between the emergency departments and the rest of the hospital, leading to further isolation of the emergency department.
- 6.45. Escalation policies typically use a colour-coded classification where green status is the lowest level of pressure on the system moving through amber to black status which indicates the highest level of pressure. It was noted by staff that, if an emergency department is in an amber position in the morning it will always escalate over the day as no additional actions are triggered or being performed by the rest of the hospital by this amber status. The review team noted that amber appeared to be 'the new green' which meant that the emergency department was always in a state of escalation which has become the new norm. On the other hand, the impact on most in-patient teams and specialties only appeared to occur at black level. Earlier action throughout the day may help alleviate the issue and prevent escalation to black.

- 6.46. The escalation at black did not seem to have an effect to reduce the level of risk and was therefore perceived to be meaningless and too late by emergency department teams. Often the escalation cards showed poor engagement by in-patient medical specialty teams which manage the majority of wards and impact the most difficult flow pathway. It was not clear to the review whether in-patient specialties fully understood the status of the emergency department at any point in time or the actions that were expected of them in each stage of escalation (and vice versa). It was also unclear whether job planning within specialty teams allowed the capacity for them to be responsive to such actions required to alleviate capacity issues across the site.
- 6.47. It was also noted that there appeared to be a discrepancy as to the use of patient divert between hospitals. The escalation cards suggested discussions between clinicians and that if hospitals are in black status no diversions occur. However, this was contrary to the experience of the teams in the Royal Alexandra Hospital and the Glasgow Royal Infirmary.
- 6.48. There was a strong view expressed that the diversion of a relatively small number of patients disproportionately impacted each receiving emergency department more than benefitted the transfer for the base hospital.
- 6.49. There was concern expressed by staff that escalation was becoming normalised, without adequate understanding of the implications of escalation, and that the process did not have a material impact on the situation for staff or patients in emergency departments.
- 6.50. There have been attempts by consultants in emergency medicine at the Queen Elizabeth University Hospital to declare “major incidents”.⁷¹ Under the existing legislation and guidance this would not, in itself, provide additional resources. The expectation would be that emergency responder partners across the entire health and care system would adjust to support any hospital under sustained and serious pressure. NHS Greater Glasgow and Clyde has not been unique in this as a health board.
- 6.51. This issue highlights the need to have far clearer statement of how hospitals in extremis are supported by the whole health and care system and the objective assessment of triggers for practical escalation and business continuity.
- 6.52. There are currently three levels of response as set out in the Scottish Government national guidance on incident response levels (Figure 6.7 below).⁷²

⁷¹ 17 June 2024 Handover Notes. Greater Glasgow and Clyde ED Consultant. Dated 17 June 2024.

⁷² [National incident response levels: guidance for health boards - gov.scot](https://www.gov.scot/publications/national-incident-response-levels/guidance-for-health-boards/pages/1/). Scottish Government; 02 May 2024

Incident response levels are defined as:

(a) Business Continuity Incident – an event or occurrence that reduces or might reduce, a health board's normal service delivery to below acceptable levels and would require special arrangements (such as temporary re-deployment of local / regional resources and mutual support) to be put in place until services can return to an acceptable level. There may also be impacts from wider issues such as supply chain disruption or provider failure.

(b) Critical Incident – any localised incident where the level of disruption results in a health board losing its ability to deliver critical services, or where patients and staff may be at risk of harm. It could also be linked to the environment potentially being unsafe and requiring special measures and support from other agencies to restore normal operating functions. A critical incident is principally an internal escalation response to increased system pressures/disruption to operations delivered by the health board. Unlike a major incident, a critical incident does not have any actions prescribed by either legislation or national guidance that must be taken as a result.

(c) Major Incident – is defined in the Joint Emergency Services Interoperability Principles ([JESIP](#)) as: "An event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder."

Figure 6.7: Incident Response Levels

- 6.53. In summary, the feedback indicates that staff perceive the system as often chaotic. This may foster a 'command and control' leadership culture, and which may in turn lead to staff pushing back against any offers of solutions. The perception of staff was that the emergency departments were permanently in 'black status' and as such this status had become irrelevant, with staff becoming de-sensitised to this. The NHS Greater Glasgow and Clyde emergency department escalation plan is perceived to be ineffective, and little can be done to prevent deterioration or even predict deterioration. This results in feelings of 'learned helplessness' and an inability to improve the situation.
- 6.54. The review of shift handover documents provided further evidence of issues rated as significant being escalated across both sites and by both staff groups on nearly every day of the week. Medical handover documents from the Queen Elizabeth University Hospital showed the highest incidence of escalations rated as significant. It could not be determined solely from the review of the handover documents whether actions had been taken in response to escalated issues, or if the outcome of any actions had been fed back to the emergency department teams. Significant issues with staffing were also evident across both sites and both staff groups to varying degrees on every day of the week. The issues related to both staffing gaps and skills mix. The handover documents indicated that staff

were being impacted by the various pressures in the emergency departments. Impact on both medical and nursing staff was assessed as significant across both sites, to varying degrees, on every day of the week.

- 6.55. The situation presented in NHS Greater Glasgow and Clyde is a manifestation of emergency departments under sustained pressure and without the identification of whole system solutions. This reinforces the sense of frustration and has an impact on staff morale and wellbeing.

Recommendation 9: NHS Greater Glasgow and Clyde should ensure its escalation and business continuity plans are practical and effective in addressing pressures at each hospital and are implemented across the whole system to ensure there is good awareness and ownership of them by teams across the hospitals. The effectiveness of the plans should be monitored and regularly reviewed through appropriate NHS board governance structures.

Essential of Safe Care 3: Leadership to promote a culture of safety at all levels

Staff morale is low within the emergency departments, with indications of moral distress. Management has not taken sufficient action to improve staff experience and wellbeing, and psychological safety has been negatively impacted by poor teamwork in the Queen Elizabeth University Hospital emergency department. There are significant gaps in the systems for learning about safety from incidents and concerns raised. This includes ensuring concerns are heard, investigated and the learning shared. Staff at the Queen Elizabeth University Hospital felt less able to raise safety concerns than staff in the other two emergency departments.

- 6.56. This section includes psychological safety, staff wellbeing and systems for learning. Due to the significance of the review's findings on leadership and culture, a separate chapter is considering this in greater depth. This chapter focuses solely on safety aspects of leadership.

Physical safety

- 6.57. Staff reported a perceived increase in aggressive behaviour from some patients which impacted on the physical safety of staff and other patients. These concerns were expressed at the Glasgow Royal Infirmary and the Queen Elizabeth University Hospital, but not at the Royal Alexandra Hospital. They were compounded by limited security presence which could often take some time to attend the department. Multiple DATIX reports have been made about poor behaviour from patients, many resulting from frustration due to delays.



Increase in aggressive and abusive behaviour from patients – no emergency department security. This has a massive impact on both patients and staff as the nursing team have to try and de-escalate this behaviour despite multiple threats and incidents of physical violence.



- 6.58. This was reflected in employee reported DATIX incidents, where violence and aggression was the most common category reported overall with 1,070 (56%) out of the total of 1918 incidents:⁷³ Some incidents are not reported so this may be an under-estimate of the issue.

Hospital	% of incidents are violence and aggression
Glasgow Royal Infirmary	63
Queen Elizabeth University Hospital	57
Royal Alexandra Hospital	41

Table 8: Reported incidents involving violence and aggression

- 6.59. Staff frequently reported concerns about the physical environment that have impacted on safe care, including broken equipment and either an ageing or unsuitable estate. Most respondents to the staff survey reported that the physical environment of the emergency department ‘always’ or ‘usually’ impacted on their role, and this was true across all three sites (Figure 6.8).

Corridor care was cited as a particular concern with staff describing it as unsafe and undignified.



[...] patient flow issues often lead to patients being moved into corridors, which compromises their privacy and safety and hinders effective monitoring, while limited space raises concerns about infection control.



⁷³ *Unscheduled Care Incident Report Oct 19 – Sep 23 Cover Paper and Unscheduled Care Incident Report Oct 19 – Sep 23 Full Paper*. Greater Glasgow and Clyde. 08 April 2024.

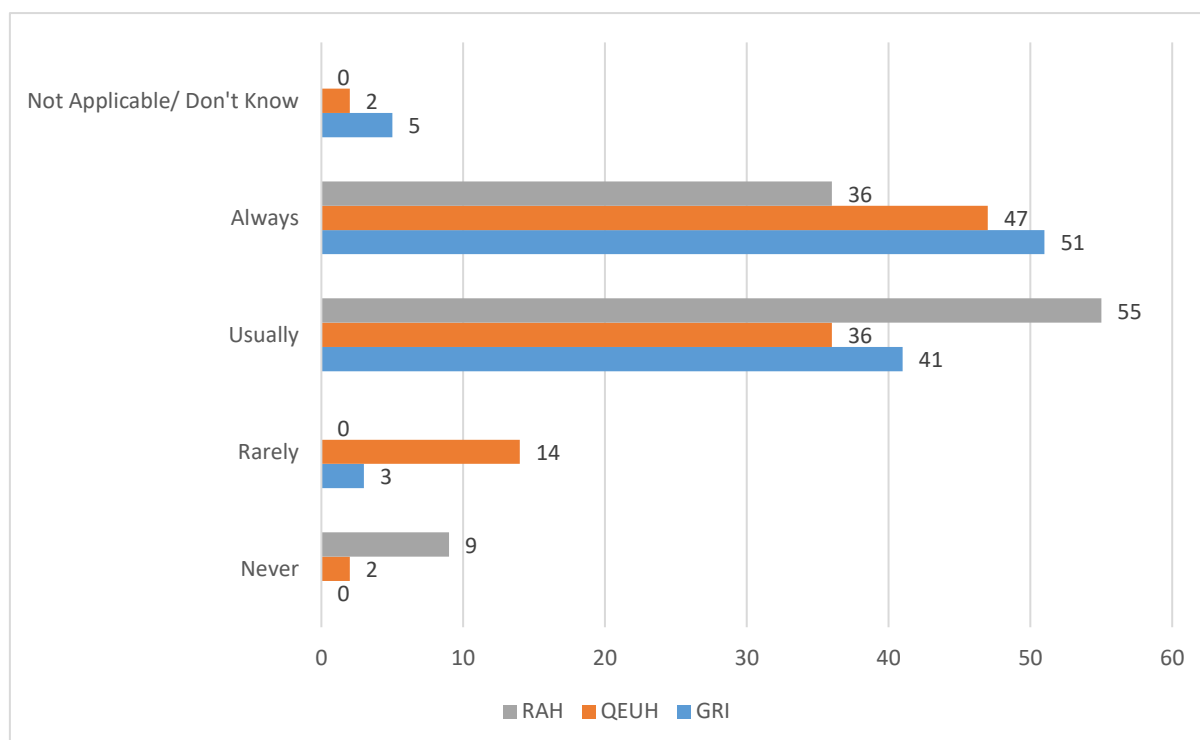


Figure 6.8: Staff views on the physical environment impacting on their ability to undertake their role (% of staff)

- 6.60. Poorly designed building layout was highlighted as an issue by staff in both the Queen Elizabeth University Hospital and the Royal Alexandra Hospital, with staff unable to always see patients which was described as a safety risk. Meanwhile in the Glasgow Royal Infirmary, staff reported that the estate was ageing with a need for capital investment to tackle issues such as a leaking roof and rising damp in the basement, and small and uncomfortable waiting areas. Broken lifts were also highlighted as causing portering delays. Limited and distant staff facilities were an issue for emergency department staff at the Royal Alexandra Hospital, along with the state of disrepair of the portacabin used there. The distance between the emergency department and minor injuries unit at Glasgow Royal Infirmary hindered effective working. Consultants cited the difficulties of access to office space on a number of occasions as the main reason for working from home. This has the potential to cause further isolation from colleagues and loss of cohesion within teams.
- 6.61. Concerns were also raised about accessing appropriate equipment and sundries, particularly at the Glasgow Royal Infirmary. Few staff reported problems with accessing digital and clinical systems.

Staff satisfaction and morale

- 6.62. Staff having job satisfaction was rated as 'rarely' or 'never' by over two-thirds of respondents to the staff survey (Figure 6.9). Views on whether the emergency department is a good place to work differed in the different sites, with 71% of Queen Elizabeth University Hospital staff saying 'rarely' or 'never' compared with 54% at the Royal Alexandra Hospital and 34% at the Glasgow Royal Infirmary.

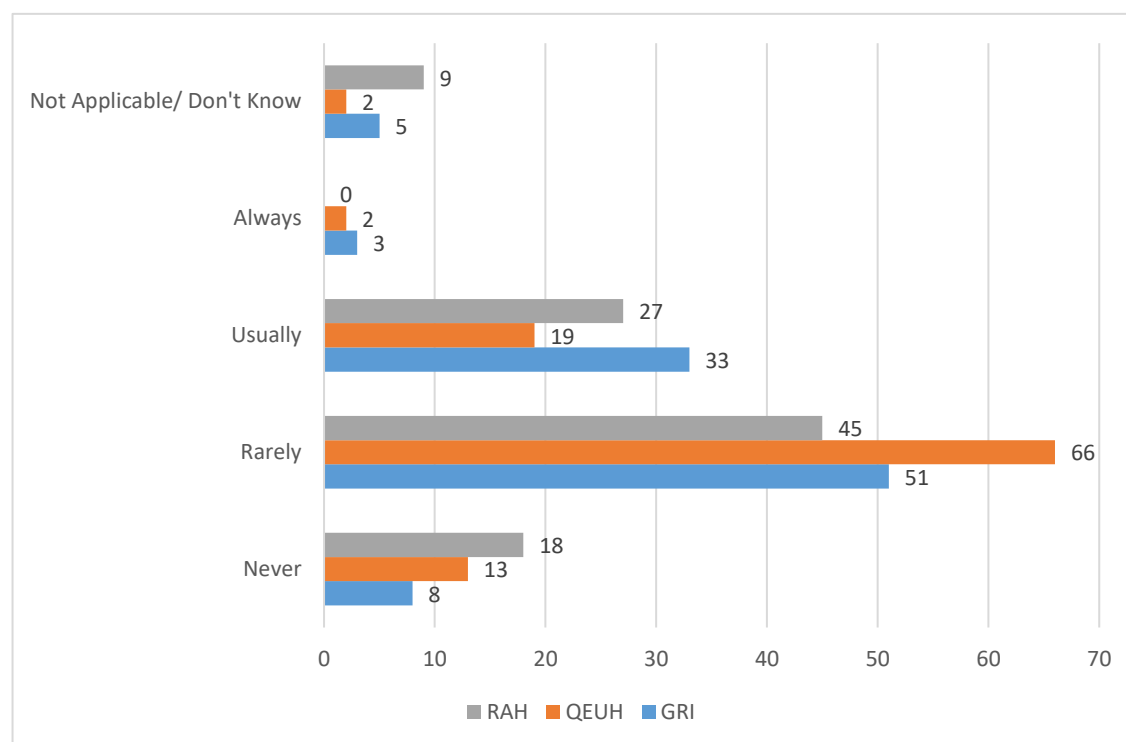


Figure 6.9: Staff sense of satisfaction from their work (% of staff)

- 6.63. Staff morale in emergency departments was found to be low by the staff survey, with the majority of participants saying morale was 'rarely' or 'never' high. There was a difference between sites, and an indication that low staff morale may be a more pervasive problem in Queen Elizabeth University Hospital, given the disproportionate percentage of 'never' responses (Figure 6.10).

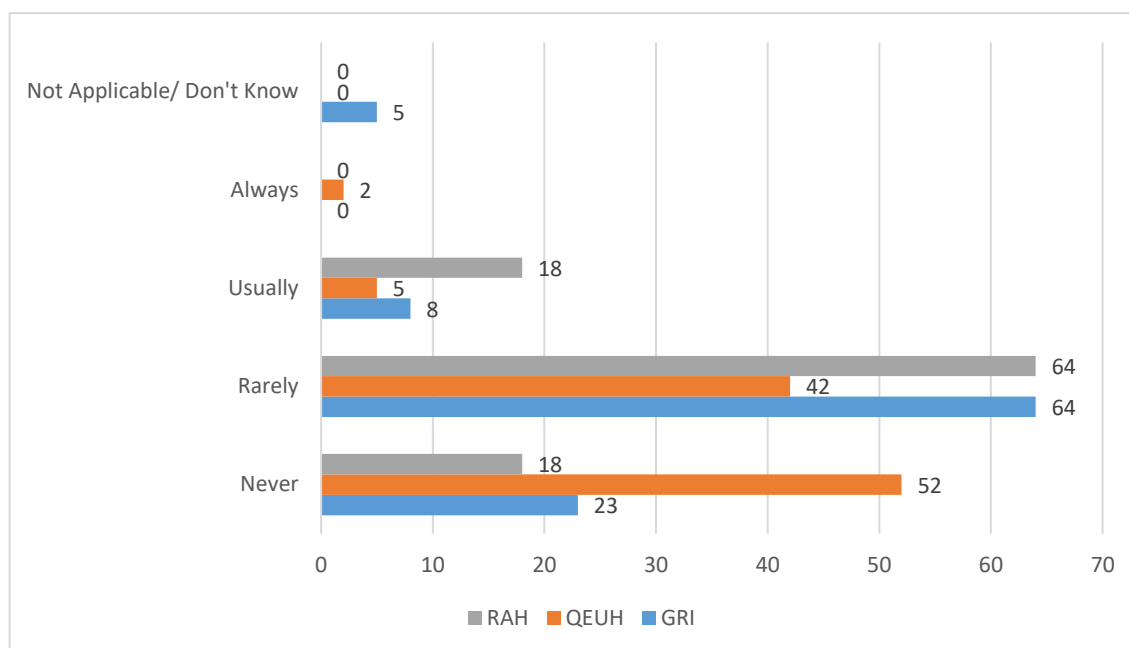


Figure 6.10: Staff reporting morale in the emergency department to be high (% of staff)

6.64. The quantitative data from the survey were supported by qualitative data, which also tended to be more negative from staff at the Queen Elizabeth University Hospital than the other two sites. Some staff described the working environment in the Queen Elizabeth University Hospital as ‘brutal’ and ‘inhumane’. Staff talked about the moral distress⁷⁴ caused by circumstances within the department that led to them not being able to provide what they described as basic levels of care. One staff member described being ‘haunted’ by some patient care experiences that had led to harm. Back-to-back trauma cases were described as ‘horrific’ with a perceived lack of space to decompress after adverse events. These staff experiences may be impacting on sickness absence rates (see paragraphs 6.101. and 6.125).

“

I used to love emergency medicine, and in many ways I still do. [...] We are losing experienced staff all the time, because they don't feel valued or supported.[...]

”

“

Multiple staff members have been off with stress recently and a large influence on that has been having to do the job of three nurses every shift. We keep getting told to prioritise basic care, prioritise investigations, prioritise treatment, prioritise infection control, prioritise flow, prioritise documentation, prioritise nursing assessments as we are failing on all fronts.

