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HEALTH AND SPORT COMMITTEE

Tuesday 24 February 2015

Session 4

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CONTENTS

HEALTH AND SPORT COMMITTEE
6th Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Dennis Robertson (Aberdeenshire West) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jackie Baillie (Dumbarton) (Lab)
Paul Gray (Scottish Government)
Professor Fiona McQueen (Scottish Government)
Shona Robison (Cabinet Secretary for Health, Wellbeing and Sport)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 24 February 2015

[The Convener opened the meeting at 09:48]

Vale of Leven Hospital Inquiry

The Convener (Duncan McNeil): Good morning and welcome to the sixth meeting in 2015 of the Health and Sport Committee. As I usually do at this time, I ask everyone in the room to switch off mobile phones as they can interfere with the sound system, although I ask visitors and others to note that some of us are using tablets instead of hard copies of our papers.

I welcome Jackie Baillie, who joins us for item 1 on our agenda.

Our first item is to take evidence from the Cabinet Secretary for Health, Wellbeing and Sport following Lord MacLean's report on the C difficile outbreak at the Vale of Leven hospital in 2007, when, sadly, 34 people lost their lives.

I welcome Shona Robison, the Cabinet Secretary for Health, Wellbeing and Sport; Fiona McQueen, interim chief nursing officer for the Scottish Government; and Paul Gray, director general of health and social care and chief executive of NHS Scotland. Welcome to you all. The cabinet secretary has asked to speak at this point, and I give her that opportunity now. After she has made some opening remarks, we will go directly to the first question from the committee.

The Cabinet Secretary for Health, Wellbeing and Sport (Shona Robison): Thank you for inviting me to discuss "The Vale of Leven Hospital Inquiry Report". First, I reiterate my sincere apologies to the patients and families affected by the Vale of Leven hospital C difficile outbreak in 2007-08. Secondly, I again put on the record my thanks to Lord MacLean and his team for their commitment to the inquiry and for producing such a comprehensive and detailed report.

Lord MacLean published his report on 24 November 2014, and in my statement to Parliament on 25 November I committed to undertake a number of actions to ensure that the recommendations in the report were implemented. The aim of those actions has been to ensure that the focus is on making improvements across the national health service. Although the focus of the work going forward is Scotland-wide, it is important to remember the patients and families affected by this tragedy. That is why they are included throughout this whole process, which will enable them to be assured that the recommendations are being implemented.

To assist the committee, I will provide a brief summary of the actions that have been taken since the report was published. I wrote to all NHS boards following publication to ask them to assess themselves against the 65 recommendations for health boards in Lord MacLean's report and to respond to me by 19 January 2015. As I stated in my paper to the committee, I am pleased to confirm that NHS boards have now responded.

The committee will recall that we undertook to implement all the recommendations, and that is what we will do. I am pleased to report that boards have assessed that, so far, they have either fully or mostly implemented around three quarters of the recommendations. Once further analysis of the responses has been undertaken and completed, I plan to publish them on the Scottish Government website. I would also be happy to share them with the committee, if members would find that useful.

I committed to establishing an implementation group to oversee the implementation of the health board recommendations. However, following its first meeting on 16 February, the group has agreed to oversee the implementation of all 75 recommendations. The implementation group has agreed its remit and terms of reference, and I would be happy to share those with the committee. The group will be chaired by Fiona McQueen, interim chief nursing officer, and it includes a number of stakeholders representing patients and families, the NHS, social care and the unions. The minutes of the group's meetings will be published on the Scottish Government's website, and we will be developing the web pages with family members. The implementation group will ensure that its work links in to current policies and the work of other groups, to prevent any duplication.

In addition to a patients and families representative being on the implementation group, I have also agreed to establish a reference group. That group will help to provide assurance to the patients and families and the wider public that the recommendations are being implemented. It will give them a voice to challenge and support the implementation group. The reference group is being established to give the patients and families and the wider public a voice in the implementation process.

Invitations have been issued, asking a number of stakeholders to nominate a member to be on the reference group, and it is anticipated that the first meeting will take place in March. As with the implementation group, the minutes of the reference group will be published on the Scottish Government's website.

In my statement to Parliament, I committed to publish the Scottish Government's full response to Lord MacLean's report in the spring. It is my intention to stick to that timetable, and I would be happy to let the committee know the publication date in due course. Scottish Government officials are working on the full response and will ensure that there is input to it from the implementation group and from patients and families.

I hope that that demonstrates the Scottish ministers' commitment to progressing this work and assures you that I am taking the necessary measures to make the improvements that are needed to improve patient care across the NHS. I am happy to take questions.

The Convener: Thank you, cabinet secretary. The first question this morning is from Colin Keir.

Colin Keir (Edinburgh Western) (SNP): I must admit that, as somebody who has come to this topic for the first time, I found reading "The Vale of Leven Hospital Inquiry Report" very trying, and I can see how it will be a very emotional subject for many people.

Will the first recommendation—that the Healthcare Environment Inspectorate be given the power to close wards to new admissions—require primary or secondary legislation?

Shona Robison: We could do it either through the vehicle of primary legislation, such as the public health bill, or through secondary legislation. I want to look at the most efficient and the speediest route for implementation, which may end up being secondary legislation. However, the committee can be assured that there will be a full opportunity to input to, discuss and debate the proposed legislation. I would like to get this into legislation as quickly as possible.

Colin Keir: In light of the report, do you have any plans to enhance the Healthcare Environment Inspectorate's inspection and monitoring process? Do you have anything in mind that is a "must do"?

Shona Robison: First, I should say that the Healthcare Environment Inspectorate is a very thorough and effective tool for inspecting our health service. It does not pull any punches. We only have to look at recent reports to see that it reveals not only where practice is good but where it is not good and improvements need to be made. It is a very effective organisation. If there are ways of enhancing that—the recommendation to give HEI the ability to close wards is part of that—no doubt there will be discussions with it and others about whether there are other measures that they would like to be taken to strengthen the work that it does.

HEI does a very good job and it has been instrumental in driving improvement, but if it comes forward and says that it would like additional powers beyond those recommended by Lord MacLean, I would certainly be willing to listen to that.

Colin Keir: I have one more question, which relates to your comments on the replies that you have had from health boards across Scotland. You said that three quarters of the recommendations have been dealt with. What is the timescale within which the health boards anticipate that all the recommendations will be put into practice?

Shona Robison: The implementation group will be working very closely to ensure that the three quarters of the recommendations that have been met are monitored and overseen in their implementation. The group will quite rightly want to ensure that they are all implemented to an extent that the group is happy with. There will be that oversight and monitoring. Ideally, the rest of the recommendations should be implemented as soon as possible, but we need to ensure that that is done thoroughly.

Fiona McQueen might want to add to that.

Professor Fiona McQueen (Scottish Government): Although we are saying that some of the recommendations have not been fully met, in many cases they are almost fully met, so there has been really good progress. Some will be met in some boards sooner than in others. I think that, by the time the response is published, we will be able to say with confidence that the majority have been met completely. The relatives in particular are keen that we do not just have a tick-box exercise, and we need to find ways—we look to our inspectors to help us—to check and test what boards have said.

