

NHS Greater Glasgow & Clyde	Paper No. 21/11
Meeting:	NHSGGC Board
Date of Meeting:	27th April 2021
Purpose of Paper:	For Noting
Classification:	Board Official
Sponsoring Director:	Chief Executive

Paper Title

Queen Elizabeth University Hospital and Royal Hospital for Children Update

Recommendation

The Board is asked to note the Queen Elizabeth University Hospital and Royal Hospital for Children - Update

Purpose of Paper

The purpose of the paper is to update the Board on the overall position in respect of the NHS Greater Glasgow and Clyde (GGC) response to the current issues associated with the QEUH and RHC.

Key issues to be considered

This paper considers some key ongoing issues in respect to the series of independent reviews of the QEUH and RHC sites, specifically:

- Oversight Board and Casenote Review publications
- Progress with the Independent Review
- Current position with regard to:
 - The Scottish Hospitals Public Inquiry
 - Legal Proceedings
 - HSE Investigation

Any Patient Safety /Patient Experience Issues

Ensuring patient safety and the ongoing provision of high quality care are central to our response to the independent reviews and the actions associated with them.

Any Financial Implications from this Paper

There are likely to be financial implications as part of our programme of work based on the recommendations of the independent reviews which will be considered as the action plans are progressed.

Any Staffing Implications from this Paper

There are likely to be staffing implications as part of our programme of work based on the recommendations of the independent reviews which will be considered as the action plans are progressed.

Any Equality Implications from this Paper

No

Any Health Inequalities Implications from this Paper

No

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

No

Highlight the Corporate Plan priorities to which your paper relates

Better Health

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NHS GREATER GLASGOW AND CLYDE

Queen Elizabeth University Hospital and Royal Hospital for Children Update

NHS Board Update 27th April 2021

1. INTRODUCTION

- 1.1** NHS Greater Glasgow and Clyde (NHSGGC) remains on Level 4 of the NHS Scotland Performance Management Framework in respect of on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) and the associated communication and public engagement issues.
- 1.2** As part of the escalation process, an Oversight Board was established, chaired by Professor Fiona McQueen, with three sub groups reporting to it, namely Infection Prevention and Control Governance, Communication and Engagement and a Technical group. NHSGGC has worked closely with the Scottish Government team throughout, providing significant amounts of evidence over the months to the sub groups, reviewing and commenting on draft reports.
- 1.3** On 8th December 2020 the Finance Planning and Performance Committee received a presentation outlining the findings of the draft Interim Oversight Board Report with the Interim Oversight Board Report being published on 21st December 2020.
- 1.4** Two further reports have now been published in relation to these issues - the final Oversight Board report and the Casenote Review. These reports were published on 22nd March 2021, with families receiving a copy of the Casenote Review in advance of its publication.
- 1.5** NHSGGC would again wish to apologise sincerely for the distress and concern that these issues have brought to our patients, their families and staff. There is a clear appreciation of the very challenging circumstances that our patients, their families and our staff have had to face during this difficult time and it is essential that we address these reports in a proactive and positive manner to ensure patient safety remains at the heart of our endeavours and that, where improvements are required, we address them swiftly and systematically. It is also essential that we ensure that we have learned from this difficult set of circumstances to minimise the risk to all our patients, in whatever area of NHSGGC they are being treated in the future.

2. OVERSIGHT BOARD REPORT

- 2.1** The Oversight Board addressed its work through a review of key documents and direct inquiry with colleagues within NHSGGC over many months. This included the examination of NHSGGC internal minutes and papers, specially commissioned papers on individual topics, material provided to the Scottish Government by some NHSGGC clinicians and microbiologists and a number of key external documents.

2.2 The Oversight Board report sought to address 4 questions:

- To what extent can the source of the infections be linked to the environment and what is the current environmental risk?
- Are IPC functions “fit for purpose” in NHSGGC, not least in light of any environmental risks?
- Is the governance and risk management structure in NHSGGC adequate to pick up and address infection risk?
- Has communication and engagement by NHSGGC been sufficient in addressing the needs of children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?