”

⁷⁴ Moral distress is the psychological distress of knowing the right thing to do but being constrained from pursuing the right course of action. Jameton A, 1984. Nursing practice: the ethical issues. Englewood Cliffs, NJ: Prentice Hall, p6.

“

We are failing on all fronts because we are fighting fires on most shifts. Emergency nursing is an amazing specialty, most of us chose it as it's an area where we feel we can make a difference, we can support the most unwell and most vulnerable patients. But realistically we are barely keeping our heads above water.

”

- 6.65. Despite the majority of feedback from staff being negative, there were some positive comments about why working in the emergency department can be positive and fulfilling.

“

We care for some people in their most vulnerable times. In my time in the emergency department, I have felt I have made a difference.

”

- 6.66. However, many staff expressed concerns that they could not do their jobs properly, leading to moral distress. Nursing staff reported to be burnt out and worried about making mistakes. Emergency medicine consultants reported feeling undervalued. Clinicians feel responsibility for harm that comes to patients from long wait times and corridor care, and staff reported that after some shifts, they could feel eroded of energy with a low feeling of worth.

Management action to improve staff experience

- 6.67. Staff perceived that they are not valued by management and that communications from management can cause anxiety. Although there was some wellbeing support available (for example, a wellbeing room), staff reported having little or no time to take up this support or even take a break.
- 6.68. All three emergency departments have developed their own wellbeing multidisciplinary groups with support from departmental management. Departmental management had also arranged for monthly psychological support for staff in the Queen Elizabeth University Hospital emergency department. This arrangement was in place until December 2024. A business case for continuing this on a permanent basis had been put forward.

“

[...] Feels like constant criticism from higher up all the time, never feel valued or part of a team. Don't want to come into work knowing the state of the place. The fact that higher-up management have no idea what the job entails and continuously cut staffing makes me want to quit. It makes me feel so devalued and I feel it's a slap in the face to the nursing profession.

”

- 6.69. The staff survey found staff had mixed views on whether emergency department management took appropriate action to ensure positive staff experience and wellbeing, with a more negative response from the Queen Elizabeth University Hospital (Figure 6.11). A similar pattern was found when staff were asked if management teams provided feedback to recognise effort, with 36-46% of staff across the three sites saying it was 'rarely' done and the highest number of 'never' responses at the Queen Elizabeth University Hospital.

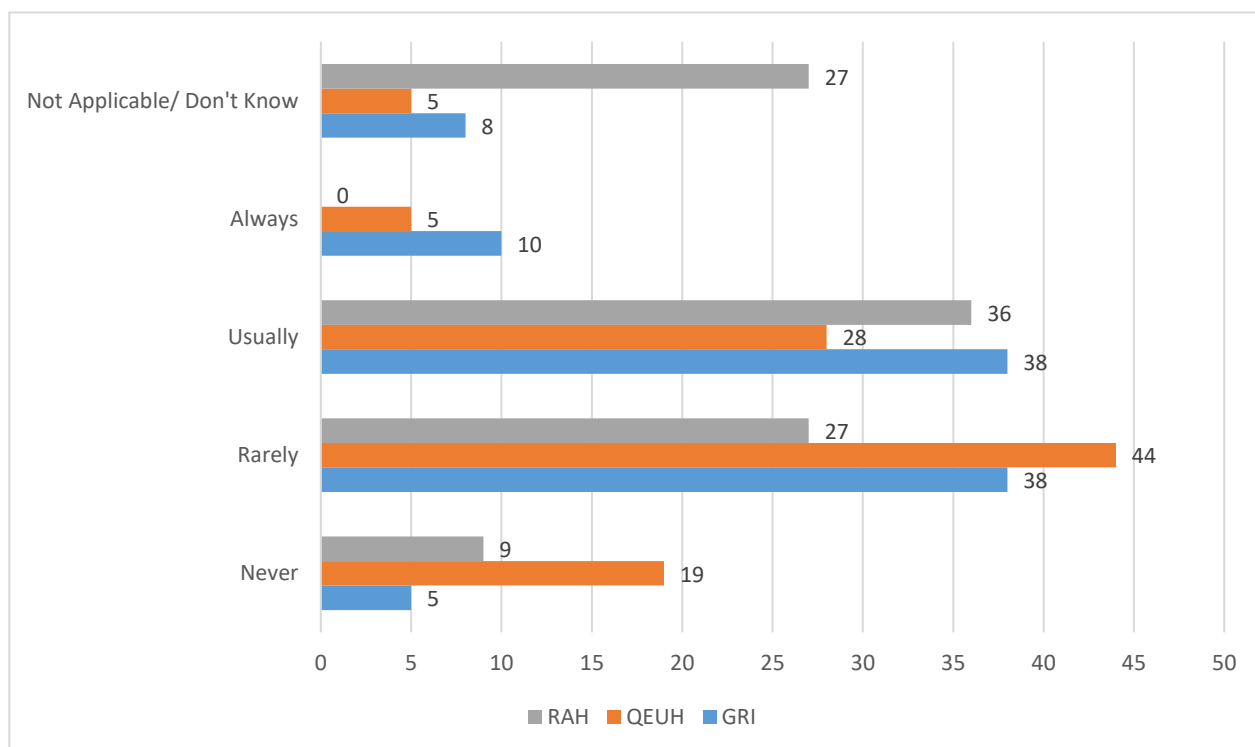


Figure 6.11: Staff views on management action to improve staff experience (% of staff)

“Staff feel like they are not listened to by senior management, the level of burnout throughout all grades is at an all-time high... Management rarely check in on staff despite knowing about challenging shifts.”

“When staff have had to cope with majorly traumatic events they are expected to move onto the next patient and not given or told to have any time to reflect which has ultimately resulted in staff struggling to cope for an extended period of time. Management have been known to dismiss/not take staff seriously when they have been approached by struggling staff members.”

Recommendation 10: NHS Greater Glasgow and Clyde must demonstrate recognition of the low morale, poor wellbeing and moral distress among staff and take actions to address these. This should include engaging with staff in all three emergency departments to identify appropriate improvement actions needed beyond the other recommendations covered in this review.

Recommendation 11: NHS Greater Glasgow and Clyde must take action to protect the physical safety of staff from aggressive behaviour by patients.

Recommendation 12: NHS Greater Glasgow and Clyde should identify and make the necessary improvements to the physical environment in the emergency departments at Glasgow Royal Infirmary and the Royal Alexandra Hospital and to staff facilities, including spaces for teams to easily meet, across all three hospitals, to ensure the environment is as safe and supportive as possible for staff and patients.

Systems for learning: significant adverse event reviews

- 6.70. Significant adverse event reviews are a structured process to analyse significant incidents and to learn from them to implement improvements. Table 9 below shows the number of Category 1 significant adverse event reviews commissioned by NHS Greater Glasgow and Clyde between 2020-2024 (The figures for the year 2024 are to October 2024 only) for the board as a whole and for emergency departments specifically.
- 6.71. The Healthcare Improvement Scotland Adverse Event Framework published in 2019⁷⁵ sets a target for the completion of the most significant adverse event reviews (Category 1) within 90 working days. The table also has in italics the number completed within the 90-working day target for each of the years.

Total SIGNIFICANT ADVERSE EVENT REVIEWS Commissioned and Completed (%) 2020-2024					
	2020	2021	2022	2023	2024*
NHS Greater Glasgow and Clyde	158 (87%)	178 (93%)	232 (80%)	256 (49%)	262 (3%)
Completed within 90 working days (%)	<i>14 (8.86%)</i>	<i>7 (3.93%)</i>	<i>0 (0%)</i>	<i>2 (0.78%)</i>	<i>1 (0.38%)</i>
Accident and Emergency	8 (75%)	14 (93%)	13 (62%)	10 (60%)	12 (0%)
Completed within 90 working days (%)	<i>2 (25%)</i>	<i>2 (14.29%)</i>	<i>0 (0%)</i>	<i>0 (0%)</i>	<i>0 (0%)</i>

* 2024 figures to October 2024 only

Table 9: Category 1 Significant adverse event reviews: Total commissioned and completed (%) 2020-2024 as notified to Healthcare Improvement Scotland

⁷⁵ <https://www.healthcareimprovementscotland.scot/publications/learning-from-adverse-events-through-reporting-and-review-a-national-framework-for-scotland>. Healthcare Improvement Scotland. 2019

- 6.72. The review heard concerns from staff about the length of time it took to commission a significant adverse event review, the timescale for its completion and whether significant adverse event reviews were always commissioned appropriately. The backlog of open significant adverse event reviews was a repeated concern raised in the Acute Services division clinical governance forum minutes. However, these issues are not unique to NHS Greater Glasgow and Clyde: the position in Table 9 mirrors serious challenges across NHS Scotland in ensuring significant adverse event reviews are completed in a timely manner.
- 6.73. The review identified variation across the three sites with regards to commissioning of significant adverse event reviews. Of the 101 commissioned in 2019-2023: 40% of significant adverse event reviews were commissioned in Clyde Sector, 31.6% in North and 28.4% in South⁷⁶
- 6.74. NHS Greater Glasgow and Clyde openly acknowledged the challenges associated with feedback and learning from significant adverse event reviews. At the Acute clinical governance forum in April 2024, it noted in a paper covering significant adverse event reviews and DATIX since 2019 that: “The percentage of actions generated from all significant adverse event reviews closed in the reporting period is 91%. While the number of actions being closed off on DATIX is increasing, the quality of data remains poor with little evidence the actions taken to share learning across the organisation and what has been put in place to reduce the chance of a similar incident occurring in the future. This is similar across NHS Greater Glasgow and Clyde and not confined to unscheduled care areas.”⁷⁷
- 6.75. Staff raised concerns about the lack of feedback on submitted DATIX reports and no information about whether action or wider learning had taken place, including for issues raised about capacity. The Queen Elizabeth University Hospital emergency department’s clinical governance group noted in the February 2024 minutes that: “Datix issues – staffing issues are not being commonly recorded, thought to be due to the acceptance of understaffing. Staffing issues should be recorded on Datix as they can affect patient care. It is important that those who submit a Datix feel that they have been heard. A response should be provided in email form, and a face-to-face response can also be arranged if required.”⁷⁸

⁷⁶ *Unscheduled Care Incident Report Oct 19 – Sep 23 Cover Paper and Unscheduled Care Incident Report Oct 19 – Sep 23 Full Paper*. Greater Glasgow and Clyde. 08 April 2024

⁷⁷ *Unscheduled Care Incident Report Oct 19 – Sep 23 Cover Paper and Unscheduled Care Incident Report Oct 19 – Sep 23 Full Paper*. Greater Glasgow and Clyde. 08 April 2024

⁷⁸ Clinical Governance Meeting Minutes. Greater Glasgow and Clyde. 1 February 2024.

Staff experience of learning from incidents and raising concerns

- 6.76. Staff reported varied opportunities for post-incident debriefs, with 88% of staff at the Queen Elizabeth University Hospital stating they 'rarely' or 'never' had the opportunity for a debrief compared with 36% at the Royal Alexandra Hospital and 23% at the Glasgow Royal Infirmary (Figure 6.12) where it was demonstrated that debriefs were used.

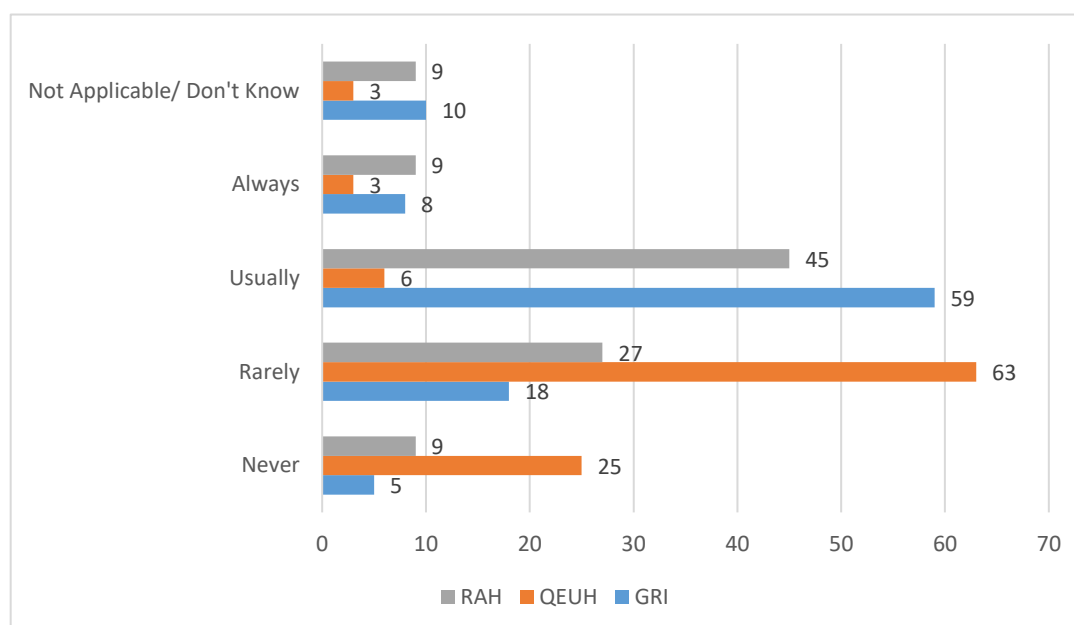


Figure 6.12: Staff reported opportunities to have post incident debriefs (% of staff)

- 6.77. Similarly, more staff at the Queen Elizabeth University Hospital said that incident reporting was not used for improvement, compared with staff at the Royal Alexandra Hospital or Glasgow Royal Infirmary (Figure 6.13).

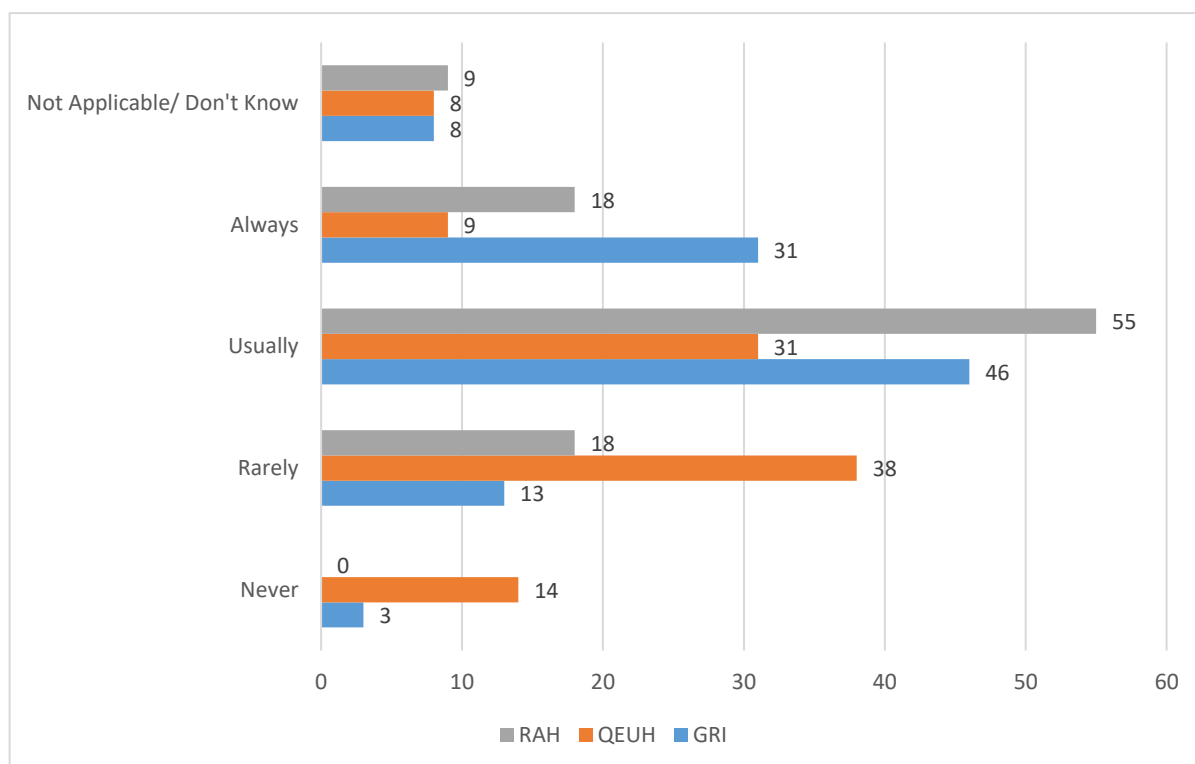


Figure 6.13: Staff reported use of incident reporting for improvement (% of staff)

- 6.78. Taken together, these questions indicate a need to improve the use of debriefs and incident reporting at the Queen Elizabeth University Hospital. These findings were backed up by qualitative data. The extent to which staff felt that their concerns regarding the quality and safety of care were addressed appeared to vary depending on the level of seniority to which the concern was raised. Some staff reported that although the leaders directly above them took reports of adverse events and safety concerns forward, they were concerned that at a certain level nothing progressed further. At the Queen Elizabeth University Hospital, staff reported that their concerns were unheard by both clinical management teams and site management teams.
- 6.79. Some staff at both the Royal Alexandra Hospital and the Queen Elizabeth University Hospital reported a perceived reluctance and resistance of some managers with regard to the reporting of adverse events relating to the emergency departments. The review team did not find further evidence to substantiate this staff survey feedback, nonetheless this has been formally raised with NHS Greater Glasgow and Clyde.



[There have been] deliberate attempts by senior management and board to downplay and cover up instances of harm (not unique to emergency medicine).



I feel well supported when I raise concerns about patient safety by my immediate managers but feel let down when their escalation is ignored.

- 6.80. Some staff reported feeling unable to raise concerns about patient care to more senior staff. Staff at the Queen Elizabeth University Hospital felt less able to raise concerns than staff at the other two sites: 52% of Queen Elizabeth University Hospital respondents felt 'rarely' or 'never' able to do so, compared with considerably lower figures for the Royal Alexandra Hospital (18%) and the Glasgow Royal Infirmary (21%) (Figure 6.14).