I think that, by the time the response is published in the spring, the majority of the recommendations will have been met—and if they have not been met, firm plans will be in place where we have to put new systems and processes in place—and the boards will have started with a trajectory of when we will be able to meet them.

Colin Keir: Thank you. That is heartening.

10:00

Rhoda Grant (Highlands and Islands) (Lab): The report recommends that each health board sets up a task force. What progress has been made with that? Does every health board now have a task force?

Professor McQueen: Every health board has a team in place. Each board has an infection control committee, and there are good lines of governance from board to bedside. Nationally, I am reconvening the task force. I am changing the approach whereby we monitor hospital-acquired

infections, and through that we will look at what is meant by a task force. We have infection control committees, infection control managers and doctors and nurses who have specific responsibilities. We have reissued our guidance on the infection control manager and are reviewing what needs to be done.

Although they might not have something that is called a task force, every board has an infection control committee that essentially works as a task force. I will be pulling the national task force together again. Although we have had systems in place to monitor HAIs, I want to take forward a smaller, more focused group so that we can fully oversee what we are doing. We will then work with boards to determine whether the current infection control committees situation is suitable and satisfactory—I am absolutely confident that they do a very good job, when we look at the rates of reduction in infections—and whether we need anything additional. They may not be called task forces, but the boards have teams that work in that way.

Rhoda Grant: Who is involved in those teams?

Professor McQueen: There is the infection control manager, infection control doctors and infection control nurses. In the majority of cases, lay members of the public are also involved as well as other clinicians and managers, cleaning staff from hotel services and facilities staff such as engineers. It is a full, wide multidisciplinary team.

Rhoda Grant: There was a recommendation that all Scottish Government policies should have an implementation strategy associated with them. Is that happening and how is it being monitored?

Professor McQueen: That is happening and it is being monitored. Within three months the HEI inspectors will be looking to ensure that policies have been put in place and are being enforced. The task force that I will chair will also oversee what is happening with the implementation.

Rhoda Grant: What focus is that creating on cleaning, which is still an issue? We still pick up newspapers and read stories about cleaning. How is that being dealt with?

Shona Robison: That is captured in some of the recommendations, but there is other action that we need to take. I regularly meet all the chairs of the health boards, and at the last meeting I asked every single one of them to go out with their senior management teams to look at the cleanliness of all their hospitals. Rather than wait for reports to come in to analyse whether their cleanliness standards are up to scratch, I want them to go out proactively and look for themselves and to report back to me with an assurance that they have done that. That process is under way. Fiona McQueen has been overseeing that, so she might want to comment.

Professor McQueen: Boards have written to the cabinet secretary with some detailed plans and proposals on what is happening to take that forward. We routinely monitor the situation, and Health Facilities Scotland monitors what is happening with cleanliness. However, you are right to say that there are areas where our inspectors find that the cleaning standards have not been met. The cabinet secretary has written to the chairs and we will look at the issue in our implementation group to ensure that we are reaching the farthest corner of the farthest ward and the cleaning standards are being maintained.

Rhoda Grant: It is not just about day-to-day cleaning standards. If there is an outbreak of something like C diff, the resources need to be available to allow cleaning teams to be pulled in almost immediately. Nurses have to nurse, and we know that they are under more strain and time pressures than ever before. They might have to decide whether to look after someone who is really ill or to clean up after somebody else. Obviously, if a nurse cleans up and then goes round other patients, that creates an infection risk. We need dedicated cleaning teams that can be called on at a moment's notice to get in there.

Shona Robison: That is part of the infection control procedures. If an issue is identified, the systems are there to ensure that that happens. However, there is a wider message about basic cleanliness being everybody's responsibility, and that it is everybody's responsibility to raise concerns. We have a message getting through about hand washing and basic infection control procedures, and I want the same attitude towards cleanliness.

There are complex issues around infection control. We can clean and clean, but it takes only one finger on one spot to spread infection, so it is not as simple as just cleaning. However, without doubt, for public confidence and patient reassurance, people should expect hospitals, particularly the areas that patients are in, to be of a clean standard. We want to do more on that to ensure that the message is pushed across and that proactive action is taken to address any shortcomings, particularly in patient areas.

We also want to ensure that we use the learning from the reports that have not been good, some of which address common themes. We should not wait for further reports; we should take that action. Each board is expected to act on those reports, whether or not they are on a board's area. The boards are expected to act on the lessons, and the work that Fiona McQueen described will ensure that they do that.

The Convener: You set a hard pace in your recent statement in Parliament. I might be an old cynic, but I noticed a difference between the language this morning and the submission that we got from the Government last week. That talked about 80 per cent of the recommendations being implemented, whereas today you have talked about 75 per cent of the recommendations. This morning, you have talked about the definition of "task force" not being clear. There was another point that raised my antenna, but it escapes me for the moment. Are you absolutely confident that the pace is not slipping and that the boards will meet the deadlines that you have placed on them for addressing the issue?

Shona Robison: Yes. Perhaps I can explain that the 75 per cent is of the 65 recommendations and the 80 per cent is of the 75 recommendations. Maybe we should have used consistent language, but you can be absolutely sure that the timeframes that we have set out and the commitments that we have made will absolutely be the case.

The fact that we have involved the families in the implementation group and the reference group should bring external scrutiny, which is important. It is not just about boards telling us that they have implemented the recommendations; it is about having that external assurance that the families are absolutely confident and feel that boards have done absolutely everything to implement the recommendations and that there is oversight and monitoring of that.

Bob Doris (Glasgow) (SNP): Good morning, cabinet secretary. Although I am a Glasgow representative, I was born and bred in the Vale of Leven. All my family are still down there, and my elderly relatives—particularly my mother and father—use the Vale hospital. Unfortunately they have to use the hospital fairly regularly. I know that we are talking about an absolute tragedy that happened in 2007, but I wish to place on record the excellent service that my family gets at the Vale today. It is in that context that I wish to ask some questions, without any complacency at all, because we must strive to implement absolutely every aspect of the recommendations. I thought it important to say that.

Lord MacLean's recommendations 10 to 12 concern information that was or was not provided to patients and relatives. There were a couple of really terrible examples, with C diff being compared to just a "wee bug" and played down. There were mixed messages about how to deal with soiled clothes, whether families should take them home, how they are stored and so on—really basic things, I suppose we have to say. My question is in two parts. I hope that those basic things have been dealt with long before today, so I seek confirmation of that.

There was a wider recommendation, to which the cabinet secretary referred in her statement to Parliament. She said that she wanted

"to roll out a robust quality assurance system, to put patients, families and their experience at the centre of that work and to ensure that information on it is ... easily accessible"—[*Official Report*, 25 November 2014; c 24.]

to the public. In other words, clear messages should be out there, at the hospital and on the wards about how to deal with all this.

As I said, my question is in two parts. First, are you confident that what might have seemed like silly wee things—but deeply worrying things—in 2007 have already been addressed? Secondly, the wider question is this: has the work on information that the chief nursing officer was going to take forward been started? If not, when will it start? What timescales apply to it?

Shona Robison: I will bring in Fiona McQueen on some of the detail.