2.3 With regard to the first question, the Report indicates that, in the absence of definitive sources, the strong possibility of a link is “undeniable”. The Report outlines that the cases “did not necessarily suggest a pattern at first” and water testing before 2018 did not provide evidence of contamination. However, by 2018, there was significant evidence of a succession of environmental defects and NHSGGC was taking action to address the issues. The “timely, robust and focused” response by NHSGGC to water contamination was commended within the Report.

2.4 The report also states that NHSGGC, national bodies and the Scottish Government lacked a strategic understanding of the complexity of the water contamination and that environmental risks associated with hospitals are now better understood overall, not least through the efforts of NHSGGC, which provide a platform for further learning and improvement in the future.

2.5 With regard to the current environmental risk, the report states “Given the water testing results, the chemical dosing system appears to have proven effective. Whilst unusual environmental bacteria can occur in all healthcare settings, the risk must continue to be monitored, evaluated, mitigated and reported”.

2.6 In the section concerning the second question relating to the IPC functions, it is highlighted that the Board was quick to react to individual incidents with clear IPC actions and had the ability to take highly challenging steps, to address any risk to the care and safety of the patients. It indicates that imagination and determination were evident in how specific issues were addressed, especially in 2018, but also states that that the ability to see and act on a wider perspective framed by environmental risks and infection incidents, was not apparent.

2.7 Issues were also raised in relation to the functioning of the Incident Management Team meetings and their short term reactive response was noted. However, it is also stated that a number of more significant decisions, such as the introduction of chemical dosing, were taken and this is recognised as being “exemplary”. It is also notes that relationships between the Infection Prevention and Control team and key services, such as Estates and Facilities and, between, and among, microbiologists at the QEUH were fraught and compromised effective working. Significant work has been undertaken since then and the Estates and Facilities interface with the infection control team has been strengthened and is now working in a more effective manner. Considerable work has also been undertaken to address the issues within

microbiology at the hospital and this work is ongoing.

- 2.8** Again, this section also highlights the significant work undertaken by NHSGGC to address all of the issues.
- 2.9** In relation to the section on governance and risk, the size and complexity of NHSGGC is outlined as a challenge in ensuring cross-cutting issues are addressed across the whole governance system. It commends the work that has already been put in place to make a number of changes, particularly with regard to the issues within Estates and Facilities, where the appropriate operational governance processes had not been followed in the past.
- 2.10** Further sections outline the fact that there was good evidence of assurance on the actions being given, but there was less evidence of challenge apparent from the Oversight Board's desk-top examination of the minutes of meetings. The approach to Risk management, specifically the description of risks, was considered to require review, although the Report notes that a different approach to recording risk would not have led to a different course of action to respond to, or mitigate, the risk.
- 2.11** With regard to communication and engagement, the Report states there was substantial evidence of a compassionate approach to communication by frontline staff but stated that communication at a corporate level was inconsistent and some patients and families considered that questions about episodes of infection were not answered in a timely or informative manner. The Report also states that fuller consideration could have been given to psychological harm in the application of the organisational duty of candour.
- 2.12** Again, it is noted in this section of the Report that a considerable amount of work has already been done, or is underway, to address these issues.

3. CASENOTE REVIEW

- 3.1** The Casenote Review was also published on 22nd March 2021. This report was commissioned by the Cabinet Secretary for Health and Sport in January 2020 to be undertaken by a panel of independent experts, led by Professor Mike Stevens, Emeritus Professor of Paediatric Oncology from the University of Bristol.
- 3.2** The purpose of the Casenote Review was to determine how many children and young people with cancer, leukaemia and other serious conditions were affected by a particular type of serious infection caused by Gram-negative environmental bacteria, from 2015 to 2019; to decide, as far as it is possible to do so, whether the infections were linked to the hospital environment, and to characterise the impact of the infections on the care and outcome of the patients concerned. The Review involved the consideration of the cases of 84 children and young people who fell within the relevant criteria.
- 3.3** The Review's findings indicate that they were unable to identify evidence that unequivocally provided a definite relationship between any infection episodes and the environment. However, the report also states that 34% of the infections might be, on the balance of probability, reasonably considered to be "Most Likely" linked to the environment. It also provides an assessment on the impact of the infections on the individual patients.

