NHS Greater Glasgow & Clyde

NHS Board Meeting **15th December 2015**

Dr Jennifer Armstrong
Medical Director

Paper No: 15/67

Vale of Leven Inquiry: Update on Progress in the Implementation of the Recommendations

Recommendation: The Board are asked to note this update.

Purpose of Paper: To update the committee on progress on implementation of the Vale of Leven Inquiry recommendations within NHSGGC.

Key Issues to be considered: Note progress to date and consider actions required to fully address remaining gaps.

Any Patient Safety /Patient Experience Issues: A number of the recommendations have direct and positive impact on patient experience.

Any Financial Implications from this Paper: None

Any Staffing Implications from this Paper: None

Any Equality Implications from this Paper: None

Any Health Inequalities Implications from this Paper: None

Highlight the Corporate Plan priorities to which your paper relates: "An effective organisation".

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Infection Prevention & Control Service
Report for NHS Board Meeting, December 2015

The Vale of Leven Hospital Inquiry
Update on Progress in the Implementation of the Recommendations

Background:

The Rt Hon Lord MacLean published his final report of the Vale of Leven Hospital Inquiry on November 14, 2014 into the occurrence of *Clostridium difficile (C. diff)* infection at the Vale of Leven Hospital (VOLH) from January 1, 2007 onwards, in particular between December 1, 2007 and June 1, 2008.

The Cabinet Secretary for Health, Wellbeing and Sport provided an initial response to the Scottish Parliament on November 25, 2014 when all 75 recommendations were accepted (65 for NHS boards, nine for Scottish Government and one for the Crown office and Procurator Fiscal Service.

The Scottish Government response to the report has been published:-

http://www.gov.scot/Topics/Health/Services/Preventing-Healthcare-Infections/Valelevenhospitalinquiry

Progress since Lord MacLean published his report:

- The Scottish Government wrote to all NHS Boards asking that they assess themselves against the 65 NHS Board recommendations in the report and responses were received in January 2015.

- Scottish Government has established an Implementation Group to oversee the implementation of all 75 recommendations. A Reference Group has also been established with representatives of the patients and families of those affected on it and the Group's role will be to support and challenge the Implementation Group.

Progress Update:

- The national Implementation Group are in the process of developing a national plan with timescales and milestones to show progress against each recommendation. It is also considering the best way to demonstrate that the recommendations are being implemented by each and every NHS Board on the ground. It is anticipated that we will have further guidance from Scottish Government early in 2016.

- The attached template and Gap Analysis details progress to date within NHSGGC against each of the relevant recommendations:-
    - 10 of the recommendations require further guidance from Scottish Government and 1 requires further guidance from the Crown Office and Procurator Fiscal service.
    - From the remaining 64 recommendations, NHSGGC has fully implemented 47 and partially implemented 16. Good progress is demonstrated against those partially implemented with a number depending on progress of major developments e.g. CAAS. Recommendation 67 is not applicable to NHSGGC.

A subgroup of the Board Infection Control Committee will convene in January 2016 to review ongoing progress and any further guidance from Scottish Government. A subsequent update will be provided to the February 2016 NHS Board meeting.

Recommendation	Response chapter Section	GGC GAPS	GAPS - PROGRESS UPDATE
1. Scottish Government should ensure that the Healthcare Environment Inspectorate (HEI) has the power to close a ward to new admissions if the HEI concludes that there is a real risk to the safety of patients. In the event of such a closure, an urgent action plan should be devised with the infection prevention and control team and management.	2.1	**SGHD action.**	
2. Scottish Government should ensure that policies and guidance on healthcare associated infection are accompanied by an implementation strategy and that implementation is monitored.	2.1	**SGHD action.**	
3. Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart.	2.1, 3.2	All NHSGGC policies are now reviewed 2 yearly. The national manual is on the desk top of all PCs in NHSGGC. Complete	
4. Scottish Government should develop local healthcare Associated infection (HAI) Task Forces within each Health Board area.	2.1	Awaiting formal confirmation from SGHD. Our understanding is that the Board Infection Control Committee and Board IPCT fulfil this remit. **SGHD action**	