One of the issues that arose was inconsistency of information. There were different messages and no clear information on, for example, dirty or soiled clothing and so on. It is hard to understand now that that was the case. There is now very clear patient information, which is standardised and clear. That work was, because it was on such a fundamental issue, taken well down the road and was sorted well before the report was issued.

Professor McQueen: On the care assurance system that we are considering, you are absolutely right: there are a number of what I would call essential components of care that have now been changed, including the information that people get and access to that information.

We have learned from the patient safety programme that if you put a big system in place all of a sudden, it does not necessarily work. Putting systems in place and testing them, changing them and moving them forward is the best way to proceed.

Under the care assurance system, we recognise that although individual components of care are incredibly important, they become even more important to people who are unwell when we consider them altogether. That includes information to families and patients' loved ones, cleanliness, nutrition and caring for people through balanced person-centred care. In wrapping all that together, we have agreed and defined standards, which we are currently testing in three health board areas. They have been well researched and well evidenced, and we are confident that they are the right standards.

Once we have agreed and once we have a form of assurance and accreditation, we will need to put those standards out across Scotland, so that each

ward is safe, clean and person centred, and so that the people who use the wards will have confidence about information.

Across Scotland, we already have information about care within wards, but we would implement a simplified and straightforward approach so that no matter which ward or department a person went into in Scotland, our care assurance system would be in place in a straightforward and meaningful way.

We have started testing the system; I expect that we will, by the beginning of May, have agreed the whole system and will be planning its roll-out. It will be clear and unambiguous and will include workforce and infection-control standards. It will be there for the public to see, so that they can have assurance and confidence. We will start rolling it out by late spring or early summer.

10:15

Bob Doris: It is helpful to get the timescale. With any care assurance system, there have to be checks and balances. The Healthcare Environment Inspectorate has been doing unannounced inspections since 2009. I would expect more cases of poor hygiene to be identified as a result of unannounced inspections, which is one of the checks and balances to ensure that health boards and hospitals do their jobs properly. I hope that there are a number of checks and balances in the system. I do not want to be alarmist but, by definition, unannounced inspections should lead to identified areas for improvement. That is why we have those inspections.

I wonder how that all fits in with recommendations 13 to 33 on nursing care in Lord MacLean's report. You have talked about nationally agreed standards. Lord MacLean talked about clear and effective lines of responsibility, the keeping of accurate patient records and the auditing of them, the role and responsibility of the nurse in charge of each ward, ensuring proper systems of care planning, communications with relatives and ensuring the right skills and staff mix in each ward. I am not sure whether that is what Professor McQueen was talking about when she gave that information. The cabinet secretary rightly said that every healthcare staff member has a front-line responsibility in relation to hygiene.

On the skills and staff mix, my wife is a nurse, so I know very well that there are domestics and auxiliaries on wards as well as various categories of nurse, each of whom has their own role in the system. I want to be confident that every staff member, irrespective of where they are as a cog in that machine, has that front-line responsibility.

I do not know whether I am talking about the same nationally agreed standards that Professor McQueen has just referred to, but when are the ones in relation to care planning and nursing documentation likely to be agreed and implemented? Will you look at the specific issue of the staff mix? I accept and agree whole-heartedly that every staff member has a front-line infection-control responsibility, but as part of that, every nurse, auxiliary, domestic and doctor has their own part as a cog in the machine. Is there a need for greater clarity about who does what? Will that be considered when you look at the skills mix? Is that the kind of thing that we are talking about when we talk about nationally agreed standards?

Shona Robison: Yes. The issue at the Vale of Leven was partly about the skills mix, although it was also about leadership and responsibility. There absolutely is a need for everybody to take responsibility, because infection control is everybody's business, but there also needs to be leadership to ensure that issues and problems are identified and, more important, that they are acted on. Of course, with the Vale of Leven outbreak, that part of the system was not there and did not work. The work that has happened since then is crucial in addressing that.

Professor McQueen: I will pick up on a few of Bob Doris's questions. On nursing numbers and the skills mix, we have the workforce tools that we are putting in place. I agreed with the nurse directors as recently as last week that we need to do more work on the skills mix, so we are doing that. The workforce is an integral part of the care assurance system.

On whose job it is to do what, with regard to cleaning, our inspectors go in unannounced and ask the junior doctor, cleaner, physiotherapist or nurse whether they know what to do with a spillage or with personal protective equipment; that is looked at. As a consequence of that we have also asked Health Protection Scotland to do more detailed work on the time it takes to do and the timings of cleanings and to check and test who is the best person to do each piece of cleaning.

Each health board currently has standards for record keeping and models of care for care planning. We will agree a national approach to standards so that there is less variability and more transparency.

Bob Doris: That is all very helpful, and I will reflect on that very detailed evidence. Are the standards that you mention a different set of standards from those for the care assurance system?

Professor McQueen: They are the same.

Bob Doris: Thank you. That is very helpful.

The Convener: Is there an agreed number of inspections to be carried out? Is there an inspection plan?

Shona Robison: Yes. There is a cycle of inspections that ensures that HEI looks at different parts of the system—the focus could be on older people's care or on the front door of a hospital. HEI considers what inspections it has done in the previous couple of years and what it proposes to do to ensure that it gets a good balance and is inspecting a sufficient range of services for it to be able to bring out any issues that could apply to similar settings elsewhere. HEI has systems to identify that.

Professor McQueen: HIS also does risk assessment by asking for information from health boards, then making its own decision about where it wants to go. There is some time between an inspection and an HEI cleaning report being published, so if the inspectors find that a hospital is not clean, they might go back the next day or the next week. The result of those inspections would be published in one report, so it would not be obvious that there had been more than one inspection. However, the inspectors follow up on aspects that they find to be unsatisfactory.

The Convener: Yes—but they inspect for a wide area of responsibilities. How do we ensure that they have got the balance right on cleanliness? There is big pressure because there are reports on the issue, it has been debated in Parliament and the cabinet secretary has appeared before the committee to discuss it. Have we got the resources to do additional inspections? Have we got the expertise among the staff? The inspectors will have different specialties. Is that an area that needs bolstering? Have we got the people and resources to do inspections properly across the board?

Shona Robison: Yes. HIS can draw on experts and inspectors from a range of different areas, depending on what kind of inspection is being undertaken. Obviously, we are giving inspections very high priority and will ensure that there are sufficient resources for them. We certainly have not had any concerns raised about that, but we keep a dialogue going to ensure that HIS has the level of resource that is required to do a good job, which I think it is doing.

On the balance of inspections, it is not the case that inspectors go in, inspect and that is the end of it. For the health improvement side of things, inspectors work with health boards, local management teams and staff to make the improvements that have been identified in a report, which is important. So, after issues have been identified and before the inspection team goes back in to ensure that their concerns have been addressed, the improvement processes will be put in place and staff will be helped to make the changes that they need to make. They are not just left to get on with it and to use best practice from elsewhere.

The Convener: I suppose that the concern is shared learning. We see many reports over a one or two-year period in which the same problems are identified. An inspection report is seen as something to survive, get over and manage publicly. In a two-year cycle, we might identify a problem in a hospital in a board area, then a year or even two years later we identify the same problem in another hospital in the same board. Why does that happen? Why is there no shared learning? Why are the issues that are addressed in one hospital not automatically pushed forward in others? That happens continuously, which is cause for concern.