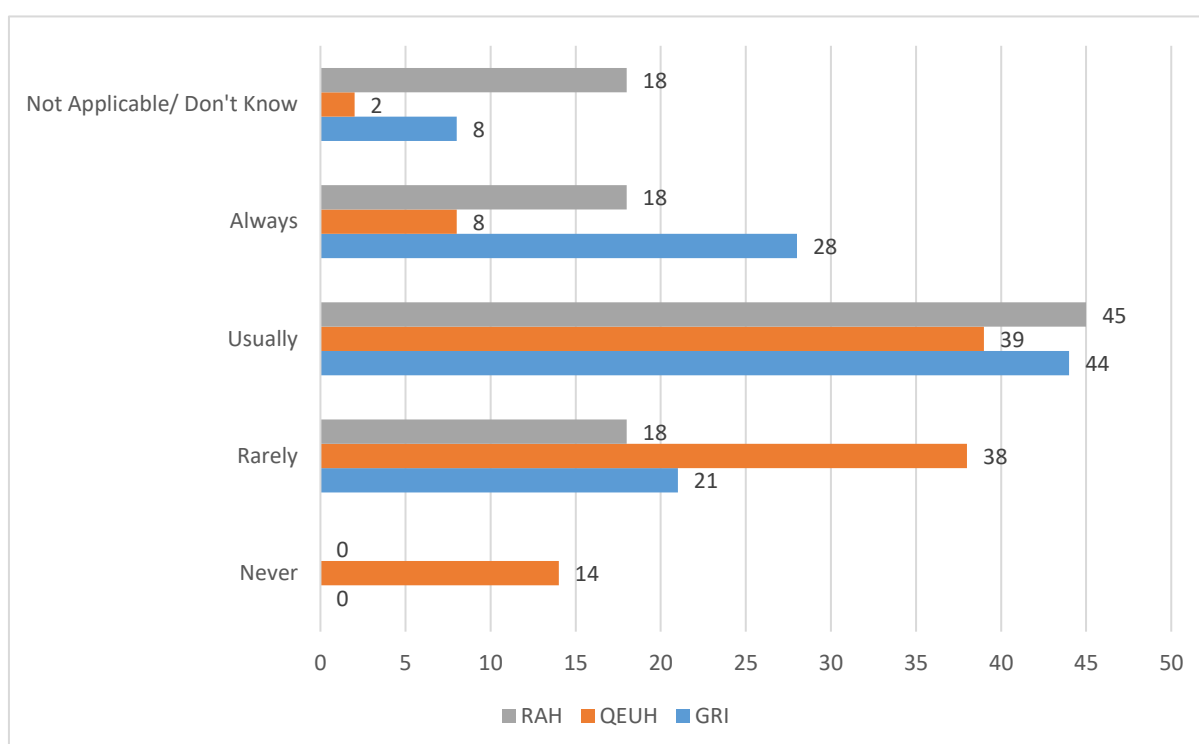


Figure 6.14: Staff reported ability to raise concerns about patient care (% of staff)

Risk Management

- 6.81. NHS Greater Glasgow and Clyde provided the review with its board level risk register⁷⁹ for urgent and unscheduled care. The risk is described as a potential failure to deliver urgent and unscheduled care standards and targets. The initial risk was determined to be a red rating of 'very high' with a likelihood level of 4 and an impact level of 5 generating a score of 20. The maximum rating score for each is 5 with a maximum risk score of 25 (i.e. 5 x 5).
- 6.82. The risk rating was subsequently amended to 'high' taking into account the board's views of the controls that were in place. The last review of the risk in the documentation provided was in November 2024. The impact level was reduced from 5 to 4, with the combined score falling to 16 (i.e. 4x4) and the risk rating falling from red to amber status.
- 6.83. The review notes that the consideration of the risk is focused on the delivery of performance metrics and there is no mention of impact for patients or the quality of care.
- 6.84. The Queen Elizabeth University Hospital risk register⁸⁰ was also provided for urgent and unscheduled care. All the review dates had passed for the update of risks on the register (date range from 21 February 2022 through to 1 August 2024). The latest update to the risk register against a specific risk was carried out on 1 February 2024.
- 6.85. Despite the serious nature of the risks (four of the seven risks were categorised as very high) covering patient safety, crowding and staffing, it was clear that many of the actions and operating context in the risk register were considerably out of date. It indicates that the risk register was not used as a meaningful tool for the identification and management of risk nor was there appropriate oversight of it.
- 6.86. The Glasgow Royal Infirmary risk register was regularly updated. The risk register identified difficulties since its inception in 2022 in resourcing the staff wellbeing team. It also identified the shortfall in nurse staffing since the 2024 inspection, with the expectation of 18 trained nurses per shift including the nurses required to care for patients placed in corridors. The risk register notes as of October 2024, "that nursing staff numbers in the emergency department are only operationally able to escalate staffing to 16 trained nurses. Workforce tool completed and submitted to CD / ACN for escalation to facilitate the protected/ allocated nursing roles on shift".

⁷⁹ Acute and Board UUC Risk Register (Datix listing report). Greater Glasgow and Clyde. 11 November 2024.

⁸⁰ Q1 – 2 QEUH ED Risk Register Nove 2024. Greater Glasgow and Clyde. November 2024.

- 6.87. The Royal Alexandra Hospital's risk register was also more up to date than the Queen Elizabeth University Hospital with regard to urgent and unscheduled care. It covered a range of risks related to service delivery, patient experience and staffing. The two red risks related to sufficiency of senior decision makers and the environment in the hospital.

Recommendation 13: NHS Greater Glasgow and Clyde must improve its systems for learning about safety concerns including the use of significant adverse event reviews, post-incident debriefs and incident reporting. It must enhance its processes for sharing learning and feedback with staff and making improvements in response to learning.

Recommendation 14: NHS Greater Glasgow and Clyde should review the risk management processes for emergency departments to ensure they provide an accurate and comprehensive assessment of current risks and steps being taken to mitigate these, with appropriate regular monitoring and oversight. The risks need to reflect the impact on quality and outcomes for patients rather than purely focusing on performance.

Essential of Safe Care 4: Safe, consistent, clinical and care processes

Emergency medicine has changed considerably since the workforce tools for defining safe staffing levels were developed. This includes significant differences in patient flow, capacity and crowding in departments, acuity of presenting patients, changes in medical educational policies and careers, and staff sickness absence rates. These changes raise questions about whether the workforce tools are adequately robust for the current context. Although an analysis of staffing levels in three emergency departments using the tools found staffing levels met national recommendations, there is a lack of confidence that the current tools can provide reliable assurance on safe and effective staffing levels.

- 6.88. This section includes the reliable implementation of processes and safe staffing.

Safe staffing: introduction

- 6.89. The Royal College of Emergency Medicine states that effective staffing is a function of capacity, capability, sustainable working and resilience. Insufficient staff numbers result in longer waits, crowding, compromises to safe practice, reduction in the quality of care, and poor experience of patients and staff.⁸¹
- 6.90. The Royal College of Nursing states an appropriate workforce is the key factor for providing safe, effective, high quality urgent and unscheduled care in a timely, cost-effective and sustainable manner. This requires a balanced team of nurses, doctors, allied health professionals and support staff, with appropriate knowledge and skills.⁸²

⁸¹ https://rcem.ac.uk/wp-content/uploads/2021/11/RCEM_Consultant_Workforce_Document_Feb_2019.pdf. Royal College of Emergency Medicine. February 2019.

⁸² [file:///C:/Users/CAROLI~1/AppData/Local/Temp/MicrosoftEdgeDownloads/8365cfd6-dc2a-4f30-bbe1-34d6fcdeb6ca/Nursing-workforce-standards-for-Type-1-EDs-Oct-2020%20\(2\).pdf](file:///C:/Users/CAROLI~1/AppData/Local/Temp/MicrosoftEdgeDownloads/8365cfd6-dc2a-4f30-bbe1-34d6fcdeb6ca/Nursing-workforce-standards-for-Type-1-EDs-Oct-2020%20(2).pdf)

- 6.91. The Health and Care (Staffing) (Scotland) Act 2019⁸³ commenced on 1 April 2024. It legally requires NHS Scotland boards to be appropriately staffed. It aims to ensure provision of safe high-quality care, to improve outcomes for service users and put patient safety at the fore. Healthcare Improvement Scotland has a duty under the Act to monitor compliance with the duties as cited in the legislation.
- 6.92. The Health and Care (Staffing) (Scotland) Act 2019 mandates that emergency departments should apply the Common Staffing Method to help determine appropriate staffing in terms of both medical and nursing staff. Current national recommendations from the Royal College of Emergency Medicine and the Royal College of Nursing can be incorporated into the triangulation process, alongside relevant available data and intelligence to inform decision making. The Emergency Care Provision staffing level tool and professional judgment tool are mandated for use as part of Common Staffing Method application.
- 6.93. Throughout this review, staff reported concerns about both staffing levels and skill mix in all three emergency departments in NHS Greater Glasgow and Clyde. The board has previously used the recommended staffing tools above to inform staffing levels in their emergency departments. However, there were concerns about the historical application of the tools and their contemporaneous relevance which resulted in a lack of assurance about the reliability of the outputs (see following paragraphs for detail).

Emergency medicine context – safe staffing

- 6.94. Emergency medicine has changed considerably since the tools for defining safe staffing levels were developed. The Emergency Care Provision tool was developed in 2013 and updated in 2019. The Royal College of Emergency Medicine guidance which uses patient attendance numbers to inform workforce requirements was developed in 2018. Specific changes that are not accounted for within the tools and which may impact on the accuracy of their output are listed below.
- 6.95. Performance against the four-hour standard across Scotland has dropped considerably since 2018 (see Chapter 4), which is associated with poorer flow, and increased crowding in emergency departments. The tools allocate a predicated number of care hours based on the patient complexity on the principle of patients moving smoothly through emergency departments.
- 6.96. Patients presenting in emergency departments frequently have greater complexity and length of stay than when the tools were developed. In NHS Greater Glasgow and Clyde this is accentuated by having a structure of separate minor injuries units which results in the main emergency department being predominantly focused on more complex frail patients with multiple

⁸³ [Health and Care \(Staffing\) \(Scotland\) Act 2019: overview - gov.scot](#). Scottish Government. Last updated 1 November 2024.

comorbidities, or in the case of the Queen Elizabeth University Hospital with major trauma. This group of patients tends to require an increased length of stay within the emergency department and the need for inpatient admission which may involve a wait for a bed and in some cases, this also results in use of non-standard bed care. During this wait, ongoing care must be provided by nursing staff and resident doctors in the emergency department which can include investigations, prescribing and administration of medicines, personal care and review with senior decision makers. Not all emergency department nurses will have experience of providing complex ongoing care that involves ward or high dependency pathways. This introduces an element of risk to patients while waiting for a bed on a ward.

- 6.97. The senior decision maker in emergency departments is a bespoke and critical role which is essential in emergency departments. They are usually a consultant, senior doctor or advanced practitioner responsible for making critical clinical decisions (regarding investigations, treatment and disposal), and leading and guiding the clinical team. In extremely busy emergency departments this person may be solely focused on trying to manage flow which can impact on their ability to fulfil the full senior decision maker role required of them. Roles such as emergency physician in charge have evolved over the past years to allow management of risk, capacity and flow across the whole department.
- 6.98. Changes in medical educational policies and working patterns has resulted in fewer trainee hours available as clinical hours within the emergency departments, which increases the workload for the medical workforce who have to cover this shortfall.
- 6.99. There is a national shortage of suitably trained middle-grade doctors. Clinical development fellow posts have become essential members of the emergency department staffing structure, but they are funded by non-recurring funding which can result in delays to recruitment. There was evidence of clinical development fellows being used to fill gaps in middle-grade rotas without these staff members having the necessary skills to provide the level of role required (senior decision maker).
- 6.100. Medical careers have changed, with increasing numbers of doctors opting for portfolio careers. It is often unclear from rosters whether these staff are included as whole time equivalent despite having less than full time clinical sessions. The national shortage of middle grade doctors has impacted on recruitment to vacancies and covering staff shortages. Additionally, more doctors are opting to work less than full-time which can have an added impact on the available workforce.

- 6.101. Sickness absence rates have risen. Sickness absences are lower in medical than nursing staff groups across all three sites (although it is recognised that recording processes are different). The lowest sickness rates were seen at the Royal Alexandra Hospital. The highest average sickness rates for consultants were seen at the Glasgow Royal Infirmary (2.95%) and healthcare support workers (17.9%), and the highest sickness rates for registered nurses was seen at the Queen Elizabeth University Hospital (8.35%).
- 6.102. NHS Greater Glasgow and Clyde acknowledges that its existing systems do not fully support the assessment and monitoring of real time staffing, along with capturing the identification of mitigation and the escalation of staffing risks to fully comply with the duties of the Health and Care (Staffing) (Scotland) Act. Practice differs across the three sites in terms of real time staffing assessment. Although there is no timescale to resolve this, the board does have a long-term plan to implement the Safe Care Live system.

Medical workforce

Queen Elizabeth University Hospital conclusions

- 6.103. The funded establishment for consultants has increased from 30 to 31.1WTE from January 2023 to August 2024 (increase of 1.1WTE). Although this is higher than the Royal College of Emergency Medicine recommended 24.7 to 27.5WTE, based on the number of emergency department attendances, this may not provide adequate provision for the patient complexity due to Queen Elizabeth University Hospital being a major trauma centre. There is a requirement to factor in additional trauma consultant cover, across the seven days, over and above the core emergency department consultant staffing numbers.
- 6.104. The total emergency department medical workforce at the Queen Elizabeth University Hospital is 78.7WTE, with a non-consultant establishment of 42.1WTE. This is aligned with national recommendations for a large emergency department. The non-consultant medical staffing levels are higher than the recommendation from the recent Scottish Emergency Care Provision Staffing Level tool which recommended a total medical workforce of 45.7WTE with a non-consultant workforce of 31.1WTE. However, the professional judgment tool recommended non-consultant staffing is considerably higher at 59.4WTE which would require a significant uplift to the current establishment. As stated in paragraphs 6.94-6.102 there are quality assurance concerns about the reliability of these conclusions. In addition, they do not reflect the additional workforce requirement for a major trauma unit.
- 6.105. The actual number of in-post medical senior decision makers is 41.2WTE. Additionally, the Queen Elizabeth University Hospital includes an advanced nurse Practitioner, who is classed as a non-medical senior decision maker, within their current senior decision maker complement. This combined total of 42.2WTE is

just above the Royal College of Emergency Medicine's minimum recommendation for a large major trauma centre of 42WTE. Once the 3WTE current vacancies are filled, this would exceed the minimum recommended level and may promote a more even spread of senior decision makers across the seven-day period.

- 6.106. It is recognised that changes in patient presentations, compounded by increased length of stay, and the complexities of medical staff working arrangements, which have occurred since the national guidance and tools were developed, have contributed to staff's perception that the workforce is insufficient for the site. This is supported by the finding of the professional judgement tool and the observed long-term gaps in rotas which would require more non-consultant workforce, in particular middle grade doctors, than the site currently has within its establishment. This is supported by the finding of the professional judgement tool and the observed long-term gaps in rotas, requests for locum cover and the staffing huddles and handover sheets that indicate medical workforce as a challenge. This would necessitate a larger non-consultant workforce, in particular middle grade doctors, than the site currently has within its establishment.
- 6.107. From the sample of the Queen Elizabeth University Hospital medical handover documents reviewed staffing issues, rated as significant, were identified in 38% of the documents reviewed.

Glasgow Royal Infirmary conclusions

- 6.108. The number of funded consultant posts has remained unchanged since January 2023 at 20WTE. However, the number of consultants in post has consistently exceeded the funded establishment varying from 22 to 24.1WTE (average 23.2WTE). This is in line with the Royal College of Emergency Medicine recommendations, based on the number of attendances, of 20.0 to 23.2WTE.
- 6.109. While the funded emergency department consultant and total senior decision maker workforce (consultant and non-consultant) at the Glasgow Royal Infirmary appears to be in line with the Royal College of Emergency Medicine's workforce recommendations, it is recognised that due to changes and complexities of role and responsibility that this may not be sufficient for the site (as described in paragraphs 6.94-6.102). This is supported by the observed reliance on locums at resident grade to cover the medical rotas. As above, the allocation of emergency medicine middle grades by NHS Education for Scotland and can vary in terms of WTE on each six month/annual allocation. This can impact on the available hours available to cover rotas and impact on the overall availability of senior decision makers.
- 6.110. The total emergency department medical workforce at the Glasgow Royal Infirmary is 68WTE, which is above the Scottish Emergency Care Provision staffing level tool's recommended medical staffing of 46WTE. However, the

professional judgment tool recommended total medical staffing is considerably higher at 71.8WTE which would require a significant uplift to the current establishment. Although it is recognised that these tool outputs may not be reliable due to quality assurance concerns (as described in paragraphs 6.93-6.107) including the use of additional non-standard bed care areas.

- 6.111. The actual number of senior decision makers is 31.5WTE, just above the Royal College of Emergency Medicine's minimum recommendation of 30WTE for a medium sized emergency department. However, there have been notable vacancies within the consultant workforce which have been vastly improved since January 2023 (from a variance of 27% to 1.3%, an increase of 8.98WTE consultants). There have also been vacancies among non-consultant senior decision makers (3WTE vacancies) which has impacted on the availability of senior decision makers to fill rotas resulting in an observed reliance on locums.
- 6.112. Other evidence that the staffing establishments are insufficient was seen within the safety pause logbook with approximately 50% of entries citing medical staffing challenges, many of which include consultant level staff.
- 6.113. From the sample of medical handover documents reviewed staffing issues were rated as significant in 12% of the reports reviewed. There was a strong positive correlation in the data related to the medical handover documents from Glasgow Royal Infirmary between staffing and reported safety concerns.

Royal Alexandra Hospital conclusions

- 6.114. There has been contradictory information provided in terms of consultant establishments, with both actual and funded establishment WTE varying by as much as 10WTE. This may be due to the number of consultants working for the Emergency Medical Retrieval Service as part of their job therefore not providing direct clinical care for the Royal Alexandra Hospital or Inverclyde Royal Hospital. Regardless, even based on the lower figure provided, which indicated that there were 21.9WTE consultants, this would meet the Royal College of Emergency Medicine's recommendation of 21.8-24.2WTE, based on the number of combined attendances across the Royal Alexandra Hospital and Inverclyde Royal Hospital.
- 6.115. While the total emergency department medical workforce at the Royal Alexandra Hospital (including additional staffing through the staff bank) appears to be in line with national workforce recommendations, it is recognised that due to changes and complexities of role and responsibility that this may not be sufficient for the site. A further complication for this Royal Alexandra Hospital calculation is that the medical workforce covers the emergency departments at two sites (at the Royal Alexandra Hospital and the Inverclyde Royal Hospital), so combined attendance figures for both sites were used. This is a challenge

because the two sites require a minimum level of medical staffing and senior decision makers regardless of patient attendances.

- 6.116. The total combined emergency department medical workforce at the Royal Alexandra Hospital and Inverclyde Royal Hospital is 60.1WTE, with additional staffing provision through the staff bank bringing the total provision of 66.6WTE (August 2024 bank figures). This is in line with the combined output of the Scottish Emergency Care Provision staffing level tool's recommended medical workforce of 58.5WTE. This could in part be attributed to the high complexity of patients recorded during the period the tools were run. The recommendations from the Professional Judgement Tool were considerably lower with a recommended total medical workforce of only 40.2WTE. However, the complexity and length of patient stay within the departments and the additional considerations in terms of ensuring appropriate numbers and skill mix of medical staffing across the two sites needs to be factored and is likely to be contributing to medical staff's perception that staffing is insufficient to meet the needs of patients. The significant reliance on medical staffing provision through the staff bank needs to be considered in terms of a future sustainable medical model across the sites.
- 6.117. The actual number of senior decision makers is 29.5WTE, just below the Royal College of Emergency Medicine's minimum recommendation of 30WTE for a medium sized emergency department, however it is noted that there are significant non-consultant senior decision maker vacancies which when filled will bring the full establishment to 34.7WTE. However, as above, the allocation of emergency medicine middle grades is reliant on the allocation from NHS Education for Scotland and can fluctuate every six months/annually dependent on the WTE of the staff allocated. It is also noted that there is a significant reliance on locums and clinical development fellows, particularly at the Inverclyde Royal Hospital where almost 50% of middle grade shifts across the 24-hour period were covered by locums and clinical development fellows. There was also a notable high level of late shift and night shift cover provided by either clinical development fellows or locums across both sites. This will add additional pressure to consultants and senior decision makers.