- 3.4** It is noted that there was an increased likelihood that the infections within the “Most Likely” group occurred in 2018 and that there was significant action taken by the Board at that time, with external support from Health Protection Scotland and the Scottish Government.
- 3.5** This Review acknowledges the steps taken by the organisation to respond to what was an extremely challenging and complex situation. It commends NHSGGC in a number of areas, including the comprehensive and detailed clinical records kept by the medical and nursing teams and the good communication between the microbiologists and the haematology oncology team in relation to the diagnosis and management of infections. It also states that communication with patients and their families was generally well documented and of a high standard, despite some patients raising concerns in this respect.
- 3.6** The Review also commends the significant work undertaken by the Quality Improvement Group established in 2017 to reduce the level of central line associated infection which currently remains low.
- 3.7** The Review outlined a number of issues where improvement is required, particularly in relation to the accuracy, use and availability of data. Concerns were raised about the ability of NHSGGC to obtain a full, and detailed picture of the position with its current processes and data systems. It also documents some concerns about the location and filing of patient records.
- 3.8** Issues relating to the systematic recording and review of all maintenance activity in clinical areas were raised and the need for accuracy in relation to precise locations/timings for testing and maintenance / repair work was identified. A systematic, fit for purpose, routine, microbiological water sampling and testing system is recommended and is now in place.
- 3.9** The Review identifies areas where the management of outbreaks required improvement and highlights areas similar to these raised in the Oversight Board report. It recommends rigorous review of all Gram-negative bacteraemia with a multi-professional group reviewing the data.
- 3.10** Recommendations are also made in relation to the functioning of Incident Management Teams and the need for a revised approach to be developed. The enhanced use of infection prevention and control audits and hand hygiene audits as an integral element of any Incident Management Team process is also recommended.
- 3.11** A number of recommendations are made in relation to clinical care including issues associated with central venous line care, ongoing audit of the use of antibiotic prophylaxis and additional morbidity and mortality reviews of any patients who have a GNE infection.

4. SUMMARY

- 4.1** A number of recommendations for NHSGGC and for national implementation are made within both reports. The final Oversight Board report has 18 recommendations, 12 solely for NHSGGC to implement, with 6 for national implementation. The Casenote Review has 43 recommendations over 15 themes with 42 of them for local action, with one recommendation for national action.

- 4.2** An overall comprehensive action plan to address all the recommendations has been put in place to address the issues. A specific delivery group (Gold Command), chaired by the Chief Executive, has been established to provide updates to the Corporate Management Team and, in turn, to the appropriate governance committee of the NHS Board to ensure focused work is undertaken on all of the recommendations.
- 4.3** Within the Oversight Board report, 5 of the local recommendations are fully or partially completed, with the remainder underway. Similarly, within the Casenote Review local recommendations, 10 are complete, with the remainder underway or about to commence. This work will be monitored carefully within the internal management processes as described earlier in the paper. Regular progress reports will also be provided to the Scottish Government and the appropriate governance committee of the NHS Board.
- 4.4** At present, NHSGGC will remain at Level 4 of the escalation framework and discussions have taken place with Scottish Government colleagues to establish an ongoing monitoring process to ensure clarity on their requirements and that continued progress is made.

5. INDEPENDENT REVIEW

- 5.1** Work continues to review the actions arising from the report of the independent review of infection control concerns at the QEUH and the RHC by Dr Andrew Fraser and Dr Brian Montgomery.
- 5.2** This is being progressed in accordance with the action planning methodology recommended by the Scottish Government. Progress is being monitored by senior Directors through the Gold Command process as outlined above. All recommendations and actions relevant to NHSGGC are either complete with on-going monitoring or are underway. This work will continue in parallel with the overall action plans relating to the Oversight Board and the Casenote Review to ensure a systematic and aligned approach.