Shona Robison: You raise a very good point. At the last meeting of board chairs, the message that I gave was about that. I told them not to wait for the inspection team to come in to inspect the services but to look at what has happened not just in the reports from hospitals in their own patch, but in the reports from hospitals in other boards. I told them to learn from them, and to ensure that they are proactively looking at the issues and, more important, that they are doing something about them.

We have taken that work further. Healthcare Improvement Scotland is also doing that work. It is learning from a report and then recommending to the health service that it needs to look at certain issues, which is exactly the convener's point—that boards should not be waiting for a report finding the same issues in another healthcare setting, but should be ensuring that their hospitals have already addressed those issues. We are stepping up that work. It is important, too, that senior management teams in each health board area take responsibility for that. There is also the role of the non-execs. A lot of boards are involving them more in that work. The convener has made a good point. What I want to see and to be confident about is that we are getting better at doing that. I hope that we will be able to demonstrate that to the committee.

The Convener: I hope that you will, but are we returning to a situation in which we spend all our time on inspections instead of on ensuring that learning is shared? I do not know whether you have assessed what needs to happen in the inspection service or evaluated the resources that the inspection agencies have, including whether their budgets and resources need to be increased, whether they need more full-time employees rather than part-time employees and whether they need to use experts from the health service in potential situations of conflict, so that people

whose careers depend on the health service are used to inspect the service rather than people who are independent of it. Do you agree that questions arise from that?

Shona Robison: In the budget, we have just allocated another £2.5 million for quality improvement, which is part of ensuring that we improve quality and that we learn and apply lessons and do not wait for inspections in order to do that.

Paul Gray (Scottish Government): There are two or three things to mention. First, I am sure that the committee is aware of this, but in case it is not, I point out that the chief executive of Healthcare Improvement Scotland comes to the meetings of chief executives and the chair of HIS comes to the meetings of the chairs. Therefore, although there is a degree of independence about what Healthcare Improvement Scotland does, nevertheless the points that the cabinet secretary and I have been making to the chief executives have been made with Healthcare Improvement Scotland in the room—it is not apart from those discussions.

Secondly, on the convener's point about whether it is appropriate to have inspections carried out by people who are in the NHS, the evidence in Healthcare Improvement Scotland's reports on, for example, NHS Lanarkshire and NHS Grampian make it fairly clear that colleagues from other parts of the service take their professional duties very seriously indeed. If a robust report is required, they will deliver one.

The risk that is associated with an improvement inspection or review being carried out by people who are not exclusively in the service when they carry out their day-to-day professional duties is that the inspection regime will depend on people who are not involved in day-to-day delivery of patient care and services. The committee is right to ask the question, but getting the balance right is very important; I want inspection regimes to continue to include people who are on the front line of delivery of patient care and services.

10:30

The Convener: That is maybe an issue we can move on to. Richard Simpson has a supplementary question.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): Does HIS look at the variation in the frequency of inspections? That is a theme that I have been pressing on a range of issues. For example, in the last report, Lothian had a rate of 48.1 bed occupied days and that had increased from 41.8. Compared with the target figure of 32, it is going in the wrong direction. Does HIS take that kind of thing into account? Those figures cover the whole of Lothian, which is a big area, and any hospital in there could be causing the problem.

Shona Robison: HIS would risk assess all that and decide where to focus its inspection. As Fiona McQueen said earlier, when HIS is making its plans for inspection processes for the coming year, it will consider all those factors and risk assess where it thinks its time will be best spent. It takes those factors into account.

Dr Simpson: The peripheral vascular catheter bundle report on Glasgow was repeated three times in three separate reports and the situation was still unsatisfactory so it is still a high priority. Under the MacLean report, what action do you expect HIS to take when it has to repeat something three times on the same high-priority issue, such as that the PVC bundle guidelines are not being followed appropriately?

Professor McQueen: Glasgow has taken that issue very seriously and invited in other help and support to make sure that the PVC bundle is put in place.

HIS would also take Health Protection Scotland's advice and look at the other infections, such as the bloodstream infections, that might be caused by the PVC bundles not being appropriately implemented. Glasgow's performance in that is good and it is looking at everything in the round. Health Protection Scotland will also advise HIS on looking at the monitoring of infections as a consequence of the bundles. PVC bundles are part of the patient safety programme, so there is a continuous improvement element to make sure that they are fully implemented.

Paul Gray: When Fiona McQueen took up her role as interim chief nursing officer, one of the first things that I discussed with her was my concern that we should follow through on inspection reports and that we should have assurances that that is happening.

If it would be helpful to the committee, we could, in due course, provide a report that describes the actions that we are taking, not just on the Vale of Leven, significant though that is, but to assure ourselves corporately that we are taking every inspection report seriously and that we are not simply waiting until the next time an inspection comes round to work out whether we have responded appropriately. It is entirely appropriate that we have that assurance, and I have asked Fiona McQueen to help me with providing it.

The Convener: That offer is appreciated. It is a long time since the committee has looked at the inspection regime. We looked at it in some detail previously, and we might want to come back to it at some point. Inspections are sometimes directed by the Government, such as those in the acute

sector, but an update on some of that work would be useful. We appreciate the offer and the cabinet secretary's offer of other information about the analysis that is currently being done.

We will move on. Nanette Milne will ask the next question.

Nanette Milne (North East Scotland) (Con): My original questions about communication have largely been pre-empted so I will go on to something else.

In my many years' experience of the health service, communication has always been an issue, not just with infection but proper communication between medical and nursing staff and patients. It is quite concerning that it is still an issue in the 21st century. I know that you have been working on that. Can any further steps be taken to get a proper culture of openness, from the top down to the patient level?

Shona Robison: We are looking at a duty of candour in the proposed public health bill. The most important thing is to reiterate the message of openness and the need to ensure that there is a duty on all staff in the organisation, no matter who they are, to report any concerns. We need to ensure that that becomes the culture.

There was an issue at the Vale of Leven. Some people brought concerns to the attention of others, but in some cases that was not acted on. Other people perhaps did not bring concerns to the attention of others. The duty of candour will add to the cultural changes that are happening and need to happen, which are about a culture of openness and people speaking up about things that they see that are not right.

Professor McQueen: Our person-centred programme, which puts people at the centre of everything that we do, will help. The Government expects there to be open visiting. If family and loved ones are in hospitals more, helping with care, that issue of communication almost disappears because they are there and know what is happening.

We expect fully open communication between people involved in decisions about care and the patient's loved ones. We know that at times getting access to consultants or nurses can be problematic, but we expect that to improve. Some of the person-centred work that we are doing is showing big improvements in how people experience communication. That will also be part of our care assurance programme.

Paul Gray: Let me start with something that does not work. There has been a long tradition in the NHS in Scotland of issuing things called chief executive letters, and I have more or less put a stop to that. There are times when CELs are necessary, such as when there is a legal requirement to convey information in that way, but to be simple about it, writing a letter to chief executives to say something is no way to get front-line staff to understand an issue or engage them in the delivery of something.