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5. Scottish Government should ensure that where any uncertainty over the future of any hospital or service exists, resolution of the uncertainty is not delayed any longer than is essential for planning and consultation to take place.	2.1	**SGHD action.**	
6. Scottish Government should ensure that where major changes in patient services are planned there should be clear and effective plans in place for continuity of safe patient care during the period of planning and change.	2.1	**SGHD action.**	
7. In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment, should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.	2.2	Complete	

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8. In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.	2.2	Complete	OD process and management structure in place.
9. Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level.	2.2	Complete	Infection control has been added as a standing item to the agenda templates and being included in refreshed terms of reference for clinical governance forums across the Boards arrangements.
10. Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where appropriate, relatives should also be involved.	4.2	Complete	
11. Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient's care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.	4.2	Complete	

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12. Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.	4.2	Complete	
13. Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board.	2.2	Medical Director – Professional Accountability and structure in place. Revised professional structure to be submitted. CASS to be implemented.	Professional governance arrangements revised and as of 1st June 2015 new arrangements in place. Professional reporting template agreed and now used for all professional meetings from SCN to Board Nurse Director.
14. Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records, and that there is effective scrutiny of audits by the Board.	3.3, 4.2	Complete	

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15. Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure.	4.2	Complete	
16. Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team.	3.2, 4.2	Complete	
17. Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient's status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously.	2.1	Complete	
18. Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.	4.1	Confirm new generic care plan has been rolled out to all areas.	Acute services new generic care plan rolled out in March 2015. This is now in use in all adult acute inpatient areas.

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19. Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in patient notes and are included in care planning for the patient.	4.1,4.2	Complete	
20. Health Boards should ensure that where a patient has, or is suspected of having, C.difficile diarrhoea a proper record of the patient's stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance.	4.1	Requires full implementation of CAAS to monitor compliance.	This is included in the SCN schedule audits and monitored by Lead Nurses.
21. Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods.	4.2	Monitoring compliance with this has still to be implemented via the Universal Patient Feedback Questionnaire which will have a specific question on the availability of staff to answer questions on care during visiting times. Monitored via CAAS.	The availability of staff during periods of visiting has been re-emphasised with staff.

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22. Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient's continuing care is recorded in the patient's notes to ensure that those caring for the patient are aware of the information given.	4.2	Confirm new generic care plan has been rolled out to all areas. This will reinforce the need to record discussion with patients and relatives. This will be monitored via the lead nurse audit programme. Complete	Acute services new generic care plan rolled out in March 2015. This is now in use in all acute inpatient areas. Space within care plan for discussion of care and negotiated care with patient and / or relative / carer. This is monitored as part of Lead Nurse documentation audits.
23. Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN.	4.3	Two of the TV nurses still to complete professional portfolio.	There are 10 Tissue Viability Nurses within the Board, 9 have completed (90%) their professional portfolio and 1 who is currently on Maternity Leave will complete in March 2016.
24. Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient.	4.1	Complete	TVNs complete NHSGGC wound assessment chart at each wound assessment which includes: 1. Analgesia Required 2. Wound Dimensions 3. Tiussue Type 4. Exudate levels 5. Peri wound skin 6. Signs of infection 7. Treatment objectives 8. Cleansing method and rationale 9. Dressing choice and rationale 10. Frequency of dressing choice

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25. Health Boards should ensure that every patient is assessed for risk of pressure damage on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit.	4.1	SPSP bundle is still being tested	SPSI testing on version 3 of Pressure Ulcer Risk Assessment (PURA) complete. Proposal being finalised for Acute Division to replace Waterlow risk assessment with PURA which focuses on daily risk assessment. Proposal will include sector timetables for roll out, education and post implementation audit. There will be no change to the use of risk assessment (Waterlow) for Partnerships.
26. Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient's condition. Compliance should be monitored by a system of audit.	3.3, 4.1	Requires full implementation of CAAS to monitor compliance.	The new wound grading tool is now in place across NHSGGC. Ongoing Tissue Viability Nurse led education continues to be delivered across the Board in relation to pressure ulcer grading and wound care. An acute wide audit of accuracy and appropriateness of treatment has been completed and fed back to Chief Nurses.
27. Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit.	4.1	Requires full implementation of CAAS to monitor compliance.	A revision of active care is currently being finalised which includes supplementary guidance in relation to pressure area care. This is to ensure the frequency of active care which includes patient positional changes is effectively prescribed for patients at high risk.