Nursing workforce

- 6.118. No significant average establishment variance (+/-10%) was noted at any of the sites for all grades of nursing staff over the 20-month timeframe covered in the review (January 2023 to August 2024). However, there is a current significant variance at the Royal Alexandra Hospital within band 5 nursing staff which is 30% (9WTE) below full establishment. This is partly due to current over-establishment of band 6 and band 7 nursing staff (4.4WTE) but requires some supplementary staffing to cover remaining hours.

- 6.119. The Royal College of Nursing recommends an emergency nursing workforce skill mix of 80% registered nurses to 20% unregistered nurses (healthcare support workers). Within this, 30% of the total nursing workforce should be charge nurses (band 6 and above) and a further 40% of the total nursing workforce should be competent emergency nurses. All three NHS Greater Glasgow and Clyde sites meet or exceed these recommendations currently, with a caveat that staff have fed back that due to the number of newly qualified and new staff recruited to the band 5 nursing workforce there is a lack of competent emergency nurses which is putting pressure on the more experienced and senior nurses.
- 6.120. The nursing workforce across the week was found to remain relatively stable in terms of numbers. It is acknowledged however, that the skill mix of the nursing workforce was unclear to the Core Review Group, along with how this is spread across the 24/7 period to ensure adequate knowledge, experience and seniority to enable effective decision-making and patient safety.
- 6.121. Supplementary staffing is used across all three sites. This generally seems sufficient to cover the establishment roles.

Queen Elizabeth University Hospital conclusions

- 6.122. The total emergency department nursing workforce at the Queen Elizabeth University Hospital of 161.6WTE seems appropriate for an emergency department as a major trauma centre. This figure exceeds the workforce requirement calculated by the Scottish Emergency Care Provision staffing level tool and professional judgment of staff during the recent staffing level tool run. There is a recognition that the validity of the tool outputs will have been impacted by the quality of the data and low level of patient complexity recorded which did not seem correct. Given the patient complexity, length of stay and additional roles being undertaken by nursing staff, there are other factors to consider to ensure that the nursing workforce is appropriate.
- 6.123. The Queen Elizabeth University Hospital nursing workforce also exceeds the emergency department standard recommendations for nursing workforce skill mix, with a ratio of 82% registered nurse to 18% unregistered nurse and 38.7% of the nursing workforce is at band 6 or above.
- 6.124. The findings of the systematic review of the sample of nursing handover documents found that the Queen Elizabeth University Hospital had the highest incidence of recording of staffing issues rated as significant (61% of reports reviewed). The issues related to both staffing gaps and skills mix.
- 6.125. The Queen Elizabeth University Hospital has the highest average rate of sickness absence (8.35%) for registered nurses of the three sites. In addition, there is a very high sickness absence rate within healthcare support workers, averaging at

15.3% since January 2023. The staffing gap has been mitigated by an increase in supplementary staffing, mainly through the staff bank.

- 6.126. There were some notable positive workforce developments within the nursing workforce with the introduction of a nurse educator and advanced nurse practitioner roles. These roles are not replicated at either Glasgow Royal Infirmary or the Royal Alexandra Hospital. Staff indicated that redirection was having a less favourable impact on role developments because it impacted on the capacity of senior emergency nurse practitioners within the main emergency department. Staff also raised concerns that the training provided did not adequately equip them to undertake the role.

Glasgow Royal Infirmary conclusions

- 6.127. The total emergency department nursing workforce at Glasgow Royal Infirmary of 105.1WTE seems appropriate for an emergency department of this size. This figure exceeds the Scottish Emergency Care Provision staffing level tool recommendation but is below the professional judgment of staff during the recent staffing level tool run. However, given the complexity and pressure experienced, there are other factors to consider: staff appear to be feeling pressure at the Glasgow Royal Infirmary due to non-standard bed care, expectation to provide redirection and lack of flow out of the department.
- 6.128. The Glasgow Royal Infirmary nursing workforce also exceed the emergency department standard recommendations for nursing workforce skill mix, with a ratio of 83% registered nurse to 17% unregistered nurse and 44.9% of nursing workforce is at band 6 or above.
- 6.129. There were concerns about the extent to which the professional judgement of nursing staffing was being reflected in the decisions about staffing. Specifically, that there were 16 registered nurses on shift, compared to an expected complement of 18 registered nurses, and often it is 14 on shift. This includes the requirement to support corridor care in Glasgow Royal Infirmary.
- 6.130. From the systematic review of a sample of Nursing handovers from Glasgow Royal Infirmary 43% of the documents reviewed identified staffing issues rated as significant, however 30% of the Glasgow Royal Infirmary nursing reports were unrated due to insufficient information. The issues related to both staffing gaps and skills mix.
- 6.131. There is insufficient recognition in the staffing model of the need to accommodate sudden surges in acuity and patient volumes and the associated requirements in resuscitation. The review noted that there was a high risk of resuscitation areas being under-staffed especially in the context of multiple attendances of urgent patients with high levels of acuity.

- 6.132. In addition, new roles to manage redirection in each site have been taken from the core establishment rather than met with additional funding to support the changes required.
- 6.133. NHS Greater Glasgow and Clyde confirmed that they had sought to obtain a tighter control on expenditure at Glasgow Royal Infirmary given that expenditure on nurse staffing was over-budget. Nursing management acknowledged that the workload was having an impact on morale and that financial constraints prevented filling vacancies when absence levels rose above the 4% budgeted contingency. There was an open recognition that staffing levels were a matter of concern and had implications for the delivery of safe care, especially to those patients with more complex needs. The position was accentuated by the use of bank nursing staff who may not be familiar with the roles, and which created a further level of stress for existing staff.

Royal Alexandra Hospital conclusions

- 6.134. The total emergency department nursing workforce at the Royal Alexandra Hospital of 67.8WTE seems appropriate for an emergency department of this size, once fully staffed with band 5 staff. This figure exceeds the professional judgment of staff during the recent staffing level tool run however, conversely with the other sites, it is lower than the Scottish Emergency Care Provision staffing level tool recommendation. However, given the complexity and pressure experienced, there are many other factors to consider to ensure that the nursing workforce is appropriate.
- 6.135. The Royal Alexandra Hospital nursing workforce meets or exceeds the emergency department standard recommendations for nursing workforce skill mix, with a ratio of 80% registered nurse to 20% unregistered nurse and 48% of nursing workforce is at band 6 or above, the highest of all three sites.
- 6.136. The Royal Alexandra Hospital has the lowest registered nurse to patient ratio of the three sites which is compounded by vacancies among registered nurses, particularly at the band 5 level, which is supported by the over-establishment of nurses at band 6 and 7 and healthcare support workers.
- 6.137. The Royal Alexandra Hospital has introduced new roles not seen at the other sites (band 4 non-registered nursing workforce and advanced physiotherapy practitioner).

Staff views

- 6.138. Staffing levels were a universal concern reported by staff who felt staffing levels contributed to unsafe care and poor staff wellbeing. Staff were also concerned about skill mix, with suggestions that some inexperienced staff were staffing areas with little support.



Being told that we are “staffed” because the number of nurses on the floor is correct with no appreciation given to the skill mix which we have been told we are not allowed to comment on.



- 6.139. Across the entirety of the sample of the Queen Elizabeth University Hospital and Glasgow Royal Infirmary nursing and medical handover reports reviewed issues with staffing, as recorded in the documents, were rated as significant in just over a third of the reports. Across both sites and both medical and nursing staff groups, issues with staffing rated as significant were identified to varying degrees on every day of the week. The higher levels of issues rated as significant recorded in the reports (38-47% of documents reviewed) occurred towards the end of the week and over the weekend (Thursday – Sunday).
- 6.140. Staff also raised concerns in the staff survey that there is a lack of support and training for junior staff, and this was leading to unsafe patient care. Newly qualified staff need educational support and structured mentoring. Figure 6.15 shows many staff at the Queen Elizabeth University Hospital and the Glasgow Royal Infirmary felt newly qualified, new staff and students were rarely supported and supervised well, compared with a more positive picture at the Royal Alexandra Hospital. This may in part be attributed to the low numbers of nursing staff from the Royal Alexandra Hospital who completed the survey.

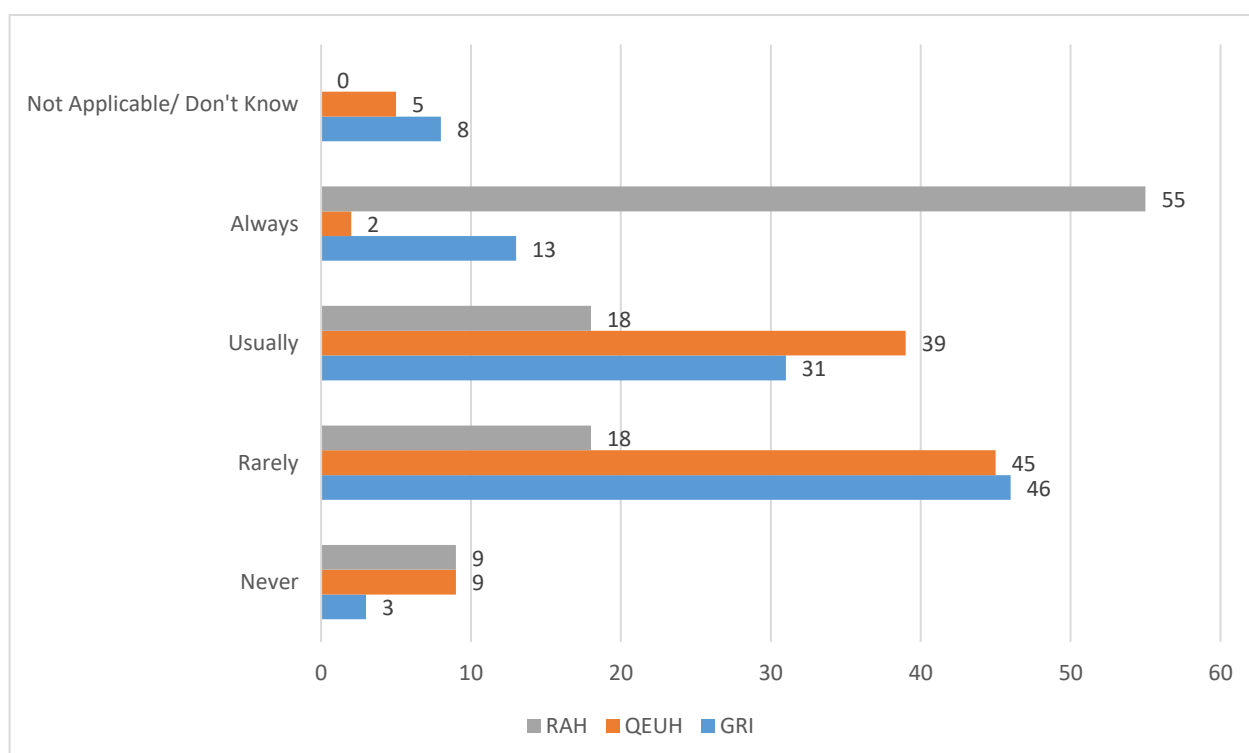


Figure 6.15: Staff views on how well junior staff are well supported and supervised (% of staff)

Recommendation 15: NHS Greater Glasgow and Clyde must undertake a comprehensive multi-disciplinary workforce review, utilising the Common Staffing Method, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

Recommendation 16: NHS Greater Glasgow and Clyde should prioritise introducing robust systems and processes for the assessment of real time staffing and the escalation and monitoring of severe and recurrent risk, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

Recommendation 17: NHS Greater Glasgow and Clyde should ensure that staff are given the time and resources to undertake required training to undertake their role, in line with the requirements of the Health and Care (Staffing) (Scotland) Act 2019.

7. Leadership and Culture

This section provides information on the importance of leadership and culture in a healthcare context. It addresses specific aspects of leadership and culture for the emergency departments at Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital to explore the extent to which:

- the service is well led
- there are robust governance arrangements
- there is effective team working
- there is a supportive culture.

Why Does Leadership and Culture Matter?

- 7.1. Over many years, separate healthcare related reviews and inquiries across the UK have emphasised the critical importance of leadership and culture.
- 7.2. John Sturrock KC in his review of NHS Highland⁸⁴ cited a *British Medical Journal* article in an attempt to define what culture meant in practice:

“An article in the *BMJ* was drawn to my attention which seeks to tease out what culture means and how this relates to service performance, quality, safety and improvement. Its key messages remind us that:

- Organisational culture represents the shared ways of thinking, feeling, and behaving in healthcare organisations.
- Healthcare organisations are best viewed as comprising multiple subcultures, which may be driving forces for change or may undermine quality improvement initiatives
- A growing body of evidence links cultures and quality, but we need a more nuanced and sophisticated understanding of cultural dynamics
- Although culture is often identified as the primary culprit in healthcare scandals, with cultural reform required to remedy failings, such simplistic diagnoses and prescriptions can lack depth and specificity.”

⁸⁴ Sturrock J. [Report to the Cabinet Secretary for Health and Sport into Cultural Issues related to allegations of Bullying and Harassment in NHS Highland](#). Scottish Government; 2019.

- 7.3. In his review report, he also referenced the Francis Inquiry and the comment by Sir Robert Francis:
- ‘There can also be various cultures within the same organisation. Different teams, different departments, and different hospital sites can all ‘feel’ different. A whistleblower interviewee described the contrast between teams in the same organisation, where one had good leadership that allowed people to address mistakes directly and question one another, and the other had a command and control style with ‘an individualistic dynamic and a blame culture’.*
- 7.4. The King’s Fund⁸⁵ in its report in 2015 cited the importance of six characteristics of culture as crucial to delivering high quality care, from sharing an inspiring vision and values through to collective leadership.
- 7.5. In the context of Scotland, the Cabinet Secretary for NHS Recovery, Health and Social Care has emphasised the need for the NHS to live up to its long-standing principles and values in how it treats and supports its staff⁸⁶. This commitment is also reflected in the Staff Governance Standard and the Blueprint for Governance for NHS Scotland which describes the need for a culture which underpins these values in everyday practice. The Blueprint emphasises that: “To support the delivery of this organisational culture, the leadership of the organisation has to be seen as competent and credible, act in the best interest of stakeholders, act at all times with integrity and are reliable in their decisions and actions, in other words they are trustworthy.”⁸⁷
- 7.6. In undertaking this review, it is acknowledged that “leadership is the most influential factor in shaping organisational culture and ensuring the necessary leadership behaviours, strategies and qualities are developed is fundamental.”⁸⁸
- 7.7. The review has therefore spent a considerable amount of time gathering and considering evidence about the nature of the leadership values and culture within NHS Greater Glasgow and Clyde and across the three emergency departments.

⁸⁵ Collins B. Staff Engagement; Six building blocks for harnessing the creativity and enthusiasm of NHS staff. [The King’s Fund – Improving NHS Culture](#); 2015.

⁸⁶ [Message from the Cabinet Secretary for NHS Recovery, Health and Social Care](#). Scottish Government; online.

⁸⁷ [The Blueprint for Good Governance in NHS Scotland](#), Second Edition. Scottish Government; 2022.

⁸⁸ West M et al. [Leadership and Leadership Development in Health Care](#): The Evidence Base. The Faculty of Medical Leadership and Management; London. 2015.

Background to this review

- 7.8. This review was prompted by concerns raised by the consultants in emergency medicine at the Queen Elizabeth University Hospital. Between 2021 and 2023 there were a series of written and in-person exchanges between the emergency medicine consultants and NHS Greater Glasgow and Clyde senior management which ultimately led to the escalation to Healthcare Improvement Scotland (see Appendix 1). This section of the review report describes the background by capturing some of the more significant exchanges between 2021 to 2024 and which led up to the current situation.
- 7.9. It is important to emphasise that the current situation has not arisen in a short space of time. Since 2021, there has been a sustained deterioration in morale and relationships in the Queen Elizabeth University Hospital emergency department, as the system emerged from the Covid 19 pandemic. This is reflected in the iMatter staff experience surveys for the emergency medicine consultants in the Queen Elizabeth University Hospital.
- 7.10. The latest iMatter survey provided by the emergency medicine consultants at Queen Elizabeth University Hospital showed a 62% response rate (23/37) with an engagement index score of 45⁸⁹. The overall score of the experience in working in the organisation was 2.4 (on a scale of 0-10). The yearly reports between 2021 and 2024 show a decline in scores across all iMatter survey questions,⁹⁰ apart from one question in relation to clarity on role and responsibility, the answer to which the score has remained static.
- 7.11. In August 2021, the emergency medicine consultants at the Queen Elizabeth University Hospital wrote to NHS Greater Glasgow and Clyde senior management, identifying a range of concerns covering crowding and the implications for patient safety.⁹¹ In their letter, they asked for three actions:
- A recognition at board and government level of the severity of the current situation and an immediate program to decongest the emergency department and mitigate the risk to patients and staff.
 - An escalation plan to address the imminent increase in emergency department activity throughout the transformation of trauma services and the winter period.
 - The formation of a board level task force to implement the core structural and process changes required to redistribute the responsibility of unscheduled care across the hospital and specialties.

⁸⁹ iMatter ED Consultants Team Report. 2024.

⁹⁰ iMatter ED Consultants Team Yearly Components Report. 2024.

⁹¹ Letter from Queen Elizabeth University Hospital emergency department Consultant Team. Dated 23/08/21.

- 7.12. The response from NHS Greater Glasgow and Clyde senior management⁹² described a range of actions intended to address those concerns. However, while it acknowledged the pressures related to staffing shortages and delayed discharges, it did not provide substantial measures to effectively mitigate the issues highlighted by the consultants.
- 7.13. In December 2022, the consultants again wrote to the Medical Director expressing serious concerns about the absence of an escalation policy and an emergency action plan which they understood had been promised in April 2022. The letter also expressed concern about poor communications. The response from the Medical Director described a range of actions that were being taken⁹³. These actions were ultimately regarded by the consultants as being insufficient to address their fundamental concerns and led to the escalation to Healthcare Improvement Scotland in May 2023.
- 7.14. After a meeting in January 2024 between emergency medicine consultants at the Queen Elizabeth University Hospital and the emergency department management, relationships worsened. The meeting focused on winter pressures, the medical leadership structure of the department and the consultants were told that some of the recommendations from a review of staffing (particularly in respect of the frequency of weekend working) could not be implemented. This news caused significant disappointment and frustration. The meeting was recorded and later viewed by others, leading to accusations of poor behaviour from both sides and a further decline in trust between consultants and senior management.
- 7.15. It was reflected to the Core Review Group that the meeting in January 2024, was for many a 'pinch point' but not the sole reasons for the deterioration in relationships. There had been an accumulation of events from 2021 onwards, with matters coming to a head as a result of this meeting.