For example, the cabinet secretary did not write to chairs and say, "Dear chairs, here is the Vale of Level report. It is very important and I expect you to do something about it." Instead, we wrote to chairs and chief executives and said, "This is the Vale of Leven report and here are the recommendations. Now come and tell us what you are doing about it." That is why we are able to report to the committee today on the progress that we have made.

On the patient safety programme, we are increasingly embedding in the culture the importance of displaying in the ward, where patients and staff can see it, information on the trends on patient safety. I believe that as we become more transparent in the NHS in Scotland we will improve services. I have said to this committee and the Public Audit Committee that sometimes it will be difficult: sometimes we will see things transparently that we wish we had not seen. However, it is only by doing that that we will improve the service and give patients and staff the confidence that it is alright to say something.

One of the parts of the patient safety programme is that it gets people to speak to one another. For example, in wards and accident and emergency departments we have morning huddles, in which staff come together and discuss what the issues of the previous day have been and what issues can be foreseen for the day ahead. I have to say that that works 100 times better than a letter from me, telling people to do something. I am very serious about face-to-face communication; it is the way forward.

Nanette Milne: I am pleased to hear that. It is almost reminiscent of what we used to have, with nurses getting together and discussing patients when they handed them over. Lots of patients are still a little bit in awe of a white coat and a uniform. That could be much less formal and better communication would be great.

I want to ask about antibiotic prescribing. Lord MacLean was very critical of the mismatch, pre-2008, between the guidance on prescribing and the practice of it. I know that there have been advances since then, but are you confident that Lord MacLean's recommendations to address that will be carried out? The report also highlights unacceptable delays in starting appropriate antibiotic treatment for patients who are diagnosed with C difficile.

Shona Robison: There has been a huge amount of progress in this area, driven by the Scottish antimicrobial prescribing group. I do not know whether the committee has seen its latest report, which was published in January and is certainly worth reading. A huge amount of work has been done on the use of antibacterials in hospitals and on the appropriate prescribing practice, and that has shown big benefits in the reduction in infection levels of MRSA and C difficile. We have come a long way, particularly in relation to prescribing policies.

We have to stay one step ahead. I visited a hospital recently and we were talking about the success of the patient safety programme. We must always try to stay one step ahead of the next big challenge when it comes to infection, because we will always face new challenges. It is difficult to do that, but that is what the work in the patient safety programme is trying to do.

There is absolutely no complacency, although there is a lot of progress. Fighting infection in our hospitals is an on-going battle, and we must keep ahead of the challenges.

Professor McQueen: I do not have anything to add apart from that our acting chief medical officer, Dr Keel, sits on the controlling antimicrobial resistance group, which is part of the national UK approach. When you consider the numbers and the scale of the reduction in antibiotics that we want, you can see that it is happening.

As the cabinet secretary said, as part of the patient safety programme, the sepsis bundle, which is an indicator of getting antibiotics to the patient within an hour, is certainly showing some good progress. We are doing well.

Nanette Milne: There is also the specific issue in C difficile of narrow spectrum antibiotics, such as fidaxomicin—Dr Simpson will keep me right on this—which I believe is prescribed south of the border for a first occurrence or for people at risk of recurrence, whereas the Scottish Medicines Consortium recommendation for Scotland is to prescribe simply for first occurrence and not for those at high risk of recurrence. Do you have any comments to make on that? The prescribing of the drug is very patchy across health boards in Scotland.

Professor McQueen: What to prescribe is a matter for the health boards, in terms of their own formularies. Dr Keel's group, under the HEI task force, will be looking at prescribing. Health Protection Scotland also gives us views and advice on prescribing. The treatment of the individual patient is up to the clinician; it is for the doctor to make a decision on what is best for their patient.

Dennis Robertson (Aberdeenshire West) (SNP): I was going to ask about antibiotics, but I shall move on. There was a question about the time taken to get a specimen to the laboratories for identification and getting the results back from the lab to the doctors. Has that improved?

Shona Robison: Yes, it certainly has. When I visited Aberdeen royal infirmary, I had the opportunity to go behind the scenes to visit the labs, and what struck me was the amount of technology and the technological improvements that have been brought in to speed up a whole range of procedures and tests that have transformed the ability to get important information back into the hands of clinicians who are making judgments. Things have improved significantly.

Fiona McQueen may have more to say about that.

Professor McQueen: No, I have nothing to add.

10:45

Dennis Robertson: In your opening statement, you referred to the reference group. Are there members of the reference group from all over Scotland, reflecting the different requirements of each health board?

Shona Robison: I shall let Fiona McQueen say a bit more about that. I have met some of the Vale of Leven families on a number of occasions. It was important that they were satisfied with the arrangements that were being put in place, and the reference group was born out of those discussions. We wanted to ensure that those people had an on-going involvement and an important role, but we also recognised that there is a Scotland-wide perspective, and Fiona McQueen has looked at that through her work with the group.

Professor McQueen: I am not sure that we have somebody from every geographical area of Scotland in the group. Families from the Vale are represented, but we also have public partners from Healthcare Improvement Scotland and third-sector voluntary organisations such as the Health and Social Care Alliance Scotland and the Scottish health council. Representative bodies that can play a representative role across Scotland are working with us.

Dennis Robertson: Is it important, given the situation in the Vale, that each area can have confidence that it is being represented on the reference group?

Shona Robison: Yes. Of course, lot of the work of implementing the recommendations is for the boards to take forward. Public partners are involved in that—we would expect boards to

involve their public partners in that work. The reference group's role is a bit wider, in that it is about ensuring that the work of the implementation group is overseen and that the public get the reassurance that there is enough pace and monitoring. In terms of local detail, we would also expect boards to involve public partners and their non-executives in driving forward the improvements that need to be made.

Dennis Robertson: Can you advise us on what discussions have taken place with the General Medical Council, given that it is the regulator for the medical profession? What is its view on Lord MacLean's report?

Paul Gray: We put the report in front of the GMC and the Nursing and Midwifery Council at the time. If the committee would find it helpful, I could ask Dr Keel to give a report in writing on engagement with the GMC on the issue. I do not think that it would be right for me to try and give a superficial account of that, but if the committee wishes I can certainly ask Dr Keel to provide a report.

Dennis Robertson: Has detailed discussion taken place?

Paul Gray: Yes. We have already been in touch with the GMC.

Richard Lyle (Central Scotland) (SNP): I had intended to ask one of the questions that Dennis Robertson has just asked, but I am more than happy to move on to another question. Lord MacLean made six recommendations to NHS boards on medical care—recommendations 36 to 41. They covered a range of measures including having sufficient medical staffing levels; undertaking clinical assessment of patients with suspected C diff; having clear and accurate patient records; and ensuring that there is no unnecessary delay in processing laboratory specimens. He found that medical care of patients suffering C diff was inadequate and that there had been poor record keeping, failures to carry out proper medical assessments and reviews, inappropriate prescribing, and unacceptable delays in the commencement of appropriate antibiotic treatment, which has been mentioned.

What does the cabinet secretary expect from NHS boards, to ensure that the lessons from Lord MacLean's report about the failures of medical care are learned?

Shona Robison: Before I answer that question, having just looked at the figures that the convener asked about earlier, I can say that 11 boards have met 80 per cent of the recommendations, and those recommendations apply to the 14 territorial boards. The average is 75 per cent across all of the boards. I hope that that clarifies the point.