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28. Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support.	4.1	Requires full implementation of CAAS to monitor compliance Complete	The use of the MUST nutritional tool is included in the NAD, the scoring of which determines the requirement for onward referral for dietetics support. Compliance is monitored via monthly documentation audit. Monitored by CQIs monthly and via nursing documentation audits corporately and by Lead Nurses to ensure compliance with nutritional screening. CSM Dietetics collects and presents data in relation to the timeliness of referrals to the dietetic service and presents to the FFN PIG.
29. Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays.	3.1, 4.1	Requires full implementation of CAAS to monitor compliance Complete	Staff are aware of the process for repairing faulty equipment and there is a contingency system in place for ongoing access to equipment in the interim.
30. Health Boards should ensure that where patients require fluid monitoring as part of their critical care, nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period.	4.1	Requires full implementation of CAAS to monitor compliance Complete	A revised fluid balance chart was introduced within acute services in October 2015. The chart includes guidance on how to use it. Compliance is monitored through documentation audit. There is ongoing education delivered on a needs basis.

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31. Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes, (due to acuity and/or dependency) an agreed review framework and process should be in place to ensure that the appropriate skills base and resource requirements are easily provided.	4.1	Requires sign off of: Roster Policy Feasibility Study Monitoring and Escalation Guidance.	Rostering feasibility completed. Roster Policy – Sign off by NMAHP Workforce Planning Group. Presented for final sign off at the September Area Partnership Forum. Partnerships service following a similar process.
32. Health Boards should ensure that there is straightforward and timely escalation process for nurses to report concerns about staffing numbers/ skill mix.	3.1, 4.1	Monitoring and Escalation Guidance	Monitoring and Escalation Guidance – Sign off by NMAHP Workforce Planning Group. Presented for final sign off at the September Area Partnership Forum. Partnerships service following a similar process.
33. Health Boards should ensure that where a complaint is made about nursing practice on a ward this complaint is investigated by an independent senior member of Nursing Management.	3.1, 4.1	Complete	The Board's Complaints Policy has been updated August 2015 to reflect this requirement and this has been widely disseminated.
34. Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay.	3.2	Complete	

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35. Scottish Government should monitor the implementation of policies and/ or guidance on antibiotic prescribing issued in connection with healthcare associated infection and seek assurance within specified time limits that implementation has taken place.	3.2	**SGHD action.**	
36. Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high-quality care.	4.1	Ongoing process	A review of junior medical staffing has taken place across all of the Board's acute sites with some re-allocation of posts where meets educational needs.
37. Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis.	4.1	Complete	
38. Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff.	3.3, 4.2	Process for Medical Documentation audit to be confirmed	Medical documentation is part of routine audit at the Vale of Leven Hospital. The Board is establishing a formalised process for morbidity and mortality reviews to be rolled out across departments with the participation of senior medical staff. This will include an assessment of the adequacy of documentation.

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39. Health Boards should ensure that medical and nursing staff are aware that a DNAR1 decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy.	4.1	As part of the Board's Deteriorating Patients work GGC have identified a need to improve the discussion and communication about patients' ceiling of care. DNACPR is part of that discussion. A pilot of this is currently ongoing in the Southern General.	DNACPR awareness is part of induction and mandatory training for all doctors. In addition, through the Deteriorating patients work in GG&C, a pilot project to more robustly document patients' ceiling of treatment has been commenced. This will include the documentation of discussions with patients and relatives.
40. Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management.	3.2	Complete	
41. Health Boards should ensure that there is no unnecessary delay in processing laboratory specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed.	3.2	Complete	