Key lines of enquiry on leadership and culture

- 7.16. Healthcare Improvement Scotland has drawn on its *Quality Assurance Framework* in undertaking this review. The Healthcare Improvement Scotland *Quality Assurance Framework* is not a checklist. It is a reference guide to support and inform reflection, evaluation and decision making about how best to improve outcomes for users of services. It is also underpinned by leadership and culture as described in the Healthcare Improvement Scotland, *Essentials of Safe Care* and the Sharing Health and Care Network (SHCIN) *Analytical Framework*.

⁹² Letter to Queen Elizabeth University Hospital emergency department Consultant Team. Dated 06/09/21.

⁹³ Email to Queen Elizabeth University Hospital ED Consultants. Dated 14 December 2022.

- 7.17. From these documents, the Core Review Group distilled four key lines of enquiry upon which to frame this aspect of the review.

Is the service well-led?

- There is a clear and well-communicated vision and purpose that aligns with its goals and values.
- The services should be designed with collaborative input from staff, patients, and other stakeholders.

Are robust governance arrangements in place?

- There is strong leadership promoting a positive culture, accountability, and transparency.

Is there effective team working?

- There is collaborative working within and between teams and involving all relevant stakeholders in the design and delivery of services.

Is there a supportive culture?

- A supportive culture encouraging respect, collaboration, and well-being among staff.

- 7.18. The Core Review Group drew on evidence from NHS Greater Glasgow and Clyde, the staff survey, team and individual staff discussion sessions, written evidence provided by a confidential mailbox, and on-site visits.

- 7.19. This chapter contains a selection of anonymised quotes in italic text from staff that shared their views and experiences during the review process (see paragraph 2.81 above). These quotes may have been drawn from the staff survey, submissions to the confidential mailbox or from discussion sessions with staff.

General observations

The review identified exceptional hard work and commitment by staff delivering services on all three sites. However, the three emergency departments in this review are working under considerable stress and it is having a detrimental impact on staff wellbeing. There are examples of poor behaviours including incivility which are undermining team cohesion, with concerns expressed about staffing levels, as well as the appropriateness of skill mix to meet the acuity and complexity of patient need.

- 7.20. There is ongoing pressure on unscheduled care in NHS Greater Glasgow and Clyde and across NHS Scotland. An ageing population, more complex patients, and higher demands on primary and community health services are straining the system, leading to overcrowded emergency departments.

- 7.21. Despite these challenges, many staff members from all disciplines, be that managerial or clinical, are working hard to provide the best care possible under extreme pressure and identify solutions to such complex and intractable issues. The Core Review Group met dedicated individuals across all levels and disciplines who are committed to meeting demand, even in difficult circumstances. However, not being able to provide the desired level of care is affecting their wellbeing and causing moral distress (see paragraphs 6.64 and 6.66).
- 7.22. Before turning to the specifics in this section, several points of serious concern must be highlighted, as set out in paragraphs 7.23–7.25 below.
- 7.23. The Core Review Group heard from staff in person during onsite activity and individual MS Teams conversations; and corroborated from the staff survey, that in the Queen Elizabeth University Hospital emergency department there are examples of significantly poor professional behaviours, instances of alleged bullying and a lack of respect that has the potential to lead to patient harm and increasing impact on staff health and wellbeing, including leading to staff sickness. All these behaviours impact on the ability of the emergency department multi-disciplinary team to function effectively for the benefit of patients and carry serious risks to patient care if they are left unaddressed.
- 7.24. The level of stress and distress among staff at all levels in the three emergency departments was palpable, with several staff members becoming visibly distressed in sharing their experiences with the Core Review Group. This included managers, medical and nursing staff, many of whom described a relentless and unforgiving environment with expectations that exceeded reasonable limits for prolonged periods. Reports of disrespectful and inappropriate behaviours were conveyed to Core Review Group members, which, despite potentially stemming from stress, were deemed unacceptable. There was no tangible evidence that these behaviours were being addressed either peer to peer or through line management routes.
- 7.25. Core Review Group members engaged with nurses from all three emergency departments both in person and via MS Teams sessions. During these interactions, nurses described specific scenarios that underscored their profound anxiety regarding their ability to deliver safe care due to workforce gaps and the perceived inability to secure supplementary staff in a timely manner because of a convoluted approval process. Furthermore, Core Review Group members received reports of a perceived lack of senior professional support, which contributed to nurses feeling that neither they nor their work were valued or recognised as essential.
- 7.26. Healthcare Improvement Scotland escalated concerns regarding these matters to the Chief Executive of NHS Greater Glasgow and Clyde in December 2024.

- 7.27. Based on the evidence over the course of the review, the Core Review Group observed that NHS Greater Glasgow and Clyde appears to have allowed an abrasive culture to develop, with evidence of poor and disrespectful behaviours, which makes it very difficult for staff at all levels of the organisation to feel safe to challenge and appropriately address this culture. This was observed on all three sites and was not exclusive to the Queen Elizabeth University Hospital.
- 7.28. The experience reported by a range of staff during this review is not in line with the shared values that are expected of all involved in the NHS in Scotland, which are:
- care and compassion
 - dignity and respect
 - openness, honesty and responsibility
 - quality and teamwork.

Well Led

Leadership and operational governance arrangements

- 7.29. The NHS Greater Glasgow and Clyde board, led by the NHS Board Chair, has established lines of governance and accountability. The NHS Greater Glasgow and Clyde corporate management team is the senior executive team, led by the Chief Executive, which reports to the NHS Board.
- 7.30. At the level below the corporate management team, an acute services division is led by the Chief Operating Officer and supported by a Deputy Nurse Director and Deputy Medical Director.
- 7.31. There are six sectors in NHS Greater Glasgow and Clyde which oversee the operational delivery of acute services. The sectors with adult emergency departments are Clyde, North and South

Sector	Services
<i>Clyde</i>	Royal Alexandra Hospital, Inverclyde Royal Hospital, Vale of Leven Hospital
<i>North</i>	Glasgow Royal Infirmary
<i>South</i>	Queen Elizabeth University Hospital

Table 10: Distribution of main acute hospitals by sector in NHS Greater Glasgow and Clyde

- 7.32. NHS Greater Glasgow and Clyde follows a triumvirate leadership model – nursing, medical and general management – which is replicated in some other NHS boards in Scotland and elsewhere in the NHS in the UK. Each sector has a sector director, chief nurse and chief of medicine.

- 7.33. At an operational level, each of the three sectors has at least a general manager, lead nurses and a clinical director for emergency medicine and at a hospital level, most departments have a general manager, clinical director and lead nurse which is consistent with the triumvirate model.

Engagement and visibility of leadership

There is insufficient engagement and responsiveness by the senior leadership of NHS Greater Glasgow and Clyde – by the board and the corporate management team – in compassionately supporting staff to meet the challenges facing the emergency departments across all three sites.

- 7.34. The board and the corporate management team of NHS Greater Glasgow have a significant and challenging role in leading and supporting the service to meet the demand whilst ensuring safe, effective and person-centred care. The corporate management team of NHS Greater Glasgow and Clyde shared the significant challenges that had arisen since the Covid 19 pandemic, including the complexity and acuity of patients presenting to the emergency departments.
- 7.35. The review recognises the requirements of NHS Greater Glasgow and Clyde – alongside all NHS boards – to meet their statutory duties and to deliver high performance. However, such duties need to be balanced with other statutory duties regarding the quality of care and involving staff and patients in decisions that affect them. NHS Greater Glasgow and Clyde need to ensure that they meet their obligations in a balanced way and to be transparent, honest, visible and engaging with staff and patients in meeting these obligations.
- 7.36. Notwithstanding the demanding agenda facing the senior leadership, there was a consistent message heard by the review that the senior level leadership – above the management tier at sector level – was perceived as distant and remote. This was reflected in the perception of a ‘command and control’ culture and poor communication between the corporate leadership and point of care services.
- 7.37. NHS Greater Glasgow and Clyde shared examples of their visits to different parts of the system by board members and directors. Despite this, concern was expressed to the Core Review Group about the understanding of the most senior leadership in NHS Greater Glasgow and Clyde about the most serious and pressing issues facing the emergency departments. As such, compassionate leadership was not consistently evident in recognising the pressures facing the service.

- 7.38. Concerns were raised during the review about the reactive nature of senior management, which hindered a strong strategic focus. As a result, operational and tactical matters seemed to dominate. This was perceived as reinforcing a 'command and control culture,' stifling local decision-making and autonomy within the three sectors. The corporate management team's pressure on sector leadership, driven by the focus on finance and service performance such as the four-hour target and elective surgery management, created tensions. There did not appear to be a climate where issues would be well-received when escalated, and there was not a perception of a respectful and supportive dialogue.
- 7.39. The review particularly acknowledges the important role of the NHS Board in providing effective and compassionate leadership and in fostering a culture where concerns are heard and acted upon. This is reflected in the National Whistleblowing Standards⁹⁴ which state that "Board members have a critical role in setting a tone and culture in their organisation that values the contributions of all staff, including the need for changes through speaking up. This leadership role should not be underestimated and is a critical function of the board when it comes to concerns raised about safe and effective service delivery".
- 7.40. The review does not deny the considerable strategic and operational challenges for NHS Greater Glasgow and Clyde given its size and complexity. However, there is a need to urgently address the cultural, behavioural and leadership issues which are impeding a more positive and healthier working relationship between the Board/corporate management team and point of care urgent and unscheduled care services.

Recommendation 18: NHS Greater Glasgow and Clyde's board must ensure that compassion and respect are at the centre of the leadership culture demonstrated through behaviours that enable the values of NHS Scotland to be consistently upheld.

Recommendation 19: NHS Greater Glasgow and Clyde should take urgent action to collectively heal the relationships across and within staff groups and sector and corporate management levels. This is a critical step to establish shared responsibility for the delivery of safe urgent and unscheduled care with visible leadership from the corporate management team and strong clinical leadership at a local level. The aim should be to devolve authority and responsibility as much as possible to team leaders at the service level, supported by greater availability, visibility and responsive support from senior and sector leaders. The solutions and outcome should be jointly owned by all involved.

⁹⁴ [The National Whistleblowing Standards](#). Independent National Whistleblowing Officer. 2021.

Whole System Leadership for Urgent and Unscheduled Care

There is a siloed approach to the delivery of urgent and unscheduled care which impedes the development of integrated solutions and shared ownership of issues.

- 7.41. The review noted that there is a heavy emphasis on urgent and unscheduled care performance by NHS Greater Glasgow and Clyde. The board approved its whole system winter plan at its board meeting in October 2024 and received an update at its meeting in December 2024. The plan describes different components of the system and how they will inter-relate in managing demand for urgent and unscheduled care and in protecting planned care. The review noted, with concern, that there was very little reference to the three emergency departments in the winter plan and their contribution to addressing pressures or maintaining their resilience.⁹⁵ While there was a strong focus on unscheduled care, the focus was on performance, especially Flow 1 patients.
- 7.42. There was an absence of genuine whole system leadership and working in urgent and unscheduled care. Each sector operates largely independently of the other two sectors, and aspects of the response under pressure reflect local policies and approaches such as escalation. The siloed nature of each sector undermined the ability to foster a genuinely cohesive and collegiate approach to the systemic challenges facing NHS Greater Glasgow and Clyde, and at operational level resulted in the diversion of patients to other hospitals when under pressure and a lack of ownership of individual patients by receiving specialties. A member of staff remarked in the survey that: *“There is a complete lack of strategic leadership as experienced in the emergency department. There is no sign of a plan to make our experience better other than simply muddling through on a daily basis.”*
- 7.43. The review acknowledges the strategic role of the Urgent and Unscheduled Care Oversight board, but it is unclear what impact this board has yet delivered in monitoring service improvements and better outcomes for patients. There is a need to build a stronger culture of integrated working which would benefit and support the achievement of the NHS board’s urgent and unscheduled care aims.

Multi-disciplinary relationships in Queen Elizabeth University Hospital emergency department

There is evidence of poor working relationships between and within staff in management roles, emergency department consultants and the nursing team in the emergency department at the Queen Elizabeth University Hospital. NHS Greater Glasgow and Clyde has not adequately led interventions which address the deterioration in relationships over the past several years.

⁹⁵ NHS Greater Glasgow and Clyde, Whole System Winter Plan, October 2024

- 7.44. From the outset of the review, Core Review Group members observed extremely difficult relationships between the emergency medicine consultants at the Queen Elizabeth University Hospital emergency department and senior management at various levels (sector, acute services division, and corporate management team) within NHS Greater Glasgow and Clyde. There was a climate of distrust and dysfunctional working, negatively impacting relationships across the entire multi-disciplinary team. The consultants felt that senior management lacked visibility, openness, and honesty, which eroded their faith and trust in the leadership. Conversely, senior management expressed concerns about the behaviour of a small group of emergency medicine consultants.
- 7.45. The staff survey highlights a very challenging working environment in the Queen Elizabeth University Hospital emergency department.
- 7.46. The deterioration in relationships has led to what has been described as a 'stand-off' between sector and corporate management and the consultants. Over time, consultants have felt that their concerns were not being heard or addressed, although actions were taken by senior leaders these were not felt to address the issues. Many of these concerns persist, resulting in significant frustration, tension, and, in some cases, visible anger among the consultants. There is a prevailing sentiment that the emergency department consultants feel 'disempowered' and unable to 'influence anything in the emergency department.'
- 7.47. Some medical staff have also said that they would be slow to raise complaints at the time of events as they feared they might be branded a troublemaker as "there would be repercussions". The implication was that it would prevent any further advancement in management. This comment was not unique to the Queen Elizabeth University Hospital.
- 7.48. Although the Core Review Group received some opinions suggesting that the concerns were primarily raised by a small number of emergency medicine consultants, the evidence from written submissions, iMatter, the staff survey, and meetings indicates that the discontent and concern were widespread among the consultants in emergency medicine. While some consultants may be more vocal and assertive in expressing their views, the review found no reason to doubt that these views were held by many other consultants regarding the functioning of the Queen Elizabeth University Hospital emergency department.
- 7.49. The review noted the heavy reliance on communication by email. For practical reasons this is understood, especially when face to face contact may be limited and individuals may not be on shift together for long periods of time. The Core Review Group acknowledges the substantial challenges associated with communication across a large site and with many individuals. However, there was a risk that seemingly harmless emails and 'reply all' responses could escalate to difficult, confrontational and, at times, unprofessional exchanges. The default

to email, especially in relation to the highly charged matters associated with the emergency department, has accentuated difficulties and diminished the fostering of a climate of openness, civility, trust or respect.

- 7.50. The review also heard concerns about some tensions within the consultant cohort. A small number of the emergency medicine consultants felt bullied and undermined and felt that their voice was not heard amongst other consultant colleagues.
- 7.51. NHS Greater Glasgow and Clyde senior management made reference to the various attempts to engage with the emergency medicine consultants. These included drop-in sessions, 1:1 meetings and updates via newsletters. NHS Greater Glasgow and Clyde sector management held a series of sessions with staff in early 2024 to explore the issues in the Queen Elizabeth University Hospital emergency department.⁹⁶ These sessions did not engage effectively with the consultants and the output was then subject to criticism of both the approach and its conclusions. The review noted the reference in the south sector Partnership Forum minutes of May 2024⁹⁷ that organisational development in the board had developed plans for a series of sessions to address tensions in the department, with a “focus on helpful behaviours, language and attitudes in the department”.
- 7.52. Despite this being a growing problem since 2021, the measures pursued by NHS Greater Glasgow and Clyde have thus far not been successful in securing a sustainable and positive approach to engaging with the consultants.
- 7.53. While the primary focus has been on the relationships between the emergency medicine consultants and management, the review believes there are broader concerns. It has identified fractured working relationships between and within the medical, nursing, and managerial teams responsible for the emergency department at the Queen Elizabeth University Hospital. This is not an issue confined to a single discipline or individual and in addition to posing risks to patient safety and quality of care, could have professional conduct consequences if not addressed promptly.
- 7.54. The Core Review Group observed that many nursing staff seemed nervous during engagement drop-ins and needed reassurance about confidentiality. Some nurses identified that they were actively looking for other jobs. Nursing staff felt that there was a lack of supportive leadership, negative behaviours from leadership had been experienced by nursing staff. These behaviours included inapproachability, undermining behaviours, favouritism and unfair treatment. Unfairness and favouritism were seen to manifest through promotion of those perceived to be ‘yes’ people, whilst others thought their ‘face didn’t fit’ and

⁹⁶ Output from engagement sessions – Queen Elizabeth University Hospital emergency department. Dated 05 March 2024.

⁹⁷ South Sector Partnership Forum Meeting Minutes. NHS Greater Glasgow and Clyde. Dated 14 May 2024.

were 'picked on' or 'ignored' leading to isolation of staff. These experiences have led to mistrust of management and for some high anxiety due to the culture within the department. There was concern about the repercussions of raising these issues.



Nursing staff do not feel heard from nursing management – the management do not feel approachable majority of the time and comes across more 'depends in what mood they will be in' on how they will react to staff coming to them with problems. [...]



- 7.55. A consistent challenge highlighted in this review across all three emergency department sites is the ability of sector leadership and managerial roles below the sector level to effect change and improve the experience for staff and patients. The managerial response was typically described as 'reactive' or adopting a crisis-management approach. Additionally, the review team observed a lack of collaboration between and within sectors and an inability to escalate matters upwards.



Management who make themselves available to the department appear powerless to do anything about the fact the hospital is more or less permanently at full capacity. Constant crisis management inhibits innovation and creates an error-generating environment. The system has failed due to permanent high hospital occupancy with no efforts to create more beds or facilitate more discharges. The solutions that management propose are always focussed on what we can do in the emergency department (redirection etc) without addressing the failures of the consultant-led-ward-round culture in medicine.



- 7.56. In summary, the review heard evidence of a significant and sustained deterioration in working relationships since 2021 at Queen Elizabeth University Hospital between the emergency medicine consultants and management. The decline in relationships went beyond this, to include relationships within and between different staff groups in the emergency department. There were also instances of confrontational and undermining behaviours by different staff groups. These behaviours were inconsistent with the principles and values of the NHS in Scotland and undermined inter-personal relationships, organisational cohesion and team working.

- 7.57. Whilst there have been numerous attempts to understand and address the collapse in trust and working relationships, the passage of time and subsequent unfolding of events reflects the need for urgent prioritisation or robust interventions codesigned and delivered at a departmental, sector and board level.

Recommendation 20: NHS Greater Glasgow and Clyde should commission urgent and credible external mediation within and between Queen Elizabeth University Hospital emergency department professional teams (medical and nursing) and separately for mediation between the professional teams and senior management (sector and corporate) in NHS Greater Glasgow and Clyde to support improved professionalism and team working amongst consultants, nursing staff and management.