The Convener: There are slight variances—

Shona Robison: I know, but it is important to put that on the record.

Richard Lyle's point gets to the nub of some of the issues surrounding medical care and nursing care. There was appalling practice. Poor record keeping was part of it, but on the whole there was poor care on the part of clinicians, doctors and nurses. That was laid bare in the report.

We have already touched on some of what has happened since then to make sure that there are no delays and that information on tests comes back. All of that is completely different from what it previously was. Record keeping has improved, but we need to keep a watchful eye on it, because sometimes still when complaints are raised, record keeping is an issue—it is not an issue to the extent that it was in the Vale of Leven report, but there are still areas that we need to improve, as it is important.

Poor communication in medical and nursing care was also highlighted very clearly. Again, although huge improvements have been made since the report came out, that is something that we need to keep on top of, because often when complaints are made, the issue is poor communication, particularly with families.

We are not complacent by any manner or means. We want to make sure that, when any other complaints are investigated or reports come up, we are always trying to make further improvements.

Do you want to say anything further about medical care, Paul?

Paul Gray: I think that this is an integral part of the board responses.

In response to Mr Lyle, I say that what I am concerned to see is that the board responses to the 65 recommendations are all of a piece, so that there is not a sense that one thing is down to doctors, another is down to nurses and another is down to cleaners, as though we had gone back to a silo approach that left people with the impression that, as long as they did their bit, everything would be fine. It only works when we join things up. In my view, the Scottish patient safety programme has greatly improved the communication between medical and nursing staff, allied health professionals and other staff who provide services face to face with patients.

My response to Mr Lyle is that it is important that we set those very important recommendations in the wider context of our whole delivery against the recommendations. I can certainly assure you, however, that the national clinical director for healthcare quality, Professor Jason Leitch, who leads the patient safety programme, as well as the

acting chief medical officer and the chief nursing officer, have been personally engaged in ensuring that the recommendations for all parts of the service are met appropriately and in line with our current safety standards.

Richard Lyle: Based on the time that I have known you, Mr Gray, I know that you are committed to the NHS and that you want to drive it forward and ensure that we have the best service in the world.

You said earlier that you do not do chief executive letters any longer. Given that Lord MacLean stated that NHS Greater Glasgow and Clyde learned lessons from the failures after 2008, what work are you undertaking to ensure that these lessons are rolled out to all NHS boards? I know that you are not doing letters, but what instructions are you putting down to the boards to say that we cannot tolerate this situation?

Paul Gray: As I have said, I have tried to greatly reduce the number of instructions, but there are certain circumstances in which I cannot do what has to be done by any other means. However, what I am seeking to convey to the committee is that I am not going to hide behind a letter and say, "Well, I've done my bit of the job by writing this." Both the cabinet secretary and I have engaged directly with the chairs and chief executives and when Professor McQueen has completed her analysis of the responses we will take it directly to the chief executives and chairs and discuss the quality and timeliness of the response and their plans for implementation as overseen by the implementation group. This is not some on-off thing that the cabinet secretary or I have done; we have done our duty by ensuring the production of a plan. This will be kept under review and will be the subject of direct discussion with chairs and chief executives.

Richard Lyle: If you will allow me, convener, I want to ask the cabinet secretary a final question. What further actions do you believe are required to implement Lord MacLean's recommendations on the matter that we have just discussed?

Shona Robison: First of all, we have to ensure that we and the implementation group are satisfied that all the recommendations are being properly implemented. Indeed, we talked earlier about the oversight and monitoring of all of this. It will absolutely not be a tick-box exercise; this is about ensuring that we also monitor those changes that have already happened. It is worth reiterating that boards did not wait for the recommendations in Lord MacLean's report and that many of the fundamental things had already been actioned and changes had been made, as you would have expected with such important and fundamental issues. We are now down to some of the other recommendations that are probably going to take a little bit more time, but they will absolutely be implemented. The issue, then, is to ensure that all this is monitored and that the foot is not taken off the pedal. We need to keep up the pressure and scrutinise these fundamental aspects of the delivery of healthcare.

I simply want to reassure the committee that we will be monitoring the situation and ensuring that boards do not just say, "We've done it." We have to know that they have done it, and we will monitor the on-going effectiveness of the recommendations that have been implemented.

The Convener: Thank you for that. We now move to Richard Simpson.

Dr Simpson: I want to ask two quick questions. The first is about recommendation 74, which is about comparison with other jurisdictions. One of the problems is that Wales, Northern Ireland and England report these things differently, and it might be useful to discuss with them having a uniform system of reporting to ensure that any opportunity to learn lessons is based on comparable data.

Two areas of variation interest me, the first of which is that England reports from the age of two while we report from the age of 15. I appreciate that there are probably very few cases between the ages of two and 15 but, even if the number of cases is small, it might be useful to understand why there is such a difference.

The other area of variation, which has been partly highlighted by Nanette Milne, is the difference in guidance on fidaxomicin, which is recommended for potential recurrences in high-risk patients in England but not in Scotland. I appreciate that that is a new drug, that it has just come out and that it is expensive but, given the difference in guidance, it might be interesting to ask the Scottish Medicines Consortium what the reasons for that are. If it has good reasons, we should stick to our guns on the matter, but it would be interesting to have that information.

Finally, what other things have you looked at with regard to recommendation 74 and various areas of variation that might tell us something?

11:00

Shona Robison: On the broader points, we absolutely learn from any reports. We wrote to boards to ask them to consider the findings of the Francis report. Obviously, we are awaiting the report on Morecambe Bay hospital and will ensure that lessons are learned for the service here.

On communication, last week I had a videoconference with the Welsh Minister for Health and Social Services. One of the issues that we were looking at was the sharing of the Vale of

Leven recommendations with the rest of the United Kingdom. He was keen to look at the application of the recommendations to the health service in Wales.

I understand what you are saying about the fact that the systems are sometimes different, and there may be good reasons why we sometimes do things in a different way. However, there are always lessons to be learned from difficult and challenging reports, no matter where the situation that they are concerned with has occurred, whether that is in these islands or further afield.

Fiona McQueen might be able to say something about the two-to-15 issue.

Professor McQueen: I think that we can ask Health Protection Scotland for advice about the differences. With the issue of fidaxomicin, we can go back to the SMC and write back to the committee on that point.

Shona Robison: We will get back to you on that.

Dr Simpson: My other question is on chapter 16, on death certification, and whether the issues around recording have been sorted out. One of the issues that the Vale of Leven families were concerned about was the fact that it was not always recorded that C difficile was a contributory factor. I hope that, if a patient experienced an episode of C difficile, we record that that is the case, even if they subsequently died from another cause, because the weakening of their condition due to C difficile is an important factor and should be explained to the families. Have those recommendations—68 to 71—been taken on board?

Shona Robison: As I am sure that you are aware, deaths through healthcare associated infection are already recorded by the National Records of Scotland and, since September 2008, the General Register Office for Scotland has published information about C difficile infection deaths on its website. However, under provisions of the Certification of Death (Scotland) Act 2011 that will come into force this year, an additional review mechanism will be provided, which will include random sampling and will give ministers the discretion to direct a review in any area of concern. That is another check in the system.