6. SCOTTISH HOSPITALS PUBLIC INQUIRY

- 6.1** The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. On 19th January 2021 Lord Brodie announced timescales for 2021 and on the 1st February 2021 issued core participants with formal evidence requests focussed on the priorities outlined below:
- Adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care.
 - Governance and Project Management - as far back as 2002.
 - Effects of the issues identified on patients and their families.
- 6.2** The first formal meeting took place on Thursday 18th March 2021 which was an initial gathering of the legal representatives of core participants, at which Lord Brodie explained the progress of the Inquiry and the programme going forward.

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- 6.3** The first formal hearing of the Inquiry will take place on Tuesday 22nd June 2021. This will be a procedural hearing to confirm arrangements for the first substantive hearings in September 2021.
- 6.4** The first substantive hearings of the Inquiry will commence on Monday 20th September 2021 and will last for three weeks. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families and it is those patients and families who will form the core of those called upon to give evidence in person at the initial hearings.
- 6.5** It is likely that the next set of hearings will be scheduled for late 2021 /early 2022, with a procedural hearing ahead of that time. Further details of what will be covered and the programme for the hearings will be published in due course, however it has been indicated that the initial focus will be on the inquiry into the Royal Hospital for Children and Young People in Edinburgh.
- 6.7** We continue to work with the dedicated team from the Central Legal Office on all issues connected to the QEUH/RHC. A number of meetings have been held with the Inquiry Team Solicitors with documents now being transferred as requested in a coordinated manner.
- 6.8** It is evident that there is significant cross over with the issues associated with the Inquiry and those of the Legal Claim and hence oversight of both elements is critical moving forward. The Programme Management Office (PMO) resources have been increased with a single Project Team being created to manage both the Legal Claim and the Inquiry. The Executive Oversight Group, chaired by the Chief Executive and attended by key Directors, meets fortnightly to ensure effective and swift decision making takes place.

7. LEGAL PROCEEDINGS

- 7.1** Further to the approval of the Board in January 2019 to raise Court Proceedings against the parties responsible for delivering the QEUH/RHC construction project, NHSGGC engaged MacRoberts LLP to act on its behalf. Court summons were served on the main contractor for the hospital project, Multiplex, and the Health Board's advisors, Currie & Brown UK Limited and Capita Property and Infrastructure Limited.
- 7.2** Throughout 2020, NHSGGC continued to engage with the appointed legal team within MacRoberts. The process of seeking expert opinion against the 11 Heads of Claim was undertaken which included site visits and preliminary reports from the independent experts to assist on the question of liability.
- 7.3** In January 2021, the Board considered the position in respect of the claim and the NHS Board approved the instruction of MacRoberts LLP to lodge the action for calling. This was completed on Wednesday 25th January 2021. The case has been remitted to the "Commercial Court" and a hearing on preliminary points was heard on 26th February 2021. The legal debate has been set for June 2021, to be heard by Lady Wolffe.

8. HSE INVESTIGATION

- 8.1** On 24th December 2019, the Health and Safety Executive (HSE) served on NHSGGC an Improvement Notice in relation to the ventilation system for Ward 4C. Legal advice

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was sought and we appealed the Improvement Notice on the grounds that there was no basis in fact for the Improvement Notice to have been served.

- 8.2** After an initial hearing relating to the Board's appeal against the HSE Improvement Notice, it was agreed that the legal representatives of the HSE and NHSGGC would meet. Due to COVID-19 there was a temporary suspension of activity. An initial hearing was held on 3rd September 2020 with a further preliminary hearing on the 23rd November 2020. The Court has provided a timeline for the appeal to proceed, with a further hearing scheduled for around October 2021.

9. OVERALL SUMMARY

- 9.1** The many issues described in this paper represent a significant amount of work over the coming months, and indeed years in respect of the Public Inquiry. The resource requirements of the senior leadership team and supporting elements, such as the PMO, have been reviewed and the level of resource to support all areas has been increased. This will be kept under regular review by the Executive team.

**Jane Grant
Chief Executive
April 2021**