Multi-disciplinary relationships in Glasgow Royal Infirmary emergency department

There was feedback that there were insufficient levels of management support to staff at Glasgow Royal Infirmary and a perception by staff that there was an undue focus on finance and performance over patient care.

- 7.58. There were a range of comments about the level of sector management support in the Glasgow Royal Infirmary. There was concern expressed about the level of support afforded to staff, especially when under pressure and the associated focus on performance targets.



It's a constant battle to keep patients and staff safe, it is clear there is no support from management about patient safety and they often care more about 'breach reports' than the patients we have in the emergency department.

Lack of senior management support/ understanding of the pressures you are under whilst working at the front door, frustration that senior management see patients as numbers on a screen and not human beings.



- 7.59. The review noted the need for stronger support to local management on the Glasgow Royal Infirmary site. Decision-making was perceived as centralised and, as a result, undermined the autonomy of local management teams. The lack of a supportive culture could also be manifested in a lack of trust and respect from more senior management directed towards sector level management and below especially with regard to budgetary matters.
- 7.60. The Core Review Group heard a consistent message about the need to strengthen the visibility and support of senior nursing leadership, especially with regard to ensuring appropriate staffing levels, and the safety and quality of care.

Recommendation 21: NHS Greater Glasgow and Clyde should ensure sector management at the Glasgow Royal Infirmary are engaged and responsive to the needs of staff at the point of care to ensure that patient care and safety receive the necessary management attention and intelligent action.

Multi-disciplinary relationships in the Royal Alexandra Hospital emergency department

The review noted concerns expressed about the visibility of management and the emphasis on finance and performance over patient care at the Royal Alexandra Hospital emergency department, while also acknowledging positive feedback regarding aspects of team collaboration at all levels.

- 7.61. The staff survey for the Royal Alexandra Hospital raised similar issues to the Glasgow Royal Infirmary about the focus of management on aspects of performance and budgetary matters at the Royal Alexandra Hospital. There was some concern expressed about the presence of sector level senior management and the understanding of the serious challenges facing unscheduled care.
- 7.62. There was a strong sense of a supportive culture within the hospital which reflected its scale and operational/clinical relationships, as described in the team working section.

Recommendation 22: NHS Greater Glasgow and Clyde should ensure sector management focus at the Royal Alexandra Hospital appropriately balances emergency department performance and flow in line with maintaining and managing the quality and safety of care.

The Clinical Director role and multi-disciplinary clinical leadership

The review noted the exposed nature of the clinical leadership roles, specifically but not exclusively the Clinical Director position. There was a lack of support in undertaking the duties and insufficient time to build and sustain relationships with the departments or beyond with other specialties.

- 7.63. Clinical leadership roles are critical in ensuring professional, credible, and effective leadership within specialties including the emergency departments. Individuals in these roles play a significant part in maintaining a strong clinical voice, developing team working, and aligning efforts. The roles are essential for advocating for the needs of both patients and staff, ensuring high standards of care, and driving continuous improvement. However, these roles can be isolating without the right support, making it crucial to provide adequate resources, mentorship, and opportunities for collaboration to sustain their effectiveness and well-being.

- 7.64. The review noted the resignations of previous Clinical Directors for emergency medicine at the Queen Elizabeth University Hospital and more recently the resignation of the Deputy Clinical Director on the same site. At the Queen Elizabeth University Hospital, a new interim Clinical Director for emergency medicine has been appointed for the emergency medicine specialty.
- 7.65. Job plans are part of medical contracts of employment. They are an annual agreement that sets out duties, responsibilities, objectives and agreed supporting resources. Job plans include the detail of programmed activities (often referred to as PAs). These are blocks of time, usually equivalent to four hours in standard time and three hours in premium time, in which contractual duties are performed. There are four basic categories of contractual work: direct clinical care; supporting professional activities; additional responsibilities and external duties⁹⁸.
- 7.66. The Clinical Director for emergency medicine in the Queen Elizabeth University Hospital has two programmed activities allocated to deliver this additional responsibility, matched by two programmed activities for the Clinical Director for medical specialties. Collectively, this presents significant time constraints and a lack of flexibility to have the presence and service development time these crucial leadership roles require. There is a lack of senior clinical leadership support to these roles within the Queen Elizabeth University Hospital and across medicine in NHS Greater Glasgow and Clyde. Significant opportunities exist to strengthen this, and ensure the clinical body feels heard and supported, and the leaders and leadership roles are developed further.
- 7.67. At the Glasgow Royal Infirmary there was a general view expressed that communication, and governance was good at a departmental triumvirate level between General Manager, Lead Nurse and Clinical Director but there was criticism of the level of communications at the level beyond the sectoral leadership.
- 7.68. At the Royal Alexandra Hospital, there was positive feedback about the triumvirate relationships, the strength of clinical leadership in emergency medicine and that of the sector level leadership.
- 7.69. This review recognises the need for Clinical Directors to have sufficient time to perform their duties effectively and to be provided with the necessary tools and support. The significance of the Clinical Director role, especially given the magnitude of the issues highlighted in this review, requires a more fundamental consideration of how leadership is resourced and supported within NHS Greater Glasgow and Clyde.

⁹⁸ [An overview of job planning](#). British Medical Association . Updated 18 September 2023

- 7.70. Given the complexity and demands of these roles, it is crucial to ensure that clinical directors are adequately developed and supported to handle their responsibilities. This includes providing comprehensive training, mentorship, and ongoing professional development opportunities. Additionally, there should be a structured pathway for identifying and nurturing future clinical leaders within NHS Scotland. Strengthening this pathway will help ensure that individuals are well-prepared for leadership roles. This should be further explored with NHS Education for Scotland.

Recommendation 23: NHS Greater Glasgow and Clyde should ensure job plans appropriately reflect the time and support required to undertake the clinical director, deputy clinical director and clinical lead roles across all three sites.

Robust governance arrangements

Clinical governance arrangements

The review noted that the clinical and care governance arrangements in place included a strong level of senior medical representation, with more limited representation of senior nursing staff. However, there was no clear evidence of escalation of concerns raised by the Queen Elizabeth University Hospital consultants through the clinical and care governance framework of NHS Greater Glasgow and Clyde.

- 7.71. Clinical governance is defined as “A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”⁹⁹
- 7.72. Clinical governance was introduced into the NHS in Scotland in 1998¹⁰⁰ with a duty on NHS boards to:
- “...create a culture where the delivery of the highest standard possible of clinical care is understood to be the responsibility of everyone working in the organisation, and is built upon partnership and collaboration within health care teams and between health care professionals and managers;
- “introduce structures and processes which assure them that this is happening whilst at the same time empowering clinical staff to contribute to the improvement of standards and involving patients and the public in this process”.

⁹⁹ Scally, G, Donaldson, L. Looking forward: clinical governance and the drive for quality improvement in the new NHS in England. *BMJ*1998;317: 61. 1998

¹⁰⁰ MEL (1998) 75 Clinical Governance, Scottish Executive. 1998.

- 7.73. It was also enshrined subsequently in legislation with a duty of quality on NHS boards to have “in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals”.¹⁰¹ Clinical governance is an integral part of the governance arrangements in NHS Scotland.
- 7.74. The clinical governance arrangements are within the NHS Greater Glasgow and Clyde clinical and care governance policy. The NHS Greater Glasgow and Clyde clinical and care governance committee, chaired by a non-executive director, is at the pinnacle of the board clinical governance arrangements. Figure 7.1 below shows the relationships between the committee and the other elements of clinical and care governance.

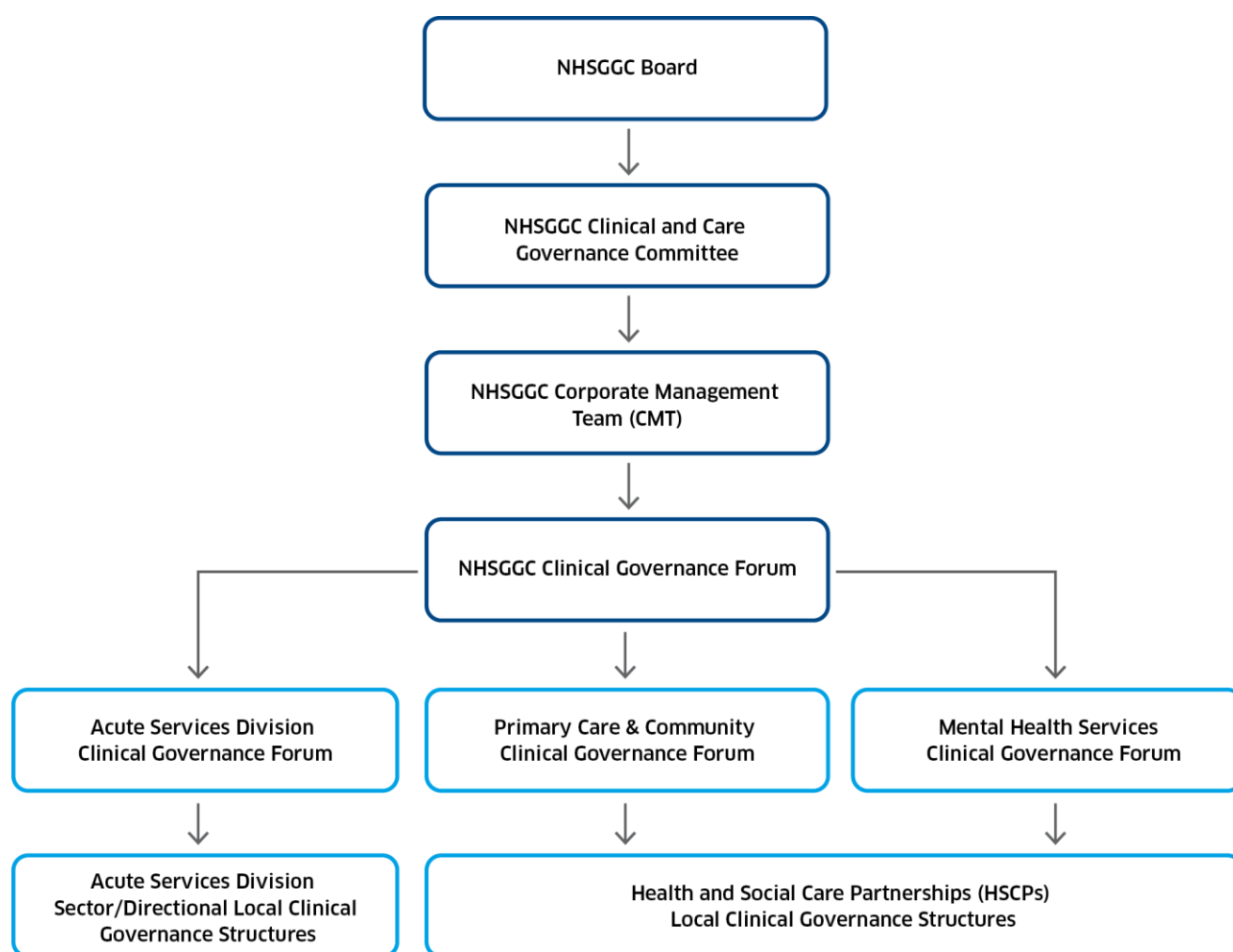


Figure 7.1: NHS Greater Glasgow and Clyde clinical governance structure ¹⁰²

¹⁰¹ National Health Service (Scotland) Act 1978, section 12 H

¹⁰² Overview of Board clinical governance arrangements. NHS Greater Glasgow and Clyde.

- 7.75. The review heard that clinical governance sits within the general management structure; with the Chief Nurses and Chiefs of Medicine for each of the sectors having professional responsibility for clinical and care governance within their role and representing their sector at the acute services division clinical governance forum. The NHS Greater Glasgow and Clyde clinical governance forum is chaired by the board Medical Director.
- 7.76. The board clinical and care governance committee is attended by the Medical Director and the Nurse Director as well as the Deputy Medical Directors. Beyond the Nurse Director, there is no further nursing leadership at the committee.
- 7.77. The review received minutes and papers from the acute services division clinical governance forum. The papers describe initiatives to drive improvements, to monitor compliance with policies and procedures as well as matters related to staff and patient risks (including DATIX). The papers are also open about clinical and operational challenges.
- 7.78. The review did not receive a sufficiently clear explanation as to how matters in each sector were formally and systematically escalated to the acute services division clinical governance forum and ultimately, where necessary, to the board's clinical governance forum or beyond.
- 7.79. In accepting the definition of clinical governance, especially with regard to 'safeguarding high standards of care', the review team could find no documentary evidence that the concerns raised by the emergency department consultants had been formally escalated to the clinical and care governance committee and ultimately the NHS Greater Glasgow and Clyde Board ahead of the media coverage in March 2024.
- 7.80. The review noted the strong presence of medical leadership in clinical governance arrangements. However, it also identified an opportunity to enhance these arrangements by ensuring a multi-disciplinary contribution in the future. By involving a broader range of healthcare professionals, including nursing, the governance framework can benefit from diverse perspectives and expertise. This collaborative approach will support more comprehensive and effective decision-making. Encouraging multi-disciplinary involvement in clinical governance will help foster a culture of inclusivity, shared responsibility, and continuous learning and improvement within the healthcare system.

Recommendation 24: NHS Greater Glasgow and Clyde should review the appropriate use of the clinical and care governance framework for systematically and consistently escalating serious concerns.

Recommendation 25: NHS Greater Glasgow and Clyde should strengthen multi-disciplinary input to the clinical governance arrangements as these currently appear to be too reliant on the singular voice and participation of the medical profession.

The clinical voice, whistleblowing and raising concerns

The emergency medicine consultants at Queen Elizabeth University Hospital lacked confidence in the existing whistleblowing mechanisms. Similarly, concerns were not escalated through the professional advisory or staff partnership structures. It is essential to ensure that the clinical voice is consistently heard, especially on safety-related matters, and that individuals feel confident their concerns will be addressed, and they will be protected.

- 7.81. There is a national policy in NHS Scotland underpinned by legislation to support and protect individuals in raising concerns about patient safety.¹⁰³ Each NHS board has a whistleblowing champion who has responsibility to seek assurance that the systems and processes are in working effectively and crucially that staff are actively encouraged and supported to raise any concerns about patient safety.¹⁰⁴ The Independent National Whistleblowing Officer¹⁰⁵ (INWO) in Scotland can review any concern that has been raised through the National Whistleblowing Standards.
- 7.82. The Public Interest Disclosure Act 1998¹⁰⁶ (PIDA) provides legal protection for all 'workers' that make a 'protected disclosure' under the legislation. Any worker that has done so has the right not to be subjected to any detriment by their employer on the ground that they have made a protected disclosure.
- 7.83. Guidance for employers on whistleblowing notes: *"If an organisation hasn't created an open and supportive culture, the worker may not feel comfortable making a disclosure, for fear of the consequences. The two main barriers whistleblowers face are a fear of reprisal as a result of making a disclosure and that no action will be taken if they do make the decisions to 'blow the whistle'".*¹⁰⁷
- 7.84. In the original concerns, the Queen Elizabeth University Hospital emergency department consultants described a situation which they believed was leading to preventable harm and compromising patient safety. The consultants considered that the principal issues creating the situation arose from crowding associated with 'exit block' and insufficient staffing.
- 7.85. The emergency medicine consultants did not have confidence in current processes within NHS Greater Glasgow and Clyde to escalate their concerns via the established whistleblowing policy and therefore approached Healthcare Improvement Scotland.

¹⁰³ [The National Whistleblowing Standards](#). 2021. Independent National Whistleblowing Officer. 2021.

¹⁰⁴ [Non-Executive Whistleblowing Champion](#). NHS Scotland, Scottish Government.

¹⁰⁵ Independent National Whistleblowing Officer – <https://inwo.spsso.org.uk>

¹⁰⁶ Public Interest Disclosure Act 1998 – <https://www.legislation.gov.uk/ukpga/1998/23/contents>

¹⁰⁷ Whistleblowing [Guidance for Employers and Code of Practice](#). Department for Business, Innovation and Skills. 2015. Pg 4

- 7.86. It is of concern that the consultants did not have sufficient confidence in the established local systems to raise concerns through the whistleblowing procedure and this was a manifestation of the poor working relationships between the consultants and the senior leadership in NHS Greater Glasgow and Clyde. It was also a consequence of the extent to which individuals felt that the system afforded them the level of protection required to raise concerns.



Consultants often feel like they are shouting into a void when the floor is very dangerous. I have heard them clearly express this to management multiple times and nothing changes.



- 7.87. As regards advisory structures, each NHS board has an area clinical forum which is constituted of the clinical professional advisory committees, and they have been in existence since 2001. The most recent guidance issued by Scottish Government was published in 2010 (CEL 16 2010). The area clinical fora have a role in ensuring that a clinical perspective is brought to bear on the priorities and decision-making of NHS boards.
- 7.88. The Blueprint for Good Governance in NHS Scotland highlights the importance of the area partnership forum and the area clinical forum¹⁰⁸ especially regarding “identifying opportunities for the improvement of services and the wellbeing of the workforce”.
- 7.89. Whilst the emergency medicine consultants at the Queen Elizabeth University Hospital did not escalate their concerns through this route, it was also noted that the area clinical forum and the area medical committee, whilst aware of the issues, did not seek to escalate or raise these concerns with the NHS Greater Glasgow and Clyde Board. Nor were these concerns escalated through the area partnership forum.
- 7.90. There is a broader observation to be made regarding the purpose of the advisory structures within NHS boards. It is crucial to ensure a clear understanding of their role and contribution, especially as nearly 25 years have passed since their establishment in NHS Scotland. These advisory structures were designed to provide expert guidance, support decision-making, and enhance the overall governance of healthcare services. However, their effectiveness and relevance may need to be reassessed to ensure they continue to meet the situation and take cognisance of other changes in the governance landscape in the past two decades. This includes evaluating their impact on patient care and staff

¹⁰⁸ [The Blueprint for Good Governance in NHS Scotland](#), para 4.95. Second Edition. Scottish Government; 2022.

engagement, as well as ensuring that their purpose is well-communicated and understood by all stakeholders.

Recommendation 26: NHS Greater Glasgow and Clyde should ensure that all staff feel able to speak up and their voices are consistently heard at all levels of management – especially in matters related to safety – and that there is confidence that individuals will be protected, and their concerns acted upon. Specifically, there is a need to ensure that the current NHS Greater Glasgow and Clyde whistleblowing procedures are known, understood, effective and trusted. This is particularly relevant for staff at the Queen Elizabeth University Hospital. It is vital that staff have confidence in the board’s commitment to the National Whistleblowing Standards and the Public Interest Disclosure Act 1998.

Performance and operational management

There was a strong emphasis on finance and delivery of key urgent, unscheduled and elective care performance targets in NHS Greater Glasgow and Clyde. The review frequently heard concerns that performance and financial management were prioritised over the safety and quality of care. Additionally, there was insufficient infrastructure to support multi-disciplinary collaboration and a lack of documented evidence of collaborative decision-making.