Paul Gray: The only other thing to say in response to Dr Simpson is that we are reviewing what the boards have put to us and we will ensure that this committee is given information on the progress on the recommendations that were not for the boards. As I said to Mr Lyle, we want to give a complete picture of the situation and not be piecemeal about it.

I entirely understand the point about accurate recording and death certification and the need to ensure as far as possible that it reflects the actual circumstances and not just a single cause that might have had other contributory factors.

Dennis Robertson: With reference to the certificates, co-morbidity makes it quite difficult to state the cause of death. Are you saying that the other factors and ailments will be recorded in the certificate? There are many reasons why people die—sometimes on an operating table, for instance—and it can be difficult to identify the cause. Are you giving us an assurance that all aspects of the patient's health that could be seen as a contributing factor to their death will be recorded?

Paul Gray: No. I cannot give such an assurance because, clearly, the decision on what to record rests with the person who is recording the information. I am not clinically qualified to decide on or overrule any such decision. However, as the cabinet secretary has said, under the new provisions, if there is a concern, based on the sampling, about the extent, accuracy or completeness of the recording, there will be an opportunity for that to be reviewed. It would be wrong of me to give the committee the absolute assurance that you seek. Indeed, the fact that there is a review mechanism in place suggests that we will want to keep an eye on this issue.

Dennis Robertson: Would it be clinicians and/or patients' relatives who would ask for a review if they were not satisfied with the certificate of death?

Paul Gray: I think that that can already be done, but if the committee would find it helpful, we can provide a more detailed briefing on what effect the legislative provisions are intended to have.

Bob Doris: I have a brief question about the recording of cases of C diff within the hospital estate. If you want to write to me with information on the issue that my question deals with, that would be fine, because I am keen to allow the constituency member to ask questions.

I understand that many people who present at hospital will be found to have C diff when they are screened on arrival. There is an issue with footfall and whether people who are found to have C diff contract it while they are in hospital. Tragically, C diff might be a contributing factor to a person's death and that might be mentioned on the death certificate, but they might have had it on entry to hospital. Is that nuance captured in the statistics? I am conscious that I do not want to tie health boards up in bureaucracy, but I would like to get an understanding of what the statistics tell us about the patient flow and how C diff moves

through the hospital estate. Is that nuance picked up in the statistics?

Shona Robison: Yes, it is. You are quite right to highlight the fact that people from the community often bring infections into hospital. That is one of the challenges that we face.

The recording of hospital acquired infection is specifically about infections that are acquired in hospital rather than ones that are acquired in the community. That is an important distinction. We record cases in which an infection has been passed from one patient to another.

Professor McQueen: That point is well made. Many people have Clostridium difficile in their systems and live healthy lives. That would be a problem if they were given other drugs that caused a flare-up or, tragically, if the infection were to be transmitted in hospital. Those figures are recorded as such.

Bob Doris: Thank you.

The Convener: I thank committee members. I will now give Jackie Baillie, the member for Dumbarton/Vale of Leven, the opportunity to ask some questions.

Jackie Baillie (Dumbarton) (Lab): Thank you very much, convener. I thank the committee for the opportunity that is being afforded to me.

At the outset, I put on record my welcome for the approach that the cabinet secretary has taken, particularly as regards the involvement of the affected families in the implementation group. To date, the reports that the families have given me on the discussions have all been extremely positive. I very much welcome that.

I crave your forgiveness, cabinet secretary, because I lack confidence in self-assessment. I note that you asked the boards, in the initial phase, to self-assess where they were against the recommendations. You will be aware that self-assessment was part of the problem in the first place. Health boards were asked to self-assess their HAI measures, and they comprehensively failed to do so.

Given that I think that we agree that we want on-the-ground verification that the situation that has been reported is real, will that verification have taken place with all health boards—I am not talking about a paper-based exercise—before you report to us in the spring?

Shona Robison: You make an important point. The involvement of the families in the implementation group and the reference group is extremely important. You are right that self-assessment takes us only so far. It was a starting point. We needed boards to tell us where they were at in relation to the recommendations. The implementation group has a clear understanding that its job is to verify, monitor and check that that is indeed the case, not just on the 65 recommendations for the NHS but on all 75 recommendations, which include recommendations for others to implement. That will be an on-going process. By the spring, we will have got to a good position as far as our response to the report is concerned.

However, we want the work of the implementation group to go beyond that. There will be on-going work to make sure that the group is satisfied—and, in particular, that the families are satisfied—that, no matter which health board it is, the boards have changed practice where that needed to change, bearing in mind that a lot of the recommendations on some of the fundamental issues were implemented well before Lord MacLean reported.

The reference group provides an additional level of scrutiny to all of that. It will scrutinise the implementation group to give families more satisfaction and reassurance that the implementation group itself is doing a good job of monitoring everything.

I feel that we have put in enough safeguards and I think that you are right that the families—to date, anyway—feel that they have been involved. However, we are not complacent and we want to make sure that that continues to be the case.

Jackie Baillie: Cabinet secretary, I suppose that what I want to know in my head is that, by the time you stand up in the spring, what those self-assessments say will be real. I accept what you are doing in the medium term but I wonder whether, in relation to that short-term check, the Healthcare Environment Inspectorate has a role to play in going in and checking the validity of what is being said.

I am also intrigued by your comment that 11 boards have reached the 80 per cent mark. Which ones have not and how close are they?

Shona Robison: When I stand up in the spring, I will want to have been assured that the implementation of the recommendations is real and making a difference. However, the longer piece of work for the implementation group is to keep up the momentum behind the recommendations, because this is not about a moment in time. It is not a case of saying, "Job done—everybody's happy." It is about ensuring that the culture changes made by the recommendations are in place for ever. It is important that families are involved and are reassured in that respect.

The three boards that have to make further progress are Dumfries and Galloway, Lothian and Orkney. They have fully or mostly implemented

less than 80 per cent of the 65 recommendations—but only just. Compliance for all three is in the 70 per cent range. We will make sure that those three boards get to the position that the other boards are in and that all boards implement all the recommendations. There are no ifs and buts—that is exactly what will happen.

Jackie Baillie: Thank you for that response. I want to move on to the HAI taskforce, or whatever we are calling it—we got a bit lost in language earlier. I will be as blunt as possible: NHS Greater Glasgow and Clyde had an infection control team, an infection control committee and all those structures in place, but they just failed to work.

Although I hear what Fiona McQueen is saying and although I absolutely agree on the need for such structures and accountability, Greater Glasgow and Clyde would argue that it had the reporting mechanisms in place to enable people to go from ward to board. We know from the report that, from July 2007, the clinician responsible did not attend meetings that she was responsible for chairing and that she did not attend Greater Glasgow and Clyde meetings for 18 months over the period when the infection was raging at the Vale of Leven hospital. Those systems were in place—indeed, we have just had a description of them—so what, specifically, is different?

Shona Robison: I can tell you that directly. I get alerted straight away about C diff cases or any other infection in hospitals in Glasgow, in Clyde or elsewhere, because the monitoring systems work. That information is relayed very quickly to us and in all cases any required action is taken very quickly. They are not necessarily outbreaks; they can simply be individual cases of C diff. That dashboard is working—and I know that it is working because I get alerts about cases. That would not have been the case in the Vale of Leven hospital and certainly not in Glasgow. I have seen for myself that the speed of the information is very different.