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42. Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention control training that includes CDI on appointment and regularly thereafter. Staff records should be audited to ensure that such training has taken place.	4.3	Reports on numbers of modules completed are submitted to sector/directorates and to AICC and PICSG. A method of auditing staff records or determining denominators is still to be developed.	
43. Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control of which a record should be kept.	4.3	Complete	
44. Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles.	4.1	Complete	
45. Health Boards should ensure that where a manager has responsibility for oversight of infection prevention control, this is specified in the job description.	2.2	Complete	
46. Health Boards should ensure that the Infection Control Manager has direct responsibility for the infection prevention control service and its staff.	2.2	Complete	

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47. Health Boards should ensure that the Infection Control Manager reports direct to the Chief Executive or, at least, to an executive board member.	2.2, 4.2	Complete	
48. Health Boards should ensure that the ICM is responsible for reporting to the Board on the state of HAI in the organisation.	2.2, 4.2	Complete	
49. Scottish Government should re-issue national guidance on the role of the ICM, stipulating that the ICM must be responsible for the management of the infection prevention and control service.	2.1, 2.2	**SGHD action.**	
50. Health Boards should ensure that there is 24-hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place.	4.1	24/7 Cover provided out of hours by on-call Microbiologists. Awaiting clarification on the national definition of 24/7 cover from SGHD. **SGHD action**	
51. Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings.	4.2	Complete	
52. Health Boards should ensure that adherence to infection prevention and control polices, for example C. difficile and Loose Stools Policies, is audited at least annually, and that serious non-adherence is reported to the Board.	3.3	Complete	

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53. Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time.	3.2	Complete	
54. Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available.	4.3	Complete	
55. Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level.	3.2, 4.2	Complete	
56. Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.	3.2, 4.2	Complete	
57. Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports and training reports.	3.2, 4.2	Complete	

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58. Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement.	3.2, 4.2	Complete	
59. Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable.	3.2, 4.2	Complete	
60. Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice, such as Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes.	4.3	Complete	
61. Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine infection prevention and control arrangements including policy implementation and cleanliness.	3.2, 3.3	Audit tool developed and is being used during FM/IPCT public partner audits. The audit tool is still to be fully evaluated.	

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62. Health Boards should ensure that senior managers accompanied by IPC staff visit clinical areas at least weekly to verify that proper attention is being paid to IPC.	3.3	Complete	
63. Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI,2 and that failure to isolate is reported to senior management.	3.1	Complete	
64. Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing with infected patients nursed in cohort bays with en-suite facilities.	3.1	Complete	
65. Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea.	3.1	Complete	
66. Health Boards should ensure that the healthcare environment does not compromise effective IPC, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective IPC practice, are not tolerated.	3.1	Complete	

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67. Health Boards should ensure that, where a local Link Nurse system is in place as part of the IPS system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.	4.3	Not applicable. We do not have local link nurses. NHSGGC utilises the national Cleanliness Champions programme and we have put in excess of 3,000 staff through the course including all senior charge nurses.	
68. Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patients care is involved in completion of the death certificate wherever practicable, and that such involvement is clearly recorded in patient records. Regular auditing of this process should take place.	4.1	Complete	
69. Health boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient's death.	4.2	Complete	
70. Crown Office and the Procurator Fiscal service (COPFS) should review its guidance on the reporting of deaths regularly and at least every two years.	2.1, 4.1	COPFS Action	

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71. Scottish Government should identify a national agency to undertake routine national monitoring of deaths related to CDI.	2.1, 4.1	**SGHD Action**	
72. Health Boards should ensure that a non–executive Board Member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHSGGC.	3.2	Complete	
73. Health Boards should ensure that OCT3 reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report.	4.2	Complete	
74. Scottish Government (whether through HPS, HIS,4 the HAI Task Force or otherwise) should as a matter of standard practice ensure that reports published in the UK and in other relevant jurisdictions on infection prevention and control and patient safety are reviewed as soon as possible, and that, as a minimum, any necessary interim guidance is issued within three months.	2.1	**SGHD Action**	
75. Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons.	2.1	Complete	