- 7.91. NHS Greater Glasgow and Clyde oversees performance and reports to its board and the governance committees via the performance assurance information framework¹⁰⁹. Like all NHS boards, NHS Greater Glasgow and Clyde has a national target to meet with regard to four-hour waiting time performance. Waiting times are recognised by the Royal College of Emergency Medicine as an important indicator of safety: “Long waits in emergency departments are consistently associated with avoidable patient harms (including mortality), poor patient and staff experience”.¹¹⁰
- 7.92. The review received sample copies of the weekly unscheduled care capacity and pressures reports which are submitted to Scottish Government.¹¹¹ These are produced by management for each of the sites and cover performance against the four-hour standard and progress against improvement initiatives.

¹⁰⁹ Performance Report to Corporate Management Team. NHS Greater Glasgow and Clyde. Dated 05 September 2024.

¹¹⁰ [Position Statement - Improving Quality Indicators and System Metrics for Emergency Departments in England](#). Royal College of Emergency Medicine. 2019.

¹¹¹ Weekly unscheduled care capacity & pressures report. NHS Greater Glasgow and Clyde. Dated 03 April 2024.

- 7.93. NHS Greater Glasgow and Clyde oversees performance through regular performance reports to its board¹¹². In respect of the emergency departments, it has operational oversight of performance management through its acute services division and down through to sectors via the performance review groups for each sector.
- 7.94. The review was provided with action plans for each of the three sectors arising from the performance review groups. Almost the entire focus was on the financial performance, delivery of targets and sickness absence. Unless these meetings had only recently been instituted, the reports of the performance review groups supplied by NHS Greater Glasgow and Clyde did not have supporting actions, or status reports or targets for the delivery of the objectives.
- 7.95. The actions contained in the output from the performance review groups reinforced the impression of a strong focus on budgets and performance: “Ensure continued work in order to improve the unscheduled care performance include flow 1/usage of minors.”¹¹³
- 7.96. NHS Greater Glasgow and Clyde provided evidence of their governance arrangements for the individual sectors and for the NHS board as a whole. These governance arrangements included the Urgent and Unscheduled Care oversight board and individual Unscheduled Care boards for the three sectors.
- 7.97. The Urgent and Unscheduled Care oversight board is jointly chaired by the Chief Operating Officer for acute services and the Chief Officer for the Glasgow City Health and Social Care Partnership. It has a membership of 24 individuals holding clinical and non-clinical managerial positions in NHS Greater Glasgow and Clyde. The minutes conveyed the impression of exchanging information and noting updates rather than actions related to tackling significant issues facing the service.
- 7.98. The review considered the minutes of sector level Unscheduled Care meetings that took place in 2023 and 2024. Based on the minutes and action notes from the three sectors there was:
- very poor attendance and almost exclusively those in managerial roles who were present
 - episodic meetings (e.g. even accounting for winter pressures the north sector unscheduled care implementation group meeting had a gap of five months between the November 2023 and April 2024 meetings)
 - incomplete terms of reference
 - poor record keeping of discussions and points of agreement, and
 - a lack of clinical engagement.

¹¹² Board Performance Report to NHS Greater Glasgow and Clyde Board Meeting. Dated 27 August 2024.

¹¹³ South Sector PRG Action Plan. NHS Greater Glasgow and Clyde.

- 7.99. It was unclear how this aspect of the management infrastructure secured meaningful engagement and support to deliver on the intended outcomes.
- 7.100. The apparent lack of recording of meetings such as through minutes at an operational level was a theme from the feedback. There was an absence of formal documentation such as minutes and where they were generated, there did not appear to be circulation to ensure individuals were informed of actions and their and others' responsibilities.
- 7.101. There was considerable attention given to financial management in the feedback by staff, and the implications for the delivery of care and for some clinical staff it was a source of frustration. The review noted that there appeared to have been a shift in focus of management from operational performance to finance and there was a limited trade-off between budgetary discussions and patient safety.



Senior staff are not being listened to by senior hospital management, and it always comes down to finances and not patient/staff safety. It's unsafe, overwhelming, under supported and just not acceptable.



We keep raising concerns about staffing levels, patient safety, lack of support but hospital management cares more about money than patient safety. Safe staffing levels are completely ignored, especially for a highly acute, critical area with a lot of clinically unstable patients. Refusing to cover short term sickness.



- 7.102. The review noted the steps that had been taken in the past four years with initiatives such as the establishment of the flow navigation centre in 2020 and GlasFLOW/continuous flow in December 2022. The absence of a structured approach across the sectors to quality improvement within each of the emergency departments was noted. There were some important quality improvement initiatives such as in respect of frailty, which had demonstrated impact on co-ordination of care. Attempts to address pathway development with specialty inpatient teams had not achieved the same level of success.
- 7.103. The review noted that there appeared to be greater traction with regard to externally generated and supported improvements such as the frailty team improvement work, but less sustained improvement generated from internally driven approaches. It was commented that there is a "tendency to expect someone else to bring the solution, and services don't own the need to find the solutions."

- 7.104. Across all three sectors, there seemed to be a lack of mechanisms for developing solutions through multi-disciplinary collaboration. Where structures did exist, they appeared to focus on relaying information and reporting the situation rather than facilitating roundtable discussions to identify and implement solutions. There was also a lack of sustained follow-through on actions, causing initiatives to start but then drift away.

Recommendation 27: NHS Greater Glasgow and Clyde needs to enhance its governance of the operational management of urgent and unscheduled care. This includes ensuring robust documentation, transparency in decision-making, and greater involvement of clinicians in the design and delivery of care.

Recommendation 28: NHS Greater Glasgow and Clyde needs to adopt a balanced approach to sector leadership, ensuring that the quality and safety of care is not inappropriately overshadowed by other performance targets or financial considerations.

Recommendation 29: NHS Greater Glasgow and Clyde needs to ensure there is an active engagement and participation across the clinical leadership and wider community in the delivery of the board's recently approved quality strategy.

Effective team working

Team working within the Queen Elizabeth University emergency department

There was evidence of poor team working in the Queen Elizabeth University Hospital emergency department amongst those in management roles, consultants and nursing staff.

- 7.105. At the Queen Elizabeth University Hospital, the relationships between the emergency medicine consultants, management and nursing staff had clearly deteriorated and this had created tensions and was impacting on the working environment. There was also reference to the team dynamic changing depending on which individual was on shift in the emergency department.
- 7.106. It is clear from the on-site visits and the staff survey that there has been a marked decline in team working and trust precipitated by a range of factors. As stated previously, these tensions do not arise between two different groups alone but are a complex set of fractured relationships within and between individuals and teams.

Team working within the Glasgow Royal Infirmary emergency department

- 7.107. Staff working relationships within the Glasgow Royal Infirmary were generally described as positive in the delivery of care. There was a strong sense of team working across a range of professional groups.



I do love my team, how well we all work together and have always felt supported despite pressures of capacity.

Good team working. Everyone's views and opinions regarding the patient are listened to and able to raise concerns to medical staff when needed. All staff are approachable.



- 7.108. Crucially staff felt that they could make an impact: “We care for some people in their most vulnerable times. In my time in the emergency department, I have felt I have made a difference.”

Team working within the Royal Alexandra Hospital emergency department

- 7.109. The review found the Royal Alexandra Hospital to be a generally positive working environment, with good working relationships between individuals, underpinned by mutual respect and appreciation. Information and feedback provided by staff suggested that relationships within the Royal Alexandra Hospital emergency department were perceived to be very good and very cohesive. There were also good links to the senior management team. These relationships were seen to stem from a smaller sized team which contributed to a good working culture and a good attitude. The Royal Alexandra Hospital emergency department is seen as a friendly place where people communicate well to solve problems.

Team working with the rest of the hospital

There is a lack of team working and ownership of the challenges facing the emergency departments across all three sites within the wider hospitals. As a result, emergency department staff feel undervalued and isolated, negatively impacting their morale and well-being. It is essential to establish a stronger whole-hospital ethos, supported by clear referral pathways and specialty support, so that all specialties have greater shared ownership of the issues and understand their contribution to the solutions.

- 7.110. Across all three sites there was a sense of physical isolation and a lack of collective ownership across the hospitals when the emergency department was under pressure.
- 7.111. There is a general lack of ownership by specialty inpatient teams for their patient pathways within each sector despite agreed pathways being in place. Often inpatient admissions areas are beyond capacity and patients are diverted to the emergency departments, by default, for the emergency department staff to review. This is particularly evident at the Royal Alexandra Hospital where all medical patients are triaged by the emergency department after 5pm and senior nurses and consultants often describe patients attending with GP letters but being refused for specialty team review.

- 7.112. Although orthopaedic patients at the Queen Elizabeth University Hospital have an assessment area for GP referrals and post operative patients re-attending this is not consistent across each sector.
- 7.113. There is reference to some post operative patients attending the emergency department instead of accessing their own team (e.g. patients with percutaneous endoscopic gastrostomy (PEG) tubes/nephrostomies not going directly to these teams for review) or early pregnancy issues not being seen directly in the early pregnancy assessment unit. Barriers were described as being put in place by in-patient teams to prevent admission and multiple additional requests for further investigations are placed prior to acceptance with teams requiring a confirmed diagnosis rather than a differential. Teams also reported they can only create new patient pathways by developing these within the emergency department and taking them to the specialty teams for review rather than those teams having responsibility for unscheduled patients.
- 7.114. A wider point was made to Core Review Group members about the extent to which emergency medicine had become by default a significant gatekeeper to the NHS and the resultant pressure on staff to meet expectations, whether it be in relation to exacerbation of chronic conditions or in complications from post-operative care.
- 7.115. In summary, the review has found the emergency departments feel under-valued and isolated. There is not the collective ownership of urgent and unscheduled care amongst specialties across the sectors. Combined with other pressures, such as rising complexity of patients and changes in the workforce, this means that a substantial level of pressure is being placed on the emergency departments.

Recommendation 30: NHS Greater Glasgow and Clyde should establish a stronger commitment to a unified approach across all sectors. This should be based on clearly defined care pathways and suitable admitting rights, supported by appropriate operational structures and a well-trained and nurtured workforce in all emergency departments throughout NHS Greater Glasgow and Clyde.

Supportive culture

- 7.116. The review considered two aspects of a supportive culture:
- the nature of support for individuals in their day-to-day experience within teams, and
 - the climate of support from the top of the organisation in responding to pressures and demands.

- 7.117. Within teams there was highly variable levels of support across the sectors. Across all the feedback received by the review, there was a consistent theme of an absence of practical support and understanding about the demands on staff by NHS Greater Glasgow and Clyde, other than the staff mental health wellbeing support booklet for staff submitted within the evidence provided to the review. There was widespread reference to the impact of the serious pressures on the mental health of individual members of staff and teams, and evidence of moral injury¹¹⁴. There were also some references to bullying behaviours and ‘burn out’ associated with stress.
- 7.118. Despite the generally positive working relationships at the Royal Alexandra Hospital referred to above, the working environment for staff was an area of repeated concern with out-dated facilities and the delays for patients to reach in-patient care.
- 7.119. In the staff survey it was commented that there was an unsupportive environment at the Queen Elizabeth University Hospital.



The department is losing a lot of staff who have been assets to the team. Whilst some may leave for promotions others are leaving due to the way they are being spoke to on a regular basis and this type of culture being almost promoted amongst management. This is not why people wanted to be nurses, people can cope with a stressful environment if they are amongst a strong team who will all support each other, and this comes from above. We need more positive safe leadership. [...]



- 7.120. Nursing staff described sign posting to access statutory and well-being services alongside management support being offered, however this was time limited and sometimes fell away after a short period leaving staff members feeling unsupported and anxious.
- 7.121. Critical incident debriefs both post incident (hot) and as part of longer-term reviews are a commonly used process to support teams to share their experiences, emotions and identify immediate or future actions and support. Nursing staff particularly highlighted the lack of opportunity to undertake these post incidents. All departments highlighted limited opportunity to undertake these with little to no feedback from DATIX reports completed. On one occasion following a serious incident which involved staff members being physically assaulted at the start of a night shift, no opportunity to debrief or have time

¹¹⁴ Moral injury: the deep emotional wounds that result in participating in or bearing witness to intense human suffering or cruelty. Gibbons, S.W., Shafer, M., Hickling, E.J. and Ramsey, G., 2013. How do deployed health care providers experience moral injury?. *Narrative inquiry in bioethics*, 3(3), pp.247-259.

away was provided with nursing and medical staff having to complete their shifts in a traumatised state.

- 7.122. Across all departments a sense of being overwhelmed was expressed. Staff described high turnover and sickness within teams particularly nursing due to levels of stress leading to an imbalance within the workforce with a greater number of junior and less experienced staff on each shift. At charge nurse and senior charge nurse level concerns were raised about their ability to nurture, support and develop their junior team members due to limited downtime or scheduled training and learning opportunities. This resulted in these nurses feeling concerned about the quality of care they were providing.
- 7.123. Staff described limited department team or profession specific meetings or forums being held however highlighted this would be a good mechanism for issues to be explored and concerns be understood.
- 7.124. There was concern about the level of support that individuals in management positions received from the most senior management in NHS Greater Glasgow and Clyde, with aspects of behaviour not conducive to a respectful and supportive working environment. There was also a concern expressed by a clinical leader that clinical matters were not prioritised.

8. Wider Implications for Consideration in NHS Scotland

This review was commissioned to examine concerns raised by emergency medicine consultants in the Queen Elizabeth University Hospital. To do this effectively, the review has considered information from a wide range of sources both within NHS Greater Glasgow and Clyde and nationally (Scotland and UK wide).

The Core Review Group is very aware that emergency departments do not operate in isolation, and that the challenges they experience reflect the pressures across the health and care system. It was not within our remit to address the continued challenges that health and care systems face when trying to enable safe patient discharges back into the community, and the impact this has on all concerned. This includes patients who remain in hospital when they no longer require this level of care and patients who are not timeously assessed and treated in emergency departments and then transferred into inpatient hospital beds. This also applies to patients in the community awaiting delayed ambulance attendance and transfer to hospital when required, or to receive elective treatment as planned.

The Core Review Group also acknowledges that significant improvement work within urgent and unscheduled care has been taking place in NHS boards, together with their local health and social care partners, and with national support, since before the Covid 19 pandemic. This improvement work was beginning to deliver some positive changes for the benefit of patients when the pandemic struck in 2020. The changes described below require a recalibration of the improvements and changes needed to enable patient and needs-centred services.

This chapter shares wider system learning which reflects the breadth of experience and expertise of the Core Review Group and External Reference Group, as well as analysis of the national data accessed during the review. These observations are based on the evidence examined and are a synthesis of collective deliberations and judgement.

The primary focus of this review is on three of the emergency departments in NHS Greater Glasgow and Clyde: the Queen Elizabeth University Hospital, Glasgow Royal Infirmary and the Royal Alexandra Hospital. However, we recognise that many of the recommended changes and improvements will not be possible for either NHS Greater Glasgow and Clyde or other territorial NHS boards without national direction and support from the Scottish Government. The changes and improvements needed will not happen without continued assistance from the national bodies named below that play a vital role in supporting the improvement of health and care services.

What has changed in recent years?

- Changing population demographics have resulted in population need becoming more complex, and the system has become more complicated for people to navigate. Patients have increased frailty, multimorbidity and may have multiple socioeconomic disadvantages.
- There is an increased burden of chronic disease management in primary care. The consequence of this impacts on the capacity of primary care to see urgent and unscheduled care presentations. This can lead to patients presenting directly to emergency departments or minor injury units rather than accessing general practice, NHS 24 111, NHS Inform, Pharmacy First or other alternative community-based services.
- Financial pressures are impacting on community-based services that have previously supported vulnerable groups, meaning people may have fewer safety nets to turn to.
- There have been changes in medical practice, for example:
 - same day/ambulatory turnaround of several conditions for example venous thromboembolism (VTE)
 - increased use and need for diagnostics, particularly radiological investigation.
- There are challenges to staffing affecting different professions and specialties across Scotland and these are having an impact across various services.
- A number of clinical services are signposting the public to other care options including support at home. This has an impact on community services to support these patients at home, especially where more complex interventions are required, such as Hospital at Home.

What has the impact been?

- Poorer outcomes are seen due to crowding in acute hospital sites. This has been highlighted in emergency departments but also affects acute receiving areas and downstream wards.
- Unwarranted variation in length of stay nationally for frail patients with multi-morbidity leading to high bed occupancy in some NHS boards that inhibits flow and leads to crowding at the front door in emergency departments.
- Unnecessarily long lengths of stay lead to physical and cognitive deconditioning that can increase the overall need for care in hospital and in communities on discharge.
- Lack of community-based services to support those with multiple disadvantages, impacting on healthcare services and leading to poorer outcomes.

- Lack of capacity for same day pathways has led to this work being performed within some emergency departments. This work usually requires longer than four hours to complete and therefore impacts on capacity within emergency departments to see and assess new patients. Emergency departments then evolve into acute assessment and diagnostic units.
- All parts of the system are experiencing higher demand which challenges the quality of care delivered, the experience of care, the experience of work and restricts the availability of clinicians to engage in service redesign.
- Tracking the effectiveness of the system is complex and data to help address this has not been developed consistently with the input of clinical teams at the point of care.
- The complexity of the system means that the quality and effectiveness of relationships between all service providers is more important and more challenging than ever.

What improvement is needed?

The collective expert opinion from the Core Review Group and External Reference Group has highlighted the following for improvement across the health and care system based on the available and growing evidence:

- Clinicians in leadership roles should have sufficient training in leadership skills and behaviours, management practice, workplace culture and change management. The quality of leadership is pivotal to successful complex whole system change.
- The importance of whole system multidisciplinary relationships must be emphasised and delivered in strategic forums as well as operational delivery. These relationships must include primary care, Scottish Ambulance Service, NHS 24, hospital services, and Health and Social Care Partnerships.
- Improvement efforts and funding decisions need to be taken with the whole system in mind to deliver realistic practice in the right place, first time so that value is maximised, and patients see the right clinician in the first instance.
- The principles for optimising flow, developed by the Centre for Sustainable Delivery should be adopted across Scotland. The model developed to reduce unwarranted variation should continue to create national clinical and operational consensus around core essential standards.
- There is good evidence supporting the safe discharge of many patients within 48 to 72 hours of admission. This practice can significantly reduce deconditioning and associated harm. Therefore, reducing unwarranted length of stay should be a primary national focus. The principles of 'Discharge without Delay' and 'Realistic Medicine' will support this focus.

- The complexity of practice means that hospital-based urgent and unscheduled care needs to be delivered in settings where there is multiprofessional, multispecialty support. In acute services this will require access to senior decision makers and diagnostic radiology on site seven days a week. Consideration also needs to be given to pharmacy and some other allied health professionals seven days a week to enable better outcomes for patients and improved flow.
- The use of data across Scotland needs to be standardised in collaboration with Public Health Scotland so that adequate benchmarking can take place.
- National bodies such as Healthcare Improvement Scotland and the Centre for Sustainable Delivery should share change ideas via learning networks and reduce unwarranted variation in practice and outcomes.