11:15

I am reassured not just that we have the processes and the people in place but that the system works and the flow of information—and, more important, the response to that information—is very quick. For example, patients are isolated and all the procedures that we would expect to kick in to prevent infection spread happen. When I go into hospitals now, I see live screens that very visibly tell the story about who is where and, if there are any cases, where they are. That information is there for everyone, not least the staff, to know, and anybody who comes on shift will know what the picture is at that moment in time.

I hope that I can reassure members on this matter. I have seen what is happening for myself, and I am absolutely reassured that the systems are now working and that, as a result, the situation that arose in the Vale of Leven hospital cannot happen again. The point is that many people are watching and monitoring that information for very good reasons and that we are not relying on a single person in the system to report. There are many people whose job is to ensure that matters are monitored and acted on.

Jackie Baillie: That is helpful to know.

Fiona McQueen might have said this inadvertently—or maybe I just misheard her—but she mentioned “reconvening” the national task force. Has it been dormant?

Professor McQueen: No, and I have tried to correct that suggestion. There is a national advisory group, and there are different structures that I think could be more efficient. I am therefore reforming a smaller and more efficient, effective and targeted group and renaming it.

Jackie Baillie: That is great. We like reform and efficiency—they are always good things.

The cabinet secretary raised the question of isolation facilities, which were particularly lacking at the Vale of Leven hospital. Can she advise the committee whether isolation rooms are now available in every hospital in Scotland?

Shona Robison: When there is an alert that someone is infected, a test will come back and the person will, as I described earlier, be moved immediately. In fact, if there are any suspicions, the person will not be in a bed alongside other people; the processes kick in straight away to minimise infection. That often happens while the test is being commissioned and the results awaited.

The way in which infection is handled is very different, and staff now know how to minimise infection potential. Unfortunately, there are still cases of hospital acquired infection, but the drop in the numbers tells its own story. The procedures, which include isolation not just when the test comes back but when there are suspicions, and all the other actions that staff now know about to ensure good infection control have resulted in huge reductions in HAIs.

Jackie Baillie: I accept what you have said about the process, but a significant challenge that nurses highlighted was that they needed isolation facilities to fulfil the process that you have described, but the facilities were just not physically there. That caused quite severe on-going problems at the Vale of Leven hospital.

My question was quite specific. Do we have the physical facilities to enable the process that you have described to happen?

Shona Robison: To give you an example, I saw for myself when I visited Glasgow royal infirmary that someone with an infection is very visibly isolated. The information makes it very clear what barrier is required, and staff and patients are alerted about the person's space. All of that is very different from some of the unfortunate issues that we had at the Vale of Leven.

Jackie Baillie: There is real pressure on beds at the moment, which was another feature at the Vale of Leven. The hospital was operating under a great deal of pressure. Over the winter period, there was significant footfall at the front door, and we are now seeing the same across Scotland. In such situations, hospitals open new beds to cope with the pressure, albeit on an interim basis, but they tend to be squeezed into the same space and are much closer together than is desirable. How do we ensure that that does not happen again in response to temporary pressures, such as those that we are currently seeing in the NHS?

Shona Robison: The system has faced challenges over the winter. There is work to be done on what has happened with the acuity of patients, particularly in NHS Greater Glasgow and Clyde, and we are also looking at issues to do with late flu surges. All of that has led, as you have rightly pointed out, to pressure on beds.

However, a lot of preparation happens for winter. Surge beds are planned for and are open when required, but we expect the guidelines on space, staffing and infection control to be the same for surge beds as for the beds that are in the system the rest of the year.

We are also developing and expanding the use of intermediate care beds. It is really important that the infection control systems for those beds are good, because they are quite often used for elderly people who are on their way home. Although they are clinically ready for discharge, they are not ready to go home and are potentially vulnerable to infection. As a result, we need to ensure that the protocols and guidelines for those beds are good and that they follow best practice in infection control.

We absolutely need to ensure that, when there is a high volume of beds and high turnaround, the cleanliness standards are met. We are keeping a close eye on that to ensure that enough time is spent on cleaning the patient area when someone is discharged from a bed and someone else comes in.

We need to keep a close eye on all those issues, not just during the winter, when beds are particularly in demand, but all year round. That is best practice and we know that it controls infection.

Jackie Baillie: This will be my final question, as I think that I am testing the convener's patience.

Recommendation 7 of the public inquiry report deals with situations in which there is structural reorganisation or significant change. It talks about

"regular reviews of the process"

and says that a review should

"include an independent audit."

I am conscious that the new Southern general hospital is probably the largest project of its kind, certainly in the Scottish NHS if not in the NHS across the United Kingdom. Has there been an independent audit of infection control? If so, when was it undertaken and by whom?

Shona Robison: On service change, you will know that, in the Vale of Leven case, there was a lack of certainty over the hospital at the time. I described it in my statement as a hospital that was

"out of sight and out of mind."—[*Official Report*, 25 November 2014; c 29.]

It was not being given the attention that it should have been given, and the lack of certainty about its future played into the issues with staff morale and all of that. Absolutely, lessons had to be learned—and they have been, as far as any service change proposal is concerned.

The new south Glasgow hospital marks a huge change as part of a long-standing acute services review in Glasgow. The new hospital's facilities are second to none and state of the art, and all the processes and procedures will be tested before staff and patients migrate to the site from April onwards. As Jackie Baillie will imagine, that will be no small feat. Migrating all the services on to the new site is a big job, and infection control is critical in that. One reason why the hospital has been built in the way that it has been, with single rooms, is partly to do with a desire to follow best practice in infection control procedures. That is part of the building's design. As a result, the member can be assured that all of those issues will absolutely be taken forward.

Jackie Baillie: I want to press you on that, given that a new hospital is going to open in the NHS Greater Glasgow and Clyde area after the public inquiry has reported. There was a specific recommendation that an independent audit be carried out. Has it been carried out? If so, when and by whom was it carried out, and can we see the conclusions?

Shona Robison: I will certainly get that information to Jackie Baillie. I do not know whether Paul Gray wants to comment.

Paul Gray: The cabinet secretary has met the chair and chief executive of NHS Greater Glasgow and Clyde to discuss the plans for opening the new hospital, and I was part of that discussion. We have asked for an update on the whole scope of the plans. If it is helpful to the committee, we can provide information, including a response to Ms Baillie's question.

The Convener: Can we cut to the chase? Has an audit been carried out as per the recommendation?

Paul Gray: I have not had the report, so the answer is that I do not yet know.

The Convener: Right. So you do not know.

Shona Robison: We will have to check that. We will do so and get the answer to you and Jackie Baillie.

The Convener: That is fine. We want to know whether an audit has taken place and what information is available.

Shona Robison: If it has not taken place, it will. We will check that.

The Convener: Okay. I thank members, including Jackie Baillie. Most of all, I thank the cabinet secretary and her colleagues for giving us their valuable time and their evidence.

As previously agreed, we will now go into private for agenda item 2.

11:27

Meeting continued in private until 11:33.

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