National Recommendations

Scottish Government

Recommendation 31: Scottish Government should commission Healthcare Improvement Scotland to lead the development of a national approach to improving the quality and safety of urgent and unscheduled care in NHS Scotland, consistent with the Quality Management System, including the development of national standards in partnership with a range of agencies including the Royal Colleges. This will build on work already commenced by The Centre for Sustainable Delivery and include urgent work needed to work towards eliminating the unacceptable use of non-standard care areas given the risks to patients and the impact on staff. This will require significant national focus and support.

Recommendation 32: Scottish Government should explore with Healthcare Improvement Scotland how best to gather patient views about experiences of accessing urgent and unscheduled care services and waiting in emergency departments to inform more detailed national recommendations on how to improve the patient experience and shape services for the future.

Recommendation 33: Scottish Government should engage with relevant national agencies to commission a review of the national guidance for specific health and care demand, capacity escalation and business continuity, which recognises the need to ensure a credible, robust and practical whole system response. This is essential and complementary to the current Multi Agency Major Incident Guidance.

Recommendation 34: Scottish Government should engage with relevant national agencies to commission a review of the professional advisory committee arrangements in NHS boards to ensure they have a transparent, independent and objective mechanism for the board to consider matters of safety and concern. There is an opportunity to refresh the previous national guidance and make these arrangements clearer and more open for all professions to understand.

Public Health Scotland

Recommendation 35: Reliable and comparable whole-system datasets are essential to support improvement in urgent and unscheduled care and optimise flow through the health and social care system. Public Health Scotland should be commissioned by Scottish Government to work with other national and local partners with the aim of progressing existing work and further developing datasets that are designed with, and available to NHS boards to support continuous improvement.

The Centre for Sustainable Delivery

Recommendation 36: The Centre for Sustainable Delivery should strengthen its collaboration with territorial and national NHS boards to engage in improvement activities aimed at:

- Reducing unwarranted variation in urgent and unscheduled care performance to enhance the quality and experience of care, as well as patient outcomes.
- Rethinking access to urgent and unscheduled care to ensure equity and that individuals are treated in the right place, the first time.
- Ensuring appropriate representation, including clinical leaders, in the recently formed Strategic Delivery Groups to drive improvement, set standards, and deliver change.
- Participating in the acute hospital site visit process to ensure that change is driven by clinical teams and tailored to meet the needs of local communities.

NHS Education for Scotland

Recommendation 37: NHS Education for Scotland should strengthen and further develop structured development programmes to identify and support clinical and non-clinical leaders in NHS Scotland. These programmes will enable NHS boards to focus on developing whole system multidisciplinary working and relationships which foster innovation, improvement and inclusivity in decisions that explicitly benefit quality of care and patient safety.

Recommendation 38: NHS Education for Scotland should be supported by Scottish Government to explore the implications, and work towards the shift to whole time equivalent medical trainee recruitment in order to strengthen the learning experience, reduce gaps in service and build a more sustainable, effective medical workforce for the future.

Recommendation 39: The review has highlighted the critical role of effective and supportive leadership by the NHS Board. It is recommended that the Scottish Government commission NHS Education for Scotland to evaluate the current national and local induction and support arrangements for NHS Non-Executive Board Members. This evaluation should aim to identify and implement any necessary improvements to ensure that Non-executive Board Members can perform their roles as effectively as possible, and consistent with the requirements set out in the NHS Scotland Blueprint for Good Governance.

Healthcare Improvement Scotland

Recommendation 40: The review has identified that the tools for appropriate staffing levels with regard to emergency departments are not sufficiently robust. Healthcare Improvement Scotland's Healthcare Staffing Programme should prioritise the development of new tools which reflect the current operating context and multi-disciplinary working to ensure safe and effective care.

Recommendation 41: Healthcare Improvement Scotland should collaborate with the Independent National Whistleblowing Officer, and other relevant bodies, to develop clear and unambiguous guidance for staff in NHS boards on the national routes for staff to raise concerns under Whistleblowing and the Public Interest Disclosure Act. This will enable NHS boards to ensure that they have effective arrangements in place and improve staff awareness and understanding.

Appendix 1 The concerns raised by the emergency medicine consultants

Background

This appendix sets out the original concerns raised by the emergency medicine consultants in the Queen Elizabeth University Hospital, Glasgow and the subsequent timeline of events, leading to the announcement of the review in April 2024. This is important in providing a context to the subsequent review.

In May 2023 a large body of emergency medicine consultants at the Queen Elizabeth University Hospital wrote to Healthcare Improvement Scotland outlining concerns about the safety and culture within the facility. The consultant body confirmed that the matters had not been raised through the NHS Greater Glasgow and Clyde whistleblower procedure as they had no confidence in local board processes and were therefore not willing to proceed in this manner. They requested that the concerns were considered through the formal Healthcare Improvement Scotland process.

Action by Healthcare Improvement Scotland and response by NHS Greater Glasgow and Clyde

In accordance with their extant process, Healthcare Improvement Scotland wrote to NHS Greater Glasgow and Clyde seeking assurance with regard to the issues that the consultants had raised. In June 2023, Healthcare Improvement Scotland received a response from NHS Greater Glasgow and Clyde with evidence as to how they were addressing the issues raised. NHS Greater Glasgow and Clyde recognised that the concerns were not resolved, and work was continuing to drive improvement in these areas. While they were aware of the concerns and had provided detailed information including how they measure and monitor the quality of care within the emergency department, there remained some areas where further detail was required for full assurance.

In July 2023, Healthcare Improvement Scotland wrote to NHS Greater Glasgow and Clyde providing feedback on their response and highlighted the areas where it required further information. Given the nature of the concerns and the emergency medicine consultant body coming forward to raise these, Healthcare Improvement Scotland met with NHS Greater Glasgow and Clyde management to discuss the issues raised. Healthcare Improvement Scotland also wrote to the consultant group to provide an update on the assessment process and next steps and shared a copy of the letter with them.

Further to requesting this from Healthcare Improvement Scotland, the consultants received the response from NHS Greater Glasgow and Clyde. The consultants responded to refute some of the information, with the strongest aspect being the statement that NHS Greater Glasgow and Clyde said the consultants did not ask to meet prior to contacting Healthcare Improvement Scotland. The consultant group attached, for context, an iMatter survey team report.

In August 2023, staff from Healthcare Improvement Scotland met with management from NHS Greater Glasgow and Clyde. There was a presentation of evidence by the management to staff from Healthcare Improvement Scotland.

Subsequent to the meeting, Healthcare Improvement Scotland wrote to the consultants to advise that they had met with management at NHS Greater Glasgow and Clyde and received evidence and data from them. The consultants responded to say that they had received a request from NHS Greater Glasgow and Clyde to meet regarding the case and they asked for our advice, given the process was ongoing, if it was appropriate to meet and if so how any meeting should be structured in order that the enquiry is not compromised. Healthcare Improvement Scotland responded to say that the assessment being undertaken by Healthcare Improvement Scotland in response to the concerns raised should not prevent engagement between them (the consultants) and the executive management team within NHS Greater Glasgow and Clyde in relation to these matters. Healthcare Improvement Scotland also clarified that a meeting between the consultant group and the executive team did not compromise the assessment being undertaken by Healthcare Improvement Scotland.

In September 2023, Healthcare Improvement Scotland wrote to the consultant body to advise that after assessment the decision had been taken to close the case under consideration.

The consultant group responded noting concern that the case has been closed without the opportunity to discuss with or assess all data points and they were concerned that a number of key pieces of information have not been considered in the response. They also noted concerns about staff wellbeing and experience.

The consultant group offered to provide this information should it be useful in reconsidering Healthcare Improvement Scotland's conclusions. They also confirmed that having met with the management team recently they were satisfied that there was now an appetite for change towards improvement, and a willingness to work with them on many of the issues they have raised. They noted that this is only the beginning of the improvement work, and they retained the option of bringing further concerns to our attention if patient safety remains compromised in the department.

The complaint

A complaint was then received from the consultant group on 21 September 2023 and was dealt with through the Healthcare Improvement Scotland complaints process by the Medical Director and the Associate Director of Nursing and Midwifery. Following an investigation including a meeting with the consultants, the complaint outcome was issued from the Chief Executive on 10 January 2024.

Two out of the three elements of the complaint were upheld relating to the quality of the engagement with the consultants – one on not providing an opportunity to discuss the concerns directly with Healthcare Improvement Scotland, and another on not offering the opportunity to provide evidence to substantiate the claims. An unreserved apology for the shortcomings was offered together with a commitment to learn lessons and make improvements to the process.

Steps to this review

Action was subsequently taken to initiate a review of the original concerns raised under the Healthcare Improvement Scotland using the 'Responding to Concerns' process. In light of the significance of the issues raised, it was announced in April 2024 that Healthcare Improvement Scotland would carry out a wider review of the concerns raised about the quality and safety of patient care.

Appendix 2 Terms of reference for the review

Aim

This review has been initiated in response to concerns about the emergency department at the Queen Elizabeth University Hospital, Glasgow but in carrying out the review, will take account of relevant considerations in relation to safety and quality of care across the other main receiving emergency departments in NHS Greater Glasgow and Clyde.

The review will also consider and report on the national context and relevant comparable data from other emergency departments as appropriate to the issues highlighted in NHS Greater Glasgow and Clyde and identify any wider learning for emergency departments and NHS boards across NHS Scotland.

The aim of the review is to:

1. Provide an evidence-based, balanced, objective and proportionate analysis of the key challenges facing the emergency department at the Queen Elizabeth University Hospital.
2. Consider any wider implications for the emergency departments at the Royal Alexandra Hospital, Paisley, and Glasgow Royal Infirmary.
3. Offer support to NHS Greater Glasgow and Clyde to identify practical, evidence-based and sustainable actions that may be required to improve quality and safety in emergency departments in NHS Greater Glasgow and Clyde.
4. Consider any wider evidence-based learning for emergency departments and NHS boards across NHS Scotland.

Scope

The review will be undertaken by Healthcare Improvement Scotland in the context of its existing legal powers and statutory duties.

The review will adopt the guiding principles and other appropriate elements of the Healthcare Improvement Scotland [Quality Assurance System Framework](#), and the HIS [Essentials of Safe Care](#). It will consider relevant national data and draw on strengths and learning identified in each of the emergency departments to share understanding of good practice, along with potential improvements in:

- **Safety:** the extent to which patients are treated in a safe environment and are protected from avoidable harm.
- **Leadership and culture:** the extent to which the service is well led, supported by robust governance arrangements, effective working relationships and team working, and a supportive culture both within and beyond the emergency department.
- **Patient experience and responsiveness:** the extent to which individuals receive timely, person-centred care; and the extent to which patient feedback and wider community engagement informs the planning and delivery of services.

The review, whilst also taking account of and considering the national context and relevant comparable data from other emergency departments, will be focused on the following:

- The three identified emergency departments in NHS Greater Glasgow and Clyde.
- The current issues and strengths in each department, within the context of the scope.
- The overall experience of patient care in the three emergency departments.

An independent review of Healthcare Improvement Scotland's Responding to Concerns process (the mechanism by which the original concerns were raised) is ongoing and is separate to, and out with the scope of the NHS Greater Glasgow and Clyde emergency department review.

Approach

The review will draw on:

- A range of sources of data and information including patient safety data, relevant performance data, safe delivery of care inspection reports, patient experience data, workforce data and staff experience data such as iMatter.
- Evidence from proportionate engagement with patients and a range of staff groups (including Partnership groups and whistleblowing champions). The approach to this engagement will include a combination of group and individual discussions for both categories, to obtain their views and perspectives on the safety and quality of care, culture, experience of raising concerns, and areas for improvement.
- Recognised standards where available, and relevant best practice principles and/or expert opinion to inform assessments of the above.

The review will comprise:

- An initial scoping phase to establish an evidence base and identify the initial key lines of enquiry.
- A discovery phase to collect data from information systems, review relevant evidence and the information collected through engagement with staff and patients. Emerging themes will be considered as the review progresses and may identify further key lines of enquiry.
- An analysis phase to synthesise the data gathered and produce a report.

Structure to Support the Review

The Executive Sponsor of the review will be Robbie Pearson, Chief Executive of Healthcare Improvement Scotland. The Senior Responsible Owner will be Lynsey Cleland¹¹⁵, Director of Quality Assurance & Regulation at Healthcare Improvement Scotland, who is accountable for the overall delivery of this work. Jane Byrne, Head of Multiagency Inspections (Quality Assurance & Regulation at Healthcare Improvement Scotland) will be the Programme Director responsible for operational delivery within HIS.

The review will have the following structural support:

- **Core Review Group**

The review will be conducted by a Core Review Group comprised of external and internal representatives (membership at appendix A). The Core Review Group will be responsible for the effective and efficient conduct of the review and the achievement of its aims within the agreed scope of the review. The Core Review Group will be supported by a dedicated Healthcare Improvement Scotland review Programme Director and programme management staff. Healthcare Improvement Scotland members of the Core Review Group will mobilise staff within their Directorates to carry out the work of the review. The Core Review Group will also include appropriate subject matter experts.

- **External Reference Group**

To provide advice, appropriate scrutiny, and validation of the work of the Core Review Group. This will consist of external experts and will be independently chaired.

The Core Review Group will report progress on a monthly basis to the Healthcare Improvement Scotland executive team and regular updates will be provided to the Healthcare Improvement Scotland quality and performance committee and Healthcare Improvement Scotland board for oversight and governance.

Any matters that require formal escalation during the course of the review will be taken forward through [established processes](#).

Timescale

It is envisaged that the work of the review will be undertaken within six months, with Healthcare Improvement Scotland feeding back emergent findings that require action from NHS Greater Glasgow and Clyde or other relevant bodies during the review process, prior to publishing a report of findings and recommendations.

¹¹⁵ Lynsey Cleland was Director of Quality Assurance & Regulation for HIS from the commencement of the review until October 2024, and Ann Gow was Director of Quality Assurance & Regulation from November 2024 until conclusion of the review

Appendix 3 Core Review Group

Name	Role
Prof (Hon) Hazel Borland	Co-Chair of Core Review Group
Dr Pamela Johnston	Co-Chair of Core Review Group
Jane Byrne	Head of Multiagency Inspections, Quality Assurance and Regulation, Healthcare Improvement Scotland (Review Programme Director)
Caroline Craig	Associate Director, Healthcare Staffing and Care Assurance, Healthcare Improvement Scotland
Michelle Cassidy (Membership from April 2024 – August 2024)	Project Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Lynsey Cleland (Membership from April 2024 – October 2024)	Director of Quality Assurance and Regulation, Healthcare Improvement Scotland (Review Senior Responsible Owner)
Kay Cordiner (Membership from May 2024 – August 2024)	Clinical Services Manager, Unscheduled Care, NHS Highland
Mary Cumming	Senior Emergency Department Nurse, NHS Tayside (retired)
Rhona Davies	Public Partner, Healthcare Improvement Scotland
Dr Simon Eaton	Associate Medical Director, Northumbria Healthcare NHS Foundation Trust
Jo Elliott	Review Programme Manager, Quality Assurance and Regulation, Healthcare Improvement Scotland
Ann Gow (Membership from November 2024 – March 2025)	Director of Quality Assurance and Regulation, Healthcare Improvement Scotland (Review Senior Responsible Owner)
Ann Hargie	Review Administrative Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Dr Jo Hughes	Consultant in Emergency Medicine, Northumbria Healthcare NHS Foundation Trust
Jo Matthews	Associate Director, Improvement and Safety, Healthcare Improvement Scotland
Sandra McDougall	Associate Director, Quality Assurance and Regulation Directorate, Healthcare Improvement Scotland
Tony McGowan	Associate Director, Community Engagement, Healthcare Improvement Scotland
Eileidh McIntosh	Public Partner, Healthcare Improvement Scotland

(Membership from May 2024 – September 2024)	
Wendy McKay	Administrative Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Iain Macleod (from October 2024)	Public Partner, Healthcare Improvement Scotland
Dr Clare Morrison	Director of Engagement and Change, Healthcare Improvement Scotland
Donald Morrison	Head of Data, Measurement and Business Intelligence, Healthcare Improvement Scotland
Shirley-Anne O'Hare	Senior Emergency Department Nurse, NHS Lanarkshire
Fiona Roberston	Chief Nurse, NHS Grampian
Moraig Rollo	Clinical Quality Lead East Region, Scottish Ambulance Service
Dr Julie Ronald (Membership from May 2024 – January 2025)	Emergency Department Consultant and Associate Medical Director - Acute Care, NHS 24, and Specialty Advisor for Emergency Medicine to the Chief Medical Officer for Scotland
Edel Sheridan	Review Programme Manager, Quality Assurance and Regulation, Healthcare Improvement Scotland
Gillian Smith	Project Officer, Quality Assurance and Regulation, Healthcare Improvement Scotland
Dr Julie Thomson	Consultant in Emergency Medicine, NHS Fife
Dr Sian Tucker	Deputy Medical Director, Clinical Directorate, NHS National Services Scotland, and Primary Care Out of Hours Advisor to the Scottish Government

Appendix 4 External Reference Group

Name	Role
Professor Sir Lewis Ritchie	Chair of External Reference Group
Suzie Bailey	Director of Leadership and Organisational Development, The King's Fund
Andrew Carruthers	Associate Director of Care Quality, Professional Development and Improvement Scottish Ambulance Service
Dr David Chung	Consultant in Emergency Medicine, Royal College of Emergency Medicine
Professor Frances Dodd	Executive Nurse Director, NHS Forth Valley
Professor Andrew Elder	Chair, Academy of Medical Royal Colleges and Faculties in Scotland (from January 2025)
Dr Fatim Lakha	Consultant Public Health Medicine, Public Health Scotland
Dr Crawford McGuffie	Executive Medical Director, NHS Ayrshire & Arran
Dr Chris McKenna	Executive Medical Director, NHS Fife
Eileen McKenna	Associate Director, Nursing Policy and Professional Practice, Royal College of Nursing in Scotland
Dr Gordon McNeish	Consultant in Emergency Medicine, NHS Lanarkshire
Dr Irene Oldfather	Director Strategic Partnerships, External Affairs and Outreach, The Alliance
Rosemary Pengelly	Public Partner, Healthcare Improvement Scotland
Orla Prowse	Physiotherapy Head of Service, Acute Division, NHS Lothian
Martin Robertson	Public Partner, Healthcare Improvement Scotland
Adam Sewell-Jones	Chief Executive, East and North Hertfordshire NHS Trust
Lesley Sharkey	Director of Midwifery / Scottish Quality & Safety Fellow, NHS Tayside
Elaine Strange	Head of Service, Public Health Scotland
Dr Shobhan Thakore	National Clinical Lead, Unscheduled Care, Centre for Sustainable Delivery
Professor Steve Turner (until January 2025)	Chair, Academy of Medical Royal Colleges and Faculties in Scotland

Professor Emma Watson	Executive Medical Director, NHS Education for Scotland

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